Message from the Health Minister George Abbott

In September 2006, the provincial government launched the Conversation on Health, the largest and most wide-ranging public discussion on health and our public health care system ever held in the history of our province. We asked British Columbians to take an active role in the discussion and help shape the future of our public health system.

As expected, British Columbians stepped up to the challenge. During the year-long Conversation on Health, we received more than 12,000 submissions. A total of 6,600 people registered for over 70 forums in every region of our province. Our web site recorded almost 6 million ‘hits’. We heard from ordinary British Columbians, patients, and health professionals. We also met with elected officials, Aboriginal populations, academics and children.

On behalf of the Government of British Columbia, I would like to convey my sincere thanks to every British Columbian who participated in the Conversation on Health. Through your participation you have helped to contribute to a stronger health care system and a healthier British Columbia.

I would also like to thank the staff of the Conversation on Health for the work they have done over the past year in meeting with British Columbians, collecting their input, and preparing and submitting this summary of input to government.

British Columbians are passionate about healthy living and our world class public health care system. They debated these issues in forums across the province, and debated them vigorously. The ideas and suggestions brought forward are thoughtful and articulate. At many forums we heard similar thoughts on how to improve our public health system. We also heard unique, innovative ideas that give pause for thought on how they can improve our system.

British Columbians told us they believe in:

- A strong and sustainable public health care system that delivers services to all British Columbians regardless of where they live, their incomes or their backgrounds and cultures;
More supports to promote greater responsibility for their own health and well-being, through sound health promotion and disease prevention and commitment to a healthy society and environment. These would provide them with the tools to stay healthy and manage their own and their families’ illnesses when they must.

An accessible system of care where health professionals and facilities offer choices and collaborate to provide integrated services; and,

An accountable and transparent system of care, where the patient comes first and where performance is measured against quality care, healthy populations and improved patient outcomes.

These themes represent some of the common views that emerged from the Conversation of Health. I encourage everyone to read the document and the summaries posted on the Conversation on Health web site, to understand the depth and scope of the many thousands of ideas put forth.

British Columbians are in agreement that change is needed to renew our public health system, but there are many opinions on what changes are needed and how soon those changes need to be made.

The input from British Columbians will guide us on healthy living initiatives, building upon the success of ActNow BC. Recommendations have been made in this document to strengthen the health of British Columbians through more disease prevention and health promotion activities. This was a common theme throughout the Conversation on Health as participants talked about moving from sick care to health care: keeping us healthy instead of focusing on treating us when we are sick.

British Columbians told us their thoughts on the health care delivery system and how we can make it run more efficiently and effectively by strengthening the principles of the Canada Health Act. They also gave us their thoughts on adding a sixth principle, sustainability. Innovation and implementing best practices were also common themes throughout the Conversation on Health.

Strengthening and expanding our health care workforce are key not only to health professionals but to all British Columbians. British Columbians and health professionals in the Conversation on Health talked about their workplaces, and their extraordinarily high commitment to the public good. Participants wanted us to think about integration of health care professionals and making full use of all of their training. We are proud of our health care professionals and we want to make sure that
they are satisfied with their jobs while the people of British Columbia benefit from their training by having the best health care in the world.

All ideas received through the Conversation will be reviewed for possible implementation in relation to the Canada Health Act and the principles of sustainability, accountability and improved patient outcomes, to help determine which recommendations will best strengthen and sustain the health system in the future. We will be reviewing this summary of input with great deal of interest and will be bringing forward our ideas and actions beginning in Spring 2008.

George Abbott  
Minister of Health
Message from the Parliamentary Secretary

Through the Conversation on Health, British Columbians have had the opportunity to engage in a dialogue with government and, more importantly, with each other.

They’ve tackled issues that are challenging for policy makers. Although these issues arouse strong emotions, the discussion remained respectful, thoughtful and focused on problem solving.

This summary of input represents far more than a list of objectives. Participants in the Conversation have placed their trust in this process and by extension in their political leaders.

As the Parliamentary Secretary for the Conversation on Health, I want to express my gratitude to all those who gave of their time, told their stories and proposed solutions.

As we work to analyze the report and give life to the ideas it contains, I am confident that the efforts of the Conversation on Health team and the thousands of participants will have a profound and positive effect on the future of Public Health Care in British Columbia.

Mary Polak
Parliamentary Secretary,
Conversation on Health
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Introduction

British Columbians and people across Canada see health care as one of their number one policy concerns. Canadians value their public health care system, and are passionate about debating its future. As governments become increasingly concerned with the rising costs of health care and the future pressures on the system, they need to consider changes to the system: its delivery, its funding, and its infrastructure. This is why the Government of British Columbia launched the Conversation on Health: to talk to British Columbians openly about these challenges, and seek their advice on how to address them.

The Conversation on Health was a year-long, unprecedented public engagement initiative that used a variety of facilitation techniques and communication channels to reach as many British Columbians as possible and understand their issues, ferret out the good ideas, and prepare for the future. Capturing the energy, vitality, interest and passion of British Columbians from every corner of this vast Province was the challenge set before the Conversation on Health when it was launched on September 28, 2006.

Process and Statistics

The Conversation on Health was guided by its key project principles: transparency, openness, inclusiveness, curiosity, innovation, focus and accountability. These principles guided the project in reaching out to British Columbians through three main streams of activity: public, health professional and health innovation.

Public Stream

The public stream used as many communication tools as possible to seek input from British Columbians, and remain true to the Conversation principles. These tools included a toll free phone line, an e-mail address, a website, and a mailing address, all of which were up and running at the launch of the Conversation. Through these channels, we received more than 12,000 submissions.

We held all-day public forums on Saturdays in 16 communities across the province between February and July 2007. Participants pre-registered so that prior to traveling to a forum they were assured of a seat. Travel costs for those coming from outside of a host community were covered to ensure that everyone could attend regardless of their financial situation. Each forum held up to 100 participants, and, in areas where
registration exceeded this number, we drew names using a random computerized selection process.

British Columbians who signed up for a forum came with something on their minds, so we came up with a format that would encourage them to engage, talk about what they care about, and move them to solutions in a short period of time. In the forums, participants started by setting the agenda, choosing which items they wanted to discuss, then working in small groups. Every participant had the opportunity to discuss and record what they came to say about health and health care. In the afternoon, ten set topics were presented and participants are asked to choose two. They then worked in small groups and the discussion was recorded by a facilitator.

In addition to these public forums, we also held patient focus groups in each of the 16 communities. Up to ten patients and their families came to share their experiences with the health care system and give us the benefit of their insight.

Since it was generally older people who were attending, we sought input from high school students through provincial-level forums. Students gave us some excellent feedback on how to improve their health in school, as well as some ideas on how high school students can lead their schools and communities to be and stay healthy.

We also held four Aboriginal community meetings. These sessions, co-hosted with the Cowichan, Gitxsan, Little Shuswap, and Seabird Island First Nations, provided excellent input into Aboriginal concerns around health and health care.

Health Professional Stream

British Columbia’s health professionals are passionate about their work and their patients. They have strong views about the health care system and they want to ensure those views are heard through the Conversation on Health. While the website, phone line, e-mail and correspondence were available to health professionals, we wanted to benefit from their experiences as both workers in, and users of, the province’s health system. A series of separate workshops with health professionals were held on Fridays in the 16 communities holding public forums.

The Friday morning sessions were attended by health professionals nominated by their associations and unions to discuss local and provincial issues. The evening health professional meeting was much like the afternoon component of the public sessions, inviting participants to discuss two issues of importance to them in small facilitated groups.
Like the public sessions, the records from all of these sessions were posted on the website. Meeting attendees provided uniformly excellent feedback on these sessions: they were seen as inclusive, open and representative. Interestingly, many health professionals noted that this was their first experience talking about health system challenges and solutions with members of other health professions.

Health Innovation Stream

The Health Innovation Stream of activities investigated more thoroughly some of the ideas put forward in the Conversation on Health in order to better understand those ideas and their application to our public health care system. We brought together experts, practitioners and decision-makers to study best-practices, innovative solutions, and ideas that have come forward from participants in the Conversation.

There were two main activities: a series of focused workshops on specific topics such as health human resources, and an International Symposium on Health Innovation. The latter activity brought together almost 150 thinkers, policy makers and practitioners from all over the world to help us understand their best practices and study their application to British Columbia’s needs and pressures. The focused workshops were smaller in scope and participation, and focused on a few key solutions identified to date in the Conversation on Health in primary care, seniors and aging, health human resources and delivery models.

How many British Columbians participated?

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<td>Letters</td>
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Reporting on What We Heard

As part of our commitment to openness and transparency, a weekly summary of input was posted to the Conversation website, along with transcriptions of all of the forum and meeting notes.

Our job is to accurately reflect what British Columbians are talking about. We compiled all of the input received into thematic summaries that describe the challenges, issues and ideas that British Columbians have discussed. Some of these summaries are quite lengthy as British Columbians have a lot to say about their health, the health of their communities and the health system in general. Each summary includes a short preface to give British Columbians an idea of the scope of issues included in that summary.

The following summary of input follows 78 meetings, more than 12,000 submissions, and a full year of engagement with British Columbians all over the Province. The summary of input has 45 sections, with short introductions to help you understand what you will read.

The summary of input does not represent a consensus. It represents all of the views and ideas presented during the Conversation on Health year-long process as accurately as possible. The views are those of the participants in the Conversation on Health and not those of the Ministry of Health or other government representatives. By reporting these comments and suggestions, the Government of British Columbia does not endorse or support them.

British Columbians talked about everything, from healthy environments and societies, to new models of running and financing health care, to addressing the concerns of our health care professionals. The summary of input is divided into three parts:

- Envisioning a Healthy British Columbia
- Envisioning a Strong and Sustainable System of Care
- Envisioning a Revitalized Health Care Workforce

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1 A visit measures the amount of unique IP addresses (individual computers) that visit a site.
2 A hit measures the number of files that are requested from a site.
3 Written Submissions Total = 76: By Association/Organization - 63; By Individual – 13.
4 Total Letters and Mail = 1,830: Letters = 537; Mail = 1,293 (includes written input to the Conversation on Health in the form of faxes, Comment Sheets from Forums, three-part postcards that the Conversation on Health distributed and mail forwarded from other parts of government to the Conversation on Health/mail not sent directly to the Conversation on Health that were not previously reported in the Conversation on Health Statistics).
5 Total includes registrations for public forums, patient focus groups, health professional focus groups, health professional forums, and Aboriginal forums.
Conversation on Health Process

The concept of and process for the Conversation on Health was raised by participants throughout the year-long engagement. They expressed concerns, praise and ideas, particularly around issues like costs, the background information on the website, the purpose of the initiative, and its utility. Here is a selection of what British Columbians had to say on the subject of the Conversation on Health.

General Comments

Some participants believed the Conversation on Health was a genuine effort at engaging British Columbians and some questioned whether the Government of British Columbia had already decided on a course of action. Regardless of which side of the debate they came from, participants for the most part engaged passionately in the discussions.

Submissions generally described the structure of the Conversation on Health as innovative for government, in the sense that it left much of the agenda-setting to the participants, particularly in the forums. That being said, some participants feel that this unstructured approach was, in itself, faulty in that it did not direct participants towards a clear objective or series of recommendations.

Advertising costs were a subject of much criticism, as were the costs and distribution of the pamphlet to households in late 2006. Some were pleased that they received the information. Some participants indicated that there was not enough advertising to know when and where the forums were being held or what the other channels of communication were.

Generally speaking, participants saw the website and phone channels as effective ways of gathering input from British Columbians. Aspects of the website, like the quiz and the health care expenditure clock on the banner, received criticism for being counter-productive and even misleading.

I very much hope that the "Conversation" is successful in generating useful ideas on changes we should undertake to ensure the long-term viability of our health care system.

- Email
Engagement

British Columbians encouraged the Conversation on Health to reach out to as many people as possible, and to pay special attention to marginalized populations. They also encouraged the initiative to hold focused sessions on key topics like primary care and mental health, or with under-represented groups such as youth and Aboriginal people.

A number of participants wrote and called to criticize the Conversation on Health for the organization of our forums, particularly for holding separate sessions for health professionals and for members of the public. British Columbians believed that this separation was counter-productive and that combining the two groups would lead to better informed debate and clearer decision-making. Others disagreed and, where health professionals showed up at forums, felt that their conversations were monopolized by the health professionals.

This is a good beginning but we want some assurance government will listen and act on the public input. Keep up the engagement.

- Regional Public Forum, Castlegar

Costs and Accounting

A number of participants criticized the costs of the initiative and felt that the money would be better spent on health care delivery. Others believe that the costs were relatively minor and would be money well spent if they led to significant positive changes and efficiencies.

British Columbians expressed concerns about the characterization of health care expenditures as unsustainable due to their growth as a percentage of the overall government budget. These same British Columbians typically encouraged the Government of British Columbia to compare health care expenditures against a different measure, such as the Gross Domestic Product. Other British Columbians believe that rising health care costs are a concern, and that sustainability is a serious issue that needs to be addressed.
Forums

The registration process for Conversation on Health forums was perceived both positively and negatively. Some participants felt that there were benefits to pre-registration, while others were concerned that the registration process was over-managed and was intended to ensure that only government supporters attended. Some from rural areas were pleased with the pre-registration as it assured them of a seat, which was important given their long travel time to the forums.

Some criticized the background information sent to participants and felt that it was biased. Others believed that this information provided good talking points to get conversation going.

The forums themselves were viewed by the participants as an overwhelmingly positive experience. Some continued to express cynicism about what use would be made of their effort and whether their input would be considered by the Government of British Columbia in the final analysis. A minority felt that the forum notes and discussions would not provide sufficiently in-depth analysis to assist the government to make decisions down the road.

_I had the pleasure of attending the Regional Forum in Kelowna this weekend. First I would like to congratulate you on a superb process for getting input in a disciplined, yet open manner._

- Email, Kelowna
Conclusion

Many participants, even those cynical about the process, wanted more discussion and consultation once the Government of British Columbia has settled on a course of action. Many differentiated the approach and nature of this process from other health consultation processes, while others remain concerned that there is a hidden agenda to undermine the public health care system. Many British Columbians were frustrated with this public engagement as another government project that puts off action in favour of study or debate. The clearest message from participants throughout the process was for the Government of British Columbia to stop talking and move to action. While this is an apparent contradiction with the desire for more consultation, many participants did in fact believe that there should be both more discussion and a move to action at the same time.

[We] hope the government shares the ideas generated with British Columbians and provides us with the opportunity to engage in a conversation as to what we want to do with the suggested solutions.

–Health Professional Forum, Richmond
General Comments on the Conversation on Health

Comments and Concerns

Reason for Holding the Conversation on Health
Process
Information and Advertising
Web and Phone Engagement

- Comments on reasons for holding the Conversation on Health:
  - Some of the ideas being expressed are in fact already being facilitated through government funding initiatives.
  - I applaud the government for taking the initiative to have this dialogue with the people. There have been lots of great ideas that are bang on.
  - The Conversation on Health is focused on health care expenditures, not value for money or improved health outcomes.
  - The Conversation on Health is an effort to convince British Columbians of inaccurate or erroneous information about health and health care.
  - The agenda is politically ideological.
  - Decisions have already been made. The process has no integrity.
  - The opening foundation for the Conversation on Health, to build a sustainable public health care system, contains an inherent bias that will direct the discussion towards a pre-conceived agenda.
  - The opening information creates fear among the public, which is manipulative.
  - The health care budget clock on the website is fear-mongering, crass, distracting, suspect, and obnoxious.
  - The Conversation on Health is a political initiative intended to demonstrate action, without taking action.
The main reason for the Conversation on Health is to see if British Columbians are open to privatization, or to convince British Columbians to adopt a United States style of health care.


The fact that the information suggests that the elderly cost the health care system too much is disgraceful.

The Conversation appears to be about costs, not about health care.

The Government of British Columbia is not prepared to consider the difficult solutions or even experiment with solutions.

The British Columbia Health Coalition says that health care is not sustainable.

Government cannot run health care rationally due to the ideological nature of politics.

The Conversation on Health does not cover homelessness.

It is important to hold the Conversation on Health.

It is important to recognize that the health system is not sustainable.

The Conversation on Health promotes community ownership of the health care system.

The way the Government framed the issue revealed that it has already made up its mind that the answer to our health care challenges is a greater role for private health care and a proportionately smaller role for public health care. Obviously, if it is interested in a legitimate conversation to determine British Columbians' wishes regarding our health care system, it would never have tried to frame the debate as negatively as that.

Comments on the process of the Conversation on Health:

- The structure of the conversation, with its meaningful engagement of the public, health professionals and patients, is a breath of fresh air.

- The Conversation on Health connects people, and shows people that they are not alone in their views.

- While current political rhetoric significantly evades touching on the issues so often raised in the process of the Conversation on Health pending evidence of the action phase, our view of the potential outcome remains optimistic.

- The process appears too controlled.

- Similar initiatives have not resulted in anything positive.

- The general population cannot make informed decisions or suggestions around health care. The Government of British Columbia should only be discussing health care with health care professionals.
• There have been too many conversations and dialogues on this topic and not enough action.
• Do not spend money on expensive trips to Europe.
• There have been enough studies that we now know what to do; we just need to do it.
• The Government of British Columbia should not ignore the results of the Romanow Report.
• Input will be filtered and the Conversation on Health will only print opinions and ideas consistent with those of the Government of British Columbia.
• The system did not breakdown overnight and we all know something ought to be done, so the Conversation on Health is a waste of money. A business person could turn this situation around.
• There is too much focus on complaints and not solutions.
• The report from the Conversation on Health will not be read or acted upon.
• The Government of British Columbia will simply cherry-pick what they already intended to do from the record of the Conversation on Health.
• There is insufficient participation in the initiative to rely on the results in order to make changes.
• There is no emphasis on the need to discuss accountability and governance.
• Experience with the failings of the system is what drives many of us to participate in these online discussions and offer alternatives.
• There is no coordination of the Conversation on Health with initiatives happening right now.
• There is opportunity for all to have input of concerns and suggestions regarding the provincial health care system.
• We appreciate those who participate in the Conversation on Health.
• The Conversation on Health will encourage ideas that are worth looking into.
• This process has embodied the true spirit of public consultation through its broad reach, transparency and variety of mechanisms for engaging the citizenry throughout British Columbia.
• The Conversation on Health is a start at solving the problem.
• The Conversation on Health is an important means to help health professionals and the public give input and share viewpoints about the way the health care system is managed and the type of health care system British Columbians would like to see in the future.
• The Conversation on Health will encourage British Columbians to make a statement on what Canadians should expect in the way of services and the new way of delivering these services at a cost that is reasonable and sustainable.
The ideas identified have merit.
I believe it is very important to get the grassroots input, and that coupled with the very knowledgeable bureaucrats, should give a sound direction to the future of our health program.

It is a very democratic process.

It is terrific to see so many people taking part in this.

It is amazing that any government has the courage to open a dialogue about such a sensitive issue.

This initiative provides a mechanism to engage all British Columbians in a collaborative effort to identify ways to improve health care and to recognize that choices and tradeoffs are required to ensure the program remains sustainable.

Conversation on Health participants have been constructive in their criticism of the system and have put forth concrete solutions.

Community creativity provides us with many innovative solutions. We need to share these ideas.

The Conversation on Health provides a critical opportunity to dialogue with the government and the public about challenges facing the health care system and the role that innovative medicines can play in improving health outcomes, building a knowledge-driven economy, and ensuring sustainability.

Compared with the traditional way of developing health policy by commissioning an elder statesman, or eminent provincial academic, the Conversation on Health is a breath of fresh air. With its forums, website, newsletter, and on-line discussion groups, an open structure has been created that supports a transparent and well resourced initiative. With the process and structure in place we can now look forward to outcomes that should be responsive to health consumers and providers in British Columbia.

The BC Nurses' Union has addressed all the issues in this brief to governments at all levels for many years. This Conversation on Health is just the latest in a long line of consultations in which we have participated.

From the ways the government has set up the exercise and articulated the issues, we cannot be optimistic.

When the Premier announced The Conversation on Health, I was highly skeptical that the process would involve a legitimate, democratic "conversation" with the people of British Columbia.

If this Conversation on Health exercise allows the Province of British Columbia to identify future policy options and strategies to move towards a more sustainable healthcare system it will be a resounding success.
• Comments on information and advertising:
  • Television advertising is a waste of time and money. Spend television advertising money on health care.
  • The house holder is a waste of money and was too large.
  • Information in the conversation starters is wrong.
  • The information is inherently ageist and directly blames the ageing population for the growth in spending.
  • Some of the questions in the house holder and conversation starters are leading to specific answers.
  • More advertising is needed for the forums.
  • There is no mention in the material of the cuts in federal transfer payments to health care.
  • Did You Know section on the website is misleading because it does not break down health care costs (for example, into capital and infrastructure and direct service costs).
  • There is a defeatist attitude shown in the way the government talks about unsustainable health care, ageing population and so on.
  • The whole initiative is structured around financial problems, which limits its utility.
  • Information inconsistent with the government view should be posted if the process is really open to all ideas.
  • The media only makes negative reports.
  • Nanaimo is misspelled in the advertising.
  • There is insufficient information available on complementary and alternative medicines.
  • The $35 million figure on the house holder grabbed attention and encouraged participation.
  • Weekly reports have been useful in allowing for expansion on the ideas or proposals that some may have.
  • The house holder is a good thing. We do not want a United States model and the contents of the flyer remind people to look after the one we have.
  • The house holder explains in clear writing what the problems are and what the costs are going to be.
  • We are concerned that these claims [on the materials and advertising] are motivated by a desire to convince British Columbians to opt for more user pay, private for-profit health care schemes favoured by some in government, rather than an attempt to improve public health care.
• Comments on web and phone engagement:
  • Little weight should be given to the results of the web poll. The nature of the questions will skew the answers. The fact that the strongly agree option on the web poll is already chosen will tend to skew the answers.
  • The postings appear to be screened.
  • The online poll is not statistically significant.
  • References to other sources in participant submissions posted to the website are removed.
  • The Web information is quite tedious.
• Technical Issues:
  a. There is concern that some would not be able to participate through the web submission function (What’s On Your Mind) due to technical complexities.
  b. The website registration did not work and was too cumbersome.
  c. Links on the website did not work.
  d. The web site is slow.
  e. Those with slow internet connections could not work with the website due to the videos.
  f. Hold music on the 1-800 telephone line is bad.
• Rules of conduct for the online dialogue were seen as a gag order.
• Some are using the online dialogue as a way to make comments about the Government of British Columbia.
• The phrasing of online dialogue questions is leading.
• There is no verification that a web poll vote has been received.
• There is no provision for the hearing impaired.
• Your Questions Answered does not answer the questions directly.
• Some online dialogue questions are loaded and leading.
• It is a handy and attractive looking website.
• Nice job on the website.
• The phone line employees were helpful.
• I submitted website links in the online forum to pages which noted ways in which we could save millions of dollars by improving patient access to some modalities. These were not included. In other words, the government is saying that this site has been created simply to let the public blow off steam and then accept being ignored!
Ideas and Suggestions

Reasons for Holding the Conversation on Health
Process
Information and Advertising
Web and Phone Engagement

• Ideas about the reasons for holding the Conversation on Health:
  • Continue to lobby the government for more funding and to dispute their figures.
  • Listen to the nurses.
  • Pay attention to the Romanow Report.
  • Hold a two day strategic planning process and report on progress around the plan quarterly.
  • The Government of British Columbia should really listen.
  • Focus on improving health outcomes.
  • Governments, both federally and provincially, need to take a hard look at the challenges facing health care systems, and set aside the rhetoric.
  • 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.
  • 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.
  • Move to action.
  • Do not hold a Conversation on Health.
  • Broaden the scope of the Conversation on Health so that it includes topics outside of health care deliver and includes other services and issues which have an impact on health care.
  • Follow the Conversation on Health with information on health promotion.
  • The changes proposed by Government should be reviewed in peer-review journals.
  • Listen to the results.
  • Use a Citizens’ Assembly structure to address health care issues.
  • The outcomes from this Conversation on Health process must produce a listing of important, sustainable actions.
• It is critical for the government to seek to balance these many competing interests, rather than make your decisions based on the volume of submissions mustered by one camp or the other.

• Ideas about the process of the Conversation on Health:
  • There should be a report back on the progress in health care at least quarterly.
  • Members of the Legislative Assembly (MLAs) should hold public forums in local communities rather than wasting money on this initiative.
  • Stop undertaking consultation exercises and take action.
  • We need strong leaders who think outside the box and have a vision and a passion that supports the well being of everyone they represent.
  • Have a Canada-wide conversation at various medical colleges and institutions that would focus on a five-year outlook and sound implementation of policy with a strategic selection of participants.
  • Have more forums modeled on town hall meetings, regularly scheduled, where people can ask questions, receive answers, and provide input.
  • Do regular random patient surveys.
  • Engage stakeholders and others in the development of new policies and actions arising from the Conversation on Health.
  • We need to assure that evaluation of the system is thorough, consistent, ongoing and responsive to individuals. The services the health system provides make up part of what is needed to create and maintain a healthy lifestyle.
  • Engage in the Conversation on Prevention.
  • Have an ongoing Conversation on Health or an ongoing dialogue on health.
  • Creating a conversation also means that we are very hopeful that the listening, the analyzing, the prioritizing and the humanizing of decisions will follow.
  • From the Conversation on Health, develop a strategic health plan for health authorities to follow.
  • Keep solutions within the framework of the Canada Health Act.
  • Take three bold actions from the Conversation on Health, not a hundred little ones.
  • Create a national conversation on health.
  • Support these initiatives in order to better inform decision-makers about important public policy decisions.
• We hope the action plan arising from this process will demonstrate a strong vision for a future which focuses on patients' needs and their safety. In developing the action plan, we hope that the various components of the change citizens deserve will inform the process and be addressed in a clearly observable manner, first in planning and shortly thereafter in the experience of primary health care providers across the province.

• This is a good beginning but we want some assurance government will listen and act on the public input. Keep up the engagement.

• Ideas about information and advertising:
  • Add links on the website to alternative views and perspectives on health care.
  • Questions posed should be open-ended, not rhetorical.
  • Ensure that we report on positive health care stories.
  • Do not group mental health and addictions together.
  • Provide a glossary of terminology in the final report.
  • Provide executive summaries and links to key reports such as the Romanow report and the Report on the European Fact Finding Mission.
  • Do not use television advertising.
  • Improve and increase advertising for forums.
  • Look to evidence that health care is putting information out to the public.
  • Use plain language.

• Ideas about web and phone engagement:
  • Keep the online dialogue going after the Conversation on Health is over.
  • Web poll answers should all initially be blank.
  • Move electronic written submissions to the What We’ve Heard section.
  • Make the website more user-friendly and accessible and more appealing (less bureaucratic).
  • We need more information on the website on costs, and breakdowns of costs.
  • Send a confirmation when a registration or input is received.
  • Eliminate the health expenditure clock.
  • Provide a topic search function.
  • Change the wording on the online dialogue questions so they are less leading and more open-ended.
  • Ask demographic questions of participants to better understand trends.
  • Have a neutral person review the website to identify navigation problems.
Outstanding Questions

Where can we see what everyone has submitted?
Are there forums for health professionals?
What are the next steps?
Are the comments on the website edited?

Engagement

Comments and Concerns

Engaging All British Columbians
Engaging Health Professionals
Engaging Rural British Columbia

- Comments on engaging all British Columbians:
  - The poor in British Columbia do not have the time or money to participate in the Conversation on Health.
  - Information collected will not be representative of all British Columbians.
  - It is primarily middle class people in attendance at forums.
  - There is lack of access by Aboriginal people on reserves to the Conversation on Health due to lack of phone and internet services.
  - There should be more forums in the north.
  - Caregivers of dementia patients may have found it difficult to participate in the Conversation of Health, so few were able to spare the time to attend.
  - Those people who opt not to participate are from the two more important groups: the funders of healthcare and the users of healthcare. These two major groups end up relinquishing control over the future of the systems to those who benefit directly from an expansion the current system.
  - It tends to be groups with particular agenda or interests they wish to advance that are called to action. The majority of ordinary British Columbians sit on the sidelines observing the process.
  - An important public initiative like the Conversation on Health presents an open invitation to any and all stakeholders to weigh in on the debate.
• Comments on engaging health professionals:
  • You need to engage health care professionals in the Conversation on Health and in public forums.
  • Separating health care professionals from the members of the public means there will be no direct exchange of ideas.
  • Employees of health authorities should not be banned from participating.
  • Implicit in this separation (if one was to adopt a negative view) is also that health professionals are biased, self-serving and as such their perspective is less valued.
  • No interest-group is more important than any other.
  • Some health professionals may be intimidated about being in the room with doctors.
  • There was lack of clarity that there would be separate sessions for health professionals.
  • I wanted to share my ideas, but I’m frustrated that the nurses and hospital workers at the meeting managed to elbow their way to the front, take control of the conversation, and create the impression that the general public is somehow in the know that the current system is just fine, and just needs more money.
  • I would like to speak but I worry about the consequences this may have at work in a public health care facility. We do not really have freedom of speak in this country, do we?

• Comments on engaging rural British Columbia:
  • Rural issues were excluded from the house holder.
  • Rural British Columbians were not effectively included in the forums due to the long distances between centres.
Ideas and Suggestions

Engaging All British Columbians
Engaging Health Professionals
Engaging Rural British Columbia

• Ideas about engaging all British Columbians:
  • Invite all British Columbians, stakeholders and organizations to participate, even those that disagree with the Government of British Columbia’s positions.
  • Create informed debates with knowledgeable people to inform the discussion.
  • Hold Aboriginal and youth forums.
  • Hold a focused workshop on primary care.
  • Follow different patients through the system to see how they are treated.
  • Engage all ministries in order to deal with all social determinants of health.
  • Hold a separate session on mental health.
  • The Government needs to take a leaf out of industry’s books: listen to the consumer; weigh what the consumer is saying; and make inroads on overcoming the shortfalls identified.
  • It is imperative that the solutions and ideas be treated with the utmost respect.
  • Hold aboriginal forums.

• Ideas about engaging health professionals:
  • Include front line workers in the Conversation on Health.
  • Send a questionnaire to all health care workers.
  • Health care workers and the public should participate in forums together.
  • The Minister of Health should undertake surprise visits to health facilities to see what they are like.
  • Remove the gag order on health care workers’ participation in the Conversation on Health.

• Ideas about engaging rural British Columbia:
  • There should be a survey of doctors of specialized medicine who travel and hold clinics in Northern British Columbia and a survey for the patients who received treatment from them.
  • Hold more forums in the north.
  • Include information on northern and rural issues in information packages.
  • Create a rural issues report from the Conversation on Health.
Costs and Accounting

Comments and Concerns

Costs
Accounting

• Comments on costs of the Conversation on Health:
  • Investment should be made in health care, not the process of the Conversation on Health.
  • Investment should be made in health care and housing before the Olympics.
  • The Conversation on Health is an effort to bankrupt the public system in order to support privatization.
  • Figures quoted by the Government of British Columbia amount to $10 per day per person for health care, which is sustainable.
  • Growth in health care spending has remained consistent as a percentage of the Gross Domestic Product and is therefore sustainable.
  • The $10 million for this Conversation on Health could have been better spent on health care.
  • We need clear facts on costs across the health care system.
  • The initiative could have been undertaken much more cheaply, for instance, just through surveys and e-mails.
  • Don’t waste government money. We need less talk, and more action.

• Comments on accounting:
  • The Ministry of Finance statistics relating to the total amount of the budget which will be used by health care in the coming decades were vague.
  • We reject the grossly misleading claims from the government that if nothing is done, health care could consume 71 per cent of the provincial budget by 2017.
  • We are concerned that government claims about unsustainable health care spending are deceptive, if not outright false.
  • Large tax cuts have superficially inflated the percentage of the budget taken up by health care. This is the kind of slight of hand that the provincial government has used to fabricate a crisis where none exists.
Ideas and Suggestions

Costs

Accounting

- Ideas about the costs of the Conversation on Health:
  - Use the Gross Domestic Product measure to accurately reflect growth in health care costs.
  - Spend money on health care not the Olympics.
  - Use the $10 million to design a health care system that addresses the challenges.
  - Do not hold expensive forums: just gather information through web, phone and email.

- Ideas about accounting:
  - Provide information on health care costs which is clear, complete and broken down.
  - Clarify what procedures are publicly-funded and how much they cost.
  - Discuss issues associated with federal transfer payment cuts.
  - Pick a baseline year, such as 2000, and then numerically quantify the actual growth that has occurred through 2005 in the health care services that are most important to us, such as the availability of family doctors, specialist physicians, nurses, other critical health care professionals, ambulance staff and vehicles, hospital emergency facilities, hospital treatment facilities, hospital beds, diagnostic services, surgical and other treatments and therapies performed, long-term care facilities, and so on. Then, continue to inform us by projecting the extent to which each of these elements of the health care system must expand in the future in order to meaningfully reduce all wait times to a level acceptable to the population at large and at the same time, fully respond to the increased demand for health care services that will result from population growth, from expected demographic changes, and from improvements in medical technology, over the next decade, say, from 2007-08 through 2016-17 or beyond.
Forums

Comments and Concerns

Information About and Attendance at Forums
Participant Feedback
Session Evaluations

• Comments on information about and attendance at forums:
  • 100 participants are not sufficiently representative.
  • A limitation on the number of participants limits the true measure of concern around our health care system.
  • There should be more forums in more communities.
  • Hopefully not only health professionals will attend, because useful information can be had from users of the system.
  • Politicians do not stay at the forum to hear all of the input.
  • The people in attendance will not know anything about what they are recommending.
  • People with vested interests should not attend.
  • Participants will be screened.
  • There is lack of clarity around where and when the forums will be held.
  • Information about forum registration came too late.
  • People cannot attend forums outside of their Health Service Delivery Area.
  • Some people who registered complained that they were not randomly selected to attend the forum in their area.
  • The forum in Vancouver is difficult to attend for someone from the Sunshine Coast.
  • There should be more than one forum in Vancouver to allow for more participants.
  • Substitutes are not allowed, even if they show up at the event, when a participant cannot make it.
  • People should be allowed to walk in.
  • There is an inherent self-selection bias because only people with a vested interest will sign up.
  • The registration process was unclear.
  • There are benefits to pre-registration.
• Comments from forum participants:
  • Participants enjoyed the day and the format.
  • Participants are skeptical about whether the results will be considered in future health care planning.
  • The facilitators did an excellent job of keeping the discussion on track.
  • There were too many special interests in attendance.
  • The facilitators were earnest.
  • The day was smoothly run.
  • Material provided in advance was biased towards a government perspective and pushed privatization.
  • There is a concern that the Province of British Columbia will interpret the information gathered at the forum to suit its own interests.
  • Participants appreciated that facilitators were public servants.
  • A broad array of topics were discussed.
  • Forums can give politicians the power to implement change.
  • It was a superb process for getting input in a disciplined, yet open manner.
  • It was a great process. The Conversation on Health should be commended for organization and pre-planning.
  • The idea of packages distributed prior to forums for preparation was excellent.
  • It was an excellent process that truly gives people the opportunity to voice their concerns, and also creates an obligation for everyone to listen.
  • Participants gained brilliant insight, awareness and passion from citizens with a variety of backgrounds.
  • It was a good exercise in citizenship and democracy.
  • The Courtyard Cafe was a good format; it was good to have facilitators.
  • I attended the Conversation on Health that was held in Vancouver. There were a lot of people there who had ideas, and a lot of them were good ideas. The reason I was disappointed because there were so many health care workers there, acting as if they were just ordinary, unbiased citizens. I am frustrated that the nurses and hospital workers at the meeting managed to elbow their way to the front, take control of the conversation, and create the impression that the general public is somehow in the know that the current system is just fine, and just needs more money.
  • I appreciated conversation which was very educational and made me proud to be part of such a passionate community and a little less pessimistic than when I walked in.
Innovative ideas were put forward.
I appreciated that there were no government officials present during the day.
Some participants would have liked to have elected government officials present during the session.
It was a great opportunity for the average person to have input.
Participants felt heard and like they were part of the solution.
During the day we worked with people with different perspectives and it is almost like anytime you are involved in planning you just sit down with people who see things the same way. But after having the opportunity to spend a lot of time with people who had different perspectives, there was a lot of learning. I actually learned quite a lot, and I have to say it was a very valuable experience.
I would like to take a moment to congratulate you for this consultative process, and for making the space, creating the pause and posing the question about progressing health.
Participants were encouraged at the possibility of improvements.
Sometimes an individual would monopolize the discussion at a forum table.
Some facilitators did not listen.
The facilitators were not able to answer specific questions about health and health care.
There was no clarity around how the project will be accountable back to the participants.
What I found today was much of this information was not in enough detail to move any of the issues forward in a more thought out and comprehensive fashion; the solutions were very high level. I also think we only touched the surface in terms of what the issues and options are.
Information distributed in advance was insufficient, incomplete and did not provide different perspectives.
The health spending clock at the forums was not helpful and was seen as a scare tactic.
The opening speeches at the forums focused on increasing costs and pressures in order to create fear.
Facilitators were not on top of the subject matter, and lacked the experience needed to elicit the most out of each subgroup.
The day was too short.
Some participants felt frustrated.
There was too much focus on privatization and not enough on issues like the social determinants of health and service delivery.
Some vested interests monopolized the agenda.
The notes on flip charts did not convey the complex thoughts of the participants.
Limited summaries were made available on the website.

Ideas and Suggestions

Information About and Attendance at Forums
Participant Feedback

- Ideas about information about and attendance at forums:
  - Forums should not be limited (in numbers).
  - Forums should be televised.
  - Anyone who wants to attend a forum should be able to.
  - Confirm that the first 100 to register will be selected, rather than using a random selection.
  - Hold forums on the weekend.
  - Provide information to participants from previous forums so they do not go over the same material each time.

- Ideas from forum participants:
  - Provide more structured discussions at the forums using existing facilitation tools such as appreciative inquiry.
  - Do not use public servants as facilitators.
  - Eliminate the health expenditure clock.
  - Have politicians stay for the forums.
  - Cut back on lunch and use the money for hand sanitizers to avoid spreading colds and influenza.
  - Ensure healthy food choices are provided.
  - Do not provide funding assistance to attend forums.
  - Carry messages from the forums to the decision-makers.
  - We need to find ways to cover all these topics in the Aboriginal community, and have more discussions.
### Session Evaluations: Roll-Up for All Public Forums

Rated on a scale of 1 to 5 (with 1 being “strongly disagree” and 5 being “strongly agree”)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Median</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>I found the session to be a worthwhile experience</td>
<td>4</td>
<td>4.23</td>
</tr>
<tr>
<td>The session format allowed me to share ideas</td>
<td>5</td>
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</tr>
<tr>
<td>The session format allowed me to hear ideas</td>
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<td>4.47</td>
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<tr>
<td>I found the agenda setting valuable</td>
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<tr>
<td>I found the morning small group discussions valuable</td>
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<tr>
<td>I found the afternoon workshop valuable</td>
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<td>4.28</td>
</tr>
<tr>
<td>I found the session facilitator effectively presented materials and concepts</td>
<td>5</td>
<td>4.42</td>
</tr>
<tr>
<td>I found my afternoon facilitators effectively presented materials and concepts</td>
<td>5</td>
<td>4.34</td>
</tr>
<tr>
<td>I found the report back and wrap up of the day valuable</td>
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<td>4.04</td>
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<tr>
<td>I felt my participation in the session allowed me to contribute to the Conversation on Health in a meaningful way</td>
<td>4</td>
<td>3.99</td>
</tr>
<tr>
<td>I would recommend to others that they participate in future Conversation on Health sessions</td>
<td>5</td>
<td>4.34</td>
</tr>
<tr>
<td>The venue was appropriate to the needs of the session</td>
<td>5</td>
<td>4.12</td>
</tr>
<tr>
<td>I found my participant registration package materials helpful in preparing for this session</td>
<td>4</td>
<td>4.10</td>
</tr>
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</table>
### Session Evaluations: Roll-Up for All Health Professional Meetings

Rated on a scale of 1 to 5 (with 1 being “strongly disagree” and 5 being “strongly agree”)

<table>
<thead>
<tr>
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<tr>
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<td>The session format allowed me to share ideas</td>
<td>5</td>
<td>4.31</td>
</tr>
<tr>
<td>The session format allowed me to hear ideas</td>
<td>5</td>
<td>4.48</td>
</tr>
<tr>
<td>I found the small group discussions valuable</td>
<td>4</td>
<td>4.24</td>
</tr>
<tr>
<td>I felt my participation in the session allowed me to contribute to the Conversation on Health in a meaningful way</td>
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<td>3.94</td>
</tr>
<tr>
<td>I would recommend to others that they participate in future Conversation on Health sessions</td>
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</tr>
<tr>
<td>I found the session facilitator effectively presented materials and concepts</td>
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<td>4.39</td>
</tr>
<tr>
<td>The venue was appropriate to the needs of the session</td>
<td>5</td>
<td>4.35</td>
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</tbody>
</table>
### Session Evaluations: Roll-Up for All Health Professional Focus Groups

Rated on a scale of 1 to 5 (with 1 being “strongly disagree” and 5 being “strongly agree”)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>I found the session to be a worthwhile experience</td>
<td>4</td>
<td>4.31</td>
</tr>
<tr>
<td>The session format allowed me to share ideas</td>
<td>5</td>
<td>4.51</td>
</tr>
<tr>
<td>The session format allowed me to hear ideas</td>
<td>5</td>
<td>4.58</td>
</tr>
<tr>
<td>I found the small group discussions valuable</td>
<td>4</td>
<td>4.50</td>
</tr>
<tr>
<td>I felt my participation in the session allowed me to contribute to the Conversation on Health in a meaningful way</td>
<td>4</td>
<td>4.10</td>
</tr>
<tr>
<td>I would recommend to others that they participate in future Conversation on Health sessions</td>
<td>5</td>
<td>4.40</td>
</tr>
<tr>
<td>I found the session facilitator effectively presented materials and concepts</td>
<td>4</td>
<td>4.66</td>
</tr>
<tr>
<td>The venue was appropriate to the needs of the session</td>
<td>5</td>
<td>4.42</td>
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</table>
### Session Evaluations: Roll-Up for All Patient Focus Groups

Rated on a scale of 1 to 5 (with 1 being “strongly disagree” and 5 being “strongly agree”)

<table>
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<tr>
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<tbody>
<tr>
<td>I found the session to be a worthwhile experience</td>
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<td>4.49</td>
</tr>
<tr>
<td>The session format allowed me to share ideas</td>
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<td>4.60</td>
</tr>
<tr>
<td>The session format allowed me to hear ideas</td>
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<td>4.66</td>
</tr>
<tr>
<td>I found the small group discussions valuable</td>
<td>4</td>
<td>4.43</td>
</tr>
<tr>
<td>I felt my participation in the session allowed me to contribute to the</td>
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<td>4.16</td>
</tr>
<tr>
<td>Conversation on Health in a meaningful way</td>
<td></td>
<td></td>
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<tr>
<td>I would recommend to others that they participate in future Conversation</td>
<td>5</td>
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</tr>
<tr>
<td>I found the session facilitator effectively presented materials and</td>
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<tr>
<td>concepts</td>
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<tr>
<td>The venue was appropriate to the needs of the session</td>
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</table>
British Columbians expressed a strong view about health and what it means to us as a province. In this section of the Final Report, you will read some of the ideas and concerns of participants around their vision of a healthy British Columbia, which includes:

- Empowering people to make healthy choices and live healthy lifestyles;
- Supporting a healthy society and environment;
- Keeping people safe in their communities and workplaces; and,
- Focusing on Aboriginal people, seniors and people with disabilities.

In this section:

Health Promotion
Lifestyle and Health
Self-Care
Social Determinants of Health
Food Quality and the Environment as Determinants of Health
Chronic Diseases
Public Safety
Workplace Safety
First Nations
Seniors
People with Disabilities
Health Promotion

Health promotion and disease prevention were two of the most common discussion topics in the Conversation on Health. The importance of addressing issues related to funding and costs, program delivery, education and awareness, health promotion in schools, and the role of health professionals and legislation were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of health promotion.

Health Promotion

It is widely understood that encouraging wellness reduces the strain on the health care system. There was concern that the health care system is currently designed to react, to fix problems rather than focus on prevention. The majority of participants believe that for a sustainable health care system, we must continue to promote increased personal responsibility for health, and prevention of disease and dysfunction. Many emphasized healthy public policy as a critical component in shifting health care from an illness driven model to one that focuses on the health status of the population.

Participants want healthy public policy to focus on population health, emphasizing health status, equity, and multi-disciplinary elements, consistent with the principles of primary health care. Given that unhealthy living can lead to expensive remedial medical procedures and hospitalization, many believe that an ounce of prevention is less expensive than medical intervention later on in life. However, some emphasize it is important to remember that “while prevention and health promotion are laudable, they are not the be-all-and-end-all of health care”; there is still a place for illness-care in the system. Some recommended the creation of a health promotion framework similar to the new Primary Health Care Charter. Many suggested setting targets and monitoring them to measure successes in health promotion. The importance of making programs accessible, recognizing the influence of social determinants of health, was often discussed.
There are a lot of barriers to accessing prevention programs because people do not understand the system. We need to address this... There are so many marginalized populations due to poverty, mental health issues, and the remoteness of where people live. A prevention-oriented approach needs to be something that is available to everybody, not just to people who live in urban centres and who are literate and speak English and have access to resources. I think it needs to be... universal, just like the universal health care system needs to be universally available

- International Symposium, Vancouver

Funding, Resources and Costs

Participants understand that health promotion and population health initiatives take about 20 years before they show a benefit. Many voiced concerns related to the cost of prevention and health promotion for the individual with some stating that prevention is not a solution to a cost problem; it only extends the inevitable. Some expressed that although we have all heard of how proactive health measures, rather than reactive ones, will ease the strain on the system, in the long run the fact remains that it costs more to get fit than it does to get sick. Many emphasised that a lot of disease prevention services are non-insured services.

We need to spend more money in prevention. It seems like a lot of money up front, but it would be very fiscally responsible long term. People who can eat properly and exercise, will be healthier long term

- Online Dialogue, Westbank

Many suggested there is inequity in the allocation of funding for healthy initiatives in communities. Recommendations for funding at the community level included: making more grants available for infrastructure improvements like biking trails and swimming pools; investing in parks; subsidizing recreation; and, designating a higher percentage of the total health care budget to health promotion and disease prevention on an ongoing basis. The majority of participants agreed there is a need for long-term, committed funding in health promotion and that funding decisions need to consider long term benefits. Many believe that by investing in the health of children we are investing in the future health of the entire population.
Health Promotion in Schools

Participants discussed the importance of gearing health promotion efforts towards school-aged children. Many suggested there should be a health education strategy from kindergarten to grade 12, with School Boards and government working together to engage parents in taking responsibility for their children’s health. Others supported changes to the curriculum to include a focus on health across all subjects. Participants discussed: mandatory physical education programs; focusing on exercise in the schools rather than athletics; supporting additional athletics programs; providing meal and nutrition programs in schools; promoting active living; teaching decision-making and relationship skills; and, instituting a sports curriculum requirement where students are required to complete a certain number of credits per year.

Many listed the cost of exercise and team sports as a barrier to participation. Some suggested that health education, including creating and maintaining a healthy diet and fitness plan, should be mandatory and a passing grade should be a condition for obtaining a high school certificate. Participants recommended focusing on environmental approaches to risk factor interventions, including promoting healthy foods, curtailing access to unhealthy foods and creating opportunities for physical activity.

*Involve youth in healthier decisions at school, improve school atmosphere for youth, promote fun activities for recreation and well-being*

- BC Student Congress, Vancouver

Some believe there should be regular medical visits by paediatricians within the schools, followed by interventions targeted at high-risk children. Others feel that community health nurses or nursing students could have an important role to play in schools. While many discussed the shortage of physical education specialists in British Columbia, there was agreement that the curriculum for all teachers needs to include a focus on health courses and healthy living.
Program Delivery

Many expressed concern that there is no mechanism for public, community involvement in the delivery of health promotion programs. They also suggested there is no linkage between the health system and the non-profits who carry out many community programs. Participants recommended supporting outreach programs to combat problems such as diabetes, obesity and smoking, coupled with a focus on nutrition, exercise and education to help communities become healthier. Outreach programs were also recommended for vulnerable or high risk populations.

Many suggested encouraging behaviour change by working with community driven solutions that reflect holistic and cultural issues and focus on the social determinants of health. Many conditions are preventable with early screening and education, and participants supported the idea of a yearly free health maintenance check-up. Some looked to the ActNowBC program as indicative of the positive potential of health promotion efforts. However, although they suggest the involvement of all ministries in the program is ground-breaking and the program is widely successful, some believe it ignores systemic issues, such as poverty. Participants supported focusing on positives instead of negatives in health promotion efforts.

*The most powerful measures for tobacco control have been identified through 40 years of global research and implementation. Although the data concerning obesity control, healthy eating and physical activity are still emerging, it is likely that the lessons from smoking will very much apply. Tackling obesity is going to require a comprehensive approach ranging from systemic/environmental levers through social marketing and community programs, to intensive clinical treatment and prevention. It is possible that many scenarios will need to be tried and evaluated before the optimum plan for responding to the obesity epidemic is realized. In the meantime, the crisis is too urgent to allow a policy of inaction.*

- Written Submission, BC Healthy Living Alliance

Education and Awareness

Participants explained that there is a lack of information in easily accessible and understandable formats that promotes healthy choices. Also, the information that is available on existing services can be inconsistent. While they agreed that people have a responsibility to ensure they are making healthy decisions, they emphasized that there are large portions of the public who lack the information needed to make good choices. While many suggested that mass advertising does not address the cultural and social barriers to increasing activity, they see social marketing as key to change.
Recommendations to increase awareness of health promotion programs and disease prevention included: focusing on prevention through partnerships and education; launching public service ad campaigns that teach consumers about healthy food; holding public campaigns to make biking and gardening fashionable; opening up discussions related to drug addiction; and, targeting programs to at risk youth. Many agreed a universal system of medical information must be available throughout the province and the country. They suggested the Government should take the lead in educating people about healthy lifestyles, supporting a strong focus on health and healthy living in our schools, communities and the media.

\[\text{Start early in childhood to teach self esteem, nutritional values, safety issues and realistic values around respect for self and others. Increase public health services to push towards raising an aware and educated generation}\]
- Regional Public Forum, Nanaimo

**Health Professionals**

Many suggested that there needs to be a paradigm shift in health care, moving from a focus on acute, immediate health care needs to a prevention oriented system. Participants suggested that physicians should receive more in-depth training in nutrition, and receive remuneration for wellness counselling. Many recommended using multi-disciplinary teams working in schools and communities to support healthy living initiatives, with wellness counsellors available to provide coaching, guidance, information, role modeling, and follow-up. Some also supported the use of community nurses and pharmacists for prevention and education.

Weighing patients regularly or providing people with an individual report card as to the status of their health were also suggestions related to increasing the involvement of health professionals in health promotion. Participants believe it is reasonable to target health promotion efforts to the health care workforce, as they comprise a large percentage of the population and could then model healthy behaviours for their clients.

\[\text{There also needs to be directives for physicians to spend more time informing and teaching patients what they can do to improve their health without waiting until the only recourse is expensive medical intervention}\]
- Online Dialogue, Salmon Arm
Legislation

Many participants referred to legislation related to smoking and seatbelts as indicative of the potential of legislation to affect health behaviours. Some suggested legislation should be passed that increases the percentage of the budget dedicated to health promotion and prevention annually. Many recommended additional legislation to decrease smoking even further including: implementing consistent, comprehensive smoke-free legislation in the province; lobbying pharmacies to stop selling cigarettes; increasing the price of cigarettes; protecting against creative attempts by the tobacco industry to market their product; increasing taxes on tobacco; improving compliance with restrictions on tobacco sales to minors; and, restricting the sale of cigarettes to government liquor stores only.

Others emphasized that healthy lifestyles will not be something that government can legislate. Rather, they suggest it has to be a community effort. Some believe that educational programs will be much more effective in encouraging behaviour change than a mandated dictum, and look to the gradual acceptance of recycling as an example of peer pressure contributing to changing social norms.

Conclusion

Participants believe that we need a combination of policies and education related to health promotion, lifestyle and personal responsibility for health to encourage healthy behaviours. The importance of moving towards a prevention-oriented system with a focus on health promotion was discussed in the vast majority of meetings, forums, and responses received over the course of the Conversation on Health.

*Keep universality, but put [the] emphasis on education, primary care clinics and health promotion to reduce foolish use or abuse of the system*

- Regional Public Forum, Kamloops
Health Promotion

This chapter contains the following topics:

- General Health Promotion
- Funding, Resources and Costs
- Food and Nutrition
- Health Promotion in Schools
- Program Delivery
- Education and Awareness
- Health Professionals
- Legislation

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- **Meeting the Challenges in Health: Building a System for BC’s Future**  
  Submitted by the Heart and Stroke Foundation of BC and the Yukon
- **BC Conversation on Health A Partnership…for Health Care or Wealth Care**  
  Submitted by the British Columbia Chiropractic Association
- **Shaping Health In BC - Observations and Suggestions**  
  Submitted by Pacific Health and Development Sciences
- **Conversation on Women’s Health**  
  Submitted by the Women’s Health Community Advisory Committee
- **Conversation on Health Submission**  
  Submitted by the UBC College of Health Disciplines & the Interprofessional Network of BC
- **Brief for The BC Government's Conversation on Health**  
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- **An Enhanced British Columbia Diabetes Strategy**  
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- **Health Needs of Ethnocultural Groups on the North Shore**  
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- **Submission to the Conversation on Health**  
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- **A Submission to the Conversation on Health**  
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- **Submission to the Conversation on Health**  
  Submitted by the Representative for Children and Youth
- **Healthy Living**  
  Submitted by TELUS
- **2020 The Future Without Breast Cancer**  
  Submitted by the Canadian Breast Cancer Foundation

**Related Chapters**

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Lifestyle and Personal Responsibility; Social Determinants of Health; Medical Services Plan; Health Spending and Health Care Models.
General Health Promotion

Comments and Concerns

Disease Prevention
The Focus of the System
Reports
Political Will and Healthy Public Policy
Personal Responsibility

• Comments on disease prevention and health promotion:
  
  • I mean, everyone in the world intellectually agrees that health promotion and prevention are better. But why don’t we get there? Because we have not integrated primary healthcare and health promotion with a community-wide strategy. We do not link the determinants of health in this country with the health care system nearly as well as other countries do. It’s big, transformative stuff on the social policy level, which we try to get around. And the biggest health problem in the country is not heart disease or cancer, it is inequality. Full stop.

  • Part of the issue is that when you look at the prevention area, they keep on saying there is no data to say that it works. All these models take about 20 years before they show a benefit. But we know it works from examples in other countries, even if we don’t know it from our own country. We have very few preventative models in our own country, but we know from Australia and what they have been able to do in prevention, that it actually does work and is cost effective, so we need to look at that evidence rather than creating pilot programs that take forever, and saying: “then we will make some implementation.”

  • Prevention often talks about symptoms and behaviours rather than root causes.

  • While prevention is laudable it is not the be-all-and-end-all of health care. We cannot even reach 100 per cent of vaccinations never mind persuading the population to eat healthy.

  • Privatization is not the issue. The bigger issue is why do so many people need treatment, what about prevention?

  • Traumatic injuries are the number one killer of BC residents under 45. What programs are in place or are being introduced to reduce this number?

  • Cancer primary prevention has not received the priority it deserves.
• Comments on the focus of the system:
  
  • Health care currently equals sick care; there is a need to promote health, not care.
  
  • There is no incentive for early intervention, which leads to reactive health care only.
  
  • The big barrier to the five action items set out in the health promotion framework for the Ottawa Charter is our focus on acute care, our focus on illness and our narrow definition of how we perceive health.
  
  • There is currently a focus on wealth, not health: illness generates dollars for pharmaceuticals and technical machinery products.
  
  • Only by recognizing and accepting responsibility for the health of community and population can society make any meaningful progress toward healthy living. We must avoid assuming that it is someone else’s job, and they will look after it. Equally undesirable, though, is to maintain the belief that it is everyone’s job, making responsibility so diluted as to lack focus, failing to assign accountability for an outcome.
  
  • Population health is not synonymous with targeted health programs aimed at specific groups, such as a prevention program for people with mental illness. Population health is about systems changes (i.e., education system, housing, recreation system) in the context of the population and the communities where people live. Population health is also not synonymous with ‘public health’, although there are many population health strategies that are advanced through public health actions.

• Comments about reports geared towards disease prevention and health promotion:
  
  • The work of the Select Standing Committee on Health, which in 2006 reported on A Strategy for Combating Childhood Obesity & Physical Inactivity in BC outlined specific action for the government to assist in attaining healthy weights and higher levels of physical activity for British Columbia youth.
  
  • A Ministry report Towards Better Health Care for British Columbians emphasized the importance of preventive measures in improving overall public health. The government created public oral health programs in various long-term care facilities, aboriginal communities, as well as dental public health screening programs for children.
• Comments about political will and healthy public policy:
  • We live in a system influenced by short-term political viewpoints. Can we set
targets that can withstand changes in political will? Who should champion
programs, the Ministry of Health or perhaps some other agency?
  • Everybody has just read the Primary Care Charter that just came out. It is a pretty
good document that provides some guidance, and some direction. At least now
we know what is going to take place and people have some framework. We need
a similar document for health promotion.
  • No candidate in this past election discussed the importance of a program of
disease prevention with an emphasis on the individual’s own responsibility for his
or her own health.
  • Our goal is broadly is to have the healthiest jurisdiction ever to host the Olympics
and Paralympics Games.

• Comments about personal responsibility:
  • As a baby boomer who exercises regularly and eats healthy meals, I want to know
the percentage of middle-aged people who actually do exercise and eat healthily.
  • The fact is that, compared against the average Canadian in 2003, British
Columbians are less likely to smoke, more likely to eat five or more servings of
vegetables and fruit per day, less likely to be physically inactive, and less likely to
be overweight. Our public policies have sometimes led the way. For instance,
Victoria was the first Canadian city to go smoke-free.
  • You will always have a small percentage of people who do not care about health
or the long term effects of lifestyle and behaviour.
  • The health of British Columbians is in jeopardy. At both ends of the spectrum, we
have crises brewing: children are heavier and less physically active than ever
before; and the sheer number of elderly people is soaring with a growth rate that
has never been observed in the province’s history. In the middle, we have a
population of baby boomer adults, ridden with chronic disease risk factors that
will be costly over the next decade.

• There is too much confusion about what is healthy and what isn’t.
• What we need for health promotion initiatives is media with the right attitude that
asks: how can I help? How can I help get this message out about the issues in this
community?
• War and adversity is bad for health. Militarism needs to stop; we need to learn better
ways to deal with conflict.
• Health is maintained or returned through happiness. As absurd as this may seem, it is not only true but the only true source of health. Happiness is an experience and a state of the mind. Happiness can be studied. Looking for health anywhere else is a waste of time.

**Ideas and Suggestions**

**Disease Prevention**

**The Focus of the System**

**Healthy Public Policy**

**Personal Responsibility**

**Integration and Partnerships**

**Social Determinants and Health Promotion**

• Comments on disease prevention:
  • We need a balanced approach. We cannot just go to prevention based when so many people are in critical need of care.
  • British Columbia must be at the forefront of health care research if we are to maintain the quality of our health care system for generations to come.
  • Encouraging wellness reduces the strain on the health care system. The 2002 Romanow report noted a lack of focus on prevention and wellness in our health care system. For a sustainable health care system, as a society we must continue to promote increased personal responsibility for health, and prevention of disease and dysfunction. All the factors of healthy lifestyles must be addressed: a nutritious low-fat diet; enough exercise; sound sleep; avoiding misuse of tobacco, alcohol and other drugs, including prescription medications; motor vehicle and traffic safety; stress reduction; and healthy (safer) sexual practices. Prevention is often a hard sell that takes both personal and community action.
  • We have to face the fact that whatever we do about prevention, whether it is primary, secondary, or tertiary prevention, we are not going to see huge gains in the next 20 years. All we are going to do is put the band-aid on.
  • Prevent the preventable.
  • Given that unhealthy living causes expensive remedial medical procedures and hospitalization, it would then be obvious that an ounce of prevention is a whole lot less expensive than medical intervention later on in life.
  • There are a lot of barriers to accessing prevention programs because people do not understand the system. We need to address this problem. There are so many
marginalized populations due to poverty, mental health issues, and the remoteness of where people live. A prevention-oriented approach needs to be something that is available to everybody, not just to people who live in urban centres and who are literate and speak English and have access to resources. I think it needs to be universal, just like the universal health care system needs to be universally available to people.

- Primary cancer prevention can occur by a combination of individual and environmental changes, such as implementing health-promoting public policies so as to create environments where healthy choices become easier choices.

- These parallel health crises and overlapping influences naturally raise the question as to whether some or all of the lessons in the tobacco wars can be transferred to the obesity problem. The following are key elements for any successful prevention program, whether it is tobacco control or obesity control:
  
  a. Interventions must address the fundamental behavioural and social causes of disease, illness and disability.

  b. Multiple approaches must be used simultaneously- education, social and community support, laws, economic incentives and disincentives. The financial levers have consistently been shown to be most crucial at the level of population health.

  c. Multiple levels of influence must be accessed: individuals, families, schools, workplaces, communities, entire provinces and nations.

  d. Interventions must recognize the special needs of strategic groups such as teens and at-risk communities, for example First Nations.

  e. Interventions must have long durations because change takes time and needs to be constantly reinforced in each subsequent generation.

  f. Interventions need to involve a variety of sectors that are not traditionally associated with health, such as business, engineering, law, and the media.

- Ideas about the focus of the system:
  
  • The health care system is designed to react, to fix problems rather than prevent them from happening in the first place. I know that prevention will not fix all our health care problems but a change in culture is needed fast.

  • It is not a question of taking either a broad population or a targeted risk group approach to health promotion and prevention. It has got to be both.
Three overarching principles that are vital to success in creating a healthy British Columbia for many decades to come include: ongoing evaluation and flexibility in implementation; sustained investment; and keeping the finish line in view.

Programs should be publicly funded, proactive, preventative: the new P3. Focus on wellness and positive re-enforcement to create a cultural shift.

Keep universality but put more emphasis on education, primary care clinics and health promotion to reduce foolish use or abuse of the system.

A population health focus means a comprehensive approach where you look at many sectors in society. So you use a regulatory approach, you use settings. You look at supports for people, you look at programs and you have to provide funding for all of those things. One of the things that is also required is public education, which is also sometimes called health promotion. Participaction was highly successful public education program because that was in the '70s and those of us who were around then remember it still today. But Participaction was an advertising program only; it was not followed up with all of the other required supports.

The focus now should be taking a life course approach, from preconception up to end of life. And you give people supports, and information as well as changing the regulations. British Columbia has a really good track record in tobacco control because the province actually took that overall comprehensive approach, leading to behavioural change in the long run.

Use a healthy community lens in decision-making.

So, if you have diabetes, how many hours a year do you spend in the health care delivery system? Most people, five, maybe ten. How many hours do you spend at work? 2000? How many hours do you spend at home? So, what does that mean? It means that the approach to health is a community issue. Think about those relative proportions. If you have something in the workplace that is only one percent as powerful as what you can pull off in the medical office, but it can be consistently applied, the cumulative effect is tenfold more than anything you could ever pull off in the medical office. So, it is about the food you serve in your company cafeteria. It is about whether you can find the stairway.

New and innovated ways of delivering health care must be encouraged and applauded. More emphasis on wellness, health promotion, illness and accident prevention is necessary.
• We must pay more attention to keeping healthy people healthy, instead of focusing on treating illness after it sets in. Reducing the incidence of preventable cancers in BC is a priority of the Canadian Cancer Society, and should be a key priority of the Ministry of Health.

• Ideas about Healthy Public Policy:

  • Health Officers’ Council recommends that the Government use the Ottawa Charter for Health Promotion in its entirety to shape a sustainable British Columbia: 1. Building healthy public policy. 2. Creating supportive environments for health. 3. Strengthening community action for health. 4. Developing personal skills. 5. Re-orienting health services.

  • When you think about the sort of thirty or forty year vision for moving to a prevention model on health, you have to think about the structural changes that need to take place and how to start that process. I do think it is important to recognize that the sickness care part of the health system is a valid enterprise.

  • I think this provincial organization needs to be responsible not only for leadership policy, but also for the development of a really excellent information base that brings together all the data and relevant indicators for the promotion of health. This information base would come from all the health authorities, from all the ministries: housing, economic development, you name it. This is absolutely essential for long term growth. And it is beyond health data. What we're talking about is citizen data.

  • Government should stop promoting unhealthy behaviours, like gambling.

  • Advocacy is an effective strategy for addressing the social determinants of health. This strategy often calls for a visible leader or spokesperson who can raise awareness and represent the need to the public, media and political bodies. Social, political and economic factors are all potential areas of advocacy for political action and policy change. Advocacy can be one of the most effective population health promotion strategies, with the end result being the development and implementation of policy that directly impacts health outcomes on a sustained basis. Individuals, organizations, businesses and governments can all engage in advocacy. The goal is to gain support for the involvement of government and non-governmental agencies in actions that improve the overall health of the populations, and strengthen the understanding of governments and populations about the broad determinants of health.
Healthy public policy is a critical component in the move to shift health care from an illness driven model to one that focuses on the health status of the population. Policy development can be a key outcome of advocacy and lobbying efforts and can be addressed at a number of levels. Healthy public policy should focus on population health with an emphasis on health status, equity, and multidisciplinary and multi-sectoral elements consistent with the principles of primary health care.

When you look at the success that we have had with smoking, it has taken thirty years to get to that level. I think there is this notion that I should just do this tomorrow and everybody's gong to be fit. The problem with all health promotion is it has a very, very long window from when you start to when you end.

We want to increase the number of British Columbians who participate in healthy activities and eating by 20 per cent; reduce tobacco by 10 per cent, and reduce the number of women who need counselling for alcohol consumption during pregnancy by 50 per cent.

What would success look like in health promotion? There is a need to set targets and monitor them.

Ideas about personal responsibility:

- It is more than not getting a disease; it is purposely making decisions to have a healthy life. Healthy life should encompass things like recycled water, healthy food, and exercise.

- Work towards establishing a Health Ethic like our honesty ethic, wherein it becomes natural to behave healthfully.

- Physical and nutrition education would help to promote good health, but so do other preventative measures. The real solution is to get people to stick to their physical and nutritional regimes. Thus, the problem is not one of education, promotion, brochures, or classes, but one of helping people acquire discipline and good attitudes.

Ideas about integration and partnerships:

- Partnerships are essential components of a population health strategy that facilitates the creation of health promoting environments and conditions for the population. Responding to health issues often requires action across more than one jurisdiction. A health authority can also play the role of an instigator of a partnership if it recognizes a health issue where the resolution rests outside its formal jurisdiction.
There is a need for a seamless system for cradle-to-the-grave health, education, and community services.

Create a permanent joint ministerial commission to listen to the public and experts in the field to work towards building a healthy population. The Ministry of Health cannot do it alone. There is a need for integrated policy development.

Health is not just about the medical system; it is also about the whole network of community support around the person.

Leadership involves recognizing the existence of a health issue or health disparity and assuming a responsibility to redress it. Health surveillance and assessment is a starting point for leadership. Population health involves reporting on health status, especially where there are significant health issues and disparities in the health of particular groups. Actions may include developing alliances, coalitions or partnerships, particularly for issues that are cross-jurisdictional such as those involving local governments or politicians. A central facet of this strategy is the development of leaders and champions within communities. If leadership from within the health sector is not practical, possible, or desirable, then the health authority can work to cultivate a champion and leader from within another sector of the community.

There is a need to develop networks for health promotion. Although we don’t have strong church-based networks any more the internet can allow people to stay connected.

The most effective and efficient strategies need to be adopted in British Columbia to achieve the 2010 risk factor targets. We have noted more than once that the most powerful measures for tobacco control have been identified through 40 years of global research and implementation. Although the data concerning obesity control, healthy eating and physical activity are still emerging, the lessons from smoking will very likely apply. Tackling obesity is going to require a comprehensive approach ranging from social marketing and community programs to intensive clinical treatment and prevention. It is possible that many scenarios will need to be tried and evaluated before we realize the optimum plan for responding to obesity. In the meantime, the crisis is too urgent to allow a policy of inaction.

Ideas about social determinants and health promotion:

The challenge for any health system is to manage the demand for health care by individuals, while using scarce resources to support the population to be healthier and more resilient. A key question in this challenge is determining the role of the health care sector in this prevention work. To be truly successful, however, the
health care system must ultimately invest in the production of health. But what does this investment entail? Eliminating poverty or promoting healthy workplaces, for example, seem a long way from a mandate to run emergency rooms and surgical services. And yet, the health system has a long and proud tradition of population-based health interventions to address the social determinants of health. At times, this is through its education and research capacity. At others it is through more direct action such as providing housing services in association with primary care treatment services or actively advocating for health promoting policies such as health and safety regulations.

- Limit noise to 50 Decibels at most.
- British Columbia already has a healthier culture than many areas.

**Funding, Resources and Costs**

**Problems, Issues and Concerns Identified**

**Funding for Communities**

**Funding for Disease Prevention and Health Promotion**

**Costs to the Individual**

- Comments on funding for communities:
  - Our city gets no grants whatsoever from the province to deliver programs that will keep people healthy and happy.
  - How can we as a city contribute to a healthy community without the resources to do it? For example, police and public safety continue to grow in demand and represent a significant part of our revenue stream while the budget for Parks and Recreation is frozen.
  - Eliminate and/or discourage corporate sponsorship from companies that promote unhealthy lifestyles.
  - Resources and funding for healthy living activities and education tend to be one-time allocations.
  - Community programming and wellness initiatives, even when they are effective and needed, are taking dollars away from hospital care.
• Many community programs are not appropriately resourced and people are forced to do things off the side of their desk, which gets very frustrating. No value is being placed on the development of partnerships and mobilizing the community to be more physically active and eat healthier.

• There is inequity in the funding allocated for healthy initiatives amongst communities. In North Vancouver, the school district paid for seconding a dietician from the health authority, so that they could implement the school food and beverage guidelines faster. The British Columbia Healthy Living Alliance decided to give some support to the implementation of those guidelines, because not all school districts were going to be able to free up money from their budgets to be able to hire a dietician to help them.

• Comparing the five health regions in British Columbia reveals that the Northern Health Authority has a particular challenge on its hands, as the population is consistently at higher risk compared with other areas of the province.

• Support recreation in rural areas, renew funding annually and make it so that First Nations communities don’t need to reapply for funding once it is awarded.

• Community prevention programs do their own fundraising but many community agencies hold deficits for senior programs. This is not the case for programs for other age groups.

• There is a lack of funding for playground and physical education equipment.

• Comments on funding and costs for disease prevention and health promotion:
  • Stop pretending that prevention and education will solve the budget crisis. It won't. There will always be end of life issues and there will be a lot more of them over the next twenty years.
  • It is tough to get funding for research on prevention.
  • Prevention is not a solution to a cost problem; it only extends the inevitable.
  • We need to look at where we are spending money on health promotion, and embrace a multi-sectoral approach. A progressive approach should include an increase to 6 per cent of the budget allocated to health promotion and subsidized taxation to support the building of community recreation centres.
  • Health promoting services are not covered under the Canada Health Act.
  • Practically all healthy Canadians have cholesterol that is naturally between 200 and 300mmg/DL. High cholesterol is not a disease, but it is a fantastic business.
• We have all heard of how proactive health measures, rather than reactive ones, will ease the strain on the system in the long run. But the fact remains that it costs more in dollars and cents and out of pocket expenses to get fit than it does to get sick.

• If one were to add up the resources put into prevention, they are almost negligible, compared with the resources that go into sickness care and treatment.

• When we become so focused on funding for surgical times and so on, we lose focus on funding disease prevention and health promotion.

• It is a myth that simply investing in disease prevention and health promotion is going to save the system money in the long run. All you are doing is you are shifting the inevitable to 5 or 10 years down the road. You still end up in the same dilemma, treating the same patients for the same illnesses.

• There are few measurement tools for long term preventative approaches that could be used to look at outcomes.

• Current testing rules are threatening to eliminate the useful, but not profitable, cures and preventions.

• I do not hold much hope on seeing a lot of spending towards prevention.

• Cutting prevention programs costs the system more in the long run.

• Home visits are taking all the funding and there is not enough left for other preventative initiatives.

• Excellent support of health research is provided through the Michael Smith Foundation for Health Research. The provincial government has recognized the importance of funding health research in the province's universities, and the critical role that personnel awards play in retaining superior researchers in British Columbia.

• Comments on costs to individuals:

  • Since the government brought in a tax on the use of some parks like Rathtrevor, the use of some parks has dropped so low that the parking cost does not cover the contract of the park attendant.

  • Prevention and health promotion can be expensive for the individual; living a healthy life can be expensive.

  • A lot of disease prevention services are non-insured services. The government seems almost afraid of prevention beyond public health education because they know it involves introducing new services and new funding for things that have
not traditionally been funded, at a time when we are talking about keeping the basics sustainable.

Ideas and Suggestions

Funding for Communities
Funding for Disease Prevention and Health Promotion
Costs to the Individual
Funding Specific Programs
Taxation

- Ideas about funding for communities:
  - Make more grants available for infrastructure. Improvements like biking trails and swimming pools.
  - Invest in parks: provide funds to maintain them and cover operations.
  - If we want people to engage in healthy lifestyles, provide incentives. For example, reduce or do away with user fees for community centres and other publicly run exercise facilities; and stop charging high rental fees for sports groups to use fields, and gyms. Organizations that run these facilities need funding. The governments should properly fund these organizations. Money spent there is saved down the road by having a healthier, happier society. Cuts to services go deeper than the dollar value. They impact people in a very real way.
  - I would hate to see the undermining of essential and successful community programs, many of them focused on prevention and harm reduction, simply to pour money into acute or chronic care. We must always remember that prevention is the best cure.
  - Provide adequate resources for appropriate surveillance and timely community-level feedback. Provide adequate resources for the evaluation of new interventions and the distribution of findings, particularly in those areas where the effectiveness of information is promising, but limited. Provide adequate resources to administer the overall plan and ensure a coordinated, comprehensive approach. Encourage behaviour change research that focuses on the application of what we already know and considers the individual in the context of a population health approach.
  - Fast food and corporate sponsorships of health promotion programs should be encouraged. Large corporations need to be made accountable to the communities they serve.
• Provide funding for school health promotion programs.

• Invest $325,000 for British Columbia Parks and Recreation Association to conduct the next phase of its Facilities Assessment Study, a Recreation Facilities Audit of 65 recreation facilities across the Province.

• The ebb and flow in funding is obvious; need consistency and long term reliable funding for health promotion and prevention programs.

• Ideas about funding for disease prevention and health promotion:
  • Get each of the ministries to put aside one percent of their budget for healthy living.
  • The Medical Services Plan should pay for preventative testing.
  • Establish a 6% resource allocation target for the total health services budget in the area of chronic disease prevention.
  • Increased and sustained funding in prevention is necessary to reduce the incidence of preventable cancers in Canada, and ultimately reduce morbidity and mortality from this disease.
  • Provide better funding for and recognition of holistic and preventative medicine.
  • Invest in primary and secondary prevention.
  • The Province of British Columbia should invest 6 per cent of its health care budget in health promotion and chronic disease prevention.
  • Increase government funding for health-promoting Active Transportation projects such as trails and bikeways.
  • Remove the sales tax from things that support health and healthy environments.
  • Preventative measures often take a long period of time to show their results. With the Human Papilloma Virus (HPV) vaccine, that group of girls is still going to have to get Pap tests every year for 25 years and, therefore, the health care system will not accrue any savings.
  • When you look at some of the areas of heaviest drain in our health care budget, they are almost entirely preventable.
  • Double the price of fuel to encourage increased physical activity.
  • Fiscal accountability is clearly very important, but certainly, we should have other goals for health services, like helping people to be healthier, to prevent disease and respond to public health problems.
• Provide front-end investments in programs, services, and intervention that are proven by data to be effective, instead of investing in costly interventions that have not been supported by evidence.

• The province should penalize municipalities that have a disproportionate number of junk food outlets per capita.

• Designate a higher percentage of the total health care budget to health promotion and disease prevention on an ongoing basis.

• We know that most of the common adult diseases find their origins in early childhood. By investing in the health of children we are investing in the future health of the entire population.

• Provide evidence-based funding investment in prevention/health promotion initiatives.

• There is a need to spend more money on promotion (like the ActNow programs). We need long-term, committed funding.

• There should be federal implementation of a standardized system of nutrition information for products that includes all foods, including at point-of-purchase. Develop a provincial program of certification for restaurant menu items and portion control.

• While there clearly are a number of effective interventions for tobacco control, the question still remains: are they also cost-effective? In health care, the average cost per life year saved is approximately $25,000 US. That is, for every $25,000 spent in healthcare, we increase someone's life expectancy by one year. An extensive review by the World Health Organization found that when all five of the most effective tobacco control interventions are combined, the cost per life year saved was only $274. The cost-effectiveness ratio of $274 US per year of life saved for comprehensive tobacco control represents about 1 per cent of the average $25,000 in cost-effectiveness for medical interventions across the whole healthcare system. The conclusion can only be that it would be prudent as a society to aggressively pursue smoking cessation by all these means in order to achieve superior chronic disease control.

• Are interventions too expensive? Although demonstrably cost-effective, some people have still been concerned that smoking bans in businesses such as restaurants will hurt their bottom line, public bans will hurt tourism, or even that reduced cigarette sales will affect government coffers. These sorts of economic arguments, however, have been consistently discredited.

• Funding decisions need to consider long term and system benefits.
I think we are back to operating a parallel system until we find further savings in the acute care system. If we do not start dealing with some of these risk factors more aggressively, we are just going to push more people into acute care. However, the way that the ministry portfolio system is set up can be a barrier because all the monies are in separate pots under the control of different ministries.

- Create a common location for funding source information.
- More long-term plans and money are needed for prevention.
- Prevention will decrease cost of drugs and hospitalization, and improve health.
- Ten years from now both government and people will acknowledge their own responsibility for health prevention and healthy living and that responsibility has to be both financial and behavioural. And I think that the financial part of it is something that we need to address right now for sustainability.
- Impose a health-charge fee for those businesses that produce unhealthy goods (for example, cigarettes).

- Ideas about costs to the individual:
  - Offer funds or support or sponsor athletes with provincial funds that are beyond amateur sporting. Offer rebates to parents who cannot afford to put children through the child’s desired sport.
  - Our government could eliminate all fees for use of public green spaces. This would help people to get free exercise and social interaction.
  - Subsidize any physical activity that has been medically or scientifically proven to improve the body’s health. There would be an annual dollar limit to the subsidy.
  - Provide compensation for real patient outcomes such as quitting smoking.
  - Make public transit free so more people will use it. Walking to the bus stop burns calories.
  - There is a need for incentives and taxation to encourage greater involvement of children in physical activities.
  - In order to promote public transportation, the provincial government should refund 15 per cent of the bus passes to British Columbia residents who use them.
  - One senior winning a gold medal and getting the BC share of his income back in the British Columbia Senior Games equals $2500.00 and the provincial government gets millions of dollars worth of advertising in return.
  - Ask gyms to lower membership fees.
• I think the government should pay people to use the parks for the good of their health.

• Governments and the health administration has little control over people's behaviour in our complex society today and we are proving everyday that when people invest in programs of prevention out of their own pocket you get better results.

• The Government should provide funding for low income families to help them avoid obesity.

• Subsidize recreation, make it accessible and affordable.

• If we are really serious about prevention, it means having housing and welfare rates that allow people to be able to live.

• Ideas about the funding of specific programs:

  • Reinstate funding for full-time or on-call lactation support. Support a peer lactation support program. This is a benefit both to encouraging new moms to continue breastfeeding and to combat the social isolation that many new moms experience - isolation which can trigger worsening of any post-partum depression.

  • In Ucluelet the Community has organized a restorative justice program. We have a facilitator for each case, but the province would not fund the facilitator.

  • The medical associations should fund patient learning forums, such as group prevention efforts for diabetics, hip replacement patients etc.

  • If British Columbia health were to increase the awareness campaign and increase the donors, we could significantly reduce health care costs: for example, renal dialysis is very expensive and many patients are on the waiting list but cannot be helped because of a lack of organs. There are many others: heart, lung, liver.

  • For vaccinations: (1) expand HPV vaccination coverage to include girls and women aged 9-26 and (2) provide access to free influenza vaccinations for all British Columbians.

  • Professional sports should purchase medical insurance for their players and not rely on the healthcare system.

  • Fund an organized, province-wide, population-based colorectal cancer screening program.

  • Maintain the Government's financial commitment to the Screening Mammography Program of BC and the Go-Have-1 Campaign, and target resources to increase public awareness.
• Ideas about taxation:
  • Increase the taxation on tobacco products.
  • Remove sales taxes from restaurant foods that are healthy, and from healthy food products such as single servings of bottled water, pre-packaged salads and fruit trays in retail stores.
  • Until the government is serious about restructuring some of the tax policies and some other policies about food, and fast food, it is going to be a losing game.
  • Remove sales taxes from sports and recreation equipment.
  • One of the heaviest uses of emergency departments is as a result of the accidents of health conscious people involved in sporting activities. So, should all sports equipment be taxed?
  • Provide tax credits/breaks for enhancing physical activity for all age groups.
  • Consider a focused trial of taxation measures for specific unhealthy foods.

**Food and Nutrition**

**Problems, Issues and Concerns Identified**

- **Children and Junk Food**
- **Poverty and Nutrition**
- **Cultural Norms and Nutritional Guidelines**
- **Home Care and Nutrition**

• Comments on children, nutrition and junk food:
  • Not all children have access to healthy choices in food.
  • Our schools and hospitals still sell a lot of junk food.
  • Nutritional information and information on how to blend nutrition with the appropriate exercises are not covered in the school curriculum.
  • Children keep eating junk food because the ads are aimed at them.
  • Many have been advocating for the removal of junk food from schools and family department stores for years, but nothing has changed.
Twenty years ago cigarettes, alcohol and drugs were considered addictive. No one thought fast food was habit forming. However, a study by Brookhaven National Laboratory involving brain scans demonstrated that when people saw and smelled their favourite foods, their brains lit up in a manner similar to the reactions exhibited by people addicted to cocaine.

Sugar is the first addiction for many Aboriginal people.

• Comments on poverty and nutrition:
  • Economic accessibility of healthy food is a concern.
  • Obesity is a real issue in Native communities. The poor quality of nutrition for many Aboriginal communities is related to poverty.
  • We all know what we should be eating but the poor cannot afford to purchase these foods. It is a waste of money to spend money trying to teach us how to eat. The money should be spent on providing the food for those without.

• Comments on cultural norms and nutritional guidelines:
  • Most people are more concerned about hygiene than healthy food.
  • Salt and sugar are overabundant in foods, which causes illness and disease such as diabetes, obesity. Excess salt from diet is also linked to deaths from heart disease and other illnesses and causes hypertension.
  • I am unable to find answers to nutritional questions like whether margarine or butter is healthier.
  • Thousands of studies over the past dozen years have failed to support the recommendations in our Food Guide aimed at lowering fat intake, and in fact many of the world's leading researchers are putting the blame for our obesity epidemic on these kinds of recommendations.

• Comments on nutrition for people in home care or recently discharged from hospital:
  • Dieticians across British Columbia have grave concerns about the lack of home nutrition services in the province and the potential implications on the health and well-being of the population. Malnutrition is preventable yet British Columbians are put at risk for malnutrition every day through non-attention to basic nutritional requirements to support life and to enhance quality of life. This situation applies to people of all ages, children and adults, who are discharged
from hospitals or institutions without consideration of how they will access, prepare and consume food at home.

- The Vancouver Island Health Authority report on nutrition in home care noted: Malnutrition compounds chronic disease conditions precipitating admissions to hospital or community care facilities, prolonging duration of hospital stays, increasing use of other health care services such as physician visits, Home and Community Care, emergency care and increasing the use of pharmaceuticals.

- The consequences of malnutrition are not confined to the aging population in British Columbia and include all people from birth to old age, those who are able-bodied and disabled, those with special needs, and those living with any acute, chronic or debilitating medical conditions whose food and fluid intake is inadequate or at risk of being impaired.

**Ideas and Suggestions**

**Children and Junk Food**

**Poverty and Nutrition**

**Cultural Norms and Nutritional Guidelines**

**Home Care and Nutrition**

- Ideas about children, nutrition and junk food:
  - Boycott multi-national corporations that produce unhealthy food.
  - There is a need to consider the effects of sugar addiction on children.
  - Ban junk food in schools.
  - Drinking water in all of British Columbia should be fluoridated. There is no reason that kids and other people in British Columbia should not benefit from increased dental health.

- Ideas about poverty and nutrition:
  - Danish examples demonstrate best practices in provide subsidies to improve nutrition.
  - Parenting education programs in nutrition, particularly for low-income families.
• Ideas about cultural norms and nutritional guidelines:
  • Despite significant improvements in public health measures to increase folate intakes through fortification of grain products, dietary intakes still fall well below recommendations. Regular use of a multivitamin supplement containing folic acid is an easy way to ensure that you receive an adequate intake.
  • Replace the current Canada Food Guide with a New Canada Food Guide modeled on the recommendations of the Physicians Committee for Responsible Medicine. A New Canada Food Guide will recommend the new four food groups (1) fruits, (2) vegetables, (3) grains, and (4) legumes, with other items mentioned as foods that people may choose to eat, but not recommended as ideal or necessary for health.
  • Community efforts should be made to encourage people to go to healthy restaurants.
  • The system needs to promote good health choices through better labelling. Perhaps a new rating on the labels on a scale of 0-10 is required to help people make wise choices. The scale can take into account a group of factors and even discourage the purchase for people with certain conditions.
  • High doses of vitamin C can prevent heart attacks.
  • Eating locally grown, organic food and limiting trans fats, saturated fats and preservatives is important.
  • All women in their fifties and most men should be encouraged to take Vitamin D to curb the extent of osteoporosis in the older demographic.
  • People who do not eat meat have a much lower risk of colon cancer.
  • Relax the laws around Food Safe. The current regulation prevents access to healthy food.
  • More organic and natural foods.

• Ideas about home care, hospital care and nutrition:
  • Ensure that healthy diets are provided to patients in hospitals, facilities and day cares.
  • Only healthy food should be available in health facilities.
  • Based on an assessment of existing home services for adults and children in British Columbia, and a review of evidence on the benefits of these services, the Dieticians of British Columbia recommend a province-wide, coordinated, integrated and accessible program of home-based nutrition services. This should be aligned with provincial and regional health authority goals with equitable
access to British Columbians in need. Home nutrition services must be an integral component of health services delivered across the continuum of care to all populations.

- **Ideas about education:**
  - Since television is widely used in homes, why not have a dietician educating people on nutritious meals to prepare, how much we need to eat, and what good snack foods are? There could be a website where people could download recipes. Giving people this kind of information would be more beneficial than just saying we are overweight and need more exercise.
  - Nutritionists are needed to help people set diet plans that meet individual needs. Nutritionists need to be more easily accessible and available.
  - Provide education on requirements related to the recommended daily intake of vitamins.

- **Ideas about banning or monitoring food products described as unsafe:**
  - Eliminate use of trans oils and hydrogenated oils in our food.
  - DES-treated meat must be banned. (DES-synthetic diethylstilbestrol). There are the carcinogenic risk factors associated with estrogenic feed additives.
  - All feed additives like: antibiotics, tranquilizers, pesticides, animal drugs, artificial flavours, and industrial wastes must be banned. They all jeopardize the health and safety of consumers of meat, milk, and poultry.
  - Ban the feeding of Canadian cattle with animal proteins, These meat products are not safe for long-term human consumption.
  - Put health warnings on food items that are highly processed e.g. white bread is unhealthy.
  - Ban the distribution of homogenized milk. It allows the enzyme Xanthine Oxidase to enter the vascular system, directly entering the bloodstream instead of passing through the digestive tract. When this enzyme enters the heart and arteries, it damages the membranes creating scar tissue. Cholesterol accumulates on the scars and gradually clogs the arteries. The increased incidence of heart attacks in Canada and other countries very closely parallels the increased use of homogenized milk. Homogenized milk fats are metabolic disruptors, which interfere with the normal digestion of milk fats and appear to directly contribute to cardiovascular disease.
  - The fluoride and aluminium compounds in any cosmetic and hygiene products must be banned.
• Stop poisoning our food with artificial additives like: cancer-causing additives (sodium nitrite); brain-damaging chemical sweeteners (aspartame); and endocrine-disrupting flavour enhancers (MSG).

• Ensure there is an admonitory labelling strategy for all non-nutritive substances and processes affecting our food.

Health Promotion in Schools

Comments and Concerns

Physical Education in Schools
Curriculum Changes
Healthy School Policies
Staff and School-Based Health Service Provision
Parenting

• Comments on physical education in schools:

  • There is a shortage of physical education specialists in British Columbia. Regular teachers can give less enthusiasm to kids regarding physical education.

  • We have generalist teachers in elementary schools, with 10-40 hours of instruction in physical education, at a stage when kids are most able to learn physical skills, but have specialists in secondary schools when it's too late, and physical education is optional. This is backwards.

  • Children these days are not experiencing and recognizing the value of being in the outdoors. There are also fewer opportunities to experience the outdoors.

  • Most of the sports in school are team-oriented and this leaves individuals at a disadvantage after leaving school if they are not able to find team activity.

• Comments on curriculum changes:

  • I do not know where the education system is expected to come up with additional time to address health promotion issues without changing the curriculum.

  • Throughout the education system, health promotion is currently not comprehensive and teachers are not adequately trained in the delivery of health related education.

  • New education in schools is starting to focus on teaching children about healthy choices.
• You cannot force people, most of all teenagers, to do anything that they do not want to. Imposing a nutrition class will not improve general health, but it will give kids another class to fail.

• Healthy school policies:
  • Other provinces, such as Ontario, New Brunswick and, most recently, Alberta are taking steps to create province-wide policies on food allergies in schools, and other initiatives. But in British Columbia we are lagging behind.
  • At my school, the food store is open at lunch time and provides nutritional snacks: sandwiches, wraps, veggies, fruit and so on. Pop has been removed from our vending machines and milk machines are being brought in.
  • I am a fourteen year old girl at Lillooet Secondary School, and I find it really unfair that we are told what to do already at school. Now that we are going to be told what to eat, and what to drink, it’s ridiculous. We are supposed to be treated like adults, since we are going to become them soon enough, so why cannot we have choices? If you have problems with the obesity level, then protest against McDonalds and all of those fast food places because pop has very little to do with it.
  • Food rewards in schools, like providing gift certificates for pizza as a reward for reading books, are unacceptable.
  • Stop students from leaving class rooms for smoke brakes during class hours.

• Comments on staff and health service provision in schools:
  • There are not enough skilled service providers in early childhood development in rural communities.
  • We use to have health educators in the schools; they were called school health nurses but were removed from the schools years ago because of budgetary concerns. Hiring teachers for health education is back to where we started. Teachers are not health professionals so why are we expecting them to be teaching health?
  • Public health services are not available or accessible to some public schools and band-operated independent schools.
  • Children in schools do not have proper health care available for them, nor is it available for the staff.
  • The public health nurse only works in a school a few hours per week.
• The Ministry of Education creates print material and audio-visual material on sexual health that goes into classrooms, but they don't have any criteria for evaluating the instructors that go into classrooms to talk about it. As a result, we have situations where we have comprehensive written material on sexual health, but the person appearing in the classroom is sometimes from one of the evangelical groups that's talking abstinence-only programs.

• As a school principal, I see similarities between education and the health care system, in particular the difficult decision between prevention and remediation (Do we give most financial resources to the youngest children to prevent illiteracy or to the older children who are already struggling?).

• Comments on parenting and education of parents:
  
  • Role models are extremely important to school children. If they do not have good role models at home, they adopt those they see in the media. So, saying schools should do more may not be enough.

  • I believe that schools play an important role in teaching our kids about nutrition and physical education; however let us not forget the first and most important influences in our children's lives is the parent! We need to make the parent more responsible and accountable for their children. We need harsher penalties to force parents to educate themselves. We can spend all day teaching these kids at school, but it is what they see at home that is the true impact in their lives.

Ideas and Suggestions

Physical Education in Schools
Curriculum Changes
Healthy School Policies
Staff and School-Based Health Service Provision
Parenting and Education
Specific Programs and Classes

• Ideas about physical education in schools:
  
  • Make Physical education mandatory part of school education. For people who have difficulties with physical education have programs to address their needs. Factor in how to deal with impacts of screen time and kids with disabilities.

  • Physical education was required when I was a kid and I hated it, but perhaps if it was done the right way it could be more enjoyable. Each child is different and, if you could find the right activity for the child to be happy, then it could be a good
investment. But it sounds impractical to me and would be hard to implement in a way that would have lasting effects on the child. Physical activity is best influenced in the home.

- More compulsory physical education will not work unless many options are given. Forcing a child to play badminton or volleyball will not work if the child prefers swimming or cycling. It is about finding the activities that fit the child.
- The focus should be on exercise in the schools not athletics. Many children are not involved in exercise because of the cost.
- Physical education used to be mandatory. There was no such thing as going home after school; you had a sport activity and that was where you went. And it was great for us because we were all in great shape. I now look at the schools and there are all these little chunky people! And they do not get to do anything and I bet they would love to. But they do not have the parental support, the parental time, and the parental economics to get these kids into all these activities because they are no longer part of the school
- Increase the field trips available to physical education students.
- Physical Education should be focused on student wishes.
- Create athletic physical education class that encompasses a variety of sports and go more in the direction of Wii sports.
- Our school has a physical education leadership class where the class goes on field trips, but only 30 students from all that sign up get chosen. If we expanded the size of the class, we would get more participation.
- Instead of having a 12 minute run, implement the Vancouver Sun Run Program in physical education classes for those of us who are simply not born with good stamina.
- Abandon the current non-competitive physical education curriculum during normal school hours. This would free up normal school hours for other classroom courses.
  Institute a Sports curriculum requirement where students are required to complete a certain number of credits per school year based on participation in their choice of intra-mural sports which take place after normal school hours.
- Hoops for Heart, and the Relay for Life are good programs.
- If you have seen that television program, x-weighted, they do a fitness test. And then, after six months, they do another fitness test. You could do those with the kids in the schools, and do the entire school, and everybody could track how they are doing.
• Create activities at lunch, like yoga day, for students who do not take physical education.

• Exercise fuels full-body health and raises students level of focus. We should begin the school day with 20 minutes of exercise.

• Ideas about curriculum changes:

  • There should be a health education strategy from kindergarten to grade 12.

  • I think that part of what the school system can do is to deliver not just education, but also lifestyle. You learn about book learning, but also about your body and how to take care of yourself.

  • While I agree that physical education, improved nutritional education and healthy living need to be included in the curriculum, it is up to each school district to decide what that should look like, which creates a discrepancy in what and how our children are taught. Until and unless these courses have a standard provincial examination, forcing schools to teach a specific curriculum, they will not be taken seriously by school boards.

  • Add health care to the provincial curriculum. We should work from the revolutionary premise that maybe health is the most important thing in our lives, and then go back through the curriculum to determine how, in all subject areas, health issues could be a more prominent feature. Kids do not really know about and learn about empathy until they're a certain age, five or six years old. But if we are going to take the opportunity to teach them empathy, right now the way it’s often taught is they get a baby in the class and the baby teaches. The same should be done with involving seniors in teaching.

  • Aboriginal children should be taught how to build dug-out canoes, pothouses, etc. This should be integrated into the school curriculum. There is also a need to re-educate the general public, their knowledge base comes from fear and misinformation. It is important to understand the effects of colonization and deal with them. Non-Aboriginals have a right and responsibility to understand and deal with colonization.

  • Integrate education on the effects of smoking into all courses in a student-centric participatory teaching methodology. British Columbia provides curriculum suggestions for teachers in elementary schools and high schools yet individual teachers decide how and to what depth these topics will be taught. Thus, a large discrepancy exists in the information provided in each school. Mandating that education on the effects of smoking be introduced via participatory teaching methods at all education levels beginning in pre-school is a defensive strategy
that enables children to better deal with inevitable messaging from tobacco companies.

• Use math problems in class showing how much the system spends on unhealthy people versus healthy.

• We know that education is the single biggest indicator of whether people will be healthy when they are older. So if we can help children be successful when they start kindergarten, then we are going to have healthier adults in 20 years time.

• Provide education on lifestyle choices from a young age, specifically for child rearing, breast feeding and changing public perception. Educational programs should be present, relevant, practical, achievable, community based, and inspire change.

• Ideas about healthy school policies:
  • Open schools for sport and active recreation before and after school hours. The main barrier to the health of school-aged children is access to facilities.
  • Healthy breakfast food should be available in schools.
  • Limit school sponsorships from unhealthy companies, like Coke and Pepsi.
  • Try to promote healthier eating; ask for better, healthier foods at the school cafeteria.
  • Remove pop machines and vending machines from schools.
  • Some school boards will not let researchers gather information. The provincial government could remove the discretion that school boards currently have on evidence gathering, and require them to participate in evidence gathering activities that have been approved by the Ministry of Health.
  • Is there a way to reward people for having a healthy lifestyle? Perhaps grade 12 students who passed a health test could received a bursary toward further education.
  • Include a health tracking model in the current passport to education system in schools. If your passport actually tracked your health status from a young child through into your adolescence and out of the school system you could map your own health status.
  • Increase participation in school activities and create activity policies in schools.
  • I think we have to emphasize the importance of personal responsibility in health. But there should also be systemic incentives, holding school boards responsible. We would not want to penalize people by taking away funding because that does
not do anything but hurt the kids. But I think it is very effective to hold school boards responsible for key measures. And if they are not meeting their goals, then that is who gets penalized.

- Focus on a preventative health model at an early age (within elementary education).
- Eliminate user fees in schools for field trips.
- Remove vending machines from schools.
- There should be no junk food in schools, supported by an advertising campaign against junk food, linking junk food to obesity and eating healthy to looking fit. More anti-smoking ads should be up around schools.
- Schools should enforce the existing health standards; it is worth the money in the long term health savings.

- Ideas about staff and school-based health service provision:
  - There should be regular medical visits by paediatricians within the schools, followed by interventions targeted at high-risk children.
  - Get community health nurse back in schools.
  - Nursing students could be doing their residency in schools, educating students about nutrition and doing health checks.
  - Use retired people to supervise after-school play areas so that parents feel that their kids are safe to be out playing and exercising.
  - Re-educate teachers and professors to be healthy role models for students.
  - The curriculum for teachers needs to include a focus on health courses and healthy living.
  - There is a need to ensure there are disease prevention workers in all schools, who also travel regularly to isolated communities.
  - Give kids a health report card.
  - Education in schools is very effective. After the public health nurse gave a course on the dangers of smoking given to my daughter’s grade six class, she will never smoke.
  - Provide inspiration. Teachers are often closest to kids and their opinions are heard by their students. Teachers should take a larger role in health promotion.
  - Involve youth in healthier decisions at school, improve school atmosphere for youth, promote fun activities for recreation and well-being.
• Arrange school events and competitions that are both physical and mental. Encourage positive behaviour through posters, presenting information in a positive manner.

• Start early in childhood to teach self-esteem, nutritional values, safety issues and realistic values around respect for self and others. Increase public health services to push towards raising an aware an educated generation.

• Community schools can provide services for children, such as dental services, drug and alcohol counselling, and nutrition instruction, creating a healthy community.

• Employ dieticians in school.

• Ideas about parenting and educating parents:
  • A survey should go out to ask parents how schools are doing at meeting the health needs of children.
  • School Boards and government need to work together to develop and engage parents to take responsibility for their children’s health.
  • Provide health information for kids’ parents because parents can also pull their kids out of health curriculum activities. And the law says that they are supposed to provide their children with an equivalent education, but it is not tracked or monitored at all. So, tightening that up would also help. If there is a class on drugs and drug use and the parent does not want their kids to take that class, then the parent must take on the responsibility for providing the kid with equivalent information.

• Ideas about specific programs and classes:
  • Sex education should be compulsory to grade ten.
  • Schools should teach decision-making skills, relationship skills, and particularly negotiating skills, focusing on raising self-confidence and assertiveness, because those skills allow kids to make decisions in a wide variety of areas. Currently, we tend to associate teaching a lot about skills with things like sex education, but the problem is that we are seeing puberty advance by about six months per generation. So, we have kids of nine and ten who are physically entering that phase but not nearly cognitively ready. We have not advanced the teaching of decision-making skills and we have to improve this situation.

  • Increase disease screening programs in schools.

  • Support hand washing programs (make them publicly funded).

  • Hand out condoms in schools.
- Encourage students to use work out rooms.
- Take students to a morgue to show them what could happen if they choose to lead unhealthy lifestyles.
- Food preparation classes should be mandatory in schools.
- Provide mental health education programs in schools.
- I would like to see government sponsored group aerobics and aquafit programs for school aged children to promote positive lifestyle and fitness rather than just athletics.
- Perhaps if the pitfalls of behavioural choices were made clear to kids, ages 10-12, they would make better choices. They usually think it is okay to try something, like drugs, once, and they do not understand how easy it is to get addicted. Sexual abstinence is also the easy way to avoid Sexually Transmitted Diseases (STDs) and HIV. Girls should also be made aware of the emotional aspect of being dumped after a one-night stand and the impact of being used by guys.
- Students should receive school credits for extra-curricular activities. Promote active living, not just sports in school.
- Continue to offer awareness presentations on Sexually Transmitted Diseases (STDs), substance abuse etc.
- Actions Schools is a good program but needs to be mandated in all schools. Having it available as an option does not work.
- We should educate people how to use natural treatments wisely and should teach simple herbal treatments for minor ailments in schools.
- Provide eye tests in schools like there used to be.
- Enforce zero tolerance for bullying in the school system.
- We need more education and services for people with Foetal Alcohol Spectrum Disorder (FASD). We also need more education on this preventable disorder in the school system.
- Establish a high school grade 11-12 Sports Management and Development Program, which instructs students on the theory and rules behind certain sports plus how to coach, train, manage a team; referee a sport; and, teach the basic elements of sport nutrition and human kinetics.
- Introduce milk programs in schools, pilot projects where schools are provided with vegetable snacks for all students and staff, as well as implementing healthy eating programs in general.
• Provide more education in the school system on diabetes, starting at kindergarten.

• Bring a mandatory meal program into the elementary school system that would embrace good nutrition. The Government of British Columbia would finance the program for those who cannot afford it and would try to make the meal program reasonable for parents in general.

• High school students should be trained to be peer sexual health counsellors.

• Expand Action Schools! program and encourage a more rapid implementation of some of its recommendations, plus coordination with anti-smoking resources, to move towards significant levels of primordial prevention among young people. Focus on environmental approaches to risk factor interventions, including options for promoting healthy foods, curtailing access to unhealthy foods, creating opportunities for physical activity and providing tobacco-free sites.

• There should be courses, maybe in high school, designed to enhance education in the field of caring for aging people.

• First aid should be mandatory, taught at recreation centers and schools free of charge. If there were a trained citizenry then more people would have a fighting chance in the golden hour related to heart problems. This would minimize problems and lower costs.

• A passing grade in health education should include creating and maintaining a healthy diet and fitness plan, as well as following healthy lifestyle choices, including not smoking or using other recreational drugs. Health education should be mandatory in school up to and including graduation and a passing grade should be a condition for obtaining a high school certificate.

• Provide education for our children on self-esteem.

• Have a course outside of the time table year round that covers exercise, healthy eating and loving.

• Increase funding for performing arts in schools.

• Nutritional education should be provided at primary level.

• Encourage education of traditional language with the help of the elders.

• In First Nations communities teach care for grandparents in high school.

• Preventative programs about hygiene, drugs and alcohol should be taught in schools from an early age.

• The ancient Chinese knowledge that there are non-physical meridians that can become blocked and so cause health problems, coupled with the Western
understanding that many actions are propagated by emotional triggers, has led to a simple way of releasing such stress by tapping release points and, in doing so, clearing the causes of health problems. This system, called Emotional Freedom Techniques, is simple to teach, easy to use, and has a proven track record; the manual can be downloaded at no cost from the internet. There are qualified instructors in British Columbia. By teaching the actions in schools, student performance and behaviour will be improved and the students will have a useful tool to use all their life.

- Show teenagers the long term consequences of poor health.
- Institute an awareness day or week or month on smoking cessation.
- Provide free fruit at breaks.
- I’m very satisfied with some of the program that schools are offering. But their primary responsibly is teaching. Looking at participation rate of the kids in physical activity and some of the other things as well could be useful. For example, if you have some kind of initiative working group at middle schools to talk about how to stay away from drugs, look at the initiative and the participation rate. I think you will see a reduction in violence in the school systems and, in general, in city communities if it actually takes off and allows students to have a better sense of themselves, and have control of their health.
- Older students can go to younger kids and create programs, showcase skits to get messages across.

**Program Delivery**

**Comments and Concerns**

**Existing Programs**
- ActNow
- Disease Prevention Programs
- Partnerships, Collaboration and Community
- Vision and Infrastructure
- Health Determinants
- Obesity and Healthy Living

- Comments about the delivery of existing programs:
  - Programs for alcohol/drug prevention and sexual health are not meeting the needs of children.
• The Nurse Line does not provide enough depth of service. It simply reiterates what is in the BC Health guide.

• Current prevention programs focus mostly on early detection of diseases rather then true prevention, such as pap smears and colonoscopies.

• We need to re-examine the role of routinely vaccinating children at such a young age, and the possibility that they are increasing the development of auto-immune problems later in life (allergies, asthma, etc). We also need to look at the role of formula feeding on health problems later in life. If we start at the beginning, it could stop so many health problems from developing later in life.

• Our health system fails women who face un-planned pregnancies. They need better information, better education, better support and affirmation in their pregnancies. A pregnancy is not a disease. It is a sign of health.

• Comments on ActNow:

  • I am not trying to be critical of the ActNow program. From what I’ve heard today, they have received a lot of awards. But a number of years ago, there was a national program called Participaction. And it had a greater in-home presence than ActNow does, and maybe that is just because Act Now has not been around long enough to get traction.

  • ActNow is good and is important, but it ignores systemic problems like poverty.

• Comments on disease prevention programs:

  • Preventative health initiatives are good, but there are not enough of them.

  • I think one problem that we need to address is stressed or overwhelmed families. And in British Columbia, one of most common reasons why a child goes into the hospital or to a private facility for general anaesthesia is extensive dental decay. And this is at the age of two and three. And many of you may have seen our ad campaigns that was funded by the government, our ActNow, where it was the picture of the baby going to bed with a sucker and trying to educate the public about putting a baby to bed with a bottle, taking care of the teeth, seeing a dentist within six months of the first tooth erupting. And yet we still have families who are going in for general anaesthesia.

  • Recent research shows that only about 50 per cent of evidence supported health care and preventive interventions are implemented.

  • I am concerned that there is no evidence that these school programs make a change. Kids may enjoy the programs but do not change their behaviours.
I think we have to develop a measure, too, where we can actually measure whether or not people are reporting that they have increased their activity or that their health has improved. That is controversial, too, because people will always report more optimistically. So, if you compare self-reports to measured, like obesity rates, you will have a huge gap.

As a male, its not our tendency to seek medical advice or access programs until we are feeling very sick and there is little incentive to be more proactive about our health.

Not enough women participate in breast cancer screening in BC. Currently, only 47% of all eligible women in BC receive an annual mammogram.

Comments on partnerships, collaboration and community:
- The health sector lacks an understanding of the critical importance of the work non-profits do. There is no linkage between the health system and the non-profits.
- There is a lack of community input and communication regarding local issues.
- There is no mechanism for public, community involvement. The public is generally not interested in health system until it impacts them.
- Holland has been very successful in addressing public health through the promotion of physical activity. There, there are no fees in community recreation centres. In contrast, in BC the rate of Provincial Park day visits are dropping because now people have to pay for parking.
- In spite of funding initiatives for healthier communities through Union of British Columbian Municipality grants and increased allocations of health funding to community based health care delivery systems major hurdles remain.

Comments on vision and infrastructure:
- If the province was more generous and quit making the goal posts so far away, it would be easier to pursue things like indoor walking tracks that could help a full range of people in having an opportunity to get exercise.
- There is a lack of walking paths, cycling trails and in line skating paths and they are not being incorporated into our future city growth.
- There is not enough focus on prevention.
- One of the structural problems is that a lot of preventive services are not built into the institutionalized formal setup. They tend to be delivered by non-government organizations and the way in which they are funded is something aside from or apart from how the national health care system is funded.
• Comments on the impact of health determinants on program delivery:
  • The public and community health programs being offered by Vancouver Coastal Health, while valuable, are not solely able to address the broad scope of health determinants. It is important to understand that a commitment to improve population health does not always demand a service or program type response to the need. However, it does demand recognition of when and where there exists a need to improve health status or reduce inequities. This recognition should result in action to bring awareness, understanding and ultimately a resolution to the issue.
  • Information on healthy choice is not enough; people need support on safety, economics, addiction support.

• Comments on obesity and healthy living:
  • There is a concern that a focus on obesity control increases the tendency towards disordered eating, particularly among adolescent girls. We do need to be cautious about obesity messages and interventions, especially with cohorts such as teenage girls who are at-risk for anorexia nervosa and other conditions.
  • Programs may motivate a few people to take action, but for example, the statistics on the rising rates of obesity among all age groups show that existing campaigns are not working.
  • There is a very serious problem with obesity in British Columbia when you hear that four in ten British Columbians are overweight, two in ten additional British Columbians are obese and that six out of ten British Columbians do not get enough physical activity to access the benefit curve of fitness and have any protection against disease.
  • Obesity can lead to conditions such as stroke, diabetes, heart disease and other chronic diseases.
Ideas and Suggestions

Existing Programs
ActNow
New Prevention and Promotion Programs
Families and Youth
Partnerships, Collaboration and Community
Vision and Infrastructure
Health Determinants and Marginalized Populations
Obesity and Healthy Living
Healthy Workplaces

- Ideas about existing programs:
  - If we were to implement the Coronary Health Improvement Project (CHIP) in British Columbia, we would save millions upon millions of dollars per year in health care costs. It is a prevention lifestyle program where people can normalize blood sugar levels in one month and be rid of or drastically reduce their need for high blood pressure pills.
  - Seattle carried out a huge project five or ten years ago, on teaching everybody who worked with the public about how to do cardio-pulmonary resuscitation (CPR) on the street.
  - In Kelowna, the local Rotary Club created an in-school cancer prevention program.
  - Smoking cessation for pregnant women in deprived areas is a very difficult issue. This particular intervention talked to the young women to say, well, what are the issues here? It's intimidating for these young people to go to the Health Service to ask for help because they do not feel they are actually being looked after properly. So they used this program as a way of actually helping and training the staff, to help them develop the empathy that was needed so they could interact with the young people. It is important to work very closely with the health profession to help them understand their target audience and their needs.
  - OsteoFit is being rolled out at BC Women's hospital and is based on evidence and best practice. And now there is a requirement that the instructors from the recreational and parks association get OsteoFit into every leisure and recreation community centre throughout the province. So things are being done
  - Flu shots should be continued.
  - Government programs such as Hearts at Work are great but unfortunately come with a price tag.
Mobile mammography is an excellent option. Statistics show we are catching things earlier. Many conditions are preventable with early screening and education.

There is a pedometer pilot project in Abbotsford and Penticton. They give people a pedometer, they do a pre- and post-assessment and off they go. Participants are instructed to walk and keep track on the log. But they are also given a referral to In Motion, which is a community initiative that really directs people to all the physical activity opportunities in the community.

Participation was a great program. Let's do it again!

Support The Horizon Project as an active community legacy for youth in the downtown core of Vancouver. Support the development of the Trillium lands for sport and active recreation.

Promote programs like Drug Abuse Resistance Education (DARE).

The municipality of Delta provides free pass for grade fives to swim at the aquatic centre.

Promote and encourage programs like the Harvest box.

Promote the Success by Six programs; teach children young and they will learn to live healthy lifestyles (increasing productivity and decreasing long term costs).

The Head Start program, focusing on parents and their children is probably the program that provides the best bang for the buck. Programs like this have been used and peer reviewed from Michigan to Hawaii to News Brunswick and, if done properly, can save money and result in a huge reduction in demands on our health care system.

Dieticians have been giving a consistent message about diet and nutrition as a key factor in the prevention of disease as well as a treatment for disease over 3 decades.

Yoga is an affordable approach to preventative health.

Prevention-oriented health promotion programs such as Communities that Care, and Strengthening Families should be supported.

Dentistry is a profession that has encouraged and focused on prevention extensively. The declines in dental decay are well documented and continue to decline. We do what's called an Adult Dental Health Survey every five years and declines in missing teeth are continuing.
• Ideas about ActNow:
  
  - Develop an ActNow North program that responds to the particular needs of northern communities.
  
  - I hope when you are sending out the ActNow toolkits, you are including regional districts in the distribution.
  
  - ActNow and the 2010 Legacies Now programs are excellent and growing. One of the very interesting things about ActNow is the way in which all the other ministries are part of it. In their plan every ministry had to say, we are contributing. I think that's a huge step. I mean policy wise, it is a huge step.
  
  - The Government of British Columbia has demonstrated its commitment to prevention and wellness, with its commitment to ActNow BC and other initiatives such as tobacco cessation programs. We, the Massage Therapists’ Association of BC, commend you for contributing to a culture of health and wellness in British Columbia.
  
  - ActNow has packages that can support initiatives that are geared towards different groups (schools, parents, daycares etc.) making the information as accessible as possible.
  
  - Initiate ActNow type programs in other health sectors. Look at what worked in previous programs (Participation).
  
  - ActNow would be a good model to follow because it goes across all the Ministries but it also has a mechanism in place making the Ministry accountable for meeting and reaching all the goals that have been set, based on this philosophy of encouraging physical activity to promote health.
  
  - Add supporting a healthy brain to the ActNow principles.

• Ideas about new disease prevention and health promotion programs:
  
  - Motivate the senior baby boomers to participate in a running program. The only cost to the public is running shoes. Having the baby boomers starting a running program will decrease weight and health issues, and result in less time at the doctors’ office or being hospitalized.
  
  - Put everyone through a once-a-year medical check. The check could be in the form of a full-body scan where a person simply walks through and problems are noted. If another country uses the system then they should have to pay for the system offsetting BC costs to the point of making some money on the program.
• A Canadian skipping dancing association would promote recreational rope skipping to improve aerobic fitness in children, using rope skipping as a tool to improve the physical, intellectual, and cognitive development in children with special needs.

• How about providing veggie vouchers to every resident? Mail them once a month with premium statements.

• If exhausted parents (especially single ones) could participate in a week-long, live-in programme, in a beautiful restful country setting, where the children are given quality care and activities while parents explore positive health options, then new lifestyle choices could be modeled and practiced (e.g. learning to grow (organic) parsley and other herbs in pots on the windowsill, or how to start a small backyard garden, or how to nutritiously cook grains).

• It is important to focus program delivery on all age groups (youth & elders).

• Personal hygiene lessons including the importance of proper dental care should be a service provided to Hastings Street and East Vancouver street people.

• Create a contest for people to join that logs exercise hours.

• I believe the health of British Columbians, particularly women, would be greatly improved by restricting access to abortion and by offering help to women to carry their babies to term. I find it strange that there is such objection to private health care and yet private abortion clinics have the government's blessing.

• I hope that more attention is give to osteoporosis screening and early prevention.

• Sleep Apnea education should be provided not only on a web site but in all the media. It's going to cost some money up front, but just think of the savings down the road and the improvement in all our health.

• Focus on educating men and their families about prostate cancer. Provide support for support groups with dedicated funds.

• Outreach projects for youth (15 - 25).

• Outreach for prenatal health.

• Support peer counselling and monitoring. Outreach programs should be created with physical, mental, spiritual and emotional aspects in mind, promoting balance.

• Be prepared for, and provide support/outreach in areas around drug/alcohol abuse, elder abuse, neglect, internal conflict with family/community, financial abuse in Aboriginal communities (especially around payout from residential school legal settlements).
Adequate dental care will lead to far better quality of life and health.

There is a need for parenting and support programs for struggling parents, teens, poverty-affected families, and immigrant families.

The chronic disease Red Book lists existing resources and should be made need publicly accessible.

Offer a general health cookbook to the public.

Prevention efforts should include regular checkups.

A yearly free health maintenance check-up should be provided, not necessarily performed by a doctor (use alternatives like nurse practitioners).

Provide a central resource with good quality information (like the health line).

Put first-time offenders in with hardened criminals for one day, to show youth the consequences of their choices.

Provide programs that teach participants how to use what's available with what you have, using local ingredients. We have lost our knowledge of how to use dried foods and we need to bring that back. We are now dependent on fresh food.

The Human Papilloma Virus (HPV) vaccine can prevent about 70% of cervical cancers and has the potential to substantially reduce both new cases and deaths from this disease. The vaccine should be available and affordable to the public.

The Human Papilloma Virus (HPV) vaccine should be viewed as a complement, not a replacement for, cervical cancer screening.

We are hopeful that BC's cervical screening program will be enhanced, and that the Ministry of Health will heed the recommendations of the Provincial Health Officer, and expand the provincial vaccination program, beginning in September 2008, to include the vaccine for human papilloma virus

Screening for potential risk factors for diseases is important because it's difficult to do something about a problem you do not know you have.

Early screen at younger ages allows for the reversal or prevention of the development of multiple chronic conditions in middle age.

Have an initial screening for cardiovascular disease available for younger individuals which may be less frequent if no problematic results are present. If risk factors are present early intervention is possible. This life-altering course correction could not only improve their health and quality of life in the future, it could significantly reduce costs to the health system over their lifetime.
• Cancer rates in BC can be improved by implementing a province-wide, population-based colorectal cancer screening program in BC, and continuing to direct resources to the Screening Mammography Program of BC and the Go-Have-1 Campaign.

• Promote healthy lifestyle through a balanced program using physical, mental, spiritual and emotional aspects to become one. When we become one, we become whole, everything else falls into place.

• Ideas about program delivery for families and youth:
  • Prenatal and early childhood is critical for a good start in life for typical children and children with special needs.
  • Babies should be screened for hearing loss. Formal speech and language screening should be carried out by age 2.
  • A great deal of research has shown very promising results from investing in the first six years of a child’s life. Evidence from the Perry Pre-School project has shown that early childhood interventions in vulnerable children’s lives can result in very positive outcomes.
  • Make sure that families, especially single-parent families, have access to programs and services and strengthen the role of non-government organizations, and non-profits in the delivery of services. Make sure that we do not just focus on health services and instead look at supporting a range of community services.
  • There needs to be more active intervention for pregnant women who drink and smoke. This would result in better outcomes for both women and children.
  • There should be a more simplified application process for youth programs.
  • Look at getting youth into activities that move them away from addictions, such as community events, sports. However, activities are often available only to those who can afford them.
  • Support kids to grow their own gardens, cook at home, and use community kitchens and community gardens.
  • Teenagers are the future leaders in 20 - 30 years and perhaps programs should target them.
  • Research supports the proposition that every dollar spent on prevention services, to support parents and their young children, saves seven dollars in intervention services in the future. Pregnancy Outreach Programs save tax dollars.
• Early diagnosis and education of significant adults in the lives of children with Fetal Alcohol Spectrum Disorder will reduce the risks that these children face in childhood, adolescence and adulthood.

• Focus on health initiatives and priorities specific to children in care and Aboriginal children with known poorer health outcomes.

• Youth and culture are our future. We need outreach programs geared towards youth, particularly in First Nations communities.

• Children thrive within families and communities that can meet their physical and developmental needs and provide security, nurturing, respect and love.

• Clear policies and practices should be developed for children in care and other vulnerable children. Those policies and practices should then be monitored and reported on. Accountability and evidence-based practice are the touchstones for these children.

• Work together on a children's plan which places the child at the centre of any planning and policy work that affects their health and well-being. This plan places a strong emphasis on performance measurement to ensure the focus remains on the child.

• Early diagnosis of disabilities and appropriate interventions can make a significant difference in improving outcomes for affected children and their families.

• Ideas about partnerships, collaboration and community:

  • We do have resource to help communities to plan and create strategies with the healthy community initiatives within the Union of British Columbia Municipalities (UBCM).

  • Provide outreach into the community to combat problems such as diabetes, obesity and smoking coupled with a focus on nutrition, exercise and lifelong education to help communities become healthier.

  • Provide affordable liability insurance for community initiatives to facilitate full use of existing facilities, for example, schools, to achieve healthier, more active communities.

  • People went to the community and said, what will we do about diabetes? And they said, we don't want a study on complications. We want a study on prevention. So we have the Khanawake School Diabetes Prevention Program. And this is an example where I think, actually, the community has influenced the health programming.
Vancouver Coastal Health’s Population Health Advocacy Workshops were held in Gibsons, Richmond and the North Shore with over 50 staff participating. The workshops were developed to build staff capacity to engage in population health advocacy work and provided an opportunity to bring together Health Service Delivery Area (HSDA) staff to work on local issues.

- Organize sports and activities for communities and have gyms open at schools at lunch and after school.
- Create opportunities for communities to get together and be active together, support initiatives such as drop in sports where you are not only giving a team a safe place to go at night but also keeping them healthy; encourage people around you to make good choices and encourage and support people making lifestyle changes.
- Provide outreach programs for those with problems.
- Provide nutritional counselling (e.g. schools/community).
- There is currently a lack of community-based counselling services.
- Provide a mentoring program, building capacity in communities so that researchers are better able to get results.
- There is a really interesting model called the Community Readiness Model, which looks at how a community can shift in readiness on an issue. There are nine stages of readiness starting with ‘no awareness’ to ‘denial and resistance’ and then moving on up through ‘planning’ and up to ‘high-level of community ownership’. So the model is used to assess how ready a community is for change. It suggests strategies; it leaves room for real community ownership of the solutions. And then it can be used to evaluate whether change happened.
- The implementation of cross-ministry initiatives rely on the existing expertise in ministries. Health promotion requires community involvement, and local communities must develop their own strategies.
- We need to have zero tolerance for violence and abuse in Aboriginal communities.
- Establish Community Action Coordinators (two per electoral riding) to mobilize strategies for risk factor reduction. Provide modest funding for up to 1,200 community groups throughout the province with ideas on how to address risk factors. Develop a strategic media plan with clear, common messages for different at-risk populations with well-conceived short and long-term advocacy goals. Consider subsidizing pedometers as a source of instant feedback to individuals who are attempting to become more physically active. Implement
point-of-decision prompts to encourage healthy behaviours. Encourage and support walking groups and physical activity events. Enhance access to places of physical activity; both indoor and outdoor.

- Enforce local laws that would be community-specific closing hours of the liquor store, community programs and employment opportunities.
- Engage non-government organizations in the community to support our patients in both the prevention and secondary prevention.
- Municipalities have an important role in health promotion and although there is funding available for those types of partnerships there is lots of room for improvement.
- Cities are well positioned to deliver programs but, without the resources to do it, we are unable to expand.
- What we do in Vancouver and the Lower Mainland is not what you can do if you are in a remote northern community. Helping these communities to become active communities is a huge challenge but there are generic things that you could do anywhere.
- There is a need to engage people and communities to decrease health issues. Encourage behaviour change, by working with community driven solutions that reflect holistic and cultural issues and focus on the social determinants of health.
- Encourage activities based on a region's demographics and environment: skiing and skating in northern British Columbia; golf in the South Okanagan.
- Health promotion and prevention programs in Aboriginal communities need to take community based approaches, identifying needs and treatment at the community level.
- There is a need for intra-ministry health promotion.
- There should be collaboration between Health and Education Ministries.
- The health ministry should work with other ministries, for example the Attorney General, to demand stiffer sentencing and protect people from spousal/family abuse.
- Build partnerships with the British Columbia Ministry of Health, Health Authorities, and the Screening Mammography Program of British Columbia to develop community initiatives to encourage and support women's screening participation.
- There are challenges associated with public engagement that include:
  a. Politicians influence what information is made available to public.
b. Politicians are not interested in cooperation across parties.

c. Competing interests.

d. Multiple demands/expectations on the system.

e. Setting clearer priorities.

f. Do people care if they are not sick? How do we involve the general population?

g. The lack of reliable information on how to access services and what to expect.

h. The public face of the health care system does not reflect diversity of ethnicity. How to deal with major demographic changes (aging, ethnic population increases).

i. The system is so complex that family doctors can refer to multiple sources.

• Ideas about vision and infrastructure:

  • Skate board parks and parks with equipment appealing to kids should be funded by the Provincial Government.

  • The Canadian Cancer Society has made a substantial commitment to prevention through an integrated approach to prevention with staff resources dedicated to education, community action and advocacy.

  • Accessible buses with Bike Racks in front are great because citizens can bus and bike around the lower mainland.

  • Create injury avoidance standards for sports helmets, and provide education for athletes in schools. Currently, ski and snowboard helmets have no minimum standards.

  • Provide programs that raise health awareness.

  • The Long Term Athlete Development plan (as mandated by the Canadian Sport Review Panel) is based on a firm belief that Health and Sport need to work together - creating the awareness of the immediate and future benefits to individuals and our communities of supporting an active lifestyle for our young people.

  • Provide family-centred programs (for native and non-native families).

  • The Infants Act in British Columbia allows children of indeterminate legal age to make their own decisions about their health care if the health care provider is satisfied they are making an informed decision. But if we take this situation to a
non-clinical setting, to a promotional setting, a preventive setting, we could get some really interesting activities going. We have already done it around sex education, changing practice guidelines so that someone who is a qualified sex educator can educate a child without the parents' consent.

- Focus on positives instead of negatives in health promotion efforts.
- Celebrate the success of healthy people and share their stories.
- Improve public health measures, such as better sanitation, cleaner water supplies and dissemination of public health information.
- Provide a report on key health measures to Province. The Ministry should then encourage changes in behaviour.
- Support harm reduction strategies (as opposed to abstinence).
- Prevention should work from the entire medicine wheel concept, a holistic approach that includes all aspects of health (physical, spiritual, mental).
- Develop policy that is consistent with goals for healthy living and encourage students and youth leaders to develop programs that will work for them.
- The last three decades has seen considerable development in the form of evidence-based, analytical tools and resources and communication.
- Secondary prevention can have shorter time frames.
- Provide health assessments tied to a healthy living formula.
- Conducting a health impact assessment is an interesting idea. We do it for major projects that impact our environment, why not ones that could possibly impact our health? Perhaps health should be included as a parameter in the environmental assessments.
- Accountability for new preventative strategies and legislative reform does not rest solely on the shoulders of the Provincial Government or the Ministry of Health, it also rests on the shoulders of the Health Authorities and the Health Care Administration, including all health professionals and unions.
- There is too much focus on illness and not enough focus on prevention. More health clinics should be focusing on education and disease prevention.
- Integrate health promotion at all levels of health care. Build a relationship for health promotion education to be more effective.
- Preventive programs are inconsistent. There is a need for core services.
• Ideas about addressing health determinants and marginalized populations:
  
  • Subsidize fruits and vegetables; make them cheaper than junk food.
  
  • While it is true that successful anti-tobacco campaigns have been comprehensive, involving multiple types of interventions and multiple settings, it also must be recognized that the vanguard in the war was clearly environmental in nature. The back was broken with respect to tobacco through large-scale socioeconomic interventions. Many authorities believe that paying similar attention to the obesogenic environment, that is, the social and physical factors which currently make weight-producing behaviour the easiest choice, will be critical to future public health advances.
  
  • An integrated approach where homeless or individuals on income assistance can get connected with care programs and professionals immediately, like the pilot projects happening in Fraser Health. Target populations with known poor outcomes.
  
  • Provide food stamps for all people so they can buy healthy food (the food stamps would only be applicable to healthy food).
  
  • Expand awareness of programs and supports (for example, expand community kitchen programs to low-income people who are not on income assistance).
  
  • Support health promotion programs for special populations, including low income populations, pregnant/breastfeeding women, the mentally ill, First Nations People and new Canadians.
  
  • Health promotion, self-management, and preventive services and programs should be delivered in a culturally sensitive manner and, whenever possible, be offered in the first language of immigrants. More outreach support to particularly vulnerable and often isolated groups (such as immigrant seniors) is also necessary. Emotional and financial support (transportation assistance for example) can further improve access to health services.
  
  • Target programs to specific populations and target higher risk groups.
  
  • Target all populations for education and activities.
  
  • Reserves should focus on prevention to reduce the need for acute care and hospitalization.
The ratio of at-risk people goes up pretty dramatically if you start looking at those vulnerable populations: Aboriginal communities, the low-income families and vulnerable population groups are probably one of the most significant population groups in terms of the potential for disease prevention and reducing health care costs.

- Ideas about obesity and healthy living:
  - British Columbia should use the occasion of the 2010 Olympic Games to improve the physical activity levels of children to prevent obesity and to raise awareness of recreation.
  - An interactive questionnaire could be used to determine risk factors for certain diseases (heart disease, stroke, etc.) and where to go for risk factor reduction.
  - The British Columbia Recreation and Parks Association is fully committed to working with the Government of British Columbia to improve the health of British Columbians and their communities and to reach the provincial goal of leading the way in North America in healthy living and physical fitness.
  - Provide exercise programs for seniors.
  - Create walking groups at local malls.
  - Make anti-drug projects fun and engaging. Lead by example.
  - There is a need for effective interventions for obesity control. Unhealthy eating, physical inactivity and people being overweight are three highly interrelated topics. A large percentage of overweight and obese individuals can trace their excess weight directly to a persistent imbalance between energy intake (food calories) and energy expenditure (physical activity).
  - Sport is about fostering healthy lifestyles and building healthy communities. It should be recognized as an effective preventative health care strategy and supported as an integral part of British Columbia’s long-term strategy for sustainable health care.
  - Here is a suggested broad outline of an incentive trial program for weight loss and its principles and assumptions:
    a. Incentive is only provided to those with a successful weight loss.
    b. There are unrestricted means of accomplishing weight loss: exercise, healthy diet, dieting, et cetera.
    c. Minimal supervision and program administration is required.
d. Interested individuals will register with a participating recreational center or physician. In addition to collecting demographic data, a mutually accepted weight loss goal and timeframe should be established. (The participating recreational centers and physicians will be trained and compensated.)

e. Trained recreational staff will provide free consultations to participants.

f. On a regular interval, a participant’s weight is taken. If there is weight reduction, a certain monetary reward will be given. In order to receive a reward, the participant must beat the previous lowest weight.

g. When a participant achieves his weight loss goal within or before his time frame, he will be given a bonus.

- Make better use of educational channels to educate the public about healthy lifestyles.
- Make exercise fun. Turn exercise into a social activity, and support environments where people are not critical and are, instead, supportive.
- Give awards and incentives to individuals and to organizations to encourage health promotion activities.
- Make it simple for people to choose to be active; provide activities free of charge.
- If we cannot engage people in behaviour change and healthy living and active living we’re going to lose the game here.

- Ideas about the delivery of programs related to healthy workplaces:
  - Provide incentives for fitness for employers.
  - Support initiatives that promote work-life balance
  - Provide incentives to corporations to support for health promotion efforts.
  - In partnership with the WorkSafe BC, unions and businesses, offer funding to assist employers and employees in creating a healthier work environment, from stairway walking campaigns to exercise facilities and healthy food choices.
  - How can we engage health care workers in healthy living (bike to work week, smoking cessation)?
  - Exercise facilities should be mandatory at all worksites where they are practical, or a stipend should be given to employees to use community facilities.
  - Employers should look at developing and sustaining health related programs for their employees on the work-site which include fitness, diet, safety, stress
reduction and related information, advice and counselling. In addition to these, incentives could be offered to encourage employees to take part in programs for smoking cessation and other outside related health programs.

- Corporations and businesses should be urged to offer programs and benefits to healthy employees who are, in turn, more effective and productive and less of a burden on the health care system.
- Require shower and locker facilities, and secure bicycle storage for new commercial or office space.
- Give workers a financial incentive if they bike, walk or use public transit to go to work. If a few can be encouraged, you will make your money back in spades.
- Employers are sponsoring wellness programs as incentives.
- WorkSafe BC arrived at a reasonable compromise protecting workers and non-smokers from second hand smoke, yet allowing a business to still choose how they wished to operate: smoking, non-smoking, or a combination of both.
- Healthy workplace initiatives should get employers on board by offering incentives.
- Telus is proactive in providing their employees with a personal health screening program which screens for risk factors associated with cardiovascular disease and is totally confidential. There is also health related counselling and support available for individuals testing positive for these risk factors paid for through an Employee and Family Assistance Program.

**Education and Awareness**

**Web-Based Information**
**Advertising and Marketing**
**The Media and Accessing Information**
**Education**

**Comments and Concerns**

- Comments on web-based education and information:
  - One of the things that is difficult with web based information sites, is that the people who access the information are the people who have been there before, and they are already converted. How do you access the folks who don’t use the web? That engagement is so important.
• Because of the internet, people are better informed about their health.

• Currently, Interior Health provides patients, doctors and nurses, with access to Kluwer's eMedical Library. This is an invaluable resource that should be available to all residents of British Columbia.

• Comments on advertising and marketing:
  • Mass advertising does not look at the cultural and social barriers to increasing activity.
  • Sure we spend money telling people about health related illnesses that are common in the public, but that is not the same as taking active steps.
  • Why is holistic, preventive health information, like that in the Blue Book, not published by the Centre for Integrated Health (CIH) in Vancouver?
  • It is hard to get marketing dollars devoted to disease prevention and promoting healthy life choices.

• Comments on the media and accessing health information:
  • The media and the Province of British Columbia provide biased information, or superficial information to the public. Corporate interest currently controls access to information.
  • There is a lack of information in an easily accessible and understandable format that promotes healthy choices in disease prevention and public education.
  • I did not get proper information on how to stop my asthma from developing further.
  • Inconsistent information is available on existing services.
  • People have the responsibility to ensure they are making healthy decisions, but there are large portions of the public who lack the information needed to make good choices.
  • The rising incidence of obesity, especially children and youth is concerning. In spite of greater knowledge, people continue to abuse their health.

• Comments on education:
  • There is a shortage of education for youth and women’s reproductive health.
  • There is a shortage of health education sources.
  • We are teaching kids not to do drugs and then contradict that message with our pill-based medical culture.
• There is a lack of education on what causes illness, for example, pesticides and asbestos.

• It is clear that we cannot simply rely on parents to provide health education or to encourage healthy behaviours in their children.

• Much of the public's education is focused on what not to do: do not smoke, drink to excess, or do drugs.

• Not enough is done to support public health education and screening.

• There is concern about the role of birth control pills in the rise of breast and ovarian cancer in young women and people need education on this topic.

Ideas and Suggestions

Web-Based Information
Advertising and Marketing
The Media and Accessing Information
Education

• Ideas about web-based information:
  
  • For those with email we can set up an option where those who register will receive reminders through email for regular check-ups and tests as they age.
  
  • You need to create a one-stop website that not only informs parents of every eligible program available to them but also provides a message board for families with children with Autism.
  
  • A universal system of medical information must be available throughout the province and the country.
  
  • The success of a website depends on marketing it in such a way that people know about it and are able to access it from multiple points. A comprehensive one-point vetted health based web application could be used to promote self-care.
  
  • It seems to me that there's so much information available that it would be advantageous, for example, to have the province designate a group to put Good Housekeeping Seal of Approval on health related websites with quality information. You could then imbed it into the Ministry's website network. The more you can piggyback on an existing platform, the lower your costs are going to be for implementing and maintaining it. If you knew that you could access really lots of different kinds of information from one site, then you would start
coming to it regularly. I think the key to the success of a big website like that is the search engine that you build into it, make it an information portal.

- Promote internet access to information on medical procedures, and alternatives.
- A provincial health information website should be created.

- Ideas about advertising and marketing:
  - Put posters in public areas so that people can gain knowledge of good health care packages.
  - I really like the commercials that say "bugs don't need drugs". It is very important that people understand that they do not always need to take antibiotics when they are sick.
  - Social marketing is a key to change.
  - All commercials for medications, whether prescribed or not, should absolutely be banned on Canadian (and all) television.
  - Launch public service ad campaigns that teach consumers how to tell the difference between healthy and unhealthy food and grocery products.
  - Use research to really get at the issues. There are similar examples in tobacco control now where they can actually target individual communities down to the postal codes to find out who is smoking and where they are buying their cigarettes. They are targeting advertising campaigns right down to that local level.
  - Hold public campaigns to make biking and gardening fashionable in the same way that campaigns have made smoking un-fashionable.
  - Increase anti-smoking campaigns.
  - Ensure that symptoms of impending stroke, cited by public awareness campaigns, include all symptoms, such as signs of loss of acuity or memory.
  - There is a need for practical, family-oriented advertising; use the BC Health Guide.
  - Use audio/visual information delivery instead of printed words.
  - Distribute a healthy living tip sheet in grocery stores, liquor stores and other public places.
• You have to sell healthy living to people. I mean that is what happened with the environmental movement, right? They had to market change. We are doing a project right now to get youth to create their own positive sexual health messages that they then share with community, so they are creating their own media. Then there is buy-in; they take ownership of it.
• There is a need to redefine what is healthy and advertise it.
• Put up posters with good looking people running so that people are encouraged to take up running.
• Counter-marketing has been effective in tobacco control. I think it could have the same impact in marketing of food, because that is an area we have not touched in terms of legislation except in Quebec where they prevent the marketing of food to children. But if you look at any television show and you have Pop Tarts and Kraft dinner and all this stuff that’s advertised, I mean, they do make it look really good. However, it’s up to governments to counter-market generally, and it’s very expensive. You do a six-week television campaign just in British Columbia alone cost about $2 million. So to justify that to your taxpayers is very tough for politicians to do. You have to put a lot of money into it, and you have to sustain the same message over a period of time. They were very effective with seatbelt use. They still promote use of seatbelts today, but that is one where we’ve turned our mind around about seatbelts, most of us.
• If we read the history of McDonald’s, it was the movie Supersize Me that had the most negative impact on the sales of McDonald’s food. It was that type of movie that actually spoke to the younger generation and so now they will not work at McDonald’s or eat their food, no matter what they do to change their food choices. Their market share is going down. I think we need to understand what makes the younger generation tick, and it is totally different than what makes us tick.
• Provide advertising of healthy choices through the media.
• Start a health television channel for generally accepted practices.
• Instead of advertising dollars to sell us products we don’t need, we should have television educational programs to teach people about health and physical fitness, etc.
• Show empowering movies that will affect whole communities. Create an awareness of the long term consequences of behaviours.
• Use humorous television ads to get messages across.
• Ideas about the media, awareness, and accessing information:
  • Promote healthy choices and healthy living, increase the available information encouraging everyone to look after the environment and helping people to lead healthy lives.
  • MLA and MP circulars could be used to present the latest findings on research into the link between lifestyle and health.
  • Ensure the entire membership of any level of government models of healthy behaviour.
  • Determine the most costly medical illnesses and their trend from rigorous study and research and offer advice, raise public awareness for active prevention.
  • The Government should march every person in British Columbia through the Body World 3 exhibit for free. The majority would come out with a new reverence for their bodies.
  • The health authority should ensure they have spokespeople who are available to speak proactively on health issues, especially to the media. The health authority should be prepared to go beyond the provision of information and should also develop education programs that can empower people to take action. This means clarifying the impact of practices and policies on health and communicating user-friendly, culturally appropriate information in different formats for different audiences. This includes liaising with community organizations and providing statements from senior leadership to provide direction or drive an issue. It can also include offering workshops within the community.
  • Support increasing awareness through activities targeted to large groups. For example, hold a health fair.
  • Focus on changing social norms.
  • There is a need to focus on sexual health and discussion, especially with young people.
  • Ensure that people have knowledge they need related to nutritional requirements and the benefits of regular exercise.
  • It would be reasonable to target healthcare, the healthcare workforce, the people that are actually delivering the service for two reasons. Number one, our health care workforce is a huge part of the population. Number two is the value of role modeling, and the ability to impart information to patients based on personal experience.
  • Make people aware of cancer prevention through nutrition and lifestyle change.
The Vancouver Coastal Health Community Health Advisory Councils felt strongly that they could be a useful resource and partner in the population health agenda of the health authority.

• Have a strong focus on health and healthy living in our schools, communities and the media.
• Create a petition and contact your local provincial and federal representatives.
• Encourage family members to make healthy decisions.
• Utilize leadership classes to take action on addiction, and health promotion.
• Have community health fairs which can effectively target ethnic communities.
• Use the media to assist with promoting health in the ethnic communities; do not just rely on translation alone.
• Start a cancer information service line.
• Have handouts for specific cancers.
• Awareness is the first step to change.

Idea about education:

• Educate the public of the dangers of radon gas that result from uranium mining and exploration.
• Parents should model healthy behaviours for their children.
• Support partnerships based on the Participaction model. Go to schools and work places and focus on education, creating a grass roots movement for physical activity and health lifestyle. The Fraser Health In Motion Challenge is a good example of this type of initiative.
• Focus on prevention through partnerships and education. Provide centres based on community needs.
• There are risk factors for dementia, and armed with that knowledge there are risk avoidance activities all of us can utilize.
• Create a wellness craze and hold local community forums to educate people.
• Educate people about smoking, as this is a health prevention strategy which is very necessary. Smoking is very bad for your health. Especially second-hand smoke in places like bus shelters where one has no choice: it’s either stand in the rain or breathe in smoke.
- The peri-natal and post-natal periods are excellent times to educate parents on how to be healthy and keep their families healthy. This type of health care education could involve retired nurses.

- Promote dental (mercury) amalgam toxicity awareness and support amalgam removal.

- I would like to recommend that the government prepare educational material that advocates the benefits of alcohol abstinence. A great job has been done of educating the public on the health hazards of smoking. Now, if the same thing was done regarding the incredible health, emotional, financial and relational hazards of alcohol abuse, a great many people would benefit.

- Elders should be educated on social responsibility.

- Provide education related to women’s health including the right to choose.

- Offer increased education about social determinants and health.

- Provide a publicly funded health education series for members of the public at the local, community level.

- Place more emphasis on prevention education. It should account for more than 3 per cent of the budget. Primary health care providers should be encouraged to speak out more on issues around prevention; they are currently not proactive enough and could be encouraging the right decisions around nutrition, fitness, and lifestyle choices.

- Health providers could also offer public forums on specific topics.

- There should be more community health care centres, offering information and education on chronic conditions (a wellness centre approach).

- Provide First Nation communities with more information sessions on signs and symptoms of common and important health risk problems, e.g. cancers, prostate, heart attack.

- Provide health education so people can make healthy choices and be proactive about it, e.g. advertise Prostate-Specific Antigen (PSA) testing locations.

- Hold workshops and education campaigns that youth can respond to.

- Education needs to come from unbiased sources (not drug companies).

- Government must take the lead in educating people about healthy lifestyles.

- Guilt people into being healthy though humour, changing social norms and education.
There needs to be more youth and public education around how to use paramedics and emergency rooms appropriately. Use posters, bus shelters, radio, television and Public Service Announcements.

Discuss everything from what causes drug addiction to how to solve it. Parents need to talk to kids. Teachers should not preach, just listen. Counselling should be available to every age group.

Share the costs stemming from teen education regarding drinking and drug use with the Insurance Corporation of British Columbia and collaborate with WorkSafe BC to educate kids about safety.

Use former addicts to advocate against the use of drugs.

Create educational resource packages to allow student to share education with family members.

Provide education on healthy living and eating from preschool to college.

Emergency rooms in hospitals should have televisions that keep displaying basic health living tips on proper nutrition and healthy lifestyles, and more.

Before a person is discharged they should be sent to the health promotion/disease prevention wing for education. Sending them home uneducated with no health and wellness action plan is just an emergency room revolving door.

Targeted resources are required in order to raise public awareness and bring mammography participation rates in BC up to 70 per cent. We do not consider the projected 60 percent increase in new cancer cases over the next 20 years to be inevitable. At least 50 percent of cancers are due to preventable factors. The earlier cancer is detected and treated, the better the outcome.

Give some specific information on how to prevent recurrence of medical problems.

Provide educational resources, library, courses and education sessions for cancer.

Information has to be available, could be through support groups for patients with different illnesses to get information and support.

We need consistent and constant messages/teaching. Bring the message clearly.
Health Professionals and Service Delivery

Comments and Concerns

Health Professionals and Prevention
Education and Health Professionals

• Comments on health professionals and prevention:
  • Doctors are treating illness and not addressing health care needs.
  • There is little focus on preventative medicine.
  • Most doctors do not talk about prevention.
  • We tell people that they should live healthy lifestyles, and that there is all kinds of
    things they should do and yet we do not pay physicians to do any wellness
    counselling with their patients.
  • Treatment is currently focused on immediate, current problems rather than
    prevention.
  • We tend to combine delivery of care with a system that is focused on disease
    prevention. They are not the same thing.
  • Though the need has been clearly demonstrated, there is still no mechanism
    contemplated through the draft dentists’ bylaws to determine standards, provide
    guidelines, or to permit certified dental assistants to practise as independent
    contractors who provide protective intervention services in specialised programs
    for infants and children. Nor is there any such mechanism for practise in First
    Nations communities, long-term care facilities, or under-serviced and
    marginalised populations such as new immigrants, the poor, and rural and remote
    communities.
  • Of the approximately 6000 certified dental assistants who are licensed with the
    College of Dental Surgeons of British Columbia (CDSBC), few have the cursory
    screening designation on their license; even less are employed by health
    authorities. This is a shockingly small number of professionals practicing in an
    environment where so much could be accomplished with appropriate emphasis
    on sustainability to meet the governments’ objectives of a healthy population.
  • I spoke to a doctor recently who said that doctors should only focus on
    diagnosing and curing disease because everyone else is in the prevention
    business. That has to be unconscionable.
• I believe very strongly that the focus on health is entirely too much on doctors and hospitals. The focus should be on disease prevention and on health maintenance, not only on crisis management. Unfortunately, doctors and their sponsors, the pharmaceutical companies, do not benefit from a well population, but from a sick one. Doctors should have input but not the final word in this discussion.

• We need to place more emphasis on health promotion and primary prevention instead of carving out pieces of the pie to manage disease as it progresses.

• When there is a family history of cancer then all measures need to be taken to prevent this disease.

• Lab test information supports better decision-making for physicians and patients.

• Pharmaceutical companies and greedy doctors are destroying our system. Doctors should be treating the whole person and doctors have no nutritional education at all. Proper nutrition heals the body. Doctors should update their education on nutrition.

• Comments on education and health professionals:

  • Body type research demonstrated that optimal diet depends on individual body type, but the vast majority of doctors do not seem to be aware of this and tend to prescribe the four food groups as a matter of course, when they are really only optimal for people with certain body types.

**Ideas and Suggestions**

**Health Professionals and Prevention**

**Education and Health Professionals**

**Prevention and Health Promotion Services**

• Ideas about health professionals and prevention:

  • We should have multi-disciplinary teams working in schools and communities and supporting healthy living initiatives.

  • Have wellness counsellors available to provide coaching, guidance, information, role modeling, and follow-up.

  • Support community nurse visits for prevention and education.

  • For physiotherapists and other health providers that have direct access with the patient, we have a big role to play in prevention.
• We should promote good health through clinics and provide more time for this promotion.

• Primary care physicians are proactive in prevention and can provide annual medical tests.

• Pharmacists also have a role to play in the education of the public, especially on nutrition and health care. Some chain drug stores have a program in place currently where pharmacists do play a role in the community on education of the public. It’s another way to seek advice at a low cost.

• Doctors need to be tougher on people to get them to look after themselves.

• Have government, health care professionals and industry partner to assist in delivering messages on appropriate models of care, therapeutic guidelines, prevention, et cetera. Use the resources the industry has to help deliver and reinforce agreed upon messages. This can be done through an open and transparent process and I know the Pharmaceutical industry is very interested in working with the Government of British Columbia, health care professionals and patients.

• Ideas about health professionals and education:

  • Clinicians are terrible clinical educators. It is not that we do not try, but we are not trained to do it, and the asymmetry of roles makes the patient a poor recipient for clinical education coming from the doctor. It is more effective when delivered in a peer-type relationship. Why do you think chronic condition and self-management classes are far more efficient when they are taught by peers rather than doctors? We need to think about how to play to people’s strengths in health education.

  • Doctors take a large portion of the funding, so they should be trained in nutrition.

• Ideas about specific prevention and health promotion services:

  • We should provide bone density scans to people for whom it could make the most difference: teenagers who still have years to build strong healthy bones and healthy lifestyles. That alone would save millions in future health care costs.

  • People should be weighed when they see a doctor and someone should talk with them if they are too thin or too fat.

  • One small token to promote a consciousness about healthy living would be simply to weigh people on admission and again on discharge from hospital and also on each visit to a medical clinic. Make it a routine just like taking blood pressure.
• Fitness instructors would like feedback from physiotherapists, physicians, to better serve their clients.

• Providing doula services for all women desiring them and lactation consultant services or other breastfeeding support for a minimum of 6 weeks postpartum would decrease medical and illness care costs for mother and baby for many years to come.

• Clinical Interventions and Management: Implement a program of prevention detailing to provide education and feedback to enable primary healthcare providers to address risk factors more fully. Cover out-of-pocket expenses for nicotine replacement therapy initiated within a recognized clinical program. Provide reimbursement for lifestyle counselling around physical activity, healthy eating and living smoke-free. Provide compensation to primary healthcare providers for lifestyle counselling around physical activity, healthy eating and living smoke-free.

• Doctors should put patients on a weight loss program, and patient should have to complete the program before medical procedures are preformed.

• There should be mandatory diet education and treatment for overweight children and parents.

• Portable Defibrillator installation should be encouraged in public places.

• Maybe people could be provided with an individual report card as to the status of their health. This might be difficult to implement, but the report card or health status could be provided either by professionals or through self-reporting via a questionnaire.

• Create a partnership with British Columbia Medical Association to ensure family physicians inform patients over the age of 40 to receive a regular screening mammogram.
Legislation

Comments and concerns

Smoking and Tobacco

Encouraging Healthy Lifestyle

- Comments on legislation concerning smoking and tobacco:
  - The social costs of drug addiction are trivial compared to the social cost of smoking. This fact should not continue to be hidden from the public.
  - Why are you failing to take steps to protect the health of British Columbians from second-hand smoke in their homes? How many British Columbians have to get sick from second-hand smoke in their homes before you understand that it is a problem that needs to be dealt with? I hope the situation will be rectified through legislation.
  - The proposed regulations under the Tobacco Act call for the establishment of a three metre smoke free buffer zone around building entrances, windows, and air-intakes. Unfortunately, evidence suggests that to reduce the harmful effect of second-hand smoke, smoking areas have to be separated from non-smoking areas by a minimum of 7.5 meters. The proposed buffer will not offer any protection from second hand smoke.
  - Bill 10, which effectively makes it difficult to smoke in any public place and to obtain tobacco on government property or public institutions, is a positive move. This not only protects non-smokers from tobacco’s harmful effects, but discourages further tobacco use by current smokers. Legislation such as this lays the foundation for further bold action that aims to reduce the existence of chronic disease risk factors in British Columbia.

- Comments on legislation to encourage healthy lifestyles:
  - Healthy lifestyles will not be something that a government can legislate and say 'we have decided that people will now do XYZ.' The community and the whole population has got to start to get involved in this discussion and change some of our behaviours. Our habits lock us into the past and our habits are locking us into some pretty dismal trends for healthy living, health costs, and other government services that we will be able to provide.
Ideas and Suggestions

Smoking and Tobacco
Encouraging Healthy Lifestyle

- Ideas about legislation concerning smoking and tobacco:
  - It is time to introduce smoke-free legislation to B.C. Simply reinstate the WorkSafe BC non-smoking workplace legislation that was cancelled in 2001. With a simple stroke of the pen, B.C. taxpayers will save millions as a result of reducing cancer-related diseases.
  - Three possible measures for tobacco prevention: 1. Provide the nicotine replacement patch at no charge on demand. The provincial taxes collected from the sale of tobacco will cover the costs. As the smoking rate declines, less taxes will be collected, but then fewer patches will be required. 2. Make tobacco use within 30 metres of a person under the age of 19 an offence punishable by way of a fine equal to 2 per cent of their previous year's gross income, or $200 - which ever is greater. 3. Increase the fines for each subsequent offence until it reaches 12 per cent of gross income or $1,200 (which ever is greater).
  - Cigarettes should be sold in government liquor stores only.
  - Parents who smoke tobacco in vehicles with their children should be charged with child abuse. The fines collected could cover smoking cessation programs for the offenders.
  - Include tobacco in the list of prohibited substances along with marijuana, cocaine, and heroin. Subsequent sentencing after 10 convictions for tobacco use should include a mandatory minimum of 500 hours community service in addition to fines and forced attendance in addictions counselling for tobacco abuse.
  - The government needs to pay for people to go to rehabilitation for smoking and help them to stop smoking.
  - Make the production and sale of tobacco completely illegal.
  - The provincial government must immediately restrict all tobacco sales to provincial alcohol distribution outlets. No other addictive, debilitating, deadly drug is available in almost every supermarket, drug store, gas station, convenience store.
  - The current law prohibiting tobacco sales to persons under 19 years of age must immediately and frequently be monitored and enforced, with substantial, effective deterrents (fines and retail license suspensions) applied to those who choose to defy the law.
• Why not legislate a graduated legal smoking age? For example, if it is currently illegal to sell cigarettes to 18 year-olds. Let's make it 19 years old next year, 20 years old the following year and so on. Eventually an entire generation will grow up smoke free.

• Tobacco taxes must be increased frequently to deter children from buying tobacco products, to encourage smokers, especially those on low incomes, to quit, and to show smokers that society disapproves of tobacco use.

• I would like the government to make a date and legislate that we will no longer support people to begin a habit that causes such great harm; then state that anyone born after a certain date will not be permitted to purchase tobacco products ever.

• Parents should be prohibited from smoking in the car with their children.

• Implement consistent, comprehensive smoke-free legislation in the province, including 100 per cent workplace bans in the hospitality industry.

• Lobby pharmacies to stop selling cigarettes.

• Increase the price of cigarettes by $2.00 per carton per year.

• Continue to protect against creative attempts by the tobacco industry to market their product, such as retail power walls, product placements, smoking in movies and magazines.

• Improve compliance with restrictions on tobacco sales to minors.

• Enforce a smoking ban on patios where smoke can drift into the windows and doors of neighbours, and at any public venue where people sit or stand in close proximity.

• If I had not quit smoking I would be dead; stopping smoking in public places is a good idea.

• Ideas about legislation to encourage healthy lifestyle:

  • Enforce legislation to discourage bad habits, such as alcoholism, drugs, tobacco.

  • I believe that an educational program will be much more effective than a mandated dictum.

  • Split the time change by 30 minutes and keep it consistent over the course of the year. This would lead to better sleep patterns for those who live in the affected regions.
• Why did people start to participate in recycling? Because it was the right choice, the easy choice, bins were provided, pickup was provided and there was peer pressure. Legislation is effective even without enforcement.

• Pass legislation that allocates a small percentage of all health, social service and Attorney General budgets to prevention every year, which will increase in tiny increments until there is less money required for remedial costs and most of the budgets are allocated to prevention and better quality of life.

• Promote the effectiveness of organizations like Mothers Against Drunk Driving (MADD) and legislate stiffer legislation and penalties for drinking and driving.

• The Canadian and provincial governments should counter unhealthy corporate food processors and services with legislation and improved educational programs in the mass media and schools.

• The fluoride in toothpaste must be forbidden.

• Advertising gambling should be made illegal.

• The policy around the sale of alcohol, particularly to seniors, is going to become an even bigger issue and impact the level of assisted care required for these people.

• The two things that made a difference to the success rate for neurosurgery patients were the helmet and the seatbelt. So there was a policy or legislation. If you do not wear your seatbelt, you pay $200. So we need a combination of policies and education related to health promotion, lifestyle and personal responsibility for health.

• Make vaccinations mandatory.

• Legislation to help make health choices the easier choices.
Lifestyle and Health

*Lifestyle and its effect on health* was a common topic of discussion in the Conversation on Health. The importance of addressing issues related to incentives and disincentives for healthy behaviour, healthy lifestyles for children and youth, smoking, and personal responsibility, were highlighted in many of the discussions and submissions. Here is a selection of what British Columbians had to say on the subject of lifestyle.

Healthy Lifestyles

Many participants voiced concerns related to unhealthy lifestyles and their negative impacts on the health care system. Many believe that the most fundamental issue related to lifestyle choice is poverty, and until every person has the means to access healthy food, stable shelter, and education, people will be unable to have full access to health and well-being. The idea of targeting incentives to encourage healthier lifestyles among vulnerable, at-risk populations was frequently discussed.

Many participants emphasized the link between healthy lifestyles, including diet, physical activity and personal habits, and lower rates of chronic disease. Some suggested there is a need to resist the tendency to look at disease specific issues and find common risk factors. Many voiced concerns related to the apparent increase in the inactivity of British Columbians, and there was widespread recognition that lifestyle improvements will require a long term campaign to educate the population to take responsibility for their health. Many participants describe ActNow BC as an excellent program and a step in the right direction. However, British Columbia’s healthy living momentum must be maintained. Many emphasized the need for integration between the environment, transportation and health. Others discussed the importance of infrastructure renewal in many communities to address the aging facilities.

*Communities can and should play an important role in keeping us healthier... Every community should have a long term development plan that stimulates healthier lifestyles, leads to less... driving and more walking, bicycling and public transportation use, creates more green spaces and community gardens, makes space for as much as possible produce grown locally*

- Web Dialogue, Nanaimo
Incentives and Disincentives for Healthy Behaviour

There was considerable debate about the idea of incentives and disincentives for healthy living. A number of participants wanted to look at penalties and disincentives through Medical Services Plan premiums that would work like the Insurance Corporation of British Columbia (ICBC) model, with health care premiums going down as risky behaviours are eliminated or counteracted. Some suggested higher taxes on cigarettes, alcohol and gambling, while others disagreed with the idea of disincentives or penalties, emphasizing that they would not want the government to set policies dictating what would be considered a healthy or unhealthy lifestyle choice.

Many feel that currently, there is no incentive to become healthier. The creation of public policy supporting healthy lifestyles was certainly encouraged by participants. Suggestions included: 100 per cent smoke free legislation, clearer nutritional guidelines on food packaging and removing junk food from public buildings. Many participants wanted to explore incentives that encourage healthier living including: tax benefits or lower fees for gym passes or weight loss programs, tax credits for those who stay healthy and the removal of sales tax from items that promote healthy living and exercise. Changes that enable people to live healthier lifestyles were also recommended, such as bike lanes and affordable, accessible public transportation, and smoke-free environments. Participants support programs that encourage healthy behavior in youth and create affordable, accessible recreation.

_If we want people to engage in healthy lifestyles, provide incentives, for example, reduce or do away with user fees for community centres and other publicly run exercise facilities. Stop charging high rental fees for sports groups to use fields, gyms etc... Money spent there is saved down the road by having a healthier, happier society. Cuts to services go deeper than the dollar value. They impact people in a very real way._

- Web Dialogue, White Rock

Children and Youth

There was widespread concern that high levels of obesity in children are associated with poor diets and sedentary lifestyles. Participants believe that school districts are struggling with lack of funds for facilities to promote healthy lifestyles, and physical education programs have been cut. Many of the youth who were consulted agreed that young people can feel they are invincible and that they will not see the negative effects of their lifestyle choices. For example, young people are smoking, despite the
knowledge that it is unhealthy. Participants suggested that although there should be more in-school promotion of activity and nutritious food choices, it is also important not to push youth to extremes in healthy lifestyles. Many believe that there are not enough incentives for children and parents to be active and programs are too expensive for children already at risk.

**Smoking**

The Conversation on Health received a considerable amount of feedback related to smoking. Many participants believe there is a direct relationship between smoking and overall health care costs. The higher smoking rates in men than women, Aboriginals than non-Aboriginals, and in those who live in the Northern regions of British Columbia were troubling for many. Covering the costs of aides to help people quit, eliminating retail displays, increasing the number of tobacco cessation counsellors and remunerating physicians to counsel patients, as well as increasing taxes on cigarettes and eliminating smoking from public places, were among the recommendations related to smoking cessation.

Several participants emphasized that former smokers continue to have a higher risk of many diseases, than do individuals who have never smoked. This stresses the fact that while smoking cessation is critical; prevention of smoking uptake in the first place is still the best approach. Many have pride in the fact that British Columbia has been very successful in reducing smoking prevalence in all age groups. However, participants emphasized that anyone that started smoking in the last ten years is not paying attention to the widely known potential health risks that are associated with smoking.

**Personal Responsibility**

Many believe that our society suffers from a sense of entitlement and does not embrace the concept of personal responsibility for health. Similarly, participants suggest the health care system itself is geared towards being reactionary instead of focusing on prevention and early intervention options. It was widely recommended that people be empowered to take responsibility and be personally accountable for their use of the health care system.
Some focused on the importance of increasing the responsibility of families and communities in raising healthy children, and providing them with the resources to do so. Others suggested the development of health care and community networks that empower people to take care of their health in a proactive way. Specific recommendations included: giving printed report cards to patients outlining actions they should take to improve their overall health, providing individual health assessments, and giving patients control over or access to their own health records. In agreeing that individuals must be accountable for their own choices, many emphasized that alternate options in health care must be readily available.

_We must focus more on health promotion and protection, and prevention of disease. Improving our collective health and maintaining wellness is surely less costly than treating disease. We must create environments, through policy and other mechanisms, to make the healthy the easy choice such that tobacco reduction, healthy eating and active living are supported by our environment, versus discouraged as is currently the case. We must pay careful attention to the determinants of health and take action to create the conditions for individuals and families to achieve their potential. Critically important is poverty reduction. Income is a powerful determinant of health._

- Web Dialogue, Vancouver

**Conclusion**

With regards to lifestyle, the majority believe that we need to make the healthy choice the easy choice, including by alleviating poverty. Participants recommended that the government play a leadership role in assisting the province to move towards healthy living. To do this, many suggested providing incentives to facilitate the adoption of healthy lifestyles and increasing people’s capacity to take responsibility for their health.

_I think there is a lot that our society can do to support healthy choices. [These can] range from regulation, to discouraging unhealthy products, to changes to our communities to make walking easier [and] to changes in social norms and attitudes towards physical activity and diet. We need to make the healthy choice the easy choice if we are going to affect behaviour._

- Provincial Congress, Vancouver
# Lifestyle and Health

This chapter contains the following topics:

- **Lifestyle**
- **Incentives and Disincentives**
- **Children and Youth**
- **Chronic Diseases**
- **Smoking**
- **Personal Responsibility**

## Related Electronic Written Submissions

(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

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Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Health Promotion; Social Determinants of Health and Self-Care.

Lifestyle

Comments and Concerns

Social Determinants
Cultural and Societal Norms
Lifestyle Choices
Promotion of Healthy Lifestyle
Costs to the System

- Comments on the social determinants of health:
  
  - The most fundamental issue related to lifestyle choice is poverty. Until every person has the means to access healthy food, stable shelter, and education, people will be unable to have full access to health and well-being. This should be done by addressing the determinants of health through a lens that focuses on promoting health for all, not through a prevention focus that blames people for their ill health.

  - Increasingly, healthcare professionals and policy-makers are paying attention to the environmental (sometimes called ecological) contributors to personal health risks. Increasingly it is being recognized that behavioural risk factors involve more than individual decisions. For example, with advancing technology and certain urban built forms, there is less demand for physical activity; unhealthy meals are often faster and less expensive than healthier meals; and there is still relatively easy access to, and extensive promotion of, an abundance of tobacco products.

  - Leading a healthy lifestyle is expensive. In many cases, the working poor cannot afford a healthy lifestyle.

- Comments on cultural and societal norms and pressures:

  - Currently, people seem to be working longer and sleeping less. If we address this it may lessen use of sleep-aids.

  - We have a growing number of people living alone; often in places where they do not have much of a social/safety network. This can result in: financial stress,
depression (poor eating, exercise, sleep, work habits); escapism (alcoholism, drugs, gambling); violence; and social isolation, particularly for single parents, those with mental and physical disabilities, the elderly and those living in rural areas.

- It has become acceptable to be overweight.
- People who are mentally, physically and emotionally stressed out are not healthy.
- It is concerning that today's generation is the first to have a shorter life expectancy than their parents.
- We are fat, we are lazy, we smoke too much, drink too much, eat too much and complain too much.
- We live amidst a barrage of marketing messages, seducing us to eat processed foods, to watch TV or spend time on the internet, instead of out walking.
- There is concern with the social pressures related to breastfeeding.
- Families are not eating together due to time pressures.
- Social policies which support the use of personal motor vehicles over public transit lead to reduced activity and increased pollution. In addition, motor vehicle accidents correlate with numbers of automobiles and their use, whereas injuries and deaths are less with increased public transit.
- The explosion of diseases in the present society is primarily caused by drastic changes in the dietary pattern and way of life.
- How we can encourage activity and physical health for First Nations peoples?

- Comments on lifestyle choices:
  - People have to consider the negative long term effects of some forms of exercise. Nobody tells you that if your knees start pounding after 25 miles of running a week while you are training to become a marathoner at the age of 18 or 19, and you are 160 pounds, that you are going to have problems when you get to be middle aged.
  - On one hand we provide free will and then we are surprised when a segment of the population makes bad choices. There is no link between various government policies particularly the sin activities (booze and gambling) and how it links to health costs.
  - I am really upset by people who lead unhealthy lifestyles and abuse the system.
  - Most of our diseases are caused by lifestyle, particularly the consumption of animal products.
Chronic obesity, smoking and drug use are voluntary conditions which cost the health system a lot of money.

It can be difficult to get people to make positive lifestyle choices.

It is important to recognize that there are major differences between obesity and smoking. First, food and activity are essential to life; tobacco is not. Second, there are possible negative consequences of a focus on obesity, such as disordered eating, that should be taken into account. Third, there are underlying genetic disease conditions that contribute to obesity. And fourth, research on the impacts and interventions related to obesity, diet and physical activity is still in its infancy. In spite of these conceptual and practical differences, there are important overlaps between tobacco use and obesity, including the fact that social influences and advertising pressures affect what we eat and how active we are. Furthermore, some have suggested that we currently live in an 'obesogenic' environment were people struggle against urban forms, transportation policy and economic factors which promote high energy intake and sedentary behaviours.

Over half of British Columbia's adults are not active enough to derive health benefits from exercise.

The public and the lifestyle choices made by the public over many decades seem to have brought the healthcare system close to the edge of irreparable failure. In short, the healthcare system is itself terminally ill.

Those who are unable or unwilling to live a healthy life style can cause significant health and social problems. Pregnant women who drink during pregnancies are likely to produce children with a Foetal Alcohol Syndrome and these children are very likely to become less or non productive citizens.

Comments on the promotion of healthy lifestyle:

My experience with pharmacotherapy is that doctors over-prescribe medicine and under-prescribe lifestyle changes. Doctors need to talk to their patients more and prescribe behavioural changes more often than medicine.

There is a shortage of day-to-day activities to help people to stay healthy.

Finland is an example of a jurisdiction that has had success in changing public behaviour and health results through actions like: distributing healthier, easy to make recipes for cooking, putting in place new policies to help farmers to switch to growing canola and growing berries. The tax policy on dairy fat and vegetable oil fats was altered so that dairy fat was no longer favoured.

Right now our elected government is very actively engaged in promoting healthy living in this province and they are doing an excellent job of it.
• It is encouraging to note that long-term physical activity is related to postponed disability and independent living in elderly individuals.

• Courses on nutrition and lifestyle change could be mandatory just as anger management courses or community services are mandatory for offenders on other fronts.

• With respect to prevention, the good news is that approximately 50% of cancers, and other major chronic diseases, can be prevented, in large part, by addressing the common risk factors of tobacco use, unhealthy weight, unhealthy eating, and physical inactivity.

• Comments on costs to the system:
  • If just 10% more British Columbians were physically active, the province could save an estimated $16.1 million every year in avoided hospital drug, physician and other direct costs. Added to an estimated $19.9 million in productivity gains, the total economic savings to British Columbia from a 10% reduction in physical inactivity could amount to $36 million.
  • Given the fact that everyone dies, is there any empirical evidence that proves that healthy lifestyles actually cost society less over the whole lifetime of the person?
  • It is no secret that the five big killer diseases in our culture are all related to lifestyle. Obscene amounts of money are spent treating people who do not know or care how to live a healthy lifestyle and then we keep them alive at the end with medical heroics when that money could have been more effectively spent on education and prevention.

• There should be a screening program to evaluate prospective parents to ensure that they have the parenting skills necessary to support their offspring.

• We must find a solution to hip and knee problems. I think it has to do with what we eat and drink and how little exercise we do early in life.

• Evidence based practice may limit innovation; there is not as much research in prevention-oriented activities.

• Amidst all the concerns about the obesity epidemic, the assistant chief statistician refuses to allow his staff to use the words obesity and epidemic in the same sentence.
Ideas and Suggestions

Social Determinants
Cultural and Societal Norms
Lifestyle Choices
Promotion of Healthy Lifestyle
Costs to the System
Infrastructure to Support Healthy Living

- Ideas about social determinants:
  - Target incentives for healthier lifestyles to vulnerable populations with increased risk: Aboriginal, New Canadian, low income.
  - Consider consequences for lifestyle choices, balanced with understanding of a person's social situation (social determinants).
  - Acknowledge and understand the barriers to behaviour change.
  - It is not so simple, because living healthy depends, to a great extent, on individual choices, but clearly individual choices are greatly influenced by larger social and economic factors.

- Ideas about cultural and societal norms:
  - Improvements in lifestyle will require a long term campaign by the government to educate the population to take responsibility for their health through lifestyle changes.
  - Maintain the current healthy living momentum.
  - It has got to be cool to wear a helmet. It has got to be cool not to smoke. And it has got to be cool to be healthy and do physical activity, because a lot of people just do not like being told what to do.
  - Vancouver is one of the top communities in the country in terms of a low prevalence of obesity. It might be worth thinking about, what it is about Vancouver that gives us a degree of protection. We are probably the lowest smoking population in the entire world. I mean, talk about success!

- Ideas about lifestyle choices:
  - How do we engage a private industry? How about the Fairmont telling me I get five per cent off my hotel if I use the gym?
People with breathing difficulties should not have pets. Pets can make breathing difficulties worse. For example, cats’ dander can exacerbate breathing conditions and can be very harmful.

To me it seems that we have two categories of medical problems, self inflicted and congenital. Self inflicted conditions are the results of poor decisions and lifestyle choices, for example, obesity, alcoholism, drug addiction, tobacco use etc. Congenital is from birth or genetic inheritance. So, a congenital condition should have a higher priority for treatment than a self-inflicted one. This in itself will not cut costs but as people with self-inflicted injuries find themselves getting bumped for congenital problem treatment, they will have an incentive to change their lifestyle.

There are a lot of fad diets are around, but what it really comes down to is eating moderate portions, choosing more healthy alternatives most of the time, and getting some exercise a few times a week.

Ideas about the promotion of health lifestyle:

- Use senior centres to educate and encourage seniors to eat healthy and exercise, teach healthy lifestyle.

- Sustainability for the future can only be achieved by educating the public on proper diet and exercise, unhealthy lifestyles, overuse of medications, and road safety.

- Support counselling for healthy living (paid coverage).

- Create public policy that supports healthy lifestyles (100% smoke free legislation, walk able safe communities and environments, taxing of unhealthy food and incentives for healthy food, removing junk food from public buildings).

- While the provincial government must play a leadership role in helping us move towards healthy living, it cannot do it alone. Partnerships are needed with municipalities, businesses, the food industry, volunteer organizations, media and others, because government funding towards supporting healthy choices will always be tiny compared, for example, to the billions of advertising dollars that is spent by the fast food industry.

- More effort should be made in the area of info on eating healthy (no fast food, no prepared food with additives etc.) On active physical life, on alternative treatment such as chiropractor, massage, acupuncture etc.

- Give people the resources to track health status, self-awareness and self-monitoring to allow for prediction of future body state. Provide people with a visual representation of personal progress relative to norms and extremes.
• Provide free bittersweet chocolate everyday and lower taxes on red wine as it helps lower cholesterol.

• Partnerships increase both the opportunity for collaboration between different stakeholders in the world of prevention and health promotion, and the possibility of focusing limited resources to achieve the greatest benefit. The fact that a remarkably short list of major risk factors relates to an array of serious chronic diseases multiplies the potential for such initiatives. The advantages of partnerships are manifold. For example, experts in tobacco control can share their learning with leaders in prevention arenas that are still emerging, such as physical activity and healthy diet. The influence of decades of research and practice around effective interventions in the 'tobacco wars' needs to be understood by those concerned with other aspects of a healthy lifestyle.

• It is estimated that 90% of all skin cancers could be prevented through healthy living and policies that protect the public. Sun exposure in childhood plays an important role in the subsequent development of cancer. Promote shade creation policies for daycares and schools. Implement legislation banning those under the age of 18 be banned from using artificial tanning equipment and increase measures to reduce exposure to tanning salons and improve shade policies.

• Ideas about costs to the system:
  • To achieve population health gains, sometimes factors need to be addressed in combination. The benefits of reducing multiple risk factors are potentially enormous. For example, focusing on both exercise and diet control often provides better weight loss or weight maintenance than either intervention in isolation.
  • Recreation and community sports are widely acknowledged to have a positive impact on healthy, active Canadians. Accepting these key benefits, the importance of ensuring the long-term sustainability of a healthy stock of community sports and recreation infrastructure becomes clear. We require actions that are multidisciplinary, comprehensive, integrated, sufficiently resourced and sustainable. People need encouragement and opportunities to adopt lifelong healthy habits that will improve their health and ease the burden on the health care system

• Ideas about infrastructure needed to support healthy living:
  • Support integration between the environment, transportation and health (to counter global warming, promote walking, and cycling).
  • Create dedicated roadways for bicycles, which allow no cars and are covered so that people will use their bikes for transportation.
• Multi-purpose buildings are a visionary way to go. Schools and seniors centres should be combined.

• More facilities to promote better health and lifestyle should be available in communities.

• Build walking trails that are accessible to wheelchairs.

• Make recreation centres mandatory in each community.

• Make school facilities available for public use (gyms etc.).

• Build proper aquatic facilities.

• Build double-lane highways right across the province. It goes beyond health.

• Infrastructure renewal is required in many communities as many current facilities are aging and facing replacement or renovation is needed.

• Recreation facilities, programs and active infrastructure (parks, trails and bikeways) are critical to creating and supporting healthy active communities and are central to binding communities through sport participation and social interaction. These facilities are also vital to the economic development of communities.

• The development of a comprehensive understanding of the condition of the facilities in the province through a recreation facility audit is needed. The audit will provide government with a comprehensive understanding of the condition of the facilities in the province in order to make educated, informed decisions that will help meet the goals of a sustainable sport and recreation system, creating opportunities to have the greatest impact on the health and physical activity levels of British Columbians. A small investment of $325,000 is required to conduct the audit which will review a sampling of 65 facilities, hire the experts to do the field work, database the information and provide a thorough analysis of the data and their report finding.

• Allow bikes on the transit system and on the sky train during rush hour.

• I would like to suggest the government to study the prospects of hybrid two wheelers or three wheelers with possible usage throughout the year.

• We need more green space for recreation. Waterfront communities should be encouraged to acquire waterfront property to add to their green space.

• Pemberton needs an ice rink.

• All British Columbian communities need to be designated green, healthy communities with a commitment to providing all the amenities that lead to good health.
Youth in Pemberton have no soccer field; we need to pull together to support team sports.

Over the past several years, the British Columbia Recreation and Parks Association has completed a three-phase study focused on gaining an understanding of the magnitude of this infrastructure problem. Through this process, the British Columbia Recreation and Parks Association has created an inventory database of municipal sport and recreation infrastructure, both indoor and outdoor. The findings reveal that, currently, over 70% of this infrastructure is over 25 years of age. By 2010, most will be in this category. It is estimated that these facilities represent a total capital investment of $3,350,000,000. Although we have experienced an increase in construction over the last 10 years, the current rate of construction is not keeping pace with approximately 20% of indoor infrastructure less than 15 years old. This challenge is particularly concerning given that it is generally understood that as a facility ages it becomes more and more costly to operate and nears the point at which large scale rehabilitation or replacement is required in order to allow it to continue to serve the community effectively.

There is a need to address transportation and environmental issues: provide infrastructure for alternative transport (for example, safe trails/paths for bikes and pedestrians); support alternative transport approaches, more buses, vans, volunteer drivers; need better sidewalks, paths for pedestrians etc. The health of our planet affects our health!

Allocate at least seven per cent of transportation-related infrastructure funds toward the development of community infrastructure that promotes the use of active modes of transportation.

We are in a bit of transition period in health care where we have traditionally treated the sick and focused on the sick, we are now trying to move towards a prevention oriented system. For a little while I actually think we are going to have to run a bit of a parallel system where you continue to invest in acute care, and then you invest as well in your other infrastructure supports to enable change to happen.

The Ministry of Transportation and their cycling paths initiative is an excellent example of a program focused on safe and secure paths.

On October 27, 2006, the Premier announced the creation of a new The Green Cities Project. The Province will invest $40 million over the next four years in a new Local Motion Fund aimed at getting British Columbians out of their vehicles as one element of the Green Cities Project to help British Columbian communities improve their environmental sustainability.
• Our town recently, through a lot of group participation and fund raising built a rubberized running track. It is now being used every day, mostly by non athletes, people with walkers, walking sticks etc. Women find it a safe place to walk, because it is out in the open and there are always others there. It shows that people will use these facilities if they are available to them.

• The other addition to our town is a dog park. Upon completion it was immediately filled with people and dogs and we see them there everyday.

• One of British Columbia’s Five Great Goals is to lead the way in North America in healthy living and physical fitness. This goal is directly linked to the ability of British Columbia’s recreation facilities and having the infrastructure to meet this challenge.

• Make walking trails accessible to wheelchairs.

• It seems clear to me that escalating health care costs are directly tied to land-use patterns throughout the province. Sedentary lifestyles in car-dependant communities are bankrupting this country and our province. The provincial government must immediately begin funding a huge scale-up in public transportation infrastructure and offer the resources for cities and communities to develop into more complete, compact, and walkable urban centres, thereby reducing the complete reliance on the private automobile for transportation.

• British Columbia Recreation and Parks Association recognizes and commends the Government of British Columbia’s recent investments in community active infrastructure projects, such as the Cycling Infrastructure Partnerships Program and Local Motion. We encourage the government to increase this type of funding, which assists local governments and community partners in meeting the quality of life needs of its citizens through projects and programs that support active lifestyles and reduce barriers to activity.
Incentives and disincentives

Comments and Concerns

Tax Incentives
Supporting Healthy Lifestyles
Regulation and Enforcing Healthy Lifestyles

• Comments on tax incentives:

  • The idea of providing tax refunds, for costs related to physical activity, is an area where I think that some deeper analysis is definitely necessary, because all the evidence we have around who it is who actually is getting sick, shows that it is very much is related to socioeconomic status. Therefore, we would be giving more money to the people who are already the healthiest, because they're the ones who get more tax refunds under our system, we reward good health, right, but the people who are suffering most from poor health are not the ones who are going to pay attention, or be affected by this. If you do not pay tax already then a tax refund does not help you.

  • The use of tax rebates to encourage healthy lifestyles may face public resistance.

• Comments on supporting healthy lifestyles:

  • The cost of healthy organic food and naturopathic medicine amounts to a tax on the health conscious. This is counterproductive for British Columbia’s population health, and as a result for its finances.

  • An incentive approach is something that we are starting to explore, particularly for older people because our understanding is that seniors love a bargain, and if they can get free physical activity and lower-cost healthy food, then that is going to be a huge incentive for them to take that up. There are some precedents in for example, school lunch programs. If you provide a school food program and you do not require people to come up and 'identify themselves as needing the support for it, you just provide it to everybody, then the people who need it will get the healthy food. Right now in recreation centres, all recreation centres provide free programming, but it is not publicized, and you have to go up and self-identify and say, "Gee, I need this." And that's a real barrier for people. We need to move beyond that requirement on the basis of need and provide that kind of access universally. It requires many sectors in society to get involved.
• In the current system, there are incentives to be sick. People in the sick role are excused of their responsibilities. We are not proactive in promoting health and recovery.

• There is currently no focus on outcomes and no incentive for being healthy. We have too much freedom and not enough responsibility.

• There are not enough incentives for people not covered under the corporate umbrella to invest in preventative, healthy lifestyles.

• The healthcare system does not reward those who take a preventative approach to health.

• Individuals, who make conscientious and pro-active choices to live their life in as healthy a fashion as possible, are essentially penalized by having to pay out-of-pocket for services/products that keep them from draining the system with chronic, costly health conditions. Why should those individuals who choose to live a less-than-healthy lifestyle, be carried by those who choose to live a healthier one, yet not receive comparable benefit from a system they must pay into.

• Obesity is in most cases a preventable health care issue that results from people not taking personal responsibility for their health. It is unjust that the taxpayers who work hard at living a healthy lifestyle must pay for the irresponsible. Not only does the responsible taxpayer pay for the consequences of obesity, but the health dollars going to obesity related health care should be going to legitimate health issues of those that have lived responsibly.

• Comments on regulation and enforcing healthy lifestyles:

• Every person’s body can react differently to the same variables. Two individuals could have the exact same diet and perform the exact same exercise regime, and one of them could be considered irresponsible because he is 25% over his recommended weight! Short of God determining who has been good and who has been bad, I do not believe you can deny services or charge extra for services to possible offenders. Health care should be available to everyone at the same level.

• The government-funded health insurance system is not voluntary. Each citizen must participate, and the system prohibits anyone from providing their own health insurance. To use this enforced system as a rationalization for further infringements on a person’s liberty, such as lifestyle rewards or punishments, is the moral equivalent of a protection racket: you do it for you own benefit (that is, lower health-care costs) not for theirs.
• Those of you who think you are doing this for someone else's benefit should consider what C.S. Lewis said: "...those who torment us for our own good will torment us without end, for they do so with the approval of their own conscience." I have never been a smoker, I have never had a car accident, I rarely ski, I don't rock-climb or bungee-jump, and I drink only moderately. I eat a reasonable diet, have low blood pressure and body fat, and am in decent shape for my age. In other words, I oppose those who "torment us for our own good" out of principle, not self-interest.

• "Big Brother" style government regulation will not make this any better without hurting freedom of choice and creating a new bureaucracy.

• I would not want to live in a society in which the government set policies dictating what would be considered a healthy or unhealthy lifestyle choice. Not only would this be an infringement on my rights as a human being, it would be a license for society on the whole to further socially persecute people (smokers and overweight people for example) even more than they already are.

**Ideas and Suggestions**

**Tax Incentives**

**Other Incentive Structures**

**Supporting Healthy Lifestyles**

**Regulation and Enforcing Healthy Lifestyles**

**Medical Services Plan**

• Ideas about tax incentives and disincentives:
  
  • Those individuals who seek out alternative or complementary care so as to not burden the system should receive tax incentives.
  
  • Implement fines for overweight people and funnel tax revenues from unhealthy substances (alcohol and cigarettes) directly into public health monies. These publicly collected funds could be used to make the system fairer for those that do not choose unhealthy lifestyles.
  
  • Provide tax incentives or tax breaks for healthy decisions, food, exercise equipment, training, etc.
  
  • Use the "Road Star" idea in medical system. Focus on self care and tax bad habits, lowering costs for those with healthy lifestyles.
  
  • Create incentive: establish tax breaks for gym passes.
• Increase taxes on cigarettes and alcohol with specific percentage targeted to health care. There should be no change to the premium structure or development of a user structure. Target prevention instead.

• Place sin taxes on junk food and give that money to health care. Prevention is the only thing that will save the health care system.

• Provide tax credits for children's sports programs.

• If the government is really concerned with obesity why do they not give a tax deduction to those that want to join programs such as Jenny Craig, Nutri-system, or a gym such as Curves? I would suggest a 100% deduction for these programs, both the entrance fee and the cost of the food supplements. Personally, if that were the case I would be on these programs tomorrow.

• I propose a system involving positive incentives. I do not believe granting credits for gym passes etc., or covering costs for yoga or pilates for example, will achieve the end point desired. There must be a system to assess health related improvement as a result of the new health programs. That is, that participation pays off in improved health outcomes. Develop a generic Individual Health Assessment and assign a tax credit value for a percentage improvement in the individual health assessment scores, assign a tax credit value for maintaining the score above a certain point and if there is no improvement or a decrease in the score, there is no penalty. The assessment could include such parameters as: Body-Mass Index; Hip to Waist Ratios; Blood Pressure; Lipid Ratios; Aerobic Exercise Capacity; Strength (hand grip); Smoking cessation; Self-Drug use cessation; Sleep quality; Nutrition quality; Stress balancing activities; Stress mapping; and, Job satisfaction. The testing could be carried out by a doctor, nurse or a specifically trained and certified assessor. Completed test results would be mailed out to the individual from the testing authority. They would then be submitted annually with the individual's tax return and a tax credit requested dependent on the percentage improvement value documented.

• There should be a health care tax on unhealthy goods and services (for example, foods such as pop, candy, junk food, certain fast foods, and so on) to offset the increased healthcare costs associated with them. Similarly there could be a health care credit or deduction for healthy goods and services that have been shown to promote health (for example, things associated with exercise). We cannot control the behaviour of others but it can certainly be influenced by incentives and disincentives.
• Rather than a charge being levied as a disincentive to inappropriate use of medical services, I suggest an incentive program. If the average cost of health care per person is $2,100 per year, why not offer a cash bonus or some kind of income tax benefit for those folks that do not use our health services.

• Ideas about other incentive structures:
  • The province needs to look at ways to encourage responsibility for our own health through incentives and disincentives for desirable and undesirable habits and behaviours. Any such initiatives should be based on proven outcomes.
  • Everyone should start with full coverage (100%), then should be penalized for their poor health choices by paying for a portion of their health care.
  • I like the suggestion of physicians applying demerit points for unhealthy behaviours on the one hand, on the other hand, a system like that would discourage patients who need to change their bad habits from going to the doctor and therefore, they would become even sicker.
  • Change behaviours with incentives and disincentives.
  • Reward a good lifestyle, punish a bad lifestyle.
  • There is no incentive to be healthier. We should have incentives like the Insurance Corporation of British Columbia (ICBC), with health care premiums going down as risky behaviours are eliminated or counteracted.
  • I believe that people who engage in injury threatening sports should be required to purchase insurance to cover the cost of injuries (for example, skiing, snowboarding, hockey, hang gliding).
  • I am in favour of implementing a user pay system for preventable lifestyle related health problems.
  • While life insurers give preferred rates to applicants who are an appropriate weight, non-smokers and so on, we all pay the same rate for provincial medical coverage. There is thus no incentive for healthy behaviour. Should the unfit, overweight smoker who abuses alcohol and other drugs pay the same medical services plan premium and have equal priority access to scarce hospital beds and overworked services?
  • Citizens over a certain age could be grandfathered in to a health care system that penalizes bad habits.
  • People who do not look after their health should be on a second list for services.
• Citizens not using the medical system at all during a given year should receive a cheque of 100 dollars and be sent a token or medal of some sort which they can display prominently if they want.

• Health is a complex system and incentive programs would have to reach all populations.

• If a patient can reduce their blood pressure by eating less salt and complying with their prescription medications they could receive a voucher for eye glasses or contact lenses.

• If someone can maintain their Body Mass Index at a normal value (18-25) then they could receive vouchers to use for spa treatments, massage therapy or other treatments.

• If someone is able to show good control of their diabetes they could have dental care coverage for a year.

• There should be rebates offered for those with osteoporosis who are actively taking up exercise regimes like weight training instead of expensive drug therapies.

• Ideas about supporting healthy lifestyles:

  • Schools with healthy food programs should be rewarded.

  • I do not think it is feasible to penalize people monetarily for unhealthy lifestyles. Maybe reducing the costs to facilities that encourage fitness would be sensible.

  • Gyms are too expensive for many people to join; there should be some incentive for people to join gyms or exercise programs.

  • Drug addiction and all of its related medical problems is a whole different problem. It is not feasible to penalize addicts as the penalty they pay now (for their lifestyle) is tremendous and nothing we could add would work.

  • Verbal encouragement to change one’s lifestyle seldom works. Money, however, often has a bearing on choices.

  • Provide encouragement for lifestyle improvement, rather than a financial tax or monetary benefit.

  • I would happily pay $90 for my next doctor’s visit if I could get my next $90 pair of running shoes for free. If it is so great for us to stay healthy, prioritize health care spending to reflect what is important.
• Subsidize the public to encourage them to keep themselves healthy. Subsidize attendance to self help programs, counselling, and education on diet and exercise and so on.

• Provide free passes to: sports; tutoring; social events; recreation.

• Ideas about regulation and enforcing healthy lifestyles:
  • The idea of a system that rewards its users for healthy life choices is not viable until the Medical Services Plan premium structure moves to a sliding scale system.
  • You can not legislate personal morality or values so incentives and penalties are not the answer.
  • The idea of punitive measures based on life style is a non-starter. You cannot vilify people for their lifestyle.
  • We need to change the system to reward patient outcomes and we need objective criteria to measure that.
  • I believe that a person who chooses poor health through self-inflicted behaviour does not deserve to be covered by our medical system or tax dollars. There is always a choice, and people should be made aware of those choices, but as a taxpayer I do not believe we should be responsible for other people’s poor choices in lifestyle.

• Ideas about incentives and Medical Services Plan premiums and coverage:
  • Reduce Medical Services Plan premiums according to a person’s healthy lifestyle.
  • The public should be tested every five years for fitness/wellness and knowledge of diet, and disease prevention. They should be given the results directly and Medical Services Plan premiums should be based on the results of the tests with special rates for handicapped.
  • Once the Medical Services Plan institutes a sliding scale to reflect lifestyle choices, random urine tests should be administered for all Medical Services Plan patrons to ensure that people who are paying low premiums are leading healthy lifestyles.
  • Make it mandatory for anyone holding a British Columbia Medical Card to have a physical/stress examination every two years and if they do not meet a minimum requirement or they lead unhealthy lifestyles they should pay heftier monthly medical premiums.
  • Passing a health literacy test could be part of applying for membership in the provincial Medical Services Plan.
• Comments on obesity and physical activity:

  • Children are experiencing very high levels of obesity associated with poor diets and sedentary lifestyles. At the same time, school districts are struggling with lack of funds for facilities to promote a healthy lifestyle.

  • When you leave school, it is harder to access exercise programs.

  • The effect of technology, the increasing time that we spend in front of computers, computer games, and video games has a detrimental impact on health, especially for the young. The general activity level of a child nowadays is much less than it was say thirty years ago. Instead of going out and playing baseball, they play it on a computer.

  • Kids are not getting the exercise they once did.

  • Existing data indicates that 70% of obese adolescents will continue to be obese in adulthood. It is crucial that we help these children and their families to develop healthy lifestyles that will last a lifetime.

  • Physical activity provides proven health benefits for children. It protects against heart disease, stroke, hypertension, type 2 diabetes, colon cancer, breast cancer, osteoporosis, obesity, depression, anxiety and stress.

  • The childhood obesity problem is epidemic and overweight kids are the norm now. These children will grow up to be chronic health care users.

  • Getting regular exercise is seen as a stronger factor for good health among 15-16 year olds than children 10-12 (95% vs. 90%) though both still strongly agree that it is important.

  • The most prominent reason children give for being in better health is that they're getting more exercise. Half of the youth interviewed chose this as a reason for being in better health. 'Eating better' is also seen as an essential contributing factor for improved health, though far fewer children raise this as a reason (26%).
• Comments on parenting:
  
  • Children are not receiving mentoring or role modeling of healthy living from their parents.
  
  • If research is correct and personality traits and attitudes are set before school age, then society has a very limited opportunity to influence each generation, except through early education of the young or through educating the parents during their children's pre-school years.
  
  • Children believe parents are most responsible for their health, although a good number also feel they’re responsible themselves.
  
• Comments on youth and lifestyle choices:

  • Youth can have the attitude that they are invincible and that the negative effects of lifestyle choices will not affect them.
  
  • More young people are smoking, despite the growing knowledge that it is unhealthy.
  
  • There is a lack of meaningful activity for youth. The home range sphere of neighbourhoods is shrinking.
  
  • There is a strong consensus among BC children that exercise, diet, and sleep are the top 3 contributors to good health. Three-quarters or more cite that these factors contribute strongly (either a great deal or a fair amount) to good health.
  
  • Youth are in agreement that the top contributors to bad health are cigarettes and drugs. Fully 9-in-10 youth surveyed stated that smoking cigarettes or taking drugs contribute to bad health.
  
  • More girls than boys felt that eating unhealthy foods, not getting enough sleep and stress contributed to bad health.

• Parents are paranoid about letting their kids play outside because of sexual deviants.

• There is over-reporting of negative incidents involving youth in the media and good news does not get reported.
Ideas and Suggestions

Obesity and Physical Activity

Parenting

Youth and Lifestyle Choices

- Ideas about obesity and physical activity
  - More in-school promotion of activity, food choices and hygiene are needed. There are not enough incentives for children and parents to be active and programs are too expensive for children already at risk.
  - Studies show that children who exercise are more likely to be adults who exercise.
  - Our children are not the ones stressing the medical system, it is the baby boomers. We need to challenge the beliefs of this group when it comes to activity and nutrition.
  - I feel that youth should be able to drop into swimming/skating sessions for no cost. The long term benefits would be to create an active lifestyle, that would become a way of life, and hopefully continue into adulthood, resulting long term in healthier adults.
  - Instead of spending money on the research and treatments, take these funds and encourage our youth to participate in sports.
  - Have a family health fitness grant available to encourage participation in fitness activities.
  - Offer incentives to get kids to lead more physical lives. Scare them into healthy behaviours if necessary.
  - Physical activity for young people is the key. We have had others highlight youth obesity and that is a growing problem. We have to cultivate in the young a life long love of sport.
  - There is a need for a balance between activity and eating healthy. Do not encourage kids to be too extreme either way. Encourage others to be active and healthy.
  - Do not sell junk food or video games to kids unless they have a card from their physical education teacher saying they ran X amount of miles in the last month or something like that.
• The Ministry of Health should ensure that the Minister of Education’s recent announcement that all students get 30 minutes of daily physical activity by September 2008 is implemented, and ensure that all schools in BC develop safe routes to school.

• Vending machines that cater to the junk food industry must be removed from our schools. They facilitate unhealthy food choices by children.

• Ideas about parenting and family planning:
  • Every child conceived should be a wanted child born to a healthy mother. There should be more access to the morning after pill.
  • Pregnancy Outreach Programs encourage at-risk women to focus on healthy lifestyles and eating, which helps to decrease obesity and chronic disease.
  • A child’s good health begins with the parents at home who have a partnership with the health system. This partnership begins with pre-conception, through to pregnancy, immunizations, and hearing and dental check ups, up until the child reaches kindergarten.
  • Kids need a stable environment where they can express their own point of view and feel at peace with their mind.
  • Encourage parents to care for children; allow them more time for meal preparation and healthier lifestyle.
  • Research found that one of the determinants of actually enjoying outdoor recreation was your childhood experience. So, if you either did not experience outdoors, or you had a bad experience of outdoors, you were less likely to engage in outdoor activity when you were older. Your experiences had to take place before about the age eleven. So, if parents do not take their children out, if there is a youth group that does, some sort of organization that takes kids out to camp, and that becomes a pleasurable experience for them, then they are more likely to enjoy other activities later on in life, it is enjoying that outdoors, which is again linking to health and activity and physical activity.
  • Parents should be held financially responsible for preventable injuries to their children if they were due to the parents not providing the proper protective gear to their child.
  • Provide foster parents with training on sex and parenting education and early pregnancy interventions.
• Address sexuality issues of children and youth in care proactively by working in conjunction with public health authorities and other resources to make sex and parenting education and supports available both during and on leaving care.

• Ideas about youth and lifestyle choices:
  • Hold a conference on healthy lifestyle for youth.
  • We need to ensure that young people understand that, the lifestyle decisions they make often shape their health outcomes for 10, 40, 50 years for now. Often we have a misplaced reliance on a magic pill that will cure the ailments of our lifestyle today.
  • Kids need a balanced life. A balanced diet, exercise, positive interactions with friends/family and an overall sense of well being, as well as good communication skills and involvement in their community.
  • Youth need to be well-rounded, having healthy role models with healthy lifestyles.
  • To be healthy you need food, water, shelter, self awareness, proper resources, a desire to be healthy and the opportunity to access help if it is needed.
  • The most popular health-related activity youth participate in is ‘getting regular exercise’. This is followed by 'keeping a positive attitude' and 'getting enough sleep'.

• Sleep is important to good health so why do we not lower tuition costs so students will not have to work two jobs as well as study?

**Lifestyle and Chronic Diseases**

**Comments and Concerns**

• Obesity and related illnesses such as diabetes, stroke and heart disease are on the rise in Northern communities including Prince Rupert.

• Lifestyle a big issue. There are now high levels of diabetes and a lack of resources for health promotion.

• Inactivity leads to chronic conditions, support campaigns like anti smoking campaigns and drunk driving campaigns.

• There is a need to link many chronic health problems to addictive lifestyle choices, for example tobacco, alcohol, drug (licit as well as illicit) use, sugar and so on.
• Some populations are genetically pre-disposed to diabetes.

• Physical inactivity is a risk factor for chronic disease. As we work toward increasing activity levels, we need to ensure there is adequate infrastructure to support physical activity in communities.

• Being significantly overweight contributes to a variety of chronic conditions. For example, almost 30 per cent of diabetes is directly attributable to obesity.

• Most risk factors do not exist in isolation in an individual. This is particularly true with smoking, unhealthy weight, unhealthy eating, and physical inactivity, which may exist in combination in the same individual.

• The relationship between eating habits and chronic disease risk is likely indirect, through an impact on obesity, cholesterol, and hypertension. Across all age groups, it is evident that British Columbians, on average, are not meeting the recommended daily intakes within multiple food groups. Action Schools! British Columbia showed that none of the nine to eleven year old children participating in the study consumed five or more servings of fruit and vegetables a day. Concurrently, the consumption of unhealthy food choices, notably sugar-sweetened beverages and high fat/sugar/sodium foods is escalating.

• A large percentage of overweight and obese individuals can trace their excess weight directly to a persistent imbalance between energy intake (food calories) and energy expenditure (physical activity).

• A sedentary lifestyle contributes significantly to a variety of chronic conditions. For example, almost a quarter of strokes are directly attributable to a sedentary lifestyle.

**Ideas and Suggestions**

• Physical activity protects against heart disease, stroke, hypertension, type 2 diabetes, obesity, depression, anxiety, and stress. According to the Canadian Community Health Survey, 38 per cent of British Columbians are physically inactive. A conservative estimate of the annual cost of lack of physical activity in British Columbia is $573 million dollars.

• Research clearly indicates that healthy eating and physical activity as well as not smoking helps to prevent the onset of type 2 diabetes even for those diagnosed with pre-diabetes. The same healthy living activities also help to prevent or delay the onset of complications resulting from diabetes.
• Resist the tendency to look at disease specific issues and find common risk factors for chronic diseases.

• A healthy diet can decrease the need for insulin for diabetics.

**Smoking and Tobacco**  
*(For tobacco legislation see Health Promotion - Legislation)*

**Smoking and Increased Morbidity**  
**Costs of Smoking**  
**Prevention and Decreasing Smoking Rates**

• Smoking and increased morbidity:
  
  • Smoking is still the single most preventable cause of morbidity and mortality.

  • Tobacco use also needs to be considered in conjunction with other factors. Most importantly, smoking exacerbates the negative health impacts of being obese. Smoking also demonstrates that risk factors are sometimes negatively correlated; the weight gain that can accompany smoking cessation, for example, must be addressed in any integrated risk factor policy.

  • Tobacco use is a leading risk factor for cardiovascular disease.

  • There are always sceptics who point to research which suggests that stopping smoking is associated with an increased risk of death shortly after smoking. Indeed, the research does indicate this trend, but this is due to the fact that many people stop smoking only after they receive news of a serious smoking-related illness. Stopping smoking at this point is often too late, and the person dies from the smoking-related illness. This suggests that individuals should be encouraged to stop smoking before it is too late.

  • Former smokers continue to have a higher risk of many diseases, even after 20 years of not smoking, than do individuals who have never smoked. This stresses the fact that while smoking cessation is critical; prevention of smoking uptake in the first place, is still the best approach.

  • Smoking causes the large majority of deaths from lung cancers and bronchitis/emphysema. The list of diseases to which smoking contributes is extensive.
• Cigarettes are addictive to the extent that children who smoke only four cigarettes per day have a 94% chance of becoming long-term, regular users of tobacco. Given current smoking rates, every 15 years, an estimated 146,000 children will become smokers as they transition into young adulthood. Of this cohort, roughly 14,000 will eventually die due to smoking (BCSTATS, 2006; CDC, 1996, 1997).

• Comments on the costs of smoking:

  • Tobacco addiction costs the taxpayers of British Columbia an estimated $2.2 billion in health care related costs in 2002 (Canadian Centre on Substance Abuse, 2002; Statistics Canada, 2002).

  • I smoked cigarettes for 30 years and quit 5 years ago. Cigarettes used to be really cheap when I was a teenager, but when they realized how dangerous they were, taxes were applied to help pay for the healthcare. The same thing happened with alcohol. Did someone forget along the way to put all this cash into healthcare? Is the stick not already in place? The carrot is there too. Food tastes better. I can walk further and faster. My cleaning bills went down. No burns on carpets, furniture or the car seat. My kids do not lecture me anymore. The dog and cat are happier. I do not need to stand in the cold every hour or so, and I have $2,500 every year that I did not have before!

  • There is a direct relationship between smoking and overall health care costs.

  • I would like to know why it is that the Government supports persons using oxygen machines when they continue to smoke?

• Comments on prevention and decreasing smoking rates:

  • The Capital Regional District imposed a total ban on indoor smoking, forcing smokers outside. Now, smokers have been told they cannot smoke outside, either, and must be a minimum distance of three metres away from any entrance. Soon, if the Capital Regional District has its way, smokers will not be allowed to smoke anywhere in public. This is wrong, and amounts to, as they call it in Britain, a nanny state.

  • The smoking rate for teenage girls is still high
British Columbia has been very successful in reducing smoking prevalence in all age groups. In 2006, smoking prevalence for British Columbians over 15 years of age was 18 per cent, the lowest rate in Canada. Over the last decade, several regulations have been simultaneously implemented, including a mass media campaign which resulted in a reduction in smoking rates of young adults by 30 per cent over a period of seven years.

Are current interventions sufficient for British Columbia to further decrease the current smoking rates? What will it take to further reduce these numbers?

There are higher smoking rates in men than women, Aboriginals than non-Aboriginals, and in those who live in the Northern regions of British Columbia.

Ideas and suggestions

Smoking and Increased Morbidity
Costs of Smoking
Prevention and Decreasing Smoking Rates
Regulation

- Ideas about smoking and increased morbidity:
  - Anyone that started smoking in the last ten years is not paying attention to the widely known potential health risks that are associated with smoking. We now have available information regarding the harm smoking causes. Those of us that started when it was considered ok in the 1960s, 1970s, and 1980s, have already damaged our bodies, but there is no reason for more people to be affected.
  - When Joe Camel becomes Joe Chemo and is in hospital dying of lung cancer from his habit we should be reminded that Joe's end-of-life care (some of the most expensive costs to the system) is not completely covered by the taxes he paid for when purchasing his cigarettes. His decision to commit tobacco assisted suicide is not a health care responsibility. And we have to remember that Joe Chemo did have a choice. Lastly, Joe Camel's choices can kill not only him but sometimes kills others around him.
  - I would like to see many more non-smoking apartments and additional protection for non-smokers living in environments where they are exposed to second hand smoke.
• Ideas about the costs of smoking:
  • Smokers already pay more for their health insurance. If a smoker goes through three cartons per month (about a pack per day), they will be contributing an extra $90 per month or $1080 of extra taxes per year.
  • Despite all the problems going on in this world, people are being inundated with propaganda that the evil smoker needs to be punished. Most steady, long term smokers end up dying before they can collect their old age pension (this must save the government quite a bit of money) and they save years and years on the costs of medication and supports most aging people need since they are already dead. So do smokers really cost society so much?
  • Increase tax by $1 per carton and double tobacco control budget. Tax on cigarettes and tobacco products in British Columbia is in the mid-range of tariffs across provinces and territories. Unfortunately, this revenue is no longer used for tobacco control like it was six years ago. It is well documented that higher taxes discourage smoking, especially in youth.
  • Higher tobacco taxes are an extremely effective way to reduce smoking, especially among youth who are particularly price-sensitive.

• Ideas about prevention and decreasing smoking rates:
  • Phase out smoking. All present smokers should register and be allocated a weekly quota to be purchased through liquor stores, or through using ration book.
  • Cover the costs of aides to help people quit smoking (for example, smoking cessation gum or the patch).
  • Ask businesses to offer their employees $100 to stop smoking.
  • There should be a group formed to visit businesses and talk to the people outside who are smoking and show them the results of smoking with the support of graphic photos.
  • Do not write off people who smoke. Instead, address the reasons why people smoke (addiction, stress etc.).
  • I would like to see that those who smoke are charged more for health premiums, more for apartment rental, more for deposit fees, and pay for their own medications and health care equipment.
  • We were delighted to learn of the 3 month pilot program, called Quit Smoking Now!, that the BC government implemented in January 2007 which provided Nicotine Replacement Therapy (skin patches or gum) to British Columbians on income assistance who wanted to quit smoking. Targeting help to those in
greatest need (ie highest smoking rates and lowest financial resources) makes a great deal of sense.

- Given British Columbia’s maximally extended healthcare system it seems logical for the province to do its utmost to reduce smoking prevalence. ActNow British Columbia has a short term goal of reducing smoking prevalence by 10% by 2010. While laudable, such a goal is limited in scope and vision. The vision - a 'smoke-free British Columbia healthy people, healthy place' - and long term goals are essential to gain wide public buy-in and the long term commitment necessary for success. For example, a long term goal consistent with a Smoke-Free British Columbia could be by 2025: (1) British Columbia will have the lowest smoking prevalence in the world, for example, 6 per cent, (2) All British Columbia residents younger than 19 years old will be non smokers, (3) 50 per cent of current smokers (2007) will have quit, and (4) Second hand smoke exposure in indoor or outdoor public places will be eliminated.

- A crucial component of successfully reducing smoking rates is the simultaneous implementation of complimentary interventions. Implementing only one intervention fails to decrease smoking prevalence. An environment that contains no cues to smoke, where second hand smoke is non-existent and where cessation is readily accessible and more affordable than cigarettes has been shown to be effective. Targeting youth averts the emergence of a large number of new young adult smokers who succumb to cigarette induced death and disease. Consideration could be given to cost-recovery through appropriate ear-marked taxation and surtaxes as has been done in Arizona and Australia. Alternatively, financial incentives such as tax refunds could be given to institutions or municipalities that have implemented smoke free policies.

- The smoking rate for teenagers is dropping.

- Sell nicotine replacement therapy in all stores that currently sell cigarettes. Nicotine replacement therapy products are now sold in BC pharmacies without prescription, facilitating access to smokers, an important step in the success of smoking cessation. Removing tobacco from all pharmacies provides an ideal opportunity to replace it with nicotine replacement therapy, along with notices about tobacco cessation websites, counselling services and telephone lines.

- Increase the number of tobacco cessation counsellors and remunerate physicians to counsel patients. Currently, the Medical Services Plan does not remunerate physicians for tobacco cessation counselling. Minimal training is necessary for assessment and referral.
• We should make a pill that causes severe symptoms like head aches and nausea if nicotine is ingested. This would be a much better way to get people to stop smoking then raising taxes and limiting where smokers can smoke.

• The comprehensive, annual monitoring techniques done in California and Arizona could be used in BC. In these areas, smoking prevalence by age group, geography and other risk factors is monitored, as is the per capita use of cigarettes. Annual reports are compiled where trends are noted and evaluation and redesign of the programs is discussed. Statistics Canada has comparable types of data that could be used by the BC Ministry of Health in similar fashion.

• Set targets with consequences for tobacco use reduction.

• Focus on tobacco prevention especially with the young; sue the tobacco companies for endangering the lives of youth.

• Ideas about regulation:
  
  • If we are going to get rid of smoking, I believe alcohol should also be gotten rid of. Both of these drugs cause untold illness that impacts healthcare costs today.
  
  • Immigration application forms should ask the question "Are you or any members of your family been or are regular smokers of cigarettes?"
  
  • Outdoor areas where children frequent are not regulated in most provinces including British Columbia. Evidence suggests that outdoor smoke is harmful and that smoking areas be separated from non-smoking areas by a distance of seven meters. Health experts recommend twelve outdoor settings commonly frequented by children where smoking should be banned; Nova Scotia leads the provinces by having implemented smoking bans in only three. British Columbia has implemented none so children are often exposed to second hand smoke when at restaurants, sports complexes, playgrounds, parks, entryways to public buildings including hospitals and so on.
  
  • Eliminate all retail displays including power walls - Seven provinces have banned point of purchase displays and two more have banned countertop displays. Unfortunately, British Columbia has not. The absence of a cue to buy cigarettes at all check out counters decreases the acceptability of smoking as well as reducing the impulse to buy. It is a simple regulation that British Columbia could implement.
• Mandate plain cigarette packaging in British Columbia. Canadian governments have not yet mandated plain packaging on cigarettes. British Columbia should lead the way by lobbying the national government. It is well known that children and young adults in particular, are seduced initially by a particular brand, and that tobacco marketing targets children. A plain package is much less interesting than an attractively decorated one both to children looking for something to buy and for those children who find one in the possession of an older sibling or friend.

• Ban smoking in all movies television programs and music videos shown on television, theatres and videos sold in British Columbia. Recently, in India, films and television programs have banned smoking, eliminating it as a source of free publicity for tobacco companies, a source that targets vulnerable youth by suggesting a link between sex appeal and smoking.

• We should let private enterprise decide if they want their establishment to be smoking or not, and let people decide if they want to work in a smoking environment.

• Institute a licensing program for the buying of cigarettes, with those licensed having to pay excess premiums and/or loose their free coverage sooner.

• Ban the sale of tobacco in pharmacies. Eight Canadian provinces and territories have adopted legislation to prohibit the sale of tobacco products in pharmacies.

• Creating a single, easily understandable, piece of non-smoking provincial legislation also enhances public and operator compliance and thereby simplifies enforcement.

• The Canadian Cancer Society recommends that the prescribed distance from doorways, windows or air intakes be at least 7.5 metres, the distance one must be from environmental tobacco smoke, before the toxins approach the levels of background air.

• There should be a smoking room in the hospital so that elderly patients in wheel chairs and dragging IV lines do not have to go outside in -20 temperatures to smoke.

• Organic tobacco has not got all those poisons in it and is not harmful.
Personal Responsibility

Comments and Concerns

Responsibility of Patients
Individual and Community Responsibility
Education

- Comments on empowering patients and patient responsibility for maintaining health:
  - We have very few patients who are pro-active with their health. Most patients do not follow instructions and they get angry when there is no phone call reminder to come to their appointments.
  - Doctors and medical practitioners are encouraging patients to be informed and involved in their own care.
  - Patients have a lack of control over personal medical charts.
  - People currently follow an acute medical paradigm. They need to be educated on how to prevent physical and emotional issues, manage their own health, and to take responsibility for their health. So many people wait until they have a medical crisis before seeking help or treatment.
  - It seems like the majority of sick people do not want to put any effort into their own health. They just want a pill that lowers their cholesterol, lowers their blood pressure, or gives them an erection. Of course, this is music to the ears of pharmaceutical companies.
  - Patients are required to aggressively pursue options and treatments, which is difficult for the elderly, and adds stress to patients.

- Comments on individual and community responsibility for health maintenance:
  - Currently, people do not have to be responsible for their health.
  - The consumer expects to be taken care of rather than taking care of themselves.
  - People abuse themselves: drugs, smoking, alcohol, poor nutrition, inactivity, loud music, boom boxes, and mufflers. There is a common attitude in society which encourages irresponsible behaviour and ultimately creates health care needs.
  - The system is skewed to rights not responsibilities.
  - A sense of entitlement exists that discourages personal responsibility.
• We live in a culture that supports the attitude of "someone else is responsible for me" which is supported and perpetuated by our medical system.

• Our current system is unfair and ineffective. Currently, people who take no personal responsibility for their health are rewarded, whereas people who take a high level of personal responsibility are penalized. For example, person A, who smokes, eats doughnuts regularly, and does not exercise, is fully covered if they need any kind of conventional medical treatment. Whereas person B, who eats healthy organic foods and exercises regularly, must pay out-of-pocket for any preventative and alternative treatments they undergo.

• I find that a lot of Canadians expect the government to pay for everything.

• The public seem to forget that as individuals, they are solely responsible for the escalating costs of health here in this province.

• Taking responsibility for one's health is what most people would want, but the standard medical system paid for by our provincial government offers no choice. Currently, one very small size is expected to fit all.

• Highway authorities treat drivers as adults, while the health care system treats citizens like children who lack information and the ability to take responsibility for their actions.

• Government has no place in the private lives of citizens. It is a person’s personal responsibility to lead a healthy lifestyle, if they so choose. We live in a free society where personal freedom is a cornerstone of our national democracy. Implementing restrictions to accommodate a prescribed healthier life goes against the very foundation of our great nation.

• Comments on education to increase personal accountability

  • Had I been more educated about being responsible for my own health I very likely would have been able to save my eye.
Ideas and Suggestions

Responsibility of Patients
Individual and Community Responsibility
Education

- Ideas about empowering patients and patient responsibility for maintaining health:
  - Focus on the patient taking responsibility for their own health.
  - Empower people to take responsibility and be personally accountable for their use of the health care system.
  - Create personal health management plans.
  - People are in a better position to take care of their own health care if they receive the proper diagnosis and health information in a timely way.
  - Patient self-management is a very, very strong thing. We have got a model where it the doctor educates the patient, the patient follows advice. How often do you think that really happens? Not often, but if you get a patient more involved and they develop what they can do to correct their disease or prevent their disease it is a different model. It is far more powerful for the patient.
  - People should have a personal health book summarizing treatment and diagnosis at each visit. This could work like a health passport.
  - As a consumer in this system, we must have some responsibility to ensure the best possible outcome for the service we are provided. This includes proper pre-operative care and discipline to prepare our bodies for surgery.
  - The majority of the time, the patient decides how they manage their disease outside of the formal medical system. We need to empower behaviour change and give responsibility for making health related decisions back to the patient, with a huge emphasis on primary care clinics. We waste too much time and money in acute care.
  - Patients need to take on more responsibility and become self-advocates (for example, keep their own medical records).
  - Some patients have issues with compliance. We have to examine how we manage hard core users in the hospital, to keep them so they can have meaningful treatment, while making personal responsibility sustainable. The system could work like the transplant system, dependent on criteria and evaluating priorities. There has to be a rationing of resources and it has to be an open dialogue. People have to be realistic and be kept accountable for their health outcomes. Prevention is good but right now, people are not listening.
The patient should manage and have control of their care, including their health record. This self-management would be supported by a team of health professionals.

Efforts should be made to foster patient doctor relationships. These relationships could also help patients take more responsibility for their own health.

Patients should be given printed report cards with their physical checkups outlining actions to be taken to improve their overall health. The level of ignorance in the general public about proactive health care is scary.

Ideas about individual and community responsibility for health maintenance:

- Emphasize the importance of self direction, self care and personal responsibility for health maintenance.
- The first aspect of promoting self care is working in your community to create healthier communities; second, is improving your personal and family wellness; third, is the treatment of your own and your family's minor ailments and injuries, part of what we think of as a core of self-care, as well as first aid and emergency care and particularly, what to do until the first responders get there. The health care system needs to train and support individuals in each of these aspects of self-care.
- You should actively take steps to support and improve your health.
- I should have the freedom to smoke, get overweight by overeating and not exercise, but I should be responsible for my decisions and not harm the welfare and health of my fellow citizens.
- Encourage people to take better care of their knees.
- The timing is right to urge aging baby boomers to take control of their own health.
- Increase the responsibility of families and communities to raise healthy children, providing them with the necessary resources to do so.
- If people would only stay home when they are sick from simple viruses it would lessen the health care costs considerably.
- The more responsibility that we can take on ourselves, the more flexibility the basic health care system has to deliver to those who are the most in need.
- Do not download health care responsibilities to families without giving them the appropriate supports.
· People who choose to live in remote areas should be responsible for ensuring that they can access health care in a timely fashion.

· People should take personal responsibility for their health and that should be reflected in the health care premiums structure.

· We need to work from an ecological model, focused on personal and social/corporate responsibility.

· I would like to see more emphasis on developing the kinds of health care and community networks that empower people to take care of their own health in a proactive way.

· The solution is for people to start being more proactive in their health and not use the system unnecessarily just because it is seen as being free.

· Individuals, at every point and level, must be accountable for their own choices. However, this means that alternate options must be readily available and discussion also available. Not only individual patients but also the people and companies involved in providing and funding health care must be seen as being accountable.

· Ideas about education to increase personal accountability:

  · Every person in British Columbia should be issued a book of health care guide that includes their responsibilities in using the system appropriately.

  · Everything comes down to awareness, communication, prevention, accountability and patient responsibility.

  · Empower people to be more personally accountable for their own health by providing life long education and support.

  · Public relations initiatives should be aimed at promoting the idea of personal responsibility for one’s own health.

  · The British Columbia College of Family Physicians Self-Management program is helping family physicians learn how to engage patients in beginning the difficult process of making changes to their core living choices in support of improved health.

  · Citizens should become more informed and be able to question medical advice.

  · If we want a health care system that is managed by the government, and is designed to serve the greater public good we must accept some controls on the system and be responsible citizens. I believe an informed public would be more responsible users of the health care system.
• An ounce of Prevention being worth what it is, the collaborative effort of physicians, researchers and nutritionists to educate the public on the benefits of a healthy diet and lifestyle for cancer prevention and survival is encouraged and would ideally be endorsed by our Health Ministry.

• 59 per cent of women believe breast cancer is primarily inherited. In fact, only 5-10 per cent of cases of breast cancer are due to inherited genes. This gap in knowledge provides women who do not have a family history of breast cancer with the false security that they do not have to be vigilant regarding healthy life choices and early detection practices. Almost half of respondents thought they were most at risk of breast cancer in their 40s. In fact, a woman's risk increases with each decade of her life. A woman needs to be informed and supported to continue healthy choices and early detection into her 70s.

• Despite citing breast cancer as their number one health concern, women in British Columbia are seriously misinformed regarding basic breast cancer facts, healthy living choices that can reduce their risk of developing breast cancer, and early detection practices that can greatly reduce mortality rates.

• It would have helped us to have been more aware of the importance of routine screening with colon cancer running in the family.
Self-Care

Self-care was a frequent topic of discussion in the Conversation on Health. The importance of addressing issues related to self-care costs, education and awareness and specific self-care tools like the NurseLine and the BC Health Guide, were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of Self-Care.

Costs

In the face of rising health care costs, many believe we have to reduce reliance on professionals and increase the promotion of self-care. In order to change behaviour, participants believe that we need knowledge and a sense of urgency with regards to the state of the health care system. In looking at the barriers to self-management and self-care, participants suggested that although a lack of knowledge is the primary barrier, it is important to consider accessibility and financial barriers as well.

Reduce costs by encouraging health self-management. We know that each of us is responsible for our own health and yet at times the system behaves as if it were the doctors who were responsible for our health, depriving us of full-information, making decisions for us and promising to solve all our medical problems

- Email, Richmond

Education and Awareness

Participants discussed the fact there is no type of reward or incentive in the system for self-education and self-discipline. Despite an increased focus on self-care, patients still receive little education or encouragement to care for themselves when they have minor ailments. Many suggested providing education in schools to support the recognition of basic symptoms to avoid unnecessary emergency room visits or producing and promoting government-sponsored information packages. The majority discussed the benefits of using the internet and the media as a public education tool. However, there was recognition that some rural communities may not have internet access, and that others do not own computers and cannot access health information websites. Starting a public information campaign on self-care, providing translations of materials, and getting education to rural communities through mobile facilities, were among the recommendations to increase the accessibility of self-care resources.
It would help if people were better educated to look after some of their health problems themselves. We don’t need to be bundling our children off to the doctor at the first sign of a snuffle or a mild fever.

- Online Dialogue, Kamloops

Self-Care Tools

Many participants discussed the change in self-care since the advent of the internet and web-based health information. A reputable web-based health application’s purpose is to develop support, while increasing the knowledge level of users which in turn ensures that they will not access services incorrectly and those who do need services will use them more often. Examples of effective websites brought up by participants included the Canadian Virtual Hospice website, and the interactive website of the Alberta Cancer Board. Many described ActNow BC as being on the right track, while others emphasized that not everyone knows about it. Participants focused on the importance of getting the media involved in the promotion of self care resources.

About ten years ago, what happened is patients started coming in. They loaded down what they had taken off the net, and the most fundamental thing changed. Their question changed. They stopped saying, ‘Tell me what to do,’ and they started saying, ‘Help me understand what this information means for me.’ [This was] a fundamental change... a fundamental change in rules. It’s the biggest change in health care in 500 years.

- International Symposium, Vancouver

The NurseLine, the Canada Food Guide and the BC Health Guide were frequent topics of discussion. While many see the NurseLine as a valuable resource, some voiced concern that it tends to move people to emergency rooms and that nurses are not able to effectively diagnose over the phone. Several people suggested staffing the NurseLine with doctors and commended having pharmacists available on the line. Some suggested placing a direct line to the NurseLine in emergency rooms to allow patients waiting for treatment to determine if they are waiting in the right place.

Similarly, the BC Health Guide and the Canada Food Guide were valuable resources for some, while others suggested they are underutilized and do not always contain the best information. Making changes to the Canada Food Guide, taking cultural choices and portion sizes into account, using the Health Guide as a textbook for health education classes, and adding a symptom to decision flow-chart to the BC Health Guide were among the recommendations suggested to make these resources more useful.
Above all, participants agreed that these self-care resources all need to be publicised, emphasizing that it is the lack of knowledge of existing resources that is currently the primary barrier to their use. Participants suggested sending the BC Health Guide home with students, advertising the NurseLine in the media and through campaigns (for example, fridge magnets) as well as adding the NurseLine number to the back of CareCards to publicise existing self-care resources.

Conclusion

In working towards making British Columbia’s health care system more sustainable, there is widespread recognition that people will have to take more responsibility for their health. An important part of this equation also involves increasing the focus on self-care, and its ability to decrease waste in and demands on the system.
Self-Care

This chapter includes the following topics:

**Delivery of Services and Costs**
**Education and Access to Information**
**The Nurse Line and Phone-Based Health Services**
**The Canada Food Guide**
**The BC Health Guide**

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**Related Chapters**

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Lifestyle and Personal Responsibility.

**Delivery of Services and Costs**

**Comments and Concerns**

- People should be able to monitor their own cholesterol without having to pay for it. To go to your doctor and check your cholesterol involves two office visits, which is costly to our medical system.

- Look at the barriers to self management and self care. A lack of knowledge is the primary barrier to self care, but it is important to consider accessibility and financial barriers as well. I spoke to the arthritis support group yesterday and one of the
women said that she would use less narcotic pain medication if she had a scooter instead of having to walk everywhere.

- Self care should be encouraged through taxes.
- In order to change behaviour, people need knowledge and a sense of urgency with regards to the state of the health care system.

**Ideas and Suggestions**

- The challenge is conveying the virtue of increased self-care within British Columbia’s health care system.

- Look at managing health for a population. I think we have to reduce reliance on professionals and be really specific about what the role of a health professional is. Do not do for people what they can do for themselves.

- Self management can help manage costs. What resources can we draw on in communities at low/no cost in terms of increasing access? There is a need for infrastructure to support, monitor and measure the benefits of self care.

- Nurses spend a lot of time giving out medication. I realize that there are some people who are admitted to hospital who are too sick or too confused or whatever to look after their own medication, but what would you do to nursing workloads if you acknowledged the fact that if a patient was managing their own medication at home, they may be able to manage it in the hospital?

- Have doctors suggest a complete annual physical exam once a year for anyone over 50. This of course should not require any payment by patients. Also give people over 50 free flu shots if they want them.
Education and Access to Information

Comments and Concerns

Use of the Internet
Education and Resources

• Comments on the use of the Internet to access health information and promote self care:
  • There is no section on the British Columbia health website for chronic illness recovery options. There is only information on how to live with increasingly degraded quality of life.
  • Health websites are overwhelming.
  • There are no well known, reliable websites that contain medical information.
  • There is no information on the government website about how much water should you drink each day.
  • Information on support groups should be available on health web sites.
  • Some rural communities do not have internet (broadband) and cannot access health information websites that help people to self-diagnose.

• Comments on education and resources:
  • There is a lack of public knowledge on how to access services.
  • There is a lack of public education or encouragement to care for yourself when you have minor ailments.
  • There is a lack of understanding about how the health care system works and how to manage self care.
  • Seniors are not getting enough information to make informed decisions with regards to their health.
  • There needs to be more information available on the body and mouth connection
  • Delivering information to patients while they are still in trauma may not be ideal and may be more efficiently done during follow up care.
  • There is absolutely no reward in the system for self-education and self-discipline.
  • The Act Now British Columbia program is on the right track but not everyone knows that it is out there. Ads are effective but there are no follow-up resources, and the infrastructure is not there. Not everyone has a computer to access sites.
• The current philosophy of health care tends to favour the conversion of normal life experiences (for example, pregnancy, cranky children) into illnesses, which must be treated with pharmaceuticals and/or hospitalization.

• I look back to when I grew up and we did not go to the doctor unless we had to and most of the time our mothers looked after us. Now there is more fragmentation, a lot of parents are not living in the same communities as their extended families and have no one to turn to for advice. The reaction to any aliment is to go to the emergency, rather than deal with these issues at home.

• Power relations between staff and patients can result in patients not being given information on their own health.

Ideas and Suggestions

Use of the Internet

Education and Resources

• Ideas about the use of the Internet to access health information and promote self care:

  • About ten years ago, patients started coming in with information taken off the net, and everything changed. Their question changed. They stopped saying, 'Tell me what to do,' and they started saying, 'Help me understand what this information means for me.' The internet has been the biggest change to health care in 500 years.

  • I got lots of information from the internet, prostate support groups and the entire home care system served me well.

  • The Act Now British Columbia program is a start in the right direction, their website is very comprehensive.

  • A web-based vetted health information site could support the family physician because they would know who to link a patient with. A section of the site could have self care tips including: diet, medication and signs to watch for. You could also have the Nurse Line hyperlinked in.

  • A reputable web-based health application's purpose is to develop support, while increasing the knowledge level of people which means that they will not use services incorrectly and those who do need services will use the services more often. The Canadian Virtual Hospice website provides an excellent example of this type of expert-patient model. If you are working in end-of-life care, it will walk you through all these things. There are chat rooms set up so that if you want to
talk to someone with the same problems, you can. They could not get the funding for a clinical nurse specialist who could actually field some of the calls that came through but you can press a button labeled 'do you need to talk to somebody', that connects you to the Nurse Line.

- Use the internet as education tool and use the media.

- In talking about the use of the web, what the Alberta Cancer Board has done is they have set up an interactive website where people can go to get answers to questions. What they are finding is that 90 per cent of their nutritional questions and needs are being met by the interactive website. This means they can actually free up the nutritionists to do education in the community. There is a cost in some of the technology, but some of it is already there and we just have to be tap into it.

- Use the web to access available information on alternative medicines.

- Provide virtual support for self care, taking a multi-faceted approach (provide education and access to information as well as health provider integration over the next five years).

- Open an online library of health resources, accessible to the entire population.

- I think there is already a book out there called the Red Book that lists all social services and health organizations, categorized by type. So, if I had arthritis, I could go to that book and everyone knows about the Arthritis Society but the book will list who I should go to in my region, not just the main number. Why are we not using this more widely, why are we not putting it on the web?

- Work is being done to implement the first Canadian Caregiver Portal. The Canada Caregiver Portal will be a virtual space where all caregivers can get the information, resources and supports they need to provide better quality care to their families and friends. It will also be a space where caregivers can seek respite for themselves. The portal will provide up-to-date, accessible, community specific and professionally vetted information that will improve their access to important health information. The Government of British Columbia could take advantage of the work that has already begun. This innovative resource should be included in the next edition of the British Columbia Health Guide to encourage and support British Columbians in taking responsibility for their health and well-being.

- Have a web-based Nurse Line.

- Ideas about education and resources:
  - Provide education and facilities to ensure personal hygiene can be adequately maintained.
• Develop pamphlets for clear instructions related to after-care for common surgeries, is would take strain off the medical system.

• Doctor’s offices should have health related books for sale. Patients would be more likely to do the research and take more responsibility for their health if medical information was more accessible.

• The government should identify credible information sources.

• Produce and promote government-sponsored information packages that provide information relating to the treatment of minor injuries and ailments in order to attempt to limit the overcrowding in emergency rooms and clinics.

• In order complete the recovery process of the patient, education relating to common illness avoidance, recovery models and future prevention should be dispensed in the form of pamphlets.

• Health Canada needs to better inform Canadians about the characteristics of various mental illnesses so we can start the process of being responsible and knowledgeable about our own health.

• Provide basic first aid education to allow people to cope with day to day health issues.

• Provide education in schools to support the recognition of basic symptoms to avoid unnecessary emergency room visits.

• Use co-operatives to teach people how to take care of themselves. This eliminates hospital visits and increases understanding of diseases.

• Educate seniors on their health.

• Start a public information campaign on self-care.

• Provide unbiased, reliable information to the public.

• When people are discharged from hospital they are not given discharge sheets or follow-up idea for self care after surgery. Orthopaedic surgery should have generic discharge notes to give patients.

• Patients need to be educated on how to take care of themselves.

• There should be mandatory emergency preparedness training, at least every six months.

• It is important to have individualized information available to the public.
• When someone is at risk for stroke or heart attack supply them with medical equipment they can use daily at home. It would be a lot cheaper to teach someone to take their own blood pressure, pulse and oxygen saturations daily, than to admit them to hospital for a stay in ICU, vascular surgery and rehabilitation for a month or more.

• Spend more resources and promote awareness on men's health so that men can start being more proactive about taking care of themselves.

• Educate individuals on self-assessment.

• Provide education to rural communities through mobile facilities.

• Support the education of youth through student help lines, student peer counseling and educational brochures, posters and websites.

• Market existing tools like the Nurses Help Line, the British Columbia Health Guide and the Canada Food Guide.

• Provide more translations of material.

• Change the culture so that patients are encouraged to coordinate their own health care.

• Appreciate pain as one's guidance system to doing what is appropriate for oneself.

The Nurse Line and Phone-Based Health Resources

Comments and Concerns

Promoting the Nurse Line
Staffing the Nurse Line
Other Phone-Based Resources
Information and Accessibility

• Comments on promoting the Nurse Line:
  • The health guide and the British Columbia's Nurse Line are not easily accessible and not advertised enough.
  • We already have invested a lot of money in the Nurse Line, but lots of people do not know about it and we have not marketed it very well. There is a core structure there, but there is a lot of capacity that I do not think is being utilized.
  • I have never heard of the Nurse Line.
• Comments on staffing and resources for the Nurse Line
  
  - People manning the lines are not knowledgeable enough and cannot be specific enough for specific needs. The information that is available is too general.
  
  - I believe it was Ontario, that said that there was a very low level of satisfaction with the Nurse Line from the public because what they could say over the phone was so prescribed that it almost always it amounted to, 'You should go to the emergency room,'. It sounds like, you know, if you give them enough real scope to actually provide assistance, you could keep people out of emergency rooms, but there are a lot of liability issues associated with giving advice.
  
  - Telephoning the health line can be frustrating because of long wait times.
  
  - The 1-800 number has language issues.
  
  - The helpline cannot diagnose over the phone.

• Comments on other phone-based health resources:
  
  - Dial-a-Dietician is okay, but they are not into using food as medicine. We should have a line for information on nutrition.
  
  - British Columbia’s Dial-a-Dietitian number provides support to schools and teachers.
  
  - The majority of poison exposures can be managed with simple first aid at home. If the poison control line was not there to provide advice about poison exposures patients would have no choice but to visit an emergency department or medical clinic for help.

• Comments about the information available and accessibility of the Nurse Line:
  
  - I called the British Columbia Nurse Line, and they could not tell me whether I should go to see a doctor or not for my condition. After calling all agencies involved including my doctor's office, I ended up in the doctor's office with him saying that there was nothing he could do and that I was already doing everything I could. The British Columbia Nurse Line was of little use.
  
  - The Nurse Line tends to move people to emergency.
  
  - The Nurse Line is good if you are unsure whether to call an ambulance.
  
  - The Nurse Line is excellent.
Ideas and Suggestions

Promoting the Nurse Line
Staffing and Resources
Other Phone-Based Services
Information and Accessibility

• Ideas about promoting the Nurse Line:
  - British Columbia’s Nurse Line needs better marketing and publicity.
  - There is a need for better promotion of British Columbia’s Nurse Line and it needs to become more user friendly (staffed by a real person from the start).
  - Promote the Nurse Line with posters and list it in the phone book.
  - Put the NurseLine number on the back of care cards to increase its profile and ensure that the public knows that it exists.
  - Most people I speak to do not know about the Nurse Line or how to get the telephone number. How about a mass-mailing of something to stick on the fridge.

• Ideas about staffing and resources for the Nurse Line
  - The Nurse Line needs better resources so that waiting times on the phone line don’t discourage use.
  - Have doctors available on the Nurses Hotline (along with pharmacists, as is now the case).
  - The Nurse Line needs resources to help with grief counseling.
  - I think the Nurse Line has done a lot for people, but ideally people would have one person that they could call. They might need somebody who they know, who they could trust. Calling can be very personal, and it can be very difficult, especially if it is related to mental health. I think in the end, you would save more time if you could just pick up a conversation with someone who already knows your health record.
  - What I am proposing is a call centre of doctors. Take the nurses off the help line and put them back in the hospitals, they are of little use on the phone. Have the call centre use a ticket tracking system for phone or internet inquiries.
• In dentistry there is a concern regarding the classification of a dental emergency, because often dental emergencies are showing up in the emergency rooms. We are working with the Nurse Line to educate patients on what a dental emergency is, what they can self-manage and where they can go for treatment. I think that rather than having a doctors’ line, the existing Nurse Line has potential and just might need some fine tuning.

• The Nurse Line also provides pharmacist advice.

• Ideas about other phone based resources:
  • I just heard about the Ontario system of TELE-Health. There, nurses man phone lines and give people advice for their ailment over the phone. If necessary the caller is referred to the Emergency Room or to a General Practitioner.
  • I love the newborn hotline but it is not open 24 hours.
  • Have a common phone number for seniors' care providers or spouse to phone to get community and government assistance, staffed by real people instead of a touch menu.

• Ideas about available information and accessibility:
  • Use the Nurse Line for first assessment.
  • The education of patients could be done on the phone or the internet.
  • The Nurse Line needs to go into greater depth in certain circumstances.
  • Have a three digit number for the Nurse Line (like 9-1-1).
  • Well, you know how in Europe there is a phone you can pick up and you can talk to a taxi? They are thinking about putting in a similar phone line in Emergency Rooms, you pick it up and it takes you right to the Nurse Line.
  • In addition to providing information about surgery to people via a hotline mechanism, those calling into the Nurse Line need to receive information about how to access supportive care during the wait period.
  • Well, one of these meetings that I went to in the past two weeks, someone suggested putting a phone in every emergency room waiting room that is a direct link into the Nurse Line so that while you are sitting there, you could call and start asking some questions. 'Well, I'm waiting in the emergency room. This is what I'm feeling like. Should I really be here,' that kind of thing.
The Canada Food Guide

Comments and Concerns

- The Canada Food Guide is a lie promoted by stakeholder industries.
- The Canada Food Guide is a good example of misguided health information. It is pathetic compared to the sound knowledge that is available about eating for health.
- The Canada Food Guide is good and the education system is moving towards promoting healthy eating for all.
- The Canada Food Guide needs to be better.

Ideas and Suggestions

- Make changes to the Canada Food Guide, taking cultural choices and portion sizes into account.
- Have grocery stores post Canada's Food Guide, and recognize the produce sections with signs stating that these are part of the Food Guide.
- Follow the guidelines set out in the Canada Food Guide.
- We know that by meeting the recommendations of the Canada Food Guide, we can significantly reduce the number of deaths from heart attack and cancer.

The BC Health Guide

Comments and Concerns

- The British Columbia Health Guide information can be wrong or out-of-date.
- The Health Guide is underutilized.
- Information about health services is unclear in the guide, for example although stability bars are mentioned, where can you find them?
- The Health Guide is remiss in a number of ways. People do not always have the money needed to purchase items or follow directions in the book.
- The Health Guide is not as useful for people with multiple health problems.
- The wastefulness of producing the printed Health Guide that is distributed to libraries, pharmacies, and so on, confuses me. That information is available in many places. Why is the government doing this? Who is reading it? No one.
• Our new British Columbia Health Guide makes no mention of Parkinson’s or the Parkinson’s Society.

• Education and prevention sound really good, but how many people actually consult the Health Guide that was sent to every home before running to the doctor?

**Ideas and Suggestions**

• The Health Guide needs to provide more information.

• The Health Guide needs to be promoted more. Send it home with kids from schools. Doctors need to promote it too.

• The Health Guide could be used as a textbook for health education classes.

• Provide funding for the Health Guide.

• In the Health Guide provide examples of: a Representation Agreement, a Living Will, and organ donor and blood donor forms.

• In the health guide provide mentoring information for seniors.

• The Health Guide is excellent, we should expand on this, it needs better marketing.

• The Health Guide has been a very good resource. I have used it many times and I know many others have too.

• Add a symptom to decision flow chart to the British Columbia Health Guide.

• The Health Guide is a very valuable tool in guiding us as to when we need to see our doctor; perhaps we should be encouraged to use this guide more by having it in every household (I picked mine up at the local Government Office); perhaps they should be delivered to our homes.
Social Determinants of Health

The social determinants of health were a frequent topic of discussion in the Conversation on Health. The importance of addressing issues such as income, housing, education and literacy were highlighted in many discussions and submissions. Participants regularly noted that although they are traditionally not considered part of the health care system, the social determinants of health have a significant impact on the current and future cost of health care in British Columbia. Here is a selection of what British Columbians had to say on the subject of the Social Determinants of Health.

Integration and Collaboration in the Delivery of Social Services

Participants in the Conversation feel that the social determinants of health are too often approached in isolation from one another, the results of which is both a lack of a social policy framework and public awareness of the social determinants. The majority of participants believe that by investing in social services now, and encouraging partnerships, integration and coordinated outreach in the delivery of social services we will see significant benefits for vulnerable populations, including improved health status.

Forming partnerships between housing and health, government and non-government agencies offers viable and cost-saving solutions to re-visioning a continuum of health promotion strategies and housing interventions to increase good health and well-being in our communities.

- BC Non-Profit Housing Society, Submission

Participants suggested that a stable social safety net reduces the rise in health care costs. According to some, accessibility to the health care system and related supports for vulnerable populations can be improved through collaboration between organizations, ministries and different levels of government.
Socio-Economic Circumstances (including Child Poverty)

Participants expressed concern that there is a barrier for low-income families and individuals in accessing both primary health care and preventative care. They would like to see increased support for vulnerable people in accessing dental insurance, high quality child care, physiotherapists, naturopaths, chiropractors, vitamins and healthy food. It was also suggested that funding be established to develop innovative approaches that increase accessibility of health services for low-income individuals and families.

Many commented that minimum wage, income assistance and disability assistance rates were insufficient based on the current cost of living. Participants believe that welfare rates were too low to pay for reasonable accommodation, to maintain a healthy lifestyle or to enable access to recreational facilities. Some feel that cuts to social safety net funding has resulted in an increase in homelessness and would like to see social services restored. Other suggestions put forward by participants include: raise the current welfare rates by fifty per cent and index it to the cost of living, rollback the employable age for receiving income assistance, allow parents to be temporarily excused from seeking work until their youngest child is seven and increase the allowable earned income supplement.

Homelessness and poverty was a topic of discussion for many participants. Many commented that homelessness is rising. A rise in homelessness was attributed to a lack of access to proper resources, such as housing, health services (preventative or primary health care) and addiction treatment centres. Participants commented on the lack of capacity within the system to deal with homelessness, particularly in rural areas. They believe that we need to recognize poverty and homelessness are costly to the health care system and that poverty needs to be factored in to long-term planning.

Child poverty was a concern for participants who think that the children from low-income families lack access to recreational activities or programs, health and dental services, and good housing. Many believe that British Columbia has a high rate of child poverty. Others commented that living in poverty affects early childhood development, long-term health status and increases the chance of developing a chronic disease. They asserted that by investing in a child’s physical and socio-emotional health, language and cognitive development we can strongly influence basic learning, success in school, health outcomes in later life and economic participation that can break the intergenerational transmission of poverty.
Other suggestions on how to alleviate child poverty in British Columbia included establishing a provincial child poverty reduction strategy that would be driven by an inter-ministerial group, increasing the amount of affordable and accessible child care, ensuring that newborns and new mothers have a safe place to live and providing children with special needs with the support they need to thrive. Many participants commented that an investment in ending child poverty would result in a significant cost saving to the system down the road.

Participants suggested that by establishing community health centres, increasing the number of shelter beds during the cold wet weather season and developing more supervised community-based housing we could reduce some of the current costs to the system. Others expressed the need to assist people in acquiring the skills they will need to navigate the system and eventually transition to employment and out of poverty. Participants were concerned that vulnerable populations, such as disabled seniors, those suffering from mental illness or disability, prostitutes and those suffering from addiction needed to have access to safe and secure help and support.

Housing

The affordability, availability and standards of housing were an issue for many participants. They believe that housing has an impact on our health and poor housing can mean an increase in infectious disease rates, poor mental health and the development of chronic respiratory problems and allergies due to dust mites, mould, asbestos and overcrowding. The majority of participants were concerned that British Columbia does not have enough affordable housing to meet the needs of families, individuals or vulnerable populations (for example, seniors, young people suffering from a chronic disease, people with mental illnesses or disabilities). A more specific housing concern expressed during consultations with Aboriginal communities was that there is a lack of affordable housing off-reserve and this is adding pressure to on-reserve housing stock.

Solutions put forward by participants in the Conversation included that Government needs to support the goal of ensuring housing for all and establish appropriate requirements and standards for housing. Rent subsidies, more transition housing for men, an increase in low-cost housing, allowing long-term mortgages geared towards low-income earners, more supportive housing complexes and establishing partnerships with landlords were among other solutions we heard.
Education and Literacy as a Social Determinant of Health

Participants commented that class disparities are a marker for the health of a population and that educated people have better health. For example, not graduating from high school is a significant determinant of future health. As such, they believe that educational equality needs to be a key priority.

Participants believe that literacy and education are areas that offer cost savings opportunities and provide a way to establish meaningful interaction with communities and community groups. This, according to some, will support British Columbia’s goal of becoming the most literate jurisdiction in North America by the year 2010.

New Canadian Populations

Participants in the Conversation also provided comments on the specific needs of new Canadian populations. They expressed concern that there is not enough done to provide interpreters and information to immigrants when they enter Canada. For participants this meant that when an immigrant has a health problem arise they are not prepared to deal with the issue. Another challenge, for some, was the lack of basic literacy skills coupled with the scarce availability of translated materials.

Solutions put forward by participants included establishing more co-located service centres for ethno-cultural communities that provide health services (for example, sexual health) in an appropriate cultural context, increasing the accessibility of translation services for medical visits and for print material, creating lists of multi-lingual doctors that are accepting patients and developing an information package on the Canadian health care system, with specific details on hospitals and community health and services covered by MediCare.
Conclusion

Participants asserted that the social determinants of health are complex and have a direct impact on an individual’s health in both the long and short-term. Most participants noted that as a result of this complexity, improving only one social determinant is not enough to increase the overall health of an individual. Providing good quality housing, for example, needs to be coupled with access to affordable food, education and health services in order to significantly improve the outcomes for low-income and vulnerable populations. Participants believe that if government works together across sectors to ensure equal access to the system, social services and health, we will see significant improvement in the health of British Columbia’s most vulnerable citizens.

Measure success of [the] health care system based on the quality and accessibility of care available to people with the least financial means.

– Regional Public Forum, Smithers
Social Determinants of Health

This chapter contains the following topics:

- Social Services, Integration and Collaboration
- Socio-Economic Circumstances
- Children and the Social Determinants of Health
- Housing Including Affordability, Availability and Standards
- Seniors and Housing
- Aboriginal Communities and Social Determinants of Health
- Specific Issues Relating to New Canadian Populations
- Education and Literacy as a Social Determinant of Health
- Outstanding Questions

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

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Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Health Promotion; Seniors and First Nations.

Social Services, Integration and Collaboration

Comments and Concerns

- British Columbia’s social services are better than they are in the United States.
- We need to invest now in our social infrastructure so that we see the benefits down the road in a reduction of cost to the health care system.
- We cannot consider the social determinants of health in isolation from one another.
- Some solutions may work in Vancouver, such as street health care, but they may not work in Kamloops or other rural areas.
- Compared to some European countries, like Norway, Canada is not doing so well in terms of social services.
- People are unaware that education, housing, income and the other social determinants of health contribute to longevity and life expectancy.
- There is no social policy to deal with the social determinants of health.
- Access to the primary health care system for homeless individuals, with the assistance of outreach workers, can still take two to three weeks for the individual to
be seen by a health care professional. The outreach and integration that is going on needs to continue but there are effects such as stress on the individual that still need to be addressed and streamlined.

- Housing as a social determinant of health has become an important and relevant non-medical determinant of health status in the fields of service delivery, public health, municipal planning, housing management, psychology, architecture, urban design, and housing development.

- There is poor public awareness of the social determinants of health.

- There is a need for meaningful buy-in by municipal governments in all areas of planning including social, recreational and health. There needs to be affordable liability insurance for community initiatives, ways to facilitate full use of existing facilities (such as schools) to achieve a healthier active community, more consultation and planning at the local level between municipalities and Ministries (for example, Health, Environment, Immigration, Agriculture and Lands, Mining, and Transportation).

**Ideas and Suggestions**

- There is no better way to prevent illness and maintain a healthy population than to ensure everybody has access to adequate incomes, healthy food, safe drinking water, effective sanitation, affordable housing and quality, affordable child care.

- We are still focusing on improving individual health with initiatives like Act Now BC. We should be developing targets that aim to improve the social determinants of health and overall population health.

- Increase community-based services and supports.

- The government needs to work together across sectors to ensure there is equal access to the system.

- It is important to find a way to ensure that people are not falling between the cracks when we are trying to help them access housing or other social services.

- A 2006 survey indicates that 39 per cent of non-profit housing providers in British Columbia are experiencing a significant increase in the need for social support services, and 31 per cent are experiencing a significant increase in the need for health services. Partnerships will be an ongoing and necessary piece to finding solutions.

- Increase spending on areas affected by the social determinants of health.

- Having a good social safety net prevents the rise in health care costs.
• Establish program that will increase and support access to anti-retroviral therapy for vulnerable populations, such as the homeless. This program could include pill delivery, helping them access housing, or achieve income stability. Currently, only 50 per cent of people in Vancouver who are medically eligible for anti-retroviral therapy are receiving it.

• Services that are provided by one ministry or agency alone are not sufficient to actually assist the client. Links between the social ministries needs to be established to create solutions.

• Develop a national affordable housing strategy. Institute a national safety network that includes affordable day care, education, housing and income assistance.

• Develop a partnership between First Nations, non-profit organizations and health authorities to increase access to land and housing.

• Part of access is creating a system that provides services in a way in which vulnerable people can navigate it. Information systems and sharing information at the bureaucratic level need to be the enablers that work together to provide an integrated and accessible system of service delivery.

• Create an inter-ministry body to develop a provincial poverty reduction strategy. This body would work with other levels of government and stakeholders to implement and monitor the strategy. Include academic institutions, non-profits and advocacy groups.

• Ensure that poverty is the responsibility of all ministries.

• Establish more social service integrated teams that consist of community resources, Government services and non-profit resources. This will increase access to health care for vulnerable populations.

• The disparities between the rich and the poor are visibly increasing. We need to bring all the social ministries together to solve the problem with a common vision.

• Form partnerships between non-profit housing and transition houses to decrease the number of women returning to violent homes, which jeopardizes their short and long term health.

• Establish community-based medical support teams that assist with social services and social housing environments. The teams should include properly trained para-professionals to execute medical instructions.

• Increase spending on social workers and programs so that they can deliver education and social training.

• Establish one-stop shops for social services based on the United Kingdom’s foyer model. By co-locating social services it is client-centered versus program focused.
• Outreach services that link vulnerable people with income assistance, housing and other services quickly have worked well in Vancouver and Kamloops.

**Socio-Economic Circumstances**

**Comments and Concerns**

**Comments on Income Assistance**
**Comments on Income and its Effect on Health**
**Comments on Homelessness, Poverty, Vulnerable and Marginalized Populations**

• Comments on income assistance:
  • Income assistance for those receiving disability benefits are insufficient to live alone. Hostels and emergency shelters still turn people away in cold temperatures and some cannot afford housing at all.
  • Health issues for individuals receiving disability assistance need to be addressed.
  • Provincial government cutbacks have resulted in many income assistance recipients to be evicted from supported housing.
  • Do not revoke disability assistance for individuals who are fortunate enough to live with someone, no matter what the relationship between them is.
  • Income assistance clients are often viewed as a burden and are not supported.
  • Income assistance in British Columbia has become primarily a program for individuals that are not expected to work and have disabilities or persistent multiple barriers. British Columbia’s assistance benefits are not generous by the standards of other provinces and there seems to be little justification for this.
  • People on income assistance use to have access to physiotherapy, chiropractic care, massage therapy, eye care, podiatry and naturopathy visits but this has now been reduced to only ten visits a year.
  • People on Canada Pension Plan disability assistance feel like third class citizens.
  • The cuts to welfare have increased homelessness, abuse and addiction.
  • It is unfair that people receiving disability assistance that have cars receive extra subsidies for car related expenses when those without cars receive nothing.
  • Welfare and disability rates are not enough to access healthy foods and still cover all other life expenses.
People living on income assistance and low incomes cannot afford to participate in recreational activities, frequent the gym or buy exercise equipment that would contribute to attaining good health.

Income assistance clients are given the impossible task of buying all groceries with a small amount of money, and are then criticized that they are making poor food choices.

The province’s disability assistance puts limitations on people with disabilities by allowing some to work and earn money and the others who cannot are left with less. Health and social issues cause stress which is not healthy.

The application for disability assistance takes a long time and this can impact how a person with a disability can access the treatment they need for a chronic illness.

Welfare and disability benefits are too low and there are too many barriers to access them.

People on income assistance receive $325 per month for shelter. In Vancouver this is only enough to rent a room in a dangerous, bug-infested single room occupancy hotel.

People on disability tend to be stressed and smoke more as a result. We should not charge them tax on their cigarettes. Cigarettes have anti-psychotic properties that help people self-medicate.

People suffering from Chronic Fatigue Syndrome cannot hold a regular job and accessing income assistance is difficult for them due to the erratic changes in their physical fatigue.

Comments on income and its effect on health:

The efficacy of preventative care is affected by income levels.

A recent study conducted in the West Kootenays showed that fewer than 60 per cent of people that responded to the survey had an income of $20,000 or less. Just over 30 per cent of the people had an income of $15,000 a year. There are many seniors who cannot afford fresh fruits, vegetables and other extras that you need to maintain good health.

Minimum wage is not enough to cover food, clothing, utilities and shelters for families. Family breakdown, substance abuse, violence, apprehension of children and poverty occur as a result of a shift in the economy and prevention efforts are moot.

Minimum wage is interfering with the affordability of healthy foods.
• Comments on homelessness, poverty, vulnerable and marginalized populations:
  • There are a growing number of homeless people, and the rates of poverty are increasing.
  • Victoria’s homelessness issue stems largely from a lack of proper resources.
  • It is the sick and most vulnerable that rely on the public system for help and they should receive the best care.
  • Access to care for the homeless and disadvantaged individuals is limited and they have to use hospitals.
  • Soup kitchen closures are a concern.
  • Poverty can increase the likelihood of a person contracting a disease. If we are going to look at population health and sustainability in the long-term we need to look at the incidence of poverty in our society. Poverty is a health care issue.
  • Some rural areas are finding that an increasing number of individuals that are homeless or suffering from addiction are coming from urban centers and that rural areas are not equipped to deal with their needs.
  • There are too many families living in uncertain or unacceptable situations.
  • The health system covers the huge cost for care of homeless people that are sick, those that are addicted to substances, and those that are mentally ill.
  • For those that are poor, access to the system is hard to achieve or not happening.
  • Homeless individuals cost the system a large amount of money in hospital care.
  • People who are poor and feel hopeless have fewer reasons to take precautions with their health.
  • Health care costs associated with serving the homeless, particularly in emergency rooms and shelters, are up to $28,000 higher per year than providing someone with supportive housing.
  • Poverty and lack of education are at the root of most chronic illnesses.
  • Often times, more money means people will be spending it on illegal substances and alcohol. They will not necessarily be spending it on nutritious meals or a better home.
  • The rights of homeless people need to be respected.
  • Money allocated for low income housing was given to the private sector to build expensive care homes. These are now dysfunctional care homes and homelessness has been increased as a result.
We need to think about how to effectively deal with the correlation between mental illness and addiction. It is 60 per cent between mental health and drug addiction and approximately 90 per cent between mental health issues and homelessness.

Poverty is the root problem that feeds mental health and addiction problems.

Homelessness is not often thought of as part of health care. We do not fully appreciate the costs that occur in conjunction with or are hidden when it comes to homelessness. For example, mental health.

As a key determinant of health, poverty needs to be factored in to planning and analysis.

Families or individuals with economic barriers and multiple generations of poverty may not have the social skills and resources to navigate the system.

The living conditions in the Downtown Eastside of Vancouver are inadequate for vulnerable citizens. We need to help vulnerable citizens to stay healthy. The single room occupancy hotels, poor nutrition, untended chronic illness and other factors lead to a high rate of hospitalization. The health care costs can be avoided if Downtown Eastside residents had the resources to improve their health and living conditions.

Income and wealth inequities weaken the social infrastructure, and cohesion. Reducing taxes directly benefits the wealthy and translates into increasing income inequity and the weakening of communal institutions that support citizens.

People living in poverty cannot buy healthy foods.

One reason for the high rates of obesity that is not often discussed is poverty.

The system is not yet ready to deal with the addictions and homelessness issues that have crept up.

Do not expose the homeless and seniors to unscrupulous landlords and poor health environments.

Vulnerable populations are more at risk. Bridge the health gap.

Isolated and marginalized populations have a difficult time accessing preventative care and proper nutritional food.

We need creative solutions to assist marginalized populations.

It is a problem that the most vulnerable and marginalized populations do not have access to primary care or general practitioners.
• The current health care system is not going to help people with social problems. At the moment, we only treat the symptoms.
• The majority of mental health patients have low income levels.
• Unemployed and vulnerable populations often do not get the specialist services they need due to a backlog in administration of premium assistance applications.
• There is a lack of services available for youth that are in need or crisis. For example, suicide, teen pregnancy, bullying or physical abuse.
• Those who are poor should not have to pay for their transportation to the medical facility where they are receiving treatment.

• Premium assistance for low-income earners should remain in place.

• Services provided by Pregnancy Outreach Programs promote healthy lifestyle choices and improve the well-being of at-risk pregnant women, their infants and families. These programs offer quality prenatal and postpartum services which include nutrition and lifestyle counseling, food assistance, prenatal vitamins, peer group support and referrals to community services. These programs also encourage a smoke-free environment for pregnant women and their families.

• Pregnancy Outreach Programs assist at-risk women and their family’s access, cook and eat nutritious food and link them with other food-related resources.

• We need to look at specific specialized populations and see what their barriers to accessing care are.

• Even if medical fees are covered it is still difficult for a working single parent to leave work and take their child to a medical appointment. Low-income families need to be supported in their attempts to access preventative care or primary health care.

• Dental care is too inaccessible for low-income people and people without health benefits packages from work.

• Dental insurance is beyond the means of most people. The services are expensive and there is no assistance available.

• Many people cannot afford emergency preparedness kits.

• Stress is a large contributor to overall health.

• Cuts in social programs have a negative impact on the individual and community level.

• We need to recognize that the working poor have real challenges with child care and food security.

• Part-time employment gives no extended health benefits so kids lose out.
• There is a lack of resources for parents in poorer communities.
• Low-income means people cannot afford the types of foods that diabetics need.
• Poor financial management can lead to devastation and addictions, bankruptcy and an unhealthy lifestyle.
• Communities that establish town squares, walkable downtown cores and have healthy community initiatives should be applauded. However, they should make sure that marginalized populations are included in the planning.
• The current level of chronic disease is a result of our social system.
• The increased Medical Services Plan costs are more onerous on people with fixed incomes.
• It is important to look at a community’s social environment.
• Hazelton has the second highest rate of violence and domestic abuse.
• Financial counseling should be offered to people making a lot of money in seasonal employment, as they may lose their job.
• Empower people in rural areas, specifically poorer socio-economic groups.

Ideas and Suggestions

Ideas about Income Assistance
Ideas about Minimum Wage
Ideas about Homelessness, Poverty, Vulnerable and Marginalized Populations

• Ideas about income assistance:
  • Disability pensions should reflect the cost of living in British Columbia and should be indexed.
  • Some services are only available to individuals or families receiving income assistance. Some of these services might be helpful in preventing some from needing to go onto income assistance.
  • Raise the current welfare rates by 50 per cent and index it to the cost of living.
  • The criteria for qualifying for income assistance should reflect the realities of child care and parenting demands.
  • The Government should roll-back the employable age for receiving income assistance.
• Parents whose youngest child is age three or over should be categorized as temporarily excused from seeking a job until their youngest child is seven.

• The increase to income assistance for single or married employable people should have also been extended to people with disabilities.

• Re-humanize the process of applying for income assistance.

• We need to ensure that youth who leave care, have special needs, or leave the educational system do not end up on income assistance. There needs to be other options.

• For income assistance, increase the allowable earned income supplement.

• Income assistance should have a component which lets people decide their own priorities.

• Ideas about minimum wage:

  • A healthy society starts with income first.
  
  • Increase minimum wage. The current minimum wage is below the poverty line.
  
  • We need to think about how we deliver services to vulnerable populations. When clients come in to pick up their checks it is a window of opportunity to connect with them and intervene or assist them in accessing other services that may be of help. If all clients are on direct deposit then you miss that opportunity.
  
  • Welfare rates need to increase in proportion to inflation rates.
  
  • Increase the housing portion of disability pensions so that they cover the full rent of a unit.
  
  • Eradicate the training wage.
  
  • Ensure that women are working for a fair wage.
  
  • Establish a living wage in British Columbia; it will increase quality of life.

• Ideas about homelessness, poverty, vulnerable and marginalized populations:

  • For people with mental health and addictions issues we should set up clinics that have a range of services. Like a community health centre that provides them with accessible services.
  
  • Make pan-handling against the law and establish community service for those convicted. Community service can teach them landscaping or other skills.
  
  • We need to look at social responsibility and see where the social structures that are not broken down are.
• Recognize the differential in rates of poverty among different groups. For example, a female single parent.

• The Minister of Health should look at the Tri-Cities homelessness report that came out. A large percentage of the homeless also have mental health issues. Port Coquitlam has food banks, soup kitchens and a mental health office but there still does not seem to be enough funding to assist those that are homeless.

• More funds need to be put towards providing basic comforts to the homeless during cold wet weather season.

• Create more shelters, supervised housing and halfway houses to alleviate the current shortage.

• Reduce demand on the health care system by planning, building infrastructure and addressing homelessness and mental health issues.

• Port Coquitlam and Coquitlam would be in favour in having a temporary shelter at Riverview.

• The high number of homeless that are mentally ill indicates that community based housing must be developed to address homelessness and the related social causes at their root.

• To address the increasing number of homeless with mental illness we need to consider the ramifications of having closed big institutions. These people receive income assistance but no other real help.

• Tackle the issues that put people into poverty such as pensions, welfare rates, availability of affordable housing, and disparities in wealth. Everyone should be able to benefit from our healthy economy.

• Help people to acquire skills, give them tools to navigate the system and to get out of poverty.

• Find proper supervised housing for the homeless.

• Increase social services, outreach and primary health care access points for the homeless population.

• If British Columbia has 10,000 homeless people and a cost savings of $8,000 to $10,000 per person can be saved by providing housing to the homeless then British Columbia stands to save between $80 and $120 million a year.

• Improve treatment towards the homeless.

• A plan to completely eradicate homelessness needs to be developed.
• Fund a project to interview homeless people to find out why they are homeless. The only people that can solve the homelessness issue are the homeless themselves.

• Provide supervised housing for those addicted to drugs and mental illness so they can be assisted with medication and rehabilitation.

• We need to find a place in our communities for addiction services. We need to have safe and secure places for them.

• Establish homes to care for prostitutes that will assist them in improving their health.

• Subsidize housing for the mentally disabled.

• We need to take care of our disabled seniors.

• Allocate funding to Burnaby for a 24-hour resource centre for the homeless and others who need it.

• The provincial government should build more supportive housing for women living in the Downtown Eastside of Vancouver.

• The provincial government needs to ensure that there is a women-only emergency shelter facility in the Downtown Eastside of Vancouver.

• Expand the services available to those who are in poverty.

• Look at alternatives to institutions for housing the mentally ill.

• Halfway houses would help people with mental illness to recover from psychotic breaks.

• Supported housing for those suffering from mental illness should include ready access to psychiatrists and psychologists.

• Make housing for those suffering from mental illness be dormitory style. Rent churches and have bunk beds with blankets. Use these shelter sites to generate a new housing registry to transfer these people into more stable housing.

• Prince Rupert needs more support for mental health and addiction services.

• There needs to be well coordinated care for people who are able to live in their community but are not fully capable of integrating completely into work or social life.

• Quebec, Newfoundland, Nova Scotia and Manitoba have passed or introduced poverty related platforms; British Columbia needs to do the same.

• Have tailored approaches to address the unique issues of each specific type of vulnerable population. Have the community involved in delivering services.
• For low income earners and families there should be access to vitamins and healthy foods as well as access to naturopaths, dentists, physiotherapists and chiropractors. All of these should be funded.

• Have social workers to assist low income and vulnerable populations to navigate the system.

• We should think about enjoying the out-of-doors as a determinant of health. Make activities and services accessible to marginalized families. For example, scouts or team sports.

• Establish targeted funding for developing innovative approaches to assist low income people in accessing health services.

• Restore the cutbacks that were made to social services that support housing, mental illness programs, child care and women’s issues. It will take a load off of the health care system.

• Teach about the harms of second-hand smoke and the dangers of poor food choices. Pay special attention to low income families who rarely have the opportunity to attend health clinics and prevention clinics.

• Measure the success of our health care system based on the quality and accessibility of care available to those with the least financial means.

**Children and the Social Determinants of Health**

**Comments and Concerns**

**Comments on Children and Poverty**

**Comments on Children in Care**

• Comments on children and poverty:
  • Children are denied, due to their family’s lack of funds, access to social and sports facilities in their communities.
  • Children in care have more respiratory illnesses and receive a higher level of antibiotic therapy than other children do.
  • Children from low income families have great difficulty in accessing adequate health services to maintain good health.
Children living in poverty that experience food insecurity may develop serious health risks including limited physical, mental and social growth are at increased risk of being involved with the child welfare program.

There is a serious lack of dental services available to children living below the poverty line.

In the past five years there has been no new social housing build for families with children. Many live in cars, tents and trailers.

Numerous health problems stem from a lack of housing.

Children living in inadequate or substandard housing are at risk of lower levels of development as a result.

There is an impact on foster parents’ options and opportunities due to poor and small housing that is available.

The Government should not be able to take a child that is given into custody up for adoption when the only thing the parents have done is become homeless. The Government should be responsible for helping the parent find subsidized housing and assisting them in finding a job. They should be allowed to keep their child.

Living in poverty affects early childhood development. Health, physical, socio-emotional, and language and cognitive domains strongly influence basic learning, school success, economic participation, social citizenry and health. These are all important for breaking the intergenerational transmission of poverty.

Family income during childhood is an independent predictor for later development of chronic diseases such as heart attack, diabetes, respiratory disease and some cancers.

That 21 per cent of children live in poverty is appalling.

For three years running, British Columbia has had the highest child poverty rate in Canada.

Early childhood development is a social determinant of health for children.

The impact of child poverty on long-term health and overall health status are a call for the health sector to take leadership on this issue.

Approximately one in four children in British Columbia lives in poverty.

Impoverished children and handicapped adults, who have no choice in their situations, are often the most disadvantaged.
• Cuts to social services that have a direct impact on women, especially single mothers, will negatively affect the growth, development and well-being of children.

• Household income seems to influence a child’s perception of stress as a contributing factor to bad health.

• Many children with household incomes below 40,000 dollars believe that stress leads to bad health. Many of these children see eating better as a reason for better health.

• The most effective strategies to improve outcomes for high-risk youth are those that enhance their resiliency and acknowledge and build on their strengths.

• Children living in households that make less than 40,000 dollars are less likely to feel healthy than other children.

• Comments on children in care:

  • Children in care have higher rates of congenital anomalies and fetal alcohol spectrum disorder.

  • For females in continuing care, the most common reason for hospital admission was pregnancy or childbirth related issues. This rate was five times higher than for females in the general population.

  • Birth control is prescribed for females in continuing care at rates two to seven times higher than for females that have never been in care.

  • Young women in continuing care become pregnant at a rate more than four times that of young women who have never been in care.

  • With the exception of cancer, children in continuing care were more likely to be diagnosed with a medical condition than were children who had never been in care.

  • It must be demonstrated that by emphasizing the strengths of a child, the health, education and other outcomes relating to the well-being of that child are improved.
Ideas and Suggestions

Ideas about Child Poverty
Ideas about Children in Care

• Ideas about children in care:
  • Introduce a policy of no smoking inside foster homes.
  • Invest in and develop a cross-ministry plan for post-majority supports for youth leaving care who require adult services. Have the Ministry of Children and Family Development take the lead role.
  • Engage in collaborative research with research communities outside of Government to dig more deeply into the causes of poorer outcomes for children in care and to study the impact, if any, of being in care or on specific outcomes for children in care.
  • Establish systematic screening for child development for all children in care between the ages of 0 and seven. Early diagnosis and treatment of conditions can significantly improve outcomes for children and their families.

• Ideas about child poverty:
  • Eliminate child poverty.
  • Solutions to child poverty should be multi-faceted with a cross-sectoral focus.
  • Affordable child care options are important for impoverished children.
  • Ending child poverty will save the system a lot of money.
  • Create a child poverty reduction strategy for British Columbia and set targets for success. This should be driven by an inter-ministerial group.
  • We need affordable and accessible child care.
  • Ensure that new mothers and newborns have a safe, warm and healthy place to live.
  • We need to make high quality child care and early learning accessible. High quality child care and early learning will lead to improved health for children, improve opportunities for workforce participation for families and vulnerable children will benefit from access to high quality care and supports.
  • Ensure that children with special needs receive the extra health care they need.
  • Use the Early Development Instrument, an instrument that gauges the state of a child’s development, on an annual basis to measure vulnerability and identify
opportunity to improve health outcomes for children in different geographic areas. This tool can effectively map various socio-economic indicators.

- Establish a tax credit incentive for organized sports programs that will assist disadvantaged kids to access them.

- The Government should extend day care hours and provide good quality child care that is publicly funded so there is equity in access.

- Reinstate funding for child care resource and referral centers.

- The Government needs to look at the First Call BC Child and Youth Advocacy Coalition annual child poverty report card.

- Provide single parents with the option of taking life skills courses on breastfeeding, healthy eating, smoking cessation, drug and alcohol rehabilitation, money management and improving self-esteem. This would be money well spent to ensure that they can better contribute to society by taking care of their own needs and improving their health.

**Housing Including Affordability, Availability and Standards**

**Comments and Concerns**

- The province has increased the budget for housing over 100 per cent in the last five years. Our population during that time has only grown four per cent.

- The lack of housing supports forces homeless people to use hospital emergency washrooms, showers, pay phones and other services.

- People are forced to make a choice between food and rent because the laws of the land say so. There are vast expanses of land under municipal, provincial and federal government control to which Canadians are denied by law. If they were not denied they could put up affordable tents or cabins and their budgets would enable them to have healthy diets as well.

- Improvements to the infectious disease rates are linked to housing.

- There is a lack of affordable housing that is safe and stable.

- The recently expanded Residential Assistance Program comes nowhere near meeting the real needs of families.

- Prevention is just one part. If we work on prevention but people do not have a place to live it is not going to help.
• The cost to the system as vulnerable populations access health care through emergency rooms is huge. There is research that shows the benefits of supported housing and how good supported housing can reduce vulnerable populations accessing health care through the acute care system.

• There is a lack of affordable housing for young people with chronic diseases, people with disabilities, and those suffering from mental illness.

• Poor housing conditions are a contributor to overall health. Overcrowding leads to conflicts, depression, communicable diseases and deterioration of the home.

• The wealthy are buying homes in the Okanagan and driving house prices up. Housing is unaffordable for low income families.

• The lack of appropriate housing is a major determinant of health, especially for those suffering from mental illness. Those with low incomes will have poorer nutrition that leads to poorer health.

• Options for safe, adequate and affordable housing are decreasing while complex housing barriers such as mental health and addictions issues are increasing.

• The biophysical aspects of health and housing are important to individual health. Lead, mould, dust mites, asbestos, and overcrowding in the home often provoke the onset of chronic respiratory illnesses and allergies, especially in children.

• As more middle-income families with children are forced to move to the suburbs to find affordable housing we will see the number of health related issues increase.

• A lack of affordable housing increases the number of people that are at risk of homelessness. Homelessness and poor health are interrelated as individuals may become homeless due to untreated physical or mental illness. Homelessness will then have a further negative effect on their health.

• When a household spends more than 30 per cent of their income on rent, the ability to make healthy and preventative choices such as good quality housing in a good neighbourhood, nutritious food, and regular exercise and recreation ranges from difficult to impossible to maintain.

• Land-use patterns in neighbourhood design can affect health outcomes. For example, longer commuting times into the city influence both child and obesity rates.

• More effort by the provincial government needs to be made to provide housing for the mentally ill.

• The provincial government needs to make it easier for people with disabilities to live independently with help available to them.
• Social housing is needed in the Okanagan.
• Urban renewal in Vancouver is causing people to be evicted with nowhere to go and rental increases. More social housing is needed in Vancouver.
• Tofino and other rapidly growing communities have a lack of living space.
• A place to live is important for young people and young adults who are released from jail. They want to stay clean and without a place to live they return to their old lifestyle and end up in jail again within days.
• Rents keep rising despite the conditions of buildings deteriorating.
• Poor quality and lack of housing causes health problems.
• BC Housing too often moves you away from your support system.
• Waitlists for affordable housing are too long.
• The Makola Housing Society is a good example of a solution.

Ideas and Suggestions
• The Government needs to support the goal of ensuring housing for all.
• The province needs to stop making variations in zoning bylaws. Each community needs to accept its share of the housing problem.
• Homes are not being built to standards and people are dealing with mould. There needs to be more regulation and assistance in having home repairs done to make houses safe.
• Establish requirements and standards for appropriate housing.
• Establish transition housing for men.
• Build more low-cost housing.
• Implement the 2006 Fraser Housing Report and provide rent subsidies and more low rent housing.
• Establish work support programs and improve supportive housing.
• Getting people good housing is the most important step that you can take in improving someone’s health. Good health does not just come from the traditional health care system.
• Several affordable housing providers have played a key role in revitalizing low income communities for children. Introducing mixed-income housing, green design
principles, recreation facilities, parks and local services assist lower-income families in accessing a variety of resources and supports in these communities.

- We need more non-profit housing.
- We need long-term mortgages geared towards low income populations and aboriginal people.
- Establish supportive housing complexes for people ages 18 to 65 suffering from chronic diseases to build social opportunities that empower them to support each other and build on their abilities.
- Establish a range of supportive housing along a graduated spectrum based on the different needs people have for housing. For example, semi-independent with a roommate, low income or short-term with high needs.
- Because of the high cost of housing in the Lower Mainland, build residential and subsidized housing for nurses on-site.
- Build more second stage housing for those in transition or are at risk of becoming homeless.
- Make access to good housing and housing security a human right.
- Create incentives to provide smoke-free multi-unit housing (rentals, co-operatives, and condominiums) so that people who cannot afford their own detached house can have the choice of protecting their health in their own homes.
- Municipalities should be given the power and be required to inspect and condemn run-down housing.
- There are no homes or facilities for follow-up treatments after detoxification or rehabilitation. Rehabilitation follow-up should be mandatory and available.
- Build partnerships with landlords to build and provide housing units.
- Develop attractive housing complexes that have a sense of community and peer support.
- Exclude development fees from social housing projects.
- Establish incentives from all levels of government to land developers that are providing sustainable and subsidized housing.
- Make supported housing a flexible and adaptable system.
- Develop internal capacity within health authorities to deal with affordable housing shortages and related issues.
- Supported housing needs to have safeguards to keep people out at night and to ensure the environment is clean and there are no cockroaches.
• Require all new developments to have an affordable housing component.

• Form a network of land-use planners, public health workers, and housing and service providers. This will encourage a systematic approach to developing affordable housing.

• As non-profit housing stock is aging, plan to invest in high air quality, non-toxic building supplies and energy efficient technology. This will be important in maintaining good tenant health and well-being.

• Bring back old-fashioned boarding houses and update them to be co-op type housing. Require people to take a workshop on the benefits, etiquette and pitfalls of co-operative living before allowing them to live there.

• Reinstate federal and provincial housing programs.

• Explore the possibility of having land trusts for affordable housing. The Government would own the land but the poor would be able to afford the rental housing.

• Change the laws regarding no pets in apartments. People with pets get more exercise and are less lonely.

• Fraser Lake needs houses, buildings, parks, schools and day cares built.

• Health standards for housing need to be imposed.

• Provide training to those in low-cost housing on cooking, nutrition and parenting.

• Increase population density and do not demolish existing structures. Add to communities.

• Ensure that affordable housing accounts for and accommodates varying mobility issues.

• Enable doctors, nurses and public health clinics to make diagnoses of ‘habitat-related illnesses’ so that Government can keep a better record of the extent of how housing can impact individual health.

**Seniors and Housing**

**Comments and Concerns**

- Seniors are struggling to find proper housing. Some cannot afford the $4000 a month for a private facility.
Ideas and Suggestions

- Homes for seniors need to have a new design that is flat and one level.
- Build more affordable housing for seniors that are public/private partnerships with community facilities.
- When seniors housing is torn down because the buildings are old you need to ensure that the replacement housing is ready.
- Develop condominiums for seniors age 75 and up that are low level patios. These should be affordable two bedroom units with storage and parking. They should be centrally located and walkable to community services and grocery stores. They should also be built in such a way that prevents falls.
- Housing seniors should be the responsibility of the Minister Responsible for Housing and Homelessness.
- Address poverty among seniors.
- Ensure that there is housing available for aging mental health patients. Their housing should include nursing services and mental health support.
- The provincial government should increase supported housing units and implement the appropriate support programs that allow individuals to maintain their independence and remain living independently for as long as they can.
- Fund and build public long-term care homes for the 5000 plus seniors that need a long-term place to live and receive care.
- The Government needs to work collaboratively across ministries to properly house seniors.
- Construct seniors housing in close proximity to a hospital.

Aboriginal Communities and the Social Determinants of Health

Comments and Concerns

- The increasing rent off-reserve for Aboriginal people is not affordable.
- There is a lack of affordable housing for Aboriginal people off-reserve which is adding pressure to on-reserve housing.
- There is a concern that children in care have a 50 per cent less success rate and grade 12 completion than First Nations children do.
- Available housing is inadequate and over-crowded.
- There is poor plumbing and unsafe housing on reserves.
- Unemployment in British Columbia is approximately four to five per cent. The unemployment rate among Aboriginal people is between 14 and 15 per cent.
- There are limited family resources available to Aboriginal people.
- It is difficult to access the people you need to deal with at the Ministry of Children and Family Development.

**Ideas and Suggestions**

- Establish transition housing for men on reserves.
- We need to look at aboriginal communities and look at how poverty levels affect nutrition and learning.
- Support First Nations people to acquire journeymen tickets in carpentry, plumbing and other building trades.
- There should be more outreach programs for women, including a shelter for abused Aboriginal women.
- Identify poor housing and act upon it to improve housing quality.
- Ensure that housing on reserves has better plumbing and building materials.
- The bands should have control over lease-to-own and rent-to-own programs.
- Return to traditional housing.
- Have housing, medical and education needs all met on reserves.
- Assist First Nations people to get into the mainstream hiring process for the mining industry.
- Put more funding toward prevention of family, sexual and physical abuse. Provide more funding to education on what abuse is and what a healthy home is.
- Support Aboriginal students who want to get into higher education. Make sure the entrance requirements do not deter them from applying.
- Ensure there is a balance in the training dollars for First Nations and non-First Nations people.
- Hire Aboriginal youth to work on First Nations projects such as housing construction.
Specific Issues Relating to New Canadian Populations

Comments and Concerns

- There is not enough done to provide interpreters and information to immigrants when they enter Canada. This means when a health problem arises they are not prepared to deal with the issue.

- One of the challenges in delivering services is the language barrier and basic literacy skills.

Ideas and Suggestions

- Co-locate services in ethno-cultural communities so that people are able to access services that are health related, for example sexual health, within their cultural context and language.

- Immigrants face unique health challenges related to cultural, historical and social factors. Language barriers, limited understanding of the Canadian health care system and conflicting family values and role expectations are among these factors. Communication with health care providers can also be complicated due to cultural differences. There are only a limited number of support services for immigrants who access the health care system. Improving access to, and quality of, health services for immigrants and ethno-cultural minorities can translate into significant reductions in health risks and economic costs to the system.

- Interpretation services for immigrants seeking medical care should be provided by health professionals as it could mean they receive better care.

- The provincial government should provide interpreter services for women in Chinatown.

- The availability of translated health education materials needs to be increased. Most resources in the Lower Mainland are in Chinese while a limited number of publications are available in other languages. To assist new Canadians navigate the health care system we should also provide materials, in print and electronically, in Farsi, Korean, Cantonese, Mandarin and Filipino. Workshops should also be provided in other languages.

- Increase the cultural competence of health staff.

- Tailor community health programs, such as prevention, disease and injury programs, to increase participation by ethno-cultural communities.
• Create a list of health professionals that are multi-lingual and accepting new patients.

• Increase supports for children in immigrant communities and for immigrant youth in public schools and community programs.

• Immediate action needs to be taken to reduce the health disparities and gaps in health service access between immigrant, ethno-cultural minorities and the rest of the population.

• Make housing programs culturally appropriate.

• In addition to offering health services to ethno-cultural communities in their own language, specific initiatives, such as printing stickers in Punjabi that outline the symptoms of a heart attack and what to do, can also assist new Canadians in accessing the health services they need more easily.

• Look at expanding the availability of cultural brokers. Often these are non-profit agencies that have ties to the community and are accountable and established.

• Health service delivery needs to take into account all levels of education and language barriers. The ability to read and write is critical to accessing the health care system and following instructions.

• Fund cultural education.

• Make the BC Health Guide and the BC NurseLine available in other languages and educate other cultural communities that this service is available.

• Develop an information package on the Canadian health care system with specific details on hospitals, community health and primary health care services. Have it translated into different languages and make sure it includes a section with frequently asked questions.

• Improve language skills development programs on the North Shore.

Education and Literacy as a Social Determinant of Health

Comments and Concerns

• Class disparities are a marker for the health of a population. Educated people have better health and people who have better economic opportunity have better health.

• Educational equality needs to continue to be a key priority.

• Not graduating from high school is one of the most significant determinants of your future health.
• Accessing education is an issue that needs to be recognized.
• We need to be more aware about literacy. Especially when it comes to directions on prescriptions, diet advice or application forms for disability assistance.

**Ideas and Suggestions**

• Health, literacy and education are areas that offer great cost savings opportunities. They provide an opportunity for meaningful interaction with communities and community groups and will have a noticeable outcome for British Columbia’s goal of being the most literate jurisdiction in North America.
• Focus on education as preparation for life. Provide students with training for employment.
• Set up a system of checks and balances to determine the level of literacy a patient has so that additional education or assistance, such as an advocate, can be provided if needed.

**Outstanding Questions**

• Is there any commitment, duty or obligation towards turning the Downtown Eastside of Vancouver into a healthy community?
• If we develop a good system of prevention but people do not have a place to live how is it going to help?
• How do you respond to the social determinants of health when developing primary care policy?
• Why not develop policies within the area of primary health care to ensure that we do not increase the disparities in health?
• What is happening to our National Childcare and Poverty Program?
• Will government take action to provide higher levels of support for income assistance clients that are people with disabilities?
• We need more pilot projects. Why not consult individuals that are accessing mental health services to determine what supports they need to keep them from becoming homeless?
• If the poor, disenfranchised, illiterate, ill and aboriginal people cannot get on income assistance where should they go to get help?
• Socio-cultural norms and expectations in a community can be a powerful influence on behaviour. How can we use this to reduce the frequency of smoking and other behaviours that are harmful to health?

• In New York, it is the responsibility of the state to ensure that citizens have a home. Government can be taken to court for not providing housing. Why can we not do this in British Columbia?
Food Quality and the Environment as Determinants of Health

Food quality and the environment as determinants of health were topics of discussion throughout the Conversation on Health. The importance of addressing issues related to affordability, access, quality and the production of food were highlighted in many of the discussions and submissions. Maintaining good health through access to good food and the quality of the food served in institutional settings and through meal delivery services were also among the topics discussed. Inter-related with the quality of food was the interplay between the physical environment and our health. We received input on the importance of recycling, regulating waste disposal, pollution, global warming, parks, recreation, transportation, agriculture and education on the environment. Here is a selection of what participants had to say on the subject of food quality, the environment and their effects on the health of British Columbians.

Food Production and Regulation (Quality)

The use of pesticides and herbicides in agriculture and the use of hormones in raising poultry and cattle was a concern to participants. Many would like to see a ban on pesticides, herbicides and hormones in the production of food. Genetic engineering was also cited as problematic as biotechnology has consequences for the health of the population which are often unknown. Some others suggested re-examining current meat inspection laws, working to establish co-operative organic farming practices, banning agricultural chemicals and working to support farmers who want to run organic food production businesses.

Participants were concerned that large industrialized food production companies are producing foods with too many processed additives resulting in nutrient loss and other unknown side effects. They believe there should be increased regulation imposed on processed food companies and foreign food imports, and a process to ensure their advertising is accurate and truthful. Other ideas and suggestions included banning trans fats from all food products sold in British Columbia, imposing heavy taxes on companies that manufacture and distribute unhealthy foods, reducing the number of permits provided to fast food restaurants, mandatory health warning labels on unhealthy foods, and a move to ensure British Columbia is a genetically-modified food free province by 2010.
Food Quality in Hospitals, Long-Term Care Facilities and For Seniors

The issue of quality was the focus of input relating to food in hospitals, long-term care facilities and seniors. Participants want to see patients and seniors provided with good, nutritious, healthy food that promotes well-being and is conducive to healing. There was support to put a stop to frozen, re-heated or re-thermalized foods being served in hospitals, long-term care facilities and to seniors receiving meal delivery services.

Affordability and Access to Healthy Food

Many expressed concern that good healthy food, particularly organic produce, is too costly or unavailable, especially in some rural areas. Some feel that specific attention should be paid to low-income individuals and families who may have bigger challenges in accessing high quality food. The majority of participants would like to see healthy foods subsidized, a greater emphasis on food security, and more support for farmers markets and school gardens that increase accessibility to good food.

Specific Issues Relating to Aboriginal British Columbians

Specific concerns raised by Aboriginal communities included a lack of traditional food gathering locations, changes to traditional diets, over-fishing, limited access to traditional foods and the absence of cultural management strategies to manage the transfer of traditional knowledge around food gathering. Their suggestions for improvement included: ensuring there is good access to traditional foods; setting aside adequate tracts of land for the protection, conservation and restoration of indigenous food systems; and, establishing educational programs in Aboriginal communities which focus on applying traditional concepts and guidelines surrounding the sharing and eating of traditional foods and medicines.

Health and Education Relating to Food

Participants believe that the food choices people make have a significant impact on their overall health and well-being. They particularly feel that the increased incidence of cancer and chronic disease in the province relates directly to the types of food choices British Columbians are making. Poor food choices cited by participants included: poor eating habits; malnutrition; vitamin and mineral deficiencies; food sensitivities; eating too much animal protein, the toxic chemicals or additives in food; and, ingesting trans fats, sulphites, sugar or monosodium glutamate (MSG).
Education on healthy food and diets, removal of junk food from schools, instituting healthy food programs in schools, and increasing awareness on what calories really mean were among the suggestions made to improve the overall health of the population.

Water, the Environment and Population Health

Participants in the Conversation on Health expressed significant concerns regarding the quality of our environment and its direct impact on individual and population health. Numerous chronic conditions, such as respiratory illness and asthma, can be attributed to the state of our environment. Participants offered the following solutions to improve the quality of British Columbia’s environment: put anti-smoking legislation in place; tax herbicides and pesticides; have environmental education be mandatory for all British Columbians; establish better recycling programs; impose anti-idling laws; provide more incentives to take public transportation; make more cities walkable; and, increase the number of bike trails in communities.

Conclusion

Participants were vocal in expressing their concerns about how food and the environment can contribute to good health. Although concerned with the availability and affordability of good healthy food and the current state of our physical environment, British Columbians suggest that increased consumer education, individual choice, a provincial focus on cleaning up the environment, and increasing support for healthy food manufacturers and farmers can lead to better population health.
Food Quality and the Environment as Determinants of Health

This chapter includes the following topics:

- Aboriginal Food Quality
- Affordability and Access
- Food and Population Health
- Education and Public Awareness
- Quality Control
- Food Production
- Food Quality in Hospitals, Long-term Care Facilities and for Seniors
- Water and Environment Quality
- The Environment and its Effect on Health
- Regulation, Recycling, Pollution and Global Warming
- Parks, Recreation, Transportation and other Governmental Jurisdictions on the Environment
- Agriculture
- First Nations Communities and the Environment
- Education and the Environment

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

- Chronic Diseases
  Submitted by the Health Officers’ Council of British Columbia
- Primary Health Care
  Submitted by the BC College of Family Physicians
- The Cost of Eating in BC
  Dieticians of Canada
- Aboriginal Conversation on Health
  Vancouver Coastal Health
- Sunshine Coast Conversations on Health
  Women’s Health Advisory Network, the Sunshine Coast Hospital and Health Care Auxiliary and the Seniors Network Advisory Group
- The Role of the Health Authority in Population Health
  Submitted by the Vancouver Coastal Health (Advisory Committees)
Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

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Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Health Promotion and Social Determinants of Health.

Aboriginal Food Quality

Comments and Concerns

- There is a lack of food gathering places which has an effect on health.
- First Nations people have to travel more now to access fishing and hunting resources.
- It is difficult to find traditional foods and medicines that do not have pesticides or chemicals.
- Teachers in schools need to be aware that some children have allergies and have gotten sick from food that is served at school.
- It can take 400 years to adjust to new diets. Aboriginal people have had less than 100 years which is causing problems.
• Colonial settlers introduced a diet that was not centered on seasonal harvests. Store bought meats, dairy products as well as saturated fats and carbohydrates from various plant sources and fruits, vegetables, and grains that are highly processed were introduced.

• Research has shown that Aboriginal populations from Canada, the United States and Australia have several attributes that lead to the higher prevalence of diabetes. A change from a traditional diet to a carbohydrate diet that consists of highly processed foods and a shift to a sedentary lifestyle from a nomadic one has contributed to this.

• First Nations peoples bodies are reacting to the cumulative effects of toxic contamination that has made its way through the food system via large scale agricultural production.

• Social factors that lead to poor mental health can be attributed to loneliness and isolation from traditional land, families and communities, as well as from a cycle of oppression and food deprivation that was experienced in residential schools and poverty stricken homes.

• Residential schools introduced unhealthy foods. The new diseases are coming from what we eat as traditional foods are no longer available.

• Health Canada is blocking traditional food methods because of standards. Good healthy foods are starting to get polluted and over-fished.

• The provincial government needs to consider Aboriginal values when granting licenses to develop crown land without consideration of traditional food territory.

• There are real struggles surrounding traditional responsibility to the land and nature and the relationship with aboriginal food systems.

• The intergenerational transmission of food related knowledge has been disrupted since contact with non-indigenous peoples and has lead to the erosion of indigenous food systems and way of life.

• The capitalist economy is forcing indigenous parents to assimilate. This makes is difficult to pass on traditional food and medicine related knowledge. Failure to manage the transfer of such knowledge and the lack of cultural management strategies and practices does not contribute to the stability of aboriginal communities.

• One of the reasons for poor health among Aboriginal seniors is that they no longer have access to traditional foods.
Ideas and Suggestions

- Aboriginal peoples should go out and hunt, fish and gather with family and friends.
- Traditional foods are the best medicine in Aboriginal communities.
- The government should set aside adequate tracts of land for the protection, conservation and restoration of indigenous food systems.
- Government needs to recognize the sovereignty of traditional picking areas.
- There need to be secure land areas so that traditional foods are available.
- The Indigenous Food Sovereignty Conference hopes to provide opportunities to establish or enhance traditional food trade relationships between various nations in the interior region. The Indigenous Food Sovereignty report contains important information on restoring food systems.
- The cultural concept of food as medicine promotes a holistic approach to maintaining and restoring health to our bodies and the ecosystems that provide us with our food.
- An annual Interior of British Columbia Indigenous Food Sovereignty Conference and planning committee has been established to organize the time and space for traditional indigenous harvesters to voice their concern, express solutions, and to address the insecurity of indigenous food systems in the Southern Interior of British Columbia. This conference has created a province-wide working group within the various indigenous nations of British Columbia, and in turn has the ability to influence and monitor policy. The Interior of British Columbia Indigenous Food Sovereignty Conference participated in the International Planning Committee on Food Sovereignty (a forum on land territory and dignity).
- In Aboriginal communities, healthy choices should be taught based on indigenous knowledge and wisdom. This means learning and applying cultural concepts and protocols that set out guidelines for the most appropriate way of learning; sharing, and eating indigenous foods and medicines.
- There should be funding and support for community-based indigenous food related projects.
- Aboriginal people should take responsibility to respond to individual and family food needs in a healthy way.
Affordability and Access

Comments and Concerns

- Organic and healthy food is too costly or unavailable, especially in rural areas.
- Good food is not affordable and there is a lack of unprocessed, fresh and organic food choices.
- The cost of junk food is cheaper than healthy food.
- A healthy diet can be very expensive, especially if a diet is required to be organic.
- Everyone has a right to quality food in adequate quantity.
- Low-income individuals or families cannot afford a healthy diet.
- The provincial government needs to address the root cause of household food insecurity and poverty. If poverty is not addressed, the government will find it challenging to achieve the health targets that have been set out for 2010.
- Food insecurity and low-income wages reduce the food choices individuals and families can make. This results in a higher consumption of inexpensive, easily accessible and energy dense foods that lack nutritional value.
- Alcohol has universal pricing but food does not.
- When the government promotes the benefits of fresh fruit and vegetables, the prices of those goods skyrocket, while highly processed junk foods are less costly.
- Low-income parents cannot afford proper nutrition for their children. Children can be provided with the best education on fitness and nutrition, but if there is no money available to their parents to purchase healthy foods, the curriculum will not have the desired benefits. We need to look at providing dollars to improve nutrition in the home as well as more knowledge in schools and for the public.
- There are areas within British Columbia that have a high density of poor children living in unhealthy environments and may be going to bed hungry or living on a diet from the food bank that is high in fat and white sugar.
- It is difficult to shop for healthy foods without transportation so many people are forced to shop at a corner convenience store. This doubles the cost of food and provides little or no choice for fresh vegetables.
- Organic foods are now available in our supermarkets with increasing prevalence.
- Farmers’ markets are becoming more popular which benefits local economies.
- Local community programs pick surplus fruit for food banks or there are allotment gardens to grow food for the food bank.
- Wider varieties of quality foods are readily available.

**Ideas and Suggestions**

- Subsidize healthy food to increase accessibility.
- Establish a regional food strategy.
- Have school gardens.
- Offer incentives to grocery stores to carry local produce.
- Relax the laws on farmers’ markets to make healthier foods more accessible.
- Bring back Buy BC programs.
- Subsidize whole grain foods, fresh fruits and vegetables, lean meats and fish and low-fat dairy goods.
- Provide food banks with a list of healthy foods so that they can be more health-oriented.
- Rally grocery stores to provide incentives for students and give them a discount for purchasing one of a selection of healthy foods.
- Institute a guaranteed annual income so that people can afford healthy food.
- Educate all health authority staff on food security as a health issue.
- Link food security issues to income, the impacts of immigration, racism and gender.
- Build links with municipalities in the area of food security.
- Remove taxes from organic, whole foods and drinks.
- Community kitchens should be encouraged.
- Establish grocery stores in small communities so that people do not have to commute so far to have access to fresh produce.
Food and Population Health

Comments and Concerns

- Kids are being bullied for eating properly.
- Restaurants located in the vicinity of schools can result in unhealthy food choices by students. Education on nutrition may prevent or moderate their consumption.
- An increase in cancer and other illnesses can be attributed to poor eating habits, malnutrition, vitamin or mineral deficiencies, or food sensitivities.
- Many food related illnesses can be attributed to social factors such as high levels of stress, trauma, depression and low self-esteem.
- Super-sizing food is unhealthy.
- The number of children who are obese and developing type II diabetes is on the rise. The types of diets that are being promoted result in unhealthy lifestyles.
- Medications are being prescribed instead of examining diet and as a result, health problems are not being treated properly.
- People are developing chronic diseases due to nutritionally deficient food.
- Sue fast food companies for the effects of their junk food on health.
- The higher incidence of disease may be attributed to the many toxic ingredients found in food products. For example, cancer, heart attacks and strokes.
- The national vitamin B intake recommendations may be too low for active individuals.
- Canadians do not recognize the higher cost of less healthy food on their wallets or their health.
- Obesity is an epidemic in North America. One half of the population is grossly overweight. This is a direct result of the increased consumption of highly refined carbohydrates in fast food and junk food that society has become addicted to.
- Wormwood is sometimes used to help cleanse the body of chemicals ingested from processed foods.
- Children in elementary schools have too many celebrations with foods that are not nutritious. For example, cupcakes for birthdays or candy awards being given for school work.
- Eating healthy is a challenge for youth. Girls between the ages of 10-14 find it harder to stay away from junk food than boys who are ages 15-16.
• Diet and nutrition is the key to our good health and many people are unaware of the deficiencies they might have due to poor nutrition, such as undiagnosed medical problems.

• A North American diet consists of nearly all foods which contribute to an acidic environment. The majority of alkaline foods are not commonly eaten, and it is difficult to find alkaline-rich foods in the grocery stores.

• It was known during the 1970s that trans fats in the diet of a woman during pregnancy could affect the health and development of the foetus.

• The presence of nitrates and sulphites in food cause cancer.

• Too many products are being consumed that have white flour, sugar, trans fats and preservatives.

• Cooking foods eliminates nutrients and we are eating too much animal protein. This results in a depletion of vitamins and minerals in our diets.

• The junk food industry does not pay for the health care costs that are a result of their products, British Columbians do.

• An important consideration is that 70 per cent of cancers could be entirely prevented through simple lifestyle changes that start with diet.

• A healthy balanced diet can help to maintain a proper balance of neurotransmitters sending messages to the brain that make a person happy, sad, sleepy or awake.

• The food industry has moved away from using monosodium glutamate (MSG) and towards other ingredients. This has been good for those who suffer from headaches, reproductive disorders, endocrine system imbalances, appetite control problems and nervous system disorders.

• People are making the choice to buy organic food to avoid the chemicals that some believe are making people sick.

**Ideas and Suggestions**

• Limit the availability of pop and junk foods that are causing a higher incidence of diabetes.

• Revise the Canada Food Guide, it wrongly discourages fats.

• Good pre-natal care that includes information on good nutrition is vital.

• The Government should offer free nutritional tours of supermarkets.

• Eat foods that are in season and avoid imported foods.
• Eat foods that come from within one hundred miles of one's home.
• An improved diet can reduce death from cardiovascular disease, stroke, cancer, and diabetes.
• A reduction in consumption of monosodium glutamate (MSG) will allow a person to rebalance their appetite and return to normal appetite control.
• Encourage nutritional supplements; they slow aging of the brain down.
• Promote raw food diets.
• Antioxidants contribute to good health.
• Athletes with poor or restricted diets should consider taking multivitamin supplements.

Education and Public Awareness

Comments and Concerns
• There is a lack of nutritional education in schools as well as a lack of availability of healthy food in schools.
• There is a bombardment of advertising of processed food products.
• There are no incentives to buy healthy foods.
• There is a lot of advertising devoted to unhealthy foods that is directed at children and aired during their favorite shows and sports programs.
• People are talking about the need for health education and nutritional programs and are looking for solutions.
• There has been a recent move by government to promote healthy choices for food in schools.
• Junk food has been banned from schools and there has been a slow introduction of quality food into school cafeterias. Pop machines in schools now have juice and water available. There are healthy choices available in school lunch programs.
• Parents are packing healthier snacks that their kids can share.
Ideas and Suggestions

- Parents should stop giving kids pop in the morning.
- Increase advertising on healthy food and diets. Encourage people to pass up fast food and to pack a healthy lunch instead.
- Establish a fruit or fruit juice program with local products instead of pop in schools.
- Increase access to and affordability of healthy foods for children in school.
- The government should establish cafeteria policies that have ministry health requirements and have to be carried out by schools.
- Increase awareness on what calories mean.
- Make school lunch programs available in rural and Aboriginal communities.
- Use education and media to get the healthy eating message across.
- Give every school-aged child a bottle of water at their desks.
- The government should counter junk food advertising with health advertising.
- Establish composting workshops.
- There should be a province-wide initiative to supply nutrition services to infant development programs.
- The Ministry of Health should continue to expand the School Fruit and Vegetable Program across British Columbia.

Quality Control

Comments and Concerns

- Although food is abundant, the quality is continuously declining.
- There is a lack of control over the large industrialized companies to ensure food quality is the priority versus profits.
- Importing foods from other countries can introduce unwanted diseases and deprives farmers of a local market for their produce or products.
- The nutritional value of our food supply is steadily decreasing and as a result, people are not getting the nutrients they need to stay well.
- There is a lack of control over large industrialized food producers to ensure food quality.
• Big food chains are taking over the organic industry and driving prices down. Farmers are unable to provide produce at lower prices.

• Food imported from Mexico contributes to pollution.

• The advertising of food products is not always truthful.

• Contemporary food processing methods result in nutrient loss by boiling or deep frying. This results in essential nutrients being broken down, and allows for a build-up of carcinogens and toxins from utensils and storage containers such as Teflon, aluminum, and plastic.

• There are too many processed additives in our food, the effects of which are unknown. For example, sugar is over-abundant in many foods and is often hidden.

• Imported foods have been grown under different regulations than local foods. There is a risk of excessive pesticide and hormone use, restricted chemicals, medicated chickens, and non-organic farming practices.

• There should be quality control over the ingredients in vitamins.

• It is hard to make healthy food choices, so there needs to be a limit to the amount of additives added to food.

• A quarter of the calories that British Columbians consume come from junk food. We are innately predisposed to want fatty, sweet and salty foods but our environment has changed.

• There should be stricter labeling requirements. For example, a label that reads ‘low salt’ may still not be healthy.

• Metabolic disruptors in most foods, such as hydrogenated oils, sodium nitrate, saturated animal fats and homogenized milk fats, can cause disease.

• Very few food additives have been adequately tested individually, such as dyes, chemical additives, preservatives and flavour enhancers, therefore, the possible synergistic interactions and their effect on an individual’s health is unknown.

• Imposing a tax on junk food is not a good answer as it will not reduce consumption. British Columbians are taxed enough and for those who rarely consume junk food it does not pose a health concern.

• Pop is not healthy and is high in sugar.

• Breakfast cereals, often the ones that appeal to children, contain high levels of sugar and chemicals.

• Sugar laden foods are not only unhealthy but cheaper than their healthy substitutes.
• Nothing is done to remove aspartame, genetically modified foods or fluoride from our food. Furthermore, accurate information on these needs to be released.
• There is a lack of minerals in our diets.
• Research shows that produce now contains fewer nutrients than before.
• If the Canadian government would stop caving in to the dairy and meat industries, we might have a Canada Food Guide that would lead to a healthy diet.
• Food labels containing autolyzed or hydrolyzed vegetable proteins are also hidden sources of monosodium glutamate (MSG).
• Talk to restaurants about making their menus healthier.
• Foods labeled as natural may contain questionable taste additives like yeast extract but are not required to label them.
• Nutritional information is required to be listed on all processed foods, for example, trans fat content.
• Institution food quality does not meet the provincial guidelines.
• Food labeling has improved but still needs to be expanded.

Ideas and Suggestions
• The Canada Food Inspection Agency should be inspecting food to guarantee that it is healthy.
• Ban trans fats and other harmful chemicals in the production of food.
• There should be long-term studies conducted on how genetically engineered foods affect human health.
• There needs to be an inquiry into the food packaging industry to reduce the toxins that are introduced into packaged food.
• The food industry needs to be made accountable for additives put in food, farming practices that are not environmentally friendly or genetically altered, and pollution resulting from production.
• The government should heavily tax products that contain dangerous man-made chemicals.
• Put health warnings on the labels of foods or other products, such as household cleaners, that contain known carcinogens.
• Put warning labels on fatty foods or high-calorie foods and drinks.
• Ensure that food labels are coded in a simple way with bigger lettering so that seniors and children can understand nutritional information.
• Establish a provincial ban on trans fats.
• Establish legislation on pharmaceuticals in the food chain.
• The government needs to pressure food companies to reduce the inclusion of harmful ingredients in foods.
• Ensure that produce that is labeled as organic is in fact organic.
• Increase co-ordination between government, cancer societies and medical professionals to be more aggressive with food, tobacco and other companies to take responsibility for chemicals, pesticides, hormones and excess sugar and salt in foods.
• Reduce the number of permits for fast food outlets.
• Increase research on food-borne and water-borne diseases and have better disease reporting mechanisms between the doctor and the laboratory.
• Sodium and salt levels in food are too high and should be clearly labeled with salt and sodium content.
• Establish an additional tax for food manufacturers that introduce toxins into the food chain.
• Adopt the United Kingdom’s simple food labeling system of green, amber or red dots that indicate how healthy the food choice you are making is.
• Legislate that advertisers are not allowed to target children in advertising unhealthy food.
• Ensure that the 2010 Olympics are genetically engineered food free.
• Establish a ban in British Columbia on selling any product with genetically engineered ingredients.
• Make it mandatory to label all foods that have genetically engineered ingredients.
• Biotechnology safety tests should be run by Health Canada to ensure that results are not biased.
• Ban aspartame and sucralose from all foods.
• Talk to grocery stores about stocking healthier alternatives.
• Restaurants should be required to disclose nutrition and calorie information on menu items.
• All foods containing fatty acids should have warning labels on the packages.
• The Watchdog Committee should give guidelines as to which additives, preservatives and colours can be used in foods.

• There should be a series of incentives and penalties for companies to produce healthier foods and products instead of imposing a tax for individuals.

• Consider using stevia as an alternative to sugar in food products.

• British Columbians should know which foods are good or bad directly from government so that suppliers cannot influence buyers no matter how much clout they have.

• Encourage fast food restaurants to serve salads.

• Products containing high levels of phosphoric acid should come with consumer warning labels.

• Do not allow food industry representatives to sit on any advisory boards relating to food guidelines and policies.

• Force meat, poultry and fish sold in stores to have labels that state their origin, feeding practices and sodium content.

Food Production

Comments and Concerns

• Livestock in the food chain are overmedicated.

• Mono-culture depletes the soil and nutritional value of food due in part to the synthetic fertilizers and chemicals commonly used in food production.

• We do not know what is put in our vegetables, cattle or pigs.

• Green peas from China are a huge warning as to what the future may bring for food quality.

• Many chronic diseases are caused by a lack of control over food ingredients and other products.

• The salt content in food is too high.

• The nutritional value of produce grown on multi-use (in a year) land does not have the same nutritional value as produce grown on a one-crop-a-year ground.

• Food that is imported from long distances loses its nutritional value.

• Tuna contains four times the mercury allowable under legislation.
• The Canadian government has lowered standards for pesticide use on fruits and vegetables.

• Eliminate illness causing ingredients like pesticides and chemicals in foods.

• Genetic engineering refers to the use of techniques of modern biotechnology such as recombinant DNA or cell fusion that overcome the natural reproductive barriers in order to artificially move genetic material between species. Genetic engineering allows scientists to take the DNA from one organism, such as a bacterium or a salmon, and insert it into another, such as a tomato or a corn plant, creating transgenic, or genetically engineered, organisms that are also known as genetically modified organisms. The results are not found in nature and cannot be achieved by traditional cross-breeding techniques.

• Biotechnology in food production can introduce proteins, to which some individuals may have potentially fatal allergies, into foods that were previously free of these allergens.

• NK603 was produced by a technique called particle bombardment. This technique involves shooting shards of metal with gene plasmids attached into the cell nucleus of the target organism. One particular danger of this technology is that it is impossible to predict where the genes will end up within the genome of the resulting organism. Many scientists now see this as an inherent flaw in the science behind genetic engineering as a consensus is growing that placement within the genome plays a fundamental role in gene behaviour.

• The emergence of genetically engineered food in Canada has been met with resistance and scepticism as to its benefits and safety. Overwhelmingly and consistently, Canadians have responded to polls and to public input processes held by federal and provincial levels of government by saying that they do not want genetically engineered food, and if genetically engineered food is to be allowed, it needs to be labelled so that consumers have the right to avoid it. In British Columbia, the most recent poll conducted in December 2006, showed 79 per cent of voters want genetically engineered food labelled before the next provincial election in 2009. Previously, in 2001, a public input process held by the newly elected Liberal government received 99.1 per cent support for mandatory genetically engineered labelling legislation, among the 891 groups and individuals who made submissions.

**Ideas and Suggestions**

• Stop genetic food modification by establishing a ban on genetically modified seeds.

• Revisit meat inspection laws.
• Subsidize and support farmers who want to be organic.
• Establish organic farming co-operatives.
• Pay farmers fair prices for their produce. Allow farm gate sales of local meats and poultry.
• Encourage people to start home gardens.
• Protect berry picking areas.
• Consider the possibility of marketing un-pasteurized milk products.
• Ban all agricultural chemicals.

Food Quality in Hospitals, Long Term Care Facilities and For Seniors

Comments and Concerns

• Food service delivery programs to seniors have poor food quality.
• The food quality in hospitals, care homes and institutions is poor and often does not meet the criteria set out by the Canada Food Guide.
• Frozen, reheated food served in hospitals and care homes is not appealing and does not taste good. The food is often cold when served and mealtimes are not pleasurable for patients.
• There is an increased presence of junk food in hospitals.
• The quality of food served in hospitals does not contribute to patients’ convalescence or assist them in increasing their strength so they can be released. If the food quality were higher there might be less of a waste of food and money.
• Seniors in private homes or lodges are being fed the same thing with little variety and little room for choices. There is also a lack of fresh fruits and vegetables in their diets.
• Seniors receiving pensions suffer from lack of proper food and vitamins which reflects directly in their health conditions.
• The quality of food provided to patients in hospital is so poor that it is not conducive to healing due to the lack of nutrient quality, the scarcity of visual appeal and the awful taste.
• Hospital meals are inadequate for sick people. Nutrition is not a priority and the food is poorly prepared.
• Hospitals should buy local food, and edibility and nutrition should be a priority.

• Contracting out of food preparation for facilities and hospitals is not a good idea as many of the containers are difficult to open and the quality is poor.

Ideas and Suggestions

• Ensure that seniors’ meal delivery programs are nutritious and have a good delivery system.

• If re-thermalized meals are deemed appropriate for the sick and elderly they should also be served to elected officials in the legislature and to the board of directors of health authorities.

• Go back to having cooking facilities in hospitals.

• Ensure that there is an adequate amount of fiber in the food served in seniors’ facilities.

• Have regular inspections of food served in hospitals.

• The nutritionists at hospitals should change their hours so they can teach families about nutritional cooking.

• Introduce universal malnutrition screening of all admitted patients and include a record of all meals eaten along with medications taken and vital signs.

• Offer hospital patients the option of paying for meals that come from a restaurant in the hospital. This way, families could also have the option of eating with patients if they were able.

• Gather menu planning input from residents and have it monitored by a nutritionist to make improvements.

• Have organic food in hospitals.

Outstanding Questions

• How do you make eating healthy foods cool for kids to eat?

• How can parents be educated on what is healthy to send in lunches so that kids are not being sent to school with pre-packaged foods?

• Has it been considered that there is a direct relationship between the rising cost of health care and the increasing number of fast food restaurants and other junk food producing industries?
• Does the food served in hospitals and other care facilities meet the nutritional guidelines of Health Canada?

• Why can fast-food companies market to children with their health outcomes being so bad and tobacco companies cannot?

Water and Environment Quality

The Environment and its Effects on Health

Comments and Concerns

• The government needs to make improving the environment a priority, as it has direct links to ensuring the population of the province is healthier.

• The environment has a significant impact on individual health.

• There is a need to look at how the quality of our environment can cause higher rates of cancer due to mining.

• Mercury is a cause for clinical depression.

• Society has become over hygienic.

• Diseases such as multiple sclerosis, Parkinson’s, progressive degenerative brain diseases and Lupus are caused by environmental factors.

• Talking about obesity and cancer without looking at the environment is nonsensical.

• Recognize the root causes of health care issues, especially in resource based communities that have poor air quality.

• The Crofton pulp mill affects the health of surrounding areas due to the levels of arsenic, lead and mercury being introduced into the environment and subsequently effecting individuals.

• Poor lifestyle choices and the increasing amounts of environmental pollutants will eventually overwhelm the health care system.

• Poisoning from chlorine in swimming pools and other sources should be investigated as they cause heart problems.

• There are noxious earth energies affecting health.

• There need to be better controls on what goes into animal feed. Antibiotics in animal feed contribute to the presence of drug resistant bacteria.
• We are facing a 200 percent increase in childhood cancers because of White Technology.

• Polluted underground streams have a negative effect on health.

• There is a possible link between the presence of superbugs and untreated sewage and eating fish.

• Smokers are blamed for so much pollution, but cars and buses are far more toxic and the fumes cannot be avoided on the sidewalk.

• Contaminated water used for the irrigation of produce, recreation (swimming or boating) or shellfish harvesting poses a serious risk to human health.

• Clean drinking water is a health issue and those governing health care must be given the power to protect watersheds from pollutants and development. Watershed protection should come under the sustainability section of the Canada Health Act.

Ideas and Suggestions

• Asthma can be attributed to the presence of chlorine, fluoride in water, fire retardants in the home, as well as other chemicals found in the home. There is a need for home air treatment devices.

• Chemical companies should be required to properly and vigorously test toxic chemicals for their toxic effects before allowing them to be introduced. People are the guinea pigs and companies learn of cancers and other ill effects of the chemical decades later.

• Mercury amalgams should be outlawed due to their negative effects on health. Specifically, mercury amalgams for fillings and any levels of mercury found in food items.

• Toxic chemicals used to treat fleas and cockroaches should be banned due to their potential effects on health.

• We could prevent health problems by forcing car manufacturers to get better gas mileage which could cause less tail pipe emissions. This would clean up the environment and prevent health problems.

• A recognizable, carcinogenic, or cancer-causing symbol would assist consumers so that informed choices could be made when considering a purchase.

• Encouraging composting versus out door burning could cut down on respiratory illnesses.
• Include the health status of the population and the ecosystem as a criterion in any scale or method used to assess prosperity.

• Allocate significant research funds to the prevention of environmentally-induced diseases and work closely with the office of the Commissioner on Sustainable Development.

• Use the carbon footprint readout for health profiles.

• The government should consider environmental ideas as part of the response to health care suggestions.

• A recent project to test the blood of some families across Canada for toxins is a good idea. This will shed some light on the toxic mix of chemicals that we carry around inside us which seem to trigger more and more cancers each year.

• Increase measures to reduce exposure to occupational and environmental carcinogens.

**Regulation, Recycling, Pollution and Global Warming**

**Comments and Concerns**

• In the past two centuries we have done more to damage our environment, our fellow beings and ourselves than in all preceding millennia.

• Do not allow forest fires to burn as they are affecting the natural regeneration of various berries and other plant species.

• There needs to be a reduction in green house gases.

• Chemicals, such as endocrine disruptors in plastics, are being allowed and are having harmful effects on our reproductive systems.

• Much of the health care system is built on single-use and disposable items. The use of toxic substances, especially in cleaning, is a problem. Stopping uranium exploration should be a government priority.

• Climate change is going to cause ecosystem shifts that will change populations and food systems. This will have an environmental impact.

• Health researchers have identified thousands of environmental pollutants affecting health but the agricultural and chemical industries claim that chemicals are being used within the acceptable limits.

• The Vancouver Island Health Authority’s plan to construct a new hospital between Courtenay and Campbell River would be outside of the existing community
infrastructure. This would mean more travel would be required, and global warming would increase.

- Communities should be responsible for taking care of their own refuse.
- Junk food companies have poor environmental practices, for example the use of Styrofoam.
- Despite the promise by Government to reduce greenhouse gas emissions and have a healthier province by 2010, two coal mines were re-opened in British Columbia.
- When tainted toothpaste was identified in Canada it was not removed from the shelves until after the United States became aware of it.
- Industry is polluting the environment with the support of government and it is killing people without recourse.
- We have a severe problem with algae blooms contaminating our fresh drinking water.
- If new coal burning plants are allowed in the Interior of British Columbia we will damage our environment further as well as our health.
- Do not put wind turbines that generate noise pollution any closer than two kilometers away from residences. The larger the turbine the larger the buffer should be.
- We should oppose the proposal made by the Federal Minister of Resources to use nuclear energy to fuel the oil sands. There would be a serious impact on the health and environment of the citizens of Alberta and also the potential for serious accidents which do not respect provincial boundaries.
- We should oppose any relaxing of current environmental standards and oppose the current Federal Security and Prosperity Partnership; the standards in Canada, the United States and Mexico are already too low.
- It will now be impossible to remove all carcinogens from our environment but 50 to 60 per cent could be eliminated.
Ideas and Suggestions

Ideas about Recycling
Ideas about Environmental Regulation
Ideas about Air and Water Quality
Ideas about Pollution and Global Warming

• Ideas about recycling:
  
  • More staff should be allocated for enforcement and monitoring of the environment. Develop integrated management plans for all areas that put the environment and sustainability first. Make recycling easy and creating garbage difficult.
  
  • Establish more recycling centres and programs. These need to be accessible and should be part of an integrated management plan that puts sustainability of the environment first.
  
  • Remote locations need to have greater accessibility to recycling containers through either drop-off locations or pick-up services.
  
  • Increase the deposit on alcohol cans and bottles to at least $1.00 to reduce littering.

• Ideas about environmental regulation:
  
  • When conducting an environmental assessment of developments the assessment should be paralleled with a human health assessment of the potential health effects of the development. Research and monitoring of human health effects should be funded equally by government and industry and should have public involvement in the nature and quality of monitoring and research. Both Government and industry should be accountable for imposing risk to human health.
  
  • Make it illegal to sell any chemical fragrances or tobacco in any facility that sells health care products or food.
  
  • Establish a policy that does not allow smoking inside foster homes.
  
  • We need to regulate and eliminate the use of harmful household products that are known poisons and carcinogens but are still permitted to be sold in stores.
  
  • Establish legislation that would require consumer products to be labeled if they contain a known or possible carcinogen. Make the symbol visually recognizable for consumers. Use a different symbol for each hazard class, such as a carcinogen.
• Direct tax dollars towards reducing pollution and the widespread use of chemicals that are linked to cancer.

• The province should establish 100% smoke-free legislation.

• Government should ban the sale and use of cosmetic herbicides and pesticides.

• Toughen provincial legislation around second-hand smoke in areas such as playgrounds and outdoor patios.

• Dramatically increase taxes on disposable single-use items.

• There needs to be a better approach to controlling environmental toxins that are linked directly to cancer.

• Establish more laws on pollution.

• Establish anti-smoking legislation and designated smoking areas.

• Require janitorial staff in facilities to use only environmentally friendly cleaning products.

• Prohibit the introduction of new toxic chemicals until Government-approved tests have been conducted.

• More funding should be put towards improving air quality. If there were more stringent regulations for air quality there could be a reduction in how many people develop chronic diseases as a result of poor air quality.

• British Columbia’s building code regulations need to be enforced to control the emissions of radon gas in homes.

• Put up anti-idling signs in communities and impose fines for violations.

• There need to be stricter environmental and occupational health laws that are enforced to prevent disease. The British Columbia Workers Compensation Board needs to be forced to do more education on prevention. Furthermore, the Ministry of Environment needs to have a bigger budget for inspectors and prosecutors in enforcement.

• Legislate a ban on pesticides and other toxic chemicals in our food, cleaning materials, industry and general environment. This would result in a significant reduction of the rate of cancer.

• The health care system should regulate the chemicals in pharmaceuticals so that they do not impact the environment in a negative way.

• Establish standards for healthy workplaces and schools by installing operable windows and full spectrum lights.
• There should be a mandatory requirement for environmental assessment of new technologies.
• Revoke the Seabed Agreement and close the Nanoose Bay testing site. This will eliminate serious environmental and health consequences that result from testing.
• There should be radioactive gauges and safety levels set for computers, cell phones, microwaves, and all appliances that give off radioactive and electromagnetic waves. Perhaps we could regulate the use of shields of these devices.
• Ban the production, use and export of asbestos from Canada.
• A ban on cleaning products should be considered.
• Advocate with other countries to reduce environmental contributors to cancer.
• Municipalities should ban the commercial use of pesticides.

• Ideas about pollution and global warming:
  • British Columbia needs clean air and a healthy environment.
  • The movement of personnel, patients and visitors to regional hospitals could be assisted by an hourly public transport system. Two communities could work with the province and perhaps fund four hydrogen-fuelled vehicles. This would reduce the carbon footprint.
  • Increase environmental protection.
  • The Ministry of Health and the Ministry of Environment should be integrated. Link climate change to health care.
  • Have more condominium projects that are designed to support a healthier environment. This means using non-toxic paints, built-in water recycling, low-flush toilets and low-volume showers.
  • British Columbians should have a right to clean air as opposed to the right to smoke.
  • Recognize the role of environmental pollution in all types of cancer. It is a result of heavy industry releasing pollution into the atmosphere and the workplace.
  • Partner with international bodies with regards to nuclear testing, nuclear plants, war weaponry, and industrial pollutants of oceans and air that circulate throughout the world.
• Create drop-off areas one block away from schools so that children are not exposed to exhaust. However, schools should have an area for students with disabilities that is closer.

• Reduce electro-magnetic field radiation by replacing cell towers with fiber-optics running to the curb with much lower power devices to bring the signal to the phones.

• The tobacco, car and truck industries, and the oil and gas industries should contribute to the cost of health care and cleaning up of the environment.

• Make people who pollute pay and use the money to develop prevention programs.

• Oil companies should be given one year to rid pollutants from their fuel.

• Plastic manufacturers should have to pay for the harm they inflict on the environment and people.

• The Government has a responsibility to protect British Columbians from substances that are addictive or poisonous in any way.

• Diesel emissions from the Vancouver Port amount to more pollution than all cars, buses and trucks on the roads. By 2020, diesel emissions will increase three fold. This is because of the port expansion at Deltaport will triple in the number of marine vessels, trucks and rail traffic.

• Laundry for facilities should be done locally and not trucked out. This will reduce pollution on the environment.

• Ideas about air and water quality:

  • There needs to be greater emphasis on improving British Columbia’s air quality.
  
  • There is a need to look at how we regulate or fail to regulate the pollution of our air, land and water.
  
  • There needs to be better protection of rivers from mining and logging.
  
  • Put more money towards infrastructure for private water systems, rural water systems and community sewers.
  
  • There is concern that the water quality is not good in British Columbia.
  
  • The Municipal Act and the Canada Health Act should be amended so that the criteria for sewer services and treatment should be based on population density.
  
  • British Columbia should adopt the European standards of water quality and sewage treatment.
There is a need to be more rigorous with testing of municipal drinking water to reduce the possibility of contracting a water-borne disease.

Boil water advisories are not good enough for people with compromised immune systems as they can get ill just coming in contact with contaminated water.

There should be support for upgrading technology that improves efficiency and promotes clean air and water.

**Parks, Recreation, Transportation and other Governmental Jurisdictions on the Environment**

**Comments and Concerns**

- All terrain vehicles, motor bikes, motor boats, and jet skis have a damaging effect on the environment.
- Sidewalks are not being cleared of snow.
- One region, independent of financial assistance from government, established a comprehensive parks and recreation program.
- We need to reduce traffic noise, congestion and pollution as they affect health.
- Developing a locally based organic food supply will become necessary because transportation of food represents 20 per cent of North American fossil fuel use.
- Persistent loud noises are bad for health.
- Vancouver and Richmond noise by-laws do not apply to the airport.
- Local governments are extremely important in this because through good local planning it provides the infrastructure for people to walk and bike safely which are often keys to providing the opportunity for people to get out and enjoy physical activity in a safe environment.

**Ideas and Suggestions**

- Neighborhood parks need to be made safe. The lack of safety in local parks is contributing to childhood obesity. If there were an increase in social services, drug addicts, homeless people and other groups would not need to take over the parks.
- Look at the trail system for walking and biking. More funds should be put towards trails such as the Olympic trail. This will help get people off the road and will help to reduce health care costs.
• British Columbia should complete the Trans Canada Trail.
• Encourage carpooling, bicycling, taking the bus and walking.
• Provide incentives for people to take the bus.
• Encourage people to buy locally, compost and reduce green house gas emissions.
• The Government should increase the investment they make in transportation infrastructure and ensure that communities are walkable. This benefits everyone, from children to people with disabilities, and creates a social environment that is conducive to healthy living.
• Convert public transportation to bio-diesel or other alternative fuels.
• Increase the number of bike trails in communities.
• Encourage parents to stop driving their children to school, and encourage the children to take the bus.
• The Government should recognize community contributors to healthy living initiatives, such as community gardens or bike paths.
• The Government should take strong steps to protect the environment and take a stand on urban sprawl and highway expansion as they are harmful to health.
• Cities should have more protected green spaces and should be committed to green construction standards.
• Establish clean-up crews around communities to pick up garbage.
• Bring back mandatory inspection of vehicles; it would do wonders for air quality and the province’s carbon footprint.
• Make our communities more walkable.
• Make bicycling paths mandatory with all future road, highway and subdivision planning and development.
• Establish interstitial green space for families with children to encourage social interaction.
• Mandate that the province protect watersheds as well as test water.
• The government should subsidize the purchase of hybrid cars for people who cannot afford them.
Agriculture

Concerns and Comments

- Our agricultural land reserve is precious.

Ideas and Suggestions

- Tax pesticides and herbicides.
- Restrict the use of pesticides and herbicides in some areas.
- Provide more education on the benefits and dangers of using pesticides and herbicides in some areas.
- There needs to be better regulation of toxins, such as pesticides, herbicides, and fertilizers that are found in food, soil, air or water.
- Examination of the effects of environmental byproducts, antibiotics and hormones in food is needed.
- Buy local compost.
- The Ministry of Health should recommend to the Government of British Columbia that they implement province-wide pesticide-restriction legislation and consumer right-to-know legislation.

First Nations Communities and the Environment

Comments and Concerns

- The government of British Columbia must prevent the location and disposal of toxic and hazardous waste on lands and areas inhabited by First Nations.
- Need to look at the water quality on reserves.
- There is a concern with the air quality in the Fraser Valley.
- There is a need to clean up corporate contamination.
- Aboriginal people care about their land and seeing what is happening makes them sick.
- Upper respiratory problems are on the rise for youth, we need to look at why.
Ideas and Suggestions

- Government needs to focus their money on root problems. Deal with air, water and food quality.
- There needs to be cleaner water filtering for drinking water.
- Involve Aboriginal people in land-use planning at the municipal level.
- There should be more education and awareness on aboriginal food gathering places. The loss of food gathering places affects the health of aboriginal British Columbians.
- The misuse of traditional food gathering places (land and water) needs to be addressed. This means that resources would be monitored and laws enforced.
- Access to and protection of traditional food gathering places is critical to the long-term health of aboriginal communities. This can be achieved by placing a moratorium on industrial development until green house gases are reduced.
- There needs to be strict control over what goes into animal feeds.
- The provincial government needs to consider the value of crown land when granting licenses to develop land, including the value of the land as traditional food gathering territory. The economic impact of losing a food site source for indigenous purposes is not factored into decisions of economic development. There needs to be respect for biodiversity values and the continued presence of indigenous peoples.

Education and the Environment

Ideas and Suggestions

- Educate children on the importance of community gardens, animals and ecosystems. It will help them get in touch with their environment.
- Teach gardening, farming and nutrition in schools.
- Target youth as the audience for environmental awareness campaigns to change the mindset of the next generation.
- Establish programs like Act Now BC for other themes, such as the environment. Use concepts like Bike to Work Week as an opportunity to convey important messages to the public.
- Have environmental education for all Canadians.
• Do more public education on radon poisoning and what you can do about it. For example, buying a radon detector for your basement.

**Outstanding Questions**

• Are regulations concerning sewage treatment set up to protect human health and the environment?

• Why is our water contaminated in so many areas resulting in boil water advisories?

• Can we combine our environmental improvement policies with health care by having someone or an organization provincially in charge to reduce hospital waste?

• Why are hospitals not going green? Why are they not having contests to see which one can cut paper use or electricity the most?

• Should the Government be giving subsidies to farmers who pollute our food with toxic pesticides?

• What are we allowing people to dump sewage into Shuswap Lake’s drinking water reservoir?

• How much is climate change going to affect health care costs and what aspects of the system will come under the most strain as a result?

• How many people are using walking or bicycle trails?
Chronic Diseases

The topic of chronic diseases was an issue raised by many participants during the Conversation on Health. Lifestyle and social determinants, prevention and health promotion, and chronic disease management were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of chronic diseases.

Lifestyle and Social Determinants

Participants feel that lifestyle choices and social determinants contribute to development and progression of chronic diseases. Some submissions linked inactivity, poor eating habits (both over-eating and eating low-nutrition foods) and smoking and drinking to the development of conditions like type II diabetes, obesity and hypertension. Others pointed out that level of income, education, housing, social supports and job type also are factors in whether or not an individual may get a chronic disease.

*After suffering with chronic illness for almost 20 years and seeking healing through many, many different avenues, I have slowly but surely improved by using natural medicine which encourages and supports taking responsibility for my own health by making informed lifestyle choices.*

– Web Dialogue, Cranbrook

The majority of participants feel that chronic disease patients should have a more active role in management of their conditions. This would be accomplished by promoting healthier lifestyle choices; strengthening tobacco legislation; providing more education; and increasing access to fitness programs. Patients would have more knowledge about preventing and managing chronic diseases and, therefore, would be encouraged to take more responsibility for their health. Some submissions also indicated that this situation would reduce spending in the health care system.
Prevention and Promotion

Participants in the Conversation on Health generally agree that British Columbia lacks education about chronic diseases. This lack of understanding, according to some, can result in chronic disease patients feeling isolated from friends and family. Some also feel that the lack of public education on chronic disease may mean that the public is not informed enough to detect chronic illness early. Submissions identified specific gaps in information, services and programs for the following diseases: Lupus; Cancer; Diabetes; Asthma; Celiac Disease; and Crohn’s Disease.

Start looking at investing some funding into preventative health care. It makes more sense to utilize preventative measures instead of waiting for health to become chronic. At the chronic stage, treatment is far more costly.
– Web Dialogue, Sooke

Many participants indicate that chronic disease education programs should be increased throughout the province and made more comprehensive. Some think that more education should be available in schools, while others believe that informing the public should be the responsibility of general practitioners and private institutions. Another suggestion highlighted the need for disease-specific seminars and group sessions. Some participants felt that increased awareness could lead chronic disease sufferers to be more engaged in managing their health.

Chronic Disease Management

Opinions about how chronic diseases are treated by the health care system vary greatly. Some indicate that health professionals do not proactively treat chronic illness and provide care symptom-by-symptom rather than addressing the underlying causes of disease. However, other participants received quality care from British Columbia’s chronic disease management facilities; one comment in particular said that the international community thought highly of British Columbia’s contribution to chronic disease management.

Many participants believe that chronic disease management facilities should provide more comprehensive care. One solution put forward was that children with chronic illnesses need better transition services from youth to adult care; another, that many complex-care individuals do not have access to follow-up services in the community. Others note that an overall increase of chronic diseases in British Columbia creates longer waiting lists and overcrowding in emergency rooms and leads to more pressure on the health care system.
Suggestions for improved chronic disease management focused on integrating services and providing greater access to care. Several participants cite the need for multi-disciplinary care centres to provide holistic treatment, while others think disease-specific medical teams would be a better approach. Some opinions requested more coverage of treatment services and equipment. Examples include: blood pressure monitors; medical supplies; hearing aids; residential care; and prescription drugs. These steps would increase community support for those with chronic diseases and assist preventative treatment.

*While I was treated well with traditional western medicine by Cancer Agency, I felt it lacked more integrated way of improving immune system to treat cancer and illness, such as what to eat, what not to eat, what exercise to do, and any spiritual aspects of treatments. I went to the Centre of Integrated Healing in Vancouver. I thought this centre's treatment methods should be a part of treatments of all cancer patients.*

– Email, Richmond

**Conclusion**

The discussion about chronic diseases centred on empowering the patient. Many submissions indicated that greater education and support services for lifestyle and disease management, along with more holistic, integrated medical care, would increase patient involvement in the treatment of chronic illness. Educating British Columbians on chronic diseases would assist with early detection and, in some cases, prevention of many diseases, resulting in a reduced burden on hospitals and decreased spending on health care. While several contributors to the Conversation believe that care for chronic diseases in British Columbia is exemplary, the overall discussion outlined a way to improve how we treat and prevent chronic disease.
Chronic Diseases

This chapter includes the following topics:

**Lifestyle and Chronic Diseases**
**Prevention and Promotion**
**Chronic Disease Management**

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Part I: Summary of Input on the Conversation on Health
Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

Research on Child Health - Final Report (Quantitative Research)
Submitted by the BC Children’s Hospital Foundation

Submission to the Conversation on Health
Submitted by the Representative for Children and Youth

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

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

British Columbia’s Conversation on Health
Submitted by GlaxoSmithKline

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Lifestyle and Personal Responsibility, Health Promotion, Complementary and Alternative Medicines, Primary Health Care, Health Care Models, Long Term Care, Home Care or Support, Innovation and Efficiency, Death and Dying, Health Spending, PharmaCare and Public Safety.

Lifestyle and Chronic Diseases

Comments and Concerns

• Obesity and related illnesses such as diabetes, stroke and heart disease are on the rise in northern communities, including Prince Rupert.

• Lifestyle a big issue. There are now high levels of diabetes and a lack of resources for necessary health promotion.

• Inactivity leads to chronic conditions; support campaigns like anti-smoking campaigns and drunk driving campaigns.

• There is a need to link many chronic health problems to addictive lifestyle choices, for example: smoking tobacco, drinking alcohol, drug use (licit as well as illicit), sugar, etc.
• Health complications from poor health and gum disease can be severe and life threatening. Research shows a link between gum disease heart disease, stroke, diabetes and even premature births.

• Non-traditional foods and sedentary lifestyle are major contributors to diabetes and other chronic diseases in First Nations communities.

• Moving away from traditional foods and environment to junk foods and genetically modified food is problematic. While food was previously organic, now everything is polluted and foreign to our bodies.

• Some populations are genetically pre-disposed to diabetes.

• Physical inactivity is a risk factor for chronic disease. As we work towards increasing activity levels, we need to ensure there is adequate infrastructure to support physical activity in communities.

• Being significantly overweight contributes to a variety of chronic conditions. For example, almost 30% of diabetes is directly attributable to obesity.

• Not all cases of diabetes are caused by obesity, an unhealthy diet, or a sedentary lifestyle. Why must people with Type I diabetes be treated the same as people who have Type II diabetes when we did nothing to cause our condition?

• Most risk factors do not exist in isolation in an individual. This is particularly true with smoking, unhealthy weight, unhealthy eating, and physical inactivity, which may exist in combination in the same individual.

• The relationship between eating habits and chronic disease risk is likely indirect, through the impacts of obesity, cholesterol, and hypertension. Across all age groups, it is evident that British Columbians, on average, are not meeting the recommended daily intakes within multiple food groups. Action Schools! BC showed that none of the nine to eleven year old children participating in the study consumed five or more servings of fruit and vegetables a day. Concurrently, the consumption of unhealthy food choices, notably sugar-sweetened beverages and high fat/sugar/sodium foods is escalating.

• A large percentage of overweight and obese individuals can trace their excess weight directly to a persistent imbalance between energy intake (food calories) and energy expenditure (physical activity).

• A sedentary lifestyle contributes significantly to a variety of chronic conditions. For example, almost a quarter of strokes are directly attributable to a sedentary lifestyle.

• Poverty and social determinants, like income, type of job, social support, housing and level of education, are connected to chronic disease.
• When afflicted by a chronic disease, it is often difficult for a person to maintain normal routines, relationships and lifestyle.

• After suffering with chronic illness for almost 20 years and seeking healing through many, many different avenues, I have slowly but surely improved by using natural medicine which encourages and supports my taking responsibility for my health by making informed lifestyle choices.

• People need to take more responsibility for themselves and their families.

• The food education component in diabetic clinics is very good; they also have great community facilities for exercise and fitness. The profile of diabetes has been raised, as well as the negative impacts of obesity.

• We have many transplanted patients that are living a healthy lifestyle today with a significantly reduced drain on health care dollars.

• Provide a community kitchen program.

• In the community of Massett, many chronic disease sufferers built a new facility and, in the co-op grocery stores, they re-labelled the products to provide advice on eating healthy foods to facilitate disease management.

**Ideas and Suggestions**

• Provide social assistance support for diabetics.

• Physical activity protects against heart disease, stroke, hypertension, Type II diabetes, obesity, depression, anxiety, and stress. In British Columbia, 15 per cent of heart disease, 19 per cent of stroke, 10 per cent of hypertension, and 16 per cent of Type II Diabetes are attributable to physical inactivity. According to the Canadian Community Health Survey, 38 per cent of British Columbians are physically inactive. A conservative estimate of the annual cost of lack of physical activity in British Columbia is 573 million dollars.

• Research clearly indicates that healthy eating and physical activity, as well as not smoking, helps to prevent the onset of Type II Diabetes even for those diagnosed with pre-diabetes. The same healthy living activities also help to prevent or delay the onset of complications resulting from diabetes.

• Resist the tendency to look at disease-specific issues and find common risk factors for chronic diseases.

• Diet can decrease the need for insulin for diabetics.
• Make healthy choices easier for people with chronic diseases. Strengthen tobacco legislation; provide education on healthy lifestyle choices, access to exercise programs and tax breaks for fitness.

• Encourage changes to our health care system that will allow for better oral hygiene by providing patients with full access to oral hygiene and preventive dental services.

• Healthy living prevents chronic illnesses, many of which have common risk factors. It is important to look at all types of healthy lifestyle choices together, rather than creating disease-specific prevention strategies.

• Develop measures and outcomes for quality of life.

• Educate people to give them options to prevention onset of chronic conditions. Provide them with healthy lifestyle choices.

• Treatment for chronic diseases could be made contingent upon agreeing to conform to rules of behaviour and making certain lifestyle choices.

• While I was treated well with traditional western medicine by the Cancer Agency, I felt it was missing out on a more integrated way of improving the immune system to treat cancer and illness, such as providing information on what to eat, what not to eat, what exercise to do, and any spiritual aspects of treatments.

• Provide a chronic disease management system that assists and motivates patients with chronic diseases to better monitor their health progress and help them to take control and responsibility for improving their health; British Columbians with chronic diseases need to take an active role in their own healthcare.

• Programs are needed to allow charitable organizations to provide affordable supportive housing with basic needs, such as nutritional food, to sufferers of chronic diseases.

• The factors that lead to common chronic conditions in the elderly are similar. The chances of being diagnosed with one of these conditions decrease markedly if seniors are active, eat healthy, and remain engaged.

• Aboriginal peoples should move back to traditional foods and clean environment.

• Support people who have chronic diseases to continue in their current occupations by allowing people with chronic illness the right to waive access to workers compensation. This will allow them to obtain a job and be productive in society.
Prevention and Promotion

Comments and Concerns

- British Columbians feel there is a shortage of education about chronic disease and prevention. Specifically, gaps in information, services and programs regarding the following diseases were mentioned:
  
  a. Lupus and Cancer;  
  b. Diabetes;  
  c. Asthma;  
  d. Celiac Disease; and  
  e. Crohn’s Disease  

- People are afraid to get tested and access treatment for HIV/AIDS. They are often isolated in their own communities because others are afraid of catching the disease, as a result of lacking education and knowledge.

- 50 per cent of cancers are preventable.

- Diabetes is prevalent in First Nations communities.

- There is a lack of early detection for chronic illness; the health care system does not focus on prevention.

- People with chronic diseases do not have access to social networking groups that could connect them with others who have the same disease.

- Roughly one third of children mention that diabetes, cancer, Sexually Transmitted Diseases and asthma are considered health concerns for children.

- There is no centralized source of information and no continuity of service for people with chronic diseases.

- Treatment programs have to be tailored to particular cultural groups. For example, dietary recommendations for treating diabetes must take cultural dietary preferences into account.

- Scientific evidence shows that if people are given the tools, skills and knowledge to manage diabetes effectively, their risk of developing the complications associated with diabetes can be reduced significantly.

- Currently, chronic disease patients spend most of their time managing their disease on their own, and only see a doctor occasionally. They need more education and tools to deal with their illness and they need more access to health professionals who can coach them.
• The recommendations for eating a balanced diet in the Canada Food Guide are contrary to what a person with Type II Diabetes should be eating. For example, the Canada Food Guide says a person should eat twelve servings of grain products per day and suggests eating processed foods such as breads, pita shells, pasta, bagels, and buns.

• There should be a more equitable distribution of research funding for all chronic diseases. Currently, cancer gets a lot of funding and other chronic diseases get much less.

• Industry spends approximately $3 million in British Columbia on patient education and training to help manage their disease. Education and training are a critical part of disease management.

• With drugs and diagnostic technologies increasingly based on a detailed molecular understanding of human biology and disease, some diseases can now be prevented or slowed even before clinical symptoms become apparent.

Ideas and Suggestions

• If we support health rather than treat disease when it is too late, costly and ineffective, we will not only save money but future generations will be infinitely healthier.

• Preventative health measures, such as regular massage, chiropractic, Chinese medical and homeopathic treatments, would provide us with a healthier population. The public would need less drugs and surgery and costly visits to doctors and emergency and walk-in clinics.

• British Columbians need to be engaged to invest themselves in prevention efforts. Organizations and government can put forth initiatives in primary and secondary prevention of chronic disease, but it is up to the general population to be engaged.

• Life insurance companies should fund the private institutions that have been struggling for years to educate the public about how to practice preventative health care at home.

• Develop programs in the classroom and community, as well as daily workshops for at-risk children and teens with Fetal Alcohol Spectrum Disorder. Education could focus on managing chronic illnesses.

• General Practitioners should educate their patients in chronic care and prevention; train doctors about nutrition and exercise as factors in treating and preventing chronic illness.
• Effective management of chronic disease can best be achieved by mandatory seminars and group sessions on the management of a particular disease.

• Put on plays for First Nations people in the schools, band offices, health fairs and public forums.

• Facilitate communication about chronic disease management between mainstream health providers and Aboriginal health workers.

**Outstanding Questions**

• When will Canada act on AIDS?

• How do we put more value into the prevention of chronic diseases? Is it through Nurse Practitioners and physicians or by involving all levels of health care workers?

**Chronic Disease Management**

**Comments and Concerns**

**Treatment**

**Cost**

**Access to Services**

• Comments on treatment:

  • Prevention and proper management of diabetes would clearly save the health care system significant expense and advance our population’s health. A high percentage of people who need dialysis, retinal operations and coronary artery bypass surgeries also have diabetes.

  • For many years, much of our public and political focus has been on surgical wait times and emergency room crowding. While these issues are clearly important, it is essential to understand that the management of chronic disease is the greatest and the fastest growing burden on the health care system.

  • Patients have little power to choose in the current system; health professionals do not treat the primary illness in time, which results in a bigger, chronic illness and the need for acute care.

  • Chronic illnesses are treated symptom by symptom; the system needs to look at all the causative factors instead.
Medical Doctors across British Columbia inform their chronically ill patients that they have no means of diagnosing chronic or multiple illness conditions; have no training in such areas; have no responsibility for the treatment of chronic diseases; and, have no support from the government or their associations to do more than prescribe palliative medications.

It takes several return visits on a regular basis for a trusting relationship to be built between a family doctor and a patient, but, the symptoms with many diseases are not serious enough that person would be prompted to visit their doctor, and it could be many years between visits, making it impossible to form a close partnership with a family doctor.

Many British Columbians have to depend on episodic care from walk-in-clinics, because they are unable to find a family doctor who will take them as patients.

Our cancer treatment, while maybe being one of the best in Canada, is still inferior to many other countries, including the United States, Sweden and the United Kingdom.

People with a chronic disability such as Diabetes Type II have to go to a doctor for prescription renewals and use up doctor’s time.

Chemotherapy damages immune function and causes permanent damage to the heart, brain and liver. Why not use natural herbs and supplements to treat cancer?

British Columbians mentioned receiving quality care from the following facilities:

a. Fraser Arthritis Centre clinic in Langley;
b. Kamloops Chronic Disease Management;
c. the Cooking For Life program at the Canadian Diabetes Association;
d. the Dr. Peter Centre for AIDS patients;
e. Center for Integrated Healing in Vancouver;
f. Burnaby Diabetic Clinic;
g. A program for women with type II Diabetes through Curves;
h. Cancer clinics;
i. Clearbrook for home and community care; and
j. Living a Healthy Life with Chronic Disease program.

British Columbia has been recognized by the international community as a leader in chronic disease management.

The province supported a pilot project, the Diabetes Initiative, using the chronic care model within a collaborative delivery system. The outcomes show that integrated chronic disease management is a promising way forward for people living with diabetes.
• The British Columbia Cancer Agency and the Canadian HIV Trials Network are examples of innovation leaders already existing within the health research centres of British Columbia. Both of these agencies are highly successful, internationally recognized and demonstrate the benefits of innovative practices applied for the benefit of chronic disease management.

• Aboriginal culture has different ways of managing chronic illnesses.

• Comments on cost:
  
  • Chronic disease treatments are expensive and not always covered; access and cost of pharmaceuticals and supplies is excessive for people with chronic disease. For example, a Diabetes patient can pay up to $5,000, which results in $100,000 per person over the span of 20 years.

  • There are recommendations for the management of many chronic diseases that are at odds with the coverage under BC Pharmacare. Health professionals suggest a treatment, yet the patient will not get coverage for it.

  • Health Canada estimates that musculoskeletal disorders, including back pain, cost society a total of $16.4 billion in direct costs and lost productivity. This places a tremendous socio-economic burden on Canada's health care system, resulting in recurring visits to health care providers and in time lost from the workplace.

• Comments on access to services:
  
  • There is a lack of focus on chronic disease management in children and no transition plan from care for children with chronic conditions to adult care.

  • Many complex-care individuals do not have local follow-up or have inadequate follow-up in nutrition services. They end up with serious health issues as a result requiring hospitalization and transfer to larger urban institutions.

  • The Fraser Arthritis Centre lacks funding.

  • There are not enough rheumatoid doctors or physical therapy locations.

  • Prince George lacks adequate cancer treatment.

  • Living on Vancouver Island and getting treatment for AIDS is difficult because of travel, seeing specialists and wait times.

• Using medicine to prevent disease only results in suffering illness later on: the person who prevents a heart attack ends up getting diabetic foot ulcers; the person who prevents foot ulcers ends up with Alzheimer’s. What society wants is to protect people from those illnesses that cause prolonged and excessive suffering at the end of life, and help them reach a quick end when it comes.
- Long term use of prescribed drugs and herbal remedies for people with chronic illnesses causes unknown interactions. There is no control on herbal remedies.

- The Health Officers’ Council of British Columbia is very concerned about the huge and increasing societal costs of chronic diseases. Chronic diseases, taken together, threaten to overwhelm our healthcare system and sentence the next generation to a shorter life span than their parents.

- Chronic diseases are almost completely preventable. At the same time, chronic diseases left unchecked threaten the sustainability of the health care system and our economic productivity and competitiveness.

- Increasingly, the BC government has provided unrestricted grants to health charities to improve the services available for certain chronic diseases. However, there are now expectations that these charities will spearhead and implement changes within the health care system, which is not the traditional role of these groups.

- This rapid, uncontrolled escalation of the numbers of British Columbians diagnosed with diabetes places serious pressure on our healthcare system and contributes to longer wait times and emergency room overcrowding. Family doctors, already overstretched, face a real challenge in finding extra time to teach their diabetic patients how to manage their diabetes through diet, exercise and daily monitoring.

- Between 2000 and 2006, the federal government provided funding to support primary care reform in British Columbia by increasing the number of nurse practitioners, expanding self-help groups for people with chronic conditions and encouraging doctors to join group practices. When the federal funding ended in March 2006, the province did not provide additional funding, and many of these innovations were discontinued.

- Overall, older chronic disease patients require longer acute care stays and have increased disability potential. Combined with the prevalence of risk factors across all age groups, the sheer number of older people in British Columbia over the next few years will have a serious effect on the health care system.

- When people stop taking their medications or drastically reduce them due to cost, the result is clogged-up emergency rooms and increased use of hospital beds for long-term, chronic conditions. This costs the health-care system far more compared to initially directing funds to providing people with chronic diseases access to cost-free medication.

- The treatment of cancer is hugely profitable; substantially preventing cancer would result in a loss of billions of dollars in profits for the oncologists, drug companies, hospitals and clinics.
• By relying on expensive remedies such as drugs and surgery without addressing underlying health issues, we have created a system that cannot be sustained.

• I think we should be doing a hell of a lot better than having only 50 percent of the patients getting the right treatment on well-established clinical protocols for chronic disease. We need to redesign the system. We need to set some targets and determine ways of measuring those targets.

• Health charities do not have a reporting, legislative or governance relationship with health authorities, who provide the care services, making it difficult to get 'accountable' results about programs for chronic disease management.

• Edmonton is setting an interesting example by screening their populations for diabetes and its risk factors. New York City is keeping tabs on people with diabetes to help them keep their health with diet and fitness. Both these examples are exciting since these ideas have potential to help reduce health care costs.

• The Ministry of Health recently released its Primary Health Care Charter. The inclusion of clinical prevention of chronic disease in the charter is a good thing.

• British Columbia researchers have a strong tradition of bringing forward advances in diabetes care that saves lives, improves the quality of life, and saves money for our publicly funded healthcare system.

**Ideas and Suggestions**

**Treatment**

**Access to the System**

**Chronic Disease Management Models**

• Ideas about treatment:
  
  • Empower patients to self-manage their chronic illnesses.
  
  • Disease management begins by first educating the patient about the disease and what their responsibilities are in treating it. Once those responsibilities are known and accepted, the patient will have the best tools to begin treatment, monitor and manage the illness.
  
  • Apply a patient-centred, integrated approach across all healthcare disciplines with the goal of optimizing care in chronic asthma, Chronic Obstructive Pulmonary Disease and diabetes disease management.
  
  • Create multi-disciplinary community care centres, which would include physiotherapy and other alternative services, as well as nursing services and
ambulatory care. These facilities would focus on prevention and spotting problems early.

- Continuity of care, getting care from one source whether one person or an integrated group, results in better outcomes than episodic care.

- Those patients with chronic diseases who receive only episodic care from a succession of physicians are at greater risk of developing complications than those who receive their care from one person or an integrated group.

- Effective management of chronic disease has to be multi-faceted. This could be done through mentoring, peer groups, community based groups, or alternative pain management. Support the families of those with chronic condition.

- Many people who have chronic diseases get very severe symptoms and will eventually need hospitalization. However, community services are available and they do not need to start receiving care at the hospital. Active community support, an informed patient and a proactive health care team are all part of treating chronic disease.

- Integrate all the chronic disease databases in British Columbia and improve both data collection for disease risk factors and reporting on the economic burden of illness and death due to chronic diseases.

- Have breast cancer physiotherapy services and massage therapy, manual lymph drainage, centralized together to support breast cancer patients.

- Create disease-specific teams and develop a centre for auto-immune disease; there are eighty different auto-immune diseases but patients only focus on their own.

- Increasing premiums would support expanded services for chronic disease management.

- Use group appointments for chronic diseases: five people who have the same disease could see one doctor for a group appointment. They would talk to each other, support each other, and learn about their disease.

- Health professionals should spend time with their patients, to develop a trusting relationship.

- Home-nursing care could assist people with chronic disease to optimize nutrition status, manage health issues and prevent further emergency visits and hospitalization.

- It takes more than 10 visits to treat diabetic ulcers. If visits can be made before the ulcer appears, it would be preventative and cheaper.
• It would be a lot safer to have access to the necessary equipment to perform tests for my illness at home. The tests would actually get done when I needed them to be done and I would not have such frequent emergencies and land in the hospital.

• Ideas about access to the system:
  • British Columbians indicated a need for greater access to chronic disease services, such as:
    a. blood tests;
    b. blood pressure monitors;
    c. medical supplies;
    d. hearing aids;
    e. ocular and optometry examinations;
    f. gerontologists;
    g. residential care;
    h. prescription drugs;
    i. patient advocates;
    j. HIV/AIDS services in First Nations communities;
    k. diabetes treatment centres for Aboriginal people;
    l. chronic disease clinics for seniors; and,
    m. support groups for people with chronic disease such as Fibromyalgia and Myofascial Pain Syndrome.

• Money should be available to help people with chronic illnesses with transportation to appointments and programs.

• Continue to expand the chronic disease management programs already started by the Ministry of Health and supported by health authorities, health care practitioners, the pharmaceutical industry, patient support groups, industry and private insurance.

• Though the Ministry of Health has initiated programs over the years to close the gap in chronic disease management, this gap is not closing. Industry should be part of the solution and carry part of the financial risk to improve chronic disease management.

• There should be a patient care coordinator for each patient with a chronic disease.

• Send patients from rural areas that require multiple hospital visits to Victoria or cover the costs of visits to a private clinic.
• Alternative and complementary medicine for chronic disease treatment should be funded.
• It is important to put money towards the infrastructure at the community level to facilitate outreach and monitoring chronic disease management.

• Ideas about chronic disease management models:
  • Create incentives for businesses to hire people with disabilities or chronic diseases who work toward recovery and proper maintenance of their illnesses.
  • In the US, in 2001, Pitney Bowes implemented a chronic disease management model, for diabetes and asthma. This model included reducing the amount employees paid for diabetes and asthma drugs with the expectation that more affordable drugs would increase compliance and yield better health and lower health-care costs. The result was significant savings. Three years after implementation, the median medical cost for a Pitney Bowes employee with diabetes has fallen 12%, while the median cost for a patient with asthma has dropped 15%.
  • Establish a 6 per cent resource allocation target for the total health services budget in the area of chronic disease prevention. This would include, but not be limited to, cancer prevention. Health authorities should receive incremental government funding to achieve this target, and should be held accountable through annual performance agreements and 3 year health service budget plans.
  • In Asheville, North Carolina, the city partnered with the pharmaceutical industry and local pharmacists to implement a chronic disease management program for diabetic employees. One aspect to the program was the elimination of co-payments for medications and lab tests if patients attended educational counselling sessions with specially trained pharmacists. Drug costs went up, but overall medical costs went from more than $7,000 per diabetic patient in 1997 to less than $5,000 in 2002.
  • GlaxoSmithKline has been a leader in chronic disease management and patient self management through health care partnerships since the early 1990's. The creation of over 50 Community Care Asthma Centres across Canada, 13 centres in British Columbia, positively impacted the lives of thousands of patients while significantly reducing consumption of health care resources.
  • Since the Ministry no longer implements programs within health authorities, central support and accountability for chronic disease management programs is required.
  • There should be more transparency in decisions around treatment approvals.
• Develop and implement a coordinated, province-wide strategy for managing and preventing chronic diseases.

• I believe in cost-sharing, not total government subsidising, for chronic disease management.

• Look at the Edmonton Health Authority model for diabetes. Develop short and long-term vision and goals for systematic, interdisciplinary, inter-ministry and inter-agency (municipalities with community partners for prevention, education) approaches to chronic disease management and prevention.

• There needs to be community infrastructure to develop towns, cities, health facilities, workplaces and industries/businesses that not only make it easy to prevent chronic disease, but also make it difficult to cause chronic disease.

• Edmonton has established a virtual asthma clinic that serves to screen, monitor and educate patients about asthma. It is a web-based tool and has been shown to reduce use of the health care system and improve the quality of life for the patients involved.

• Funnel savings from instituting preventative measures for smoking and obesity into investigative studies for chronic illnesses for which there is no known cure, such as Lupus, Parkinson’s disease and Multiple Sclerosis.

• Expand the construction of chronic care facilities immediately to reduce the number of occupied beds in your hospitals. This would immediately result in savings.

• There should be more information, support groups and funding to manage illness.
Public Safety

Public Safety was among the issues raised by many participants during the Conversation on Health. Epidemics and infectious diseases, public safety, and hygiene and public awareness were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of public safety.

Epidemics and Infectious Diseases

In general, participants expressed concern about the possibility that disease will spread and cause an epidemic. They pointed to overcrowding, poor availability of testing and immunization, and increased environmental sensitivities among the public as potential factors that may contribute to an outbreak of SARS, avian bird flu or other illnesses.

Discussion focused on increasing services and regulations as a way to protect British Columbians from a future pandemic. Some believe vaccination programs should be free to the public, while others believe that Canada should be more careful about letting foreign products into the country. Other options for preventing epidemics include testing for more diseases to identify illness early and avoid serious consequences, developing a comprehensive strategy to avoid cross-contamination, and preventing people with communicable diseases from travelling.

Make free immunization programs available to all. With global warming it will be easier for tropical diseases to survive in our climate so travellers should have to have their immunization current when leaving the country so diseases are not brought back to Canada.

– Email, Victoria

Hygiene and Public Awareness of Disease

There was general consensus that public awareness of hygiene was not good. Some participants believed that sanitation in public areas, such as restaurants and retail stores, should be higher and that unclean and crowded conditions in health care facilities contribute to the spread of disease.
Some submissions to the Conversation on Health pointed to education as the key to preventing the spread of disease. Improved awareness about the benefits of hand-washing, both for the public and for health professionals, is important. Education programs and publicity campaigns for specific diseases like sexually-transmitted diseases and tuberculosis also received significant attention.

*I'm concerned about avoiding a future pandemic, Avian Influenza or otherwise. It seems the cheapest strategy is to refresh health first-responders that soap kills flu germs.*

- Email

Public Safety

Many participants feel that public safety was also not adequate. They think that traffic accidents and unsanitary accommodation risk public health and that few rules exist to protect the public from accidents.

Generally, participants agree that more comprehensive regulation and supervision would increase public safety. While some feel that a safe and clean home should be a legally enforceable right, others believe that more rules and a greater police presence would reduce traffic accidents and, therefore, reduce pressure on emergency rooms. They also think laws to reduce the chance of falls, improve crosswalks, and make seatbelts compulsory in all vehicles should be put in place.

Conclusion

Public safety encouraged strong opinions throughout the Conversation on Health. Participants emphasize that the population needs to be safer and more hygienic to protect against infectious diseases and accidents. Overall, they suggest that better publicity and education around disease management would aid early detection and prevent a potential outbreak, while more stringent rules would promote greater public safety on the road and at home. Though the message about the public's need for better safety and sanitation is clear, the ideas for achieving this goal are varied and will continue to be debated.
Public Safety

This chapter includes the following topics:

Epidemics, Infectious Diseases and Hygiene
Public Safety
Administration

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

Do Not Harm
Submitted by the AD-AV Society

Related Chapters
Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Patient Safety; Public Private Debate; Training; Morale; Access to Hospitals in Rural Areas and Chronic Disease Management.

Epidemics, Infectious Diseases and Hygiene

Comments and Concerns
• The spread of drug resistant bacteria can be rampant.
• Pets transmit illness and parasites and belong outside.
• Upholstery is a source of disease.
• Remove the magazines from hospitals as they increase the spread of germs and disease.
• It is inappropriate for long-term care facilities to keep live birds as pets as they carry diseases which put the elderly population at risk.
• Aircrafts could be a major source of the spreading of diseases.
• Flu shots cannot be obtained in Cranbrook.
• Since society is dealing with many new environmental illnesses, any illness that cannot be explained by normal testing must be taken more seriously.

• Many young professionals have not witnessed major disease outbreaks and as a result do not see as much need for vaccines.

• A future epidemic could have an impact on young people and be detrimental to the workforce, especially hospital workers.

• Since privatization has come into health care, our hospitals are not being properly or thoroughly cleaned and superbugs have proliferated. Where is the accountability?

• I am disgusted at the disorder in the hospitals. The hallways are cluttered with gurneys, blood equipment, wheelchairs, boxes, bedding and other stuff that makes cleaning very difficult. The washrooms and toilets are disgusting by anyone’s standards. The consequences could very well include the spread of diseases such as SARS and other viruses.

• The public and patients are not informed that they are carriers of infectious diseases.

• Overcrowding in hospitals enhances the spread of infections.

• The 2006 pneumonia outbreak in the Downtown Eastside resulted from overcrowded emergency rooms.

• Mixing sick and injured patients in offices and hospitals often leads to infection of otherwise healthy, injured individuals, which costs them personal grief, money, time for treatment, and a loss of productivity to society.

• There needs to be a better understanding of the systemic impacts of Methicillin-Resistant Staphylococcus (MRSA).

• Health Canada failed to inform the public that antibiotic misuse can cause immune dysfunction.

• Superbug infections, illness and death are often caused from taking unnecessary antibiotic treatment.

• A commercial was done on the use of antibiotics with kids telling us not to take antibiotics for the flu.

• Canada does not acknowledge that Lyme disease is a problem; the test needed to properly diagnose Lyme disease is not available in Canada.

• Radon as a cause of lung cancer is not adequately publicized.

• X-rays are a health danger. The radiation is lifetime accumulated. No records are kept about how much, how often and when patients get X-rays during their life.

• Why is Health Canada warning people not to take colloidal silver?
The Department of Microbiology at the University of British Columbia is working on helping us to be better prepared the next time a pandemic hits. One of its projects focuses on new means to battle infectious disease pathogens with significant public health implications, such as food-borne Salmonella and E.coli.

**Ideas and Suggestions**

- Refresh the knowledge of first-responders and remind them that soap kills flu germs.
- Implement hand washing education.
- Educate doctors not to prescribe antibiotics when they are unnecessary.
- Retail owners need to keep up hygiene standards.
- Restaurants should maintain good personal hygiene standards since disease can be transmitted very easily.
- Have humidifiers in our houses to cut down on flu transmission.
- Canada should take more time to check the products coming into the country.
- There should be hospitals specifically set up to address epidemics.
- Separate people with infectious illness from other patients; divide the emergency area in two and station a person at the entry to direct patients to the proper area.
- There should be more information and education about the benefits and drawbacks of vaccines.
- Provide public reports about the effectiveness of mass vaccinations for influenza.
- We need more sites set up to distribute flu shots.
- Make immunization programs available to all and encourage people to keep their immunizations up-to-date.
- There are vaccinations for girls that can prevent cervical cancer, which could be added to the group of vaccines that are given to all children in school.
- There should be some type of medicine travellers or visitors can take before they enter the country so they do not pass on an infectious disease such as the Avian flu.
- Travellers should be required to have their immunizations current before leaving the country so diseases are not brought back to Canada.
- There should be more education on sexually transmitted infections.
- Increase access to Lyme disease testing.
• Publicize tuberculosis particularly at bus stops and on the downtown streets.
• Encourage persons to stay home when ill to prevent the spread of contagious illness.

**Outstanding Questions**

• Could the public health system cope with a SARS-like outbreak?
• Are change rooms available for health professionals to change out of their scrubs before leaving for home?

**Public Safety**

**Comments and Concerns**

• The new regulations restricting commercial drivers’ licenses for those with diabetes are unfair, discriminatory and unnecessary.
• Illegal drugs on the market contain more chemical substances.
• The public uses cell phones too much; they are dangerous to use without a headset.
• Aerosol-pressured dilators caused 1,700 deaths in one year in the United Kingdom.
• Life-threatening allergies are on the rise, yet there is not a lot of public awareness.
• Bed bugs are a significant health hazard.
• Too many people live in unsafe houses and apartments; these places should be condemned by the law.
• Road accidents kill more young Canadians than any other cause and a high percentage of health care costs are caused by vehicle crashes.
• Falls are a leading cause of death and unintentional injury-related hospitalizations.
• A woman called 911 because she was being threatened and by the time the police arrived she had been severely beaten.
Ideas and Suggestions

- Have a standard test for bus and truck drivers to ensure they are not operating such machinery under the influence of any drugs.
- Develop more stringent rules for the roads and add more police. This will result in less congestion in the hospitals due to accidents.
- Look at highways and road maintenance and design with the goal of reducing road-related health care costs.
- Advertise Electronic Stability Control systems for vehicles to help reduce accidents and have the Insurance Corporation of British Columbia advertise them in insurance renewal notices and offer insurance premium discounts for its use.
- Make the Malahat highway safer.
- Provide stronger sentencing for violent offenders to keep them off the streets so that innocent people do not end up in hospitals.
- Make hanging laundry out in public illegal.
- Clothes in a second-hand store should be fumigated before being sold.
- There should be a provincial policy in schools for children with allergies which would provide a universal standard of care for this important health issue.
- Schools need supervision to ensure that quality food is provided.
- Hockey helmets should be banned and the sport reverted back to a game of fun rather than a sport with a kill-em attitude.
- Legislation should be in place for bar owners or concert promoters to provide hearing protection to patrons if the music is played over a certain decibel level.
- Crosswalks should be designed to maximize accessibility in order to cut down on jay-walking accidents.
- Create legislation for fall prevention accountability (due to ice and snow) and to make seatbelts compulsory in all vehicle including buses.
- There should be stricter regulations and safety inspections on imports, particularly toys.
- There should be warning labels on products such as sunscreen, so that people with environmental sensitivities do not use them.
- Make a clean, safe and bedbug-free home a legally enforceable right.
- Ban guns in British Columbia.
Administration

Comments and Concerns

- The government did not provide adequate assistance during the boil water advisories; bottled water should have been available for the public.
- Discharging patients too early results in a high infection rate for disease.
- Funding cutbacks have resulted in unclean hospitals.
- Lifting bans on chemical products would result in unsafe products being available to the public.

Ideas and Suggestions

- Develop a comprehensive plan to address cross-contamination.
- The government should have a plan to provide medical care to citizens in case of a bird flu pandemic.
- Appoint a panel of experts to review and recommend changes to British Columbia’s infectious disease policies.
- Institute measures to counter the spread of new virulent strains of tuberculosis.
- The Provincial Emergency Program would be good training for the public.
- People who have serious communicable diseases should not be allowed to travel on public transport (buses and planes).
- People who are aware they are carrying life-threatening diseases and continue to infect others should face criminal charges.
Workplace Safety

Workplace Safety was among the issues raised by many participants during the Conversation on Health. Work environment, prevention and health promotion, and administration were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of workplace safety.

Workplace Environment

In general, participants feel that workplace conditions are not good and contribute negatively to employees’ health. Many submissions indicate that chronic illness, stress and addictions are the result of unsafe office practices, long hours of work and harassment in the workplace. Others think environmental causes such as smoking, exposure to asbestos, and improper office cleaning techniques increase the risk to workers.

Many people believe that introducing new rules and regulations will make the workplace safer. Some want increased anti-bullying and no smoking legislation implemented, and others think that regular working hours, and reducing overtime and split shifts would be a good idea. Suggestions also included more regulation surrounding air quality and hazardous products.

_They need to outlaw smoking in front of the main entrances at British Columbia hospitals. If a smoking area is needed, they need to locate it somewhere totally out of the way of the general public._

– Web Dialogue, Victoria

Prevention and Health Promotion

There was general consensus among contributors to the Conversation on Health that a focus on workplace wellness is important. The majority of people think that a new focus on health promotion at work will help employees to be happier and more productive. Suggestions to accomplish this goal include providing exercise facilities and healthy food, inspecting the workplace for air quality and ergonomics, and covering massage therapy treatments.
We have to shine the spotlight on lack of occupational health because it causes chronic disease. Education and legislation enables change. One gram of prevention is worth a kilogram of cure.

–Regional Forum, Vancouver

Administration

Many people believe that new rules for the administration of workplace safety are needed. Some submissions proposed that WorkSafe BC should have an increased ability to review complaints about safety issues at work. Others suggested that an independent investigative body be set up, or that the courts review workplace safety issues in the event that complaints go unresolved.

Conclusion

The majority of participants in the Conversation on Health believe that employers and the government should provide a safer and healthier work environment for British Columbians. They suggested that wellness programs, including nutrition, fitness and education on health lifestyles, would improve workplace conditions, while stricter rules around environmental determinants and employee behaviour would reduce the risk to employees’ health.
Workplace Safety

This chapter includes the following topics:

**Work Environment**
**Prevention and Health Promotion**
**Administration**

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**Related Chapters**
Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Morale and Patient Safety.

**Work Environment** (asbestos, smoking, etc.)

**Comments and Concerns**

- Working conditions are not good.
- Many chronic diseases are related to activities at the workplace (bricklayers/osteoarthritis, sports players).
- Worksites may indirectly support addictions with long work hours and shift work.
- Workplace bullying can lead to chronic illnesses.
- Workplace violence causes people to keep returning to the health care system for treatment.
- No assistance is available to the patient who displays the symptoms of anxiety, depression and other illnesses resulting from being bullied at work.
• Environmental and occupational triggers such as toxic chemicals cause many people to become ill with cancer and respiratory disease.

• Tree planters and produce harvesters are exposed to dangerous chemicals and do not clean up properly. They are not informed about the dangers of these chemicals.

• The Government of British Columbia should not have rescinded non-smoking regulations in the workplace.

• The Government needs to partner with employers to ensure worker safety from carcinogens.

• Nurses are being put at risk of being infected with diseases because unsafe cleaning techniques make hospitals unsafe.

• Provide more funding for ceiling lifts and other equipment in hospitals so that staff members do not need a no-lift policy to avoid injuries.

• Why do they use toxic cleaners in hospitals? Get rid of every cleaning product that needs a Workplace Hazardous Materials Information System label. There are better, safer, cheaper, non-toxic cleaning products sold all over North America. Staff and patients will benefit from that simple change.

• Why does the hospital in Chilliwack have no staff change rooms, shower rooms?

• Hospitals are not secure enough and, as a result, staff members are put in danger every day.

• Smoking is allowed at hospital entrances and people entering or leaving must breathe in second-hand smoke.

• Workplace harassment is slowly being recognized as a medical health issue by other jurisdictions.

**Ideas and Suggestions**

• Clean, safe school and work environments are important.

• People are suffering from asbestos-caused diseases; Canada should ban this substance.

• The Workplace Hazardous Materials Information System (WHMIS) and the Hazardous Products laws are a good start but need to be expanded to include pesticides.

• Improve sanitization practices for staff and increase supervision.

• Create legislation regarding bullying in the workplace.
• Provide effective and immediate assistance to employees suffering from illnesses resulting from being bullied.

• There needs to be more attention given to common sense safety issues (better signage, more information).

• There appears to be no provision in collective agreements for sick leave when a person is a victim of workplace violence.

• Improve the working conditions of health professionals (less overtime and fewer split shifts).

• Look to Sweden: they purify the air in their factories.

• Outlaw smoking in front of the main entrances at hospitals in British Columbia.

• Every employer who has more than 20 workers on a work-site should have a safety committee and conduct regular inspections.

• First aid kits should be mandatory in cars and in workplaces. Fire extinguishers and glass hammers should also be compulsory in vehicles.

• British Columbia should look at the emergency rooms in the United States; there, they are sealed and locked so nobody gets in unless the staff lets them in.

**Prevention and Health Promotion**

**Comments and Concerns**

• When communication is lacking there is an added occupational health and safety risk for health professionals.

• Currently, employers have to pay for health authority staff to talk to their employees about subjects such as nutrition, diabetes and heart health. This may be a financial burden for many employers.

• The Prevention and Early Active Return-to-Work Safely (PEARS) program is under-funded and is only available in a few hospitals.

• Our approach to ActNow BC is engaging others.
Ideas and Suggestions

• Provide workplace wellness programs which provide great benefits on many levels.

• A focus on workplace wellness can increase productivity levels. This would positively affect the economy while improving the overall quality of workers’ lives.

• For every dollar invested in comprehensive prevention and health promotion programs, companies save money in the form of reduced health costs and gains in productivity.

• Comprehensive health programming for businesses includes health promotion and assistance interventions; recognition of workers’ needs, preferences, and attitudes; recognition of lifestyle behaviours; consideration of the different environments in which programs operate; and, support the development of a strong health policy in the workplace.

• Provide employees and employers with healthier options, such as exercise facilities and healthy food choices.

• Provide employers with resources, such as the BC Health Guide, to distribute and promote to their employees.

• Offer free health workshops to employers, facilitated by health professionals.

• Post the locations of clinics in first aid rooms at work.

• Increase funding for massage therapy. Massage is a safe, drug-free form of treatment for pain and stress management.

• Implement workplace inspections, including testing air quality, assessing ergonomics and access to nutritious meals.

• Change the number of hours people work during holidays.

Administration

Comments and Concerns

• Some people fall through the cracks because everyone assumes that others, such as employers, WorkSafe BC, Public Health, or unions, are going to take care of workplace safety.

• WorkSafe BC focuses on industrial workers and manual labourers and does not assist employees in other areas.

• Hygiene standards for industrial disease are not applied consistently or extensively.
• WorkSafe BC regulations can conflict with collective agreements in some cases and cannot be enforced for that reason.

• The WorkSafe BC non-smoking regulations should not have been rescinded.

• To fully plan, implement and evaluate healthy workplace programs takes a 2-5 year time span.

• Workplace safety boil water advisories are not good enough for people with compromised immune systems since they can get ill just from coming in contact with contaminated water.

**Ideas and Suggestions**

• There must be an independent investigator to examine complaints about workplace safety.

• Safety concerns not addressed by the employer should be reported to WorkSafe BC.

• Regulations should be changed to make it mandatory for WorkSafe BC to deal with safety concerns reported by employees and not addressed by the employer.

• If WorkSafe BC does not succeed in addressing safety concerns, these concerns should be settled by the courts.
First Nations

The Conversation on Health conducted a series of forums with First Nations communities around the Province. These forums offered a unique First Nations perspective on the health issues facing British Columbia. Governance, access and service delivery, mental health and addictions, elder care and determinants of health were topics highlighted in many of the discussions. All sections of the report contain samples of feedback from these sessions. This introduction will provide a broad overview of what Aboriginal communities had to say about the health care system.

Governance

Participants expressed frustration with the lack of collaboration between the federal and provincial governments around serving First Nations communities. They emphasized that increased control on the part of First Nations over their own health care services would help to ensure improved treatment. Some looked to a First Nations Health Act to better define the roles and responsibilities of the levels of government involved in delivering health care to First Nations. They also suggested these definitions would be community driven, create accountability and aid in building local capacity to administer and deliver health care services.

Many feel that whatever the governance structure, adequate funding must be distributed equitably and accountably to First Nations communities if health outcomes are to improve. Many feel that current funding does not meet the needs of First Nations and that the funding process is too complex and cumbersome and leads to unequal access to funds across First Nations communities. There was also concern expressed about funding equity for Aboriginal people living off reserve and for other Aboriginal groups, such as the Métis. Many look to the federal government to address these issues with improved funding for off reserve services.

We still have too many conundrums between ‘is this a federal government issue, is this a band issue, is this a provincial government issue’…until we resolve the outstanding issues around land claims and delegation of authorities, we are not in a very good place with the health agenda.

– International Symposium, Vancouver
Access and Service Delivery

Many participants expressed concern about accessing medical services in rural areas of the Province. They feel that the challenges created by the remoteness of many First Nations communities are not being addressed adequately through current travel policies and transportation options. Offering more services on reserves was one solution to alleviate the need to travel outside the community. Equality of access to services on and off reserves was an issue for many participants. Funding for many programs on reserve does not recognize people living off reserve and their needs. Some participants hoped that improved communication about available services both on and off reserve would help address this issue.

It is important for many that the health care system respects Aboriginal cultures and traditional practices. They feel that the health care system lacks cultural sensitivity and that this negatively affects the health care First Nations receive, especially in the case of end-of-life care. Some see the delivery of more health services by First Nations health professionals as one solution. Others hope that increased education for all health professionals about First Nations cultures will increase understanding and help to break down long-standing barriers. Many suggested that small changes, such as taking more time to listen to concerns raised by First Nations patients and making space for First Nations spirituality in hospitals could make a big difference in their experiences with the health care system.

When the community is designing and controlling its health services, and when you have Aboriginal health professionals delivering it, it's actually getting at this underlying problem…

the reason why I believe there's persistent health status disparities is there has been a mismatch in terms of the theoretical assumptions and the mechanistic frameworks of health care delivery.

– Focused Workshop on Delivery Models, Vancouver

Mental Health and Addictions

Mental health and addictions were areas of great concern for First Nations participants. Most feel that there is a lack of resources and services available to help those with mental health and addiction problems and that too often these issues result in suicide. Others expressed concern that even when treatment is available, it is short-term and there is no follow up or support for families. To be successful, participants suggested mental health and addiction services need to be available in First Nations communities, delivered by First Nations people incorporating traditional teachings and offering long term supports.
Many participants suggest the intergenerational effect of residential schools is a cause of many of the mental health and addictions issues facing First Nations communities. Many suggested consideration must be given to this factor when First Nations people are diagnosed with mental illnesses. Failing to recognize the impact of residential schools affects the ability of patients to truly overcome their issues. Participants also believe residential schools have impacted the parenting skills of many Aboriginal families. Some suggested that compensation funding is too often used to treat the symptoms caused by these experiences instead of being used to help in rediscovering traditional identities crucial in overcoming this history.

Elder Care

Elders play a crucial role in First Nations society. Many participants expressed concern about how and where Elders are cared for. Many First Nations feel that keeping their Elders close to their communities maintains a link to culture and tradition which is integral to their health. Elders require safe, affordable, culturally sensitive care on reserves so they are able to continue to help their communities. There was concern expressed about Elder abuse, with many participants wanting families and caregivers to be held responsible in cases of abuse or neglect.

Determinants of Health

There are a number of factors that directly impact First Nations health and result in poor outcomes when compared to other British Columbians. Many participants believe that the move away from a traditional lifestyle, including traditional foods, has resulted in a rapid deterioration in their health. A return to traditional practices and foods would help in this regard along with increasing the availability of healthy foods on reserves. Others feel that poverty among First Nations is a contributing factor to poor health. To address this they suggested improving access to higher education and empowering people with skills and resources.
The prevalence of chronic disease in First Nations communities is a cause for concern for many participants. Rates of diabetes, cancer and HIV/AIDS are all higher for First Nations than for other British Columbians. Participants feel prevention and education are vital in addressing chronic disease issues. They also feel that locally-delivered, culturally appropriate services and treatment options must be available to help those living with chronic illnesses.

When I was a little boy, you were rich if you had bologna and poor if you had fish. And, you know; now it's shifted back to the right perspective… Once more…you relish in the idea… that you have access to fish. But some of our people’s diet is still stuck in there, and what they think of as good food is killing them.

– Chief Leonard George, International Symposium, Vancouver

Conclusion

First Nations participants in the Conversation on Health brought a number of unique issues and concerns to the forefront, such as the lasting effects of residential schools and the complex governance and funding models in effect in First Nations communities. Other concerns such as access to services in rural areas of British Columbia and the needs of Elders and seniors were consistent with concerns raised in forums all over the Province. These common concerns and unique issues highlight the complexity of delivering services to First Nations, and the need for continued dialogue with First Nations to ensure their voices are heard and their needs are met.

I hope this conversation turns into action…We need some process in place, a partnership with the province and First Nations.

– Little Shuswap First Nations Forum.
First Nations

This sub-theme includes the following topics:

Access to Health Care Services
Service Delivery
Health Human Resources
Residential Schools
Mental Health and Addictions
Determinants of Health (Culture, Parenting and Childcare, Health Outcomes, Socio-Economic Status, Environment, Chronic Diseases and Diet)
Intergovernmental Cooperation, Governance and Funding Models
Elder Care

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

From The Beginning To The End
Submitted by Bella Coola Discussions on Health
Aboriginal Conversation on Health
Submitted by Vancouver Coastal Health
Submission to the BC Conversation on Health
Submitted by Victorian Order of Nurses for Canada
Submission to the Conversation on Health
Submitted by the BC Cancer Agency
Submission to the Conversation on Health
Submitted by the Representative for Children and Youth
A Submission to the Conversation on Health
Submitted by the Canadian Cancer Society

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Access to Hospitals in Rural Areas; Complementary and Alternative Medicines; Environmental Determinants of Health and Food Quality; Addictions; Chronic Disease Management; Mental Health; Training and Social Determinants of Health.
Access to Health Care Services

Comments and Concerns

Access in Rural Communities
On and Off Reserve Access
Travel for Medical Care
Socio-Economic Issues

Comments on access in rural communities:

• Isolated and rural communities have unique and special access challenges for obtaining health care.
• The current programs offered by communities, reserves and health departments do not reach the majority of First Nations in their communities.
• Local health services are not provided.
• There are gaps in service delivery to Aboriginal communities.
• There is an absence of 24-hour health care in most small communities; however, Ts’ewulhtun Health Centre is always open.
• Our nurse only works three and a half days per week for a population of approximately ten thousand people.
• Not all areas of British Columbia have an affiliation with a Friendship Centre or a health service delivery society off the reserve.
• It takes a long time to obtain blood tests results in Cowichan, British Columbia.
• Health nurses do not do home visits. One nurse comes to the community twice a week.

Comments on access to health care for those on and off reserve:

• Access to health care is not equal for all Aboriginal people. A person living off the reserve cannot go to their Band for medical services such as the flu shot.
• I have reserve people who cannot access services because they live on the other side of the road.
• There is a lack of information accessible on what is available to status and non-status Aboriginal people.
• Some bands collect funding for members living in rural areas but do not extend services to them.
• Sometimes, on-reserve services do not meet the needs of those living in rural areas.

• Comments on the difficulties of having to travel for medical care:
  • Arranging for transportation and accommodation can be problematic and costly when one requires treatment to a larger centre that is not close to home. Communication between the doctor and the travel clerk is difficult and complicated due to the need for a referral and the amount of paperwork involved. Discharge plans do not include transportation and accommodation plans for post emergency services.
  • Finances for medical travel may not be available, which increases stress and illness. Medical travel may be planned for three days in advance of an appointment but extensions occur, which increase the complicated paper trail. There is also a three month delay before one is reimbursed for medical travel expenses.
  • The rising cost of transportation to send people for medical care continues to escalate while the federal government continues to apply cuts to what they currently pay for.
  • Travel expenses are incurred when one must travel to obtain prescription renewals on a monthly basis.
  • Lack of transportation limits access to urban health services for people on reserves.
  • Ambulance services do not always respond to calls from remote and rural areas.
  • First Nations people do not want to travel from their communities to obtain health care.

• Comments about socio-economic issues:
  • Aboriginal people have traditionally, both here and internationally, had very poor access to health care, particularly primary health care, for a variety of reasons involving financial, geographic, social, cultural and linguistic concerns.
  • There are geographic barriers, language barriers, transportation issues, poverty and literacy concerns and a lack of health education and accessibility to health education in Aboriginal communities at the present time.
  • Some dental clinics refuse services to First Nations people because money is an issue.
The fact that prescriptions are covered means First Nations people have access to treatment for illnesses.

Non-Insured Health Benefits (NIHB) are restrictive in what they cover and their reimbursement is not in the range of fees charged by service providers. Service fees are too high.

Ideas and Suggestions

Access in Rural Communities
On and Off Reserve Access
Travel for Medical Care

- Ideas about access in rural communities:
  - Go to the remote Aboriginal communities and talk to the people there, to get them involved at the grassroots level.
  - Have spokespeople in rural areas.
  - Provide community health representatives in First Nations communities.
  - Aboriginal communities require funding to implement plans to help them deal with their many needs.
  - Provide more locally-based Nurse Practitioners to work with the doctors.

- Ideas about on and off reserve access to health care:
  - Ensure equal access or even better services on reserves than are currently available off reserve.
  - Provide equitable and timely access to health care services.
  - Enable the mobility of status rights within the Province and across Canada.
  - Recognize that members would like to move back to reserves but are unable to for a variety of reasons. When considering funding requirements we should be able to consider them as living on reserves. Registered members of a band should get health care funding regardless of where they live.
  - Provide Women's Transition Houses on reserves.
  - Provide better information that is better circulated regarding the services available to those living off the reserves.
  - Strengthen on and off reserve client response.
• Services provided should be community specific, both on and off the reserve.

• Increase funding for urban Aboriginal health services. Offer the same programs on and off reserve. Our band helps members on and off the reserve but we do not get funding for the off reserve people.

• Develop partnerships and agreements with the off reserve resources.

• Have Registered Nurses visit the reserves.

• Have health centres on reserves for youth (12-18 years) with Elders providing the teachings.

• Ideas about the difficulties of having to travel for medical care:
  
  • First Nation and Inuit Health should not make it difficult for health care providers to assist First Nations people to access the resources needed to assist with the increased cost of living and medical travel.

  • Provide access to government sponsored medical transportation vehicles.

**Outstanding Questions**

• Are the Aboriginal health centers funded by the Department of Indian Affairs?

• Why do Native people not pay for medical and pharmacy services?

**Service Delivery**

**Comments and Concerns**

**Administering Services**

**Culture and Traditional Medicine**

**Health Professionals and Treatment**

• Comments on administering services:
  
  • The definition of Indigenous needs to be clarified and not defined by the Government as a way to restrict or restrain health care funding, thereby limiting incurred health care costs.

  • We need to define whether First Nations applies only to those living on a reserve or for all those with Aboriginal ancestry.

  • Aboriginals are not always identified by the health system which means that the statistics and their health statistics are incomplete.
First Nations do not have enough say about their service delivery.

There is a lack of funding for social services due to Government cut-backs. Social services are not aware of the sexual abuse among children.

We really need stabilized funding for youth health programs.

There is a lack of understanding of what is medically covered and about medical billing practices.

The closing of the First Nations/Inuit Health branch has had a detrimental effect.

There are a lot of programs and services that only a select few tend to know about and are able to access.

In order for us to take responsibility we need to know what is available. There seems to be barriers that are keeping information from us.

Despite numerous meetings and requests by Carrier Sekani Family Services for the National Health Authority to fund or subsidize this service, the contracts continue to be given to non-Indigenous agencies that do not provide services on the reserve.

Comments on culture and traditional medicine:

Aboriginal families do not feel welcome in hospital settings because of how they have been mistreated in the past. The Aboriginal world view of health and life process is not respected.

The medical system views patients as diseases and do not treat the whole patient. There is no room for spirituality and the physical, emotional and mental aspects of health.

There is no recognition of the traditional healing methods of Aboriginals.

Aboriginal culture does not fit within the current medical system.

There is a lack of culturally sensitive care.

There is a lack of sensitivity by health professionals regarding the styles of communication, language, cultural issues, ceremonies and amount of family visits required by Aboriginal patients.

There is a lack of traditional healers in some communities.

Access to health information and resources that are intrinsic to Indigenous communities have been overlooked or systematically dismantled.

I believe that there has also been a persistent marginalization of Indigenous ideas and systems regarding health, which results in some inefficiency.
• There is a stereotypical attitude towards the First Nations population and their health issues.

• Health care policy makers need to be aware that Indigenous cultures may appear to be simplistic but actually contain a science that is based on thousands of years of empirical understanding from living off the land.

• Both Bella Coola and Bella Bella hospitals are superb examples of Native and non-Native communities working together to a common good for all in the community, despite real or perceived boundaries, cultural differences and visible barriers for funding sources.

• Comments about health professionals and treatment:
  • There is a lack of appropriate services, resources and alternatives for issues that are growing and becoming more complex. We need to move beyond the crisis model and think beyond the programs that exist today.
  • Doctors over-prescribe medications to Aboriginal people.
  • We always have a problem with prescription drugs and their side effects on our health.
  • The knowledge and application of traditional treatment methods are helpful and should be used rather than always utilizing antibiotics.
  • Some health care providers discriminate and refuse to provide services to Aboriginal people.
  • Doctors do not listen to Aboriginal people.
  • First Nations individuals see hospitals as a place to die.
  • Many First Nations people are very scared and resist going to hospital because of the racial discrimination they receive and because of past associations with hospital treatment being the end-of-life or the last stop.
  • There is a disparity in the delivery of Aboriginal health services.
  • There needs to be more support and services for people with chronic illnesses.
  • There is a lack of confidentiality and anonymity in small communities.
Ideas and Suggestions

Administering Services
Culture and Traditional Medicine
Health Professionals and Treatment

• Ideas about administering services:
  • The First Nation’s crafted vision for First Nations health includes all people of Aboriginal ancestry and sets standards for best practice and quality assurance.
  • Reports from the Royal Commission and the Kelowna Submissions both identify the need for Aboriginal communities to control their own health services.
  • Privatization of health care is not the answer. The Government must realize that the privatization of vital health services is not cost effective and results in harm to our communities. The answer to funding shortfalls in health care requires a greater focus be placed on preventative medicine and other creative solutions. By addressing the root causes of poverty, which is one of the most detrimental health indicators, the Government will save money and treat the people of this Province with the dignity they deserve.
  • Review current programs and services to determine what is needed. Think beyond what is currently available. Focus on priority-driven rather than investigative-driven research. Education, social services, poverty, capacity building and housing are issues that need to be factored in as part of the transfer process.
  • Work with the Assembly of First Nations and read the information on their website.
  • Develop publications that are geared to First Nations families.
  • Introduce a province wide identification system for all Aboriginal people to track all users of Aboriginal health. Current status cards only track those living on reserves.
  • Implement electronic health records for Aboriginal populations.
  • Ensure that Non-Insured Health Benefits (NIHB) aligns their fees with the current dental, dental surgeon and optometrists fee schedule.
  • Ensure that adequate treatment is available to First Nations people. First Nations people generally do not have the money to pay and will instead do without.
  • Aboriginal health needs in each community must first be identified and then matched with the health professionals and resources to meet those needs.
• Information about the programs available needs to be shared.

• Have people with knowledge available as a community resource.

• Increase connections and partnerships with other community resources, such as the Aboriginal Friendship centre, to facilitate access to health services.

• Utilize Elders as community resources.

• Develop and build the capacity for health service providers to work with Aboriginal people on and off the reserves.

• Hold a forum with all First Nations health organizations and front-line health workers to clarify what resources are available.

• Aboriginal communities need to control their own health services, as recommended in both the Royal Commission on Aboriginal People and the Kelowna Submissions.

• Implement an identification system on all forms to aid in health care service delivery.

• Increase cooperation between various authorities regarding health delivery.

• The Elders’ yearly conference is a great way to get health information out and to share teachings.

• Build positive educational opportunities in the community through newsletter inserts, contact with the Royal Canadian Mounted Police and other outside agencies.

• Have Aboriginal support workers liaise with Aboriginal and non-Aboriginal professionals.

• Provide an alternative to electronic forms.

• We need full service clinics based in First Nations communities.

• There should be non-segregated clinics that are operated and staffed by Aboriginal people.

• Have a health department specifically for Aboriginal bands.

• Provide health care and support for Aboriginal women working the streets.

• Ideas about culture and traditional medicine:
  • Non-Native people lack of cultural awareness.
  • Traditional practices need to be respected. External Governments need to recognize and support traditional practices.
  • There needs to be more recognition of traditional medicines, teachings, healing and culture. Learning and respect leads to patience, compassion and understanding.
  • Use traditional medicines.
  • Traditional healers and methods need to be accepted politically and professionally so they can be structured to benefit the communities. When acceptance is there, there is structure and then funding flows to the communities.
  • Fund traditional health and spiritual Aboriginal practices.
  • Traditional medicine should be accessible and affordable.
  • Increase the connection between traditional and western medicine.
  • Utilize both allopathic and traditional Aboriginal medicine in the treatment of Aboriginal people.
  • Health professionals need to be sensitive and aware of the communication requirements of Aboriginal people. Informing Aboriginal people through the use of written material is not necessarily effective. Instead, health professionals need to let Aboriginal people take the lead by listening to the anecdotal stories and providing a more interactive environment.
  • Develop an integrated community-based model using best practices and offer culturally-based services involving First Nations using mainstream resources and a professional approach. There needs to be a comprehensive health intervention plan created with a best-outcomes result. Build a continuum of care for Aboriginal people.
  • Have the Aboriginal community design and control their health services and have Aboriginal health professionals deliver these services. This will alleviate the mismatch in terms of the theoretical assumptions and the mechanistic frameworks of health care delivery.
  • There needs to be recognition that First Nations programs are the best. The best programs are run by community members because they also provide community role models.
  • There is a lack of education for Canadians around Aboriginal issues and history.
There is a lack of understanding about colonization, oppression and the after effects. Canadians need to see First Nations people as Canadians. First Nations people need to understand that they have rights and a voice in the hospital.

- **Ideas about health professionals and treatment:**
  - The level and quality service prior to the treaty being signed must be restored which includes the restoration of key staffing positions in the nursing area as well as substance addictions counselling and public health.
  - First Nations people need to determine what their health needs are and then take ownership and responsibility for meeting those needs.
  - Many First Nations people fear hospitalization. This could be reversed with mutual, sincere respect and compassion.
  - Schedule listening time so doctors and nurses can treat the whole person within their family and cultural context.
  - There is a need for a Center of Excellence for Aboriginals which treats the whole person.
  - Utilize a holistic and client-centred approach when treating Aboriginal people.
  - Provide translators where language is a barrier.
  - Priorities for families with children up to six years of age include a focus on health promotion, disease prevention and the provision of supportive health services.
  - Have professionals who accept welfare and status Aboriginal clients.
  - Have a First Nations person accompany anyone with a disability to the hospital so that no assumptions are made and they receive appropriate care.
  - Create a program where local pharmacists and doctors come into the community to review each person’s medications.
  - Provide medication subsidies to individuals in need.

**Outstanding Questions**

- Why are our First Nations people of British Columbia excluded from proper education regarding alternative medicine which is what these people used as their medicine for thousands of years?
- How do we get the First Nations Leadership Council to support and promote traditional healing?
Health Human Resources

Comments and Concerns

- Health professionals do not want to move to remote Aboriginal communities even though there is a great need for them there.
- Recruitment of health professionals, for example in Bella Coola, is an issue. The demand for health professionals in the larger centers puts pressure on the rural, remote areas because applicants are scarce.
- There is not enough recognition for the nurses that work in Aboriginal settings.
- In order to be effective, health care workers need to have a good rapport and fit well within the First Nations community they are working in.
- It is difficult and frustrating for First Nations people to communicate with doctors.
- There is a need for more Aboriginal health care workers and providers.
- There is a lack of First Nations specialists.
- Provide incentives to get more First Nations people involved in quality health care at the community level.
- There is a lack of Aboriginal presence in health care at all levels, not just in health care professions.
- The cost of nursing school (for First Nations students) for one semester is $1,600 which covers tuition, books and a stethoscope.
- Human resource systems do not always support the hiring of Aboriginal people.
- There is almost no monitoring or accountability of band health staff and programs.
- There are addictions workers who have no training or professional supervision.
- It is difficult to find traditional healers with accepted credibility.
- Other provinces recognize traditional healers and allow them to bill for their services as doctors do. This is not the case in British Columbia.
- Seeing a Native person in a position of authority is healing and gives our children hope.
Ideas and Suggestions

• More recruitment incentives need to be offered to attract and retain qualified health care professionals in rural, remote areas of British Columbia. Doctors, nurses and other health care workers are in short supply. It is necessary for the Government to continue to assist communities in attracting and retaining vital medical personnel by continuing to offer incentives like living allowances and student loan forgiveness. Similarly, the importance of volunteer ambulance attendants has been underestimated by the provincial government. The Government needs to make being an ambulance paramedic worthwhile by giving these hardworking medical professionals a living wage and helping them with the expenses of training. The two dollar an hour pager wage must come to an end.

• Compensate health care workers appropriately.

• Increase the mileage rates paid to health care providers to compensate them for traveling to rural areas.

• Funding should be spent on hiring more health care workers and not on administration.

• Have doctors do their practicums in rural areas.

• Focus on the training of Aboriginal people.

• Make it easier for an Aboriginal person to become educated as a health care professional. Have more openings in doctor’s training programs for minority people in rural British Columbia, for example at the University of Northern British Columbia. Bring health care training to rural communities such as Williams Lake.

• Provide financial incentives such as grants, bursaries and scholarships to Aboriginal people to cover or assist with their health education tuition costs.

• In Aboriginal areas, where the majority of people are Aboriginal, there should be a high percentage of staff who is Aboriginal.

• Develop a mentoring program for traditional healing training.

• Utilize traditional healers to treat the physical, emotional, mental and spiritual health of the people.

• Non-Aboriginal people need education to understand the reality and effects of colonization on Indigenous peoples.

• Teachers, social workers and health care professionals need to be educated in the teachings of our Elders.

• Provide cultural awareness and sensitivity training for all health care professionals and workers. We need to develop the capacity to critically synthesize and
communicate appropriate cultural knowledge to primary health care service providers.

- Cultural awareness training should be taught by Elders because of their wisdom, knowledge and personal experiences.
- Make a video depicting life on the reserves which would include the overcrowding and poverty, the culture and the joy for life.
- Coordinate the networks between health care providers, social workers, school counsellors and agencies.
- Certified Dental Assistants (CDA) are trained and licensed oral health care professionals. They can provide oral health promotion in tobacco cessation, nutrition relating to oral health, pre and post natal oral care and self-care (brushing and flossing), as well as preventive services for under-serviced populations in British Columbia.

Residential Schools

Comments and Concerns

Health and Safety
Life after the Residential School
Mental Health and Addictions
Treatment of Residential School Syndrome

- Comments on health and safety:
  - Residential schools did not care about the physical health of the children. Children were exposed to coal and lead paint. Children performed jobs without proper safety protection which resulted in health issues that include cancer and lung diseases.
  - Vegetables and milk were not provided in residential schools. An inadequate diet provided to Aboriginal children has contributed to the health problems today, including obesity, diabetes and osteoporosis.

- Comments on life after the residential school:
  - Residential school experiences resulted in a lack of trust for the health system, a lack of trust within the community, fear and disempowerment.
  - Aboriginal people have trust issues with authority figures as a result of attending residential schools.
• Hospital experiences can be frightening for Aboriginal people because of previous residential school experiences.

• The residential school experience resulted in the loss of Aboriginals' native languages.

• There is a link between lack of parental skills, as a result of the parent attending a residential school, and mental health and addictions.

• The influence that residential schools had on the parenting skills and child rearing methods of those who attended them needs to be recognized. Parenting skills were lost. Violent and abusive discipline replaced traditional ways that previously included social skills, values, culture, legacy and traditions. Aboriginal people who attended these schools often have difficult issues they are dealing with personally which prevent them from paying attention to their children. The younger generation has to understand or imagine what their parents went through to break the cycle so that it is not repeated.

• Residential school survivors overcompensate for their children.

• The effects from attending residential schools are: not being able or allowed to ask for help; alcohol and drug abuse to cover the psychological pain and a negative influence on raising children.

• Whole families are affected by experiences resulting from residential schools. Compensation is available to children of residential school victims and survivors but is not available for people who have already passed away. The effect of residential schools does not stop in one generation. Direct compensation is not enough because money is needed throughout the whole system to correct these issues. Understanding needs to happen over multi-generations surrounding the issues of the loss of culture and language.

• Aboriginal people who are getting their monetary settlements are afraid of being robbed and beaten.

• Comments on mental health and addictions:

  • Residential school trauma is a multi-generational concern that affects all First Nations communities. There are very few resources available to address this root cause of most of the mental health and addiction concerns in our communities.

  • Residential school trauma was identified as a major cause of mental health and addiction concerns within Aboriginal communities.
The survivors of the sexual, psychological and physical abuse which occurred at the residential schools has often resulted in those individuals requiring treatment and counselling for drug and alcohol addictions and for perpetuating patterns of continuing abuse.

Residential school history and issues affects the mental health of Aboriginal people today.

Children need the love of their parents to grow up properly and to have good mental health. Children in residential schools grew up without their parents and their parent’s love. Suicide can be one of the results of poor mental health.

Residential school compensation payments are not adequate to cover the treatment costs for the mental health issues resulting from attending these schools.

A large portion of the money awarded to Aboriginal people as compensation for the residential school experience goes to the treatment of alcohol and substance abuse but this money does not solve all the problems.

Comments on treatment of residential school syndrome:

Aboriginal people with residential school syndrome are not being diagnosed correctly.

People in residential schools did not have control over their lives. They were made to do things they did not want to do. It is a big issue that will never go away but people need to have the chance to open up.

Clinical counsellors are expensive but much needed to deal with the effects of the trauma of attending residential schools through the generations. If this issue is not addressed now, it will drag on forever and continue the expense into the future.

Ideas and Suggestions

Mental Health and Addictions
Treatment of Residential School Syndrome

Idea about mental health and addictions:

Provide counsellors for Aboriginal people who have experienced residential schools.
• Well-educated facilitators need to be available to come in and work through an individual’s trauma. A broad array of treatments needs to be available for residential school survivors.

• Have people who have recovered from residential schools provide the help and counselling to those who are still struggling to get better.

• Ideas about treatment of residential school syndrome:
  • Traditional healing needs to play a role in helping residential school survivors.
  • Intense spiritual healing is needed for the survivors of residential schools and it needs to be covered by the medical system.
  • Implement a proactive, community-based model to address the complex issues resulting from having attended residential schools.
  • Provide lifetime funding for multi-purpose buildings that house supportive healing journeys and the resources needed to break the cycle of residential school experiences.
  • Have support groups for people to help them rediscover their identity. Increase counselling available for people. Support has to be culturally sensitive and community driven. Find a way to help people relieve their burdens and hurt feelings. Include Elders because they have a spiritual way of communicating. Have a healing circle and centre or meeting place in a community where everybody can feel comfortable.

• Educate children about what happened in residential schools.

• The Chief and Council need to educate their people on how to look after and invest their settlement money properly.

**Mental Health and Addictions**

**Comments and Concerns**

• Mental health and addictions, suicide and schizophrenia are real concerns for Aboriginal people.

• We have so many young people committing suicide because there is no hope. We need to be able to show them that there is a future for all people in British Columbia.

• There is a lack of appropriate services, funding and facilities for youth with mental health and addiction issues.
• There is a lack of preventative services for youth in the area of mental health and addictions.

• There are no mental health programs in the community.

• It is difficult for reserve members to access mental health and addiction services in urban centers because of a lack of transportation.

• The issues of drug and alcohol abuse must be confronted.

• Alcohol related deaths are four to nine times higher for Aboriginal people compared to the general population. Drug induced deaths are 1.7 to 6.9 times higher for Aboriginal people compared to the general population.

• The National Native Alcohol and Drug Abuse Program community health representative is so busy travelling and doing paper work that she is barely able to see patients and do preventative work.

• The problem is how to get valuable health prevention strategies and resources out to the hard to reach groups, including aboriginal communities and people with mental health and addiction issues.

**Ideas and Suggestions**

• Create a model and health portfolio for engaging people with concurrent mental health and addiction issues.

• Provide a continuum of care system that includes outreach service, emergency services, short-term care, long-term care, home support and ongoing counselling and family services for people with addictions and mental health issues.

• Establish a mental health and addictions pathway for First Nations people and Aboriginals at all levels of health care. Engage the families.

• There is a need to provide training and education for the family on what to expect and how to help a relative returning from treatment for addictions.

• Elders can teach people and provide role modelling.

• Grandmothers are the spiritual health healers and can help youth with their problems.

• We need our Elders to teach our children about spirituality, language, alcohol, drugs and cultural history to steer them in the right direction.

• Focus on treatment now and then move to prevention. We need to take a multi-faceted approach to counteract drug use and misuse.
• Need proactive, long-term and ongoing follow-up and funding for mental health and addictions.

• We need ongoing resources, support and funding to decrease the prevalence of drug use.

• Have the Province invest some funding for mental health and addictions programs on the reserves to complement their existing services and allow communities to benefit from having complete community services.

• Fund crisis intervention for suicide and depression.

• We know in British Columbia that self-determination of health services saves lives. There was a study in the Province that indicated that youth suicide was actually reduced in those communities that self-determine. It is recognizing Aboriginal people in a fundamental way because they are people first.

• Banish the drug dealers.

• Promote physical activity, sports and recreation.

• Involvement in recreation and physical activity equals suicide prevention.

• Provide education on the prevention of mental health and addition issues.

• Mental health and addiction treatment programs need to be tailored to the cultural of Aboriginal people.

• There needs to be treatment facilities where there is a cultural understanding and emphasis such as remote, longhouse style treatment facilities and residential care.

• Have Aboriginal critical-incident response teams. Provide outreach programs for youth and have them recruit their peers to help. Put on plays for students which deal with suicide. Build self-esteem from an early age.

• Provide mobile health professionals and services for people with mental health and addiction issues.

• There is a need for First Nations trainers for programs on suicide prevention. Provide core funding to ensure we do not lose any more of our children to suicide.

• Provide a place for people with addictions to go to ensure there is a separation from temptations. For example, a wilderness program where the people live off the land in the wilderness for a 28 day period.

• Implement the Addictions and Mental Health Report from Carrier Sekani Family Service.

• Establish a 24 hours a day, seven days a week health clinic in the downtown where the police can take people they have picked up who have drug or alcohol problems.
• Implement strategies to increase counselling for pregnant women about substance use during pregnancy.

**Determinants of Health**

**Comments and Concerns**

**Culture**

**Parenting**

**Health Outcomes**

**Socio-economic Status**

**Environment**

**Chronic Diseases**

**Diet**

• Comments on culture:
  • I think we have to recognize that we have failed First Nations people.
  • Dysfunction has become considered normal in First Nations communities.
  • There is a lack of culture being maintained among Aboriginal people.
  • In cities there is isolation, both from the environment and the home, and a lack of understanding. First Nations people that move to big cities lose contact with family and have little to fall back on in times of hopelessness.
  • We should not guilt our young people into our culture. It is each parent’s responsibility to teach culture to their children.
  • Becoming in touch with your culture at any age is healthy.
  • Concerns about racism were raised.

• Comments on parenting and child care:
  • In British Columbia there is a disparity in outcomes for infant mortality rate. First Nations’ infant mortality rate across the Province is approximately two to four times as high as the rest of the population.
  • There are a number of areas where Aboriginal children were diagnosed about ten per cent less frequently than non-Aboriginal children, including cancers, endocrine system conditions and congenital anomalies.
  • Aboriginal people make up seven per cent of the total population in British Columbia, yet 56 per cent of Aboriginal children are in care.
More than one in seven Aboriginal children has been in care at some point in time in their lives. The health outcomes for children in care are especially poor.

Aboriginal children in care will likely remain in care longer and will constitute a higher percentage of children in continuing care in the future.

Twenty per cent of Aboriginal children who are in care of the ministry graduate from school compared to 40 per cent who are cared for by their family.

Aboriginal males, formerly in continuing care, were admitted to hospital for assault-related injuries more than twice as often as non-Aboriginal males, formerly in continuing care, were. The rate was almost three times higher for Aboriginal females than for non-Aboriginal females.

The disconnection of Aboriginal youth in care from their cultural and community roots is a continuing reality that increases the likelihood of their engaging in high-risk activities.

There are no parenting classes for males.

Families used to work and live together as a tighter unit. The grandmother was the core of the family. Everyone in the community helped each other with food gathering and sharing of supplies.

Parenting involves parents, aunts, uncles and the whole community. It takes a whole community to raise a child.

Youth are easily influenced by non-traditional ways. It is difficult to reach the off-reserve youth.

Youth today are the patients of tomorrow. Concerns were expressed about Aboriginal youth smoking, their obesity and their lack of exercise.

Youth are more sexually active at a younger age.

Comments on health outcomes:

The University of Northern British Columbia is home to the National Collaborating Centre for Aboriginal Health which has a mandate to work with Aboriginal communities to enhance their capacity to address their determinants of health.

The gap in health status between British Columbia’s Aboriginal people and other British Columbians spans a long list of indicators, including life expectancy, mortality, youth suicide, infant mortality, diabetes rates and childhood obesity. These poor health outcomes arise from a number of social and environmental factors that are outside the normal purview of Canada’s health care system.
• Health outcomes for Aboriginal populations, both on and off the reserve, are far below average statistics.

• I am optimistic that I will reach the age of 40 shortly but a lot of the friends that I grew up with are not here. This is a reality of our community and not the complaint of another Indian leader talking about injustices.

• First Nations people have a life expectancy that is seven and one half years shorter than the rest of the people in British Columbia.

• The Central Coast of British Columbia has the lowest life expectancy in the entire province with an average life expectancy of 68.5 years compared to 80 years in the rest of British Columbia. People of First Nations descent make up 70 per cent of the population of the Central Coast.

• Less than a year ago, we signed the Transformative Change Accord and we hoped that by November of this year we would have a plan that would raise First Nations people across the province of British Columbia to the same level of health determinants as the rest of British Columbia.

• Our young people are dying at an alarming rate from a whole series of issues that in many ways culminate in suicide, which is absolutely tragic.

• Aboriginal people’s use of residential care in Vancouver is twice as high as the rate for the general population. Hospitalization rates and preventable admissions are equally higher.

• Clear indicators show that Aboriginal people in British Columbia suffer higher rates of disease, including diabetes, addictions and suicides than the rest of British Columbia and Canada.

• There are higher smoking rates for men than women, Aboriginals than non-Aboriginals and in those who live in the northern regions of British Columbia.

• Teenage Aboriginal girls smoke more than any other group today.

• Comments on socio-economic status:

  • Alternative and innovative solutions to close the socio-economic gap between our people and the rest of society cannot be explored before first establishing a base-line of what exists today. Then we can take a ten year planning approach and be able to measure progress with clear indicators.

  • First Nations communities have even less resources today. The poverty that exists in our Aboriginal communities is unacceptable. Economic factors influence the health care of First Nations people.
• There are Aboriginal people that do not have an income and some who cannot
get social assistance. The unemployment rate for Aboriginals is around 14 to 15
per cent as compared to four or five per cent for the rest of British Columbia.

• Federal funds allocated for reserves must go to them but there is not enough
housing on reserves for all Aboriginal people to live there.

• Comments on environment:
  • The appropriation and destruction of Aboriginal land, forests, water and air has
    eroded Indigenous food systems and ways of life.
  • Water in the community is not potable.
  • The sewer and water systems on the reserves are substandard.
  • There is a clear link between health outcomes and broader socio-economic
determinants, including housing, education and general social economic
conditions. Aboriginal communities in both urban and remote, rural areas each
have specific and unique problems.

• Comments on chronic diseases:
  • First Nations people’s rate of diabetes is triple that of the rest of British Columbia.
  • First Nations people have a 400 per cent greater chance of getting Type II
    Diabetes.
  • Our middle aged people are dying in unprecedented numbers from diabetes
    related illnesses such as heart attacks and strokes.
  • Research has shown that there are several attributes that contribute to diabetes,
    which include a high carbohydrate diet of highly processed foods and a sedentary
    lifestyle. The Canada food guide is not well suited to all people. The concept that
    a diet should consist of 55 per cent carbohydrates is not beneficial to Indigenous
    populations that typically have a high rate of Type II Diabetes.
  • AIDS and HIV deaths among Aboriginal people are double those in the rest of
    British Columbia.
  • Human papillomavirus (HPV) vaccine will be particularly important in the
    Aboriginal populations because research indicates that Aboriginal women tend to
    have higher cervical cancer rates than the general female population.
  • It seems that prostate cancer is still a mystery in First Nations communities.
• Comments on diet:
  • The negative effect the change in diet has had on our people has never been recognized.
  • The change from a traditional Aboriginal diet has resulted in diabetes and obesity.
  • The abundance of culturally important foods is declining.
  • Traditional ways of sharing and providing food have been lost.
  • Allergies to seafood do not allow the natural diet needed by Aboriginal people to be followed.
  • Diet is very important for good health. People on welfare cannot afford the proper and necessary food. Aboriginal people are eating Kraft Dinner, hot dogs and white bread because the average Aboriginal person cannot afford fruits and vegetables on their current income.
  • Health Canada’s food guide does not work for us.
  • It is hard to get the right diet for Elders who are dying. For example, Gorge Hospital does not cater to the dietary needs of Aboriginal people.
  • Junk food is given out on reserves.
  • Obesity often equates to poverty.
  • Government laws and policies have affected fishing practices.
  • The centralization of food production in the mainstream culture has resulted in a sedentary lifestyle and decreased access to Indigenous hunting, fishing and gathering sites throughout our traditional territories.

Ideas and Suggestions

Culture
Parenting
Health Outcomes
Socio-Economic Issues
Environment
Chronic Diseases
Diet

• Ideas about culture:
  • Encourage involvement in traditional cultural activities.
• Educate Aboriginal people about the traditional ways to keep oneself whole; physically, mentally and morally. Return to traditional values and lifestyles to regain perspectives on wellness. Take the shame out of the process of learning culture and language.

• Communities need to take responsibility and receive support for revitalizing culture, traditions and language.

• We are the only caretakers of our children and it is our responsibility to care for them. Our youth have the right to the lineage of our ancestors.

• Culture needs to be taught, learned and lived at home and in school.

• We need to examine the philosophy and lifestyle, in terms of how aboriginal communities are living today and to look back at some of the traditional medicines.

• We need education around spiritual, moral, mental and physical health. If we are educated in the ways of our Elders, we are safe. We need to go back to our roots.

• We need the ability and finances for travel to visit and re-establish connections with relatives.

• We need to embrace the Aboriginal communities whose residents believe in slowing down, being with family and traditions. Their beliefs are about a sense of peace, wilderness spaces and the earth which all help to improve health.

• Hope affects our health. We need to instil hope in all Aboriginal people.

• Do culturally relevant, on-reserve education on foetal alcohol syndrome, safe babies, diabetes, hypertension and diet.

• Re-introduce Aboriginal people to their culture.

• Elders could video tape and talk to the grandchildren to preserve historical teachings.

• Implement colonization and de-colonization education in public schools to increase the understanding of how things happened and why. This should take place province-wide and not just for Aboriginals.

• Teach the history and culture of First Nations in school.

• Build community strength that is balanced with western exposure.

• We need a progressive Chief and Council who care about their people.

• Bring traditional beliefs into the school system.
• Ideas about parenting and child care:
  • Social housing and care for children policies that help support the actual needs of children and First Nations families.
  • Partner with the Ministry for Children and Families to be proactive with children in care.
  • Engage in a renewed effort to connect Aboriginal children and youth, in the continuing care of the Government, with their cultural and community roots to enhance their sense of belonging.
  • Strategies for improving outcomes for Aboriginal children and youth in care should focus on enhancing their sense of belonging by engaging the Aboriginal community in the development and implementation of these strategies and by including a cultural component.
  • Provide daycares on reserves.
  • Provide more support for parents when their children are young.
  • Provide earlier assessments, such as vision screening, for Aboriginal children to improve health outcomes.
  • Consider the recommendations from the Rural Aboriginal Maternity Care Project.
  • Improve the quality of care during and following child birth.
  • Return to traditional parenting methods to instil the understanding of traditions. Parenting skills can be learned from Elders.
  • Create a community-based model for Aboriginal health care that focuses on family health promotion: from pre-pregnancy through to birth and after care.
  • Provide parenting classes for males.
  • Enhance healthy parenting through education that addresses mental health, life skills, anger and addictions.
  • Raise our children appropriately to ensure they have high self-esteem.
  • Provide services to all children with special needs.
  • Provide sex education to our youth.

• Ideas about health outcomes:
  • We need to define health for ourselves.
  • Solutions for Aboriginal health problems lie in merging traditional knowledge with modern science. Integrating information on traditional knowledge,
environmental contaminants, food composition, food availability, environmental changes, cultural factors and socio-economics issues will help communities find solutions they can endorse and promote among themselves.

• We need to step up and respond to Aboriginal health needs by reducing health status inequities and focusing on health outcomes. To do this, we have to pay attention to the determinants of health and work with partners involved with those determinants.

• Invest money for proactive and preventative strategies for rural communities or Indigenous organizations, such as Carrier Sekani Family Services, to prove that annual health reports can be changed to improve long-term outcomes.

• Infrastructure is needed to ensure positive health outcomes in isolated areas. Although highways and cell phone coverage may not seem like health care issues, in isolated areas poor roads and lack of cell phone access can decrease health care outcomes. Speed of delivery is one of the most important factors in emergency medicine. Highway 20 needs substantial upgrades and cell service must be made available to residents of that area.

• Ideas about socio-economic issues:
  • Empower people with skills, knowledge and resources to build capacity for bettering their lives.
  • Eliminate the life expectancy gap between Aboriginal and non-Aboriginal people by 2020.
  • Improve access to post secondary education for those from rural remote communities who have the hurdles to overcome, which involve moving from their communities, leaving their families, moving to larger centers with an associated higher cost of living and coping in a world that can be very unfamiliar to them.
  • Promote exercise and physical activity.
  • Quality food, employment, affordable and adequate housing, health services and education are inextricably linked and vital for a healthy community. Healthier economies allow access to better health care.

• Ideas about environment:
  • The Government of British Columbia must prevent the location of toxic, hazardous and atomic production, practice and waste disposal on the lands and areas inhabited by the poor, disenfranchised and First Nations.
  • The Province should take over the responsibility for sewers, water and fire protection on the reserves.
• Ideas about chronic diseases:
  • Focus efforts and funding on chronic disease prevention and community health initiatives to address poor health behaviours.
  • Focus on diabetes prevention, education and resources in the schools and the communities.
  • The higher prevalence of chronic diseases suggest that preventative programs must be targeted at early ages so children can learn how to live a healthy lifestyle that will continue throughout their adult life.
  • Identify Aboriginal people with chronic diseases in the system to ensure they receive extra support and financial assistance for nutritious food and medical transportation.
  • Create and set-up local chronic disease management programs that include prevention, diagnosis, management of treatment and follow-up.
  • Fund or increase funding for diabetes prevention and management.
  • Focus more public education on ovarian cancer.
  • Have the British Columbia Cancer Clinic partner with First Nations groups in the various regions of the province.
  • Increase activities and services that reduce the risk for HIV and AIDS, Hepatitis C and sexually transmitted infections among First Nations people.
  • The Victoria Order of Nurses has recently agreed to a Memorandum of Understanding with the Assembly of First Nations to undertake joint efforts in the development of strategies and initiatives intended to improve the health of First Nations people. Victoria Order of Nurses understands the unique community health needs and social issues of First Nations communities across Canada, such as isolation, determinants of health, access to services on-reserve and the high incidence of diabetes and renal disease. Many of the issues within this submission, specifically health and wellness and chronic disease management are highly relevant in all regions of British Columbia, including Aboriginal communities.

• Ideas about diet:
  • Incorporate natural foods back into the diets of Aboriginal people.
  • Implement nutritious lunch programs in rural and First Nations communities. Provide traditional foods in schools.
  • Promote healthy foods.
- Have healthy foods available at affordable prices.
- Educate people as to what constitutes a healthy diet.
- A combination diet of traditional foods and western foods needs to be looked at.
- Establish community kitchens.
- Provide funding and support for community based, grass roots level, Indigenous food related projects.
- Set aside adequate tracts of land for the protection, conservation and restoration of Indigenous food systems.
- Enhance education and awareness of Indigenous agricultural skills to alleviate the loss of food gathering locations.

**Intergovernmental Cooperation, Governance and Funding Models**

**Comments and Concerns**

- **Governance Models**
  - Inter-Governmental Cooperation
  - Jurisdictional Issues
  - Funding

- Comments on governance models:
  - There is a historic mistrust of the Government of British Columbia by the Aboriginal community that extends back to colonization.
  - Pan-First Nations approach does not work; one size does not fit all. First Nations’ needs in each community are specific and unique.
  - From an Aboriginal perspective, we have gone from the best set of health care programs in the Trudeau era to the worst programs in this country with the current Government.
  - I am also interested in ensuring that we look at this in a complex way so that Aboriginal health does not get marginalized. For example, there is a need for complex thinking concerning outcomes. This province does not do a very good job of measuring Aboriginal health outcomes, so they are only measuring health outcomes of about 50 to 60 per cent of the Aboriginal population to start with.
  - Local bands and First Nations politics often get in the way of good ideas.
Nurses from various bands expressed their concerns about the deterioration in health programs for bands that now directly receive and manage their health funding instead of receiving it through the federal government. The nurses said they were unclear as to whether these bands were receiving the same level of funding as they had before the devolution.

The Nisga’a Valley Health Board was designated immediately following the effective date of the Nisga’a Treaty to be the health services provider and became known as the Nisga’a Valley Health Authority. Over the last six years, health care services progressively deteriorated to the point that it became a crisis during the last fiscal year. During that period, the services had become dismally diminished and of apparently low quality. Seriously disabling staffing turnover was evident and important community health services and facilities began to disappear, particularly in this community.

Indian and Northern Affairs Canada do not cover many health issues and have a limited budget. There are many Aboriginal people in poverty situations that cannot get medical services.

The First Nations Leadership Council, Chiefs and Councils agree that there is a problem and that is why there was the Transformative Change Accord and the Memorandum of Understanding. The reality in our communities is that very little is going well.

First Nations communities throughout Canada continually express widespread dissatisfaction with the quality and quantity of health care services now provided by the First Nations and Inuit Health Branch or Health Canada.

It was recently alleged by First Nations leaders that Canada continually seeks to provide health services to First Nations and Inuit communities by striving to apply only the minimum requirements of the Canada Health Act.

There is an erosion of coverage under Indian Health. Confusion was expressed as to who holds the First Nations health policy.

There is not a lot of action coming out of the Aboriginal reports. Aboriginal health has not been given a chance to do things differently to save taxpayer’s money.

Comments on inter-governmental cooperation:

People who are familiar with policy work will understand the problem of government policy cycles. The Kelowna Accord was signed off but then the federal government changed and the new Government has not followed through on the financial commitment of the previous Government.

There is a perception that there is a lack-of-will to partner with First Nations.
• The goals of the new government-to-government relationship with Aboriginal people of British Columbia are commendable. Victoria Order of Nurses supports the restoration, revitalization and strengthening of First Nations and their communities to improve the circumstances and eliminate the gap in standards of living with other British Columbians.

• Comments on jurisdictional issues:
  • We still have too much confusion over whether an issue should be managed by the federal government, the provincial government or the band. Until we resolve the outstanding issues around land claims and delegation of authorities, we are not in a good place to resolve health issues. There needs to be a meaningful consultation with Aboriginal people to ensure that their voice and a voice from each individual community are heard.
  • There are some realities of jurisdictional issues. The federal government started out by trying to emulate the American Indian Health Service and hired their own doctors, dentists, dental therapists and pharmacists, to provide services to either on-reserve Indian people or to Inuit in the Arctic on the hospital ships. Then they decided this approach was a bad plan and it would be better to rely on the provincial health care infrastructure and somehow integrate the populations for which they were responsible with the provincial health care systems. They started paying health care premiums where premiums already existed for Indians to get services from the provincial health care system. And they contracted with pharmacists, dentists and others to provide non-insured services. That is how these anomalous patterns emerged because the plan was changed mid-stream to save money.
  • Up until recently, First Nations communities had only remote and dysfunctional relationships with the British Columbia Ministry of Health while other British Columbians received abundant medical and health services.
  • There are gaps, duplication of services and a lack of coordination and teamwork between the federal and provincial health systems.
  • It is hard to figure out where one fits in the competing tiers of federal, provincial and Gitxsan Health.
  • There is concern over exactly who is responsible for monitoring finances allocated to First Nations Health locally, provincially and federally, and whether new guidelines are needed.
• Comments on funding First Nations health care:
  • There is not enough money to do what needs to be done. There is a lack of skilled educators to direct the funds. An imposed system of governance interferes with the traditional system of governance. Multiple levels of government and unions create barriers. Demands for programs must be balanced against the costs of running programs.
  • The Government of British Columbia does not distribute money evenly among Aboriginal groups. This money only goes to First Nations people.
  • Concern was expressed about the accountability of both the federal and provincial government in how Aboriginal health is funded and how the funds are allocated.
  • There is a lack of funding for Métis and other Aboriginal groups.
  • When health services were devolved to First Nations the resources were inadequate. The funding formulas are generic and do not take into account the northern and remote issues. The funding formula does include the costs of patient transportation. Formula dictates the number of surgeries that can be performed and that has been cut back.
  • The Government of British Columbia does not give money to the Métis Nation.
  • The federal government only allows a certain amount of spending on medical and dental health care.
  • The issue of lack of funding may be because proposals must be written and submitted before being granted.
  • Provincial and federal funding issues result from a lack of resource sharing and integration of services. When the transfer from federal health services to First Nations communities was made there was less funding for some of the work.
  • Funding is not at the level it is supposed to be. Provincial money going to the Northern Health Authority should go directly to the communities because there is no need to create another bureaucracy.
  • There is no accountability of the bands to the provincial government for money to access programs.
  • As an urban Indian, my band counts me as a per capita for health transfer funds but does not allow me to access it.
There are too many silos and ministries that require funding. No one wants to share resources. There is a lack of communication between ministries regarding funding.

Many First Nations issues are costing both the Government of British Columbia and Canada and the tax payers money because of a lack of cooperation between the federal and provincial governments and the isolated reserves.

Aboriginal people are one of the vulnerable groups. There are many different rules and regulations surrounding funding for Aboriginals. Health Canada and Indian and Northern Affairs Canada pay for certain groups of people in certain locations. These restrictions need to be changed. There is a lack of awareness of what is available and what is covered by Indian and Northern Affairs Canada.

Some provincial cuts in the areas of extended health and dental coverage have really affected the Aboriginal population.

**Ideas and Suggestions**

**Governance Models**

**Jurisdictional Issues**

**Funding**

**First Nations Health Act**

- Ideas about governance models:
  - We need to define our own governance structures.
  - To deal with the inequalities that exist in Aboriginal health you will need an inter-generational commitment of at least 25 years which will extend beyond one political party.
  - An Aboriginal Advisory has been created for First Nations input.
  - Develop a First Nations Global strategic approach to include and respect all things as sacred to sustain the health and well being of all inhabitants of the planet. Teach and embrace the Seven Sacred Values to ensure the future of our children, grandchildren and seven generations into the future. When planning also look seven generations back.
  - In New Zealand’s current strategic Primary Care Program, the Government attempted to build on the general practice organizational developments of the 1990’s by establishing what are called Primary Health Organizations (PHOs). These organizations are capitation funded, require an enrolled population and feature a range of primary care providers. They are governed by provider and
community representatives and aim to provide preventive care and reduce inequalities, especially among the Maori and Pacific people. There has been additional funding to improve services and access, although the cost of this focus on primary care has been around six to seven per cent above current funding. The resulting system, based on Alma Atta principals, has resulted in the development of numerous, exciting initiatives.

- Re-read the Romanow Report.
- Re-visit the Kelowna Accord.
- Communities should manage their own health benefits and services.
- Ensure there is credibility with our own Aboriginal research institutes.
- Bands are capable and should do their own research.
- It is important to support the health component in treaty negotiations.
- Provide legislation to ensure title, rights and equality for First Nations.
- First Nations people should use the same medical system that all of the people in British Columbia use.
- Have provincial, federal and regional government staff available for the people that are connected to and have relationships with Aboriginal communities.

- Ideas about jurisdictional issues:
  - Develop a framework for Aboriginal health that facilitates communication across jurisdictions. The Tripartite Agreement between the chiefs and the Province was a process for communication that worked until the funding ended.
  - Foster cooperation and collaboration between governments and other stakeholders to ensure that Aboriginal care does not remain fragmented.
  - Our leaders have to look back to ensure that the people are following. We have to be proactive, not just reactive. We need to talk about funding and resources and step out of the box to allow the securing of long-term funding. Provide a clear focus on accountabilities and rights among First Nations, federal and provincial governments and health authorities as to who is responsible for what and how and that there be a collective governance.
  - Ensure clear roles and responsibilities are defined for First Nations communities, the Government and health authorities.
  - Collaborate and partner in the development and implementation of tri-party transfer process. Include socio-economic factors to come up with community solutions, including capacity building.
• More conversations are needed with all the stakeholders. First Nations should have a say on the premium paid from the federal government to the Province for health premiums.

• Ideas about funding First Nations health care:
  • Invite the federal government to participate financially as the guarantor of First Nation's health care.
  • Respond to new federal and provincial initiatives and funding to update the Aboriginal Health Plan.
  • Provide a funding formula that will change as the population changes.
  • We need to evaluate delivery and efficiency of federal dollars because over sixty per cent of Aboriginal people do not live on reserves.
  • Money should not be divided by individual and separate pots but provided as a whole for the First Nations to use based on the needs of their communities.
  • There needs to be a clearer understanding of the process involved to apply for funding.
  • Each community and district’s needs should be assessed before being funded.
  • There should be protection from politically motivated cutbacks.
  • Use the Manitoba funding structure for First Nations health.
  • Additional funding is required for Community Health Representatives and the National Native Alcohol and Drug Abuse Program.
  • Start over or review the transfer process with First Nations input and leadership. Roll provincial funding into the transfer process. Renegotiate the overall transfer process including manpower, dollars and the funding formula.
  • Aboriginals should pay for their own health care.
  • Increase the link to the federal government’s Aboriginal Health strategy, which includes the implementation of the Aboriginal Health Transition Fund.
  • The Government must hold organizations on or off reserves accountable for program monies.

• Ideas about a First Nations Health Act:
  • Investigate the possibility of First Nations Health Legislation and a First Nations Health Act. Improve communication between nations, authorities and governments. Create a more practical funding formula that reflects the new economic realities.
• Develop, in consultation with the First Nations people, a First Nations Health Act which would connect to the Treasury Board’s secured core funding resources.

• A First Nations Health Act should be understandable, have a sustainable funding mechanism, have accountability and have practical applications versus academic.

• A First Nations Health Act would provide more credibility. Consider a Transformative Change Accord in preparing a First Nations Health Act. Identify and ensure clear roles and responsibilities.

• Legislation needs to increase choices, entrench sustainable resources, be community driven and recognize tribal boundaries not necessarily Canadian or provincial boundaries.

Elder Care

Comments and Concerns

Elders’ Role in the Community
Elder Abuse
Elder Health and Access to Health Care

• Comments on Elders’ role in the community:
  • One of our most precious resources in our community is our Elders who are the keepers of our histories, our protocols, our traditions and in many cases, the only speakers of our languages. Keeping them well and healthy is very important to us but they seem to be the ones who are leaving us very quickly.
  • Elders help us understand our sense of identity and pride in who we are.

• Comments on Elder Abuse:
  • There is concern for Elder’s social, financial and physical and emotional well-being, especially for those who suffered abuse in residential schools.
  • Elders have a fear of getting old due to concerns surrounding who will care for them coupled with fears of racism, abuse and neglect.
  • There are concerns surrounding Elder abuse and the lack of Elder care resources.
• Comments about Elder health and access to care:
  • Our Elders are passing on at an unprecedented rate from cancer.
  • Challenges faced by seniors affect all areas of health care delivery.
  • It needs to be understood that aging is not a disease.
  • Many of our Elders in our communities are dealing with osteoporosis which adds to our inabilities to care for them.
  • Many seniors are taking a large number of medications.
  • Inflation and the high cost of living leave Elders barely able to manage financially on just their pension cheques.
  • The population is aging across the Province and this includes First Nations people. Clearly, the Government must take action now to ensure that all seniors, including those in Aboriginal communities have access to the support they need now and in the future.
  • There needs to be more funding not cut-backs for Elder care.
  • Staffing and family education are not keeping up with the increasingly complex physical and mental care required by seniors.
  • We need safe, secure and affordable care facilities for Elders and seniors in remote and isolated communities.
  • Lack of proper housing for seniors creates pressure on emergency rooms.
  • Elders living with family members may result in over crowding in the home environment. There are a scarce number of designated home support workers and a lack of relief for caregivers of Elders. Caregiver burnout or illness may result in Elders not being cared for.
  • A high per cent of all medicines used by seniors are used inappropriately which results in more physician visits, emergency room visits, hospitalizations, institutionalized care and death.
  • Elders should not have their access to out-of-town specialists limited.
  • Elders cannot afford to pay for travel costs to receive health care.
  • Elders cannot afford lifeline call buttons.
Ideas and Suggestions

Elders’ Role in the Community
Elder Abuse
Elder Health and Access to Care

- Ideas about Elders’ Role in the Community:
  - Honour what our Elders do for us.
  - Have the First Nations Leadership Council validate Elder’s knowledge of culture, medicine, food and practices.
  - Provide funded day facilities for Elders on the reserves. In Cowichan, the facility for Elders provides traditional lunches twice a week, staff that can communicate in the native language, access to health specialists and activities. The facility has also been really useful and powerful for maintaining and creating intergenerational connections.
  - Build relationships with seniors. Have a mandatory school program with students volunteering in the community with seniors.

- Ideas about Elder Abuse:
  - Hold family members accountable for theft and abuse of Elders in their care.
  - Professionals need to take a firmer stand in cases of abuse and neglect. Provide independent guardianship of Elders to help with their affairs, bills, shopping and money.
  - Elders should be made a priority and have appropriate care.

- Ideas about Elder health and access to care:
  - Increase resources and support for Elders to ensure integrated care plans for inpatient and outpatient seniors.
  - The same system must be in place for all seniors. This means that it is affordable, sustainable and safe, and is a respectful environment which meets the needs of seniors and their families. And above all a system that preserves the dignity of our seniors.
  - Provide culturally relevant care for Elders in facilities on the reserves.
  - Provide education from the ground up to assist Elders with geriatric needs. Educate the chief and council on elder-care. Educate Aboriginal health care workers in other health care fields on geriatric issues.
• Gas, meal, hotel and ferry costs for medical travel should be covered for Elders.

• Reintroduce First Nations people back to the traditional ways instead of relying on prescriptions. Medication may interfere with the spirit.

• We need to increase the monitoring of medications for seniors which will result in savings.

• Increase the number of assisted living beds for seniors.

• Increase respite and adult day care to help seniors taking care of seniors.

• Increase resources to allow Elders to safely stay in their homes.

• Increase the number of home care nurses and train volunteers to perform home assessments.

• Assist home support providers both on and off the reserve.
Seniors

The health care needs of seniors were a frequent topic for discussion in the Conversation on Health. Many of the issues important to seniors, such as long-term care, home care and community care are covered in detail in their own chapters. This section focuses on seniors and their interaction with the health care system. The importance of addressing issues related to the cost of health care, accessibility and service delivery, demands and the quality and safety of care were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of Seniors.

Costs of Health Care

Many seniors are concerned about the costs of health care and maintaining an active lifestyle. Participants worry about losing extended health benefits when they retire and the added costs this entails at a time when their income is declining or fixed. There is concern that extended health insurance is very difficult for seniors to purchase and that without that coverage there are many services and products that they have to pay for. Medical Service Plan premiums and the PharmaCare plan are two areas where costs are seen to be out of line with what seniors can afford. Many seniors feel that they have paid into these programs for their whole working lives and that these costs should not continue to be a burden for them as they age.

Participants suggested it would be less expensive to provide the services seniors require to maintain their health, than to deal with the consequences of not meeting these needs, such as increased demand for acute and long-term care. Seniors are concerned about the costs of transportation and how this expense limits their ability to live active, social lives. Many suggested supporting programs to address transportation expenses, providing access to community centres, increasing social integration, and ensuring seniors eat well as ways to increase the quality of senior’s lives and limit their need for expensive medical care.
Accessibility and Service Delivery

Many participants feel that services for seniors lack continuity and coordination. Some suggested that programs for seniors should be consolidated under one ministry to facilitate access and ensure seamless service delivery. Others suggested that there needs to be a seniors advocate or ombudsman to make recommendations to government about how best to deliver services for seniors and assist them in accessing those programs. Many feel that there is a lack of information about available programs and that too often the information that is available is not in a senior-friendly format. Participants suggested that there should be one phone number that seniors could call to obtain information about all of the available services and programs.

Demands on the Health Care System

Many seniors feel they have unjustly been singled out as a burden on the health care system and that their contribution to the system over the course of their lives is not recognized in the sustainability debate. While it is clear that the population of British Columbia is aging, many participants feel that this factor is not a primary cause of increased health care spending. Others point out that seniors today are living healthier lives than any generation in the past and that this will result in a lower demand on health care services than has been predicted.

We heard about what a problem seniors are, but in fact senior living is no longer characterized by failing health and loss of independence. This generation that is over 65 is healthier and living longer than any previous generation and most older people in British Columbia have active lives and different expectations. Some people call this the ‘new old’.

– Provincial Congress, Vancouver

I suggest you examine how the UK, Australia, New Zealand and other countries organize health care for older people, particularly frail older people. They provide not only medical care at home by primary health care teams but also acute and rehabilitative hospital care specifically designed to meet the complex needs of people with multiple illnesses, mobility, sensory and cognitive impairments.

– Web Dialogue, Victoria
Quality of Care and Patient Safety

The quality of care for seniors was raised as a concern by participants. They worry that some seniors are abused and neglected and feel that there is no authority that is adequately tasked with addressing this issue. Complaints by seniors need to be taken seriously if abuse and neglect are to be eliminated.

Many are concerned that seniors can be negatively affected by excessive and misused prescription medications. They are concerned that there is insufficient control and monitoring of prescription medications for seniors and suggest that pharmacists could be asked to play a greater role in overseeing drug usage. Others believe that there is a need to do more to ensure that senior’s residences are safe and suited to their needs. They feel health authorities should play a bigger role in inspecting homes and ensuring that safety features such as bath bars and non slip stair treads are installed to prevent falls.

Conclusion

Many participants feel that seniors should be treated with greater respect and dignity in the health care system. The perception that seniors are being blamed for increasing health care costs was seen by most as unfair to those whose effort and contributions built the health care system British Columbians are working to sustain. Many participants feel that an emphasis on prevention, improved access and service delivery, and healthy, active living will shift the perception of an aging population from being a burden to being an opportunity to improve the lives of seniors while controlling costs.

I appreciate the need to be realistic, but are we adopting an attitude as a culture that caring for our aged citizens is too expensive? A civilization that makes millionaires of its sports and entertainment heroes but questions whether it can afford to care for the pioneers who made these luxuries possible is troubling.

– Regional Forum, Fort St. John
Seniors

This chapter includes the following topics:

- Funding and Costs
- Demands on the System
- Service Delivery
- Quality of Care and Patient Safety
- Accessibility and Support
- Health Human Resources
- Education and Health Promotion

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

- Presentation to Conversation on Health
  Submitted by the Massage Therapists’ Association of BC
- Addressing the Home Care Nutrition Care Gap in BC
  Submitted by the Dieticians of Canada, BC Region and the Community Nutritionists Council of BC
- Submission to the Conversation on Health
  Submitted by the Certified Dental Assistants of BC
- HEU Submission to BC’s Conversation on Health
  Submitted by the Hospital Employees’ Union

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Wait Lists/Wait times; Long Term Care; Death and Dying; Palliative Care; Euthanasia; Home Care or Support; Community Care; Assisted Living and Persons with Disabilities.
Funding and Costs

Comments and Concerns

Seniors’ incomes, retirement and pensions
Programs and services for seniors

• Comments on seniors’ incomes, retirement and pensions:
  • Expecting seniors to live on $22,000 a year is unrealistic and results in many seniors living in poverty.
  • Seniors on low incomes are over-paying for services.
  • Seniors on low incomes are not accessing services because they believe they need to pay and cannot afford to.
  • Many seniors cannot afford private health care services.
  • People on fixed incomes feel extremely vulnerable, particularly due to the rising costs of goods and services.
  • The loss of benefits with retirement can cause financial hardship.
  • I am 64 years old. In order to stay healthy, I need to continue to be able to eat organic food and supplements. I also need to be able to continue to have access to physiotherapy, acupuncture and massage therapy. This costs money. Yet, the outdated laws on mandatory retirement in British Columbia will force me to retire next year. This will mean a drastic reduction in income. As a result my health will decline. Why not change these outdated laws and allow me to continue to work so that I can take care of myself appropriately?

• Comments on programs and services for seniors:
  • The government of British Columbia is not spending enough money on the health and well being of seniors.
  • A number of programs are being cut that would help keep seniors healthy. Programs that get seniors out of their home prevent them from being isolated, get them out doing exercises and provide valuable outreach services, are being cut because of funding issues.
  • Funding is being found and allocated towards the Olympics, yet little is being extended towards seniors’ health services.
People face difficulties when trying to purchase extended health care coverage at age 65. There is inadequate and misdirected funding and little information available in this area.

The PharmaCare cost-sharing of medications does not work for seniors or for young people (18-30) who cannot afford their medications and most often do not have added private medical plan drug coverage. These people stop taking their medications or drastically reduce them and often end up in emergency.

Hearing aids could be refurbished but are not because the manufacturers want to sell new ones.

In Ontario, the people do not have to make contributions for medical coverage, except for 100 dollars per year to cover prescription charges. How do they manage this?

**Ideas and Suggestions**

**Seniors’ incomes, retirement and pensions**

**Programs and services for seniors**

- Ideas about seniors’ incomes, retirement and pensions:
  - Reinstate benefits after retirement.
  - If seniors have paid income taxes in British Columbia for 20 years they should be given a free bus pass or a ticket to allow them to hire a taxi once a week to shop.
  - Income assistance for low income seniors should be provided to offset the cost of certain aids and treatments, such as hearing and vision aids.
  - The mandatory retirement age is out-dated and should be changed.
  - The pension plan should ensure that seniors have money for food, shelter, physical activity and recreation.
  - British Columbia Medicare premiums are far too high for seniors. Those who are living on a fixed budget need better coverage. The seniors who have been paying into the system for so long need to be better looked after.
  - Society should provide supplemental funding, over and above pensions, for basic medical needs (dental, eye care and socialization).
• Ideas about programs and services for seniors:
  • I think it would save our medical system a lot of money if we could refurbish
    hearing aids, glasses and other medical aids for low-income seniors and others.
  • If services could be provided based on savings to the health plan relative to the
    costs of hospitalization, rather than on their ability to pay, more seniors would be
    likely to access services.
  • Ideally there would be long term funding for a Seniors Resource
    Coordinator/Supervisor in our community who could organize programs for
    seniors at every level in a central location.
  • Offer financial incentives for seniors and pre-seniors for community facilities such
    as gyms and pools.
  • Offer discount bus passes to seniors for transportation.
  • Fund senior’s centers! A healthy body and mind costs little.
  • British Columbia should start a recycling program for health aids for seniors
    (including glasses and hearing aides).
  • Not everyone is covered by a dental plan and not all dental plans are the same,
    but the issue is that seniors who retire often lose the coverage that they had.
    Seniors should be able to put money away in a health spending account
    throughout the course of their lives so they can draw on it once they are retired.
    Health spending accounts should be protected from taxation while people are
    working.
  • There is a need for targeted funding to help seniors get active.
  • Government should introduce a bill to allow seniors to be covered up to 700
    dollars per year every few years in hearing aide expenses.
  • Seniors should have a different cost-of-living index to working people, as their
    needs are different.
  • Seniors should have all medical services paid for.

• Aging is not the problem or the source of the burden on the health care system; it is
  the cost of the last five years of a person’s life that is the problem.

• Governments should acknowledge and recognize that seniors built our province
  and are entitled to priority treatment and respect and should receive priority
  funding over addicts, street people and youth.
• Charge fair and equitable costs for various support and care levels to elderly people who are well-off.

• Review the policies and rules of the Workers’ Compensation Board regarding funding for seniors.

• Drop the health care premiums for seniors just like the Alberta Government did.

• There should be portability of funding, no matter where seniors want to live (home, assisted living or long term care).

• Extra funding should come from Ottawa to finance the flow of the elderly population to the west.

**Demands on the System**

**Comments and Concerns**

• We are part of an aging demographic in British Columbia. Today, about ten per cent of the population is over 65. By the time we get to 2020 or 2026 we will have over 25 per cent aged 65 and over. That is going to impose some major challenges to the health care system. The aging demographic is already posing challenges for us today.

• As our population ages, huge demands are placed on our health care system, both in terms of numbers, cost per capita and cost as people get older and consume larger chunks of health care. People are aging and living longer. People are living ten to 15 years longer than they would have 30 years ago through the advances of technology, new medications and new ways of treating diseases.

• When listening to the news and to discussions about the budget and the deficit in relation to health care, the emphasis is always on the amount spent on caring for the elderly as we are now living longer. It seems like the elderly are being singled out and described as a burden on society.

• Most policies are predicated on the erroneous assumption that seniors have excessive incomes and resources and can cope with cuts and the downloading of medical expenses. In actual fact most seniors have very limited resources.

• The increasing retired population is not typically paying the level of income taxes they once were. British Columbia is the retirement place of choice for many Canadians, who paid health care premiums in other provinces where they lived healthy lives but who are retiring to British Columbia at a time in their lives when they need medical services more than ever.
• The increasing number of elderly residents in British Columbia is not a serious contributor to the demands placed on the health care system.

• I appreciate the need to be realistic, but are we adopting an attitude as a culture that caring for our aged citizens is too expensive? A civilization that makes millionaires of its sports and entertainment heroes but questions whether it can afford to care for the pioneers who made these luxuries possible is troubling.

• Policies like cuts to Pharmacare, home care, de-listing services previously covered by the Medical Services Plan, the closing of public/non profit complex care facilities and the promotion of for profit facilities, the conversion of senior housing to hard-to-house adults housing and the closure of hospitals and contracting out of hospital services are concerning to seniors and advocacy groups.

• The baby boomers may not receive the care they are entitled to as they age, despite paying into the system their entire lives.

• Abortions reduce the younger demographic that could otherwise be brought up to support the elderly in the future.

• Seniors’ lives are no longer characterized by failing health and loss of independence. The generation that is over 65 is healthier and living longer than any previous generation. Seniors in British Columbia have active lives and different expectations. Some people call this the new old.

**Service Delivery**

**Comments and Concerns**

• In British Columbia, when it comes to delivering the broad range of seniors care, we are leaders. We are the model of best practice in this province and that is something that I am very proud of.

• There are age cut-offs for certain types of care or services including surgeries for seniors.

• Seniors are often given lesser priority for acute problems.

• Inadequate dental care can increase malnutrition in seniors.

• Currently there is no assistance offered by the province for those suffering from age related hearing loss.

• Many people, especially vulnerable seniors, have a pervasive fear of the health authorities and are afraid that speaking out might affect their ability to access needed health services in the future.
• Drugs, alcohol, gambling and addictions issues for seniors are not being addressed properly.

• There is a lack of awareness of depression related conditions among seniors.

• A participatory community-based study of the care and support needs and issues of seniors living in the areas of Castlegar and Kootenay Lake found that 88 per cent of seniors needed some or total help with housework, 73 per cent needed help with minor home repairs, one-third needed help with shopping and one-third could not manage these tasks at all. Walking, housekeeping and light gardening as well as exercise programs were identified as sources of activity with 38 per cent wanting to do more physical activity and 43 per cent wanting more social activity. The most common method of transportation was getting a ride with friends or family because taxis are too expensive and the handy dart is too difficult to organize. Doctors’ offices were the most common source of information for seniors regarding care and support services. Pharmacists, local newspapers, family, health brochures and public health units were the next most common sources (the internet and politicians were only used by 14 per cent.) Fifty-four per cent of seniors wished to live in different types of housing while 46 per cent wanted to remain in their homes. 81% indicated that they had a primary care giver (most frequently seniors’ children).

**Ideas and Suggestions**

**Delivery of Specific Programs for Seniors**

**Implementation of Programs for Seniors**

• Ideas about the delivery of specific programs for seniors:
  
  • More social activities and dancing should be available to seniors and people suffering from depression.

  • There should be a drop-in location for seniors to go to talk about mental health problems.

  • Feet are one of the first parts to wear down in the elderly and for them to be healthy in old age they need services that provide foot care.

  • Increase the availability of publicly funded day care programs.

  • Identify and provide programs for seniors with mental health and addictions needs.

  • Institute senior mentorship programs.
• Block watch seniors centres and other community initiatives need to be focussed on seniors so that they are able to live at home.

• Develop programs to support dementia clients.

• Every two years seniors should have access to an Elders tune-up that would include a health check for dentures, glasses, and hearing aids.

• Mobile clinics should be instituted to service apartment buildings with many elderly residents.

• Extend and increase community-based wellness programming for seniors to reduce hospital admissions.

• Expand the provision of a variety of affordable community-based social and recreation programs.

• Increase social programs for seniors who are confined to their homes.

• Registered Massage Therapists (RMTs) assist seniors to meet the many challenges of healthy aging. They can teach seniors how to move and lift to avoid future injury, and how to stabilize themselves to avoid falling.

• The work that the Council of Senior Citizens' Organizations of BC in health literacy, education for seniors on accident and sickness prevention and health promotion, elder abuse awareness, the mature safe diving programs and seniors advocacy is beneficial and more programs like these should be supported.

• Ideas about the implementation of programs for seniors:

  • We need to consider the timing of closure of existing programs, facilities and services, so that the new service provides a seamless continuum of care.

  • There should be no gaps between services and seniors should not be made to feel that they are a financial burden on the system.

  • If fragmentation exists in seniors’ services then coordinate it under one ministry to deal with topics such as geriatric health care and all other seniors’ needs.

  • The Ministry of Health should work with other ministries to ensure supports for seniors are always present.

  • The Ministry of Health should take back control of providing counselling for gambling addictions.

  • There should be a Ministry for Seniors. Resurrect the office of seniors that was under the Ministry of Health. Seniors should participate and be part of the decision-making in government.
• A Planning Board for Older Adults could report to the minister, link to health authorities and service providers, have legislative authority and an ongoing mandate with links to the academic community and research. This board would operate with a certain level of autonomy, would be broadly representative, and would be clearly accountable for the implementation of plans and the distribution of targeted resources for community health.

• Link the primary health care charter with seniors’ health.

• I suggest you examine how the United Kingdom, Australia, New Zealand and other countries organize health care for older people, particularly frail older people. They provide not only medical care at home by primary health care teams but also acute and rehabilitative hospital care specifically designed to meet the complex needs of people with multiple illnesses, mobility, sensory and cognitive impairments.

• One way of engaging older adults is looking at the idea of leaving a legacy. We are all looking at how we can make it a better world for our kids and grand kids. There may be a way of getting them involved with that message.

• There is a need for a new approach to elder care. The elderly should be brought into daycares and schools for the benefit of both young and old.

• The challenge is really integrating a framework for healthy aging, with the life cycle, and the recognition that there are going to be some changes that we all will have to accommodate.

• Stop lumping seniors together. Recognize the different cohorts (65-75, 75-85, 85+) and their needs. Rural communities will require creative solutions. It will not be one size fits all. It is not realistic to expect rural communities to give up their senior population to larger communities for the convenience of bundling health care.

• There is a need for health clinics for seniors, open 24 hours a day and seven days a week and adequately staffed. These could have an effective triage system that could be carried out by a nurse practitioner, in order to avoid emergency visits.

• In England, the Royal Society for Prevention of Accidents has a programme called Amnesty Slippers, where older people living alone are encouraged to give in their old, worn out slippers for brand new ones. I think this would be a good idea for the elderly of British Columbia.

• The Vancouver Island Health Authority should visit buildings containing senior residents to find out from building superintendent what problems exist that can be helped.
• There should be an ombudsman that would help seniors and their families work through the system to find the services that are needed as well as lobbying for those that do not yet exist.

• The elderly should be given a sticker for their wall or fridge with the health line number and their CareCard number on it.

• In Australia there is a Men Shed where men of all ages go. It is somewhere for them to hang out and work on cars, and so on. It is population based, rather than age based.

• The cost of Lifeline Alerts should be covered.

• Learn to take care of elders with respect, dignity and compassion.

• Seniors deserve our respect and compassion. We are not dealing with a commodity to be bartered to the lowest bidder. The strength of a community can be measured by how they take care of and treat their most vulnerable citizens.

• Programs have to be sensitive to the reservations of older adults (for example, some people will not go to a seniors’ centre but prefer to exercise with people of the same age. There should be older adult programs in general and integrated community centres).

• The whole notion of the policy equivalent of population health, where you are engaging the elderly in all aspects of society should be explored. Social inclusion of the elderly is necessary as is prevention, acute care and end of life services, to create a broader framework of which integrated care is a significant part.

• There is a need for a way of monitoring and assessing the health of seniors that is proactive, rather than waiting until crisis. This could be done through home visits.

• In Penticton we have a very active Seniors Computer Club. At present we have well over two hundred members. We also have about 15 volunteer instructors. Using a computer helps keep the mind active and the Provincial Government would do well to establish similar computer clubs across the province to assist in keeping seniors healthy.

• Mills Memorial would like to be involved in physical rehabilitation of the elderly. This initiative would require more space and staffing within the hospital.

• In an area lacking a centralized hospital with trained specialists, referral of seniors to a gerontologist, for a specialized examination, could lessen the number of medical conditions which develop later into medical emergencies.

• There is a need for a geriatric assessment unit in the North.

• Is it time for an "Older Adults Health Care Charter?"
Quality of Care and Patient Safety

Comments and Concerns

Elder Abuse

- Comments on elder abuse:
  - Up to seventy-five per cent of seniors having surgery have permanent cognitive damage afterwards.
  - Families of elderly can push for dramatic interventions against the wishes of the senior.
  - Many seniors have difficulty managing finances and this can result in family members controlling seniors’ money.
  - Seniors are often abused and neglected. This needs to be addressed and reported if suspected. Outreach may be a solution. There is no clear authority for dealing with elder abuse.
  - Seniors overuse prescription pharmaceuticals.
  - Dementia may be a result of medication interaction or over medicating.

- The lack of ability of seniors to select their caregiver is troubling.
- The aging population has poorer health in general due to the high incidence of chronic disease, lifestyle choices and poor nutrition.
- Quality of life does not depend on when you retire. Retirement can be a major cause of disease for seniors. They may have had an active life, and then suddenly have nothing to do.
- Geriatric care quality is a concern and is currently negatively impacted by unions and their work-to-rule regulations.
- There is a need to ensure that communities and centers are age friendly. Depending on where you live, some of the sidewalks are not ideal.
- There is a lot of concern about seniors falling and the costs of that to the health care system.
- Political action by seniors has a long way to go in Canada. They currently have little political influence.
- Is there any constitutional underpinning for a statement on the right of senior citizens to satisfactory general health? Recently a week-long series by CTV (a
television station) included the story of Alice who found herself homeless for the first time at age 70. Do seniors under such conditions have a right to satisfactory general health with a commensurate commitment, duty or obligation by society at large, acting through governments?

**Ideas and Suggestions**

**Elder Abuse**
**Care for Seniors**

- **Ideas about elder abuse:**
  - Encourage seniors to live cooperatively to support each other through taking on advocacy roles for friends and colleagues.
  - There is a need for a seniors’ advocate to act as a liaison between families and seniors.
  - Support senior advocate organizations, social workers, and so on. Hospitals should also have objective seniors’ advocates on staff who are employees of the health authority.
  - Doctors need to take senior’s complaints about verbal threats from family members more seriously.
  - There needs to be a system where concerned people can voice the need for help for a senior who will not ask for help themselves.
  - Create a separate number for phone calls related to complaints of elder abuse.
  - There should be a registry for health care workers convicted of abuse.
  - The Auditor General should look into the abuse of elders.

- **Ideas on how to care for seniors:**
  - Many seniors are over-medicated or suffer from reactions to medication that can lead to hospital admission. Pharmacists should have greater role in overseeing prescriptions and flagging potential problems.
  - Individuals should be monitored to ensure medications are taken correctly.
  - Gel packs of medication which non-medical people can administer at appropriate times would help to avoid accidental overdoses.
  - Seniors could take responsibility to identify and supply data sheets related to their medical history for paramedics and home care workers.
Every human being deserves medical care through their entire life, and families and society should be involved. We should observe and listen to our ethnic and aboriginal community on how they care for their elders.

Listen to the health care providers, we know how to fix the system and move more decision-making into the hands of individuals.

Assist seniors to make home and surroundings safe.

Building code changes are needed to facilitate the installation of bath bars for seniors and disabled and non-slip treads on stairs.

Every room in a hospital should have automatic clock with automatic calendar (wards) to alleviate confusion of people. Clubs should raise money to have this service in the hospitals for the patients.

Seniors are a powerful voting block and should have a louder voice in political issues.

### Accessibility and Support

#### Comments and Concerns

#### Availability of Resources for Seniors

- Comments on availability of resources for seniors:
  - The elderly may be accessing services or using medical system for social reasons.
  - There is little information available to seniors on how to navigate the system.
  - There is a lack of advocacy resources for seniors.
  - Today’s culture is youth-based: seniors are frequently marginalized.
  - Isolated rural retirement communities in British Columbia do not have many services for seniors.
  - There is often no one to explain technological situations to seniors (such as problems with the telephone company, and so on) and there is a lack of accessible information on services.
  - There are not enough handy dart buses and passengers are often not secured properly.
• Most people are not prepared for aging. Since the Government has cut funding to community resources, seniors no longer know where resources are in the community.

• HandyDart services are available and provide a good service. The drivers are friendly and as it can also carry patients in heavy Cuts to federally funded computer training programs have made it difficult for seniors who want to learn how to access web-based information.

• Travel to appointments can be difficult for seniors, particularly for those who live in rural areas and have to travel in the winter

• The National Council on Aging out of Washington has created an age-friendly facility locator. We have about 2,500 facilities on it that have met the criteria of being age friendly. We have a 13 to 16 page application form for facilities. It defines what an age-friendly wellness centre is. They are creating a database, defining what makes a park age-friendly, and so on. This provides more information on access and more best practices for the professionals to create the environments that become more welcoming.

• It can be difficult for older people to stay in smaller rural communities.

• The senior health care has improved a considerable amount since the Interior Health has been developed in Cranbrook and the surrounding area.

• Hospitals in small towns such as Princeton might not be fiscally efficient, but they are important for seniors. Seniors are moving to bigger areas in droves, only to be closer to a hospital.

• It appears that our most vulnerable citizens are suffering the most and are the least likely to fight back or demand the service they require. This is probably due to their vulnerability and inability to ask for help, sometimes as a result of their deteriorating health.

• For elderly people, the cost of travel to doctors can be high.

• Many seniors may do not see themselves as at risk and therefore they may not want to access outreach services.

• Seniors care does not receive media attention.

• For seniors, a one-size-fits-all approach does not work from a physical, cultural or socio-economic perspective.

• In Australia there is a Men Shed where men of all ages go. It is somewhere for them to hang out and work on cars, and so on. It is population based, rather than age based.
• My semi-retired father is currently only able to eat soup or other mashed foods due to the fact that he has lost all but two or three of his teeth. As the current medical system stands there is no support to remedy this problem. With the bare bones pension my parents currently live on, he can have all his teeth pulled within a hospital but will then be left with no means of eating as dentures are not considered a necessity within our health care system. However, the system will cover the inevitable intravenous life support and bed-stay he and many others can look forward to as a direct result of the lack of financial aid for dental care in the Province.

Ideas and Suggestions

Availability of Resources for Seniors

Accessible Public Transportation for Seniors

• Ideas about availability of resources for seniors:

  • Information and promotion of seniors’ services is currently very passive and often consists of a bulletin board or a bunch of pamphlets. We need to support a more active interaction between seniors and the organizations and resources that exist to provide them with services.

  • Walk-in clinics should be located near seniors’ facilities.

  • Establish a paid coordinator position to coordinate information about community and health services in regionally and in each community.

  • Encourage the participation of seniors in social and physical activity programs by providing assistance for participation such as buddies to accompany seniors to programs and transportation for seniors to programs.

  • Develop senior-friendly information services (for example, live people versus a recording, provide accommodations for people with hearing, vision or cognitive impairments, and so on).

  • Put together videos of resources for seniors. Teach businesses what they can do for seniors.

  • Create a 24 hour phone line that seniors can call for any problems they encounter. This would also give them someone to call for banking, groceries, trips to the doctor, and so on.

  • Foster the growth of seniors’ communities and mutual support networks.

  • We need more accommodation for seniors, in all levels of accommodation and care models.
Social isolation planning can help seniors to access services. Theoretically what would happen is you would come into a centre and you would be met by a navigator. The navigator would help develop your plan based on three questions: what do you want to do? What is stopping you and how do we get beyond that? What do you think you need? You answer those three questions and then you go off into the social network stream. There, you are assigned a facilitator. And that facilitator asks: who is important in your life? What kind of connections do you have? What kind of support do you need? And they build a social network usually of about ten people that surround you. Some of it could be geared towards helping you do your grocery shopping or your banking. It might involve finding someone to help you get up in the morning or making sure that you get to bed at night or take your medication on time. In this way services are tailored to the specific needs of individuals.

Create a BC Health Guide style book for older adults (who to call for food, rides, access bus, meals on wheels, advance directives, and so on).

There are consultations going on in terms of developing age-friendly communities and the idea of age-friendly communities should become a focus in British Columbia.

Ideas on accessible public transportation for seniors:

- Provide seniors with physical assistance to use public transportation.
- More hours are needed on weekends and evenings for handy dart services. Wait times for pick up are too long.
- Create schedules and routes that consider a senior’s physical strength and endurance and winter and night services that consider increased needs in winter and dark conditions.
- Provide senior friendly public transportation services.
- Develop/expand affordable transportation alternatives for seniors who cannot physically or cognitively use buses.
- Assess streets and sidewalks for wheelchair, walker and scooter accessibility.
- Provide financial support for seniors who need overnight accommodation and transportation to access services.
- Extend seniors’ bus pass program to include handy dart services.
• Raise the profile of seniors and aging.
• Focus on engaging seniors, because many elders feel disenfranchised and tend to suffer from depression.
• Encourage inter-generational activities.
• Talk with seniors to determine the nature of their concerns and needs. Find ways to keep seniors more involved in their community.
• With the idea of a Senior’s Leadership Board seniors’ organizations and frontline workers would be represented, along with academics and researchers and would have the opportunity to take advantage of having a multi-stakeholder group where people are going to be listening to each other and their expertise coming from different perspectives.
• We need to encourage education and improvement around legislation related to seniors policy (such as end of life agreements, wills and so on), and a long-term financial commitment from provincial and federal governments are needed to support standardized and regulated, government services.
• Establish seniors’ health centres next to recreation centres. Support collaboration between health and other community centres and address the fragmentation of services. Establish a volunteers’ program.
• Provide more support services for elders living off reserve.
• Give authority over health care to First Nation governance bodies.
• Design communication tools to assist seniors.
• At 75, my dad will not walk 1,000 feet to the shopping mall if there are not benches along the way for him to stop. He is the stereotype of how people used to think, whereas you now have things like the Seniors’ Olympics on the rise at the other end. The question is: how do we offer the services to fit a diverse group of people’s needs?

Health Human Resources

Concerns and Comments
• There are too few skilled specialists for seniors.
• Some doctors do not want to work with seniors.
• Many doctors do not understand the needs of elderly patients.
• Gerontology will soon be paid less than other branches of medicine, including general practice.

• It can be tough for geriatrics to compete with more glamorous practices.

• For many seniors, seeing a doctor is understood as the only legitimate form of health assistance.

**Ideas and Suggestions**

• There is a need for incentives to attract more professionals into gerontology.

• There is a need for a higher number of life-skill workers, with a skill base geared towards seniors.

• Recruit and attract staff to the senior sector by providing more flexibility regarding job sharing, more casual hours, part-time work, child care packages and work and life integration.

• There should be specialized geriatric teams in hospitals to provide increased skills to manage increased complexity of care.

• Registered Nurses could also be used to better monitor the health of elderly patients that need more frequent consultation, but not necessarily with a doctor.

• There should be a dedicated person at the clinic to track health records and direct follow-up (follow-up for at-risk patients, avoid costs associated with complications, and so on).

• More volunteers are required to help out seniors.

• Provide equitable opportunities for training and compensation for attending training to work with seniors.

• People need better education and support for workers to work with seniors.

• Build exposure to geriatrics through family practice residency.

• More specialized training is needed for HandyDart drivers. More staff are needed on buses to help with wheelchair clients.

• For seniors, a case manager has significant benefits. They provide one point of contact to manage all different services and options and are able to follow patients through the system, so continuity is not lost.
Education and Health Promotion

Comments and Concerns

Seniors’ Health Education

- Comments on seniors’ health education:
  - There are few resources available for elderly people who are concerned about keeping healthy and want limit their need to use the health system in the future. There is little interest in designing healthy living programs specifically for seniors (such as yoga programs).
  - Government branches should work together to lead a strategy for the education of seniors to let them know what is available to them in terms of health services (for those 65 and over). Coordinators should be mandated to take a training course.
  - The best way to provide education is word of mouth because you can spend millions on advertising. You can spend millions on materials but the best way to reach the elderly is word of mouth because that is their traditional way of communicating.
  - The new population of seniors is very educated.
  - We have a lot of information. The BC Recreation and Parks Association did the community consultation on active aging. There are lots of recommendations and lots of promising practices around how to promote active aging. We are incorporating that into a provincial active aging plan that is coming out in October.
  - There is the rural and remote guide that is coming out that particularly identified the benches in rural and remote areas. The Village of Alert Bay is one of our pilot sites and they have commissioned a First Nations contractor and he is creating all these First Nations benches along commuter routes to their Municipal Hall or bingo or wherever. There is lots of guidance that is coming out in this area.
  - Seniors are not taking responsibility for their own health care or taking preventative measures, such as exercise to help them maintain their health.
  - Many seniors have physical afflictions caused by arthritis, lack of exercise or a lack of knowledge of how to exercise. Many of these people need physiotherapy. Many of these people just need exercise, but are afraid because they are not sure what to do or how to get moving again. It can be as simple as a daily walk, but a senior who is
nervous or shaky on his or her feet might not try walking alone. It costs much more to care for a person who is immobile, than it does to keep a person mobile.

- **Why focus on active aging?** This should be a focus for all ages.

- There are five secrets of longevity based on research done on three hotspots of longevity. There were these five factors that they all have in common. It is about the quality of life in those later years. They do not smoke, they put family first, they are physically active every day, they eat the right amount of fruits, vegetables and grains, and they are socially connected.

### Ideas and Suggestions

**Seniors’ Health Education**

**Promoting Seniors’ Fitness**

- Ideas about seniors’ health education:
  - There should be ongoing educational opportunities for seniors.
  - There should be education available on prevention. Seniors should look into what is available
  - Be proactive by educating people about aging the process and what services are available through forums, in house visits or nurse monitoring.
  - We need education programs for physicians on community supports.
  - Create more information networks (for example, through the internet, 1-800 lines, advertising, doctors and others, and seminars).
  - Hold seminars in the work place to educate people on aging and resources in the community.
  - Information should all be accessible in one place, like a brochure, listing all services, specific to the community.
  - Eating healthy is more expensive and time consuming and ways to do this should be taught to seniors through, for example, tips in the newspapers, inserts in checks, bills, and so on. Perhaps programs could be started where seniors could cook together and take home a week’s worth of healthy meals.
  - There is a need for active senior living residences that would teach seniors to be active partners in their health care.
  - Better education is needed for all who deal with seniors.
• Ideas about promoting seniors’ fitness:
  • Dedicate time, place (like a fitness gym) and people who understand the
    physiology of seniors’ bodies to teach seniors how to solve or deal with the
    problems they have individually.
  • People in their 50's and 60's have a different attitude than the previous, older
    generation. They are more active and more interested in participating in their own
    health care. Exercise for this population should be a major focus: make it easier to
    access and cheaper.
  • There should be more encouragement of seniors to maintain a healthy active
    lifestyle and try to maintain their own health rather than be admitted into a long
    term facility.
  • Group rehabilitation and exercise programs provide excellent models of health
    promotion programs geared towards seniors. These include:
    a. Osteofit, a program in Burnaby;
    b. the Healthy Heart program; and
    c. Living with Chronic Disease (a six week program).
  • Concentrate on wellness by partnering health with recreation, community, and so
    on as wellness partners.
  • Being over 80, walking half a mile a day really keeps you feeling healthy.
• We need to focus on the prevention of health issues for seniors.
• Make information senior friendly, understandable and available.
• Once or twice a year, local papers could publish a list of the available services.
• Promote wellness clinics for seniors.
• The increased costs that come with aging can be reduced with comprehensive,
  community-based wellness plans that encourage fitness, education and counselling.
  These programs allow seniors to remain active and independent as long as possible
  and could also help reduce falls.
• If the interest for prevention is there, then seniors should be able to get a yearly
  physical exam. Currently one cannot get a physical at all.
• With sustainability in mind, British Columbia must enhance its promotion of healthy
  aging. While there is a strong lifestyle component to healthy aging, on the medical
  side there is a need for earlier intervention, before conditions become critical or
  chronic.
• Encourage financial planning for seniors.
People with Disabilities

Participants in the Conversation on Health were concerned about the availability and accessibility of services for people with disabilities in British Columbia. The importance of addressing issues related to people with disabilities, including housing, social determinants, and children and families, were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of people with disabilities.

Access to Services and Programs

The majority of participants cited the cost of acquiring help as the primary barrier to accessing services for people with disabilities. Available services are fragmented and limited, with little investment in patient discharge planning or follow-up care. This results in daily activity needs not being met. Other participants expressed concerns that people with disabilities often do not know how or where to find support and that they may be easily deterred.

Participants encourage the Government to work with existing non-profit agencies and civic groups to create more opportunities for people with disabilities through wellness and employment programs. Participants also recommended that the health care system be made more organized and user-friendly, so people with disabilities would be able to access the support they are entitled to. Many agreed there needs to be more adult daycare facilities, including psychiatric daycare, respite care and convalescence support for patients.

…we actually pull the agencies, community… and government together into some physical sites where someone would come in looking for aides and devices and you’d have a navigator function… that actually links you to the appropriate programs where you get the funding and supports, and have an OT [occupational therapist] on site, have a housing advocate on site, have a MEIA [Ministry of Employment and Income Assistance] income support person on site…to provide that linkage and accessibility. So there’s a big interface with the primary care system because they’re doing the assessments, and they may be actually doing the diagnosis and so on, but it’s actually outside of that in terms of delivery.

-Focus Workshop Primary Health Care, Vancouver
Social Determinants

British Columbians spoke out regarding the difficulties people with disabilities face, and put an emphasis on the importance of educating health professionals and the public. Many agreed that disabled people are marginalised, which negatively affects their physical, mental and emotional health. The overall quality of life on long-term disability is low, which serves to further isolate people with disabilities.

Housing and Residential Facilities

Participants feel that British Columbia needs affordable housing, assisted living and complex care facilities in all communities. Many participants expressed concern that disability benefits for the mentally ill are not sufficient to pay for housing and food, and that the Government does not recognize the higher costs of living in different areas of the province. They suggested having group homes with twenty-four hour care for people with disabilities.

Families and Children

Many participants expressed concern that there are inadequate facilities and therapist supports for younger disabled people. Participants asked for more information and resources for families with children who require rehabilitation for a disability, as well as early intervention and assessment programs for Foetal Alcohol Spectrum Disorders (FASD), Attention Deficit Disorder (ADD), autism and other mental illnesses. Some expressed concern that families of disabled children receive minimal funding from the Government for treatment programs, and that the treatment costs are primarily shouldered by the families. For many British Columbians, this means that parents caring for disabled children need increased support and assistance. Participants further recommended that the Government and community provide assistance to people with disabilities and children at risk.

*Early treatment…will help us to recover many children and will save millions of tax dollars in the long-term. It will also drastically improve quality of life for our autistic children, their families and our society!*

- Regional Public Forum Open Space, Surrey
Conclusion

Participants discussed the need for increased acceptance of people with disabilities within the health care system and an increase in core funding for special needs. The majority of participants who explored these issues agreed that people with disabilities should be asked what they want and need from the health care system. Through that consultation, a new system could be built to support people with disabilities.
People with Disabilities

This chapter includes the following topics:

Access to Services and Programs
Social Determinants
Housing
Families and Children

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

Submission to the Conversation on Health
Submitted by the BC Cancer Agency

Related Chapters
Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Long Term Care; Home Care or Support and Community Care.

Access to Services and Programs

Comments and Concerns

Availability and Effectiveness of Services
Funding and Costs of Services

- Comments on the availability and effectiveness of services:
  - People do not have equal access even when we have a universal health care program. Persons with disabilities often do not know how or where to find support, and they may get deterred easily
  - Too many services for the disabled have been eliminated.
  - When there is a shortage of health care professionals, people with complex needs are less likely to be accepted on a doctor's patient load.
The creation of Health Services for Community Living, a province-wide government initiative that provides community nursing and rehabilitation services to adults with intellectual and developmental disabilities has been a successful program.

Available services are fragmented and limited. There is a lack of coordination, follow-up care and discharge planning.

There is a lack of services for persons who are deaf or hard of hearing, and for persons for whom English is a second language.

Victoria has nothing to accommodate the spinal cord injury quadriplegic.

There are annual transit passes available for those with disabilities.

When a person with a disability is given a tool to address their problem but not given instruction or support, that tool becomes ineffective.

When people who are deaf receive chemotherapy they should have the option to receive it intravenously on other parts of their body because their hands and arms are their means of communication.

The health care system uses a disease model to deal with disabilities.

Coordinating transfer of care needs to be more effective and efficient.

Many disabled persons are dependant on the transit system and do not qualify for HandyDART.

Seniors or persons with disabilities often do not feel they are an equal partner with their health professional.

The criteria for disability benefits does not include going through detoxification, depression or short-term illness.

Comments on the funding and costs of services:

Canadians with disabilities cite the cost of getting help as their primary barrier to accessing services.

British Columbia spends 4.3 billion dollars on persons with disabilities. The province offers a lot of services, but we do not access those services properly.

There is a lack of financial commitment to comprehensive support and services, such as HandyDART.

The Canada Pension Plan is not a full solution for disability funding.

Welfare and disability rates are too low.
Ideas and Suggestions

Availability and Effectiveness of Services
Funding and Costs of Services

- Ideas about the availability and effectiveness of services
  - The health care system needs to be more accepting of people with disabilities.
  - There needs to be more care available for the physically and mentally disabled. A new system should be built to develop supports for persons with disabilities.
  - Persons with disabilities should be asked for their input on what they want and need from the healthcare system.
  - Professionals need to listen to what people with disabilities require rather than just telling them what they need.
  - The health care system needs to be more organized and more user-friendly, so persons with disabilities are able to access the support they are entitled to.
  - Long-term disability patients should only have to apply once for government programs, but remain responsible to notify government of any changes.
  - There needs to be physiotherapy recovery centres all over British Columbia.
  - We need to create more opportunities for disabled to participate in wellness programs.
  - There are some pilot interpretation projects at some hospitals; however, these should be increased.
  - There should be a modified care facility created for those in their forties and fifties and unable to function in society.
  - There should be centres where the various agencies, community services and government come together into locations where someone could find assistance. There could be a navigator, whose function would be to link appropriate programs, funding and supports. There could also be a housing advocate and a Ministry of Employment and Income Assistance income support person on-site to provide linkage and accessibility.
  - There needs to be more adult daycare facilities, including psychiatric daycare, respite care and convalescence support for patients.
  - Better transportation programs are needed for those with disabilities.
  - Livestock therapy for disabled individuals should be readily available.
• Physicians should not be able to opt out because a patient is on assistance.

• Health care programs should put pressure on city councils to enforce handicapped parking regulations.

• Ideas about the funding and costs of services
  • It is paramount that there is special funding for special needs.
  • The government should work together with existing non-profit agencies and civic groups (for example, Vancouver Access and Inclusion Advisory Centre) to address disabilities.
  • The government should provide core funding to social service agencies and increase contact levels to allow them to keep high quality counsellors and administrators.

**Outstanding Questions**

• Do we provide the right service for the person at the right time?

**Social Determinants**

**Comments and Concerns**

• People are speaking out more about the problems that people with disabilities face.

• Quality of life on long-term disability is low.

• Living a healthy lifestyle is difficult, especially for the physically disabled.

• A social network for those with disabilities is very important.

• To a certain degree disabled persons are marginalised, which then affects physical, mental and emotional health.

• Education of the public and professionals is important for people with disabilities to obtain respect.

• Not all disabled people are the same. There are many that are mobile, with limitations and/or assistive devices.
• We have over three hundred thousand disabled British Columbians and the vast majority of them would love to work. There may be little difference in the education levels between disabled people and the general population. Yet, there are thousands of people in the province who are unable to get a job.

• Most small employers will not consider hiring a person with a disability.

• The provincial Ministry of Employment and Income Assistance bureaucracy creates marginalisation and isolation for the disabled.

• Many people don't want to admit that they've got a problem, and there is a certain amount of pride with that. They may be afraid to ask for help with daily tasks, such as shopping for household items.

**Ideas and Suggestions**

• Vulnerable populations need to be considered if there is going to be equity.

• Enable people with disabilities to participate in environmental movements and get exercise by adapting sporting equipment to their needs and abilities. For example, a customised bicycle.

• Permit disabled persons to use their annual transit pass in order to get other discounts, since their income is less than seniors' income.

**Housing**

**Comments and Concerns**

• Disability benefits for the mentally ill are not sufficient for housing and food, and do not recognize the higher cost of living different areas of the province.

• There is too little affordable housing.

• There is a need for assisted living and complex care facilities in all communities.

• Affordable housing is especially important for families that have one or more member with a disability. Without supportive families, the costs to the government for people with disabilities to live independently would rise drastically.
Ideas and Suggestions

• We should have group homes with twenty-four hour care for the paraplegic, quadriplegic and other persons with disabilities.

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Families and Children

Comments and Concerns

• Some families are able to finance treatment (at personal sacrifice), but many cannot. This imposes a terrible financial burden on families to ensure their children have the treatment that is necessary for them to live productive lives. These children may be destined for life-long institutional care with additional costs and a low quality of life.

• Families of autistic children get minimal funding from government for treatment programs. Children who have early intensive treatment have a nearly fifty percent chance of recovery. Those who go untreated may end up in life-long institutional care, which is very costly.

• Autism is a medical and developmental disorder and treatment costs should not be shouldered by families.

• Applied Behaviour Analysis therapy for Autism does work.

• Families are able to choose care providers that are right for their children.

• There is a lack of facilities for younger population of disabled persons.

• There is an inadequate number of occupational and physiotherapist supports for children and adults with disabilities.

• There is accountability and parents are able to be directly involved in their children's programs.

• Parents require support and assistance when caring for special needs children.
Ideas and Suggestions

• There needs to be early intervention programs for Foetal Alcohol Spectrum Disorders, Attention Deficit Disorder and other mental illnesses.

• Early treatment (with full funding, like is provided in Alberta) will help us to assist many children and will save millions of tax dollars in the long-term. It will also drastically improve quality of life for our autistic children, their families and our society.

• There needs to be better assessments for children who have Foetal Alcohol Syndrome and ongoing assessments for those children when they become adults. Supports should be made available.

• Integrate and increase occupational and physiotherapist supports for children (early and middle years) and adults with developmental disabilities.

• There needs to be more information and resources available for families with children who need rehabilitation for a disability.

• Give support to families who are caring for a severely handicapped person.

• The government and community should provide assistance to people with disabilities and children at risk.

• De-institutionalize people with developmental disabilities.

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Part II: Envisioning a Strong and Sustainable System of Care

Participants were passionate about debating the merits of the current health care system, its challenges and what we need to do to ensure that it is there for our children and grand-children. In this section of the report, you will read some of the ideas and concerns of participants around their vision of a strong and sustainable system of care, which includes:

- Developing a strong vision and framework for health and health care;
- Managing access to the system in an equitable way that achieves optimal health outcomes;
- Creating an accountable and transparent system of health care;
- Re-thinking the primary care system;
- Empowering patients to choose care that is equitable, safe and appropriate; and,
- Encouraging collaboration and innovation within the health care system to support positive patient outcomes.

In this section:

- Health Care Models
- Collaboration in the System
- Canada Health Act and its Principles
- Public Private Debate
- Primary Health Care
- Governance and Accountability
- Innovation and Efficiency
- Information Technology, E-Health and Electronic Health Records
- Health Financing
- Health Care Spending
- Medical Services Plan
- PharmaCare
- Access
- Wait-lists and Wait-times
Part II: Summary of Input on the Conversation on Health

Patient Safety
Rural Health Care
Community-Based Care
Home Care and Support
Residential Care and Assisted Living
Death and Dying
Palliative Care
Assisted Suicide
Mental Health
Mental Health Facilities and De-Institutionalization
Addictions
Health Care Models

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

Health Care System Visions

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

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

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

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

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

- Email, White Rock

Assessing the Health Care System

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

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

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

- Provincial Congress, Vancouver

Change Management and Innovation

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

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

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

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

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

- Email, Summerland

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

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

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

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

- Focused Workshop on Health Human Resources, Vancouver

**Patient-Centred Care**

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

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

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

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

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

- International Symposium, Vancouver

Conclusion

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

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

- International Symposium, Vancouver
Health Care Models

This chapter contains the following topics:

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

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## Related Electronic Written Submissions

(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

| Submission to BC’s Conversation on Health | Submitted by the Hospital Employees’ Union |
| Submission to the BC Conversation on Health | Submitted by Victorian Order of Nurses for Canada |
| Submission to the Conversation on Health | Submitted by the BC Nurses’ Union |
| BC Conversation on Health A Partnership…. for Health Care or Wealth Care | Submitted by the British Columbia Chiropractic Association |
| Shaping Health in BC – Observations and Suggestions | Submitted by Pacific Health and Development Sciences |
| Recommendations for Better Health Care: Eye and Vision Care Services in British Columbia | Submitted by the British Columbia Association of Optometrists |
| Submission to the British Columbian Conversation on Health | Submitted by Life Sciences British Columbia |
| A Submission to the Conversation on Health | Submitted by the Canadian Cancer Society |
| Maximizing Value for Health Care Investments | Submitted by ABBOTT |
| British Columbia’s Conversation on Health | Submitted by GlaxoSmithKline |
| Governance and Accountability in Health Services Delivery: A Submission to the BC Conversations on Healthcare | Submitted by Tim Lynch |
| Re-organization of Health Care | Submitted by John Living |
| Conversation on Health: My Views | Submitted by Nancy Kenyon |

## Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Governance and Accountability; Innovation and Efficiency; Health Spending and Public Private Debate.
Health Care System Visions

Comments and Concerns

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

- Comments on health care vision and values:
  
  - Health is both a complex social goal and a major enterprise in Canada, based now primarily in the public sector. While compassion and human rights lie at its base, there is also a need to see it in terms of social and economic benefits for whole populations. The United Nations links health to human rights, as in the World Health Organization’s constitution: "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..." However, the World Health Organization also promotes utilitarian concepts of health which portrays it as an investment, that is, health as a resource for everyday living and health as an ultimate purpose and outcome of society’s economic pursuits. No society anywhere has achieved health with equity without investing substantial amounts from public expenditures; virtually all nations failing to meet this human right are demonstrably deficient in related areas of public policy and financing.
  
  - The ideal role would be to keep people healthy as the first priority. The current cut and paste strategy of drugging and slicing our way to good health is not working.
  
  - The public equates health care with hospitals.
  
  - The Province has a great vision and leads Canada in innovative thinking.
  
  - Government only thinks in terms of election timelines. In health care, we need an incentive to change to longer term visions and plans.
  
  - There should be a national perspective on health care to determine the vision and to identify sustainability concerns.
  
  - What values do British Columbians hold related to health and health care? These should be reflected in the health care system vision.
  
  - The British Columbia College of Family Physicians looks forward to being a partner with the Ministry of Health, Health Authorities, educational and licensing bodies and other professional disciplines in further developing a robust, efficient, effective, equitable, engaged health system.
• You need to focus on planning for 3, 5, 7, and 10 years out, and not simply on the period from election to election. We are preoccupied about the 5,000 beds and quite frankly that is not the right question to be asking. It is a political question, but it is not the right question from a planning point of view.

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

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

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

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

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

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

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

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

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

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

Comments on universal public health care:

Universal health care was not designed to cover all technical advancements and the numbers of seniors with which we are faced.

And, of course, I do not need to speak about our neighbours in the United States where every thirty seconds, someone files for bankruptcy due to serious health problems.

There is a lack of commitment to public health care by the Ministry.

The health care system cannot be coercive: we need to let people make their own choices. But all people regardless of age, gender or income will have to have the same rights, freedoms and choices.

What is the definition of a Canadian? It is an unarmed American with health care. I do think Canadians value that and I suspect they will demand more, and will continue to support a universally funded, universally administered health care system.

Medicare provides lower business costs and avoids health care bankruptcies, which benefits the economy. It ensures equality.

Fiscal considerations must not be allowed to stampede us into making changes to a comprehensive, almost universal, almost portable, accessible and publicly administered health system which works pretty well and only needs to be rounded out. A major rounding out I support, would be the inclusion of pharmaceuticals to some extent. Another would be the integration of mental health services more successfully into the general health portfolio.
• Comments on illness or wellness orientation of the system:
  
  • The current paradigm is a disease paradigm.
  
  • The current health care system is blindly and disastrousely skewed toward allopathic medicine, encompassing extremely expensive medical technologies, expensive invasive procedures, and extremely expensive pharmaceuticals which in a very significant number of cases result in the patient not being healed as advertised or in fact creating worse health conditions for that person.
  
  • The system is illness-oriented and should be focused on wellness.
  
  • We tend to treat symptoms rather than the underlying causes of disease.

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

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

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

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

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

Ideas and Suggestions

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

Ideas about health care vision and values:

- We have to shift from the current system to a future system that will use extensive bio-monitoring instead of episodic testing. It will emphasize education and coaching. Evidence-based decisions are the rule with electronic information flowing freely. Care is customized and the patient and family are active participants.

- I see the future role of our health system would be to provide every person with an equal right to appropriate health care, not just adequate, which is the case now.

- We need to come to the realization that health care is a necessity not a luxury. The health of the citizenry is a responsibility of the Government. It is the Government's responsibility to ensure that its citizens have clean air to breathe, clean water to drink, nutritious food to eat, adequate shelter for the climate and access to medical care on demand.
The health care system needs to be re-designed according to the World Health Organization recommendations that three levels of health care exist. The first is where patients see low-level trained people, such as dieticians, kinesiologists and paramedical personnel for screening tests and simple health recommendations, and so on. In the second level come highly trained practitioners such as chiropractors, nurse practitioners, naturopaths, acupuncturists, and so on, who can deal with the majority of problems people face in a safe and inexpensive manner. In the third level patients see physicians. This only occurs in acute emergencies, or when there are problems that are not responsive to other treatment modalities. This will create a sustainable health care system that will benefit everyone including physicians, who are trained to deal with acute problems and not trained to deal with most chronic problems or most musculoskeletal problems.

- We need a paradigm shift to a preventative, qualitative, holistic approach which values all aspects of health to prevent a real crisis of sustainability.
- We do not believe there is a crisis but in order to have a healthier system we value a preventative, holistic approach which respects all aspects of health.
- We need a system anyone can access with no barriers.
- We need a product-line approach, including more macro managing of the system.
- Move outside the realm of allopathic medicine into the accommodation of a hierarchy of care. People need to be able to afford alternatives.
- We need a patient centered, integrated health care system, including alternative and complementary medicine.
- Government has to listen and learn that we need an economically, socially, environmentally-sustainable community-driven, publicly-funded, publicly administered and delivered, not-for-profit, wellness-focused system.
- We need the provision of culturally sensitive care for Aboriginal people.
- We need a health care system that can provide basic care, prevention, health promotion and accessibility within a set budget, allowing for differences.
- It is crucial to attempt to envision the long-term future. Focus on creating inexpensive medical technologies that can be self-administered. Envision a way in which not just Canada but the entire world can have good health care. Empower the poor worldwide to manage and finance their own health care.
- Look to other jurisdictions for improvements in delivery. British Columbia has a diverse geography, so one solution may not work for all parts of the Province. A management team could undertake this study.
• Model the system after the National health care system of the Netherlands, where hospitals, clinics doctors and insurance companies are all privately owned and operated and may compete on price.

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

• There should be an overarching framework for health care.

• Focus on community care rather than acute care.

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

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

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

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

• There should be equitable service and open access.

• Improve cultural sensitivities within the system.

• Extend the medical system to include mental health.

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

• We require stronger federal and provincial coordination.

• Remove doctors from the apex of decision-making.

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

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

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

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

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

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

Restore and enhance preventative home support services.

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

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

Increase housing and income support for vulnerable populations.

Support the development of a national drug formulary.

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

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

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

Ideas about a holistic and client-centred approach to health care:

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

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

- Train physicians in the client-centric model.

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

- Publicly fund the development of health care infrastructure.

- Increase public investment in new post-secondary health care programs and in innovative projects to better utilize the existing health care workforce.

- Ideas about the illness and wellness orientation of the system:
  - We must focus on root causes of symptoms including poverty, mental health, and domestic issues.

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

  - Change from an illness model to a wellness model.

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

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

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

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

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

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

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

• The provincial government should increase supports for all mothers.

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

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

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

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

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

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

• Establish more community clinics.

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

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

**Outstanding Questions**

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

Comments and Concerns

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

• We need to manage client expectations.

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

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

• This is a good system which is sometimes abused.

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

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

• The care, once received is very good.

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

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

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

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

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

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

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

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

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

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

• Comments on Cuba:
  • I wouldn't want to live in Cuba and be attempting to practice free speech, but if I had to get primary care for what looks like $125 total spending per capita and have a pretty long life span, I would go to Cuba. It is a remarkable health achievement on value for money grounds.
  • I strongly recommend that the Cuban system be studied. It is my understanding that their universal system, at a cost of around $ 600.00 per person per year, yields a life expectancy only slightly lower than that of the United States.

• Comments on the American system:
  • There are a multitude of systems around the world that demonstrate that better care can be delivered at a lower cost. The worst example of the opposite is that land to the south that is often trumpeted as a beacon in health care delivery. I have worked as a physician in the United States for several years and when health became a personal issue I returned to Canada.
  • The Health Maintenance Organizations (HMOs) are expensive, bureaucratic, and inefficient and certainly offer no solution for Canadians.
  • In Canada, if a doctor finds melanoma, a surgeon cuts it out, then lets it heal for six weeks, then cuts out a bigger piece of the same area just to be sure. In the United States, if a doctor finds melanoma, a surgeon cuts it out, then lets it heal for 12 weeks, then sends you to the nearest bio-med lab for an ELISA TA90 blood test. If the blood test comes back positive, they do the second operation. If it comes back negative, no more operations unless a future test comes back positive.
  • I have an acquaintance in Seattle who had an injury and received a Medical Resonance Imaging (MRI) within a few days. In Canada we are educated to believe that our health care system is superior to the United States. Is it?
  • Some people are finally recognizing options other than the United States model.
  • The absolutely poor, via Medicaid, and the very wealthy, via their own funds, are the only ones with decent coverage in the American health care system.
As a person who grew up in the United States with many family and friendship ties to that country, I know with certainty that Canada's public health care system is the envy of a vast number of Americans.

Comments on Asia-Pacific examples:

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

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

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

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

- Comments on European systems:
  
  - It would appear that the present European models provide perfectly good examples of what we need to adopt in the way of health care. They have no waiting lists and cost no more per capita than our present system. In addition everyone still has access to their medical systems and there are no ongoing arguments about private versus public resources being used to meet the need.
  
  - The often cited mixed European models that provide better delivery at lower cost to the tax-payers are a myth for those un-informed. There, the very systems (Sweden and France) touted as solutions (because they happen to have some private hospitals) spend a considerable deal more from the public purse than we do. If these are served as best in the field, we should be increasing taxpayer funded health care options and not decreasing them. The reverse is simply illogical.
  
  - We should move in the direction of a European system as soon as possible and leave the pitiful ranks of the few countries that make it illegal for their citizens to seek health care outside of the government system (Canada, North Korea and Cuba).
  
  - I think our distance from Europe shelters us from the reality of their medical systems. Their systems are not perfect either and you rarely hear all the complaining when you live in Canada. When I lived in England for four months, people were constantly complaining about their mixed health care system and the news was full of stories about screw-ups, high costs, and waiting lists for procedures.
  
  - The National Health System: while the system is state, the standards are state, the money is state, increasingly, we are willing to use private providers where that makes sense. And by providers, I do not mean private insurance, but private providers who will do particular services, provided they meet our quality standards at our prices, and they are willing to share information and be part of our information systems and so on.
  
  - The United Kingdom model is destroying the National Health Care System there.
  
  - Not all doctors are happy with the changes in the United Kingdom because there are specialists surgeons who are out of work because they have no patients to operate on. But in general, the British Medical Association has supported it.
The best health care system I have seen so far is the Swiss system. In terms of total expenditure on health care, Canadians spend almost as much as the Swiss do, yet the quality is nowhere near theirs. As a matter of fact, the Swiss government does not spend as much. The difference is in the private and public combination.

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

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

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

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

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

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

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

Comments on other health care reports:

- The Romanow Report was a biased work arguing from a foregone conclusion. It put forth all kinds of tempting services without any realistic ways of paying for them.
- I am disgusted with Romanow report as it only advised throwing money at the system and did not advise any system changes.

Comments on comparing other systems:

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

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

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

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

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

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

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

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

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

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

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

### Ideas and Suggestions

**State of the Health Care System**

**Comparing to Other Systems**

**Other Health Care Reports**

**Information**

- Ideas about the state of the system in British Columbia and Canada:
  - We owe it to our fore-bearers and to ourselves to try and inventory what we do well and what we do less well. Look at the achievements of the existing system. The Canadian system is different from any other system in being focused on hospitals and doctors.
• Hire an outside consultant (non-government) to review the current system.

• We need to look more creatively at how we deliver health care, who delivers health care, where we deliver health care and the role of the patient.

• I think we need to do this on a province by province basis. I think each province is going to be completely different from other provinces. The solutions that may work in British Columbia, may not work in Quebec. And something that might work in Alberta is not necessarily going to work in Ontario.

• We need more understanding about cultural differences and its effects on health.

• A gender-based analysis needs to be built into the system itself, as a means of working towards women’s equality.

• A publicly funded insurance plan covering medicines as well as all the components of health is the only real solution.

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

• Ideas about other health care reports:
  • The Mazankowski Report was far more realistic. That is what we should be adopting.
  • Implement recommendation made in previous reports including Romanow, Fykes, and Kirby.
• Ideas about information:
  • Keep the public updated with facts, not opinions.
  • The general public does not actually understand the system or how it works. Information is very media driven. People always hear the problems; they do not hear the good things.

**Outstanding Questions**

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

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

**Change Management**

**Comments and Concerns**

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

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

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

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

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

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

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

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

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

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

- Understanding the processes that need to be put in place and the structures to enable the outcome is critical. What frustrates me is that I am told to change, but there is absolutely no understanding of the change, no understanding of the people, the culture, the structure, the work process and what you actually need to put in place, and the time it takes to actually make things happen.
• Comments on stakeholder, community and public input:
  
  · How do we get the perspective of the client, patient, resident, family, community, nation, and the public? And how do we incorporate that into planning, delivery, evaluation, and all of the change management processes. What do they want? What do they need? In the alcohol and drug system, one of the things they do is have patient advisory groups. Once you have gone through treatment for your addiction, you can go on a patient advisory committee and give them feedback.

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

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

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

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

• Comments on leadership and political will:

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

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

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

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

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

- The British Columbia Medical Association has too much influence.

- The Government needs more courage to act.

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

- Comments on resistance to change:
  - The system is not adapting fast enough.
  - The Canadian psyche is inflexible around the public health care model.
  - There is no mechanism for dealing with non-traditional demands or new types of demands.
  - There is a culture of entitlement, beliefs, expectations, and limited resources.
  - When you look at a system, the reason it is so hard to change is because there are some people for whom it works perfectly fine, thank you very much. How do you deal with that, because if it made sense for everybody there would be no reason to change it. There are some people for whom it is working but there are a lot more for whom it is not working. There is this concept that people really want things to be different but nobody wants to change. It is not being happy where you are necessarily, but the resistance can be a barrier.
  - I know the culture is very challenging. We need to shake up the system. We have to shake it up and you have got to do it without alienating physicians or nurses or home care workers. But we have got to shake the system up and we are way too conservative in this. Culture shifts in response to things that happen, and the biggest things happen where you put the money.
• The white elephant on the table is what are we doing about our culture in health care? We talk about our lack of ability to innovate in Canada. What are we doing to have our physicians, our nurses, our health care workers, our politicians and our administrators change the culture? That is the biggest barrier in all this stuff. I honestly think that we can come up with all kinds of great ideas that would help people access this system, for example, consolidate clinical practice so that it is more standardized, or implement more value-based outcomes with clinical interventions. But we cannot seem to get there.

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

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

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

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

• Comments on making successful changes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Ideas and Suggestions**

**Rationale and Planning for Change**

**Stakeholder, Community and Public Input**

**Leadership and Political Will**

**Resistance to Change**

**Making Successful Changes**

• Ideas about rationale and planning for change:

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

  • What I would like to see you guys doing is some serious analysis of the countries at the top of the health care provider list from a service provisioning and cost basis. The world is a big place and there are lots of good models already in place for you to learn from and try to emulate. My suspicion is that some of the best are combinations of public and private health care!

  • Nothing short of a complete overhaul of our system will suffice. We need to get the other provinces and the Federal Government on side and get started on this painful but necessary journey.

  • Canadians need to be ready to absorb the changes.

  • Change the viewpoint that there is only one magic solution. People need to be open-minded.

  • Develop an interdisciplinary group to analyze data and make decisions.

  • Create social events to bring practitioners together and hold interdisciplinary conferences.

  • There is a need to focus on creating an environment for change that will move us to a model that is more patient-centric and more efficient.
• Health delivery solutions and changes are advocated without critical, lateral or 360 degree thinking and analysis. In particular without full consideration of the applicability of the local situation and local input. For example: As a student on a project to farm whitefish in the sub arctic, it was the plan to cut a hole in the ice and keep it open. The local Inuit walked by and said that it would not stay open. Every day they cut a hole in the ice and, despite all efforts, every day it froze. Another example: In the twenty-four hour general practitioner urgent care centers in the United Kingdom, patients rapidly learned that these centres offered the most convenient way to get seen and subvert the traditional but high quality family practice and chronic disease management.

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

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

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

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

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

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

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

Comments and Concerns

Implementation of Best Practices
 Evidence-Based Programs and Studies

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

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

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

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

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

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

**Ideas and Suggestions**

**Implementation of Best Practices**  
**Evidence-Based Programs and Studies**

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

• Release more information on positive experiences.

• Ideas about evidence-based programs and studies:
  
  • Create evidence-based and best practice programs.

  • Look at the model in the United Kingdom, namely, delivery councils, which are multi-disciplinary teams that operationalize various initiatives. These councils gather budgets from different levels of government to implement initiatives. While one level or delivery arm is the lead, delivery and operations are at the local level.

  • Research needs to be re-focused so it is not just about the current medical model, which is only a pharmacological model. Do not focus on technological solutions. Think outside the box.

  • We are committed to the current public health care system and to strengthening it to include evidence-based complementary medicine and preventative medicine.

  • Encourage behaviour change research.

  • We need more health policy based on health research which is evidence-based.

  • Make clinical phase three data public.

  • Implement a return to honest, factual scientific integrity to replace present public relations propaganda.

Patient-Centred Model

Comments and Concerns

Defining Patient-Centred Care
Implementing Patient-Centred Care

• Comments on defining patient-centered care:

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

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

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

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

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

- Comments on implementing patient-centred care:

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

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

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

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

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

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

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

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

- Demand is instinctual.

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

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

Defining Patient-Centred Care
Implementing Patient-Centred Care

• Ideas about defining patient-centred care:
  
  • When we talk about patient-centered care, above everything, above any model of reimbursement or whatever, it is important to put the patient at the centre. That should be an overarching principle, prior to any discussion of models.
  
  • I would like to see a whole kind of patient self-care. The patient is in control of their health care, and managing their health care.
  
  • The patient is what we should be focusing our efforts on, and politicians, doctors, and pharmaceutical companies, should all come second. As leaders, we have to focus in on the patient: put the patient first.

• Person-centered care pyramid:

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

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

- Create a culture of continuous quality improvement.

- Incorporate the patient into a high level of planning.

- Incorporate a seamless, customer-oriented system.

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

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

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

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

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

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

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

- Service delivery itself should be patient-driven as opposed to provider driven. It is not about what the provider brings to the patient, it is about looking at what the patient needs and then finding the right provider to bring that to the patient.
Participants point to the need for more **Collaboration in the System** in order to improve patient care. They raised issues such as collaboration across the entire social sector, integrated and holistic care, and multi-disciplinary care in their explorations. Here is a selection of what British Columbians had to say on the subject of **Collaboration in the System**.

**System Collaboration**

Many participants talked about the apparent lack of coordination between social agencies. Social inequities cannot, they argue, be solved through health care alone. Similarly, non-profit organizations suggest that there is more that they could offer if they were more effectively integrated into the health care system and into social services generally.

One recommendation is to create a single database for all ministries so they can more effectively understand the inter-relationships between their various mandates, from criminal justice to income assistance. This is particularly valuable for working with at-risk or marginalized populations. Without a more holistic understanding of the issues facing those populations, participants argue we will waste money in trying to address problems in isolation.

First Nations say that this whole system approach is critical to finding real solutions to the complex problems facing their communities. They suggest integrating Aboriginal healing and traditional lifestyle practices with social services and the health care system would begin to address these challenges more effectively.

Participants encourage government to consider a no-wrong-door approach, whereby a citizen can walk into any service agency and find a way into the system to address their needs, including health, housing and income.

Practically, participants believe that to achieve this systemic integration you need to get ministries to start planning together. They need to understand the populations they are serving, think about how their programs link together, and focus on integrating services to improve population health and health outcomes. Many believe these measures should apply across organizations, not just to the Ministry of Health. Participants want to acknowledge that prevention and health promotion are cross-
ministry functions. They also believe that accountability for population health improvement is something that should be shared across agencies. Participants think that formalizing this shared responsibility into the accountability structure will build links across agencies and throughout the system.

…[H]ealth is a very complex issue that touches along social status, education, …housing [and so on]. But our …bureaucratic structures are not set up to consider health within that context. Now, if we started to think about health within the social determinants and tried to ensure a healthy population, our structure should enable that. And so one of the questions we should be asking is: are our … bureaucratic structures and how we’ve organized things…enabling what we’re trying to accomplish, which is a healthier community? Or are they becoming barriers for us to have the conversations to build the coalitions, to understand the accountabilities and responsibilities and who’s doing what?

- International Symposium, Vancouver

I still get shocked frequently by the perception that the health care system is the Ministry and the health authorities, and there are so many other players out there that have hands on levers that make differences. There’s no one group that can control it and if we don’t work collaboratively together at all different levels, we can’t solve the problems that they would face.

- Focused Workshop Health Human Resources, Vancouver

Integrated and Holistic Care

Participants’ visions of an integrated system of care share some common components: they look at the population and society they serve and design systems of care for the whole population or system; they look at patients holistically, considering their physical, mental, emotional and spiritual well-being; they integrate all social services; they focus on health promotion and disease prevention; and, they bring all health practitioners together. Models such as collaboratives, clinical microsystems (which are all of the inter-dependent health and social facilities, services, and people that provide the building blocks of care for a population where the patient is the focus), and, on a smaller scale, integrated clinics are all suggested as ways of creating a system of holistic and integrated care. Participants want to define the philosophy and services that would form the basis of this type of care, and then build it.

Participants argue that an integrated system, with a focus on prevention, health promotion and interdisciplinary care, is by its nature more efficient. As a result, they suggest that these systems, whether through clinical Microsystems or integrated community clinics, will result in savings down the road.
Administration and facilities for this type of care need to be carefully considered. Participants argue that there are some excellent examples of integrated care in operation throughout British Columbia right now, including the Healthy Heart model at St. Paul’s Hospital. They also argue that the lack of funding to certain health services has undermined a move to integrated care. As a result, they believe funding mechanisms and facilities must be changed to support integrated care.

Some participants warn that shifting from our current system, which they argue is fragmented in silos, will require a focus on change management at the top of the system and from the bottom. Many argue that health professionals are ready for this shift, but they lack the funding and administrative support to make it happen. Similarly, participants suggest that discussions need to happen within communities to ensure that British Columbians understand the vision and can adapt to its expectations. Managing the change to this model must be structured and well planned, including consideration of the expected health outcomes and measures and tools to monitor those outcomes. Participants also suggest health professionals need to be trained differently in order to operate in an interdisciplinary fashion.

It seems every time a conversation around health care is opened, it turns into a party verses party argument about funding or turf protection. The idea of an open conversation, collaboration and team work seem like foreign concepts to many higher level health care professionals and administrators.
– Web Submission, Vancouver

Multidisciplinary care is one possible solution to challenges. Multidisciplinary care 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, Multidisciplinary care 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).
– British Columbia Medical Association, Submission

Models of Collaborative and Multidisciplinary Care

Participants often discussed models of collaborative care where the different health disciplines work together to improve the health of a patient. They suggest that integration of different health disciplines into treatment plans and facilities means more focus on patient needs and fewer barriers to their care. This also links discussions around embracing different practitioners as entry points to the health care system into primary care.
Tools discussed by participants to help make collaborative care a reality include integrated community clinics, electronic health records that practitioners can share, and an accessible database which monitors population health. New approaches to funding to encourage and support these community clinics are also needed.

In smaller communities, many feel integrated clinics can assist in promoting community stability. They would be able to measure the health of the community, identify challenges, link with social services and may even play a role on the local business council, advising on community needs and encouraging ways to promote growth and health in the community.

Participants also argue that integrated models are particularly effective for marginalized populations, such as residents of the Downtown Eastside, where citizens often find the social support and health care systems difficult to navigate, and feel the structures operate to exclude them. A more integrated system would help those citizens access services and provide the support to improve their lives. For Aboriginal people, the integration of traditional healing practices and practitioners would help make them more comfortable within the health care system. Many participants also focus on integrating alternative and complementary medicine into this model as a key to addressing chronic illness or developing and maintaining good health.

Participants also encourage consideration of smaller interdisciplinary teams intended to address specific illnesses or situations. Mobile palliative care teams are an example. These teams would be called to situations, at home or in health facilities, where they could use their collection of skills and knowledge to properly treat the patient and counsel the family in as low-stress an environment as possible.

Participants noted that barriers to collaboration and more integrated patient care involved administrative and funding models and lack of facilities. Similarly, they suggest current professional training practices may discourage integration. Participants encouraged exploring the current funding models, particularly the physician fee-for-service model, and the consideration of models which would bring new health practitioners into a practice or clinic setting. They also ask for removal of barriers, allowing other practitioners to be entry points into the health care system by permitting them to refer to specialists or order diagnostic tests. Many believe these are first steps to empowering the system to become more integrated and helping patients get the care they need.
An interprofessional approach to health care benefits patients, through decreased morbidity and wait times, and patient empowerment, as well as health professionals through increased efficiency and efficacy, and mutual respect and appreciation for the expertise of all practitioners.

- The UBC College of Health Disciplines and the Interprofessional Network of BC, Submission

Conclusion

The themes of integration and collaboration came up frequently throughout the Conversation on Health. Participants wanted collaboration whether it was in relation to forming collaborative practices with nurse practitioners, larger integrated community clinics with a number of health practitioners from many different traditional conventional health disciplines, or seeking systemic collaboration between all social agencies in the delivery of services. While there are administrative, cultural and infrastructure barriers to implementation of this approach, many participants see collaboration and integration as a key step towards creating and maintaining good health for British Columbians.
Collaboration in the System

This chapter includes the following topics:

**System collaboration**

**Integrated and Holistic Care**

**Collaborative and Multidisciplinary Care**

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**Related Chapters**

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Information Technology; E-Health and Electronic Health Records and Health Care Models.
System collaboration

Comments and Concerns

Need for System Collaboration
Aligning Planning
Aligning Budgets
Aligning Delivery

• Comments on the need for system collaboration:

  • There should be integration between the Ministries of Health, Education and Finance. We were there 30 years ago.
  
  • There are inequalities that cannot be solved by health care alone. Health care is part of the problem in inequalities and we must change it.
  
  • The not-for-profit sector needs a really serious look in terms of its contribution to the health system generally. We end up subsidizing the public health system in many respects. What makes us interesting is that while our transactions may be with the patient, because of the way not-for-profits work, the purpose of what we do is change in the community, change in the community's health status and so on.
  
  • It is shocking that there is a perception the health care system is the Ministry and the health authorities. There are so many other players out there that have hands-on levers that make differences. There is no one group that can control it and if we do not work collaboratively at all different levels, we cannot solve the problems that they would face.
  
  • So there are criteria for Indigenous success, including the need to think about kinship and relationality, the need to positively engage local community as well as global society and also the need for autonomy and self-management. If we are going to link them to health services, we need to think about health services that promote family and community as well as individual health status.
  
  • Externally imposed programs, which are mostly based on your Western biomedicine and public health, do not work very well in isolation. The assumptions are quite different than the assumptions around health in local context. They work a little better if Indigenous health workers are involved in their implementation. We need to be able to assess the quality of these different kinds of knowledge.
  
  • We should be working with Indigenous community members to nourish and support them in applying their local knowledge, because it will make for more
effective health systems, context is everything. Critically underlying the possibility of achieving success is developing the relationships with Indigenous communities, and relationships that build over time, that are multi-faceted, multilevel, and build trust and build relationships on a professional basis.

- It is funny that we actually have to talk about the fact that things are not dealt with in an integrated manner, that we do not think about health and education and housing as related issues that all affect one another.

- There is only so much that you can ask the system to do and the rest of it is beyond the system and about the individual and their lives.

- In Saskatchewan there is a great system of regional inter-sectoral committees that are supposed to coordinate policy. However there is very little to show for after many years of work. They keep running into traditional barriers to integration. It is tough.

- Partnerships are critical to our ability to make constructive contributions to our health care system. By working with the provincial government, health authorities, health professional associations, research funding agencies and others, our education and research activities have a broad and positive impact.

- Prevention needs to cross barriers of ministries to support functional families.

- When we are talking about linking, we do not just mean government or community agencies, we mean family, friends, and relatives too. You want to think the whole big picture here.

- Practitioners of all sorts run into social problems, but they do not necessarily know what to do or where to go. The information sent to physicians is in a thick binder, in which is buried Healthy Kids (delivered by income assistance). But it is buried so deeply that it is not accessed.

- So income assistance should be able to tell people about mental health and addictions services with some knowledge of what is available in their community and who to go to.

- Someone needs to take full responsibility for special needs children.

- If you are really pushing prevention, it moves outside of health to education and highways for example. So then it becomes the mandate, not just of health, but of every government ministry. They all should be involved in the sustainability of prevention in the health care system. That really does become a challenge.

- It is the provincial government’s job to set up necessary social networks for vulnerable populations.
Government tends to inadvertently encourage competitive, non-communicative behaviour. For example, with the Health Innovation Fund we sought input and ideas. That is an inherently competitive process. I am not going to talk to the guy at the university, or over at the Health Authority because if he gets money, I might not. There has got to be a better way to encourage innovation than just a blanket call for proposals and a competitive process judging who is best.

The military and provincial medical systems do not communicate.

There needs to be linkages between the various ministries, between local governments and the primary health care, and between communities and community groups and agencies. So that is the interface, and that is where things can fall between the cracks.

If you look at the pharmaceutical industry, one of the things they do is they motivate their members to go out and build relationships with the people that are going to make the decisions about buying their drugs or using their drugs. They literally hold them accountable for the number of contacts they have made, the level at which they have made those contacts, and how fruitful the relationships have been. That accountability for the relationship is key. It may not be the best example to use, but it has been successful.

What we have really been not very good at is the notion of sharing best practices. We have six different health authorities who sometime collaborate on initiatives, but there is an incredible duplication of effort. We cannot afford to do that anymore in this system. We have to be able to put in the necessary infrastructure or supports to share the information.

We will not break down ministry silos in the foreseeable future.

Where is leadership on the notion of whole systems stewardship?

Health is the responsibility of many agencies and ministries.

There is a lack of resources for ministries that deal with local community engagement in remote, rural and northern communities.

There is no teamwork within government between decision-makers and staff.

Enquiry BC has worked.

It is hard to break through entrenched communication methods between major players. How do we influence the political and senior ministry levels to set the goals that would be most meaningful?

We really need to think outside the box and understand the way that everything is connected to everything else, and that social supports are particularly important.
Without a quality, accessible, flexible childcare system, you are going to have more women leaving the health care workforce.

- There are examples of where government works against itself. For example, there was work done on Aboriginal health at the same time that there was work on the new relationship. Side-by-side, these two initiatives did not square because the health one was about putting power down to the local government level, and on the Aboriginal side it was a brand new provincial level, government-to-government relationship.

- Comments on aligning planning:
  - We have the ActNow BC Assistant Deputy Minister’s Committee, which is focused on ensuring that all Ministries look at the outcomes that are desired for ActNow BC. Each Ministry has a responsibility to deliver something in their service plan. That is being lauded as a silo busting initiative that is showing some success.
  - Engaging data across ministries is essential to the wellbeing of a very vulnerable population. We are all involved with that challenging population, whether it is the criminal justice system, income assistance, health, or housing. It costs us huge amounts of money and we are not very good at it.
  - We need to look at multiple kinds of evidence and develop different approaches and skills to evaluate the evidence, think about the diversity of context and understand that we are not going to reduce health status inequities by looking at health services on their own.
  - We need to understand that the processes, expectations and responsibilities of a health services partnership might be a bit different.
  - There is a need to shift the approach to accountability measures for Indigenous-specific services to a more collaborative model rather than a top-down model. For example, the reporting on performance measures for Indigenous community-controlled health services is now done collaboratively and published results are published in collaboration with that sector.
  - We need to integrate at the business planning level between ministries as we develop our service plans. If the Ministry of Health is developing a service, they need to get income assistance and justice staff and management there to develop the integration with those services from the beginning. The model that is happening now is we implement a service and we undertake the implementation after the fact. The integration should be done right upfront, at the planning stage and develop the solution across the sectors.
• Comments on aligning budgets:
  
  • We have acute care pockets of funding and community pockets of funding, which is further divided into social services. Look at an integrated funding model first. Not only do we have fracturing in terms of funding, we have fracturing in terms of providers.
  
  • This goes beyond ActNow BC: the second phase of ActNow BC which would really create this inter-ministerial coordination where everyone can come and talk to their part of the solution. It is very clear that if we do not have Ministry of Finance, housing, economic development, or health there, they are all parts of the puzzle. We cannot just be pointing to one another saying it is your money.
  
  • Nobody seems to work together because they are all balancing their own budgets.
  
  • You need to make sure that the players who carry your message are adequately equipped. They need the actual dollars to carry that message forward, and they need incentives to carry that forward. You have to make an investment with those partner participants who are going to carry your message back to the grass roots.

• Comments on aligning delivery:
  
  • So on the positive side we see things like access to care being focused upon, dealing with marginalized populations, mental health, substance abuse, chronic disease prevention and management and as well as healthy living, which all make up one's health. There has also been nothing but consistent praises for that Primary Care Health Charter that has just come out.
  
  • A model of Primary Health Care is supported by interrelationships. We need to invest in those relationships and that investment takes time, commitment, and priority, and it needs to be facilitated through communication tools. We need to use tools like appreciative inquiry and build on interest based solutions. We often make decisions in health care based on positions. We should move to interest based solutions.
  
  • For seniors, we are really talking about a system that has a large number of components, from services in the community like adult day care, meals on wheels, home support, home nursing, to residential services, chronic care, assisted living, and the specialty geriatric centers. Essentially, what you have is a system that has a broad community base and is integrated horizontally that way and also has institutional components so it is integrated vertically.
• Leaders at all levels, including our own First Nations leaders and representatives, are not getting the information to the front line workers and membership in general.

• The three pillars of senior care are nutrition, mobility and social connectedness, and those three things are all outside the health system. They are systems that are beyond just health and into the area of community, transportation, housing, and so on.

• Health is a very complex issue that touches social status, education, housing, and so on. But our bureaucratic structures are not set up to consider health within that context. Now, if we started to think about health within the social determinants and tried to ensure a healthy population, our structure should enable that. So one of the questions we should be asking is whether how we have organized is enabling what we are trying to accomplish or creating barriers?

• We need to look at the notion of no wrong door. You can walk into any service provider and find a way into the health system. Those linkages are totally absent in the health care system right now. The only problem is if there are so many entry points, how do you keep the continuity and know the history of the patient. That is where information technology comes in: to improve communication across sectors. In most provinces in Canada, we do not have those lines of communications open between the social and the community and the health organizations.

• Look at the difference in how we handle health care delivery and social service delivery. Health care delivery is premised on a kind of an asset pool. We would already have your premiums paid. And we encourage you to be healthy. And if you need help, you go in and it is essentially covered. In social services, we give you a certain meager amount of money and watch you like a hawk in terms of how you spend it. We give you a rent allowance instead of letting you decide. It is all deficit-based. Imagine if we could walk into a social service on the same basis as we can walk into health services and get care in that way. And if we were to integrate to that degree. The different departments would need to communicate more effectively, and that is difficult in itself because everybody has their budget envelope.

• Too many funding jurisdictions and service boundaries make the system difficult to navigate.
Ideas and Suggestions

Need for System Collaboration
Aligning Planning
Aligning Budgets
Aligning Delivery

• Ideas about the need for system collaboration:
  
  • Collaboration across the health care system can contribute to improved management of disease and improved health care generally.
  
  • We need partnerships with all levels of government, health professionals, non-profit organizations, schools, businesses, and foreign countries.
  
  • You need political will and strong leadership if you want to influence all of those sectors.
  
  • Part of the answer is leadership at the highest political level making it a priority. ActNow BC is a really interesting example of a very heavy leadership message of, this is important in this province and it is not just the little slogan of the week. That kind of leadership helps the competing, or maybe not quite so aligned, programs and ministries to find better ways.
  
  • Use the Auditor General’s office to help encourage collaboration across ministries.
  
  • Develop a system that integrates First Nations values and traditions into a clinical approach to wellness from both directions.
  
  • In terms of sustainability, you have to broaden the focus to include population health rather than just intervention. You have to take a broad approach that integrates medical, health, social and economic agencies and any of those should be a point of entry into the primary care system. We need greeters, not gatekeepers, as some of our clients do not access all aspects of this system. We need some strong leadership from government to deal with this fragmented care and that leadership can go upwards to affect federal agencies. We also need strong communication and outreach programs to reach downwards as well to the general public and to clients. We have to create some sort of a value proposition to get the general public to buy into this approach.
  
  • Broaden the health lens to other ministries, and the Federal and local governments.
  
  • We need a partnership between schools, cities, health professionals and communities to promote healthy lifestyles.
  
  • Social services and health care should not be separated.
• There should be more collaboration between branches of the Ministry of Health and more collaboration between Health Authorities.

• We urge the provincial government, through its Conversation on Health, to take action across government ministries to improve the health and wellbeing of British Columbians. It will be a missed opportunity if the provincial government focuses solely on recommendations under the jurisdiction of the Ministry of Health.

• Ideas about aligning planning:
  • There should be shared responsibility for health issues and concerns (housing, employment, education, community, aboriginal affairs), including integrated health planning.
  • Commit to a bi-annual meeting (Interior Health CEO and First Nations Chiefs) to establish benchmarks of health targets to achieve the quality of life required.
  • Create a vision statement and create an inter-ministerial committee.
  • Create a side table allowing First Nations community health directors to interact with planning and integration and cultural safety of all health programs and service delivery with the Health Authority on a par with their counter-parts.
  • Develop and implement a policy framework to ensure that policies are developed collaboratively.
  • There needs to be a systems level dialogue before closures take place to ensure that there are the necessary community supports available for patients and clients.
  • There should be community level responsibility and accountability for funding and planning including housing.
  • Bring all providers into the accountability framework, perhaps through a pilot study.
  • Link the determinants of health to health care policy, advanced education and economic development.
  • We need more in-depth meetings with specific groups of experts to address special and vulnerable populations.
  • Develop communities of practice.
  • Develop a strategy for each group within vulnerable populations based on accessibility which is client-driven and includes client choice.
• Look at a broader network of community services facilitated by a co-operative structure.
• Health authorities should be engaged with municipal planning.
• The First Nations Health Blueprint must be examined by both federal and provincial governments at the same table.
• We must address federal-provincial gaps in jurisdiction and improve coordination and communication.
• Improve integration across social services.
• Empower staff and involve them in decision-making.
• Enhance local, regional and provincial networks.
• Government should lead a round-table of government ministries, non-profits, professionals and the public.
• Expand bilateral dialogues to strategic discussions with partners.
• It is important to share best practices around change management and work flow that already exist to feed into the culture shift that needs to happen. As you foster these initiatives they need to have tight evaluation models built into them.
• There should be proper urban planning that incorporates consideration of health care needs.

• Ideas about aligning budgets:
  • Merge health and social services ministries and programs and sharply increase spending on programs and services that reduce harm and crime. Increase welfare and provide more mental health and home care services and so on to reduce the pressure on hospitals.
  • The federal Government role is as a partial funder, and also a collaborator on some meaningful issues. The Federal Government has been in on some important discussions with the provincial health minister on how we can do some things together, whether it is to increase accessibility, decrease wait times, or move forward towards the next logical extension of reducing wait times, which is the wait times guarantee.
  • Align all ministry budgets around key health priorities such as prevention or health human resources.
  • Require ministries to invest in policies and programs that support populations to lead healthy lives.
• Ideas about aligning delivery:
  • Coordinate and utilize the many participants in the health care continuum.
  • Services should take a holistic approach, community-focused, and spend time looking at whole person.
  • Recognize and respect health programs on reserve.
  • Increase the number of partnerships between agencies (government ministries) to improve communication and services to First Nations communities.
  • Integrate federal and provincial services, particularly around Aboriginal health.
  • The Ministry of Health needs to partner with and fund non-profit organizations which provide health-related information and services, particularly for women.
  • There could be community non-government organizations that provide services around some of the other determinants of health.
  • The system needs to communicate, not deal with each episode separately.
  • Health initiatives need to be partnered with other government agencies and initiatives to address the larger picture.
  • Get beyond the turf issue.
  • Try new models and see how they work.
  • Listen to feedback.
  • Have the entire provincial health care system managed by one group.
  • Form partnerships between three levels of government to coordinate, and not duplicate services.
  • Promote discussion between unions and the health region.
  • Work co-operatively with our American and Albertan neighbours to allow for greater mobility of information and equipment.
  • Throwing money at the problems will not necessarily solve them. We need to start looking at the redundancies in the system, get people talking and working together, and efficiencies will likely begin to emerge.
Integrated and Holistic Care

Comments and Concerns

Design and Vision
Change Management
Impacts of Integrated Care
Administration and Facilities
Costs and Funding Models

- Comments on design and vision:
  - We need an approach that is going to develop not just primary care but actually clinical micro-systems. You need to determine who you are serving, what kind of problems you are serving and what you are addressing with the system.
  - Develop a system that integrates First Nations values and traditions into clinical counselors’ approaches to wellness.
  - You have to have vertical and horizontal integration, so that people are able to access all social and medical services. This is more like primary care based models, where physicians would coordinate with these other services. The trick here is the linkage and authority over these different vertical levels, so they are all part of the same system.
  - One of the opportunities is to find opportunities for collaborators in the fields without offloading. Who are the grassroots collaborators who can facilitate sustainability? BC Hospice and the Palliative Care Association, we are very cognizant of coalition development. It is done at the national level with all the end of life care coalitions. So how can the Ministry utilize its resources within the framework of the practitioners? Who are the care delivery people who know best what can be sustainable.
  - What matters is that the concept of a fully developed, integrated system of care is accepted. Then you need to look at which system makes sense in British Columbia.
  - A more integrated system of achieving health is about health promotion and disease prevention, and also about palliation, facilitating people to get to the best level care possible with wherever they are at in the disease process, and do it in the context of the system being integrated from beginning to end. This way we can plan for outcomes and costs and ensure that we have got enough providers.
  - We need a system where diagnosis, prescription, treatment and education are fully integrated.
We need a clear understanding of what holistic means.

We need to open the lines of communication between social, medical and health professionals and sectors.

There is a need for multi-disciplinary services including: home care, public health, health authority programs, seniors support services, and community based programs.

If you try to set up some clinics, they do not tend to necessarily do well. But if you set it up in networks, it actually works a lot better. The value in networks is that there are relationships between providers. You do not get structural change, you do not change people's pay cheque, so it is easier to introduce. But better inter-professional integrated practice happens when the space facilitates it, and co-location is one of the important factors. It is easier if you are on the same floor working with a colleague regardless of what your profession is than it is to go down the road, across the street, to the next province, and so on.

People are looking at the system today saying it does not work. So it is not a conflict, they are just saying that there another model and they are throwing up a community based clinic as an alternative.

The physicians that would be hired as the core team for a collaborative are not going to end up doing conventional physician work. The doctors that work in the clinic become a liaison between the findings of the whole professional team at that centre and the doctors in the community. So they play a supervisory role: they are supervising health planning. They interface with the physicians.

The one-size-fits-all approach will not work across the province. Clinics need to be targeted to each area. You need to understand the population, age, and demographics. You need to think about cultural sensitivity, whether it is the South Asian community or the Aboriginal community.

How can we make sure the resources we are spending in health care, particularly in a primary health care setting, are spent appropriately to optimize patient access to a range of inter-disciplinary practitioners?

Do not do what the Ontario government around family health teams. They have spent hundreds of millions of dollars on it. They are all different: they do not have a standardized clinical model. There is no standard structure on who administers this type of clinic, how big the clinics are, and so on.

The evidence does not support an integrated health care model. These models can work, so they certainly have applicability. But they do not necessarily have applicability to primary care in a sense of the general population. There does not seem to be any evidence that suggests, for example, that solo general
practitioners are much different from group practices or much different from the integrated healthcare context. The evidence suggests that solo medical practices are not an ideal model, and that it is better to have two or more physicians. This is mainly because of work load management issues. But in terms of quality of health care literature, the case for integrated health care has not been made. In fact the evidence would seem to run the other way. It is a policy in search of the evidence as opposed to the evidence trying to drive a policy.

• There are examples of integrated clinics. The Centre for Integrated Healing is a cancer centre where they do specifically cancer therapy using different modalities. They receive high dose Vitamin C from naturopathic doctors, acupuncture, counseling, nutritional counseling, and all in conjunction with chemotherapy and radiation. Maybe it is a matter of setting up more disease specific centres. But then there is a danger of not treating patients as a whole.

• Ultimately there has to be a lead agency. Even though it is multi-disciplinary and there is funding that comes from multiple places, somebody at the end of the day has to take the lead. The lead agency could have some kind of ministerial status and a pivotal place inside the government system, including sustainable funding.

• My experience of working in an integrative health care environment in Washington state is that all people involved benefit from this model of care. Physicians were grateful that naturopathic doctors could spend the time with patients to help them make the changes they needed while providing expert advice on areas of nutrition, prevention, responsible screening and supplementation etc. I was grateful to be able to consult with physicians regarding complicated cases and to refer those patients that were not responding to natural medicine. Of course, the patient was happy having the choice to see both providers in a collaborative environment.

• Our bodies and our systems are very complex and require a diverse group of practitioners to efficiently and effectively address all of the challenges the people in our society face.

• The federally funded Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) pilot project in Hamilton, Ontario points the way to true interdisciplinary health care models. The Rosedale pilot project is a very successful physician-run clinic which serves approximately 14,500 patients in the Hamilton area. Rosedale is focused on efficiency of service and inclusivity in health care provision. The range of services at Rosedale is broad. There are family physicians, nurses and nurse practitioners, chiropractors, mental health counsellors, physiotherapists, pharmacists, a breast-feeding and parenting specialist, home care coordinators as well as a range of technical and other support staff. At
Rosedale, integration is so thorough that it has become part of the work culture and occurs seamlessly.

- Multidisciplinary care is one possible solution to challenges. Multidisciplinary care 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, multidisciplinary care 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).

- Integrating massage therapists into hospitals, community health centres, educational institutions, community centres, sporting facilities, workplaces, neighbourhood houses and elsewhere would offer the benefits of massage therapy to a broader audience, producing a healthier population.

- Politicians and administrators at best guide but do not run health systems; that responsibility ultimately belongs to the practitioners, at many levels. It is important therefore that professional and related health organizations continue to have a voice in how the system is designed and developed, operationalized and evaluated.

- The non-profit sector continues to function in spite of the lack of adequate funding as a result of their knowledge of their clientele and its needs.

- There has been no recognition provincially or regionally of the key role that rehabilitation plays in the care of the elderly and those with chronic disease.

- Comments on change management:

  - We have this massive system in its silos, with its different funding mechanisms and lack of connection and everybody wants to go to team care. But what is going to catalyze that? What is going to make people want it? What is going to make healthcare professionals excited? Healthcare professionals are already there. They already want it and know how important it is. But they do not have the money or the power to make it happen. So you have to go back to the top and work down. You have to go to the federal government to earmark certain funds to the provinces to start the system. And then they have to give guidelines.

  - It seems every time a conversation around health care is opened, it turns into a party verses party argument about funding or turf protection. The idea of an open conversation, collaboration and team work seem like foreign concepts to many higher level health care professionals and administrators.
We need leadership at all levels, including the highest levels, to be modeling the cooperation and collaboration.

Let us have a collective conversation about what accountability across the country might look like.

It is recognized around the country that we are the most successful province in terms of dealing with cancer care. It is partly because of the kind of culture that emerged that everybody was willing to work together, and that is part of the key to success. Is there a willingness to really collaborate and cooperate to make a thing happen, and get beyond the competing interests to complementary interests?

A major challenge common to all systems appears to be integrating physicians fully into the system as core partners and people who share the same goals and the same accountabilities and the same stewardship as the overall system does. This is a vestigial problem of the way the profession is developed. In North America, it is a particularly strong tradition of independent contractors working with the system rather than being fundamentally integrated into the system like some other countries.

There is a systemic bias within the College of Physicians and Surgeons against complementary therapies because of the threat of disciplinary action.

Comments on impacts of integrated care:

If you have an integrated system of care, you do not have stovepipes and competing policies. It is better care for the client because you can move them through and respond to their needs more actively than if you have a whole bunch of different services and professionals where people are getting in each other's way.

Can we effect the model with the health human resources we actually have available?

At the care delivery level, acute care and home and community care aren't closely associated; palliative care programs are not typically provided to people with dementia, health records are not routinely moving with the patients as their dementia journey takes them to different health care services, the new Assisted Living program is unavailable to people with dementia, very few health care providers throughout the system have received appropriate up-to-date education about dementia...and policy, health care delivery and people's needs are not aligned.
• Dementia care is provided through at least five branches of the Ministry of Health, and working together is challenging for staff who are extremely busy and working on priorities that may not be properly strategically linked.

• A physician or a group of physicians cannot do it all, particularly the way the system is structured today. One thing that we found is that interdisciplinary team, not multi-disciplinary but interdisciplinary, where providers are working to the fullest scope of their practice, actually supports good outcomes, particularly around chronic conditions.

• Implementation would go beyond a term of government.

• Too many eggs have been put in that one basket (integration). There is some good stuff going on with the integrated primary health care networks. But this has been a pipe dream for at least ten years. We have been having the same discussion.

• Doctors who are in their offices get kind of angry and bitter and lonely and blue. When they work in collaboratives, they develop personality, become engaged, get excited and actually start to do things. The highlight for most of us is actually the interpersonal socialization and the rest is all just gravy.

• We have to start with a meaningful discussion at the community level that includes patients, health care providers and administrators. There is something before that: a top down direction from the ministry, including the parameters. Then you have community dialogue around those parameters. Otherwise you might end up just getting road blocked. There has to be some money aligned to the process. Then there has to be development of the criteria as to what we are trying to achieve, and perhaps some principles aligned with how that objective is achieved. To some degree people are getting tired of consultation because they feel that they have been consulted. So this whole process of the Conversation on Health will have a wealth of information that can be appropriated into this process. You can actually feed back what was heard and the expert panel will validate it.

• We need to implement integrated clinics by: training health professionals differently and providing incentives for collaboration.

• Multiple medical visits between many different health practitioners is tough for people with disabilities or older and poorer people.

• New doctors want things like time off with their families and work life balance. So there is more than just a business incentive to have a clinic, because with more staff, there are more people available to cover for you, and this improves your quality of life.
• In a multidisciplinary clinic, where you have a group of patients coming in, you do not necessarily have to have the physician see that patient on every visit. You could have a nurse practitioner, dietician or nutritionist conduct a group session where you bring in maybe 20 or 30 of your diabetic patients. And then the physician would be there as a resource for that particular visit. But the physician would still be managing the overall medications, the goals, the targets for defining good diabetic care and again we have had some experience with the diabetic with collaboratives in diabetic care in British Columbia.

• Holistic health centres could reduce costs.

• If a health system talks about bringing in inter-disciplinary practices in an unstructured way, the physician alignment and payment systems do not work. As a result, the doctors will not want these people because when they see a patient rather than the doctor, the doctor does not get paid. We have a huge disincentive working against some of our models. The nurse practitioners are leaving because they are not satisfied with the work they are doing.

• One important piece of this was looking beyond primary health care to include services provided by other ministries and community based service organizations, encompassing the wide spectrum of services, from a population health perspective, that help support folks in terms of maintaining good health, preventative health issues and treatment. So working across ministries and sectors and creating an innovative integrated service delivery model will help increase access for vulnerable populations.

• One of the advantages of a clinical micro-system is that in a sense if you can resource this appropriately you are dealing with a small system that can work within itself. Change management is less difficult if you do not have to be taking into account directives from a whole bunch of higher level agencies.

• It is possible to do the things we were all talking about, like team based care and electronic medical records, and actually make no difference to patient outcomes.

• An integrated system is better from a cost effectiveness point of view because if you have a single authority and single funding envelop, you can then be studying and looking at what are the relative distributions. If you have a lot of people, or some people with relatively low care needs in a facility that could be looked after in the community, maybe you could reallocate the resources, and in fact provide those services in the community where they want to stay at a lower cost, so you are also getting efficiencies.

• From a policy perspective, integration allows you think about the whole system of care. So if you are making policies, you can make policy about how home care is
linked to residential care is linked to specialty geriatric care and what is it that is best for the client and what is the best way to do it.

- The integrated health care system might reduce demand, because it is focused on prevention. It might move demand to more appropriate places and less into acute care. It may also actually increase demand if you get really good at your case management and you have really good networks, because there are people that are not being served now that will be served.

- If, in fact, there is any merit to the argument that there are efficiencies through an integrated system that you cannot get through a splintered system, then it is more sustainable because essentially it is a more efficient and effective system. Also you can make the tradeoffs that you need to make. That does not mean in terms of total dollars that you may not have a problem, but it is more sustainable. So if you have an integrated system, it is probably about as sustainable as you are going to get, depending on what dollars you have, and certainly more sustainable than non-integrated systems.

- There is fragmented delivery of primary care.

- An integrated system is more cost effective and efficient.

- Comments on administration and facilities:

  - The Healthy Heart model at St. Paul's Hospital links cholesterol testing with dieticians.

  - Integration includes community delivery models.

  - The Cancer Society has an admirable system. It supports people who are who are pursuing alternative medicine; they are very open and holistic, and they really follow people.

  - There has to be one person where the accountability and the responsibility falls on a multi-disciplinary team. One person has to have the legal liability, and it is usually a physician.

  - A Collaborative is a structured event that is a quality improvement model. Before funding collaboratives, put the resources into defining what the standard of care and administrative model is actually going to be. The planning has to be from a business model perspective: what is the population scope, where are they going to be in terms of transportation, and so on.

  - Many things in their plan for Collaboratives in Ontario were good, but they did not identify how it could be delivered effectively and efficiently, how it should be organized and administered, or what systems they could put in place. They did not develop a package to hand to the core service provider system.
A community clinic would provide a resource centre for after-hours care, education, and support, and would take the burden off of emergency departments.

In Australia they had their health services in a community centre with a pool and gym. There was the room where they had pregnancy prenatal care and there was the place where the elderly folks came and had access to all of their chronic disease support.

There is a role for volunteers in an integrated centre.

There is a similar model in terms of addressing HIV prevention needs among gay men. Previously it was all about dealing with talking about people about condoms and viruses. As holistic approaches to health and population health developed over the years, it has now been adopted into a gay men's health approach. There is a gay men's health centre in Vancouver where folks can go in and address some basic level health needs in terms of sexually transmitted diseases screening, prevention counseling, and so on. They can also get employment counseling, supported housing access and talk about how to get rid of your debt.

There are some marginalized populations which require that you go where they are. For example, the Community Transitional Care Team provides IV antibiotic care in a community residential setting for active or recovering drug users. While they are there, income assistance workers come in to do their work, and we could bring in a range of other services to plan for their discharge and case manage them and support them after they are discharged.

Comments on costs and funding models:

The integrated model of health care is already available at a cost.

In Alberta, they are trying to move forward on primary care networks. The idea behind them was to create an incentive for physicians to work more collaboratively with other people in the system. So, if you join a primary care network, you get a supplement of $50 per head, and the physicians can use that whatever the way they want. Some physicians have used it to increase the complement of other nurse practitioners and other allied health professionals. We had one case where they just pocketed the money. The supplemental pay was supposed to be to invest in improvement, but part of the problem is the money goes to the physician, not to the team.

What funding models would support integrated clinics and what are the factors for their success. Urban clinics appear to do well, but others do not. Is it about the
volume of patients or funding models? They need to make it a viable operation. Fee for service is very limited in a lot of ways.

- We have stopped funding pharmaceutical services, physiotherapy, most of community mental health, and many of the other practices that we now consider as part of an integrated health care system. So either those components are optional, and therefore unimportant, or the whole thrust of our health care policy to this point has been misguided. We have no appetite for funding nutritionists and physiotherapists and so on, and we are in fact progressively funding fewer of them, and yet we do have some kind of appetite for having these one stop shopping places for health care.

- We need to be realistic about cost and having a multi-disciplinary team available for every kind of health need 24 hours a day and seven days a week would actually bankrupt us.

- In the South Community project they have physicians and midwives working in the same models, spending the same time, so, until the Ministry got it organized to give them a funding model, what they did was take all of the fees and put them in a pool for everybody and divvy it up and pay everybody the same. Now the Ministry has actually put together funding that fits that model. Here is a group of people who wanted to do this and make this innovation and they took the existing system and said, well, it is going to take them a couple of years to figure out how to change it and we have this access to federal money now so let us just create our own solution.

- We do not know what integrated clinics would cost, and we have no space for building new centres. Land is highly expensive.

- The Copeman Centre has fees for holistic treatment. They have taken the whole primary health care agenda and privatized it and made it a profitable business.

- We need an administrative and funding model for collaborative health centres. We have to put the funding model there somewhere.

- Fee-for-service motivates physicians to spend as little time as possible with patients.

- You cannot take the current money from doctor compensation and pay a multi-disciplinary clinic system on the basis of no added money. Where is the funding for facilities and staffing going to come from? You have got to add some money into that system. If you want a multi-disciplinary clinic you have got to buy some bodies to staff it. The only money we are talking about in primary health care right now, the funds in the budget, is for doctors. And out of that they are already paying for the 2000 offices and staff and so on around the province.
• This is an opportunity to be as creative as possible with an envelope of money. You may get some groups who want to use naturopaths and others who do not. They should be allowed to use whatever they want. It would be community-specific. Those services will change depending on the community.

• Looking at multidisciplinary clinics, our biggest problem as physicians, particularly family physicians, is that we do not have adequate funding.

**Ideas and Suggestions**

**Design and Vision**
**Change Management**
**Impacts of Integrated Care**
**Administration and Facilities**
**Costs and Funding Models**

• Ideas about system design and vision:

  • We need to define the core: the philosophy, the guidelines and what the service is. We have to understand what services are necessary in order to fall into the category of collaborative care, or integrated care centres or whatever you want to call it.

  • There needs to be a recognition at all levels of the health care system that rehabilitation is an essential part of the system which provides value to payers and improves the function and quality of life of persons with impairments and disabilities.

  • It is time to completely redesign the model upon which our health care system is based. We should adopt a wellness model, in which the entry point for access to the health care system would be provincial wellness centres located in each community. These centres would offer a variety of services and would be supervised by medical health officers. They would be staffed by teams of nurse practitioners, nutritionists, physical therapists, kinesiologists, dental hygienists, and the like. Examples of services a wellness centre could provide include: routine dental examinations and cleaning, especially for school children; diabetic foot care; nutritional counselling and meal planning for families on fixed incomes; exercise programs and pool therapy for arthritis sufferers; adult day care for seniors who live at home; a drop in centre for single, teenaged mothers; an obesity support group; and, prenatal monitoring and pregnancy management.

  • Government must foster voluntary participation in multidisciplinary care by: removing financial barriers to incorporating allied care providers within physician
offices; ensuring that expanded scopes of practice for allied health professionals are granted on the basis of sufficient training and demonstrated expertise; ensuring that where health professions take on new levels of care they assume responsibility and liability for that level of care; and, expanding successful General Practice Service Committee initiatives to other chronic disease management areas.

- Multidisciplinary care 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 multidisciplinary care 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.

- An individual pursuing optimum health can access their modality of choice from within a safe, efficient and kind system of provincially licensed practitioners.

- Create a Cardiology Centre that will result in significant cost savings ($25 million per year with additional long term savings), incorporate nurse practitioners in our rural and remote communities, develop an effective tele-video conferencing information highway to our most remote communities, incorporate a preventive care arm designed in rural British Columbia for the unique problems of that population, and create rural physician and nurse practitioner-based chronic disease programs to avoid the hospitalization costs of chronic cardiac problems such as congestive heart failure.

- A series of multidisciplinary pilots in health clinic settings, which incorporate chiropractic care, will demonstrate to provincial jurisdictions that chiropractic saves money and enhances care.

- Taking a leadership role in alternative medicine research will eventually attract talent to the province and perhaps we can develop sufficient expertise to start some centres of excellence that may eventually have revenue generating opportunities as well as cost reduction.

- Consider a multi-disciplinary approach to family health care where individuals and families are attached to a family health care team, and the team has a identified a group of people that they will provide to. Should the user decide to use care outside the team, a fee would be imposed. There would be funding incentives for good results which would be based on evidenced standards of professional practice. The health authorities would continue to run hospitals and residential care facilities and allied support.
Primary health care should be re-defined to be a multi-disciplinary, salaried cooperative with health care teams focused on the needs of each community.

Follow models, as in Sweden, where like pharmaceutical and dental services are all contained in medical system.

Provide funding and incorporate a more holistic approach to wellness and health care throughout the system.

Part of the whole shift is to enable teams to work creatively and innovate. Doing this effectively, however, required a distinct plan so that all of the communities are working together and talking to one another.

Look at European systems where integration has been successful.

Address a patient case through a holistic approach, including nutrition, day care issues, mental health, addictions, marriage issues, as well as primary medical needs.

To be effective in promoting good health for British Columbians, the government must regain control of the health care system, and include healers who work in the non-physical dimensions to heal the causes of illness, not just the symptoms.

We need a more holistic model where eastern and complementary modalities are recognized.

Networking could spread province-wide. In addition to having local collegial meetings, you would have a province-wide collaborative once a year. Obviously not everybody can attend, but you would go to one every two years or so. It would unify all of the primary care providers and make sure that we get efficient use of resources and desired outcomes, and that our patients do not slip through cracks anymore.

A location in which a group of health professionals work as a team to promote healthy living, and prevention and treatment of disease.

Partner with hospice to provide longer and proper convalescent care.

Family practice networks and collaborative multidisciplinary family practice clinics should be supported, including: proper chronic disease management, increased patient self management, collaborative care models and more non-facility community home supports. Family physicians and community supports will help to minimize unnecessary use of facility care.

Establish integrated health care clinics in British Columbia that would be lead by communities, health authorities, health providers groups, or not for profits. We would build these on the principles of inter-professional, collaborative, population based, population centric, innovation with multiple entry points and an outreach.
focus. The process would be to develop an expert panel that would include funders, community experts, educators and practitioners. That group would also develop the principles and the criteria. There would be community discussion to decide how these would go ahead and the communities themselves would lead that. We would hire an executive director, we would implement the clinic whenever possible and then we would do a lot of communication. Success would be when we had improved population health with provider satisfaction, improved accessibility, decreased pressure in the system and community satisfaction.

- A one size fits all approach will not work, so we need to tailor or fit the health care services to be provided to meet local needs. To help do that, we will collect health data. So if there is a predominance of certain diseases or issues in a local area, build the primary health care clinic to meet those needs.

- Another model of health care delivery that has shown to be extremely cost-effective, and leads to better health care is the creation and funding of community health centres. These centres employ salaried multi-disciplinary teams, including doctors, nurses, social workers, and home support workers, and incorporate community participation and community development in their planning of activities. A study in the Canadian Medical Association Journal shows that such centres are more likely to have organized approaches to care, including more counselling and education for its patients and other community residents who need such wide-ranging care.

- Implement integrated primary health care clinics that are accessible, comprehensive and efficacious. In order to get there we need a new model with a service framework, a governance structure, incentives, flexibility in business arrangements, and a comprehensive information technology structure tailored to the needs of the target population.

- British Columbia 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.

- Both workers and the public would be more willing to go along for the ride in the policy making and governance process to develop ideas like multidisciplinary community based primary health care centres. Our health care system needs teams of professionals working together (on salary) serving their local communities. Such centres can provide total care to a given population and the team can focus on the task of providing continuing care without worrying about their personal incomes.
• Encourage and open more opportunities for registered massage therapists to
work in an integrated health care system with other health care professionals,
particularly in hospital settings.

• Ideas about change management:
  • We need to train the health professionals to work in a collaborative model.
  • You need financial incentives for multi-disciplinary models.
  • We do want a sustainable system, but that means doing things differently. We
  expect a level of responsibility from everyone. And we need to find a way of
  trying to work together in it. It may sound a bit too idealistic, but there are ways of
  breaking away and reframing the system. There needs to be the courage and the
  leadership to do that and take steps towards it, like not renewing contracts, unless
  we find something that is in the common interest.
  • To implement collaborative Teams you need to deal with the actual and perceived
  barriers or limits regarding scope of practice.
  • Increase the integration of non-profits with health care.
  • In order for the various health care providers to be effective, it means setting aside
  old conflicts and voluntarily working together with government in the
  restructuring process. It does not mean a refusal to change. Rather, it mandates
  that as part of our responsibility to deliver care to our patients, we must learn how
  to change and how to manage the change process.

• Ideas about impacts:
  • Redo how the health care system is structured and identify the parts that work
   well and those that are not integrated.
  • Restructure health care delivery to make team-work necessary.
  • Research shows that jurisdictions with multidisciplinary primary health care teams
   have healthier populations and lower costs. Professionals working with teams can
   also spell each other off and live more reasonable personal lives.
  • People have been recommending the whole community health centre concept.
    Those arguments are right; we are not going there in the near term or even the
    medium term. There are a whole lot of doctors out there who do not want to go
    there. There may in fact be more in the future who may want to go there, because
    there is a lot of material about the new cohorts of physicians who have very
different references. But they are not in charge yet. It will take another 20 years as
we get more and more physicians with a different philosophy of life who do not
want the hassles of running a practice, dealing with overhead, hiring, firing, and negotiating leases.

- This is not a new concept for by the way. We do have in our northern communities for example. They are called Diagnosis and Treatment centres (D and Ts), which actually to some extent serve as the health care hub for the community. Pretty much everything is housed out of them including senior's daycare programs.

- There is an Aboriginal healing framework strategy in Ontario for about twelve years. It is responsible for hundreds of millions of dollars of programs, costing about seventy million dollars a year. There are eight Aboriginal health access centres and there are programs for physical, mental, emotional and spiritual health. There is a focus on the continuity of care right from health promotion and prevention through to treatment and chronic care. The assumption is that this would work for any population not just Aboriginal.

- It is not like there is no groundswell of support for this. But we need to be very careful and strategic about making sure that we have the right processes and structures and that we do it in the right order, and that we start getting rid of stuff that gets in the way.

- In a team-based clinic environment, the patient population is analyzed within the clinical team to assess and develop group visit opportunities. The clinic engages representatives from all service domains to analyze results of care outcomes, patient input, efficiency measures, quality and safety measures and searches widely for examples of excellent practice with a view to constant improvement. Clinic staff evaluate themselves as an organization (team) on how well they (together) achieved key goals.

- There has to be some transitional funding.

- Rapid implementation of integrated clinics is the best way. We do not want this going around in circles and upper echelons for eons: we want rapid implementation so we can address the incoming surge of over sixty-five patient populations coming.

- Ideas about administration and facilities:
  - Move to a joint practice model where nurse practitioners, nutritionists, doctors, and so on work together.
  - Use decommissioned schools or public facilities for clinics.
  - Set up the core module or centres with defined amounts of space to do the core services with flexibility to add other services and do it in a highly leveraged way.
Wellness prevention and holistic care should be in all facilities and community programs.

Wellness clinics could detect conditions early and properly service the health needs of vulnerable groups alleviating backlogs in emergency.

Integration of services needs to be scaleable. There may be a gold standard where somebody might come in to an integrated service centre and have a really great ongoing relationship with a primary health care team, an income assistance worker, and a case manager, and would have connections with the cultural community and so on. That might be the gold standard, but not everyone is going to need that. So it is going to be scaleable and more intensified as their needs increase.

Address liability concerns for collaborative practice.

Implement independent clinics run by Nurse Practitioners to look after a defined range of medical services including Midwifery. These clinics could be set up by government and rented to individuals or groups of nurse practitioners who would provide certain defined medical services for set fees paid for by Medical Services Plan and refer onto general practitioner doctors and in certain defined cases to medical specialists any problem beyond the range of their expertise. These clinics could relieve general practitioners and hospital emergency departments of some patient load and thus provides the required service at somewhat lower cost to the overall health care system.

The literature is pretty clear that in terms of team building and collaboration, one of the most effective things is co-location. The virtual systems are not as effective in terms of building team and collaboration.

Establish a structure around safety, confidentiality, efficiency, effectiveness, quality of care and accountability, but allow the teams to decide how they deliver the service.

Geography is really important in terms of accessibility. It has to be servicing a small enough area that people feel comfortable going there. It really needs to be community based. I would almost go by postal codes.

Bring in an inter-disciplinary team.

Design a patient centered addiction and mental health primary care facility.

Look at the Mid-Main and Reach Clinic models where they use nurse practitioners and dieticians to positive effect, the pharmacy is available for consultations, and doctors have more time for care and diagnosis and to just talk to patients.
• Establish pilot programs through the Northern Health Authority and the Lytton Health Centre to improve acute care and community health services utilizing an integrated approach to health and community programs as directed by the needs of First Nations.

• There should be a centralized space with multiple-practices, such as a community health centre.

• Have more multi-disciplinary health care centres focused on prevention and holistic care.

• A multi-disciplinary community care facility or one-stop shop with twenty-four hour access is needed in communities across British Columbia.

• Community health centres employ salaried multi-disciplinary teams, including doctors, nurses, social workers, and home support workers, and incorporate community participation and community development in their planning of activities. A study in the Canadian Medical Association Journal shows that such centres are more likely to have organized approaches to care, including more counseling and education for its patients and other community residents who need such wide-ranging care.

• When you are looking for financial sustainability you cannot come up with a concept like a collaborative, and just throw it open to grant applications. You need a standardized clinical model and a standardized administrative model. Otherwise it is just a dog’s breakfast.

• The services needed for your integrated centres will be different in Cranbrook than Victoria, and it depends on the demographics.

• In a clinic you need some diagnostics, nurses, nutritionists kinesiologists, psychologists, a mental health team, para-natal support, and self-management support. Physicians need a really good risk assessment tool and then we need to have a way to move people to the appropriate place, whether it is a community centre or a supervised area like cardiac rehabilitation centre.

• There should be integrated health centres for the treatment of cancer victims, including homeopathy, nutrition, and counseling.

• We need more integrated health centres at the community level that are independent of a particular disease.

• Develop mobile clinics to service vulnerable populations, for example in isolated communities.
To make the inter-disciplinary team work, we need appropriate information technology and information management infrastructure in the form of electronic health records, principally, but may also tele-health in rural communities.

- Ideas about costs and funding models:
  - Payment should be structured for the team. For example, everyone is salaried but there are contract milestones that they must meet in terms of how they provide care and who they provide care to and the outcomes they must achieve for the populations served. You cannot lose the team concept because that is key in terms of recognizing the value that each of the health providers, professionals brings to the team and valuing that contribution.
  - The provincial government should fund multidisciplinary care teams.
  - Remove patient caps from clinics.
  - It will take some financial commitment to put community health centres together but monies are available for this type of initiative via federal primary health initiatives.
  - Clinics should be funded through a pool of money, with designated leadership roles and flexible teams.
  - Create a governance structure and get community partners and build this thing up from the ground up. Then there will be resources there. That is what we are trying to do in the disability strategy is to build it one community at a time. No more pilots! In that way we will not be doing a pilot only to find that the funding will be pulled two years down the line. It is outcome focused. You have to add some new money because you have to create attractors. Money is a great attractor.

Collaborative and Multi-Disciplinary Care

Comments and Concerns

Models and Services
Administration and Funding
Human Resources
Facilities and Equipment

- Comments on models and services:
  - There is a lack of multi-disciplinary team building for specific disease conditions.
• General practitioners are currently the gatekeepers to health care. This needs to stop.
• There currently are too many designated gatekeepers to the health care system.
• The challenge may lie in getting health care practitioners to collaborate with each other.
• The public might harbour preconceived notions about what primary health care teams will look like.
• Very few inter-disciplinary practice settings actually exist.
• Collaborative care has become a buzz word and needs to be given context.
• There is not much opportunity for inter-disciplinary collaboration in the workplace.
• There is no universally accepted model for a collaborative team. Professionals have their own expectation or concept of the team, and the reality is something completely different.
• The body is a complex machine. The doctor cannot be an expert in mental health and nutrition and exercise physiology as they do not possess the knowledge. There is no way one person can possess all the knowledge required to act as a psychologist, dietitian, kinesiologist, and to a certain extent, nurse. However that entire body of knowledge is necessary to actually deal with a patient.
• In New Zealand, the physicians and nurses are working with each other.
• A collaborative approach to health care will increase British Columbia’s general health outcomes.
• Pregnancy and birthing is a great example of how in the last three or four years we have moved from women being pregnant to families being pregnant. We have engaged the partners a lot more in bringing them into the delivery rooms and engaging in the process.
• Is the health care system actually structured in a way that would facilitate collaborative care on an ongoing basis?
• Physicians often have a certain position of power in a healthcare system. When a practitioner has that kind of power and autonomy, there must be a lot of incentive in order to share responsibilities health care delivery.
• Physicians see themselves as independent practitioners who provide service to the system but are not necessarily part of the system. It is so entrenched that in order to have a multi-disciplinary approach that is truly interdisciplinary, we have to be able to build in financial incentives.
Physicians are operating small businesses while the rest of the health care system is trying to be interdisciplinary.

Managerial staff are not properly integrating front line workers into a communicative implementation effort.

There is little coordination among the major players in health care; schools, policy makers, regions, and front line workers are all separate pages.

Teams of practitioners providing services based solely on the needs of the community would avoid over-crowding of emergency rooms and hospitals.

**Comments on administration and funding:**

There a risk that if team care is executed poorly, lacking basic administration and systems for coordination and communication, patients will fall through the cracks. There is a higher risk of this in a team-based model than in a single practitioner model.

At present the hospitals and care homes have many people working together but there is no clear chain of command. It is anarchy with each person following a job description without specific coordination or direction. Each shift needs a boss able to move their staff around to give additional help or to take on additional tasks. They need to be responsible to and for their team members and their individual and collective performance.

The current performance-based pay system will have to change.

The inherent difficulty in implementing a collaborating system changing individually funded care model.

In order for collaborative care to be successful, it must be proven that various administrations and staff are capable of working together.

In North Vancouver, a pharmacist educates doctors about drugs. This program has returned 150 percent of its costs.

The British Columbia Medical Association needs to change their standards as a fee for some hinders teamwork.

Fee for service system inhibits integrated care.

It is challenging in a situation where you have part-time workers or students who are present once or twice a week. It is a challenge to bring them into a team in an effective way.
• What is lacking is a policy framework for funding a real collaborative model.

• The stumbling block to the collaborative model is that if you have your Registered Nurse, neurosurgeon, medical doctor, naturopath, and your chiropractor, and the patient gets to choose, or is advised that among those five they are going to have to pay for two of them themselves? That limits their choices to the other three.

• Acute areas like emergency or a birthing unit or a critical care unit turn over so much that you might have a group of people who work together on a given day, yet they might not work together again for four months.

• Is collaborative care something that the Health Authority provides in the interim, or is it something that physicians will have to adopt on their own?

• Comments on human resources:
  • There are all kinds of health care professionals such as dieticians and respiratory therapists who are involved in chronic disease management but are not very well integrated. The issues lay with their scopes of practice and physical facilities.
  • Where does one go to see a team actually working? A student is kept in little isolated boxes for virtually of their educational and professional careers. There is no idea what the end vision is.
  • Social workers are often left out of articles and public announcements from the health authorities. They are suddenly the forgotten profession. Occupational therapists and physiotherapists seem to have made some inroads, but social workers are taking a back seat. It is very important in communication to use distinct professions such as child protection workers, hospital social workers, mental health, and psychiatric social workers.
  • Decrease the workloads of older professionals in order to allow them to deliver mentorship to new students.
  • There may be issues integrating older health professionals, who have little experience in team-based care, into a collaborative model of care.
  • Professional associations are more of a hindrance and they should not be considered the gatekeepers to health care.
  • If the team is made up of poor quality employees, the quality of care will lack.
  • Specialization and unionization will present a barrier to team-based care.

• Comments on facilities and equipment:
  • In Japan, many general practitioners’ offices have small surgical units with three to ten nurses on staff, with areas for administering vaccinations and nebulized
There is also laboratory equipment to enable simple blood tests to be done, such as hemoglobin and cholesterol with results delivered in 15 minutes. There is no need to make another doctor’s appointment for test results and treatment.

- The people of an Okanagan community are very happy with the health care centre and the nurse practitioner who has done a fabulous job, they work collaboratively. They have figured out where the value added was and who was doing what. They have also really reached out to the First Nations peoples.

**Ideas and Suggestions**

**Models and Services**

**Administration and Funding**

**Human Resources**

**Facilities and Equipment**

- Ideas about models and services:
  - These multi-disciplinary teams need to include community services.
  - Develop a holistic, prevention-focused, health care system utilizing all health care and social professionals. Resources and information should be shared among these professionals housed in a single location.
  - In a practice encompassing four or five doctors, the health authority should recruit a home-care and public health nurse to support the team. Involve them in the team and focus on the care of that patient. This would also allow the physician to do what is needed but also to be responsible for coordination with the nurse’s support.
  - Teams must cater to the needs of a changing population with higher rates of various chronic diseases and illnesses.
  - A health care team should be responsive to the patients needs. The team should be built of professionals selected for each particular patient’s needs. The team would also be flexible enough to provide care that is regionally appropriate.
  - The co-operative idea could be a health human resource retention strategy. Absorb older health care providers such as the older physician, the older physiotherapist, or whomever wants to work fewer hours but still has an interest in practicing. They would be the mentors to the medical students, the nursing students, the physio students, who all have to go out and do their co-operatives for clinical practice.
There are a number of advantages of a co-operative model of multi-disciplinary care, especially in smaller communities. It provides one a very well organized place to take a measure of community health. It will also aide significantly in helping communities achieve social sustainability, because the co-operative has such a potent capacity for networking into both the education and social services. The co-operative as an entity in the community might as well be part of the Board of Trade, which allows you to bring in the private sector as part of the players, the cast of characters in creating community health.

- Involve more than just lab technicians in dealing with patients who volunteer for clinical trials for cancer-treating pharmaceuticals.

- Allow allied health providers not function independently, but connected to the whole. More than just medical doctors have the ability to diagnosis and treat patients. Re-assure faith in all other health care disciplines such as; registered nurses, nurse practitioners, physiotherapists, dieticians, occupational therapists and so on to allow them to function to their full scope of practice.

- In the more urbanized areas, birthing clinics could be set up staffed by midwives and obstetricians acting together to provide care.

- Promote and fund multi-disciplinary clinics that are staffed by physiotherapists and dieticians among other professions and that are triaged by a registered nurse or nurse practitioner.

- A more highly developed team approach involving psychiatrists, nursing staff, social workers and family members to determine for those with mental illnesses:
  a. Medication adjustments;
  b. Counseling needs;
  c. Potential housing after release; and,
  d. Follow-up care in the targeted community of release.

- Community care teams must be reorganized to work with clients in all housing types within their community. They are to provide planned care for every patient rather than working with individuals who have often been released too soon.

- We need community health care teams that include all professions like care aides, assistants, nurses, counselors, doctors, chiropractors, naturopaths, massage therapists, physiotherapists, pharmacists, and nutritionists. Health dollars should go to support the integration of all modes of therapy with the patient empowered to manage his or her care for optimum health.

- Encourage the team-nursing concept into hospitals. Couple registered nurses with aides or licensed practical nurses to increase support.
The future of primary care will depend not only on the family physician, but on strong collaborative relationships between specialists and other allied health professionals.

Professionals working in multi-disciplinary teams can contribute to inspiring healthy behaviors.

When the team of health care professionals is nurtured they have the strength to deliver quality care and will be reflected in public confidence. There needs to be a feedback mechanism to ensure the team continues to function.

Service should move from strictly medical doctors in solo or group practice to clinics which include dieticians, nurse practitioners, physical exercise specialists, naturopaths, chiropractors, and spiritual directors.

A registered nurse who is qualified to give psychological, nutritional and fitness advice could perhaps be engaged more in future health care teams.

Create a clinic staffed with a nurse and pharmacist to work with local physicians.

Community pharmacists should move from behind the counters, to working with physicians and patients on-location.

There is a need for collaborative and comprehensive care from a variety of health care professionals. This involves community health care teams that consist of a wide range of health care providers. These teams need to have mutual respect and appreciation for the expertise of all practitioners. Better integration and cooperation need to be part of the culture among health professionals. This can be achieved through team building, joint information sessions, and centralized professional services.

Allied health care professionals are specialized in their field of practice, yet are underutilized. A team approach would be more beneficial to patient care and compliance. Grouping patients and types of care to be delivered in a coordinated way would ensure continuity of care.

Have physicians collaborate more with pharmacists, drug companies should be able to contribute to but not conduct seminars.

Inter-disciplinary wellness care from birth to death - accessible to everyone supported by collaboration between all health care professionals.

The Kaiser Permanente Heath Management Organization teams could be used as a model for multi-disciplinary care teams.

Create a multi-disciplinary team trained in the field of hospice and palliative care available by pager twenty-four hours a day, seven days a week for consult to end of life patients in their home or community facility setting. The team would
consist of a palliative physician, a registered nurse, a social worker, an occupational therapist or physiotherapist. The team would be accessed by community nursing, the general practitioner, a nurse practitioner, or physician who has been managing the care of the patient. The team would be dispatched to the patient’s setting to initiate and or titrate drugs, evaluate physical, environmental, mobility, placement needs, and making recommendation for course of action and facilitating resolution of the crisis. This team would work on a limited basis and address the crisis, not take the place of community services. This limited time intervention would be less stressful and provide more attention to the patient and caregivers than sitting in an emergency room. When admission is necessary, it could be done in a smoother fashion, and when unnecessary, it can be avoided. The team findings would be recorded with copies going to the patient’s family doctor and transferred on the patient’s person when transferred to a palliative care unit or into a new facility. If records were computerized, this information could be entered by a member of the team as evaluation takes place. Avoiding unnecessary use of emergency room and admissions would save health care dollars, decrease emergency room congestion, and free up bed availability. Calm in a crisis and facilitation solution at the end of a person's life is the humane thing to do. Palliative care teams are greatly needed.

- The composition of primary health teams will vary by region in British Columbia. This must be researched and embraced so as to create effective delivery models based upon the needs of a specific community or region.

- Include the family and patient within change decision, treatment, and discharge plans.

- Allow physicians to hire those with the specific skills needed to address smoking and help in cessation.

- Implement Short Term Assessment and Treatment teams (STAT).

- Success would consist of health practitioners maximizing the expertise of available health practitioners. Patients would experience fewer complications, greater choice of access points, greater percentage of health needs met, and comprehensive electronic health records.

- Share best practices in Aboriginal health programs between communities.

- When dealing with chronic disease and aging, family members must be included as essential members of these teams.

- Different chronic disease societies should collaborate with the medical community and the pharmaceutical companies to find solutions to treatments
such as Multiple Sclerosis. Streamline chronic care patients by making their need understood by everyone on staff.

- Put an emphasis on integrating some of the long established treatments like naturopathy, homeopathy, chiropractic, massage, acupuncture, reflexology, hydrotherapy, colonic therapy, traditional Chinese medicine and art therapy, with allopathic medicine. Encourage Medical Doctors to learn how to incorporate these treatments in their practice as they will always have plenty of patients. By developing integrative practices, they can treat more people rather than less and share some of the burden of difficult to treat patients.

- Policy change is necessary to support a new approach to health care, one that involves a team comprising a variety of health professionals collaborating to provide efficient, high quality, patient-centered care.

- Empirical data that proves multi-disciplinary care model to be more efficient than the current model of is needed.

- Engage the Health Authority directors in planning.

- Create demonstration projects in smaller, rural settings.

- Ideas about administration and funding:
  - There must be a reduction on the monopoly that Medical Doctors have on treatment decisions.
  - Use a multi-disciplinary primary health care model to expand access for patients beyond the emergency room. Instead of using three Medical Doctors in a nine-to-five clinic, employ one Medical Doctor for an eight hour shift, with three shifts per day.
  - Health team practitioners must be accountable for safety, confidentiality, efficiency, effectiveness, and to be as innovative as possible.
  - A team approach with team meetings and care including patients works very well.
  - Integrated teams do not meet just once a week or a month or even once a year. A well functioning team stops two, three, four times a day. They will stand up and the meeting will take two, three, four to five minutes maximum.
  - Each team should analyze the needs of those served and the skills of each member to jointly reassign work and maximize efficiency.
  - Nurse practitioners may lead these health care teams.
• One of the issues in relation to multi-disciplinary teams is liability insurance. There is a need to look at different models of liability insurance as they are provider specific. When one is working in a multi-disciplinary team, the accountability and responsibility becomes blurred. It is not always clear who has made what decision.

• Abolish contracted agencies providing home supports. Everything should be under the health authority and be part of one health care team.

• Health care teams held accountable for outcomes and paid as a unit.

• Funding of the multi-disciplinary model should be approached like a co-operative Integrated Health Network. As an incentive for sign-up, members would not be required to pay Medical Service Plan premiums. The Provincial share of those patients’ Medical Service Plan dollars would be moved into the Integrated Health Network Fund. There is double incentive to join such a network; the patient gets integrated care at little to no cost, and the Integrated Care Network receives a funding source and patients.

• Increase funding to collaborative care efforts to ensure that midwifery fits seamlessly into the range of maternity care options in each community, and that relations are clear, positive, and proactive.

• Facilitating the access of psychological services through primary care physicians would mean huge cost savings in the long term with no cost to the province.

• Move forward to ensure effective integrated team-based delivery through a capitated fee structure.

• Increase the levels of coordination of services between cross-disciplines such as mid-wifery, naturopathic, and pharmacy.

• Physicians may need to hold legal liability for those teams and the privacy laws that govern them.

• Building the team will require conflict resolution tools. People will imagine that the team is going to take the load off and then suddenly they have all these relationships to manage.

• A committee of multi-disciplinary practitioners, including practitioners from similar fields who are likely to understand the treatments, should review each of the therapies and treatments and recommend which to include under Medical Services.

• Address the liability concerns for collaborative practice.
• A team-based model should be take cues from oral health. Dentists operate under a fee-for-service structure, but harbour a much more team-based kind of environment. Canadian dentists work with a hygienist, an assistant, and sometimes a denturist. This model is possible because dentists are free to set it up. Insurers are more than willing to pay for the hygienist to clean teeth, rather than have a dentist who cleaning teeth.

• Ideas about human resources:
  • We need stability, not a constant change in teams.
  • Teams have to have time to get to know one another and should possess conflict resolution skills.
  • Provide training to organizations such as the Royal Canadian Mounted Police, social workers, and community service providers on how to compassionately handle those with mental health issues.
  • General practitioners should be encouraged to work openly with allied care providers.
  • There must a clear understanding by professionals regarding their responsibilities and their interlocking roles. The team is not handing over or giving away responsibility, it is about working together and using collective responsibility to provide patient care.
  • Create a patient care manager to access and build specific care models.
  • Doctors should be required to work closely with dieticians and nutritionists to avoid prescription mistakes.
  • Allow for more licensed practical nurses in community health service teams.
  • Increase the scope of practice for registered nurses, licensed practical nurses, registered care aides, and dental hygiene practitioners to facilitate a better team-based approach.
  • Provide support to General Practitioners to meet and discuss how to set up a primary health care team.
  • Managers and leadership must actively involve their staff in finding solutions to bridging the gaps between professions.
  • Educate the College of Physicians and surgeons on integrated care.
  • Create incentive to physicians who utilize allied health care providers.
  • Physicians must be able to volunteer into such a model of care. They must not be forced into them.
• Leadership from the Health Authorities is needed to begin the collaborative care model.
• Allow for autonomous practice within the collaborative system.
• Publicity is needed for the existing programs that are producing results.

• Ideas about facilities and equipment:
  • Physicians and other practitioners should be grouped together in clinics. The health authorities could start by setting up clinics, hiring staff and setting standards. These clinics must be public as the private systems are inefficient. Transition funds must come from the provincial government. Additionally, communication and patient flow must be administered and maintained.
  • Technology is needed to eliminate waste and to free up health care providers to provide comprehensive treatment in one facility.
  • There should be a centre in the Fraser Valley that assesses the needs of elderly patients as a whole, including gerontology, psychology, family medicine, physiotherapy and rehabilitation. These providers would be in contact with each other and agree on a resolution to the patient’s problem together.
  • Collaborative, inter-professional care in group practice settings, well resourced with space and electronic medical records should provide the core of support.
  • Tools such as electronic health records can help in building interdisciplinary teams and provide better coordinated care.
  • Adequate systems and technical support are needed to make multi-disciplinary teams successful.
Canada Health Act and its Principles

The Canada Health Act was the subject of discussions at every venue in the Conversation on Health. Participants focused on the values underlying the legislation, as well as the principles it espouses. Participants also debated the proposed sixth principle of sustainability. Here is a selection of what British Columbians had to say about the Canada Health Act.

Canada Health Act Values and Foundation

Participants debated whether the Canada Health Act represents an expression of a human right, or is simply a piece of legislation which can be flexible and adapt to the changing requirements of society. For some, the principles dictate an approach to health care delivery deeply embedded in Canadian society. Other participants object to this view on the grounds that, to them, it prevents the health care system from adapting to new requirements and demands. For some participants, the Canada Health Act contravenes freedom of choice.

Though some participants believe that the Canada Health Act was created to address basic medical care, they also think that basic medical care has evolved to the point that the system can no longer accommodate the demands placed upon it. For others, the issue is not the original scope and the growing demands, but the lack of investment in the system by governments over time.

The debate represents a clash of values and principles on a number of fronts, particularly between those who advocate freedom of choice as the most important human right and those who see accessible universal health care as a fundamental human right. Regardless, for many participants, any discussion of the Canada Health Act and its principles needs to be national in scope.

“Canada Health Act to be strengthened and enforced based on the five existing principles only, within a publicly funded, publicly administered, publicly delivered system with treatment and pharmaceuticals equally available across Canada.”
– Regional Public Forum, Castlegar
If the Canada Health Act and provincial legislation are proving to be stumbling blocks in the way of efficiency and effectiveness, then there should be an amendment to [the] old rules that don’t fit the needs of the twenty-first century.

– Letter, Richmond

The Canada Health Act is integral to our culture…

– Health Professionals Forum, Cranbrook

Public Administration

For many participants, the principle of public administration underscores their contention that health care in Canada should be publicly funded and delivered. Others argue that this principle may require public funding, but does not dictate the manner of delivery and should not be read in that way.

Some argue that the fundamental aspect of public administration is to preserve the universality of medical care and its accessibility regardless of a person’s financial means. For these participants, the Act prohibits user fees precisely because they may restrict British Columbians who are less well off financially from accessing the system, even when there are checks and balances in place to prevent this situation from happening.

Some participants believe that the principle of public administration requires that health service delivery and funding be accountable to a public authority at all times, ensuring its responsiveness to public interests over private for-profit interests.

There is no escaping government’s responsibility to seek ‘health for all British Columbians’. Equally, in its stewardship role for health as a public good, this must be done equitably and with due regard for priority setting and resource allocation based on sound evidence and good management practices. It does not necessarily follow from this that government must be directly involved in all aspects of the delivery of health care, but if it is not so involved, it must take responsibility to see that its delivery meets the intent and requirements of the Canada Health Act...

– Pacific Health and Development Sciences Inc., Submission

[Public administration means that the levels of government have various overall responsibilities with regards to a publicly funded program but the mechanics… can be separate from the government.

– Regional Public Forum, Cranbrook
Comprehensiveness, Universality and Portability

Participants see comprehensiveness, on the one hand, as raising expectations that the health care system cannot meet, and, on the other hand, as a guarantee that all essential medical services will be provided to Canadians. Many participants debated the challenges associated with comprehensiveness. Some believe that the principle of comprehensiveness means receiving the right care when it is needed. Others believe it is more restricted to insured core services; in other words, it is only applicable to insured services and is not determined by demand or need. Some believe that comprehensiveness should consider the addition of alternative medicine, preventive dental and eye care, and a range of other services. Participants have called for a definition, or re-definition, of this principle to accommodate new demands.

Universality, for many participants, is tied to the idea of socio-economic status. For some, universality means that all Canadians, regardless of their income, receive the same treatment for the same illness or injury. For many of these participants, this precludes the ability to pay for services since those without means could not pay. For other participants, universality means that all Canadians have access to the same services through the public health care system, but does not preclude a person’s ability to pay for faster or different care through a separate system, as long as this does not have a negative impact on public health care.

Many participants argue that benefits are not really transportable across Canada. While the principle of portability is clear in the Canada Health Act, it does not provide, in practice, for the same or similar access to health services across the country. Some note that provinces have no incentive to ensure consistency of services, and without clarity on which services should be provided, there is unlikely to be portability in an absolute sense.

Accessibility and Medically Necessary

Participants often debated the meaning and intent of accessibility and medically necessary in the Canada Health Act. Like the other principles, there are a variety of interpretations, often founded on perspectives founded in values and rights. Many believe that medically necessary means any procedure required to sustain life. Some believe that a guarantee of access to such services should include timeliness, cleanliness and respect. For a number of participants, the medically necessary terminology in the Canada Health Act actually undermines freedom of choice when you really need it, that is, when a procedure is actually necessary.
I think the concept of "medically necessary" is probably one of the most corrosive parts of the Canada Health Act. Under this provision, the moment your need becomes critical, like a diagnostic for a serious condition, you are obligated to go into the public system. But if you wanted to get that MRI when you don't actually need it, you can pay for it.

– Online Dialogue, Victoria

Participants debated what the public expectations should be around reasonable access, and what, if any, impact geography and other variables should have on that access. Some participants believe that only health care practitioners can define medically necessary, and some think government should make this determination, while others believe that the courts should play a stronger role.

Come to a realisation that we must set some standards and define accessibility providing government follows through and implements.

– Regional Public Forum, Surrey

Reasonable access as it relates to "wait time" is subjective and can and has led to endless debate. Neither the courts or any other jurisdiction will provide a definitely "correct" answer, what is required is that Provincial Governments (individually, or collectively) establish wait time targets for individual medical and surgical interventions based on the best available health data.

– Online Dialogue, Victoria

Sustainability

Whether or not to consider an additional principle of sustainability was a topic for discussion. Those in favour suggested it would lend a more focused and measured approach by requiring that decisions on health services balance the other principles with the question of whether that service would contribute to a sustainable public health care system. Those arguing against this proposed sixth principle were afraid that this balancing would undermine the other principles and may in fact undermine the meaning and intent of the legislation as a whole and therefore destabilize the public health care system.

DO NOT add the sixth principle of sustainability to the [Canada Health Act]. Its addition implies that cost is more important than the first five principles, and thus could be used in the future as a justification to allow more privatization which is NOT needed to keep it sustainable anyway and which could justify the erosion of the first five principles of the Act.

-Individual, Submission
The federal and provincial governments [should] 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.

– British Columbia Medical Association, Submission

Conclusion

The Canada Health Act and its principles came up throughout the Conversation on Health, alternately as the positive foundation for our health care system, a fundamental right of all Canadians, and the sacred cow that stops us from making positive changes. Most participants support the Canada Health Act, but there is no real agreement on what it means or stands for. Discussions around each of the five principles of the Canada Health Act, and the sixth principle proposed by the Government of British Columbia, highlight some of the debate around this topic.
Canada Health Act and its Principles

This chapter includes the following topics:

- **Canada Health Act – General**
- **Public Administration**
- **Comprehensiveness**
- **Universality**
- **Portability**
- **Accessibility and Medically Necessary**
- **Sustainability**

**Related Electronic Written Submissions**
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

- Health Human Resource Responses  
  Submitted by the British Columbia College of Family Physicians
- **HEU Submission to BC’s Conversation on Health**  
  Submitted by the Hospital Employees Union
- **Submission to the Conversation on Health**  
  Submitted by the BC Nurses’ Union
- **Submission to the British Columbia Conversation on Health**  
  Submitted by Life Sciences British Columbia
- **Bring Services for Mental Illnesses “Out of the Shadows”**  
  Submitted by A. Donald Milliken

**Related Chapters**

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Public Private Debate; Health Care Models and Health Spending.
Canada Health Act - General

Comments and Concerns

- We hold on to the principles of Medicare very firmly. A wise thing. But sometimes we hold on to the particular forms that Medicare takes too firmly. And we get rigidity there. It is good to have the principles as an icon. It is not good to have particular ways of doing business as an icon. We need to decouple those to a certain extent.

- Health is not a choice: it needs to be accessible, universal, and affordable.

- Canada is a good place to be because of the Canada Health Act.

- Our flaw is that we hold onto the principles very firmly, which we should. But we also hold onto the structures and patterns and historical characteristics of the system that we should not.

- The health principles are good. We just need to adhere to them and be accountable.

- When originally passed, it was supposed to provide basic medical care through tax funded health care services, but it is so limited and restricted that it is totally unable to provide effective and timely treatment to Canadians.

- The Chaoulli decision is relevant across Canada.

- How do we preserve the generally accepted principles of a public health system, and improve it with a lot more agility and creativity and success than we have now?

- The government is denying the public consensus that we want universal health care which respects the Canada Health Act.

- Amendments are required to the Canada Health Act in order to sustain a good, fair level of health services to all Canadians.

- How can you have a real conversation about delivery models and health care with the Canada Health Act in place?

- The Canada Health Act (1982) should have been added to over the years, not reduced.

- We don’t realize how unique it is to be able to go to the doctor and not pay, to get treatment automatically if you have a medical problem without figuring out how the costs will be covered.

- In a civil and just society, everyone is taken care of regardless of race, disability, age, sex, and so on.
• The health care challenges today are different from those that were there when the Canada Health Act was designed.

• Why raise the question of changing the Act?

• The Act is outdated in its interpretation. It cannot possibly render all services in all places across the province, but it is essential to maintain a universal public system allowing for coverage of all conditions.

• The Canada Health Act is one of the biggest stumbling blocks and is restrictive.

• The Canada Health Act is integral to our culture and is being challenged.

• The Canada Health Act is a right that is being attacked.

• The Canada Health Act must be flexible enough to evolve with Canadians.

• The Canada Health Act prevents a non-public payer.

• We can change the Act.

• The real enemy of health care in Canada is the Canada Health Act.

• Health care costs, flexibility, efficiency and sustainability in British Columbia cannot be achieved without the proper amendments to the Canada Health Act.

• The Canada Health Act guarantees Canadians health care and is a wonderful asset for Canadians.

• Canadians are defined, in part, by our publicly-funded medical system.

• We are happy with the system overall: it is accessible and the principles in the Canada Health Act are serving the country well.

• The Canadian collective identity is strengthened by our continued commitment to a publicly funded system.

• The Act is open to interpretation. We want to change it or change our interpretation.

• The Act was meant to cover doctors and hospitals, not other practitioners that are integral to health care.

• A lot has evolved since Tommy Douglas. What we have today started with one man. He was like a dog with a bone on policy. He ran into resistance, but he did not let that resistance stop him.

• We have not modernized the legislative and policy framework for health care in twenty-five years. We have tinkered around the edges. There have been some big attempts, like Kirby and Romanow and even the Seaton Report in British Columbia.
• The *Canada Health Act* sets very minimal standards. What it says is with respect to physician services at hospitals. It does not even say you cannot shift cost onto patients. It just says if you do, there will be financial penalties that apply to the provincial government concerned. There is potential for a lot of other constraints but they have never been applied.

• Yes, we have a *Canada Health Act*, but people go around it all the time. So surely we could have a discussion about how we put some bits around that so that it protects the public system. At the end of the day the average provider and the average Canadian wants a strong, universally funded, universally managed health care system.

• The existing *Canada Health Act* is ineffective realistically and needs to be reviewed to provide universal health standards and options for private delivery.

• The principles of the Canada Health Act should guide the system.

• Existing principles work well, but need to be enforced and in particular private/for profit should not be allowed in system.

• The federal government is not ensuring the provinces follow this Act or are applying it evenly.

• When you are talking about the health care system, are there any sacred cows in the system that we are not willing to talk about, that we are not willing to bring to the table?

• The first observation is that it is pretty much impossible in entering into this conversation to avoid some of the ideological, sacred cows, or sacred ground and the visceral reactions that such conversations elicit.

• The *Canada Health Act* needs to be expanded to include community services and prevention.

• Tear up the Act.

• The Government refuses to spend surplus dollars on solutions to the *Canada Health Act*.

• The system cannot be all things to all people and we do not have a clear understanding of what is essential. Any shift in the expectations, therefore, will take time, perhaps a generation.

• The Act received Royal Assent on April 1, 1984. I refuse to say April Fool’s Day in 1984, but it has assumed the status of Holy Scripture. It is really an Act that stipulates the terms on which federal funding will be granted to each province.
• The principles have existed since the 1970s and the principles were formulated over 50 years ago. It needs to be updated for the 21st century.

• The Canada Health Act has been enacted now for over 50 years and it is time now to see if we can revisit and find out new definitions or ensure in our own minds what is really meant, because in 50 years things have changed.

• My question really is to our colleagues from Ottawa who have the prerogative of enacting and revisiting this Act, to see if there is an appetite today in their minds of starting a conversation on health nationally with the purpose of revisiting the Canada Health Act.

• One of the things that is evident in the Canada Health Act is that there are no definitions around the five principles. There have been administrative practices that have been put in place but there are no definitions. One of the goals that we have in British Columbia is to work towards definitions of those five principles, including a sixth principle which is sustainability.

• Amending the Canada Health Act is a discussion that needs to take place, not just here in British Columbia but across Canada.

• There is a mathematical brick wall that we are slamming into and we must continue to remind ourselves of that mathematical fact: that there is not and will not be enough money in the public purse to pay for all that we ask for. We have to start dealing and grappling with the issue of modernizing the Canada Health Act.

• British Columbia is a provincial jurisdiction so we cannot change the Canada Health Act. We can work towards definitions of the principles of the Canada Health Act, and if the Federal Government disagrees with them, they can let us know.

• Nearness to a hospital and surgeons available 24 hours a day at hospitals are the most important principles.

• Opening up the Canada Health Act could result in weakening the principles.

• The purpose of the Act is to prevent catastrophic loss.

• The public health care model is a great idea, but now it has become a political tool to maintain the status quo.

• The onus is on government to manage its budget to meet the principles of the Canada Health Act. Add a sixth principle around efficiency.

• The Canada Health Act lacks teeth and does not work, but we would have more problems if the current legislation was not in place.

• Looking at your health care values and vision is significant. Your values, universality, portability, accessibility, comprehensiveness, and public administration, are
significant values. You might want to consider whether you would want to add equity as well. That is implicit but you may want to make it explicit.

- The Canada Health Act currently states that charging for any medically necessary procedure is illegal. The Provincial Government is looking for loopholes to privatize services.

- What is the Canada Health Act supposed to be? Quality medical care for everyone. Guidelines for delivery in Canada. Values and beliefs of Canadians. Getting the same health care access across provinces.

- The Provincial Government does not have the ability to independently alter the Canada Health Act 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.

- It is disappointing that provincial governments have not tried to move in the direction of a national health plan providing broadly similar services to all Canadians, but this issue seems to raise little public discussion.

- What does the Constitution say with respect to the right of Canadians to good general health and the commensurate commitment, duty or obligation of government toward that standard?


- If one has concluded that health care demands cannot be met from taxation alone, does the Conversation on Health permit a discussion of the ways in which patient co-payment can be integrated into the Canada health care plan, without jeopardizing basic objectives?

- The Romanow Commission’s approach to elucidating the values that Canadians have in common regarding their health care system was sound, and we should be building from there.

- Politicians underestimate the public will for change and citizens are receptive to measures that contravene the Canada Health Act or involve private clinics paid by the public purse.

- It is rather disconcerting to characterize health care as a right. It is certainly not a right in the category as a right to free speech, expression, or association. Health care is a privilege.
• Premier Tommy Douglas had eight tenets for a sustainable health care system. The first five are largely embodied in what has evolved over the years into the Canada Health Act. The missing three tenets called for a plan which, according to Premier Douglas, had to embrace a form which will operate effectively, efficiently and responsibly. Sadly, if governments both provincially and federally had adopted those critical principles (effective, efficient and responsible) no following legislation would ever have been passed that allowed for or excluded the use of many different forms of health care delivery nor the adoption of health care policy that was neither properly funded nor sustainable. In addition, while Premier Tommy Douglas is the acknowledged father of public health care, he never promoted nor intended to have the delivery of health care controlled by the government.

• The 1984 Canada Health Act has exclusionary clauses, continuing to isolate patients with serious psychiatric illnesses from the mainstream of federal healthcare funding. Faced with this reality, and like many other provinces, British Columbia has never produced a consistent, coherent and effective policy to ensure that mentally ill patients receive services at a level equivalent to those offered to physically ill patients with an equivalent level of disability.

Ideas and Suggestions

• There should be the same coverage and fees throughout Canada.

• Promote a more constructive interpretation of the Canada Health Act which embraces the principle of sustainability and one that will adhere to the original forward-thinking vision of Tommy Douglas.

• We need to guarantee a fundamental level of care.

• If the health care system cannot provide care, every citizen must have the right to find solutions. No one should ever be legislated to live with health problems.

• Communicate changes in the health care system to the public.

• Adopt best practices from Europe that are consistent with Medicare.

• Government should set standards and enforce them.

• Ensure universal accessibility through the public system.

• Ensure a publicly funded system that is comprehensive, accountable, transparent, measured, universal, accessible, innovative and efficient, and that is focused on wellness rather than just acute care.

• Entertain change without eroding the acceptability of care.
• Add accountability as sixth principle.
• Set clear goals and objectives of what type of health care system we want in Canada, what are we willing to pay for and what do Canadians want to have. But it has to be a clear goal and a clear objective so that Canadians will understand it precisely.
• Begin exploring the reconfiguration of legislation and ways and means of addressing the health care challenges in all of our worlds.
• We need a legal framework to allow timely action to enforce accountability.
• The Canada Health Act should be strengthened and enforced based on the five existing principles only, within a publicly funded, publicly administered, publicly delivered system with treatment and pharmaceuticals equally available across Canada.
• Strengthen and enforce Canada Health Act. Stop eroding it.
• There should be consistent quality of care for all.
• We need a better definition of the existing principles.
• The Canada Health Act is fine the way it is.
• Stick to the five principles.
• We need a strong advocate(s) to maintain and enforce the five health care principles.
• The Canada Health Act should be amended to quicken end of life.
• Keep the politicians accountable and maintain the core values and principles enshrined in the Canada Health Act and enforce the standards provincially.
• Update the Canada Health Act with clearer, more modern definitions.
• The Canada Health Act is outdated. It needs to be updated and improved to include the accountability of government and the individual.
• Systems, mechanics of delivery, attitudes, expectations and medicine have all changed. The Canada Health Act needs to change as well to suit these shifts.
• Provide more resources and maintain the integrity of the Canada Health Act.
• If the Act is no longer working, it should be changed, for example to suit the changed times, conditions, and life-expectancies.
• Flexibility has to be one of the strongest factors in determining how health care is provided, so more flexibility should be included in the Canada Health Act.
• Tax payers through their provincial government should have the right to amend the Canada Health Act.
• Timeliness should be a principle.

• Revisit the Canada Health Act by expanding it to look at other facilities that could be funded.

• The Canada Health Act should focus on the standard of health not the standard of delivery.

• Strengthen and enforce the Canada Health Act. Ensure consistent application across the country. Fund health care adequately and do not put the Act at risk.

• Conduct a review of all principles and consider new ones, for example technology, innovation, health standards, and private delivery.

• Add principles of transparency and accountability for public funds.

• Quality of care should be included in the Act.

• Involve the public in rewriting the Act and redefining the five principles for today’s society.

• The Act should be opened up from time to time to be updated.

• Revise the Canada Health Act to ensure there is a clear identification of how the principles will be upheld and who is accountable for components.

• Enshrine the Act in the Charter of Rights and Freedoms.

• Consider changing the Constitution to allow all health care to become the responsibility of the Federal Government.

• We may be willing to pay more to maintain a system that is evidence based, accountable and efficient.

• People do not trust the system. The health care system needs to work with the media to ensure proper messages are reported, and enhance the public’s knowledge on the Canada Health Act. We want this report to be utilized and not put on the shelf like the Romanow Report. None of this will work without political will.

• Amend the Canada Health Act to allow for a non-government funded private two-tier system.

• Include responsibilities and consequences for actions such as bottlenecks at hospitals.

• Canada Health Act 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.
• The Provincial Government should continue to recognize health as a public good, recommit to the principles of universality and equity in the delivery of health services, and curtail private for-profit entities as an alternative in any area of core or essential services. While not all health services must necessarily always be delivered by government health agencies *per se*, clearly government must ensure that how it puts together services must be in compliance with the *Canada Health Act*.

• We need to have a federal, and possibly a provincial, person whose job it is to act as an advocate for public health care and ensure that it is kept intact, publicly run, and gets the funding it requires.

• Build on the strong foundation of the *Canada Health Act* by providing research funding for healing techniques that complement drugs and surgery; and by including reportedly effective techniques from world medicine and traditional practices.

• The Provincial Government should keep certain principles in mind when changing the health care system: extend universal access to services on the basis of need and not ability to pay; establish clear public purpose objectives and regulations; finance services out of public revenue; favor grants or subsidies over contracted services; and if services are contracted, adopt standard government procurement procedures.

**Public Administration**

**Comments and Concerns**

• It is not possible to set up a system that depends on each person taking on their own risk because you do not know what the risk is. You make decisions over short-term fantasies about what your risk is, and yet the actual risk to you is spread out across your lifetime in unpredictable ways. So the first criterion is, how well does whatever insurance plan you have spread the financial risk across the population? The keyword here is usually equity.

• The Supreme Court of Canada handed down a significant decision in a case from British Columbia. The Health Services and Support case. In that case, which involved legislation enacted by the legislature of British Columbia to restructure or to permit a various restructuring within the healthcare system including contracting out and changes to certain Collective Agreements, the Supreme Court of Canada ruled that certain provisions in that scheme of legislation were unconstitutional because they limited the right to collective bargaining. Now, what this does is it displays the frailty of litigation as a way of designing social policy. Because if you
had taken the *Chaoulli* lens and applied it to this Health Services and Support case, you might have said, well, the goal of this restructuring is to enhance accountability to patients, or to enhance service delivery to patients so that there is better service delivery, more efficient use of resources. But no, the litigants here were largely trade unions and other health care workers saying that their rights were being limited. So the court said, yes, your rights are being limited. And by an eight to one margin, ruled that the legislation was unconstitutional, which limits the ability, or will limit the ability of governments going forward, to restructure in this area, which again suggests that what you may force indirectly is the emergence of some kind of private, alternative or parallel system. Because if you cannot restructure within the public system, you are not going to be able to deliver care in a timely way.

- The litigants in the Health Services and Support case were not in favour of a parallel private system. They want to keep the rights that they have, the Collective Agreements and so on and so forth. However, there are unintended consequences of decisions from time to time. Looking at the justification that the government relied upon in 2002 when it enacted that legislation (Bill 29), they wanted want to make the system more sustainable by being able to be more flexible and enhance the ultimate delivery of services to patients. Maybe they were wrong. The one unintended result is that governments have not as much flexibility or legislatures do not have as much flexibility as they did before. Now you might say it is a good thing that now there is a Constitutionally-recognized right to collective bargaining. But the effect of it is undeniable: it is going to make it more difficult for governments to act to implement forms of restructuring.

- The *Canada Health Act* prevents provinces from implementing any kind of mixed delivery system (such as a public and private mix).

- The *Canada Health Act* is not fully implemented, for example we have not implemented prevention and health promotion.

- The province decides what is in and out of the Act.

- Current restrictions imposed by the Act make it difficult to deliver health services.

- The Act does not allow for user fees.

- The Federal Government balances their budgets by absolving themselves of their commitment to funding health care. What they give now is so small the provinces should tell Ottawa to keep their insulting bribes that pin us to an inflexible *Canada Health Act*.

- Take a serious look at the *Canada Health Act* and what it means. There is nothing in there that says that the delivery of health care cannot be from the private sector.
• Public administration means that the levels of government have various overall responsibilities with regards to a publicly funded program, but the mechanics can be separate from the government.

• We need better standardization of services provided for under the Act in all the provinces and territories.

• The federal government can hold back money if the provinces are not honouring the Act.

• The Federal Government is exercising undue influence over provincial government health care policy.

• Wait times and equipment issues need to be addressed.

• What can we do under the framework of the Canada Health Act?

• The five principles do not agree with a system that rations health care.

• The Canada Health Act has become a huge financial burden on all provinces.

• Does the Act define the quality of the equipment and services provided?

• Public administration does not protect public interests, but protects the institution.

• What the Act does is prevent provincial governments from offloading costs onto patients, or at least makes it expensive for them to do so. It does not prevent them from doing it, but they will not gain from it fiscally.

• We should change the Act to allow the system to charge user fees.

• It may be nice to believe that just a little bit of a user charge would cause people to think more carefully about contacting a physician. It will not. What it will do, is it will just change the distribution of who bears the brunt. It is not going to improve efficiency or effectiveness. There is quite a bit of evidence on that. Therefore, do not to spend a lot of time trying to loosen up the Canada Health Act and increase the supply of private money because that is going to be inequitable.

• 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 British Columbia this authority is the provincial government which is ultimately responsible for its performance. No 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 that the health care insurance plan of a province must be administered and operated on
a non-profit basis by a public authority appointed or designated by the government of the province; the public authority must be responsible to the provincial government for that administration and operation; and 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.

- The weakness is that there is a lack of accountability both at the provincial level and the federal level. Each one blames the other for either not appropriately utilizing the funding or not providing sufficient funding. As a result, there is abuse of the *Canada Health Act*.

- The health field therefore entails a struggle among competing interests past, present and future. While the principles under the *Canada Health Act* resonate politically, not all health modalities are equally recognized. Nor are they equal in terms of need, quality of supporting evidence, nor necessarily affordable. Choices have always have been made. As health care has moved historically from being a private matter between patient and caregiver, to a public sector enterprise that values effectiveness and efficiency, so too has its design, standards and management moved from the grass-roots to more centralized systems, be the latter government ministries, regional authorities or university faculties of health professions. Whether these systems are now sufficiently in touch with local needs is a legitimate question.

- Government does not need to be directly involved in all aspects of the delivery of health care, but if it is not so involved, it must take responsibility to see that its delivery meets the intent and requirements of the *Canada Health Act*. Clearly we live in times when our health system is potentially under threat, especially from those who do not share in the vision of a common social contract to deliver on the principles and promise of the Act.

- The introduction of these private insurance choices has meant we are going back to the time before Medicare when many people did not seek care when needed because they did not have the money to do so. I remember what it was like before Medicare and my parents had to choose between food on the table and taking us to the hospital or doctor.

**Ideas and Suggestions**

- We should have free health care and better insurance.

- Standardize the interpretation of the Act.

- Create a mandatory medical savings plan, similar to the Canada Pension Plan.
• We need planning and public education around the *Canada Health Act*.

• No private insurance plans should be allowed whatsoever. When a person is ill they should be looked after. We initiated a universal Medicare so people did not have to worry about being covered when they needed help.

• A functional and humane health care system cannot be built on a split foundation.

• Health care decisions should not be made in courts.

• Close up loop holes in the *Canada Health Act*, that is, do not allow doctors to practice in both systems.

• Do not allow advertising of private health care and drugs.

• Government should not pass laws and policies that only benefit companies: we should have a patient protection law.

• Repeal the drug patent protection law.

• There should be a transparent process for defining publicly funded benefits under the *Canada Health Act*.

• We need a common understanding of what is covered under the *Canada Health Act*.

• We need national standards for treatment of outcomes, such as waiting times for surgery.

• Create a clear definition of what the purpose of the health care system is and place all that falls outside of that definition outside of what health care provides.

• Get home support included under the *Canada Health Act*.

• Focus on patient not the Act. Take the politics out of it.

• The Canadian Government should establish qualifications and standards for health care professionals and facilities.

• Fund basic health care services, such as visits to professionals, required procedures and a negotiated portion of facilities required for these procedures.

• Increase transfer payments to adequately fund health care.

• Separate the *Canada Health Act* from private health care and create an insurance market for private delivery.

• Put pressure on the federal government to enforce the *Canada Health Act* and increase transfer payments.

• There must be more accountability for how money is spent and ensure that it follows the Act.

• All doctors must be practising under the *Canada Health Act*.
• Restore 50/50 shared funding with the federal government.

• Push the federal government to counter the *Chaoulli* decision.

• We need the political will to penalize provinces who are in contravention of the *Canada Health Act*.

• The *Canada Health Act* inhibits provincial decisions. Provinces need more autonomy.

• The Federal Government should protect Canadians from inter-provincial differences.

• Identify what public health is: stop stretching the meaning of the Act. Decrease the influence of lobbyists.

• Educate the public they have a contribution plan and not a defined benefit plan.

• Remove provincial authority over health care policy. The federal role is to define standards and enforce consistency between provinces.

• The *Canada Health Act* must be modernized and administered by the Federal Government. A national plan is a national plan, not differentiated by provincial boundaries. The *Canada Health Act* must live up to its name.

• We have a tendency every once in a while to default to the *Canada Health Act* and say it is stopping us from doing things. The *Canada Health Act* does not stop us from doing a whole bunch of things that we can decide to do if we decide to do them. We all have to recognize that it is actually a pretty flexible document in terms of what we can do.

• Add alternative medicine to the *Canada Health Act*.

• Maintain the *Canada Health Act* through public and private health care. Staff and doctors in private clinics should be governed by the *Canada Health Act*.

• Areas mostly covered by public spending should be enshrined in the *Canada Health Act*, including ambulances, mental health and addictions.

• Include home care and long term care under *Canada Health Act*.

• The Federal Government must ensure that health care funding to the province is targeted to health care. The Province is accountable for proving it went to health care and not to other programs.

• People need private choice options that they can purchase and that are not restricted by the *Canada Health Act*. 
• Government should re-examine now what services should be core or essential, and to consider expansion of the scope of publicly financed provisions, with emphasis on serving the more vulnerable populations. This would seem particularly timely in the context of record budget surpluses in the face of public needs.

• 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.

• 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.

• The federal and provincial governments should jointly agree on a defined Canada-wide Basic Scope of Universal Health Care (BSUHC) which they consider to be affordable. The coverage would be 100% portable between all provinces. Beyond this coverage, each province should have the right to expand the scope of coverage, but should be required to provide the funding for excess costs to provide the services beyond the Basic Scope of Universal Health Care.

**Comprehensiveness**

**Comments and Concerns**

• We have to start acting in a more honest fashion and letting the people know that we are promising things that we cannot deliver.

• Comprehensiveness means everyone has the right to essential medical care when they need it across the life span.

• The most important priorities are preventive tests, drugs and timely surgery.

• Quebec and Newfoundland both have dental care for children and youth as part of their public health care systems.

• 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, 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 the existing interpretation of core services is inadequate. This is because more and more services have migrated out of the hospital setting and many services previously provided in hospitals are now delivered through a combination of community-based services and drug therapy. Also, services that continue to be provided in hospitals increasingly involve day surgery, or 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, is funded in a variety of ways. Core services are fully government-funded. 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.

- This principle, that insured persons should receive all necessary medical and hospital (and even dental) services, was initially stated in a very general and even circular way to avoid interfering with either professional judgments on patients' needs or the specifics of provincial health service plans. The phenomenal changes in medical, pharmaceutical, hospital and other aspects of health care in the past forty-seven years confirm the prudence of being non-specific in the statement of the comprehensiveness principle.

- Comprehensiveness and portability mean to me that in a universal Medicare program no premiums are charged and it is funded totally through our taxes so it is equitable to all.

- Universal means coverage for all citizens, not coverage of all things. I agree that we do need to make hard decisions about what we include in our public system.

**Ideas and Suggestions**

- We need more consistency in service between provinces.

- We need accommodation in law for the right of adults to choose their health care on any grounds, whether spiritual, religious or moral, and the accommodation of those
who give that care, such as Christian Science practitioners and Christian Science nurses.

- Write new legislation (something like the Canada Health Act) to cover prescription drugs, vision, dental care, hearing, home support, and so on.

- All Canadians should have the same benefits.

- Review the interpretation of comprehensive to consider the addition of alternative medicine, massage, homeopathy, dental, and so on.

- 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.

- 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.

**Universality**

**Comments and Concerns**

- Problems of achieving the ideal of universality are intertwined with accessibility, as patients in remote areas are often faced with significant travel costs to receive medically necessary treatment services. As is the case for accessibility, a shift in emphasis to coverage of medically necessary services rather than providers would broaden the base of professionals available to patients in outlying areas and reduce the discrepancy in universality that currently exists.

- The right for each person to have their basic health needs met equally regardless of their socio-economic status and this is paramount to a health care system that is not privately operated. The government needs to ensure that this quality of care standard is met. If it is not and there is the option for a person to be able to purchase private insurance it would most likely mean that the wealthier would have quicker access to care and a different standard of care.

- Universality has proven to be cost effective.

- Universality is supposed to be equal treatment for all. Reality says that if you have a recognizable name, face, or affiliation, you will get better treatment.
• Universality is the opposite of the insurance company approach of denying coverage to people based on their health profile and history.

• We are afraid of the European system because we are stuck on the concept of universality. There is no reason why a mixed system cannot supply the historical universality that we have protected so strongly. In fact, we will see an improvement in universal access. Universal is a myth anyways. If some people can afford to seek health care outside of the *Canada Health Act*, they will always be able to find it. Universality has become a political football, nothing more.

• Canada is the only country in which it is illegal to write a cheque to buy health care. This either makes us the smartest or the dumbest country in the world. Not only are those odds not in our favor of being the smartest, a system that does not work in any province indicates that we are the dumbest. Let us catch up to the rest of the world.

• Universality is like a universal level of coverage: basic health insurance for every Canadian covering the costs of regular checkups, small problems, emergencies, and a portion of drug costs.

• Government has failed to demonstrate sufficient commitment to universality and to protecting the essential public nature of health care over the long term.

• Universality does not mean you get what you want. Entitlement is a huge issue especially when it involves requests for unwarranted tests by those with the money to buy them.

• We all have access to a full range of services.

• Universality defines us as Canadians.

• There is basic universal health care with no accountability and no uniformity across the country.

• Universality must be maintained federally and provincially.

• Access is part of universality. The two-tier system is contrary to universality.

• Universality means the same coverage, and access and service for all.

• If we really want to provide universal access, the funding should follow the patient wherever he or she chooses to be treated in the province.

• Something needs to be done to improve equity across regions.

• Universality varies from province to province.

• Universality does not apply to PharmaCare. There are have and have nots in relation to medication.
- The idea of universality is suspect.

- Health care must be two things: accessible and equitable. That has to be evident throughout Canada. It has to be accessible and it has to equitable to all Canadians: to rural or urban, to all First Nations, Metis and Inuit, to rich, to poor, to young and to old.

- A mixed public and private system may affect the universality principle.

- There should be equal access and equality before the law.

- All citizens and landed immigrants should have access to publicly funded health care.

- Is it realistic to expect someone in the north will receive similar services as those in the south?

- The original intent of the five principles is good, but provincial governments have interpreted them differently to suit their needs. Universality is not happening. If you have money you can get better care and better service.

- Universal health care means zero cost to individuals. We should aspire to universal health care for everyone.

- Access by immigrants to the system is poor.

- A common misperception is that the Canada Health Act applies to every Canadian equally. However, the Canada Health Act clearly outlines groups or services not covered by its principles. Some of these groups access services differently (and often faster) than other Canadians, which is legal under the Act. For example, if a person covered under the Workers Compensation Act in British Columbia 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.

- Universality in terms of the Canadian health care system is whatever the provinces and Federal Governments reach agreement on as the base line (minimum) standard of service that all provinces will meet. Because health care is a provincial responsibility and the economies of each province will vary there is bound to be differing levels of coverage between provinces above the national base line.

- The Federal Government tends to use this so called universality to justify its own stance on health care delivery and a diminishing federal commitment to it and especially as leverage to control provincial policy.
Ideas and Suggestions

- The system could be made more efficient as long as its universality is not compromised.
- Maintain universal health care.
- Equal access and service to everyone.
- Ensure the system is designed for equity.
- Make all aspects of the health care system universal: ensure that there is less autonomy to provinces and more penalties for non-observance.
- Public universal health care for all British Columbians.
- All Canadians should have equal access to quality health care.
- We require good quality care regardless of means and income levels.
- Do not compromise the principle of universality.
- Health care delivery should be equally available to every citizen paying either Medical Services Plan or funding hospital operations as part of their taxes.
- Any methods of delivery, including costs or fees, cannot unduly disadvantage any segment of society.
- We should not undermine the universality of the Act, meaning we should not be able to buy extra insurance or create a two-tiered system where people with money get the best and most expedient care.
- Maintain universality through public funding.
- Defining the principle of universality further in law is not necessary given the provisions that already exist in the Canada Health Act.

Portability

Comments and Concerns

- Benefits are not really transportable across Canada.
- Responsibility for delivery rests solely with the provinces.
- In general, the principle of portability does not require further legal clarification. However, 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.
• True portability will not be reached until Canadians can get much the same health services when travelling within the country as when at home. It is not going to happen for a long time; provinces are not motivated to move on this front. It is worth considering, however, whether some of the fraudulent use of health cards occurs when residents of one province want to obtain service in another, whether because of waiting times or views about the relative quality of services. If services were more portable within Canada, would the administrative costs of the provincial health plans be thereby reduced?

• Portability means that there needs to be a list of commonly-agreed-upon basic conditions that would be covered everywhere in the country, but that each jurisdiction would have the ability to provide services beyond this basic list for its own citizens.

• Portability means if a Canadian requires essential medical care anywhere in Canada, health care should be provided without the individual incurring costs normally covered by the health plan.

• Portability means that the same services are available across the country and that anyone from one province can access the same services regardless of the province they are in when they require them.

**Ideas and Suggestions**

• We should be able to go anywhere to get treatment.

• Portability between provinces must be strengthened.

• PharmaCare and treatments should be equal in all provinces.

• There should be more federal and provincial coordination, including standardization of portability and accessibility.

• Portability means that anyone under Medicare is covered no matter where they live in Canada. It does not mean that we should be paying for travel insurance to get additional coverage when travelling.
Accessibility and Medically Necessary

Comments and Concerns

Chaoulli Case

- Comments on the Chaoulli case:
  
  - A parallel private system would not only expand supply (the quantity of care) but would offer competition to public sector hospitals in terms of the efficiency of production and the quality of care. Competition also applies to physicians: free to compete, they would enjoy improved incentives to attract patients with effective care and provide that care as efficiently as possible. The Chaoulli case in Quebec is a welcome step in the direction of sanity, quality, and sustainability. Should the two sectors be solitudes with a fence between them? Obviously, cross-over rules, say, relating to physicians working in both sectors, would be necessary, but there is no reason why Canada cannot emulate the example of Sweden, Australia, Austria, Belgium, France, Germany, Japan, Luxembourg and Switzerland by permitting private health care providers to compete directly with public sector hospitals for services paid for government under the universal system.

  - Many people have argued that Chaoulli somehow establishes a right to private health insurance or somehow mandates a two-tiered healthcare system, which is not the case. But it certainly does augur for change in the health care system. Basically what the judges indicated was that they were not willing to somehow rewrite the basic terms of the healthcare delivery system that we have in Canada, and somehow to mandate that there was a Constitutional right to a separate parallel private system. But, what Senator Kirby and his colleagues advanced to the judges (in their submission) was that it is perfectly acceptable to establish a monopoly publicly-funded system as long as patients can access services in a reasonably timely way. There does not seem to be an answer to it, because it would be really contrary to the entire purposes of the system to require people to suffer or die, and prohibit them from protecting their own health in the guise of preserving access to a quality healthcare system. The Supreme Court of Canada, by the narrowest of margins, four to three, did accept this argument.

  - The Supreme Court of Canada says in the Chaoulli case that if the government wishes to prohibit people from using their own resources to protect their health, then the government has to ensure that services are available in a reasonably timely way, in a manner or to a standard determined by medical experts, not by judges. Otherwise the system violates the right to life and security of the person.
• The Supreme Court of Canada in *Chaoulli* was quite clear in saying that there is no right for the government to pay for your health care, whether it is in a hospital or any other setting. What *Chaoulli* was concerned with were prohibitions on the individual citizen’s right to utilize their own resources.

• The broader principle that is established in *Chaoulli* could be described as one of patient accountability, where patients now have the right to demand accountability and they must be seen as at the center of the health care system, and that their needs must be taken into account. There is a legal accountability. There is the opportunity for patients now to say that if you do not provide me that service in a timely way, either you are going to have to provide that through the public system, or you are going to have to allow the development of some other parallel or supplementary form of private health insurance.

• The *Chaoulli* decision, whilst presently relating only to Quebec, opens the doors of tens of thousands of similar law suits in the other nine provinces citing the same *Charter* violation in regards to unwarranted denial of access to private medical services and insurance.

• The *Chaoulli* case is just an excuse to bring in private Health. The Act is fine the way it is, funds just need to be used properly.

• Canada and British Columbia have highly dispersed populations. The challenge is to extend equality of access to health care across very far reaching populations. One of the things that we have to be cautious about is introducing models that are based on cities where millions of people live.

• A 100 per cent government-controlled system has a legal obligation to provide timely care.

• Reasonable access is not for the courts to decide. It is up to our elected representatives in parliament to debate and find out what the public thinks through referendums.

• Medically necessary should be any operation that is required to sustain life, maintain health, or restore body function where the chance of success is at least five per cent without throwing money at procedures that are unlikely to work.

• Guarantees should include: speedy access to necessary tests, services and procedures, a maximum limit on wait times in emergency, having basic hygiene needs met while in hospital, hospital equipment (in good working condition and enough supplies to go around), an expectation that regular mistakes are avoided, and guarantee that you will be made comfortable and be respected as a person.

• Medically necessary is simply anything that is demonstrably causing harm (emotional or physically) to a patient that can be cured or alleviated with access to
medical help. If we are unwilling to have courts tell us what these terms mean, why do we expect a private firm to be any more honest, or reasonable?

- Accessibility must be defined.
- The basic problem with the Canada Health Act and the medically necessary designation is that it imagines a mythical scenario where someone would never want to choose something outside the public system. Well, these days a lot of people would like to have a choice because the public system is not a viable option. To maintain such an antiquated approach in our healthcare system just seems ludicrous to me. When you are in pain, getting better is the only thing that matters. Why do we have to stand in the way of that?
- The concept of medically necessary is probably one of the most corrosive parts of the Canada Health Act. Under this provision, the moment your need becomes critical, like a diagnostic for a serious condition, you are obligated to go into the public system. But if you wanted to get that test when you do not actually need it, you can pay for it.
- Treatment should be deemed medically necessary if the evidence shows that it has had reasonable success.
- The word reasonable is subjective. The judicial system does not have a definition for it and so we cannot define it either. We should just model after the judicial system and elect or appoint a panel of our peers, with the assistance of experts and administrators to define the term.
- Medical necessity is determined by political necessity and who has the loudest voice gets the services.
- Defining medically necessary and reasonable access should be part of the continuing public process. The courts will inevitably be involved in hard cases, and this can help signal which issues require additional policy attention.
- Enshrine in the Canada Health Act a provision of the Criminal Code, namely gross negligence causing bodily harm. That speeds up the access to medical services and clearly defines what is necessary for the patient.
- Reasonable access is a highly changeable number given all the variables it is affected by across geographic, economic and demographic groupings. We need to identify and examine the variables that affect access and try to identify how these can be individually and collectively minimized.
- Medically necessary is an ambiguous term.
- The Canada Health Act stipulates that Canadians must have reasonable access to insured hospital and physician services. In the Act, reasonable access means:
patients not having to co-pay for core services, and 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.

- Canada's First Ministers should jointly seek an enhancement of the accessibility principle of the Canada Health Act in relation to core services by: implementing clear maximum allowable wait time benchmarks for all scheduled surgical and diagnostic procedures from time of referral through provision of service; providing the necessary infrastructure to ensure that reasonable access can become a reality; and 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. 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.

- 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 unequal distribution of medical personnel, particularly medical specialists, in rural and urban settings makes it difficult to achieve the ideal of equal accessibility. The problem has been exacerbated by the historical emphasis on physician- and hospital-based care in our publicly funded systems. A shift in emphasis from the provider to the service provided would make health care more accessible by allowing a broader range of choices for patients and decreasing the inappropriate burden placed on general practitioners and medical specialists. This is especially true for eye care in the remote and rural areas of the province that are chronically under-serviced, particularly by ophthalmologists.

- Reasonable access is subjective and can and has led to endless debate. Neither the courts nor any jurisdiction will provide a correct answer. What is required is that provincial governments (individually or collectively) establish wait time targets for individual medical and surgical interventions based on the best available health data.
• The topic of medically necessary is easier to define with the experts in our midst: the physicians. However, we are exposed to television shows where everyone is seen running to the doctor for everything, and the doctors treat everything. It is glamorous, it is Hollywood, and it sells.

Ideas and Suggestions

• 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.

• There should be equitable access with no preferences as a result of where you live or what you do for a living.

• We must set some standards and define accessibility providing government follows through and implements.

• We need access for everyone, ensuring health care is fair and affordable, and including alternative methods.

• A system anyone can access, with no barriers.

• Meet health service delivery needs with an appropriate level of service, not the highest level.

• Doctors and health professionals should be the ones to define the concepts of reasonable access and medically necessary.

• We need to define medically necessary.

• Define medically necessary in Canada.

• It needs to be made clear what basic services the public health care system will provide, and which it will not. What is considered medically necessary under the Canada Health Act?

• Let the courts interpret reasonable access and medically necessary when a dispute arises. Just get real courts. The current system we have where the one with the most money wins is a joke.
Sustainability

Comments and Concerns

- It is a good idea to debate what sustainability means.
- Sustainability is a cynical recommendation. It lacks clarity and meaning.
- The word sustainability is irrelevant and dangerous to the current principles and should not be there.
- What does government mean by sustainability?
- Adding term "sustainability" would give potential for first five principles to be trumped.
- Sustainability is an escape clause if we include as a sixth principle.

Ideas and Suggestions

- Add boundaries for the new sustainability principle. And, if the sustainability principle is not added, the boundary conditions could still be added under other principles, such as public administration.
- Sustainability is already included in the Canada Health Act, so there is no need to consider another tier of funding.
- Enforce the Canada Health Act principles and do not allow a sixth principle.
- The Canada Health Act must be refined to suit the need for an effective, economical, and sustainable health care system.
- The five principles of Act are critical, and add sustainability as sixth principle.
- Sustainability needs to be defined under some sort of quantifiable instrument (such as linking it to Gross Domestic Product, GDP, or percentage of the provincial budget).
- The principle of sustainability needs to be something that can be measured.
- 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.
- The federal and provincial governments should recognize a sixth principle of sustainability in the Canada Health Act that meets reasonable and defined standards of health human resources, infrastructure, clinical outcomes, and fiscal capacity.
• Do not add the sixth principle of sustainability to the *Canada Health Act*. Its addition implies that cost is more important than the first five principles, and thus could be used in the future as a justification to allow more privatization and erode the first five principles of the Act. Privatization is not needed to ensure the sustainability of health care.

• If you are going to add sustainability to the five principles of the *Canada Health Act* and include them in provincial legislation you should remove the principle of public administration.

• It is crucial to generate new strategies to control the complex mechanisms that affect expenditure and performance of health care schemes, while striving to achieve the core principles and objectives of the *Canada Health Act*, including universal access, high quality standards, efficiency and effectiveness of care, as well as balancing the demand for adequate funding and satisfaction of patients.

• Given the government’s misleading characterization of the sustainability issue, we cannot support the stated intention to add the principle of sustainability to the *Canada Health Act*. 
Public Private Debate

Whether the health care delivery system should be public or private or a mix in terms of funding and delivery was a hotly debated topic throughout the Conversation on Health. There was no consensus on this matter, but participants strongly urged the Government to provide an avenue to continue the discussion and provide more information on the status quo. The following is an illustration of the Conversation on Health’s Public Private Debate.

International Models of Public and Private Delivery

Participants looked at models of health care funding and service delivery around the world. In the end, there was no consensus on which models could be copied and which to avoid. Many participants looked to European models of service delivery for replication in British Columbia. Mixed systems of public and private delivery (not funding) were often described as more efficient in terms of their ability to treat patients quickly. Others warned that it is impossible to review these systems effectively without looking at the other aspects of that social infrastructure which support people’s health. The system in the United Kingdom received opposing reviews in terms of its efficiency and ability to serve all of its citizens.

While, for the most part, the American system came up short in terms of its ability to provide adequate health care services to all of its citizens, a number of participants wrote in to describe their positive experiences within that system. Those participants challenged us to consider which aspects of the American system may be worth studying.

The Conversation on Health also looked to Australia, New Zealand and Asia for examples of health care delivery models. Most of those systems include some aspect of private funding or delivery, to varying degrees of success, according to the participants.

Participants concluded that it helps to look at other models of delivery, but we need to be careful about trying to replicate those systems without due consideration for the other factors that may contribute to its success.
Public Models of Delivery and Funding

Participants, for the most part, believe that the public model of funding health care represents a fundamental Canadian value. Participants were divided on whether or not this must also be a public model of delivery, a mixed model, or a private model. Some argued that the focus on public health care is one of political ideology which has resulted in deterioration in the quality of care for all British Columbians. Others argued that this deterioration, if it exists, is a result of political decisions to reduce funding and support for the public system, allowing the private system to make inroads. These same participants suggested that an increase in funding, services, and facilities would resolve these problems within the public system without the need to resort to a private sector system of funding or delivery.

Many British Columbians supported the principle of a purely public system, but argued that there is not enough public money to support it, and that the only choice is to allow some private funding and delivery to take the load off of the public system. Others contended that it is premature to look to private options when positive public examples of improved services and efficiencies exist.

Private Models of Delivery and Funding

Among those who supported private models of funding and delivery are those who argued that there is an inherent motivation to attract patients through improved patient care in a private model. Their view is that competition is what drives improvements and efficiencies.

Those who argued against private delivery and funding suggested that it is the profit motive, not patient care, which is the key business driver in this model, and is therefore sure to undermine patient interests over time.

Few participants argued in favour of a purely private system of both delivery and funding.
Mixed Public and Private Models of Delivery and Funding

The vast majority of those advocating for some involvement of the private sector in health care delivery or funding wished to pursue a mixed model. Most preferred a mixed model of delivery, while maintaining a single public payor. Many participants were concerned that there has been no good debate or informed discussion about this issue. A number of participants believe that the issue is universal health care, not whether the health care is delivered by public or private entities. Others argued that universal health care requires public delivery in order to keep profit out of the system and manage costs more effectively.

Once the idea of new payors was introduced (that is, the ability to pay for medical services if you have the means), then the debate became significantly more impassioned. Those who argued against a mix of payors said this will lead to two health care systems, one for the rich and one for the poor. They believe the best health care professionals will then move to the for-profit system to gain better wages, the for-profit system will have better equipment and better hours, and wealthy British Columbians will inevitably receive better care. Many participants also argued that the private sector interests would take the simplest patients and leave the complex patients to the public system, thus increasing their profit margin and increasing the costs of treating patients in the public system.

Those who supported some mix of payment systems do not believe that these are consequences of a two-payor system, and suggested ways of mitigating these possibilities, for example, requiring that health professionals practice in both systems, and that equipment be similarly shared. Those who advocated for the ability to pay for services argued that this will relieve the burden on the public system, reduce wait-lists and focus the public funding and system on those who cannot pay. These same participants also argued that this is a question of freedom of choice, that is, the ability to choose to spend their money on medical services they need. Those medical services, they argue, could be made available through a mixed public-private system.

What this debate brings into focus is a conflict of values as well as a debate on the merits of the system. For those advocating for a public system (both funding and delivery), the essential value is universality and equality of access: all British Columbians receive the same care regardless of their financial means. For those advocating for some mix of private care in the system, the essential value is freedom of choice: the ability to choose providers and services and pay for those services if they so choose. It is for this reason, that there are fundamental values at issue, that the debate has been so fractious throughout the Conversation on Health.
While participants could not come to a consensus, many did demand more information: more information about the current system, how it operates, how it is funded, and who practices in it. They also demanded more information about other systems, such as the European examples. Finally, most participants wanted to continue the debate, although for some the debate is over and they believe system should include no more private funding or delivery mechanisms than it already does.

*Access to quality care is more important than who is delivering it.*
- Health Professionals Focus Group, Cranbrook

*To me, the key is to permit private facilities to compete with public facilities within a defined framework and within the provincial medical system. This will force the private facilities to prove they can compete effectively with the public facilities and it will force the public facilities to become more cost-effective.*
- Email

*In fact, the more that healthcare is a mix of public and private and profit and non-profit, costs tend to be higher when you have a higher proportion that is not government funded, and costs tend to be higher when they’re delivered through for-profit care. The other thing that happens when you do this, of course, is that you increase inequity and you tend to fragment the system because you no longer have a single payer and all the administrative efficiencies there. You’re purchasing power is diffused and all the other consequences which you know about. We do know pretty definitively that administrative costs are lower in single payer systems.*
- International Symposium, Vancouver

*[There is] insufficient education of the pros and cons of private versus public systems. [It is an] emotional issue between supporters of the public or the private stance.*
- Health Professional Forum, North Vancouver

Public-Private Partnerships

Another focus of debate was around public-private partnerships and their utility in the system. Detractors pointed out that there is no evidence these partnerships save money in the long-term, and suggested that there is ample evidence that the projects fail to deliver public benefit or savings. A concern raised frequently by participants was that public-private partnerships have no clear accountability to the people of British Columbia and without this accountability they cannot properly serve the health care system. Some participants argued that there should be more investigation into partnerships with other public or non-profit entities before turning to the private for-profit sector for partnerships.
Those participants who spoke in favour of public-private partnerships argued that the private sector maximizes profit by finding efficiencies, which would by necessity force innovation and improved business processes into the health care system.

Conclusion

While the vast majority of those in attendance at the forums were in support of the continuation of public health care in British Columbia, this same level of support was not as clear through the other avenues of input in the Conversation on Health. The debate between those in support of some element of private sector involvement in health care delivery and those who suggested a fully public delivery model and funding system continues to be fractious. While the Conversation on Health has managed to elevate this debate to some extent, it is fair to say that the debate among British Columbians around both the existing model of health care delivery, and new models (whether fully public or some combination of public and private) is still in its infancy.
Public Private Debate

This chapter includes the following topics:

**International Models of Public and Private Delivery**

**Public Models of Delivery and Funding**

**Private Models of Delivery and Funding**

**Mixed Public and Private Models of Delivery and Funding**

**Public-Private Partnerships**

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**Related Electronic Written Submissions**

(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

- **Four Initiatives for Healthcare Change in BC**
  Submitted by Cogentis Health Group

- **Is BC’s Health Care System sustainable?**
  Submitted by the Canadian Centre for Policy Alternatives

- **Physicians Speak Up**
  Submitted by the British Columbia Medical Association

- **Why Wait? Public Solutions to Cure Surgical Waitlists**
  Submitted by the Canadian Centre for Policy Alternatives

- **Saving Medicare Policy Brief**
  Submitted by the Canadian Independent Medical Clinics Association

- **Sunshine Coast Conversations on Health**
  Submitted by the Women’s Health Advisory Network, the Sunshine Coast Hospital and Health Care Auxiliary and the Seniors Network Advisory Group

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

- **A Written Submission to the BC Conversation on Health**
  Submitted by the UBC Centre for Health Services and Policy Research

- **Conversation on Health: My Views**
  Submitted by Nancy Kenyon

- **Submission to the Conversation on Health**
  Submitted by the BC Cancer Agency

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

- **Submission to the Conversation on Health**
  Submitted by the British Columbia Government and Service Employees’ Union

- **Submission to the Conversation on Health**
  Submitted by the BC Nurses’ Union
Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Health Care Models; Training; Access to Hospitals in Rural Areas; Health Human Resources; Innovation and Efficiency; Health Spending and Morale.

International Models of Public and Private Delivery

Comments and Concerns

European Systems
American System
Asia-Pacific Systems
United Kingdom System
General Comments on International Experiences

- Comments on European systems:
  - We need to look at European systems, which have universal access and a mix of public-private delivery to varying degrees.
  - I like the health care system in Switzerland where basic health care is purchased by citizens and where health insurance is not controlled by the government but by consumers.
  - The European tour report describes the Swedish system as a successful mix of public and private systems, and that this is an accepted reality. In fact, in January 2006, the Swedish Government legislated an end to the creation of any further privatization of health care and rejected the notion of grafting for-profit onto the public system. A statement from the relevant Ministry says that Swedish health and medical services should continue to be democratically controlled, provided on equal terms and according to need. This sounds like an endorsement of Medicare, not of privatization.
It is difficult for me to understand the hostility towards a private health care system side by side a universal one. I come from Germany where those two systems have been practiced very successfully for many years. There are no waiting lists and people in the public system have quick access to all kinds of operations and treatments. I have to admit that the citizens of Germany pay a lot more into their health care insurance and they are willing to do so. One cannot expect a Rolls Royce if you only want to pay for a Datsun.

The mixed German system tried to get patients in and out as soon as possible. There was little or no follow up for the patients and the burden of follow-up was on the public system.

Perhaps there is something in the Italian San Patrignano model of social co-operatives that can bridge the divide between the private and public health-care dichotomy, to contribute to the sustainability of the health care system.

When looking at the complete picture of the European model one can observe that their entire social system affects health care outcomes. For instance, poverty is addressed as well as old age and prevention. Social issues have a huge effect on the cost of health care delivery so to pick and choose parts out of the model is a mistake.

In Scandinavian countries, you have to factor in the small wage gap between lowest and highest income earners. If a high and equitable standard of living and quality of life was valued in Canada in the same way as it is in Scandinavia, then privatizing services would not prevent people from accessing them.

A large body of evidence has emerged over the last 15 years from a long and still growing series of European studies regarding the distribution of financial burdens and care use in different member states of the European Community. These studies indicate that equity in care use (defined as equal access for equal need) is better achieved in systems that have greater equity in financing. Less reliance on out-of-pocket payment, which is the principal determinant of regressivity of financial burdens, is associated with greater equity of access. Inequitable financing systems generate inequity of access, which is certainly intuitively plausible. In principle these two dimensions of equity could be separated, but in practice they are not.

If a privately owned clinic in Sweden can offer services 24/7, supplying physicians, nurses, family medicine and specialists as well as a wide range of diagnostic, treatment and prevention services, then why can not publicly funded clinics in British Columbia do the same?
Those German citizens that can afford to pay for medical services pay for them. This has allowed the long queues for medical help to lessen. The Canadian Government seems to think that if you speak about private health care then we have to follow the American model. Yet Americans admit their system does not work as there are 50 million people in the United States with no medical insurance. I think we could easily adapt to one of the European systems.

- Comments on the American system:
  - There is no evidence that private health care is more efficient than a public system. The very expensive American private system seems to indicate that private is far more expensive and that it discriminates on the basis of income. I do not see these as desirable characteristics in a health care system.
  - There are some important advantages to the American system for the insured population. These include more timely effective care than in Canada and much more attention paid to innovation and client interests. The American system is much more responsive to demand than the Canadian system, as the United States ranked first in responsiveness in a World Health Organization study. So we can learn something from the American system, but it is a costly hodge-podge of public and private care and is not an attractive model.
  - The United States has a very quick patient care and delivery system that is 100 per cent run privately and spends twice as much as Canada per capita, yet the life expectancy is shorter than that of Canada and people go bankrupt if they don’t carry critical illness insurance.
  - Health in Canada, on average, is superior to the care people receive in places such as the United States, where private services are the norm. While we do not have the whizz-bang service that the wealthy Americans receive, the average Canadian receives far better care than the average American at a lower cost per capita.
  - The scare tactics used by some people when they reference the American system in a discussion about health care is simply a mechanism of fear and a resistance to change. While it is true that many Americans have no health care, those who are covered have excellent, state-of-the-art care. Canada has a unique opportunity to combine the best of the American system with the established national care system to develop a system that could lead the world.
  - The Mayo Clinic in America ends up being less expensive to patients’ than St. Michael’s in Canada.
  - United States has more uninsured citizens than the entire population of Canada. People are forced to declare bankruptcy therefore losing their possessions and homes in order to pay for procedures.
• Comments on Asia-Pacific systems:

  • Australasia has a private health care system that is very tightly regulated so that it
does not eat away at the public system.

  • In the Australian choice-based system, doctors are required to spend time in both
the public and private systems. This ensures access to the best of physicians in
both systems.

  • Australia’s system incorporates some sort of two-tier system for which some
higher-income people willingly pay a surcharge for. This takes stress off the free
component for the majority.

  • We need a two-tiered system. Most of us have extended health through
companies we work for or have worked for. For not much more money
something could be worked out that those who can afford to pay an extra
premium per month can use a private system. Or set up private medical insurance
so if someone needs hospitalisation or surgery it would be covered. This would
allow Joe Average to have private health care without having to pay thousands of
dollars for it. I was hospitalized in New Zealand where there were no waits, I had
my own private room and bathroom, and a menu was offered for my food choices
as well as a glass of wine. How civilized.

  • Australia has a universal system of health insurance with a mixed public and
private system. Primary health care services are fragmented, as they are delivered
through a number of different services. The two mainstream or non-Indigenous
funding schemes responsible for the support of the primary health care system
are the Medical Benefits scheme, which provides subsidy to general practice, and
the Pharmaceutical Benefits scheme, which provides a subsidy for our
pharmaceuticals.

  • The benefits provided by social insurance in Japan, Korea and Taiwan differ. For
instance, both Japan and Taiwan cover dental care, but only Taiwan covers
Chinese medicine. In Taiwan, benefits are much more restrictive and providers
will often provide services that are not on the public schedule. As a result, prices
are unregulated and providers can charge exorbitant costs that patients bear
directly. There is very little private insurance that would cover co-payments or full
payment of uncovered services.

  • In Japan, Korea and Taiwan, service provision is dominated by the private sector
and patients are free to choose among providers so there is very little gate-
keeping within any of these systems. Patients will simply self-refer as they see fit
to any provider. So you can go to a specialist or a general practitioner or straight
to a hospital without any need for a referral. This, of course, has implications for
the provider landscape. In Japan, for example, hospitals have very large out-patient departments that often provide quite simple primary care, while a third of doctors’ clinics in Japan have in-patient beds and provide specialist services that other countries like Canada or New Zealand or England might only be provided in hospitals.

- Health care provision in Singapore is mixed. Around 75 per cent of admissions are in public hospitals and about 20 per cent of primary care doctor visits are publicly funded. In Singapore, public hospitals were corporatized in the 1980’s and the lesson here, for those interested in corporate structures, is that it was not necessarily a fruitful innovation.

• Comments on the United Kingdom system:
  
  - The National Health Service (United Kingdom) has been turned into a chaotic, inefficient system, facing a $1.6 billion deficit since moves towards privatization were made. Administrative costs have risen from eight per cent of the budget to 22 per cent.
  
  - In Great Britain, activity-based funding was initiated and private clinics were introduced to compete with the public facilities. The private clinics even received subsidies; of course, they took the simplest patients and left those with high risk and multiple problems to the public facilities. According to a report, administrative costs have increased and the number of National Health Service managers has risen three times as fast as the number of clinical staff, doctors and nurses. Between 2000 and 2007, National Health Service spending increased by 20 billion pounds, a 40 per cent rise. Some hospitals have been unable to compete and face the possibility of bankruptcy and closure.
  
  - The recently established for-profit surgery clinics in the United Kingdom that are called Independent Sector Treatment Centres (ISTCs) have had problems with less safe care. In a House of Commons Health Committee report, both the Royal College of Surgeons and the British Medical Association voiced concerns about the quality of care received in these centres. In addition, a survey by the British Medical Association of clinical directors in the National Health Service (NHS) who work in orthopaedics, ophthalmology and anaesthetics, reported that two thirds of the patients had returned to the National Health Service for after-care with higher readmission rates from the for-profit Independent Sector Treatment Centres than from National Health Service-run clinics.
  
  - I was a believer in a two-tier health system until I had a chance to experience it first hand at a hospital in England. I had a multiple fracture and through a mix-up with my travel insurance, ended up being treated not as a private patient, but
courtesy of Britain’s national health system. While I lay with my leg in several pieces, I waited for three days for a surgery space to open up. In that time, anyone with private insurance that came in was provided with immediate service, regardless of the severity of their injuries.

- General comments on international experiences:
  - A parallel public private system would not only expand supply (the quantity of care), but it would also offer competition to public sector hospitals in terms of the efficiency of production and quality of care. Competition also applies to physicians and if they were free to compete, then they would enjoy improved incentives to attract patients with effective care and to provide that care as efficiently as possible. The Chaoulli case in Quebec is a welcome step in the direction of sanity, quality and sustainability. Should the public and private sectors be solitudes with a fence between them? Obviously, rules for physicians working in both sectors would be necessary, but there is no reason why Canada cannot emulate the example of Sweden, Australia, Austria, Belgium, France, Germany, Japan, Luxembourg and Switzerland by permitting private health care providers to compete directly with public sector hospitals for services paid to government under a universal system.
  - In South Africa, there is a government system and a private system. The private insurance provides better doctors and health care. Most seniors cannot afford the private insurance option and end up waiting in line-ups for hours on end.
  - It makes no rational sense that Canada along with Cuba and North Korea are the only countries in the world that don’t allow private health care to co-exist with publicly funded health care. In countries that are more socialist than we, this is the norm and efficient delivery of services is a reality.
  - Australia, New Zealand and the United Kingdom have similar systems and allow for some degree of private delivery.
  - The international experience with private surgical facilities is that they tend to charge higher prices for the same surgery in a publicly-funded hospital.
  - In the Israeli system, doctors work 80 per cent of their time in the public system and 20 per cent in the private system.
Ideas and Suggestions

European Systems
American System
Asia-Pacific Systems
General Comments on International Experiences

• Ideas about European systems:
  • Implement a public-private system as they do in Europe. These provide an opportunity to reduce waitlists. Take pieces of different international systems to make something workable for British Columbia.
  • Open more centres and outsource these to private companies using the Swedish model.
  • Even the nurses’ unions in Sweden were asking for reforms that allowed a private system to be more vibrant because it allowed their workers to have more jobs.
  • Check out Norway’s system: multi-tiered publicly funded with private delivery. People are happier, there is more quality, and it does not need to be a for-profit private system.

• Ideas about the American system:
  • Implement a regulatory regime to prevent the American model.

• Ideas about Asia-Pacific systems:
  • Private sector delivery has been shown to work in the East Asian context, but it requires careful government involvement and development to ensure that there is affordability, equitability and equity. Perhaps the most promising insight from East Asia is in primary care with the advanced services delivered in community settings.

• General ideas on international experiences
  • Do hospitals need to be owned privately or publicly? Look to other jurisdictions and use what is working. Emulate those pieces that are working.
Public Models of Delivery and Funding

Comments and Concerns

Values
Cost and Efficiencies
Assessment
Choice and Coverage
Health Human Resources

• Comments on values:

  • I am a tremendous admirer of Tommy Douglas and his goal to maintain the public health system.

  • Some say the debate regarding public versus private health care is simply an ideological one. And in one sense it is. Really, do we want to look at everything, including the care we need when we are vulnerable or ill as a commodity available to the highest bidder? Or do we want to continue to promote and expand our brand of universal health care that has defined us worldwide as a country that puts common good and fairness above profits for a few?

  • Health care is a public service paid for out of public funds.

  • Canada has an excellent model of socialized medicine.

  • What the Supreme Court of Canada says in the Chaoulli case is, if the government, the state or the legislature wishes to prohibit people from using their own resources to protect their health, then the government has to ensure that services are available in a reasonably timely way; in a manner or in a standard determined by medical experts, not by judges, or the system is a violation of right to life and a violation of the right to security of the person.

  • The Supreme Court of Canada in Chaoulli was quite clear in saying that there is no right for the government to pay for your health care, whether it is in a hospital or any other setting. What Chaoulli was concerned with were prohibitions on the individual citizen’s right to utilize their own resources. I think the broader principle that is established in Chaoulli could be described as one of patient accountability, where patients now have the right to demand accountability and be seen at the center of the health care system, and that their needs must be taken into account. And when I say accountability, there is a legal accountability. There is the opportunity for patients now to say that if you do not provide me that service in a timely way, either you are going to have to provide that through the public system, or you are going to have to allow the development of some other parallel or supplementary form of private health insurance.
• Political ideology is interfering with public health care delivery and has caused a deterioration of quality of health care.

• Public care is a cornerstone of British Columbia and it should be funded on a needs-based system.

• No one should be denied basic health care on an ability to pay, but neither on government's inability to deliver.

• Keep the health system public and accessible to all with no user fees. We do not charge for a visit by the fire truck: fire protection is funded for all and does not depend on ability to pay.

• All of health care, including prevention cure and management, should be publicly funded and managed. Nothing should be delivered privately.

• Medicare is a Canadian value.

• Canadians remain firmly committed to universal health care, but believe that substantive changes are urgently needed to reduce wait times and improve quality. There is also broad support for additional home care services and a national PharmaCare program. 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.

• Comments on cost and efficiencies:
  • While it is ideal to have an all public system, it is not realistic because there is not enough money in the public system.
  • Ineffective use of public resources is opening the door to two-tier health care.
  • The public delivery system delivers better long-term health outcomes, and is more respectful to patients and health care workers.
  • Introduce more public facilities as per the Romanow report.
  • The erosion of public services is due to increased demand.
  • The optimum foundation for sustainability for our health care system is good health, and for this we must invest more in a properly functioning public health care system.
  • If you reduce demand in the public system without removing resources, then we will be able to save our public system.
• It is utterly absurd to claim that Canada, one of the wealthiest countries in the world, cannot afford universal public health care for its citizens. It may be true that a percentage of government revenue costs are going up, but that is because government revenues have been in relative decline through tax cuts and the like.

• 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.

• Less invasive surgeries can be performed on a day-surgery basis, and do not require all of the overhead associated with a hospital. Private clinics have sprung up, such as the Cambie Surgery Clinic, along with much rhetoric about how much more efficient private clinics are. However, as experience in Alberta suggests, specialized day surgery clinics may make good financial sense, but the same efficiencies and cost savings can also be realized in the public sector, rather than private surgery clinics.

• If public hospitals are allowed to be innovative and flexible they have proven they can be more cost effective than private.

• Comments on assessment:

  • Our public health care system is the envy of Americans and Europeans. Keep it public.

  • There is a groundswell of public support for publicly funded health care.

  • The present system is more efficient than a for-profit system.

  • The public system is not working for everyone. Operating room time for doctors is not well provided or organised, which is frustrating for doctors and patients.

  • Why should our laws be allowed to sentence people to never walk again, see again or die because the public health care system cannot provide the health care needed?

  • The reality is that Medicare, Canada's publicly funded and delivered model, costs less and delivers better health outcomes. Many peer-reviewed sources validate this reality.

  • Challenges with public health care include: approximately two million Canadians are on health care wait-lists (92 per cent increase from 1993) and 50 per cent of children wait a medically unacceptable length of time; health care spending is unsustainable; and nearly 45 per cent of provincial budgets are spent on health care and climbing. Under pressure to maintain sustainability, provinces are
rationing health care services by restricting access to facilities, physicians, devices, pharmaceuticals and biologics.

- The health care system can adopt and implement any surgery or procedure cheaper or faster when in public hands.

- Does the private sector do things better, cheaper and more effectively in health care as well as in manufacturing? Well, here is what Harvard Medical Professor Emeritus and Editor in Chief of the New England Journal of Medicine told a Senate committee studying health care: “I have lived my whole career asking: what is the evidence? What are the facts? The facts are that no one has ever shown in fair, accurate comparisons that for-profit makes a greater efficiency or better quality, and certainly no one has ever shown that it serves the public interest better, never.”

- Private systems depend on making profit. This motivation does not work for services such as health and education. A well-off nation such as Canada, and a rich province like British Columbia, needs to fund wellness for all. The better off must subsidize health care for those less well off.

- Canada trails the world in health care delivery: Canada's health care system is rated 30th in a World Health Organization survey; Canada is one of the top three countries in health care costs; and Canada is near bottom in access to new technology. Most developed countries, such as France, Germany and Britain, provide universal health care systems complemented by private sector options. The World Health Organization’s top six ranked countries have no wait lists and spend less.

- Comments on choice and coverage:
  - Let the rich travel abroad for their health care as most of them have duel citations anyway.
  - The current system does not allow freedom of choice.
  - The public system can provide a focus on prevention and wellness.
  - The wealthy are paying to get service.
  - Should it not be all public but public coverage should be defined and transparent?

- Comments on health human resources:
  - Community health workers want to work in the public system.
• While most physicians would prefer to remain in private practice, at least some would welcome the opportunity to work as medical health officers in a provincially-funded wellness centre where they did not have to shoulder the cost of setting up an office of their own.

• The supply of human resources and the length of waiting lists are very real issues. But they are issues that have been, or should have been, obvious for years. Time, attention and energy that might have been devoted to working out solutions have instead been squandered in public-private arguments. Turf protection by professional associations has been allowed to block efforts to find genuine solutions through streamlining surgical through-puts, re-structuring primary care, or rationalizing nursing education. Nearly 20 years ago, the British Columbia Royal Commission on Health Care and Costs declared bluntly that the health care system needed more management, not more money. But the echo came back, then as now: more money. And calls for more private money links the interests of providers with those of the healthy and wealthy.

**Ideas and Suggestions**

**Values**
**Cost and Efficiencies**
**Assessment**
**Choice and Coverage**
**Health Human Resources**

• Ideas about values:

  • 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.

  • We need to define what public health care is and how we utilize our resources (people and money).

  • Everybody is entitled to equal health care, whether they can afford it or not.

  • We need a publicly funded, accountable health care system.

  • Continue to improve and support universal health care that does not discriminate against anyone from receiving the best medical care and services possible.

  • Equal access to health care for all British Columbians.

  • Work harder to put health interests above those of big business.
• The majority of people want a public system so our leadership needs to protect the public good.

• Get more competition in our system. Today you just have to take the doctor you are given.

• Ideas about cost and efficiencies:
  • Support a fully-funded, wisely-managed public health care system that encourages preventative measures, focuses on education, has long-term planning and includes better use of other health professionals for more cost-effective use of health care dollars.
  • The public system needs more financial accountability.
  • Invest in and improve public health care so that all are cared for.
  • There should be public partnerships and collaboration in program and service delivery planning within the public system.
  • Health care should be run on sound business principles.
  • Control costs by not going private: invest public money now for future returns and avoid two-tiered, income-based health care.

• Ideas about assessment:
  • Ensure open and transparent public ownership and delivery.
  • Make the system more efficient while protecting the universality of our public health system.
  • Universal health care should remain publicly-funded because that is the most effective, efficient and affordable way to deliver health care.
  • We need more accountability in the publicly funded system. To make the system accountable, an independent agency could randomly select patients and follow them throughout their hospitalization. A data collection system could be implemented to not only follow mortality or accidental injury but to subjectively document patient and family satisfaction and impressions. If we truly want a better system, we must have knowledge of where to focus the improvement and not simply a strategy where accreditation signs off on all responsibility and everything else only comes to light with accidental diagnosis or demise of a loved one. We do not want a system that employs lawyers to encourage transparency; we need the public system to be more transparent.
• Ideas about choice and coverage:
  • Fully fund and establish public community health care clinics.
  • Support public health care in funding and delivery.
  • Improve the public delivery system through specialized public clinics, expansion of multidisciplinary health care teams and an expanded role for health care providers.
  • Chronic issues and procedures should be done by the public system, which is best suited for this work.
  • Create publicly-funded, publicly-delivered surgery centers and use operating rooms in hospitals to full capacity.
  • Keep health care public and include new improved technology in publicly funded health care (such as renal dialysis).

• Ideas about health human resources:
  • Pressures can be alleviated by better management and administration and by implementing recommended efficiencies within the public system.
  • The public system needs to recognize performance and ability and reward those qualities.

Private Models of Delivery and Funding

Comments and Concerns

Values
Cost and Efficiencies
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Health Human Resources

• Comments on values:
  • Once health care is privatized there are two groups that receive care: the rich and the poor. The rich because they can afford it, and the poor because the government subsidizes them. It is the middle class who will do without.
  • What private financing mechanisms actually do, as compared with public financing, is redistribute the burden of payment from higher to lower income individuals, and from the healthy to the sick. At the same time, they improve the
relative access of those with higher incomes. This in itself is sufficient explanation for the continuing advocacy of more private financing, which tends to come predominantly from organizations representing upper-income groups. But these conflicting economic interests tend to be paralleled by differences in ideology or values.

- I want my health care provider to be primarily concerned with my health care and not considering which post-operative medication will make them more money or which procedure will give them the most money for the least effort.
- The accumulated evidence makes it clear. The interminable public-private debate arises from conflicts of ideology and economic interest, conflicts that are real and permanent, and so cannot be resolved by the accumulation of fact or the refinement of argument. Private financing mechanisms do not result in more appropriate patterns of care use, and private delivery systems do not yield more efficient or more effective care. There is evidence on both counts and it is negative.
- Private can work well, but it is ideologically different from public health care. It will have good customer base and will work well and does not need any public funding.
- The private system does not have incentive to reduce illness.
- Canada is the only industrialized country that does not permit private insurance for medical services. The Lowest Common Denominator approach to health care is not necessary.
- There is no private system to fall back on if public system fails you.
- Large systems need renewal.
- Under-funding of the public system has created the crisis.
- The goal of private companies is to make money. This is accomplished by charging more or providing less.
- There are no controls or accountability in a public system. The private system has to make it work, while the public often is not motivated.
- Are we waiting for the public system to deteriorate so the private option looks good?
- The developmentally challenged and special needs community, often with a life-long dependence on health care, do not fit into a business model or a private style health care system. There is not a lot of interest in that aspect of health care because there is not a lot of profit to be made of the poor.
There is not a lot of money to be made in remote communities so the for-profit and business interests do not look to remote communities as a way to get involved in the health care system.

I do not see people lining up looking for ways to provide health care to the mentally ill as a for-profit model.

I see that we are split along lines of those who have means and those who do not. Those who have the means see all kinds of logic in a business model, in a fee-for-service or a two-tiered or private model.

There is an apparent conspiracy among physicians to move towards a private system.

We need to get the laws of supply and demand working for us with more competition and less monopoly.

Keep health care public. Our per capita costs are much lower than in the United States and we all have access.

Sometimes for profit health care is not provided with the best interests of the patient in mind.

The profit from health care should be public money. Public health care should not be allowed to suffer under any public-private partnership because the business model is short-term thinking. The public model is long-term thinking.

The drive to private care is coming from international agreements which are threatening the public system.

Every dollar given to private for-profit health care means one less dollar for public care. It allows the wealthy to queue jump and means that everyone else waits longer for needed care.

A profit-based system increases quality, and attracts more investment and human resources because of improved quality of services.

For-profit owners are in it for the money, not for the good of the patient.

The public is not fairly educated as they only get sound bites. There are too many mixed messages.

Preventative dentistry is an example of the private sector promoting healthy choices, which is also a pay system.

Private health care cannot deliver the quality of service equal to the public system due to profit motive.

The private system is good if you have the money.
• The big American corporations are pushing very hard for privatization so they can rip us all off and too many politicians are listening.

• Comments on cost and efficiencies:
  • If we can prove through economic evidence that the private system can do it better and cheaper than the public system, then we will consider a role for the private system.
  • In a public operating room, all the tools needed for a surgery are prepped and opened, even if they are not necessarily single use tools. This would not occur in a cost-monitoring private surgery facility.
  • If health care is expensive now, why would you privatize it and immediately increase costs by at least 20 to 30 per cent to cover higher administrative costs and profit?
  • Private systems include additional costs such as advertising.
  • Private clinics and hospitals have to use an activity-based model to keep track of costs. They can use private capital to invest in equipment and extra frills that public hospitals lack and then charge a premium for each element of care to make profit. They can pay specialists more.
  • That the private hospital may actually make a profit seems to bother some people. If their operators can do so, then more power to them. There are ways of making a business more efficient other than by cutting corners. Could it be that the public institutions are still going around corners that should have been eliminated long ago?
  • It is interesting to note that British Columbia increased private sector spending by 48 per cent from 2001 to 2006. As a result, British Columbia now ranks fourth in private spending in comparison to the other provinces and territories, up from seventh in 2001. In contrast, British Columbia slipped from sixth to ninth 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 British Columbia performed better than most other provinces. This suggests that there may be some potential to increase public spending on health.
  • Owners of private, freestanding surgical clinics argue that the profit motive encourages a more efficient and lower cost supply of surgical services. But here the evidence is at best inconclusive. The problem is that private facilities tend to provide a limited range of services to generally healthy patients. A for-profit facility has incentive to select the patients that are most profitable. They avoid the
more complex and expensive cases, elderly patients with multiple co-morbidities, and leave these to public hospitals.

- The public system does not seem to know the costs of doing things.
- It seems illogical that you cannot purchase services.
- Private care depends on the quality of monitoring and oversight as well as managing need and access.
- For people who can afford to pay for private services, it works.
- Privatizing vehicle insurance was supposed to result in the cheapest insurance rates in the country. However, the cheapest rates are in three provinces, which have publicly held vehicle insurance.

- Comments on assessment:

  - A general flaw is suggesting that a market economy model will work for health care like it works for buying groceries. The market model works on a large scale to some degree, but as soon as you introduce features that do not respond well to mass approaches such as rare conditions or diseases, health promotion or vulnerable and disadvantaged populations, the market model generally fails miserably.

  - Public services allow for detailed accountability through the legislature, with public officials being held responsible and if necessary replaced. The only form of control for private services is the extreme one of breaking the contract if service delivery becomes clearly unsatisfactory.

  - There is government pressure to move to private care through scare stories and bad press about public health care. The public system is under-funded and poorly administered. Private health care does not work: it is just as costly for government (or more so) than the public system.

  - Privatizing of services will result in lower levels of goods and services and loss of local jobs.

  - A growing body of research evidence suggests that the profit status of health care providers does make a difference in the type and quality of care provided. The case of pharmaceuticals is pretty straightforward: pharmaceutical companies are interested in securing long patents on their products, in marketing those products to physicians and directly to consumers, and in ensuring that branded products (rather than cheaper but therapeutically equivalent alternatives) are prescribed wherever possible. The combined affect of these strategies is to drive costs in this sector of the health care system steadily upward without necessarily achieving an offsetting health benefit.
• Privatisation is not going well in dietary services and cleanliness.

• Emergency medicine and diagnostic services are excellent in the public system and do not need to be privatized.

• Kaiser Permanente, a private American firm, has a good prevention system.

• Maintenance and support services are poor. We do not want to hand over control to private companies.

• The for-profit facility will appear to be more efficient, but its lower costs may simply reflect the selection of lower-cost cases. The specialized facility also has the advantage that operating room schedules do not have to be disrupted by emergency cases or unexpectedly time-consuming procedures. It may well be entirely appropriate that the more complex and costly procedures are referred to hospitals, where the back-up facilities are available. But it is entirely inappropriate to compare the relative costs of procedures in the two settings as if they corresponded to equivalent workloads. Furthermore, establishing specialized facilities to serve the cheap and cheerful could be, and in some cases has been, done within the public system. This approach has no necessary connection to private, for-profit delivery.

• Is for-profit health care better and/or cheaper? The answer is no. Romanow’s review, which was pretty systematic, said no. McMaster has done systematic reviews of the quality of care with a bit of a cost component, and it is shown to be sometimes equal but usually lower when it is provided in a for-profit sector. Kirby was a dissenter. Kirby said that we do not have the evidence.

• Comments on choice and coverage:

  • There are many myths and illusions created by private health insurance and one of them is that you will be able to get the care you want when you want it with no line ups. Wrong. Private health insurance companies are far more ruthless when determining who is eligible for what services.

  • Outside the Lower Mainland there are not enough doctors and not nearly enough permanent facilities to provide adequate care. If a for-profit group was willing to improve the quality of service in outlying communities and would only charge the going rate to the medical plan then there is no reasonable case for denying them the opportunity. There is certainly a need for the service that the system clearly is not meeting.
• Insurance companies are notorious for refusing service on a number of bases, including a pre-existing condition, not medically necessary procedures, and deemed experimental procedures. Private insurance companies also come with extremely large deductibles.

• Private dental and veterinary systems work well. Both dental and veterinary systems have price caps.

• Private insurance models are too costly. In private insurance there are many exclusions, no control and too many options, and subsidised premiums do not provide universal coverage.

• People think private means the American system and they will have to pay using a Visa not a CareCard. People think the profit component will increase costs.

• Comments on health human resources:
  • The reasons Registered Nurses choose to work at private facilities are flexible schedules and less critical patients, while the reasons they quickly leave these facilities are understaffing, low pay and poor patient outcomes.
  • Contracting out of nursing services, housekeeping and dietary results in less money into care because it goes to profit.
  • Under-funding of the private system has created a staffing and quality of care crisis and increased workload, particularly in seniors’ care.
  • Privatisation in health care demoralizes workers.

**Ideas and Suggestions**

Values
Cost and Efficiencies
Assessment
Choice and Coverage
Health Human Resources

• Ideas about values:
  • Do not focus on privatisation to the exclusion of other possibilities for fixing the public system.
  • Obey the *Canada Health Act* and stop the increase in for-profit delivery of health care.
• Government should accept the fact that citizens want a public health care system and they support a truly public health care system through funding and legislation. No privatization.

• Ideas about cost and efficiencies:
  ∙ Independent auditors need to monitor care provided in private facilities.
  ∙ There is a role for private delivery, for example, to address overflow or ensure prompt surgeries.
  ∙ End the use of public facilities by for-profit health care providers such as WorkSafe BC, the Insurance Corporation of British Columbia and the military.
  ∙ Save money by privatizing certain aspects of health care, for example, laboratories.
  ∙ Get government out of health care delivery and let the private sector take over. Efficiency in a system that includes big government, big business and big unions is extremely hard.

• Ideas about assessment:
  ∙ Some private models may work, but we need a more open discussion.
  ∙ Privatized services need to be better, with more consistent enforcement of cleaning and food services standards.

• Ideas about choice and coverage:
  ∙ Set up a public corporation which focuses on health to deliver services.

• Ideas about health human resources:
  ∙ Make doctors practice either in public or private health care, not both (which would result in double dipping).
Mixed Public and Private Models of Delivery and Funding

Comments and Concerns

Values
Cost and Efficiencies
Assessment
Choice and Coverage
Health Human Resources

• Comments on values:

  • There has been no meaningful public debate on mixed model health care delivery for one main reason, in my view: governments dare not bring this up because it is viewed as electoral suicide to question the Medicare status quo.

  • The issue is not really public versus private but universal health care. If everyone has equal access to the private side and the public side all paid out of the health care budget it should not matter if we have for profit clinics and hospitals.

  • Private health care should be allowed and encouraged. The public or private debate is a red herring. Medicare was never envisaged to cover all the things it attempts to cover now. It was basically developed to ensure that if you had to go into hospital and have emergency surgery, then you did not lose the farm. Develop a basic but comprehensive package of medical services of what the system should and could cover and allow people to purchase additional procedures if they want to. One size does not fit all. We do not tell people what make of car or size of house to buy. Why do we stop them from spending money on the most important thing in life, their health?

  • It is not fair to all citizens that a person who has the means to afford the high cost of private health service would get priority to that service.

  • The public system rests on a fundamental value that health care should be available to Canadians on the basis of need, and should be financed on the basis of ability to pay. Those values are widely, but not universally, shared. The competing ideology that would base access on ability and willingness to pay does tend to be concentrated among those with greater ability to pay. A consequence of these conflicts in values and economic issues is that the real and important issues of health care management tend to be overlaid by the public-private lens. Discussion is further distorted by the fact that all expenditures are by definition equal to someone's income. Public financing systems have proven more effective at containing costs than have mixed public-private systems. Provider representatives accordingly advocate more private payment as a way to increase,
or at least protect, their incomes against the (relatively effective) constraints of single-source funding. For their part, the preferred answer to all health care issues is never better management, but more money, which automatically becomes increased income.

- British Columbians are being asked to choose between two models, but not all the information is there for consideration.

- What is so fundamentally wrong with allowing a parallel private system and giving people a choice to go and purchase private services outside of the system if they choose to, in so doing reducing demand in the public system?

- People are blind to the fact that 40 per cent of the existing system is private.

- I am not interested in using the spectrum of health care as a lever to try to open up the Canada Health Act and find ways of flowing more private money into hospitals and doctors. I think that is something that there will be a continual fight over, and quite rightly. I think the population has made its choice. I think that a lot of our leaders have made a different choice and that is one of the reasons why it is so contentious. I think it has to do with the fact that our leaders are drawn from the upper income strata of our society, which is growing very rapidly. One of the underlying things which we have not discussed, but we need to keep in mind, is that since 1980 the proportion of total incomes in Canada going to the upper 10 per cent, the upper one per cent and the upper 10,000th of a per cent has been growing really quite dramatically and continues to grow. So our public policy debates in health care are increasingly driven by the interests of relatively wealthy people and they are not interested in paying taxes to support health care for the rest of us. And they are interested in making sure that they have preferred access to the care that there is.

- Vested interests continue to mislead the public.

- Is there a way to have private care while preserving public system?

- Remove profit from medical care.

- Information is starting to come out that private providers already exist (for example, the British Columbia Bio-Med), and that you use your CareCard to pay.

- Two-tier health care creates a concern that we are moving away from universal, publicly-funded care to a private care system.

- There is a conflict of interest in a mixed system.

- If you increase private health care funding and delivery, then you are now having a small group of shareholders who are determining health care policy.
• It is not whether the system is public or private, or a mix, or from Britain or from Norway, or from Mars, it is what works. When my child is sick and I take them to the doctor, do they get fixed?

• There is an unwillingness to look at different solutions, or even to acknowledge that we already have a two-tier system.

• There is insufficient education of the pros and cons of private versus public systems. It is an emotional issue.

• Health care has changed over the past 50 years with new technologies and treatments available. Government spending on health care has sky-rocketed. This cannot continue unless the public is willing to spend money on the situation through a public-private split.

• Increasingly health employers and authorities are contracting out more of the work to private sector even though it costs the taxpayers of British Columbia between one hundred and three hundred per cent more than performing the same work in-house. The reasons for this are three-fold: lack of qualified staff due to uncompetitive wage rates; a mind-set and an ideology that favours the private sector regardless of the cost or quality of the work; and lack of accountability and ability to recognise the best way to deliver health care maintenance and renovation services.

• The Premier asked what does it matter who is providing service be it private or public. It does matter. A private company is entrusted and legally obliged to earn profit for its shareholders. The environment of today demands the highest return on their investment and this may lead to a sacrifice in quality over quantity. We want a public system.

• Comments on cost and efficiencies:

  • Please be aware that government policies have created a two-tier medical system. If I could not afford the naturopathic care and supplements and massage therapy, then I would still be in excruciating pain. I have diligently tackled my problem, but it has cost a great deal of money. It is unfair that if I went the allopathic route (as unsuccessful as that may be) my treatments would be free. But going an alternative route, I have had to bear the full costs myself.

  • Every privately run company in this country is de-centralizing, outsourcing and contracting out. But the company still pays for the work – it is just not done in-house. So why are we struggling along with backlogs and waiting lists, with everything done in house. Why does not the government just pay for the services to be done by private clinics, hospitals and so on? They can bill the government for the work done.
Public funding of private facilities leads to public subsidising of the facilities provided by the private practitioner to use for their private patients, that is, the public funding is paying for private services.

Nearly every general practitioner and specialist in British Columbia (the exception being those who are employed or contracted directly by hospitals or health authorities, such as emergency room doctors), operates as a private entity. Government funds, namely through the medical services commission, pay doctors on a fee for service basis. From this, the doctor must pay for rent, supplies, staff, telephone, and other operating expenses. Providing publicly funded surgical care in a private centre is much the same principle. The government is paying the centre for providing this care, and patients do not pay anything directly.

Virtually all doctors’ offices (and after-hours clinics) are already private clinics: their services to patients however are paid for by the public health system. There are very few doctors who actually work for a hospital. They are private contractors who enter into an agreement with the hospital that usually exchanges hospital admission privileges for on-call duty and on other services.

Any move to a two tiered system would increase the cost burden for people on fixed incomes that worked in the private sector and do not have extended benefits.

As long as the facility is accredited and qualified personnel is running it and the fees are according to the government contract then it does not matter. Competition is healthy and one may find out that the privately run facilities are much more economical for the taxpayer. For example, the cost of looking after a simple ear infection in an emergency room is probably somewhere near $200 and in a private walk in clinic it is less than $30, and yet the clinic makes a profit.

It is my strong view that we should have a combination of public health care paid for exclusively out of the public purse and private health care. The private sector can bring investment and efficiencies that government and unions will not or cannot. To say this does not exist today is to lie to the public, as, the last time I looked, my eyes and teeth are part of my body and there are no waiting lines for these areas of my body when I need service. The socialistic approach to medical care in the 1940's will not cut it today with advances in medicine and technologies and we need to explore other more progressive ways to handle the looming problem. And if government cannot handle the problem, then it should get out of my way and the private sector way and let us find solution to problems with other resources. Government is historically demonstrating it cannot handle the problem. The old ways just do not cut it anymore.
Be careful what you wish for: If all deficiencies were costed, then the case for private health care may be strengthened.

Cream-skimming refers to the fact that for-profit clinics have a material interest in serving patients for whom procedures are less complex, outcomes more predictable and costs lower. It allows for-profit clinics to minimize their risk and maximize their profit. It also results in an increase in the average level of severity among patients who remain in the public system, and in the costs associated with their treatment. Consequently, the average cost of treating patients in public institutions rises. If payments to the public system do not increase to reflect these higher costs, then the public system becomes less sustainable. Evidence suggests that when public authorities are confronted with deteriorating health among patients waiting for care, they will divert patients to private clinics to relieve their suffering even when this may threaten the sustainability of the public system in the long run.

The two systems (private and public) are not properly coordinated.

One thing we do know is that if you add private insurance options with the view to reducing waiting lists and waiting times, you are not going to be very successful.

We spend more private dollars in Canada than any other country in the world except the United States, and all other countries actually have a mixed system for a lot of acute care and they provide a lot more coverage for complementary and community medicine.

We have more private health care in Canada than people think. Over 30 per cent of health care spending is to the private sector for diagnostics, pharmaceuticals, non-listed surgical interventions and other types of therapies (dentistry, massage and plastic surgery for example).

Private does not necessarily mean personal payment.

If parallel private health care is initiated, then it should follow the United Kingdom and European systems. They take care of all of the issues related to the administration of services in terms of clinical care and the system of private insurance. Using a single insurance agency also makes it cheaper to run.

Australia is an interesting example: they created a movement to encourage the purchase of private insurance, which would get you, in essence, faster access to a number of services. It started off reasonably well, then it ran into trouble, and it was on the brink of failure until the government had to step in with a policy that subsidized people for buying private insurance, which is a bit of an oxymoronic concept when you really think it through. But I think there is a cautionary tale
there that if you leave private insurance purchase to the market and you do not intervene in people's decisions about whether or not it is worth their doing when you have a reasonable public system, intelligent people tend not to want to. This is why Canada does not ban private and parallel health insurance for the publicly financed system (medical and hospital services) and there is no market for it.

- Once British Columbia, or any jurisdiction in Canada, formally sanctions a mix of public and private health delivery, the North American Free Trade Agreement will kick in, allowing American health corporations the ability to move into Canadian health care with the same rights to public funding as Canadian companies. In no time, the public system would be bankrupt and we would have an Americanized corporate health care system. In non-free trade Europe, these are not issues.

- There is too much fragmentation of health services and too much bureaucracy within a mixed private and public system.

- WorkSafe BC dances to its own tune. It should contribute more to our health care system.

- Support the 2003 First Ministers’ Accord on Health Care Renewal.

- There would be an inequity between those who are financially secure and pay for services, while those without resources have everything free.

- A mixed system results in private enterprise competing with scarce resources from the public system (such as doctors).

- When you offload you shift costs, but you do not contain them. In fact, costs tend to be higher when you have a higher proportion that is not government-funded, and costs tend to be higher when they are delivered through for-profit care. The other thing that happens when you do this, of course, is that you increase inequity and you tend to fragment the system because you no longer have a single payer and all the administrative efficiencies there. Your purchasing power is diffused and all the other consequences which you know about. We do know pretty definitively that administrative costs are lower in single payer systems.

- Comments on assessment:
  
  - We contract out day care surgery in Kelowna to a private center and the patients rave about the facility. They do not ever want to go back to the hospital after having their surgery at the private surgical center. As long as they are not paying out of pocket, no one cares.

  - There is no doubt the system is under strain, most acutely in waitlist times for elective surgery. However, it is not clear this crisis actually exists, and research shows that private, for-profit investment in health care is not the right approach
to deal with the challenges that do exist. There are many innovations within the public system working to address waitlists and other health care challenges. The policy priority must be to expand and build upon these successes.

- Procedures in the public system do not face the same level of scrutiny or competition as the private sector. Consequently their level of complexity and inefficiency tend to be greater.

- I am sure that upper middle class and wealthy persons believe that it would be to their advantage to have both private and public care. It would not be an advantage to the middle and lower classes.

- Claims about the superiority of mixed public and private European health care systems are made without reference to the rest of the European social program package (including income equality, generous social benefits, low post-secondary tuition and labour rights). These other benefits have no appeal to those advocating that mixed health care systems be imposed in British Columbia.

- Canada and British Columbia have always had a large component of private delivery of health care services. Physicians operate as private businesses. Hospitals are public, but are not owned or operated by provincial governments, as they might be in other health care systems (for example the United Kingdom). Another critical distinction in health care delivery, however, is for-profit versus non-profit. Hospitals are not-for-profit providers, and physicians, while private, have significant motivations other than profit. In contrast to this, there is a mix of non-profit and for-profit nursing homes in British Columbia, home care services are provided by both for-profit and non-profit providers, and the pharmaceutical industry is entirely for-profit.

- The majority of what is done in our public system tends to be the high cost, high complexity and high risk. In the private system, it tends to be high volume, low complexity and low risk. So making comparisons across systems is really difficult in that environment.

- It is no longer easy to determine how to keep the profit motive out of influencing an individual’s health care. Each layer of intermediary private contractors between the payer, that is, the government, and the client receiving health care introduces the potential for profit considerations to influence the health care given. To preserve the non-profit principle of public administration, therefore, the number of private-sector layers must be minimized. Moreover, the government must set and administer strict guidelines for the contractor or contractors and must fully accept responsibility for the actions of the contractor or contractors.
Canadian independent medical clinics are meeting patient needs and the expectations of provincial health authorities with timely and quality care. We have, however, only tapped a fraction of the potential for quality patient care available in the independent health care sector. A change in the regulatory framework could widen opportunities for greater public and private health care partnerships that could enhance the sustainability of the public health care system.

Over seven out of ten Canadians support the Supreme Court decision allowing supplementary private health insurance and care (COMPAS poll, January 2006). Over five out of ten Canadians agree with the option to pay privately for faster treatment (Pollara poll, June 2005).

International studies show that countries with parallel public and private health care systems have longer, not shorter, public-sector waiting times than other nations. Canadian studies point to similar results. A 1998 study from the University of Manitoba found that cataract patients whose surgeons worked in both the public and private sectors waited 23 weeks for surgery, more than twice as long as patients whose doctors only worked in the public hospital system. The problem stems from the fact that there is a finite pool of health professionals, both doctors and nurses. Private hospitals and clinics draw scarce human resources out of the public system, lengthening wait times for patients who want to access public services. As the Manitoba cataract example suggests, waitlists are longest for patients of doctors who work in both the public and private systems. One reason is that doctors who work in both systems have an incentive to keep public waits long so that way they have a steady pool of patients willing to pay for private service.

We already have a multi-tier system: public care, insured services through employers and individual patients.

A key reason for poorer quality of care and health outcomes in for-profit facilities is the lower number of skilled personnel employed. In 2002, a study in the Journal of the American Medical Association reported that patients at for-profit dialysis clinics had an eight per cent higher death rate than those attending non-profit clinics, and a lower chance of being referred for a kidney transplant. But it was not the only study to find such sobering outcomes. The same group also published an overview of all individual studies comparing mortality rates for 26,000 for-profit and non-profit hospitals serving 38 million patients. They found that adults had a two per cent higher death rate in for-profit hospitals, while newborns had a ten per cent higher rate. They concluded that concerns that the profit motive may adversely affect patient outcomes in for-profit hospitals were justified. The
investigators estimated that if all Canadian hospitals were converted to for-profits, there would be an additional 2,200 deaths a year.

- The private sector has traditionally played a pivotal role in the delivery of health care services in Canada. Medical clinics, staffed by doctors, nurses and health care providers operate as private businesses treating patients and billing government.

- Provincial health authorities have taken advantage of private-sector services by sub-contracting patient care to independent health care facilities.

- Contract services can have lower standards.

- Private clinics do the most profitable and least complicated procedures, leaving the public system with more costly procedures.

- Private health care may not result in improved wait times. For example, the recent significant improvement in hip replacement wait times came as a result of more efficient organisation as well as more money.

- Mixed private clinics for certain diagnostic services are controversial but seem to be useful.

- Private clinics are necessary to mitigate wait lists, to provide timely access and to address the concerns raised by the Chaoulli decision.

- Private Clinics can be better integrated into the medical system, providing more medically necessary services that are publicly funded. The issue is who controls the system, not who delivers the service.

- Private clinics have been operating for decades, and even though they are for profit, they are still able to provide care much faster and often for less money.

- Private and public delivery can co-exist within a common government funding model: look at the French model.

- The privatisation of housekeeping, laundry and food services has resulted in deteriorating services.

- There is a political attitude that we can operate both a public and private health care system without compromising equity, availability and quality of care.

- People are giving up on public health care because of horror stories and the current government is pushing the message that the system is broken. The government is failing to implement positive public solutions in favour of promoting private sector incursion into health care.

- Public-private models end up dividing people into two groups and it is the wealthy that drive the changes.
There are various tiers of health services right now that are avoiding the Canada Health Act (such as WorksafeBC and the Royal Canadian Mounted Police).

95 per cent of the clinicians in this country are private practitioners. It is a privatized system in many parts. So let us just do it in the most successful way we can.

Private clinics could speed up surgeries.

There is an underlying assumption that private care is substandard.

How does the North American Free Trade Agreement (NAFTA) impact on our maintenance of our Medicare (public) system if private involvement increases? Do not allow North American Free Trade Agreement (Chapter 11) to have any jurisdiction over public services like Medicare. Provide a guarantee that North American Free Trade Agreement will not apply to Medicare and clearly inform everyone about its implications, as well as what government will do to protect the Medicare system.

I disagree that if we open our public services up to competition North American Free Trade Agreement will destroy it.

Essentially there are two delivery models: private and public. All alternative health care is private. The conclusion is that the health care in British Columbia is fragmented.

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.

Researchers have analyzed data from studies that compared outcomes at non-profit and for-profit hospitals. Their conclusion? Non-profit facilities produce better outcomes, and this is after controlling for differences in the type and complexity of patients cared for in these different hospitals.

Comments on choice and coverage:

I once read that Canada has a much higher percentage of self-employed people than does the United States because of our public health care system. As a self-
employed person, am I going to be at a serious disadvantage in a mixed model system?

- Why is Canada the only nation in the developed world which does not allow private health care?
- We need private health facilities as well as public.
- The wealthy will continue to go outside country for their health care needs. Why not allow them to obtain and pay for the service here?
- It is not fair or reasonable that a person, out of frustration, or pain or impending death, is now prevented from paying for their care over-and-above what they pay through taxes.
- Many services are already provided and funded (at least in part) privately. These include dental, vision and hearing care, physiotherapy, chiropractic, acupuncture, most prescriptions, alternative medicines and so on. Sophisticated diagnostics and even simple tests are already being judged as to medical necessity (and therefore whether or not they are covered by the Medical Services Plan), and they are being offered by both public and private providers. This medical necessity determination must be used to retain any possibility of sustainability. However, those who desire (and can afford) a more aggressive medical approach should not be denied the right to do so, provided that the services used are funded privately.

- We have two options: reduce current levels of care and maintain the current budget, or maintain and potentially expand existing levels of care and seek alternate payer sources.

- All health care systems present problems of cost-containment and value for money. But this real issue has been converted into a fallacious claim of lack of sustainability to which the answer offered is not better mechanisms for cost control but a shift of costs from public to private budgets. No one's income is threatened, indeed new income opportunities may be opened, but the re-distribution of access and of cost burdens will favour the healthy and wealthy.

- 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.

- Demand management, or different ways of delivering, is quite different than looking at funding mix options.
• At a private surgical centre, you would be shipped out to a hospital if you went in to anaphylactic shock or cardiac arrest which is scary.

• Many people have argued, incorrectly, that Chaoulli somehow establishes a right to private health insurance or somehow mandates a two-tiered healthcare system, which I do not think is the case. But it certainly does augur for change in the health care system. Basically what the judges indicated was that they were not willing to somehow re-write the basic terms of the health care delivery system that we have in Canada, and somehow to mandate that there was a Constitutional right to a separate parallel private system. But, what Senator Kirby and his colleagues advanced to the judges was that it is perfectly acceptable to establish a monopoly publicly-funded system as long as patients can access services in a reasonably timely way. There does not seem to be an answer to it, at least I have never heard an answer to it, because it would be really contrary to the entire purposes of the system to require people to suffer or die and prohibit them from protecting their own health in the guise of preserving access to a quality healthcare system. The Supreme Court of Canada, by the narrowest of margins, by four to three margin, did accept this argument.

• Comments on health human resources:
  • Skilled professionals will not leave in droves to the private sector, just as municipal employees and teachers have no shortage even with private institutions such as private school operating alongside them. If there is a two tiered system, then public salaries and benefits will be kept attractive when compared to the private system.

  • Many people fear the best doctors and nurses would go to the private side in a two-tier system, the inherent assumption being that people and medical professionals are so greedy that the good ones would chase the big dollars and only the duds would be left for the rest of us. I would like to think that some of those medical people would want to actually help regular people. I am not sure I would want a doctor who was totally focused on money anyway.

  • Proposals by some health authorities to remove simple day surgical procedures to off-site private, for-profit clinics will drain nurses and other professionals away from hospitals, increase operating room staff shortages and leave remaining staff confronting a never-ending burden of complex cases.

  • The creation of a two-tier system will create more pressure on available health care professionals.
The government was free to alter the health care system as it chose and as the electorate would get away with it. But they could not do so without consulting with the workers involved, which is the workers’ right under the Collective Agreement.

There is a false sense of shortage of staff in a two-tier system.

A mixed model reduces number of doctors available within the public system.

The system will remain inefficient as long as the private sector competes with the public system and poaches support services and professionals.

The private sector can provide new and innovative ideas to the health care industry. However, the danger that many doctors would leave the public system for an unregulated private system is very real. Right now, a doctor in the public system is paid a flat fee for services which is far less than that doctor could charge for the same service in a private clinic. The incentive to go private is obvious. Incidentally, these private clinics have existed for many years: just ask any professional sports athlete how many weeks he waited for his knee surgery.

Irras and Suggestions

Values

Cost and Efficiencies

Assessment

Choice and Coverage

Health Human Resources

Ideas about values:

- Access to quality care is more important than who is delivering it.
- At the core of this discussion is the need to reaffirm provincial commitment to the principles of universal health care, including public funding and public delivery of our health care services. Canadians cherish universal, public health care.
- Have public funding, but include public and private delivery.
- Canada has the required science, technologies, and talent needed to create a sustainable industry, which can translate our public and private investment into improving patient outcomes, both in British Columbia and for export around the world.
- The public could contract services to the private system: they would be paid for by the public at public rates.
• Health care delivery should all be not-for-profit, even when there is a private component.

• When opting for private treatment, you should also bear the costs of diagnostic services delivered through the public system.

• Have private clinics help with services, but charge the public rate if services are funded by the taxpayer. People who want to be fast-tracked for elective surgery should pay out of their own pocket.

• Remove partisan politics and ideology from health care and make the best decisions for the common good.

• We need to examine opportunities for the private sector in the health care system.

• The Provincial Government should purchase the buildings rather than shutting down seniors’ homes and moving the seniors to public-private owned buildings.

• Work on reducing the fear the public has about mixed private and public delivery systems.

• Implement a two-tiered or multi-tiered system, but require a compulsory contribution to British Columbia Medicare. Low income earners would have the same treatment.

• People, who can afford private health care, should not take away from, or have priority over, those who depend entirely on the public system.

• Keep private and public separate as they are ideologically different and are crashing in on one another. Private care has its merits and Vancouver has a larger population able and willing to keep up the private system along with the private insurance catering to it.

• Government should be insurer, payer and setter of standards, but allow delivery by both public and private facilities.

• The family should be able to pay for their care if the system does not work.

• No public money to private initiatives.

• Health care services should be publicly funded with co-existing public and private delivery.

• Some health services should be allowed to be conducted by the private sector.

• We have to dispel the horror stories being spread about for-profit alternatives.

• Health care needs to be funded publicly and adequately, and managed publicly.

• We need improved communication of the nature of and potential benefits associated with private delivery.
- Support a publicly-funded single payer system of health care, but if government is unable to provide a timely, adequate level of care a second tier will be demanded and developed and should not have artificial barriers placed around it. If the government wishes to fully fund health care in British Columbia, then it has the obligation to ensure that the level of care available is timely and appropriate such that there is no need for a second tier.

- Support a single-pay, fully government-regulated system that permits the use of privately built and owned facilities.

- Encourage funding models and innovative programs that reward positive health outcomes and respect the past, while not being afraid to explore the benefits of other models.

- The private company should not have a say in quality control or accountability measures.

- Private care must follow strict regulations and control.

- Look at private options, not funded by the public system.

- The discussion of public and private is very difficult so we need to create a way to have the discussion.

- Governments should retain the principle of public administration and implement it more whole-heartedly. Therefore, whenever government contemplates contracting out a function in the health care system, it should first: 1. ensure its own health administration is of top quality, with particular emphasis on first-rate information management systems including financial and statistical information; 2. examine the relative costs and benefits of improving its own systems in comparison with the costs and benefits of policing those of a potential private contractor; 3. set strict, detailed and enforceable guidelines for the actions of contractors; and, 4. accept government responsibility for a contractor’s actions.

- Our health system is an educator and an insurer rather than a provider of services. Private industry should provide the services, with our system underwriting the cost.

- There should be a three-tier health system in Canada. Tier one of universal coverage and access to health care services and facilities as it is now. Tier two of regulated private care where doctors have access to public facilities such as unfunded or empty hospital beds, operating theatres and equipment and their fees and standards of care are set in provincial legislation or regulation. Tier three of regulated private care where standards of care are set in legislation or regulation but fees are not.
• Ideas about cost and efficiencies:
  
  • A dynamic health system will find an optimal blend of private and Government-subsidized services that compliment each other and jointly deliver quality services while creating a robust sector which benefits all.

  • Determine the total cost of each major service in the public system. This figure should include overhead, including the cost of operating the hospital, insurance and so on. Next, allow private clinics to perform these services at a five or ten per cent discount and have the public health care system pay the bill. The result is a win, win situation for all parties.

  • There are proven models where industry has been a major partner that have been executed within Canada and other jurisdictions that can be adapted to create pilot programs within British Columbia that can provide insight into measurable improvements for patients and provide insight as to how to optimize resource allocation. This will ensure that the costs borne by publicly funded health care within the province provide the highest possible return on investment in improved patient outcomes and within the health care system.

  • 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, then those efficiencies should be captured provided it can be done within a properly regulated framework.

  • Government should 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; and, d) where necessary, utilization of private facilities as the safety valve if wait time benchmarks are not achieved.

  • The private system should kick in after the maximum wait time is exceeded. Care should still be paid by public funds.

  • Private clinics may enable specialists to bring special equipment and services to rural areas.

  • We need to eliminate the notion that the word profit is synonymous with escalating costs, irrespective of where you sit on the private versus public debate. This has been repeatedly proven through history to be flawed logic, both economically and with respect to basic human behaviour.

  • Allow private care facilities, but make them pay higher taxes.
• Have a blended system where service providers handle both private and public. Improve funding through co-payment by patients (a nominal amount) for doctor visits and other services.

• In order to sustain the economy and at the same time, find additional payer sources for the health care system, employers and disability insurers must become legitimate payer sources for a wide range of health care services for their employees. This will reduce the cost of attraction and training of temporary replacement workers, increase the number of payer sources for health care and ensure that employees are well cared for.

• Direct the attention of Canada's health care decision makers toward the untapped potential of the independent health care sector. The sector should not be viewed as a competition to Medicare, but as an arch of support that can release some of the pressures on the public health system and contribute towards Medicare's fiscal sustainability.

• Improve patient care with a renewed universal publicly funded health care system complemented by independent health care facilities.

• Structure health care financing through a publicly-insured system complemented by private sector financing and insurance options (strengthen government funded universal health care coverage); amend provincial legislation to accommodate private health care insurance; lift the ban on private insurance by amending the Canada Health Act; and give patients the option to pay for medical procedures through private health care insurance or out-of-pocket).

• There should be public health care for children up to age 18 and it should be Cadillac care. From ages 18 to 25, the government could assist with payments for an individual's choice of health plan. After age 25, you are on your own. Pay for what you want.

• Authorize regional Health Authorities to call for tenders from private clinics for specific diagnostic and repetitive type treatments. For example, a private Medical Resonance Imaging (MRI) machine might operate 24 hours a day and seven days a week: a patient could be given the option of having the scan done within 24 hours, knowing it might be at 3:00 in the morning, or waiting two weeks to have it done at the hospital between 8 a.m. and 6 p.m.

• Why should British Columbians go elsewhere to pay for medical procedures? Here it would fuel the economy and create highly paid jobs with taxes paid in this country.
• The key is to permit private facilities to compete with public facilities within a defined framework and within the provincial medical system. This will force the private facilities to prove they can compete effectively with the public facilities and it will force the public facilities to become more cost-effective.

• Ideas about assessment:
  • A comprehensive list as to the cost of procedures should be maintained by the health authority. When a patient is diagnosed with a condition that requires surgery, then they receive a voucher that is worth the amount listed for the specific surgery. It is then the job of the patient to redeem that voucher at any health services facility, be it public or private. This will force the public system into a more efficient and cost effective mode.
  • Private clinics need to have all services available in case of complications.
  • Show the public that new innovations and technologies provided in the private sector can offset costs associated with the profit motive. High costs of administration in large bureaucratic systems often cost more than the profit component in private systems. The private system can benefit the public system.
  • Acknowledge that the public-private system exists.
  • Educate people that change is not bad. Truly study and compare other systems in the world. Allow private delivery of publicly-funded health services. Promote Canada as a destination for innovative quality modern health.
  • Allowing private participation brings innovation and new technologies to the system. The public system is so large and bureaucratic that this does not happen there.
  • Look for blended systems rather than completely separate delivery systems. That is how we start to overcome some of the critical mass of density-driven decision-making models: not by further segregating our delivery of health care, but by working together and blending our systems so we can assure the population that our people actually get the best care.
  • Explore options for other insurers to administer the non-insured health benefits plan.
  • Do a cost analysis to determine if an alternate provider is more efficient and effective.
  • We need an open mind on the subject and the ability to test private supplementary programs.
  • We need more criteria for deciding whether to pursue public or private systems.
Private and public health care should be analyzed to determine if there should be a mix of both or if one is superior.

A model for a mixture of public-private funding needs to be developed for the population of British Columbia to vote on.

Ideas about choice and coverage:

- If there are private clinics, maybe the system could be set up as a fee for service based on a person’s income. Therefore those who can afford to pay would and those who could not afford to pay would not. This way everyone would have access to services and would pay according to ability.

- Choice of public or private is critical.

- Government should continue to explore models to contract with private general anesthetic facilities for low-risk surgeries.

- British Columbians should still have health insurance, but there should be a choice about where to spend our health care funding. Every person should get health insurance and take it to whatever institution that gives the best care.

- Services intended for birth control, fertility and premature birth should be housed in a private, non-profit facility.

- Put all the options on the table: other countries, the results of the Premier’s visits to Europe and the dental system of care.

- Use private clinics where the government pays for the treatment. Allow private insurance to pay for a higher level of service or faster access. Give patients a choice.

- Basic health care must be covered by either public or private delivery systems. Allow patients to pay for private services through private insurance or direct payment.

- Private clinics could be utilised if all of the services were universally available and were covered by the Medical Services Plan. No one should be able to pay for treatment as that will mean queue jumping and preferential treatment for the rich.

- Create a parallel system, rather than two-tier and therefore introduce choices.

- Educate British Columbians that the private sector is already working in the public system.

- We need more options without causing a negative impact on the public system.

- Persons able to pay should go to a private facility.
• Out-source to private services as long as they use the same fee schedule.

• Running private clinics under provincial guidelines can take care of non-essential procedures thus freeing up spaces in our public system.

• Allow patients to choose between the public system and a private clinic for medically necessary work. The government would pay in either case.

• Keep regulation but offer patients greater choice in medical care.

• We should consider allowing patients to pay for diagnostic tests.

• Cost effective health care with equivalent outcomes, regardless of the delivery system, should be encouraged.

• The public will have to expand their acceptance of private providers to include services such as advanced diagnostic imaging, cancer screening and surgical services.

• Not-for-profit specialized clinics should be used.

• Commit Canada to having the best health care system in the world by offering universal health care to those who need it as well as having options (delivery, payment and health insurance) in a private form to those who can utilize it.

• Provide real choice via parallel private system, while maintaining mandatory Medical Services Plan contributions and a universal access public system. The choice to pay for extras or alternatives should be a personal matter for patients, but staff in private practice should be required to work at least part-time in the public system, to avoid a dramatic drain of talent.

• Ideas about health human resources:

  • Regulate physicians and other staff around working in the mixed system.

  • Government could legislate that doctors work in both systems: two days private to three days public.

  • Allow practitioners to access all available tools and facilities irrespective of whether they are private or public and have the government pay.

  • Limit the number of hours that doctors can work in the private system.

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

Comments and Concerns

Values

Assessment and Cost

Governance and Accountability

- Comments on values:
  - There is not enough of a track record of public-private partnerships in the health system to say how it works. However, public-private partnerships are companies out to make a profit. Do we want to have companies controlling our health care?
  - The government is looking to the private sector for partnerships before community and non-profit options are explored.
  - Partnerships British Columbia is not critically analysing private-public partnerships. The idea seems to be motivated from a desire to provide investment opportunities for large pools of capital. Infrastructure will degrade near the end of the contract. The risk is carried by the government and profit goes to the private sector. Private-public partnerships waste money because of higher interest rates and the need for profits. Workers are not treated well. The Abbotsford private-public partnership has been a disaster as a result of construction delays and consultation costs.
  - The companies who build the hospitals and hold the lease are only doing it to make huge profits. The last year of the lease they do no maintenance and you eventually inherit a dilapidated structure.
  - Public administration does not require or imply public ownership of physical facilities. That had been clear since the introduction of the national hospital insurance plan well before Medicare. However, once health care became a full-blown industry, the established pattern of hospitals owned by public trusts and religious orders was augmented by the appearance of for-profit hospital companies. These provoke some controversy in the same way that non-hospital institutions for personal care do (extended care homes, seniors’ residences, nursing homes): do the facilities generate profits through low standards of care and exploitation of their employees rather than through higher standards of administrative ability?
  - Quite clearly, the continued use of public-private partnership 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.

- Comments on assessment and cost:
  - Capital projects and some operations are constructed by private for-profit organizations and then run by public organizations (public-private partnerships). Nothing is good about this. It is a more expensive way of doing things.
  - While public-private partnerships can be a good first step if designed properly, they do not go far enough. The benefits of outright privatizations are well established and result from the key differences between how the private and public sectors behave and the incentives each faces.
  - There are no cost benefit analyses for public-private partnerships.
  - Doctors' offices and hospitals work well when funded by the public sector.
  - With no evidence to show that privately financed, constructed, or maintained hospitals were any more efficient than public hospitals, the province began to implement its public-private partnerships and P3 hospitals. The fact is that all the evidence from other jurisdictions had already shown that these sorts of P3s were more expensive than the traditional public hospital projects. Experience to date in British Columbia bears that out: the new P3 hospital in Abbotsford is way over budget.
  - In the long run, costs to tax payers are greater for public-private partnerships than for publicly-funded projects.
  - Private facilities pay taxes, contributing to government.
  - Privatized assisted living and long-term care beds are much more expensive.
  - Public-private partnerships are more expensive and drain the public system.
  - Public not-for-profit long-term care centres can work well and do not have to involve public-private partnerships or privatisation and the costs that go with it.
  - Are private-public partnerships cheaper? I think the evidence we have here is conclusively no. The biggest review of this has been done by Allyson Pollock in the United Kingdom. She calculated that the private-public partnerships generated an approximate average rate of return of about 18 per cent guaranteed for the private partner. I think the central issues here are why would you think it would be cheaper when you need a private partner who:
    a. will not put him or herself at risk in a long-term expensive project;
    b. will want a relatively high rate of return for engaging in it; and
c. can you borrow money at a higher rate than government, or must borrow money at a higher rate than governments can?

So it is both logically unlikely that they would be cheaper, and it is empirically, I think, fairly well established that they are not. The attraction of private-public partnerships, of course, is that you keep the capital costs off your short-term books as the government. So it is other people's capital project, not yours, but you end up paying a pretty high price for it.

- The annual lease payments for the Abbotsford hospital have already escalated ninety-four per cent from $20 million to $39.7 million per year.

- Shareholders in private-public partnerships expect a profit and this cost is factored into the lease payments. Private-public partnerships come with additional layers of legal, financial and administrative bureaucracy, all of which costs more and diverts funds away from patient care.

- When the accounting is done, all the projected savings from public-private partnerships turn out to be hypothetical assumptions based on risk transfer. In the United Kingdom, after a 15-year experiment with public-private partnership schemes, tax-payers are outraged over cost overruns, poor design and construction and inadequate service levels.

- Having a privately owned and operated hospital in Abbotsford will be very beneficial.

- Comments on governance and accountability:
  - Public-private partnerships have no accountability to the public.
  - Privately owned entities are not accountable and it is hard for the public to access the information.
  - Public-private partnerships allow for reduced accountability for the government.
  - In private-public partnerships, building design is not directed by a user group. If there are cost over-runs, then they are borne by government.
Ideas and Suggestions

Values
Assessment and Cost
Governance and Accountability

• Ideas about values:
  • Implement a sustainable primary care facility through a private-public approach or through a public cooperative (that is, a non-profit service).
  • We need to create more dynamic, public-private partnerships. The public system cannot do it all. There are times when the private sector could make a huge difference with not a lot of funds. They have most of it there. They just need a little bit to push them over the edge, instead of re-creating it all.
  • Eliminate private for-profit options for public buildings.
  • Encourage public-private partnerships or private enterprise if it will improve accessibility (wait times) or sustainability.
  • Develop dynamic private-public partnerships, as in the Ontario community centres partnerships with private fitness clubs.
  • Explore innovative ideas for service provision through public-private partnerships.

• Ideas about assessment and cost:
  • The Government of British Columbia should look at some recently publicized public-private partnership disasters in the United Kingdom.
  • Look at public-public partnerships, as was done on the Queen Charlotte Islands, with active community involvement.
  • Government can borrow at better rates than the private sector. Use government directly to build and run our public facilities.
  • Public-private partnerships should be explored. This would be helped with more communication and education.

• Ideas about governance and accountability:
  • The advent of public-private partnerships is a secretive, non-publicly accountable system for spending taxpayer dollars. It must end.
  • All capital expenditure must be owned and operated by the Province of British Columbia, not private corporations where profit is expected.
• We need to establish safeguards to ensure the long-term viability of the asset and if that cannot be done then the government should not permit public-private partnerships. The profit motive must be eliminated from the public-private partnerships model.

• The focus of sustainability of health care should not be on public-private partnerships, but on good quality health care run by the public system, not businesses.
Primary Health Care

*Primary Health Care* was a popular topic for debate and discussion in the Conversation on Health. Participants compared their visions of primary care, the administration of primary care and its facilities, how other countries manage primary care, and the need for patient advocates, navigators and case managers as a way of helping to maintain quality of care. Here is a selection of what British Columbians had to say on the subject of *Primary Health Care*.

Primary Care Models and Visions

Participants generally agree that primary care is an extremely complex subject area, and that the keys to improved population health and efficiencies in the health care system may lie in primary care. A number of participants praised the provincial governments’ Primary Care Charter.

Participants argue that, with pressures on the health care system such as chronic disease management and increasing demand on acute care, the focus should be on prevention, demand management and self-management. These are all part of an effective and efficient primary care system.

The vision of primary care that many participants share involves a system where the physician is not the only gatekeeper: nurses, nurse practitioners, chiropractors, naturopathic physicians and other practitioners could also play this role. They suggest, an effective primary care system focuses on maintaining and improving the health of the population. This means reaching out to all of the citizens to ensure they are receiving the social services and health supports they require to get and stay healthy. Patients are dealt with in an integrated team environment, where practitioners work together to provide the best possible care plan for each individual. Links to the community are important as it is through these links that participants see opportunities to focus on population health.

This vision would take the load off of the acute care system by providing more entry points to patients, focusing first on maintaining and improving health and self-care before turning to the more expensive acute care system. This new concept of primary care would also encourage greater integration among practitioners, resulting in more patient-centred care.
Participants warn, however, that movement to a truly new system of primary care will require some major systemic adjustments, beginning with a new approach to remuneration and incentives for physicians and a new societal attitude towards health and health care. This is a long-term change management process, which needs to be designed and managed effectively across government and communities with strong leadership in order to make it happen.

*Primary Health Care is a relatively neglected component of the health care system. Some of the most effective and lowest cost health systems are based on a ‘primary care’ foundation, supported by a thoughtful healthy public policy framework. This would represent a significant change for BC, but offers a chance to move from a position of conservative, timid change where the inefficient, inequitable, costly private health care alternatives is allowed to creep in by default. This is not a time to be timid, but to learn from evidence and to invest wisely rather than react to headlines.*

– BC College of Family Physicians, Submission

**Primary Care Administration and Facilities**

Facilities, funding models, and accountability structures were all explored in discussions around new models for primary health. One of the key areas of debate was whether primary care should be managed by health authorities. Some participants argued that moving primary care under the rubric of health authorities would provide a more holistic perspective on community health and the ability to better service the needs and demands of the population. Others argued that this approach would add bureaucratic inefficiencies and should be avoided.

Community health clinics came up frequently as a way of encouraging a health promotion ethic and incorporating new practitioners into the medical system. Most argue that these clinics should be publicly funded and easily accessible.

Some participants argue that a new approach to primary care will also require a new approach to funding models. There needs to be a way to compensate a physician for activities that support community-based disease prevention and health promotion. They argue that without new funding models, introducing new entry-point practitioners into the system would be difficult. One suggested model is to create salaried physicians who would serve a designated population. The physician would be responsible for the health promotion and prevention needs of that population, measured based on population health outcomes, as well as individual health outcomes. Participants also advocated for the inclusion of certain primary care health services that are not currently funded through the Medical Services Plan, such as preventive eye and dental exams and care.
International Models

A number of participants had experience in or knowledge of primary health care in other jurisdictions, and many recommend a better understanding of these systems in order to identify best practices, which could then be imported.

One example put forward was from New Zealand, where primary care has gone through an overhaul over the past decade, culminating in the implementation of a primary care strategy in 2003. New Zealand has moved to primary health organizations responsible for a defined population. Their focus is not just services, but preventive care and the reduction of health inequalities within their population. While expensive, New Zealand hopes that its investment will yield long-term savings through health promotion and disease prevention.

Patient Advocates and Navigators and Case Management

Participants describe the health care system as complex and challenging. Similarly, participants suggest the lack of continuing care affects the health of patients and creates more pressure on the acute care system. Many believe that patient advocates and navigators could help patients through the system dealing with both this complexity and the continuity of care. This would be particularly true for British Columbians with different cultural backgrounds and language barriers.

Many suggest a patient navigator could be very effective for older British Columbians living at home who may have a variety of practitioners and specialists as well as home care services. A navigator could help them understand the care they receive, and how best to take advantage of that care. An advocate could also push for different care and services when they feel it could improve patient outcomes and avoid expensive acute care intervention. Participants also suggested creating a patient ombudsman who would receive and follow-up on patient complaints within the system.

Navigators and advocates would help patients understand the system and the care they are receiving. This would encourage and empower patients ultimately to manage their own care.

In pushing for an integrated approach to patient care, participants believe that there needs to be a new way to manage care, and they often suggested case management as an effective approach. Through case management, all practitioners would be able to understand every aspect of the patient care and work together to make it most
effective for the patient. Similarly, participants advocate for improved discharge planning to coordinate services after a patient is released from hospital. Effective planning, they argue, will avoid hospital re-admission and secondary health ailments.

You need a better sense of a system of care into which a lot of senior’s care fits. What you need is a broad base of services, in an integrated and coordinated system of care, managed or facilitated through good quality case management so that there is a champion for each person that comes into the system of care. The components of the system see themselves as part of the system and therefore they also agree to conform to the general policies about accessibility and how you get in, and what kind of care you get. What this allows you to do is provide much more seamless care for individuals if you have this kind of integrated system.

- Focused Workshop Seniors and Aging, Vancouver

Conclusion

For most participants, a new vision of primary care focused on the health of populations. Integration of services and practitioners, continuity of care, and a focus on health promotion and disease prevention would all be supported by new facilities and funding mechanisms. Patient navigators and advocates, along with case management and discharge planning would all work towards keeping people healthy and helping them manage their own care. Participants argue that investments in primary care that work towards this vision will yield savings in the long-term.
Primary Health Care

This chapter includes the following topics:

**Primary Care Models and Visions**

**International Models**

**Primary Care Administration and Facilities**

**Patient Advocates and Navigators and Case Management**

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**Related Electronic Written Submissions**
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**Related Chapters**

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Access; Scope of Practice; Health Care Models and Collaboration in the System.
Primary Care Models and Visions

Comments and Concerns

System Design and Vision
Entry-Points
Citizen- and Patient-Centred Care
Change Management

• Comments on system design and vision:
  • We need to define what success looks like from a medical system perspective (chronic and acute care), from a socio-economic perspective, and from all points of entry. Economic arguments are critical. The gatekeeper cannot be restricted to doctors.
  • The business model equates to short-term thinking as opposed to the primary health care mode, which is about long-term thinking.
  • I read the Primary Health Care Charter in the last couple of days and I am amazed at what is there and I would really encourage everybody to read it. It is a really good overview of where primary care should be going in the province.
  • Primary care is that continuum from prevention of disease through health promotion, healthy lifestyles, and also includes aggressive best practices management of chronic diseases.
  • Primary health care is complex, belying its secondary position in the health care system. Efficiency, safety and effectiveness warrant engagement of a range of skills; reliance on family physicians as the sole clinical resource is outdated.
  • Primary Health Care is a relatively neglected component of the health care system. Some of the most effective and lowest cost health systems are based on a primary care foundation, supported by a thoughtful healthy public policy framework. This would represent a significant change for British Columbia, but offers a chance to move from a position of conservative, timid change where the inefficient, inequitable, and costly private health care alternatives are allowed to creep in by default. This is not a time to be timid, but to learn from evidence and to invest wisely rather than react to headlines.
  • 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.

- For the last ten years I have watched family practitioners and family practice just heading downhill and it looked like there was no future at all for family practice. And now that has been reversed with things like the Primary Healthcare Charter. It is really encouraging. When I saw that Primary Healthcare Charter originally, I put it aside because I wondered what the point was, and thought it was just more government stuff that they have in committees that I sit on. From my point of view, if there is no economic reason for family doctors to change, why would they change when they are already running as fast as they can and making about 40 per cent of what specialists do.

- There is a significant body of research out there demonstrating that a robust system of primary health care improves health outcomes and quality of life and reduces the burden on the acute care system, yet we have a growing shortage of primary health care providers in British Columbia.

- We need to do more to encourage family doctors back into the hospital. For economic reasons, they have fled the hospital. There are studies to show that hospitalists can get people out of hospital quicker than family doctors normally. But if the family doctor is involved they are discharged quicker still. So I think we need to have both the family doctor and the hospitalist involved in the hospital.

- The key piece of the primary care vision is to have coordination, collaboration, and a team facilitated by appropriate tools, like the electronic record, so that the primary caregivers have the time and space to coordinate their teams, communicate with each other and interact relationally with the people they are providing care for. It is that connection and relationship that helps us really deal with those lifestyle issues that were mentioned and with real preventive care to keep people out of the acute care system when they do not need to be there, and to provide efficient and effective care.

- Right now we have acute care as the foundation of the system and everything else is feeding into acute, and that is why patients that are unattached are going to the Emergency Departments. If we flipped it and said no, primary care is the foundation of the health care system and we are building the system to support primary care, then you ask how you provide access for these unattached patients. What are the social determinants that we need to look at? What are the social behaviours that we need to support? So there are huge significant questions in order to start challenging the design of the health care system.

- Primary health care covers many themes. The first theme is the capability of the people. The second theme is ecological, because health involves communities,
volunteer sectors and non-profits. The third theme was the systems, like the primary, secondary and tertiary systems and their integration. The fourth theme is healthy public policy.

- A primary health care model starts with the person in the centre and the relationship that that person has with the health care system and the players in the health care system. The circle around the person is the primary health care system and that that primary health care system is based on human needs, both the human needs of the patient and the human needs of the providers. The pentagram around the outside represents the players in the health system and their interaction, integration and relationship is really important. So the policy makers, the professionals and health care workers, the academics, the community, volunteers, non-government organizations and so on, and then health managers. There are relationships that need to be built between all of those different players. This is the lens that we would use to look at finding the solutions to some of the challenges we have in the health care system.

- The clinical practice approach needs to be based on health planning: planning people's health and being proactive with call backs and care of the client.

- I prefer community-based and multi-disciplinary approaches to what I call the doc-in-a-box model of primary health care, which is just expanded overgrown family practices employing numerous doctors. The literature reviews do show that some chronic diseases, for example, have better outcomes when managed by nurses as opposed to physicians. So, I think we need to go where the evidence takes us.

- Current directions in primary health care talk about patients without mention of families and coordinating services.

- Health care should focus more on keeping people well, including, nutrition, getting additives out of food, chemicals out of the environment, and people off of drugs.

- We need better primary health care focused on preventative medicine. Education on root causes of poor health can improve the overall delivery of health care services.

- Primary care has to be linked to social determinants and tertiary care to create an integrated accessible system.

- You want to have good linkages. You want to be able to support the doctors and other practitioners.
• The quality of care is far superior with the classic example of the family doctor who knows your medical history and is willing to engage in productive dialogue along with a proper examination.

• Right now the two systems are working against each other. This is the critical divide and health authorities and Ministry of Health are strategically pushing this.

• Physiotherapists and doctors can give opposite advice. A primary health care team could talk together and have patient conferences to develop a common approach to the particular ongoing problems of an individual.

• There are some examples now where health authorities have set up primary care clinics. Our health authority set up one in Ladysmith when we shut down the hospital.

• There is a population-based funding clinic called Spectrum Health and they have five doctors in there. They divided up their work and took leadership roles in a variety of ways and they were very innovative. They did not have to report to the health authority. They went out and got funding from other sources to bring in some other professions to work in the team. They are far more flexible and less limited by the bureaucracy.

• Primary prevention has proven that it will save you money in the long run. Since we have attacked this problem from an acute care model for so long, and it is not getting anywhere, let us change our focus. Maybe we set up clinics. Maybe we set up something even within the acute care system. We have so many hospitals that probably have space that you could put the clinic in the hospital. So you are still going to the hospital, but you are seeing a different practitioner there in a different environment. We have already made a major shift in how we deal with ambulatory care.

• We have something called Care North. It brings nurses and physicians together to hold group appointments with patients. Patients will come in with other patients and have access to a variety of professionals.

• The Ontario Health Services Restructuring Commission produced the best overall statement of what primary health care ought to look like. But what is happening in Ontario is just a consistent atrophying of the model into physicians and physician extenders.

• Do not talk about primary health care: talk about prime disease management goals. Pick three sentinel conditions and set goals for how these should change in the population over time. This will drive the primary health care revolution more than all of the conversations that we have had up to now will.
• We take from acute care and put into primary health care to achieve risk avoidance. The idea is that if you spend a hundred million dollars more on primary care, then you save the system in laboratory costs and acute care costs that do cost a hundred million dollars. That does not mean a hundred million dollars comes out of the system, it means that as people age and people get more diabetes and everything, none of those people get turned away because you have now made some room in the system.

• We need an attractor for a collaborative model. Stage one is to fully develop the funding model, and then open it up for migration. We have to get it through the medical association. Phased uptake will be two to five years. You announce long term intent with phased implementation. Gradually establish the collaboratives in the regions that are interested early and move through the province over time. The speed of the uptake will be dependent on the algorithm that is created through the funding model: who will profit from it, and that is where your early adopters are going to be.

• The Primary Health Care Transition Fund contributed to the development of primary care offices in the newly reconstituted health authorities. These began to develop connections with community-based primary health care clinicians, developing some contracts for novel activities.

• The historical model of family practice had advantages. It offered much freedom for physicians: clinical freedom, freedom of styles of practice and hours of service, freedom from the need to negotiate. Many of these are as limiting as liberating. Some gradual co-location is occurring. Historically family physicians collaborated in after hours care, but with the breakdown of family physician involvement in hospitals, this has started to erode. Some family physicians joined together to work in walk-in clinics, chiefly on a fee sharing basis, but focusing on simple short-term, episodic health issues. Others have worked on a contract basis with health authorities, either in community clinics, or, increasingly in hospitals as hospitalists.

• Future planning for primary care should use advanced models for the health care system including the Results-based Logic Model for Primary Care, and the Clinical Microsystems model as organising frameworks. The latter has a great number of tools and management approaches directly relevant to care and care management.

• Primary health care reform in Canada is overdue and high on the public policy agenda. In the last decade the solution to the crises in health care has been to pass out more money. Recent efforts, most notably under the Primary Health Care Transition Fund, have been too narrowly defined since chiropractic and other
non-medical health care disciplines have not figured largely in these reform efforts.

- A pilot model in maternity care is the South Community Birth Program, which is a collaborative model with family physicians and midwives providing care in a team with nurses and postpartum support and doulas to a multi-ethnic, multi-lingual community and where the primary caregivers do not have all of those languages they make sure that there is doulas. They do group pre-natal care in a centering pregnancy model. It was funded with federal health transition money.

- The DEHACEM collaborative was a Vancouver Island Health Authority pilot with a group of ten doctors where the community home care nurse, instead of having a geographic region, was attending to that office of ten doctors no matter where the patients come from. Everything was dealt with through the collaborative, so the patient has got a home. They have got the lab and the pharmacy there: everything is there. The doctors are delighted, the patients are delighted. It took a lot to broker that with the union, changing that focus.

- We need to take staff from the health authority and match them with physicians throughout the area to create efficiencies.

- What we need is a government structure at the provincial level that brings in different people, is cross-sectoral, and has people that are very well respected. When you have a multi-stakeholder governance structure, you have to be more accountable because you are going to be caught out by different groups. That would provide some legitimacy and support for what we need in relation to the Ministry of Health. If you had a council that represented all of us, then it would be strong enough to make changes that would affect everyone, even physicians.

- Comments on entry-points:
  - We are talking about entry points rather than response points as if somehow there was an element of privilege in being able to get into the health system. So, do you need an entry point password to get past the gatekeepers?
  - Physicians are gatekeepers but patients do not always need that step.
  - Meals on Wheels are in a perfect position to do a quick visual scan of a senior’s residence and just see what is out of order. Are there medications sitting around that maybe are not being taken, for example. There are other interactions that many other people have with parts of the population you might want to track more carefully that we are not making use of.
One of the challenges we have got is how to get people to understand their entry points. You have to be proactive and confident in managing your own health care, which many people are not equipped to do. We are taking people from picking up the phone and having the ambulance comes to their door to being proactive in managing their health care. People have been socialized to expect immediate response. How do we help people take control of their health?

Emphasis needs to be shifted from the current mode of delivery where physicians are the only gateways into the system to a cheaper first line provider. This is already taking place to some extent with nurse practitioners and health hotlines, but this is the long term direction for health care.

We need to see a system where a social worker refers clients to the health care system if they determine that part of your problem is a health or a medical problem. We are so far away from that. It works in clinics when you have social workers in the hospital or in clinics, but not in the community. That raises questions of how many sectors need to get involved, where does the health care system begin and end and how do you coordinate with everybody else about it?

In urban centres most apartment buildings have more people than are found in many isolated communities. Why not have nurses assigned to these high rise apartments with their many hundreds of people as the first line of health care? Two nurses, sharing duty in a high rise apartment, could divert any number of people from the expensive and over crowded hospital emergency rooms. In this way real need cases would get to the emergency while others would be treated on site or held until the next day for a doctor’s appointment.

Patients fear alienating doctors by seeking different entry points.

Primary health care does not need to offer same day access to care unless it is an acute illness or emergency.

Family physicians are central to British Columbia’s primary maternity care system. Midwives also function as primary maternity care providers with first-contact access, as nurse practitioners do in other areas of primary care.

We need to think about how we unload the physician, how we surround them with services to help us manage some of these chronic diseases. We have set up the physician as a single point of failure! If we continue to put primary care doctors in the position they are in right now, then they are all going to quit. They should in fact quit because we are expecting them to do magic.

Doctors of Optometry are primary care health care providers specializing in the examination, diagnosis, treatment, and prevention of diseases and disorders of the visual system.
• Comments on citizen and patient-centred care:

  • What we are really talking about is those services that citizens need that are provided in a coherent and consistent way across the system that is holistic. It comes back to redefining the services that we should actually include, and then rethinking that fundamentally.

  • Provide patients and caregivers with education. The system needs more engaged patients.

  • A primary clinic provides the whole context. What is the reason for someone's ankle sprain? If it was a kid who was not wearing appropriate protective gear on a skateboard, you could educate that child. You could educate that parent. If it is a senior who was a bit frail and lost balance and sprained her ankle that way, you can then look at all the circumstances and provide the information and assistance that person needs. A single family doctor usually does not have enough time to do this in their short visit.

  • If we have a patient focus, then the professionals come together better because they keep being driven to the patient needs. They would be able to put their provider silos away a little bit and not engage in so much turf war.

  • People say primary care systems are person-focused and not disease-oriented, but they can be stage-of-life oriented. If you have got people in that stage of life where they have got all of these chronic diseases flowing, then the disease focus comes.

  • To manage performance, you need to look at the balanced scorecard approach applicable to a team working to achieve outcomes collectively.

• Comments on change management:

  • Practitioners at the local level have to realize that they are not isolated players, but that they are members of the community in promoting health and not just part of the health care system.

  • Rural communities can really be a test bed for new models of care because it is easier to get your hands around it, test it, evaluate it and then expert it to the larger centres.

  • In 12 years, since we have been running low-cost sexual health clinics in the province, adolescent pregnancies have dropped 40 percent. These sexual health clinics are combined with school education in a lot of the communities. So this is an example of where a service that exists outside of the stamp of the institutional system actually can have an impact.
If we want clinicians to be accountable for a practice, for a population of patients, then we are going to have to give them tools so they can actually manage a population of patients. Managing a population is as much about the patients who are not coming in as the people who are. You need to be able to look across your population of patients and say what are the unmet health care needs of this group of people? Who are the people who most need my attention? But also who are the people that have needs that could be met in an alternative way?

The medical association needs to be really involved in building a vision for a new way of organizing primary care and an ultimately the health care system.

There is a conflict of ownership as a result of vested interests engaged in primary care delivery.

Because we are being a little bit more cautious and worried about the bottom line, we are encouraging doctors to first form together in a network and then co-locate and seek group funding. We realized that we could not do it without support of the Ministry of Health, and we could not do it without support from nurses, dietitians and social workers. Those three practitioners were critical to moving it ahead, getting doctors to interlink with them and allowing those practitioners into their offices.

We need a greater focus and investment in primary care.

We need to think outside the box and connect things that we think of as traditionally part of the health care system with the community and think about what health is, not just as it is defined necessarily by the Ministry of Health. We need to think about how those connections can be made.

These models exist in Europe and the United Kingdom. They work perfectly well and yet we do not seem to have a true primary health care strategy. We have not changed the fundamental incentives to make it run appropriately. We have not asked: what do we want this picture to look like? How do we want people to work together? How should we pay them? How should we motivate them? We are not tracking them anyway, in terms of the data, so if they are actually delivering care according to guidelines, we are not able to track that and actually show that they are making a difference.

We should act quickly. We are in a crisis right now in primary health care. Maybe the government actually has to look at some of the things that people are doing, politics aside.

Creating effective clinical microsystems requires changing to an electronic medical record. There needs to be effective implementation through: time and support to plan personalized patient care (patient has their own cycles for testing
and patient care), a change in practice model, prompts to use the electronic medical record, knowledge about tools, and reminders to all key partners.

- You will have to persuade physicians to change their practice. Physicians now are working in solo practices with fee for service. There has to be a different way of compensating them. Maybe it would be capitation. Maybe it would be salary. There are probably some models to work on and just expand. If you have a number of folks building the model, or participating in it and understanding what is going on, then they can extract the pieces that will work.

- Start with where there is interest and gradually peel away and reconstruct from the related budgets over time. You are not going to flip a switch and all of a sudden one day everybody goes from operating totally one way and being funded one way to another.

- If you look at the hardest problems and you tackle something like the Aboriginal population, there is a huge economic development agenda there and you are probably talking about a generation to really make a difference. Look at the tobacco experience: there were significant changes as a result of the first round of legislative changes, then it flattened a bit and now there is another little drop. But it does take a long time. This is the idea of social marketing: it is a heavy marketing effort to actually engineer society the other way.

**Ideas and Suggestions**

**System Design and Vision**

**Entry-Points**

**Citizen- and Patient-Centred Care**

**Change Management**

- Ideas about system design and vision:

  - Ten years from now family physicians will manage people proactively and by exception. They will get to their desk in the morning and have a report that, for argument’s sake, has 80 names on it. They may be effectively doubling their existing capacity to manage people today. They will go through that report. It will have been compiled by an inter-professional team that, by the way, includes closely integrated mental health professionals as well as nurse practitioners, kinesiologists, registered dieticians and others, pharmacists, and so on. They will effectively be able to manage twice the number of people in a day than they do today. However, they will only see in a given day maybe ten or 12 patients. And
when they see those people they will spend the proper amount of time with them and they will achieve the outcomes that they are striving for professionally.

- A system of care based on the pillars of primary health care as delineated in the Romanow Commission must be implemented immediately: continuity of care; early detection and action; better information on needs and outcomes; and new and stronger incentives for health care providers to participate in primary health care approaches.

- Allied health care professionals could provide a mobile service to doctors’ offices for some of the more simple diagnostic tests and patient education.

- Develop an enterprise approach, bringing all of the pieces together, not as fragmented or silos, and including governance and needs and risk analyses.

- An effective primary health care centre develops strong links to the community and community based services.

- Primary health care should have an emphasis on health promotion, education and wellness, chronic and debilitating diseases, and mental health with a special program in non-pharmacological intervention.
• Challenge the assumptions on which the system is built. Do not move everything upstream into primary care on the backs of physicians.

• Keep a public system that decentralizes the delivery into manageable geographical areas by using a multi-team approach.

• Look at an integrated system of care including population health, palliative care and social integration.

• The framework should include case management, coordination and system navigation.

• Rebuild primary care: bring it into the accounting system.

• To maintain a strong public health care system we need transparency and accountability with a focus on primary care delivery (from acute care) and prevention in order to do a better job with the money we have.

• We need publicly funded, not for profit primary health care in integrated health care centres, administered at the community level and supported by documented evidence and in compliance with the Canada Health Act.

• The delivery model has to take account of available funding and the demand on that funding and develop a system that is inter-professional and collaborative.

• A new primary care system would have welcoming environments with integrated and convenient access. The attitude of professionals would be both positive and collaborative. The key outcome would be higher client satisfaction. This vision would include a values-based approach to training institutions and programs.

• The vision would be an innovative, integrated primary care and chronic disease delivery model, which is publicly funded and privately delivered.

• There should be a provincial framework which includes a case management and system navigation component, with government oversight and collaboration between agencies.

• Primary health care centres goals should be to improve the population health of the community and alleviate pressure on acute care.

• Create a publicly-funded and administered health center where family physicians, specialists, diagnostics, home care nursing and other resources are in one building.

• Success would look like no one would have to use a primary care centre. If you have ultimate success, then you have an extremely healthy population.
• We have to remove some of the disincentives because the notion of having general roster general practitioners and then having primary clinics sounds good, but the ethics of our communities is such that people believe that they have to see their own private doctor all the time for everything.

• Develop a model based on emerging best practices for primary care with remuneration based on a blended capitation and fee for service approach. Some of the features would be a group of physicians and other health care providers working together in an integrated system of primary care with clear accountability. It would provide incentives for performance based on sound, evidence based, quality improvements and it would have flexibility for services based on community needs and desires.

• British Columbia needs community clinics like Ontario and Saskatchewan which focus on the team approach.

• Create ways to bring nurses, social workers, dieticians, mental health counselors and other helping professionals into networks with existing family practices to make it easier for family doctors to coordinate multidisciplinary services for their patients.

• Future planning for primary health care should explicitly address consideration of productivity within the context of safety and effectiveness.

• Government should fund a measurement-based study of primary health care models including piloting and evaluating different models with different cost structures. Government should look at existing programs, and politics aside, consider which ones to base pilots on.

• Our health is not just comprised of one or two things, but a multiple of disciplines. This should include, among other things, physiotherapy, dental, fitness, mental and so on, which all contribute to our wellbeing.

• Ideas about entry-points:
  • There should be multiple entry points (clinics, phone, and internet) designed with an understanding of who the patients are.
  • Include economic and social services organizations as an entry point (or as a pre-entry point).
  • Making the front end of medical care more responsive and efficient will doubtless require the introduction of reception cells, appropriate diagnostic machinery staffing, reducing set-up and set-down times among other tools for minimizing waiting times and waste.
The provincial Ministry of Health should recognize all primary contact health providers on an equal basis to support the daily choices the public makes for necessary care. This will help to fully integrate primary health care and also acknowledge the public’s right to choose who their primary care provider will be at their time of need. From the public’s choice, regulated health professions are not alternative, supplemental, or complementary, but are mainstream, core services that support the public health care system.

There should be formal recognition of minimal standards of primary eye care as a component of a comprehensive health care system, and parity in the scope of optometric practice across Canada.

Develop a collaborative model of vision care services including optometrists, general practitioners and ophthalmologists.

Embrace a primary care model that has a multidisciplinary approach with multiple access points.

Develop health care clinics that encourage the devolution of power from physicians.

There should be different points of entry into the health care system, including physiotherapists, nurse practitioners, chiropractors, naturopaths, and so on.

We need to increase entry points into the health system. We need to change the conversation from a question of access to a primary care physician to access to primary health care, which could include nurse, practitioners and others. We need to look at appropriate primary care through different lenses, through evaluation research to look at what works and what is needed. We need to incorporate the notion of multi-disciplinary teams and multiple access points to primary care in medical school curriculums as well as public education.

Clinical microsystems provide the most health care to most people. They include everything that goes into providing that care, from staff and technology to information and behaviour. The patient is at the centre of the clinical microsystem. The quality and efficiency of the patient care cannot exceed the quality and efficiency of the system providing that care.

Ideas about citizen- and patient-centred care:

Shift to infrastructure changes and implementation strategies which are all about the patient.
• Ideas about change management:
  
  • Primary care should be a focus of the new model as the gatekeeper to the system: the current approach needs to change and we need to develop incentives to encourage that change.
  
  • We need a top-down prescribed strategy to create public confidence in the system. Leadership from the province can influence the federal government positively.
  
  • Challenge the normalization of Aboriginal health inequities in the province. Work with Aboriginal community partners. If they are not coming, then look at your process to ensure that the theory and mechanisms of health services deliveries (not just the outcomes) fit with local Aboriginal health knowledge and systems.
  
  • There are no reasons why Indigenous people should not be on hospital boards and management. There are no reasons why Indigenous people should not be involved in the management and delivery of mainstream or non-Indigenous specific primary health care services.
  
  • Government has lost the public relations battle and needs strategy for capturing the public's mind. The government does not fight back against malicious attacks. Can we assure decision makers that we will support them in making tough decisions? You cannot mandate change when there is sabotage.
  
  • Be careful about being pulled towards what we already do because it is comfortable. Look at different complementary medicine and therapies do not be afraid of test-driving some of that.
  
  • We need to be piloting and evaluating different models of primary health care.
  
  • Moving to a primary health care model requires a wholesale change. We have only just started.
  
  • We need an outrageous target for primary healthcare in British Columbia, like by 2010 we are going to have two hundred integrated health care clinics in place across the province in these communities.
  
  • No more pilots. Put the money in the bucket and do it. It is not a pilot, because in order to get this to work, you have to make a structural change. And that requires courage, and often governments do not have courage because they want to get re-elected.
• If one of the goals is to re-think primary care and move to more of a team-based approach, how do we go about motivating general practitioners and providing mechanisms that would enable them to be successful in that kind of a model? The physicians themselves want different things.

• General practitioner registers are closed off because they are so busy they cannot take more patients on, so there is actually no threat to them whatsoever. They can break down these scope of practice barriers and allow some other primary care practitioners to work much more closely alongside of them, taking off some of their workload. In fact, they may be much less stressed and still make pretty much the same amount of money, and maybe even more if there are new incentives to work around chronic disease management programs and so on, and to provide coordination and health promotion services.

• Ensure fundamental conditions and resources for health are available in communities where people live, work, play and invest.

**Primary Care Administration and Facilities**

**Comments and Concerns**

**Administration and Funding**
**Management and Accountability**
**Facilities**

• Comments on administration and funding:

  • While still small in number, midwives have the potential to increase the Province’s primary maternity care capacity. Yet right now the system is losing its capacity. Over the past nine years, the percentage of British Columbia births by family physicians has dropped from 59 to 45 per cent and there are 47.6 per cent fewer family doctors delivering babies right now. In the same period, midwifery numbers have risen from 29 registered midwives in 1998 to 106 currently. We have gone from providing care for about 1 per cent of deliveries to 7.3 per cent as of March, 2006. But that is not filling the gap.

  • How many physicians would there be? How many facilities in different areas and districts? How many clinics would it take? What kind of population would be served by one team? There are a lot of things to think about. You need to get the population data and determine what characterizes their health needs, and then tailor it, and then be willing to monitor that data over time because it will change.
It would be nice to have some baseline health data and follow outcome data over time. Before you were to launch these primary care centres, you would have to collect data and analyze existing data, and then tailor it to meet local needs.

- How would this look different in like an Aboriginal community? Most of them are quite small and so they have trouble sustaining facilities and infrastructure. Most want health care provided by their own people and their own health care system. But we are not going to have two systems. So we need to figure out what is going to work that will be okay for them, and have more health care workers who are Aboriginal. How about developing capacity to partner with neighbouring communities. Around Hazelton there are eight or nine different communities all trying to build a health service. How can we work together with the folks in those Hazelton villages to plan these resources together to make something bigger for all of us?

- There are some successful initiatives, and one of them in Vancouver Island is the collaborative for chronic disease. Using that as a framework, we could set up a system of clinics collaboratively-linked that would be able to provide services to our patients across the Island. This would require these individual clinics to work collaboratively: they would have regular meetings together, and they would share inter-professional advice and learnings to go on and improve, not only how they function, but improve patient outcomes as well.

- There is now a demand for family practice to do prevention counseling with their patients. We were told not to do it before. There needs now to be a shift in funding models that will accommodate this shift.

- Payment structures for physicians are historically rooted in the British Columbia Medical Association agreement. It will require some initial very strong, top-down, decision-making and commitment to re-structure certain aspects of the system. We need the political will and a plan that we will all invest in.

- Fee-for-service motivates physicians to spend as little time as possible with patients.

- There was an example in British Columbia of the development of the population-based funding model in 1998. Payments went to the group, not to the doctor, so each group had to determine how they would share the funding.

- Practitioners out there are ready for this. The medical organization may or may not be, but the practitioners certainly are ready to do this. Even if you went a small baby step in one health region and said, "You know what? If you are a family practitioner, you cannot practice here unless you have privileges in the region," you would have a battle royale. The gain would be a better system for looking
after the population. Let us say that the only way we can make this work is that we need contracts where health authorities perhaps tender the work they want done in primary care and we take all of the primary care money and put it in the health authority. You have got war. If we work with the existing money, how are you going to do it? Two billion dollars in doctor compensation in the last five years, and nothing is different. We need to be wise about it instead of doing it the way the medical association wants to do it. But if we do not do it the way the medical association wants to do it, we have got war.

- Physicians are part of a group of primary care physicians, and they would love to hire all sorts of other auxiliaries to rebalance the responsibilities, but they cannot do it in a world in which all the income has to come in to them as fees for their personal services.

- You really have to provide doctors an income that is equivalent to or better than what they have got at the moment. They still do not like the concept that we can give them at least what they are making now, and get them to work in a capitation model. They want the fee for service. And they have the power right now that they use to get the fee for service. They are reluctant to work in capitation models. Fee for service for physicians really represents their professional autonomy. There are individual physicians who are ready and they are interested in the model. But there seems to be a bit of a disconnect between the physicians and their medical association on this.

- If we implement it at a capitation blend model, using everyone to their maximum scope and capacity, the weight of utilization of physicians may actually drop through the use of teams. If you actually have a nurse that is working with you, you do not need two doctors.

- How do we resource the primary care system? 85 percent of British Columbians see a family physician every year, amounting to about 3.5 million contacts annually. A majority of it certainly is based in family doctors' offices, the funding for which is through their fee-for-service payments. In the United Kingdom it used to be that there was an allocation and an assessor would come around and look at the premises and the practices used, and then they will get assigned a reasonable payment for the premises. They also had innovation funds to upgrade the premises or put other mental health, community health nursing, physiotherapy, or occupational therapy services into practices depending on the needs of the population they serve.

- If we really think it is important to have a more team oriented approach, there needs to be a robust way of endorsing that at a practice level so that people do not actually face negative incentives. Physicians are not resistant to doing this,
but they are not stupid. They are not going to drive the practice into bankruptcy by hiring other people for whom they receive no recompense. The reason why physicians are all uptight often is not only just the fees, but their fees have to cover their overhead costs. The fees are structured around the fact that physicians are self-employed entrepreneurs, they get no benefits. So the fee is paying for their pension, their staff, their equipment, and their vacation. The difference when they are on salaries, they forget, although they might be getting less money, it is not actually costing them more. They have to factor in that they do not have to pay for the staff, the equipment, or the lease. So when you start talking physician reimbursement, look at the whole picture, not just the fee. When you go to a salary base, you will find their dollar is going to go down, but they will be ahead of the game because these other things will be added. Anytime we want people to change what they have been doing, change things that they care deeply about, you have to be prepared to make it attractive.

- Population-wide access to continuous primary care cannot be guaranteed under fee-for-service remuneration.

- There is evidence in the literature that inefficiencies and higher costs for care are associated with fee-for-service remuneration and smaller practices.

- In British Columbia, the majority of primary care is given by physicians working in doctor-only offices and remunerated by fee-for-service payments. Consequently these physicians have to provide all patient-related care, even that which does not require a physician's skill or knowledge, and have to see each patient in order to receive payment. Many of these practices are small, with one to three physicians working as a group.

- Comments on management and accountability:
  - A comprehensive approach to health care would improve the ability to measure cost and benefits.
  - If we are going to have health authorities, there needs to be a connection to primary care. Clarify who is responsible and accountable. In our current system, there is no accountability for primary care and no identification of success factors or clear outcomes and measures.
  - Currently the organization of primary care services is inefficient and excludes approximately 600,000 British Columbians from access to continuous primary care, thus putting them at risk of inadequate care and treating them inequitably.
  - All geographic health authorities do have a primary health care department program portfolio. We really appreciate the charter because it tells us this year and in years out some of the things that we can be doing to support primary
health care providers as well as patients in the community. What other roles would be helpful to patients and providers? We do not have a locus of control over primary health care, general practitioners, our independent business folk, community pharmacists, and community physiotherapists that are not funded by the health authority. Dentistry is also another key factor there.

- We do not have primary care organizations with flexibility to meet standards however they wish. We have micro regulation of who can deliver a particular service, and very little macro accountability about having outcomes from those particular services. Accountability is always better when it is more localized. If it is provincial, then there is always lots of red tape. The problem is that there is no organized locus of accountability for care for a patient.

- In Ontario they provide bonuses for being on call 24 hours a day. The statistics in Ontario demonstrate that there are about half a dozen phone calls to doctors per night. They are paying a huge bonus for this access, but they receive maybe six calls a night. But people want access 24 hours a day and seven days a week, and so they deliver. It is not worth the extra money for having doctors on call, because they do not get called.

- Comments on facilities:
  - The Saskatoon Community Health Clinic works well.
  - Primary care centres encourage the shift to a health promotion paradigm.
  - Implement paediatric walk-in clinics staffed by paediatricians and paediatric nurse practitioners.
  - I work in a health authority-run centre, and I would hate to see those replicated. They are terribly inefficient, bureaucratic and very expensive.

**Ideas and Suggestions**

**Administration and Funding**

**Management and Accountability**

**Facilities**

- Ideas about administration and funding:
  - Create a larger role for private delivery.
  - We should target the average time for the primary care visit being something like thirty minutes. It would mean that the primary care visit really has value.
• Reorient primary health care to help the public system perform better and more efficiently.

• Give them the framework and the system for collaborative care. The care providers are good at delivering the care. Set up the infrastructure.

• A database for certain chronic illness patients with specific relevant emergency treatment information and patient medical history could be designed to link with patient Care Card numbers. Or, the typing of a patient’s Care Card number could flag their patient file with a warning to check a dedicated database for treatment information.

• The evolving best practice model is one in which the practice rather than the practitioner is funded. There are groups of physicians cooperating with teams of other of professionals. The practice is reimbursed by a combination of capitation and fee for service. Capitation implies that the practice is responsible for a defined group of people. You do not want the practice to be able to select the least cost patients, which is why the reimbursement will be based partly on capitation. It has got to be adjusted for the characteristics in that population. It will be partly based on fees for the performance of procedures, which have been well established to be effective as prevention.

• Primary eye care should be explicitly recognized as an essential component of general preventive health care. The components of primary eye care (refractive status, binocularity, and ocular health) should be recognized as an integrated suite of data that should not be fragmented.

• Consider a health co-op model, owned cooperatively by practitioners and the community, and offering an integrated service setting with a number of different practitioners under one roof. With the co-op approach we share the costs, so it helps the consumer but it also helps the provider. That is one of the things we think is important in primary care: the provider gets some benefit out of this as well as the consumer. If you banded together and worked out some way where you could share the overhead, provide extended hours that would improve access, provide an expanded scope of services, and share the workload, you would be doing it for yourselves and your patients. The other dimension is the opportunity to open doors for delivery of other community and private services. The co-op provides more potency for getting that network in place than a single practitioner might achieve.

• Government should develop a standard approach administratively and clinically to do collaborative care and it should fund multiple disease prevention management centres.
• The government should explore the potential of making individual practitioner-based patient population health profiles available to family physicians.

• The successful models out there are all a blend of some sort of capitation, combined with some element of fee for service. That seems to be the most successful model out there. The contract has to be held with a group of people so that there is a clearly identified group who is responsible. The objectives of primary care must be stipulated in the contract. If it is fee for service-based, it can be based on outcomes or the service level. You want capitation because that defines the population for which this group is responsible but you want a fee for service component because that is the lever for improved population health.

• Make doctors employees of health authorities.

• Physician compensation should be salary based.

• Eye care services that are deemed essential to a comprehensive health care system should be covered equally under the publicly administered program regardless of whether they are provided in a clinic or a hospital, by an appropriately trained and equipped optometrist, general practitioner, or ophthalmologist.

• In addition to workload based incentives, the Ministry of Health should consider health gain based incentives for the primary health care system.

• Physicians are provided funding through either the health authority or the government for an interdisciplinary provider and/or team that is required to meet their patient population. Each physician’s group practice has a nurse, at a minimum, funded not by that physician. It is paid for by somebody else, because the return on investment back to the health system would be quite significant in terms of reduced acute care utilization, and so on.

• The Government should fund physician practices through the health authorities, and a significant portion of that funding should be tied to the number and characteristics of the population registered with the practice.

• Ideas about management and accountability:

• Implement a new funding model for primary health care that combines outcome and performance payments with fee-for-service and population-based payments. Create the appropriate governance and policy supports for team-based care for identified populations. This will require increased transitional costs and supports for change management. A key element is effective use of a robust electronic medical record by the primary health care team to manage delivery of care and promote health.
Primary health care must be locally controlled and management, and appropriately linked to secondary services such as training and education.

Increasing practice size would lead to economies of scale and higher incomes for family physicians, without any additions to the available amount. The need for locum services may be reduced in a practice where there are enough physicians to manage the workload when one member is away.

Ideas about facilities:

- Create publicly funded urgent care facilities which are open 24 hours a day and seven days a week.
- If hospitals are about health care, there should be one wing with a free Naturopathic Doctor, herbalist, acupuncturist, osteopath, massage therapist, Chiropractor and so on, and a free fully equipped fitness center open 24 hours a day, seven days a week.
- We need nursing clinics: a physician would be in charge, and minor health concerns can be addressed; ongoing injections can be administered, such as allergies, B12, flu shots, and so on; routine dressings can be changed and monitored; and, many other services can be provided by a Registered Nurse.
- Create more holistic care facilities in a community clinic model and setting which are publicly funded.
- There should be more inter-disciplinary birthing centres.
- Put primary care services in malls.
- Provide mobile primary health care services.
- We need more non-profit clinics like Read and Mid-Main who operate in a team environment with a global budget and a prevention and health promotion angle.
- The primary care system should capitalize on technology.
- Implement primary health care centres, but continue to fund and support walk-in clinics where family general practitioners continue to practice.
- Mall facilities would have nurse practitioners, nutritionists, and counselors. They would provide advice and information on support programs, vaccinations, exercise programs, pharmacists, and outreach services.
- An inter-disciplinary health care centre is needed in the Interior.
- Centralize cancer care.
- An investment in community health centres would be one key positive allocation that could be made from the Ministry of Finance’s Health Innovation Fund for the
2007-08 fiscal year. These centres have a proven record in helping prevent illness and keeping people out of hospital. They have been touted as a critical reform to make medicare work as far back as the Hastings Commission of 1971, and again by Roy Romanow in 2002.

International Models

Comments and Concerns

• When I lived in Australia, we had community based health centres that were open 24 hours per day and staffed with salaried physicians and nurse practitioners. These centres were multi-disciplinary, had lab and X-ray ability, and during the day offered out-patient physiotherapy and massage therapy. Access was free with your medicare card. The emergency room at the hospital was the place for ambulances and emergent situations like a heart attack or trauma.

• In the United Kingdom, physicians set up health care trusts and can be paid for the full range of services that are being offered. It does not matter whether the physician is offering the services of a nurse practitioner, a pharmacist, a dietician, a physiotherapist, and so on. All of a sudden some of the reasons for feeling very protective about the turf start to evaporate and there is an incentive to want to create the team. It is funded through a contract to provide services to a known group of people. This is the same within the Health Maintenance Organization (HMO) in the United States). But the satisfaction levels reported by people enrolled in those Health Maintenance Organizations and the National Health Service is low, because patients do not like it. Arguably it is more effective because it is cheaper: you have a single fixed rate contract with someone who is providing a full range of services to a known population, and they in turn make all the decisions about what personnel they are going to employ. In Britain they have cut their wait lists, and our patients are furious about wait lists. So basically we have to choose which problem we fix because on some level it will be a trade off.

• The concept of primary care in Japan, Taiwan and Korea is really quite different. Most primary care physicians in Korea and Taiwan hold specialty qualifications. Public and private providers, community providers and hospitals compete fiercely for patients in all three of these countries and that is because patients bring with them all-important social insurance money.
• I lived in the States for a number of years before I moved to Victoria. We never saw our doctor. We had the clinic, and we had a really solid cross-section of practitioners. And, generally speaking, we saw the nurse practitioner in triage. Once I was shown what a nurse practitioner was, that was not an issue.

• Look at the Swedish primary health care example.

• In New Zealand, what the government attempted to do with its primary care strategy in 2003 is build on general practice organizational developments of the 1990's by establishing what are called primary health organizations. We now have about eighty of these primary health organizations covering the country and they are capitation funded, they require an enrolled population and they should feature a range of primary care providers. They are governed by provider and community representatives and they must aim to provide preventive care and to reduce inequalities, especially among Indigenous Maori people and Pacific people. There has also been additional funding for services to improve access for care plus initiatives and for health promotion programs. Now the concentration on primary care has not been cheap, it has been around six to seven percent in addition to existing health care funding. However, the seeds have now been sown for a strong primary care system and numerous quite exciting initiatives have resulted. The implementation path has been far from straightforward though.

• One of the features of both the United Kingdom discussion and the New Zealand discussion is the notion of reimbursing practices rather than particular individuals.

• In the United Kingdom we actually have a contract with the general practitioner practice, not with the individual physician. It may be a practice of four people to provide a range of services. We have actually made it so that it is the physician is responsible for the practice and they can provide the service in whatever way they see is right, provided again it meets our quality standards. So what you have seen in recent years is a big increase in the number of nurses and others who are employed in general practitioner practices. There have been some studies which show now that general practitioners are doing something like twenty percent of the direct hands-on work that they used to do and it is the top end. There is an awful lot more that is now being passed on. The chronic disease management system run by a specialist nurse may actually be a much better way of providing the service than periodic meetings with the doctor. So it a focus on the practice and getting rid of the professional barriers that say that only a doctor can do this.

• In New Zealand there is a nationally agreed primary health organization contract which was negotiated across all the various different primary health organizations representative groups and that includes the medical association and various other associations that work in primary care. It says that if you become a primary health
organization, you will provide a range of primary care services. You will include a range of primary care providers in your organization. You will be responsive to certain communities and groups who suffer from particular conditions and so forth. It says that you will also be eligible for additional funding if you can provide a plan for services to improve access. That is very broadly defined so it is up to the primary health organization to come up with a plan for how it might improve access to, for example, new migrant groups or groups of patients who have never ever been seen by a general practitioner in the last fifteen years, or groups of people who are perhaps morbidly obese and need a nutrition plan and an exercise plan and so on. So it is quite flexible and the financial incentive is definitely also within that contract because people who are not members of those primary health organizations are not gaining access to the money that the primary health organizations do have. General practitioners these days are doing much less work than they once did, they are also still very busy people, but they are working much more collaboratively with a range of different primary care providers.

Ideas and Suggestions

- The government could come up with some scholarships for leading medical professionals to travel to countries that already have similar kinds of arrangements, like New Zealand. New Zealand has been going through this major reform of primary care over the last ten, and especially the last five years. The doctors are really behind it and totally into it. It would be quite good for some Canadians to go down there and visit some of them.

Patient Advocates and Navigators and Case Management

Comments and Concerns

- Comments about system navigation:
  - Navigating the system is challenging and daunting.
  - People have difficulty navigating the system because there are too many services under one ministry.
• System navigators help us move through a very complicated system, because even on equipment assistive devices we are looking at 17 programs in five ministries. Imagine.

• Increased understanding of the differences between Canada’s health care system and those of other countries would enhance cross-cultural understanding between health professionals and the clients they serve. Frustrations around access to health services are, in part, due to an immigrant’s limited understanding of how to navigate the Canadian health care system. Health education workshops delivered in the first language of immigrants are required.

• I think the healthcare system performs really badly in terms of being responsive to client needs and navigation.

• It is not unreasonable to ask for convenience in terms of access, information and navigation.

• Services are unevenly divided resulting in fragmented care and isolated decisions.

• A successful Service Canada initiative involved placing staff into community service (non-government) offices for ethnic communities providing service in their own language for a day or a period of time.

• In a team approach, patients will want one person that would be the leader, someone in charge. They will not want to be the coordinator of all these people.

• When you have got, for example, mobile health services, home care, or community health nurses, you have got all these disintegrated services each doing something for the patient, each doing maybe their own care plan, each working on different standards of care and all with different information. That is one of the biggest concerns about primary care, aside from the access. You have total fragmentation with the patient in the middle either trying to navigate all the services or trying to understand what everybody is saying and doing and that is an incredible duplication. It is inefficient and ineffective.

• The public is confused about the cancer agency and cancer foundation. We need identification of what the different organizations do.

• Cancer patients are almost helpless to find their way into the loop: they are diverted by the professional jealousies of assorted health practitioners.

• Comments about patient advocates:
  
  • Conceive of the advocacy as empowering people to be self advocates, and empowering the profession of carers to be better advocates. With self-advocacy you can do a lot of work in a year by talking to people about the concept of self-advocacy, putting material on the web, and putting material in handouts. We can
do that in a year at minimal cost. With respect to empowering providers to become more advocates, that is a longer timeframe. You can work with them to develop those concepts. You can talk about remuneration. You can provide information or continuing medical education.

- There is an important role for patient advocates and organizations to work and partner with health authorities and the Ministry of Health to raise the profile of patients' needs.
- There needs to be a place to go to provide advocacy. There should be a process within each health authority to specifically deal with roadblocks.

- Comments about case management and discharge planning:
  - Early case management of problems can prevent hospital admissions.
  - There is inconsistent discharge planning.
  - Do most people assume the primary care physician is supposed to coordinate services? That is not the right person, particularly when we are looking at having more gatekeepers in the system.
  - There is quite a bit of work in Australia around care coordination, particularly with general practitioners or primary care physicians. Family physicians are the worst because they do not know the other parts of the system, so they are very bad at coordinating, and not very interested in it.
  - Part of the problem is we are really set up for people who have a specific problem. In that context the health care system works pretty well. But when we are dealing with a population with significant risk factors, the system works very badly. That is when we look at good case management. There is a real person with a real face who has some responsibility for care coordination.
  - Case management and care coordination are not things we have invested in.

- Comments on continuity of care:
  - The available medical literature suggests that interpersonal continuity of care is associated with significant improvement in at least some care outcomes with the strongest evidence of such an association (being) for those outcomes that have been most frequently studied: preventive services and hospitalization
  - Patients value continuity. They focus not only on the family physician, but on other members of the team.
  - There is very solid evidence that having a consistent provider improves personal satisfaction. There are a variety of continuities: informational continuity, personal
continuity, geographic continuity and so on. But if you have personal continuity, working with the same person or persons, people's satisfaction is certainly much higher. Usually it is higher still if you select the person.

- Each patient has to have a primary provider. That primary provider would provide the continuity of care and some coordination of services.

- All future planning for development of primary health care in British Columbia should explicitly focus on actively supporting continuity in care, in all domains.

**Ideas and Suggestions**

- **System Navigation**
- **Patient Advocates**
- **Case Management and Discharge Planning**
- **Continuity of Care**

- Ideas about system navigation:
  - To assist patients in navigating the system there could be a two-pronged approach: a passport for patients and one for care providers. You could have the dementia road map, kidney road map, cancer road map, or palliative care road map.
  - There is an advocacy role that serves two purposes: helping people enter and navigate the system; and helping the health care professionals go to the right health care solution.
  - A system navigator helps the person through the health and social systems. It does not have to be a person. You could set up a central information system or a general referral system.
  - We want to avoid the word system navigator because we do not want to elevate it to too high a professional level, we would like to it to be mostly lay people.
  - The potential exists also for saving money, because if you have care coordinators presumably the patient outcomes will be better faster. You will reduce the need for ad hoc services, visits to emergency rooms and so on.
  - A requirement of the care coordinators is that they have the skills and perhaps cultural ethnicity to match the population they are working with.
  - People need to be well trained to do this job.
  - You need people who know the whole system, instead of somebody phoning 15 different places and still trying to figure out who to call. It is a single entry system
so you do not have to find all these services yourself. If you are admitted you have got somebody working with you who really knows the system and the linkages to other services. It is really their job to match the best possible set of services that they can, to the needs that you have and to check on you every so often to make adjustments as appropriate.

• Care coordinators do not have to be separate: they can be your doctor, your pharmacist and so on. It is a philosophy. There are community based organizations that do these kinds of things too. There is a difference between advocacy and navigation. Advocacy is about representing someone’s interests. A navigator provides you with information and shows you how to get from point A to point B, and what sort of stops you might want to make along the way. They are not advocating for you. They are providing you with tools so you can do something yourself. They empower you to do something. Some people require both.

• We need to improve care for foreign or other language speakers.

• Ideas about patient advocates:
  • We need a well-informed, paid individual to act as advocate, ombudsman and liaison for seniors. They should have nursing or social work training.
  • Patient advocates are needed and valued.
  • Professional health advocates are needed to facilitate access to care, assist with referrals, and improve access to education and information.
  • Actions taken to address ethno cultural health needs be done in partnership with members of the communities themselves, and with community service agencies.
  • Create a medical ombudsman to provide a place for individual cases to be heard and information to be distributed.
  • First Nation and Aboriginal liaison workers are needed in hospitals and in the community.

• Ideas about case management and discharge planning:
  • You need a better sense of a system of care into which a lot of senior’s care fits. You need a broad base of services, in an integrated and coordinated system of care, managed or facilitated through good quality case management, so that there is a champion for each person that comes into the system of care. The components of the system see themselves as part of the system and therefore they also agree to conform to the general policies about accessibility and how you
get in, and what kind of care you get. What this allows you to do is provide much more seamless care for individuals if you have this kind of integrated system.

- There should be better communication between doctors, specialists and patients regarding diagnosis.
- Primary care coordinators could be catalysts for innovation in the system.
- Vancouver General Hospital orthopaedic surgery has top-notch quality of care and integrated case management.
- In Montreal they focused on case management and developing a very strong personal relationship. You could call this person anytime and they would be there. So if you ended up in emergency, your case manager would come in to you and they were responsible for fitting in all the services. You did not have to schedule your appointments. They found that overall satisfaction was up and hospital visits were down, but costs were about neutral because they used a lot more physiotherapy and other services.

- Ideas about continuity of care:
  - We need preplanning for visits to the doctor which involves a physician review of a number of components of patient care including: past assessments; promotion, prevention and management issues; prearrangement of tests; assignment of provider(s) according to needs; and the duration and nature of physician encounter related to needs and choices of the patient. Each task is provided by the least expensive provider with appropriate training. Understand when the patient may be able to manage tasks themselves, with a view to enhancing engagement in their care.
  - A Medical Intuitive should be assigned to all patients. Medical Intuitives could be used in hospitals to assist patients seek out different healing modalities rather than the pharmacological modalities within the hospital setting. The Medical Intuitives would also quickly identify any problems. The use of Hands-on Healing, Therapeutic Touch, Meridian work, Chakra clearing, Auric cleansing, Homeopathy, and the use of non-pharmaceutical vibrational medicines should be priorities, while the use of pharmaceutical drugs (including vaccines) should be reduced to a minimum. All medicines should be assessed for the individual patient using Dowsing and Kinesiological methods. The Ministry of Health must not be dominated by members of any one modality to the detriment of other modalities.
Governance and Accountability

**Governance and Accountability** within the health care system was raised time and again by participants in the Conversation on Health. Participants are concerned that the governance structure for the health care system undermines its ability to undertake proper long-term planning. They also worry that the structure is too fragmented to ensure effective delivery of health care services, and that there are no consistent performance management systems to analyze the success of that delivery. Some suggest inefficient health authority administration contributes to the fragmentation of the system. Here is a selection of what British Columbians had to say on the subject of **Governance and Accountability**.

Health Care Planning

Participants uniformly seek improvements in how we plan around health care. Currently, participants believe planning is fragmented between health authorities and the Ministry of Health. They argue there is no overarching plan forming the basis or foundation for health care delivery across all health authorities. Furthermore, the budget, information technology and health human resource plans appear to be separated from any consistent health care delivery or system plan. Participants are also concerned with what they perceive to be undue political interference in the planning process, which will lead to short-term goal setting at the expense of long-term improvements. Similarly, British Columbians are worried about the influence of lobby groups, industry, unions and professional associations on planning and decision-making. In the absence of a clear and consistent planning cycle and approach, participants believe that we will be unable to develop a clear health plan that will lead to systemic improvements in the delivery of care.

Many participants suggested that there be a centralized planning function, which would set goals and measures for the whole system. The central function would develop long-term plans and would also be responsible for sharing those plans with the public. While many feel there should be a centralized long-term health system plan, they suggest that in order to be effective it must be integrated with other plans across the Government of British Columbia affecting the health of our citizens. Plans associated with housing, income assistance, and children must all speak to one another and be accountable to similar population health measures and outcomes. Participants understand that this is a challenge for government, but emphasize it must be overcome if we are to truly contribute to the health of our population.
British Columbians believe that a strong and disciplined planning cycle will yield improvements in the overall management of the health care system. This cycle must include the ability to evaluate progress over the course of the year and make improvements and adjustments. While many participants were concerned with adopting business practices into the health care sector, most wanted to see at least some aspects of business models incorporated, including accountability structures, process improvement, results measurement and the adoption of best practices.

Transparency is a big part of any successful planning cycle, and participants want to see more openness around health care planning, budget management and reporting. A number of participants advocated for an objective third party oversight of the health system. They suggested common report cards, organizational reviews, results measurement, and audits as ways of more effectively measuring the success of the health care delivery system and reporting on that success publicly.

*Planning needs to be longer term and better coordinated, based on cost effective outcomes and driving towards change. The vision needs to be structured so it can be operationalized and it needs to be properly financed. To build this plan and the vision, we need to first think about the kind of health care system we need, then information technology and infrastructure become a means to that end, and flexibility can be built into the system.*

- Health Authority Board Session, Vancouver

**Governance Structures**

There was some debate about the existing roles and responsibilities within health care delivery and whether or not they serve the needs of British Columbians. In particular, the roles and responsibilities of health authorities came under intense scrutiny. For some, the shift to larger health authorities away from smaller, locally elected boards marked a dramatic and negative shift away from community-based responsibility. For others, this same shift was seen as an improvement over a more fragmented system of delivery which was unable to cope with system-wide changes and needs. Regardless of their perspective, most participants believe that the governance and accountability structures need to be clarified and operationalized. For some, there is too much interference from the Ministry of Health in operational matters which should be within the scope of the health authority’s responsibilities. These participants want to see the Ministry of Health set broad strategies, policies and targets for outcomes, provide the tools and resources to do the job, then leave the health authorities to get it done.
Some participants raise the idea of creating a health Crown corporation structure. They argue that this would reduce political interference, increase overall responsibility, and create a clear legal governance framework. They suggest a Crown corporation model is able to more easily engage in long-term planning and would provide a provincial perspective to the health authorities, which would be treated as operating arms.

There was a debate among participants, particularly through the Online Dialogue, about the extent to which there should be a governance structure that is more national in scope. For some, a nationally run system would be expensive and unwieldy, and would lead to greater, not less, segmentation within the system. A number of participants raised the current constitutional structure which gives the provincial governments the authority to run health care. That being said, many participants believe that there is a national perspective which would ensure greater consistency in terms of the level of care without undermining the need for local and regional adaptation.

Many participants advocate for a return to more local democratic engagement in health care, whether through elected hospital boards or health authority board members. First Nations also believe that they need to be involved in management of health care delivery to ensure that the unique needs of their communities are understood and accommodated. Some participants suggest community health advisory bodies, which, they argue, already exist in some health authorities. Regardless of the means, many British Columbians believe that their input is important to ensuring that the system runs smoothly and is accountable to their requirements.

Accountability structures were raised as an important tool for maintaining the course over the long-term. Participants believe there needs to be guidance and accountability throughout the system, from the Ministry of Health through the health authority boards and administrative structures. There was no consensus on what this structure would look like, but many agree it needs to include holding individuals accountable for the successes and failures of the system and its programs. This also includes ensuring that adequate resources are provided to ensure the success of the programs.

There was also some debate about whether primary care should be the responsibility of health authorities. The question centred around whether moving primary care to health authorities (including physicians) would result in improved population health.
Regardless of which side of the argument participants landed on, most are looking for a governance system that encourages innovation, replicates best practices across the province, is transparent in its reporting and management processes, and has consistent measures and long-term goals. Consistency between health authorities in terms of measures and data is a key component of a successful health care system. Participants believe that these are the ingredients to ensure that the delivery of health care continues to improve and adapt to accommodate the changing needs of British Columbians.

I think one of the hugest barriers in Canada to getting it right is the fact that we’re so fragmented that every province has their own system. [T]he Federal Government hands out money, and then the provinces hand out money, and then the health authorities hand out money. But nobody’s minding the gate. Nobody’s saying, ‘Okay, this money goes with this attached. You have to do this, this, and this or we’re not giving it to you.’ And that never happens… It has got to start from the top and work down if we’re ever going to get together...

- International Symposium, Vancouver

Performance Management

Participants generally perceive the current approach to performance management to be sub-standard. Insufficient attention to incentives, lack of clear measures or of measures that focus on outcomes, and lack of provincially available data, among others, are the reasons British Columbians think that the health care system needs a revitalized performance management system.

One issue that came up frequently was the lack of specific financial information related to health care costs. Specifically, participants want to know what the total costs are for any given procedure. They argue that, in the absence of this data, it is impossible to judge the efficiency of any approach, and therefore impossible to know which approach to adopt.

While many suggest that a culture of accountability needs to be driven in throughout the system, there is recognition that we also need to focus on data gathering that allows us to effectively measure the progress of the health care system. Measuring population health in the same way throughout all health authorities should be a priority. Participants believe reporting on those measures and being transparent in the actions to achieve the goals will increase accountability across the province. Like the planning cycle, we need to have a long-term perspective on the measurement and achievement of goals and objectives.
You can be either tight on the outcomes you’re going to achieve and free the system up to get to those outcomes, or you can be tight on the process that you ask people to follow to give you all the outcomes… One of the UK successes was they established some very, very rigorous targets for delivery and then … they put some money into the system and they said, ‘You have to hit the target. Do what it takes to hit that target.’ What we do here is … we have to have targets but often we don’t invest and put the resources in.

- International Symposium, Vancouver

Health Authority Administration

Many participants wrote in or discussed their individual views and perspectives of health authority administration. Their most common concern is that the boards fail to engage and listen to the members of the community. These same participants often call for a return to elected boards which are accountable at the community level. There was also a frequent request, particularly by northern and interior participants, to divide the larger health authority regions into smaller areas.

Another concern is the focus on financial objectives and achieving budget targets. To many participants, this is done at the expense of quality patient care. They advocate for the introduction of new measures for success for health authorities beyond budget management.

Administrative staff came under fire during the Conversation on Health. Participants cannot agree on whether boards and health authority executives need to have a background in business or the health profession. There is a concern about high salaries, large payouts to departing executives, too many executives and managers, and a lack of attention to health outcomes in favour of a strictly financial approach.
Conclusion

There is no consensus around how to or who should manage the health care system. Participants debated the governance structure, the extent of public involvement, the administration of health authorities and the performance management system. Through it all, there was agreement that there needs to be more disciplined attention on all of these aspects of the delivery of health care. Furthermore, participants uniformly believe that there needs to be a long-term integrated plan, along with some common way of measuring how the system is doing and whether it is meeting the needs of British Columbians. To the participants, focused attention on governance and accountability structures would help the health care delivery system meet the needs of the citizens of British Columbia today and into the future.

We have to have continuous annual evaluations and re-evaluations of what we are doing. We are not going to get it right the first time. We are going to have to continue to meander down that course to the end goal, but making sure that we go back to Canadians, go back to the one single payers that pay the bills and say, ‘this is how far we have gone, here are our successes but also here is our failures’ and let them know in transparent form, where we have gone and where we are going.

- Provincial Congress, Vancouver
Governance and Accountability

This chapter includes the following topics:

**Health Care Planning**
**Governance Structures**
**Performance Management**
**Health Authority Administration**

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**Related Chapters**

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Health Care Models; Health Human Resources; Training; Access to Hospitals in Rural Areas; Morale; Innovation and Efficiency; Public Private Debate and Health Spending.
Health Care Planning

Concerns and Comments

Planning Terms, Cycles and Linkages
Planning Responsibilities and Accountability
Local and External Involvement in Planning

• Comments on planning terms, cycles and linkages:
  • Decisions are being made on ideological basis, not on quality of service and cost-effectiveness.
  • There is no priority-setting in communities regarding services or capital projects.
  • Politics needs to leave the health field. It seems that if you have effective lobbying, your problem or disease gets funding. This results in certain areas not getting addressed.
  • There is no provincial vision, plan, or accountability for rehabilitation.
  • It is difficult to plan, develop, implement and evaluate initiatives that are either piloted or run in an organization and are subject to operational variances or dependent on variable one time funding.
  • It is absurd that our provincial health authorities are provided with budgets that are not based upon concrete facts.
  • The Ministry previously committed to developing a directional plan for health care, but it still has not produced that plan. We had an entire Ministry of Health Planning that did not produce a health plan. You do not want a detailed plan that is inflexible, but you do want a directional planning exercise so that we know where we are headed and can empower all the various health authorities to head in a similar direction, but not to tell them what to do.
  • For the providers and distributors of medical device technologies, a major challenge is determining where their product release fits within the health authority region’s budgeting cycle. For example, if a new technology is released mid or even later in the year, regions do not have new funds and are required to reallocate resources to purchase the recommended medical device technologies.
  • The goals need to be focused on our biggest long-term concerns, not necessarily the concerns that, this month, have the greatest fear factor.
  • The provincial framework on end-of-life care has a statement that is absolutely glorious and is not translating into the health authorities. They give it to the health authorities as a guiding principle but the health authority has a choice as to
whether they take that on or not, or how much they do. There are a couple of planning tables around end-of-life care at the health authority level, but we have been planning *ad nauseam*. We are no further ahead now than we were before, because there are no teeth in what the health authority is doing.

- Health policy needs multi-year strategies (not tied to the election cycle).

- In a health authority you look at finance, information technology and the whole spectrum and how it interrelates. Another way of putting it is taking a systems approach.

- If a shortage in health human resources is the number one risk to delivering health care in the future, why are we as an organization not talking about corporate accountability and a corporate approach?

- There should be a definite link between regional growth and health care planning.

- Health authorities are concerned that long-term health planning is complicated by the political reality of four-year terms of office. As a result, it is difficult to look forward past the four-year timeframe to make effective long-term plans.

- We have to have continuous annual evaluations and re-evaluations of what we are doing. *We* are not going to get it right the first time. *We* are going to have to continue to meander down that course to the end goal, making sure that we go back to Canadians, go back to those that pay the bills and let them know how far we have gone, what our successes are, and also what our failures are. *We* have to be transparent about where we have gone and where we are going.

- There is a need for a strategic plan that identifies the priorities across health authorities.

- The challenge is that we want to improve health outcomes. To do that, the government needs to take a much broader and more integrated look at what health programming is being done in different ministries.

- Planning is improving, but not enough and not quickly enough. Planning must be evidence-based, and political agendas should be set aside.

- We need plans that actually work.

- The British Columbia health care system has long operated under a so-called silo model. Under this approach, the health care system is divided into a series of discrete segments (for example, hospitals, health insurance, health protection, health promotion, mental health, drug programs, and so on). Planning, budgeting, administration, management and delivery activities generally are aligned to these individual program areas.
• Comments on planning responsibilities and accountability:

  • Hospitals and services for rural areas cannot be planned at a desk in Victoria. Planners must work in concert with doctors, nurses, municipal officers and residents before decisions are made.

  • There are so many professional and union groups successfully pressing their own agendas on the federal and provincial Ministers of Health. It is time that an office headed by an Auditor General for health practices be set up by the federal government, preferably with the support of the provincial governments.

  • There is a clear role for public policy advocacy by health authorities. Health authorities have a responsibility to advocate as they have the knowledge, research, expertise and the overall mandate for health that community groups and individual citizens lack. It is critical that advocacy be done in areas where it is clear that negative health outcomes will occur in the absence of a specific public policy initiative. Health authorities will need to have the courage to step forward on some controversial issues. Further, they have to be selective in the advocacy choices they make to maintain their legitimacy to speak out on issues outside the jurisdiction of health care. This is necessary because the strength of their messages may become weak if they are too diffuse in their priorities. Also, there is limited capacity for this work. Clear priorities include the importance of economic status. The strong connection between poverty and health means health authorities have a responsibility to highlight this and suggest government solutions.

  • Are we prepared to undo what has happened over time, which is this gridlock of interest groups, each of which essentially has a veto on any big change. Nothing else matters at this point.

  • The health authorities should operate like a business. In the business world, incentives and recognition are offered to those who increase efficiency and improve profitability. Outcomes are measurable at many levels, whether through a decrease in medical errors, re-admissions to hospital, patient care, and so on. If institutions are held accountable at every level to their regional health authority, we may see an improvement.

  • In the business world, when problems of this extent occur, it is a common practice to change leadership. This means replacing the administration staff starting from the top executives. These people have had plenty of time to resolve the situation and have been unsuccessful, so it is time for new leadership.
• In any area of public policy where we establish a monopoly, we require and impose legal obligations on the service provider to meet basic minimum service standards. It should be the same in the healthcare system. If we say that there is a single-payer system, then that system has to be able to provide some basic standards to citizens.

• We need to move from a culture of non-accountability to a culture more focused on measurable results.

• Comments on local and external involvement in planning:
  • There is a lack of local input and control. The provision of new facilities process is slow.
  • The Northern Health Authority is asking for and listening to concerns.
  • Why not put local Indigenous knowledge at the core of health service programming and policy planning. That is bottom up planning.
  • Citizens must play a vital role in re-inventing health care to make it work. In Australia, the Consumers' Health Forum was formed with government support after citizens demanded a place at the table. The association, a coalition of health care community groups, allows no providers or care workers or corporations. It publishes articles and reports, handles complaints, and speaks to the government on behalf of the citizens. A democratic health care system would foster other areas of development. Literature indicates that front line workers with more autonomy function better in more democratic workplaces.
  • You should be able to get bipartisan support for the principles and the long-term plan, and then you would not lose direction every time you change government.
  • Of course, sustainability is important and, to that end, we need government to stop crying that the sky is falling and be open to trying new ideas wherever they come from. If those ideas do not work, be ready to say so and try again.
  • How do you get that voice at a very high level of planning that is representative of a non-academic, non-systemic, non-health professional perspective? We keep designing research that maybe is not as relevant as it could be to the people that actually receive the services and deliver healthcare. The priorities may be different.
  • The Vancouver Island Health Authority must consider local interests and concerns in planning hospital facilities.
  • Planning must include the user.
• Aboriginal and First Nations people were asked where they wanted the regional hospital and their preference was ignored. There were problems with affordability of homes and lack of support services.

• Government has put themselves at a distance by using health authorities.

• Community lead health allows the community to be innovative and creative with their health needs.

• The community can best determine their needs.

• Fraser Health must evolve to recognize aboriginal health councils as a partnership, not as an authority.

Ideas and Suggestions

Planning Terms, Cycles and Linkages
Planning Responsibilities and Accountability
Local and External Involvement in Planning

• Ideas about planning terms, cycles and linkages:

  • Planning needs to be directed at outcomes. The Ministry of Health determines what care needs to be delivered and how to achieve pre-determined objectives and funding is then spent accordingly.

  • Planning needs to be longer term and better coordinated, based on cost effective outcomes and driving towards change. The vision needs to be structured so it can be operationalized and it needs to be properly financed. To build this plan and the vision, we need to first think about the kind of health care system we need, then information technology and infrastructure become a means to that end and flexibility can be built into the system.

  • We need a plan, do, check, act cycle.

  • The government needs to commit to making the necessary long term decisions and supporting funding to ensure sustainability.

  • We need a planning framework related to health and health human resources, but it has to be underpinned by solid data and evidenced-based best practices.

  • The directional plan should include a vision describing what success looks like based on a needs-based analysis. The time frame of the plan should be projecting out 20 years, with 5-year planning increments. There should be a complementary information technology plan and capital plan.
• The planning process should focus on future trends beyond 2008 to achieve a long-term plan (five to seven years).
• Plan for flexibility. However well you plan at the beginning, there will be unexpected consequences, push back, and change and you have got to be flexible enough to adapt and move on as you discover new realities.
• Develop management guidelines. Specify the objectives and keep them focused (only five or six). Provide criteria by which success will be measured and define specific performance indicators for the management of all health regions. This will not include details on how doctors do their jobs, but it must include how the administration and boards manage the system.
• Focus on continuous improvement. You must constantly re-evaluate.
• Undertake evaluation of new programs.
• We need a risk management framework. We do not know what the real risks are.
• Drive the system to look at operations management principles. These principles drive an organization to look at labour allocation, equipment design, premises, room design and the like.
• Adopt the best of business models into the health care system: accountability, process improvement, measurement of results, best use of resources, efficient services, and use of best practices.

• Ideas about planning responsibilities and accountability:
  • Create a single governance body for strategic direction and outcomes, and restrict influence by politics and politicians. This body would set mid- to long-term goals, and develop proper metrics to know where costs and funding go, measured against outcomes.
  • The Ministry of Health needs to do long-term planning and share the plan with the public.
  • Government's role in health care should be limited to:
    a. Determining what public healthcare will cover;
    b. Setting the price of all types of care, operations, medications and all hospital stays that are included in public healthcare;
    c. Setting the maximum waiting period for all types of operations and demand they be met in the country or elsewhere;
    d. Setting the price of the annual healthcare insurance premium;
    e. Requiring that every person is insured; and
f. Requiring that insurance companies insure anybody who requests to be insured for no more than the annual premium.

- Government should set very concrete and specific health and quality goals, rather than telling health authorities how to achieve them.

- Government develops broad strategies, policies, targets for outcomes, and provides the tools and resources to do the job.

- Developing the plan is important. The Ministry of Health should be accountable for this plan and should lead its development. Ministries and health authorities should actively participate in plan development. They are also responsible for plan implementation and operationalization. There should be a continuous information exchange with a representatives forum. The plan must include a health human resources plan.

- Health authorities need to discuss their resource requirements with government, in terms of implementation of government strategies to ensure that this can be done effectively.

- There needs to be a stewardship perspective for whole system.

- Create new integrated planning processes and accountability structures that focus on the root causes of systemic demand to improve the health of the citizenry, integrate services and address social determinants of health (such as poverty). This is only achievable with strong political leadership.

- We need to have local decisions rather that having all the decisions made in Victoria.

- Health authorities must release business plans and other internal reports so the public can be better informed and better able to participate in policy decisions.

- Develop health authority, hospital and doctor report cards.

- We must hold the regions accountable for their budgets. More effective planning would result in more accurate and realistic budgets. There must be incentives for excellence and rewards for efficiency.

- Develop an accountability framework for transfer payments that would allow the Provinces the flexibility to use the money effectively.

- The public needs to hold government accountable for long-term commitments.

- Audit and continuous business improvement processes are required.

- There should be an organizational review by an independent third party with criteria and controls set and maintained by local communities.
• We need an independent audit of the entire health care system, including: where money is being spent; viability; efficiencies; creativity in the use of public funds; and creating accountability.

• Locally governed groups provide needs, feedback and input to one aboriginal led health council.

• Ideas about local and external involvement in planning:
  • Pressures will be alleviated by long term planning made by a citizens’ council on health which is independent of political and economic special interest groups.
  • Establish a strategic planning for health group. The group would be small, only two or three people that can provide specific advice on how to get the job of reform done. This must not be a high level group of thinkers only, but an implementation group. They would provide hands-on advice to the upper management of health authorities and the government. This group would initially get aligned with the Minister and focus on system reform concepts.
  • Involve the public and health care providers in strategic planning.
  • Health authorities need to understand what First Nations are entitled to. We need to collaborate to sort out services together. There should be stewardship of all health authorities for the whole system. They are all responsible for delivery across all health authorities.
  • Decision-making needs to be streamlined. We need to shift from a reactive to a proactive approach. If First Nations representatives are not invited, we should just go there and be in the room until they ask us to sit down.
  • The regional or local First Nations health authorities should develop plans to include a health advisory committee process into the health authority in their region or territory. This would feed into the provincial process for First Nations. Adequate funding would need to be provided for the process to be efficient and successful.
  • There should be information sharing and joint planning between the province, health authorities, regional hospital districts, and hospital foundations.
  • Encourage local planning, not top down. Make use of the expertise of the front line worker.
  • Local governments and the public should have significant input into the location of facilities. Local government should pay significant dollars towards health care facilities but should have a greater say into what and when facilities are built.
• There should be greater inclusion of Regional Health Districts into health authority planning and implementation.

• Increase the involvement of the public and employees in planning. The public would define levels of care and identify what is important. There would also be public education on the health care system. Learn from the Oregon experience, which included a lot of public involvement.

• There should be education and resources to enable constituents to be involved in finding solutions through action plans, budget allocation, and resources.

• Recognise in planning that one size does not fit all: urban solutions are not necessarily applicable to rural areas, and even rural areas differ from one another.

• Government needs to include communities in decision-making on what is feasible and desirable in health care services.

**Governance Structures**

**Concerns and Comments**

*Legal Governance and Funding Framework*  
*Accountability and Transparency*  
*Administrative Structures, Roles and Responsibilities*  
*Regional and Local Interests*

• Comments on the legal governance and funding framework:

  • Health authority boards are somewhat at arm's length from government and responsible for delivering health care to established targets within a given budget. They also provide advice on direction and strategies.

  • Health authorities see the current structure of six health authorities managed by boards appointed by government as being significantly more effective than the structure of the early 90s.

  • The Government appears to be increasing their control over health authority communications, making it difficult for health authorities to manage issues that arise within their jurisdiction, and to manage strategies and approaches to communications.

  • A number of overall governance responsibilities continue to lie outside of health authority responsibility, but have a large impact on health authority operations and performance (for example, delivery of primary care).
• Review the 1960-70 models of administration.

• The stronger the governance responsibilities of Boards, the more likely they will be to attract and retain world-class management personnel.

• New Zealand's present system has twenty-one district health boards. These are composed of a mix of elected and appointed representatives. They are served by a secretariat and they must plan and fund a range of services for their respective populations. The district health boards are guided by the New Zealand Health Strategy, which contains a series of national health goals and targets. The system has a number of positives, especially that it is underpinned by a population health improvement philosophy. Also, there is a strong emphasis on reducing inequalities and boosting primary care. There are many negatives as well. One is that there are an extraordinary number of transaction costs, and confusion and complexity in running twenty-one separate planning and funding organizations for such a small population. At the moment, the country is going through a major debate about whether there should be a merger of some of those boards. There have also been difficulties with maintaining national consistency across a range of organizations.

• What is interesting in the United Kingdom is that they have set up a model where they have created delivery councils, which are multi-disciplinary teams that operationalize various initiatives. They go out at both a federal and a local level and they gather funding to allocate it to the delivery council. There is always a lead assigned, but the operation then goes down to a local level. So rather than trying to change the government's structure, they are simply developing a new delivery model at the front line that is inter-disciplinary.

• Nationalize health care in Canada.

• Australia is a federated health system. The Australian government is primarily responsible for the financing of the health care system, while states and territory governments are primarily responsible for the administration and delivery of the system. This is an extreme form of vertical, fiscal imbalance, which is just a fancy way of saying that the commonwealth has all the money and the state and territories have all the responsibility.

• Health Advisory Committees act as a conduit between the health authority and the community. The Prince Rupert Council has established a Health Advisory Committee.

• We, in fact, are only partially regionalized. Huge arms of the budget remain in Victoria, for example in terms of what physicians are paid and the pharmaceuticals budget. We think we are regionalized, but in fact we have got one foot in the old
world and one foot in the new. This is partially why regional health authorities cannot follow the directions that come from Victoria. It impedes progress when drugs and physicians fall outside of regionalization. However, the regional authorities are not ready to take on additional responsibilities.

- Government has to take a more active role in determining where it wants things to happen. They should set the goals clearly and then back out of the way and wait for the right managers in the health authorities to deliver.

- All health care has been centralized in regional boards and boards are appointed by the government. Decisions made are top-down. Local hospital boards are not considered and are usually treated with disrespect or dismissal. The Chair has a corporate background and a life-line to the government, and so claims to know everything and does not listen to the health authority directors. Boards know nothing of rural and remote areas.

- Health authorities find the internal government departmental structure inconsistent with the goal of working effectively for patients. They advocate for more interaction between government departments.

- We have regionalized the Ministry of Health, but we have not regionalized the health care system.

- Perhaps a more useful role for modern health governors would be to protect the health system from politicians trying to micro-manage local crises on a daily basis. In British Columbia, these days are referred to as a Deputy Minister’s bad hair days. Such rules of engagement exist with the relationship between BC Ferries Corporation and the provincial government. Perhaps the best way of managing the health system is by forming a similar professionally managed BC Health Corporation with an independent board. This structure provides professional administration and accountability with minimum political oversight. This entity would be responsible for supervising the allocation of close to 40 per cent of the provincial budget. The challenge is that this structure denies politicians credit for expenditure decisions.

- The system needs to be departmentalized, with one person taking responsibility for each department. Every year the department heads of problem areas would be called upon to form solutions for cost cutting measures for the next year.

- Thinking national anything is big buck expensive, usually inadequate, and laced with extensive and expensive study.

- There is a regulatory division between the federal and provincial governments.
• The government ought to create regulations and enforce those regulations. Regulations that ensure doctors are qualified, hospitals are clean and properly equipped, and patients are treated in a timely manner.

• The province does not want to tell the regions what to do, and the regions do not want to be told what to do.

• Oversight of programs delivered at the community level requires different cultural governance than is required at the secondary, tertiary and quaternary levels of care. These cultural criteria are critical in defining the responsiveness of the respective governing bodies to the communities being served. Community based primary care, mental health or drug addiction programs have different needs and limitations that are usually expressed in real time. Centres of Excellence in medical research (tertiary/quaternary care) have to be planned for on a longer timeline, with stringent recruitment and investment decisions. Both these levels of care have to adopt different roles if they are to serve their respective communities.

• When I go to an emergency or doctor’s office, I expect to find doctors and nurses, not politicians or paperwork for politicians that the doctors are required to complete so politicians can approve medication or care. Keep the system public and get some medical professionals to run it.

• Should the province revisit the old model of hospital boards, or is there another model that might allow us to better utilize potential space or resources to address our particular needs?

• Health care is a complex system without a real governance system to unify it.

• British Columbia has a first class health care system, and it does not need fundamental changes.

• Health is a provincial and federal responsibility. There should be no initiatives or programs that result in downloading onto municipalities. Downloading will only result in duplication of bureaucracies. Regional districts should not hire medical experts. This is a function for health authorities.

• One of the hugest barriers in Canada to getting it right is the fact that we are so fragmented. Every province has its own system. Within every province, there are health authorities that have their own systems. Then there is the private system involvement. The Federal Government hands out money, and then the provinces hand out money, and then the health authorities hand out money. But nobody is minding the gate. The Federal Government has no responsibility for the delivery of health care and constitutionally the provinces do. It is a provincial problem.
• Health Authorities are only answerable upwards to the Ministry of Health and are, in essence, agents of the provincial government. Government is supposed to be the watchdog, but there is no one watching the watch dog. No one is responsive to the public.

• It is not the politicians that hold the vision, but it is the bureaucratic infrastructure that holds the vision. I would be interested to know what the demographic profile of our bureaucracy is, because if it is anything like health care, most of your people are between the ages of 55 and 65, and they are all going to retire in seven years. Who is going to take that vision going forward? Because we need that infrastructure support from government, the people in the bureaucracy who are going to hold the transition for the next 15 years.

• Each of the provinces has programs that are similar. However, each province has its own way of defining what these programs should accomplish and who should have access to them. Consequently, Canada does not have a national health care system. Canada has a national medical free access system at time of need. Understanding these differences became most relevant in conversations about the tendency of federal politicians claiming to be defenders of Canada’s national health system, when the Canada Health Act only guarantees Canadians access to medical, diagnostic and in-patient hospital services.

• Health authority funding needs to be based in part on outcomes and patient satisfaction surveys. This goes not only for hospitals, but public clinics, clerical attitudes towards patients, response times from health authority officials to public inquires and how closely the health authority follows guidelines, mandates and directions from the Ministry of Health.

• We need to isolate political pressures from how the system is funded.

• Nothing is going well at the present time. It was going well before there was a regionalization. It was much less costly when there was an unpaid volunteer, elected board serving the hospitals.

• The current system of Health Authorities is costing taxpayers more money than the centralized Ministry of Health with elected Health Boards did 20 years ago. We are paying for administrators and administrative assistants and secretaries and liaison staff when most of us want to be paying for direct care. We want doctors and nurses and physiotherapists and the drugs we need to become healthier.

• The 2002 Health Authorities Act of British Columbia provided a legal framework for the government to transfer funding for all health and social services to five regions of the province and a provincial authority. Each region is under the oversight of a board of directors appointed by the government, whose mission is
to provide oversight in the administration of health and social services under one governing authority.

- Evidently there is a need for a legal mechanism, such as the health authority structure, to account for the funding transferred between the Ministry of Health and the regions. Such a legal entity is required to facilitate medical staff organizations and the granting of privileges to physicians who require operating rooms, and so on in order to practise their profession. Conversations about the independent solo medical practitioners in the community and the relationship some have with health authority boards can be most insightful from an accountability perspective. The model appears to offer full entrepreneurial privileges with little entrepreneurial risk for the physicians.

- Health Authority Boards are served by professional health administrators. Over the past thirty years Canada has created a cadre of highly professional health administrators. The spending practices administered by these professionals are usually designed to achieve the outcomes dictated by their Board. Within this paradigm, it is the Board to whom the Chief Executive Officer reports and who hires and fires the Chief Executive Officer. Is this the point of transition from political accountability to when a more professional accountability occurs?

- Canada is supposed to be a democracy. The decision to dissolve local health care boards and replace them with appointed regional boards has not improved health care or reduced costs.

- We need to first describe what improved health is. Is it increased longevity, more hospital services, increased access to drugs, or increased health care expenditures, and so on? Then our leaders should let those responsible for health care clearly explain changes they would propose and expected outcomes that would result and how these would be an improvement over current practice.

- Due to envelope funding, there is no ability to do a good job and expand services.

- Ideally, the Province should get out of the business of paying doctors and switch to funding medical services through the Health Authorities. It is the Health Authorities who can best determine how many family physicians they need in each area, and who are in a position to set appropriate targets for their area, and monitor what the practices are doing. These practices would also use a team of other health professionals (nurses, nurse practitioners, midwives, social workers, and psychologists, physiotherapists) to provide care when required. These other professions could be employed by the clinic, rent space there, or be in some other type of arrangement. It would be important that the Health Authority funds the practice as a whole, based on the number and type of patients served, and allows the practice to choose which physicians and other professionals to employ or
have an agreement with, although there should likely be a physician for every 2000 (say) patients.

- Comments on accountability and transparency:
  - Democratically-elected boards were dismissed in favour of highly paid government-appointed boards. This is more expensive as it comes out of our health budget.
  - We elect school boards, regional and municipal people, why not allow transparency and let us elect our regional health boards and directors? Elected representatives would choose the chair.
  - Medical care is a provincial responsibility therefore national control is unconstitutional.
  - The health authorities make a little information available on their web sites but not nearly enough.
  - It is very difficult to modify behaviour because there is no competition in the system. Physicians do not have to perform as long as someone gets access to them.
  - In order to shift the culture, people need to begin to be held accountable for their behaviour, starting at the top. Employees mirror the pathology of their leaders, and leaders need to acknowledge the role they can play in helping to shift the system. This requires that the ministry relinquish a bit of control.
  - The Government has given health authorities the power to review events confidentially in keeping with a no-blame review aimed at identifying and improving systems issues. The Government then turns around and contradicts its position by acting in a punitive and blaming manner. The continuous scape-goating of senior leaders by the Government creates mistrust within the health authorities and also between the health authorities and the Government. Firing senior executives does the opposite of what is needed.
  - Health authority administrators get a bonus for cutting costs, which impacts the delivery of services.
  - Consistency, accountability and transparency are needed, with skilled management at the working level, rather than the top.
  - There needs to be some form of guidance and accountability for individuals and health authorities.
  - It is the function of government to ensure that health care options are available to all areas of the province, and to ensure that the services providers are competent.
• Health authorities are holding citizens for ransom and our government is allowing this to occur. By letting health authorities provide us with this low standard of care, our government has shed itself of this responsibility and is now not reacting to the health authorities’ shortfalls, poor judgment, and lack of short and long term planning.

• When something goes wrong the health authorities just shout for more money and blame the government.

• The decision-makers at the head of the Health Authorities really have no say in terms of budgeting and allocating resources.

• A case management approach allows for clearer accountabilities.

• There is no accountability throughout the system. The public receives services without signing off on the costs or having any means to evaluate the quality of the service. The doctors do not seem to be unaccountable to anybody and the system administrators, while reporting to boards, really do not seem to be performance-driven, as the quality and accessibility of the services deteriorates on an ongoing basis.

• We need a larger role for the Ministry of Health including government letters of expectation.

• I would like to see the administration of the health authorities take responsibility for the success or failure of their programs. They should be given adequate resources to make long-range plans with secure funding; they should be rewarded for providing efficient, effective health care, not for simply slashing programs to meet budgets, and they should be held responsible for their failures.

• Everyone should be accountable for every dollar that is spent. All facilities funded by the Ministry of Health should be audited by an independent auditing firm to ensure that monies are being spent wisely and not misused.

• The range of oversight organizations in other jurisdictions includes health complaints tribunals or ombudsman. They can look at corruption, quality of health care, and performance of health authorities relative to a range of indicators. It can be an independent oversight organization.

• We need to get health authorities looking beyond acute care to the full responsibility for primary health care. They are now doing that in New Zealand. That is the direction we all need to go, so health authorities can make rational decisions across a wide spectrum of services that influence population health outcomes.
The way the regions are constructed is much more efficient at providing sick care. You have multiple communities of moderate size distributed over vast areas. In most of those communities the actual acute health care system has improved in terms of the number of specialists because resources are pooled, and not everybody is doing the same things.

We do not have any transparency or factual information on the accountability of Health Authorities.

The public is not a force to drive policy within health authorities.

Each health authority region is independent of the others for delivery.

Health authorities are micro-managing health and they are bungling the job. People are suffering as a result.

Since many individual health cases are raised in the Legislature, the Minister, and consequently the Ministry, are drawn into debates around issues that belong more properly within the purview of the health authorities. This issues management approach also tends to detract government and the Ministry of Health from consideration of long-term and complex policy questions. Health authorities recommend that these issues be referred back to the health authorities rather than continuing the debate in the House or through the media.

Health authority boards have left clinical care to doctors, even though it is a board responsibility.

Every community has a right to a fair and efficient process for resolving differences with their health authority, including a rigorous system of internal review and an independent system of external review.

There is a total intransigence of the Interior Health Authority, including management level staff, to accept any input from the public.

Over recent decades, the system in British Columbia has witnessed transformation from a provincially directed structure with effective local input, to one now dominated by regional health authorities. Positive elements of this, such as flexibility, are counterbalanced by negative ones, such as artificial barriers to sharing of information and budget responsibilities. Accountability has not necessarily benefited, nor is the expertise at the regional level always sufficient to speak either to the larger provincial need, or to locally unique needs. This aspect of the province’s system design should be revisited to examine potential for improvement.
• The financial problems and unwarranted secrecy of the present unelected health authorities indicates an ongoing massive failure of the province (Ministry of Health) to control spending and fully ensure effective provision of health care services to all British Columbians, and to ensure that there are sufficient fully qualified medical and nursing staff to provide fast efficient service, especially in the emergency rooms.

• There are no consequences to government as a result of making poor decisions or mismanaging the system. Health authorities have too much control without accountability.

• The further you get away from where services are delivered the less connected they are. You cannot sit on the top floor and deliver effective services. Managing a billion dollar system centrally is not working.

• We have to re-think the Ministry of Health. We always think about it as the Ministry of Illness. So much of the budget goes to illness, not to health.

• The health authorities do have a variety of accountability mechanisms that are supposedly designed to hold our collective feet to the fire to help us achieve provincial goals. This is where there could be areas for improvement. The government letter of expectation in the future could be more focused.

• There is no accountability to the public from the health care system.

• The government should either strongly support and apply the principles of quality management to the health care system, or explain to the public why they will not. Quality management can be applied to any system.

• There is a lack of ownership with regards to shortfalls.

• Comments on administrative structures, roles and responsibilities:

  • With the emergence of highly competent public administrators in both provider organizations and the central funding agencies, and the increasing development of population health based e-health authorities, the traditional role of health governors, besides their fundraising duties, appears to be becoming redundant.

  • There is a brave new experiment in British Columbia over the last five years with the creation of the health authorities of a certain size. If you go looking elsewhere, health authorities have been around in various forms in other countries for many years and there is plenty to learn about out there and it is really exciting. One has to question whether or not we have finished with the evolution of the health authorities or whether we should, in fact, rethink what they are doing.
• From an administrative standpoint health authorities perform a useful function. However the current corporate philosophy tends to exclude or marginalize appropriate patient care and acceptable outcomes.

• The decision in 2001 to create six mega regions was interesting. After three or four years of stumbling, the regions seem to be finally figuring out how to work. Do not do away with health authority boards and create one provincial board.

• Look for a different delivery and management model. The direct management by the Ministry of Health has been proven not to work. It is bureaucratic, unresponsive, expensive, and inefficient, delivering an unacceptable product quality. Some models to look at would be something that is more reflective of private industry, with more accountability and a market-driven component. Review other successful pseudo-Government organizations such as the Insurance Corporation of British Columbia. Even a Crown corporation structure or another structure that would get more performance-driven management and accountability into the system and allow for a market-type enterprise with accountability, incentives and motivations for those in charge.

• Employees should have been consulted before health authorities were established.

• The structure of managers reporting to managers might not be needed if staff was more empowered and authority shifted down towards front line staff. The current pyramid needs to be turned upside down, with front line workers at the top.

• One has to ask where our democracy is when the few people at the top of the pyramid totally ignore the majority. Before the province ended the Health Councils, every area had some elected officials who were accountable, and they were volunteers, not costing the tax payers the huge amounts that the current regional boards do. We now have to pay more for less. Where is the cost saving in that?

• Micromanagement has been shown to not work in any business and health care is no exception. The decisions that have been made for health authorities over the past two years have been increasingly government controlled, unwise, short-term, simplistic, political and damaging to the health care system in the long run.

• When the health authorities were set up there was no corresponding geographic response with respect to social services, so right away you have dysfunction at the core of the health system.

• This province has identified the health authorities as the custodians of the health of the population. If we do not like that, let us get rid of it. If we believe it, then somehow we need to build upon it. We are not there yet.
• The move to six health authorities from what were 52 distinct authorities has been an important step ahead.

• Recent changes to the Board appointment process have seen responsibility for this within government shift to a departmental role. There is a concern that grouping health authority appointments with other government appointments will undermine the overall importance given to health authority board appointments.

• Appointees to health authority boards do not care about rural communities, are not impacted by their own decisions, and are often ignorant about vital aspects of the delivery system.

• Regionalization results in doctors leaving their offices in outlying centres and moving to the vicinity of a regional hospital.

• The ones who should be in the driver’s seat are the people and not the physicians or the other health care providers.

• As a result of the structure of governance through the Ministry of Health and health authorities, there are multiple layers of bureaucracy.

• Inexperienced people are appointed to manage branches and then when they screw up they just get moved. There should be some recall for those in charge who do a bad job at managing.

• The present institutional infrastructure is mainly concerned with reducing the liability of the institutions and practitioners within the system.

• Put Ministry of Health staff energies to something that adds value to the system instead of being demanders of trivia.

• Many complaints have been received about the pressures put on middle management by the layers of management above them. Over the past few years, a large number of middle management personnel have resigned out of the sheer frustration of being given impossible tasks.

• The relationship between the provincial ministry and health authorities is fraught with disrespect and inconsistency. Everyone is building an empire.

• Comments on regional and local interests:

  • It is natural that people are concerned about problems at the local level, they want to participate in finding solutions and want a say in the management of issues that they care about. The challenge is to decentralize political power through citizen participation at the community level.
Vancouver Coastal Health maintains four Community Health Advisory Committees as part of its overall governance and accountability structure. The mandate of these committees is: To assist Vancouver Coastal Health in establishing mechanisms for ensuring public input throughout the region as mandated by the Ministry of Health.

There needs to be a focus on community needs and delivery models. The health authorities are run by a bunch of people with no accountability to anybody in the community. When you make presentations to open board meetings (when they have them), the board goes away and you never know what happened with your input.

We need to decentralize planning and budget allocation and focus on community-based decision-making.

The Province is downloading health cost pressures to local governments.

Regional inequalities must be addressed, including: acute care bed ratios, long term care bed ratios, community supports and diagnostic facilities as well as the availability of health professionals.

The centralization of services leads to a reduction in rural capacities and eventually reduced community viability.

Almost without exception everybody sitting on a health authority executive has an acute care background. The future is in the community, but we default to acute care.

We do not know Board mandates from Government. Board members represent government not the community.

Regionalization of health centres is a good idea.

There is a loss of relationships and no link to community through health authority boards.

During the regionalization process, small communities lost their voice and the ability to manage their own facilities and hospitals. Centralization of provincial administration, with provincial standards and local input and decision making, would be more efficient and just. Also the economics would improve.
Ideas and Suggestions

Legal Governance and Funding Framework
Accountability and Transparency
Administrative Structures, Roles and Responsibilities
Regional and Local Interests

- Ideas about the legal governance and funding framework:
  - Make health care universal across Canada with one health authority based in Ottawa. This would result in cost savings and is consistent with many European countries which only one health authority.
  - Consider the United Kingdom governance model, which is a Public Benefits Corporation. This would decrease political interference in health service delivery.
  - There is so much overlap and duplication in some of the things we are trying to do that we need to think more creatively. We need to move to a regional concept where provinces as partners are delivering certain aspects of health care. We provide a lot of services to people in the Yukon and the Northwest Territories here in British Columbia. We also send people back and forth between Alberta and British Columbia.
  - Increase health authority autonomy.
  - Health authority boards need to be governing bodies, and not have the role of advisory bodies.
  - Government needs to allow Boards to govern their health authorities without detailed management by government or the Ministry of Health.
  - Government should stop micro-managing health authority boards.
  - It is recommended that, along with exploration of more functional funding models, the Ministry of Health work with primary care organizations to develop robust effective governance models to share with the practicing community and offer them as companion elements in implementing the changes canvassed in this document
  - Expand and confirm our national standards for all.
  - There should be sub-regions for health authorities, particularly larger ones.
  - Form an independent entity that is free from government involvement, and managed by a consortium of health care professionals.
  - The Ministry of Health should take over responsibility for all hospitals and clinics and disband the regional health authority models of governance. Administration of these models would be eliminated as well.
There should be one overall Hospital Management team overseeing all of British Columbia’s hospitals and have sub-groups in each hospital.

The provincial government should put an end to the health authorities and allow the Ministry of Health to do the job it was designed to do. Health care is not a business but a service.

Primary care and chronic care are linked and are seen as among the most important areas on which we should focus. As a result, primary care providers should be brought into the system.

Get rid of health authorities.

There should be a review of the overall responsibilities for health across government and health authorities. This review would include a question of whether the responsibilities are within the purview of the right department or organization.

Re-evaluate the health authority model.

There should be Aboriginal health authorities.

There needs to be a mechanism to facilitate policy and legislative change within government to allow health authorities to implement innovations and changes. Often these policy and legislative changes take too much time to help health authorities meet their business goals.

Health authorities need an opportunity to discuss strategies and policies under development with government.

Government, with health authorities, could investigate a Crown corporation model of governance, which has an enhanced ability to do long-term planning, and would include the Ministry of Health and health authorities. There was a suggestion that this may result in a more coherent governance and accountability framework and would isolate government from day to day issues management and operations.

Administration may be able to be better managed in a Crown Corporation format with a President and Board of Directors functioning at arms’ length from the political authority.

Break down barriers created by competing self-interests by creating a strategic top level body responsible for developing a complete health and wellness system from cradle to the grave. This is a strategic governance model that requires a paradigm shift to wellness care including the social determinants of health.
• The Ministry of Health is responsible for creating public policy in collaboration with health authorities, physicians, health professional unions and associations, and local government.

• There should be a Cabinet level coordinating committee for human services in government.

• We should have duly elected Hospital Boards returned to ensure accountability to the people.

• We need to elect the health authority board to ensure accountability. We need an opportunity to direct the health authority, especially around budget and capital spending.

• Deliver health care funds in a coordinated manner across urban and non-urban areas.

• Ideas about accountability and transparency:
  - Increase public accountability. The activities of the various health bodies should be regularly published on the Internet so that the public can learn about what they do, how decisions are made and perhaps begin to understand some of the difficulties.

  - Regional Health Services are the way to go but it must be through 15 directly elected regional councils (including one for First Nations communities) throughout British Columbia that would be fully and openly accountable solely to the public (taxpayers) and not the provincial Minister of Health.

  - Increase Health Authority accountability by: requiring government and health authorities to annually publish status reports on their progress towards satisfying accessibility criteria, such as wait times; linking health authority performance assessment to patient outcomes in addition to expenditure targets; and, 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.

  - Accountability is focused on the wrong aspects of health care. It should be focused on population health.

  - We need an independent organization in each region that has the power to report on the health system, similar to an auditor general.

  - We need a health watch dog.

  - Broaden health boards to include members of public and health care workers.
• Have open board meetings and consult communities. Make health authorities more visible.

• Set a universal standard for care across the country.

• Set quality of care and access standards, and have a system for establishing them, making the system accountable to them, before we consider changing our delivery model.

• We need to establish a system of accountability to the public through citizen participation.

• There should be more public consultation.

• Increase the number of elected officials involved in delivering health care.

• Put health professional representatives on health boards.

• We need systemic change around accountability structures.

• Create an accountability framework tied to current needs and outcomes for the non-profit sector.

• Provide quality, timely and cost effective health care with a patient focus to all residents as close to home as possible.

• Competition should be regional and national, not just local. Why do people go to their local hospital with cancer? Because they have no idea who is best. If you had a cancer that is killing you, you would want to go to the best Cancer Centre.

• We need transparency to understand what is happening in the health system. Report everything. Make it all public.

• Any changes to the system should have value for all three stakeholders: patients, payer, and providers.

• We need to embed system-level accountability: to patients and the public and to the multitude of stakeholders.

• Align incentives and targets with goals.

• Health Authorities need to become more pro-active in providing accurate, clearly understandable and regularly accessible information to seniors and the general public on matters that are of concern to seniors.

• Ideas about administrative structures, roles and responsibilities:

  • There should be seniors on health authority boards.

  • Encourage health authorities to cooperate and share ideas and resources, but stop dictating or directing policy. The health authorities need to own the policy,
not pawn it off on the Ministry of Health to create so they can botch the implementation or point fingers at the government when clients complain.

- There needs to be balanced talent on the boards, not just financial and big business.
- We need a balance between central and local methods of decision-making.
- The Government should create facility advisory committees for each area served by each health authority to improve accountability of the facilities and authorities.
- Regional health authorities are not communicating. They need cooperation and an agreement on what will be implemented, how things will be integrated, scope, timelines, leadership, multi-government, and long term commitment.
- Information technology and infrastructure are strategic components of the business of health care. As a result, health authorities should own these assets and manage them to ensure they benefit health authorities.
- There needs to be a greater diversity of representation and perspectives on boards.
- There is a strong desire for improved collaboration and communication between health authorities. A secretariat devoted to this purpose would help to ensure that this happens.
- Health authorities need to get out of all business unrelated to health and focus on core health service delivery.
- Use volunteer health boards not paid chief executive officers.
- Integrate physicians and drugs into the regional health authorities.
- Make management accountable for efficient and effective systems.
- We need to set-up a permanent process to monitor the healthcare system globally, looking to cherry-pick the best ideas.

- Ideas about regional or local concerns:
  - Community focus and direction must be developed within health authorities to allow for a non-political direction and initiatives from communities, including Aboriginal communities.
  - Establish local or community advisory bodies.
  - While government might be concerned with the operation of some of the health authorities in the province, do not give up on the model. Regional health planning and service delivery is the correct structure. Do not give in to calls for local government appointees to these boards. Regional Health Authority Boards must
make decisions on behalf of the region as a whole. Local representation will only introduce parochialism into the process.

- A health council with a delegated authority could become a way into the community.
- Dissolve regional health authorities and replace them with locally elected volunteer health boards.
- Aboriginal people should come together to design a health council, and they would define and determine the most pressing health issues.
- Breakdown jurisdictional barriers affecting delivery of services to Aboriginal people and communities.
- Integrate and partner.
- The delivery of health care should be solely at the provincial level.
- Health programs and services must be developed locally based on traditional values and practices.
- Give back all the hospitals you closed to the communities at no cost. You stole them without compensation. Allow them to function on a non-profit basis. The provincial government would pay these hospitals the equivalent cost of a bed in a current hospital. Doctors using these hospitals would be entitled to charge for their services.
- Hospitals should again be under local control.
- We must allow the provincial government to have greater flexibility and control over how the public sector's delivery of health care should be managed.
- Keep primary level care as community-based, including salaried staff. Retain tertiary care as regional resources with a combination of salary and personal services contracts.
- Decisions regarding seniors should be made at the local level.
- If a local government is willing to fund facilities to a higher level in Fort St. John than Prince Rupert it should be allowed to do it.
- There should be decision-making at the local level including through regional hospital boards. There should be citizen committees.
- Embrace more community-based decision-making.
- De-centralize services.
- There is a need for shareholder accountability in the delivery of public health services provincially and nationally.
We have lots of figures and research that suggests municipalities can have a significant role in terms of health care.

Create flexibility in the framework to suit the community.

Create healthy communities funding to include a supportive role of municipalities, regional districts, First Nations, the educational sector, and so on to improve public health and overall community wellness.

Consider a village structure where the government sets standards and provides funding but does not run the system.

Health programs and services must be developed locally based on traditional values and practices.

Accountability and spending should be decentralized.

We need something that is provincial, that lays out the principles, but needs to be responsive to the local reality too. Delivering care in Fort St. John will be very different than an urban environment in the Lower Mainland.

Service delivery should be based on populations (for example, seniors, young adults, and aboriginal).

Vancouver Coastal Health has divided up the city into community health areas. Each community health area has one or two community health centres to deliver traditional health services on site, or through an outreach model. They have relationships with contracted not-for-profit agencies. We have not gone far enough in terms of looking at the range of services that need to be co-located there. You could look at that sort of community based one-stop-shop model and increase the range of services provided.

In order to address the many health concerns that affect the fifteen municipalities and three regional districts, the Northwest Municipal Association requests that the Ministry of Health update the Northwest Health Services Plan.

Health authorities should cover smaller areas.

In the north, there should be more than one health authority.
Performance Management

Concerns and Comments

Approaches to Performance Measurement
What to Measure
Availability of Data

- Comments on approaches to performance measurement:
  - The current focus on accountability through performance agreements is seen by health authority boards as a positive step.
  - There seems to be an inability to root out even the most irrational incentives in the system.
  - The current government letter of expectation to health authorities appears to set clear performance measures without equally clear benchmarks, making it challenging to plan for, or achieve, the measures established.
  - The government letter of expectation to health authorities appears to place more decision making authority in the Ministry of Health, affecting the overall governance structure. The letter of expectation has moved from a high level directional document to much more detailed instruction, which has inconsistencies with a board model of governance.
  - Primary Care suffers from a major dearth of measurement. The reasons are many, including a major lack of information technology infrastructure in primary care, dependence on a payment system which reinforces an episodic approach to care rather than a population base, and lack of standardization in data terminology, aggravated by a dependence on a disease nomenclature which is inappropriate for primary care. As the amount of alternative funding grows in British Columbia, the completeness of fee-for-services data as a source of population-based information decreases.
  - Outcome measurement is a good tool for determining change in health care services. A more thorough look at diverse research in health care, including health promotion, prevention and early intervention will likely yield better choices with respect to the direction of change.
  - Measurement is a tool for all four system levels in health care. Patients can use measurement to self-manage components of their own care, for which they require tools and education. Practices need measurement to know who they are serving, who is receiving care and who is not, and who has achieved health (promotion, prevention, treatment) goals and who has not, how long care takes,
what it is costing, how patients perceive care, and so on. Health organizations need measurement for most of the same needs, and for assessing where needs are within their domain of responsibility. Health systems need measurement at a similar congregate level, for broader policy and outcome analysis and planning.

- Measurement generally does not just happen. It needs stimulus, support and tools, ideally those which can capture data of relevance in the course of activity, with a minimum of additional work.

- There are two really significant parts of the performance measurement framework in Australia in Indigenous health. The first is the Aboriginal Trust around the health performance measurement framework, which included adding domains grouped into three tiers: health status and outcomes that determine self health and health systems. It was actually developed off a Canadian model. This approach significantly shifts the focus of performance measurement onto the health system as a whole.

- When all services were administered in Victoria, standards of care were developed by teams of specialists, which resulted in consistent care across the province.

- Governments should be very precise about what the goals are and then turn the system loose to figure out how to do it with a lot more flexibility. Regional health authorities have far too little authority. When I read in the paper that the Ministry of Health says to Vancouver Coastal, 'You have a $40 million deficit. We don't like it. Take it out of your travel budget. And by the way, you can't cut any services,' it is just not logical.

- Performance agreements are not being adhered to.

- High performing health systems establish much stronger accountability among physicians through measurement and strong contractual relationships around service provision and performance. You need less clinical autonomy. When there are variations in practice, people do something about them. It is a hallmark of quality improvement that people doing the same things in the same circumstances will produce higher quality outcomes than people doing vastly different things in the same circumstances. What distinguishes Canada from almost any other healthcare system in the world is the degree of clinical autonomy. We have a phenomenal tradition of clinical autonomy. Clinical autonomy, of course, is a good thing for a professional and probably for the professional's charges, their clients, but if it is not combined with good measurement of performance and accountability, you end up with a quality problem. And I think we are facing that in spades in this country.
• Performance measurement and information related to it must be transparent. For example, when the Interior Health Authority performance agreement was obtained by Freedom of Information most of it was blacked out. A non-partisan auditor needs to put forth a summary of the Interior Health Authority performance agreement with an evaluation of how they have done with appropriate, binding interventions and recommendations. British Columbia has a right to know how our money is being spent.

• If you do not measure results, then you get this equation: Value equals the inverse of the cost, that is, the best program is the cheapest one, which is the one with the least service. Now this is an obviously absurd result, but that is where we are. We do not measure the results. So what we end up looking for is the cheapest programs and the ones with the least service.

• There is no apparent connection between the variations in patterns of care, and the needs of patients and the outcomes. You need both databases of responsibility and accountability from which to try to bring together divergences in how things are done. Variability is natural. A lack of variability would be a big problem because we could be stuck in this state. But in the end, government or the payor should actually have a good sense of what they got for their money, because they do not have that now.

• Comments on what to measure:

  • In most countries health care is not thought of in terms of products. If you do not measure outcomes and cost, then you cannot know who is better, faster, and cheaper.

  • There is a lot done by the Canadian Institute for Health Information around performance measures. They catalogue lots of categories of things that go on in the health care system and they do comparative analysis between provinces and health authorities.

  • Patient satisfaction is actually a robust measurement for overall function. At the end of the day if patients are better served, they are happier.

  • It is inappropriate to set outcome indicators for regional health authorities unless you include the physician groups in a model of best practice accountability.

  • Patient outcomes are the responsibility of the health authorities. If a pattern at a particular facility or with a specific service develops then it is the job of the health authorities to find solutions.
• All health authorities and physicians should be funded only on the basis of health outcomes. It troubles me that our addiction levels, obesity levels, incidence of chronic diseases are all increasing. Yet, health authorities have responsibilities and jurisdiction over these things. What are they doing? Where is the accountability?

• You can be either tight on the outcomes you are going to achieve and free the system up to get to those outcomes, or you can be tight on the process that you ask people to follow to give you all the outcomes. We need some very clear management. For example, the United Kingdom established some rigorous targets for delivery and then put some money into the system. Here we establish targets but do not invest in achieving the targets, nor do we develop plans to achieve the targets.

• There are no measurable gains that can be evaluated or checked against current standards.

• Outcomes require more time to occur and measure than is politically acceptable.

• We need measurable markers of health across the lifespan.

• Accountability to the Ministry is through service agreements but they do not require that we measure health outcomes and utilizing best practices. Accountability is in the wrong places.

• We decided not to measure infant mortality, maternal mortality and morbidity as those numbers started to fall.

• What indicators do other provinces use?

• If physicians are appropriately supported, they are able to provide comprehensive care and measure their success using patient satisfaction surveys.

• Today we measure the patients’ length of stay, not the outcome, what it is costing, what the complications levels are, and what the readmit levels are. We are measuring patient days per 1,000 people. We are not measuring health.

• We need to stop counting the things that are easy to count, and start counting the things that count.

• In Australia, some people say that they do not really want to measure inequalities because that measures us against a non-Indigenous norm. I want to measure inequalities because I do not want to monitor Maori health but I do want to monitor the Crown’s commitment to Maori health.
• It is essential to know where you start from. We need to converse about who is Indigenous, provide systems for counting, provide education and training, and make sure that we move forward with complete, consistent and continuous data.

• A rights-based approach is to honour people by counting them. After we have decided who has the right to be Indigenous, we must honour Aboriginal people by counting them.

• Comments on availability of data:

  • There are national surveys that happen through Statistics Canada every year, which are helpful to some degree. But they are not at an adequate level of granularity to be useful. So I think just overall, we need to look very carefully at the information we have. We need more focused information on the social determinants of health.

  • Family physicians should invest in studying epidemiological data to understand their impacts on the communities they serve.

  • There is data that is sufficient to get started and support decision making.

  • We do not have a good acute care financial tracking system.

  • We do not have an accurate picture of the costs of individual procedures and services.

  • There has been lots of work done to develop 146 indicators, most of which we do not actually collect in our data sets. So we should at least collect a few useful indicators as a province that each health authority can have so we could report to our boards on progress.

  • There is a lack of consistent data from health authority to health authority.

  • We do not collect enough data on quality issues.

  • Data is missing in order to properly measure outcomes. For example, the Kelowna Accord is focused on five outcomes because they know to address inequities you have to focus on outcomes. But they may not be outcomes. British Columbia signed off on them, but there is no data on any of those outcomes. How is it at this high level policy discussion with all the chiefs, all the national Aboriginal organizations, all the Ministers of Health, and the Prime Minister’s office that no one put up their hand and noted that, while the outcomes are good, there is no data. For example, we do not know what the rates of childhood obesity are. We do not even know how many of our children there are in the province.
Ideas and Suggestions

Approaches to Performance Measurement
What to Measure
Availability of Data

• Ideas about approaches to performance measurement:
  • Institute a province-wide system for tracking safety and quality standards. Ensure that hospitals do not allow unnecessary operations.
  • Make a culture of accountability the cornerstone of public health care.
  • Create an accountability office to recommend system-wide changes.
  • There should be no bonuses for saving money in health care.
  • Foster the idea of corporate responsibility
  • Provide bonus points for meeting targets and improving quality. Incentives for quality care targets can be a catalyst for getting people out of their old patterns.
  • Look at local targets and management, but report provincially.
  • We need funding in order to meet targets, otherwise it is just a bureaucratic exercise.
  • Health authorities must be accountable for the implementation of guiding principles.
  • Get performance agreements that focus on positive improvements in the health status of the community with an agreed set of indicators of a population health nature. Health authorities would then be given the tools to make the decisions they need to achieve those outcomes.
  • Practitioners need to be accountable for their patient outcomes, not just the process. To do this, we need to improve our approach to measuring outcomes. Similarly, we need to move to a longer-term planning and budget cycle.
  • Create a results-based system instead of system that rewards the number of procedures done.
  • Set goals and specify results.
  • We need to identify who produces good results, and how much it costs.
  • We have to measure outcomes and provide rewards for positive outcomes.
  • We need to decide on the systemic changes we want to make, and then determine what success would look like. Then we must determine what performance measures we need to use to measure when we have achieved that
success. This can be done through setting annual targets. By the first year, there should be some measured improvement.

- Create an independent non-political evaluation of performance agreements with mandatory, binding decisions.

- Health authority performance should be assessed on efficiency gains: reductions in waiting lists, dollars spent (including staffing costs) per procedure in each department, complication rates, and employee turnover and morale (using employee surveys).

- Fund health authorities based on how well they do their primary job: delivering healthcare to their constituents.

- Funding to health authorities should be based on the population they serve and the particular services and expertise they provide.

- Ideas about what to measure:
  - Government should shift health authority funding to a mix of block and service-based funding to improve performance. Health authority performance assessments should be linked to patient outcomes in addition to expenditure targets.
  - Make health authorities accountable for deaths.
  - There should be more accurate reporting of how our health dollars are spent, not just whether we are going to increase the budget, but detail on how the money will be distributed to programs, services and equipment, and so on.
  - Establish health targets to determine our success. We need to identify what we want the health care system to achieve both in terms of health status and health outcomes.
  - We require qualitative measures and a rating system for facilities.
  - Measures need to be specific for the populations with which you are dealing. For example, look at the particular needs of the Aboriginal population and set measures to address those needs.
  - Accountability needs to be in ways other than fiscal.

- Ideas about availability of data:
  - Publicize key health care indicators and outcomes for the regions and make them accountable. Provide comparative data from systems in Europe and the United States.
  - Undertake a forensic, impartial audit and reporting of health care expenditures.
• Establish the cost of hospital performance before and after bed closures, decreased surgeries, and staff reductions.

• Encourage graduating students and universities to partner with communities to get measurable data on health care goals.

• We require better accountability and data on home support from health authorities.

• Create transparent expectations which are measurable, so that British Columbians know what to expect from services and treatments.

• We need a data base so that we can, on an annual basis, see what progress the First Nations communities have made, to be able to see where the gaps are and what we need to do to make the necessary alterations to achieve our objectives. For that to be done, we need to go into the communities.

Health Authority Administration

Concerns and Comments

General

Specific Health Authorities, Services or Facilities

• General comments on health authorities:
  • Health authorities are not effective.
  • Health authorities are top heavy with management.
  • Health authorities fail to listen to the public and the front-line staff.
  • They do not make their performance agreements, data, financial statements and other reports available to the public or easy to find.
  • Board membership is skewed to a business perspective.
  • Decisions are having a negative impact on population health.
  • Smaller communities have fallen through the cracks.
  • Regionalization has not resulted in flatter organizations or more community input (closer to home). It has resulted in large corporate organizations that are top heavy with consultants and analysts and low on front line workers.
  • Too much money is being spent on wacky administrative costs.
The health authorities operate in the absence of public scrutiny and accountability and therefore the public is usually unaware of a problem until it comes to the media’s attention.

Communities and patients no longer have meaningful influence over health policy. Until it is re-established as part of the health authority corporate design, we will continue to witness the problems being exposed on the six o’clock news.

What is never mentioned is that we have physicians accepting payment from the public system, using publicly-funded facilities at no cost to themselves (for example, operating rooms, laboratories within hospitals, and so on) with accountability only to the patient.

The problem with our health care system is that no one knows the real cost of procedures, health professionals time and even medical supplies. Once these costs are determined all items should be charged on a per use basis. Everything else in the world is paid for according to a specific price. Once we understand the real cost of health care, our provincial health authorities should be provided with money based the actual cost of the health care, not uneducated guesses.

There is an apparent missspending of health care dollars by health authorities. The use of extremely expensive facilities for meetings with full catering and all the trimmings is very costly and the same could be achieved by having meetings at more reasonably priced facilities without having to go on retreats. There are too many perks for the people running the authority and not enough going into the actual care side of the business.

Health authorities are top heavy in administration with excessively large salaries.

Health authorities have ballooned with their administrative empires as they become similar to large corporations. Health dollars are going into corporate positions intent on centralizing systems and procedures, rather than going into direct patient care.

Health care in the health authorities has placed the administrator and Chief Executive Officer as the top of the pyramid instead of the patient.

It is a waste of money to spend $100,000 to teach staff to wash their hands.

What is wrong? Not lack of resources, but mismanaged resources. The priorities within the health regions are all out of kilter. As long as management within the health regions is solely measured by their ability to stay under budget we are going to continue to fall further and further behind the rest of the developed world in terms of access to care.
We should expect the health authorities to be operating efficiently and with due diligence. We should expect the highly paid and educated administrators to be able to manage a budget based on the needs of the area that they are managing. This would help to utilize health care dollars more efficiently. The government could audit the health authorities to make them accountable for their spending decisions.

Health authorities do not seem to understand local concerns or stick to budgets.

Front line managers spend too much time on budgets and not enough on improving processes to improve care. They should be auditing more to ensure care needs are being met satisfactorily.

Health authorities need to be run by qualified and wise Chief Executive Officers who will stick around for a long time. The longevity of Chief Executive Officers correlates to successful organizations.

Health authorities waste money on one restructuring after another.

There are too many contractors paid exorbitant hourly fees and there does not seem to be any cohesive organization of redundant projects and programs as these over-paid contractors milk the system by coming in and getting out. They then move on to yet another health project, often taking the expertise that they have gleaned from their previous position so the health organization is left starting again.

The non-profit sector is vigilant in accounting for its revenue and expenditures and has accountability is to its donors, Revenue Canada and its board of directors. It publishes annual reports to its community and raises awareness through stories, donors, media, advertising, programs and services. You do not see this connection with community from health authorities.

Health authorities do not respond to First Nation inquiries about why their project proposals and initiatives were not successful.

Comments on specific health authorities, services or facilities:

I can only speak highly of the Vancouver Island Health Authority.

The North Vancouver Island Regional Hospital is scheduled to be built on agricultural land. There are no First Nations or Aboriginal people that live nearby. It will cause a larger barrier to access to our most marginalized, lowest socio-economic groups of the North Island, with a population profile of young moms and children. We have time to change the location to Campbell River.
• Fraser Health appears to have the responsibility without the ability to control the key inputs, the patient demand and the surgeons. If [health] providers are expected to innovate, they must have the resources to do so.

• We do not want a public private hospital in our area instead of two non-profit community hospitals, which is what we currently have. The Vancouver Island Health Authority has only listened to the profiteers (some specialists, developers, private corporations). They have not listened to us, the tax payers and patients, and the notion of accountability to us has been swept away by greed.

• I am hearing about growing administration at Interior Health but I am not hearing about decreased resident and care-worker ratios.

• The Interior Health Authority has gone back on its commitment to re-open Deni House.

• In the Williams Lake area, the Interior Health Authority shut down all public run facilities under the guise they were old and repairs were too expensive.

• The health care system in the Northern Region is appalling. Simple communication should not be an issue.

• At British Columbia Children’s Hospital, we experience top professional care.

• Stop punishing the big health authorities (Vancouver and Fraser Health Authorities) for going over budget. What on earth are they supposed to do with the demand being so high?

• The high profile resignations by the Chief Executive Officer of the Fraser Health Authority, and a member of the board of directors of the Vancouver Coastal Health Authority in response to the firing of the Chief Executive Officer of the Vancouver Coastal Health Authority, for a $40 million shortfall just shows that this $10 million Conversation on Health is a total waste of time and money.

• The Interior Health Authority has closed facilities giving extended care in anticipation of private facilities to provide non-urgent care.

• The sole purpose of the Vancouver Island Health Authority is meeting the budget. The only way they can see to achieve this is to cut health care. While they continue to squeeze and choke the life out of our health care system, they continue to develop positions in management to attempt to gain more control over it. As a result, health care monies are transferred from the actual helping of people to the management of the system, and costs continue to rise, while health care declines.
The effective delivery of health care services can be enhanced if it takes into account local community concerns and insights on how best to meet that community’s health needs. The Southern Gulf Islands Community Health Advisory Committee provides an example of a representative community consultation model that provides for local engagement in health planning for Gulf Island communities.

There are substantial differences in standards of health care delivery between the Fraser Health Authority (mediocre to poor) and Vancouver Coastal Health (good). Vancouver Coastal Health tends to be much better in terms of speed of access, shorter wait times for diagnostics and treatment or emergency services, better access to general practitioners and so on.

The Interior Health Authority’s decisions are not based on any realistic evaluation of its constituents. They have ignored the community and set an authoritarian standard which is insensitive to the community’s opinions.

Interior Health will not listen to the people of the West Kootenays.

The Chief Executive Officer of the Fraser Health Authority had plans as to how to alleviate the problem with the influx of new patients. Now he is gone and it will take someone with the same speed and determination to address the problems as he did.

Interior Health Authority employees act as advocates with a blatant bias.

The inability to recruit a Chief Executive Officer for Fraser Health is a very tangible example of the difficulties that arise when one micro-manages.

The Interior Health Authority region is too big. Face-to-face meetings are very difficult and expensive.

Since the amalgamation of the North Shore and Vancouver Regions, the opportunity for input from North Shore residents has been minimal. The region is too large. The interests of the two are not always similar and the distance to attend board meetings is unreasonable.

In Vernon, the operating rooms are closed for more hours than they are open. We have huge numbers of highly paid administrators and rooms that once had beds in them are now used for offices.

The Vancouver Island Health Authority prioritizes the three C’s (cancer, children and coronary) and does a good job on these. Why not rationalize the rest of the services in the same way?

Fraser Health has started on the right foot, adopting a collaborative, multidisciplinary approach to clinical service planning through its Acute Care...
Capacity Initiative (ACCI) and it has begun a comprehensive process to understand its current state and study its potential future directions. Fraser Health has also approached this organizational change incrementally; a transitional structure is appearing as evidenced by its recently formed Council of Surgical Chiefs.

Ideas and Suggestions

General

Specific Health Authorities, Services or Facilities

- General ideas for health authorities, services and facilities:
  - Have a round-table with front-line staff.
  - Cultures of success take time to build. Every time you restructure or make another Chief Executive Officer move on, you disrupt that culture and put the organization back to square one. Seek ten to 20 year terms for Chief Executive Officers and find principled people who love a challenge and keep finding new ones every year, while they stay in their job for ten years and build a healthy culture. Right now health care is one of the unhealthiest places to work. Let us change that!
  - Make health authorities transparent. Ensure that all reports are made public.
  - The head of administration preferably should be a physician trained in administration.
  - No more money should be spent on the administrative side of the health care system.
  - Reduce the size of the health authorities and give facilities more autonomy so that they regain ownership and pride.
  - Create 15 health authorities (one for each geographic region in the province) which will be totally accountable, directly elected (every two to three years), and fully transparent to the electorate.
  - Implement community advisory bodies.
  - Consider smaller health authorities, or creating community bodies that report to health authorities.
  - Eliminate health authority boards and create elected boards.
  - Ensure health authority boards have a cross-section of talent and interests represented.
• Do not focus entirely on the bottom line.
• Undertake a review of the health authority model.
• Constantly evaluate the effectiveness of health authorities through clear performance measurement.
• Services should be managed province-wide.
• Create an independent health authority ombudsman.
• Elect front-line worker representatives, First Nations representatives and local community representatives to health authority boards.
• Improve communication with people within the regions and communities.
• Plans need to be made for the next 15 years. Think of the future.
• Consolidate and centralize management functions.
• Shake up upper management at health authorities. The only way to initiate a change is to start at the top. Hire someone with new ideas and someone who is willing to treat their staff with the dignity and respect they deserve. Hire someone from the outside who has not worked in health care but is a real go-getter and make it better.
• The hierarchy in the regions should be investigated, as it has become very top heavy in the last ten years. While workload on the wards becomes extremely heavy, more and more managers are hired.
• There must be a reorganization of the health authorities. They are all top heavy in administration. Highly paid staff members are replacing the old hospital boards that ran primarily on volunteers, and did a much more efficient job of keeping a hospital running in good order. Health authority administration requires expensive offices, vehicles, and many other perks that cost the system plenty.
• Improve the relationship with the unions, as too much time and money is currently wasted on this relationship.
• Communities should have a fair and efficient process for resolving differences with their health authority, including internal review and an independent external review process system.
• All health authorities need to be evaluated by an outside, independent body.
• The budget to each health authority should have a percentage factor set up that administration costs shall not exceed. This would then create more flow of budgeted amounts to the needs of the people rather than to the creation of an
extremely large bureaucratic jungle that sucks up budgets like a huge sponge and
delays any immediate reaction to problems.

- Rid the system of unions: get pride back in the workers and build self-esteem.
- A return to administrators running hospitals and nursing homes would be a step
  in the right direction. We need people with health backgrounds organizing health care.
- Ensure that professional and patient advisory councils have a far greater say in
  regional health care policies.
- Identify those health authorities under stress and direct the necessary resources to
  meet their specific targets and then publicize the specific progress made on all
  targets regularly on a regional basis.
- Let the north east of British Columbia control its own health care. This will allow
  us local control of our own lives, and respect and dignity for our seniors.
- We should elect public advocates.

- Specific ideas for health authorities, services and facilities:
  - We need better co-ordination between the Northern Health Authority and
    community service providers.
  - In order to give rural health care a working chance, the government needs to
    revamp the way health authorities are structured. The Interior Health Authority's
    Kootenay Boundary regional structure has not been working.
  - Eliminate Interior Health and bring back the hospital board.
  - Helping others to receive improved surgical services from Fraser Health can be a
    unifying cause for our surgeons and other health professionals across Fraser
    Health. Designing a model that increases access to underutilized surgical capacity,
    with the surgeons and other key stakeholder participating in the design, allows
    culture and mission to shape the organizations strategy and increases the long-
    term fit between culture and strategic directions.
  - Fraser Health should make its best efforts to assess the impact to specific patient
    and community wait lists, specific surgeons and sites and target these sites and
    surgeons for catch-up by means of pilots, one-time infusions and other
    transitional plans. For example, these surgeons might be offered opportunities to
    access the additional capacity at another site.
  - Fraser Health should identify those changes that it can initiate immediately and
    move forward on making the necessary changes in order to create momentum
    and reengage the physicians and surgeons.
 Fraser Health should develop a set of guiding principles for physician transitions
and a comprehensive transition model including the pre-negotiation of any
stakeholder and third party participation. Providing evidence of new approaches
to transition should be advanced incrementally through models and pilot
projects. This allows for selected targets, models to be fine tuned and physician
leaders to contribute and advocate based on recent, positive experience.

Part II: Summary of Input on the Conversation on Health

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Innovation and Efficiency

Ideas around *Innovation and Efficiency* were discussed often in the Conversation on Health. Participants covered topics like service delivery and innovation, best practices, capital planning, and administration and management in their exploration of this topic. Here is a selection of what British Columbians had to say on the subject of *Innovation and Efficiency*.

Service Delivery and Innovation

Participants expressed their frustration that there seems to be a lack of focus on innovation in the health care system. In particular, they explored ways to improve the quality and efficiency of service delivery. Some, for example, pointed to misuse of the helicopter ambulance service, unnecessary testing, inability to track patient misuse of the system, duplication of programs and strategies within and between health authorities, and an apparent inability to set priorities within the system.

Participants encouraged government and health authorities to seek out and implement efficiencies throughout the system. For example, they suggest permitting pharmacists to re-fill prescriptions under limited circumstances. This, they argue, will reduce the need of chronic disease sufferers to see a physician or specialist when a simple refill is all they need. Other suggestions include: doing more regular testing at home with simplified reporting mechanisms so the doctor can see test results without the need for a visit; understanding the costs of individual tests and procedures and comparing these around the system to find the most efficient approaches, and then adopt these approaches everywhere; and centralizing more services, like sterilization.

Some participants believe that the lack of patient input into the system leads to overlooking areas where efficiency, innovation and quality can be achieved. Solutions suggested ranged from a patient bill of rights, to comment cards available to all patients as they leave facilities and a feedback loop to ensure that comments and suggestions are acted upon.

A number of participants talked about their experiences in the system and the apparent lack of coordination of patient care, resulting in duplication of tests, improper diagnoses and waste. Similarly, some believe that there is insufficient rigour in the system to manage patient demands, meaning that treatments, tests and procedures are often undertaken without meeting clear evidence-based criteria.
Some argue that patients will visit a walk-in clinic, the emergency room and their family doctor for the same ailment. Sometimes this is due to a lack of information about where to go, and sometimes it is about patient preferences. Often, participants suggest a provincial overview of service delivery in order to move patients to where there is space for tests or procedures. Similarly, participants recommend good discharge planning, streamlining the coordination of services, and methods to help patients cope with their conditions. Specialized clinics, designed to handle a specific procedure, came up time and again as a way to help move patients with particular conditions through the system quickly. There is general support for more options and smaller settings for procedures and treatment to reduce reliance on hospitals. Similarly, participants raised mobile clinics and diagnostic tests as options for service delivery to rural communities, improving access, ensuring faster testing and diagnosis, and possibly averting serious conditions before they progress and require acute care.

Participants are concerned that there is no funding to pursue and implement innovative ideas. Many feel there are no mechanisms to seek out those ideas and study or test them. There is some support for the Innovation Awards and the Innovation Fund, but participants want to see innovation as part of the ongoing business of health care, and not a special event. Some suggest an external committee or panel of experts who would constantly search out innovative ideas around the world and recommend their application to British Columbia.

_It would be helpful to have an experienced "soccer Mom" scheduling the specialist's time. No one should have to wait two hours in a cast clinic when they have an appointment. Yet everyone does wait, it turns out they book 3 patients for every 15 minute time slot and they get delayed every day as they take ER patients first. If it happens this way everyday why not change the way this is scheduled???? The patient's time is just as valuable as the Doctor's._

- Online Dialogue, Surrey

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

Participants are concerned that the health care system seems unable to consistently study and apply best practices from British Columbia and around the world. They argue the system needs a shift in culture to an environment that embraces change, identifies its needs and finds its solution. Systems need to be implemented that will continuously improve health care delivery and operationalize innovative ideas and practices. Participants argue that we need to seek out and implement best practices, rather than always trying to re-invent everything.
While some participants believe that the current focus on evidence-based practices is suspect because scientific proof sometimes appears fleeting, others argue that a strong foundation in evidence will ensure that health service delivery is always based on the clearest scientific evidence supporting positive health outcomes.

Similarly, there is an ongoing debate about the usefulness of pilot projects. Some believe that pilot projects are an effective way of testing an idea or new approach. Others, however, suggest that we use pilot projects to avoid implementing anything new. They cite examples of successful pilots that ran out of money and were never implemented. For these participants, pilot projects are only useful if there is a commitment to implementation once they are proved to be successful.

*I think that if we’re going to be moving ahead and making major changes in our thinking outside the box, one of the overlays we really want on that is a strong evidence-based scientific evaluation of these things before we bring them in and after they have been brought in,… (and) they should be evaluated to a high standard.*

- Focused Workshop Health Human Resources, Vancouver

**Capital Planning, Infrastructure and Equipment**

Participants are concerned that there is no apparent capital planning to ensure efficient purchase and implementation of facilities and equipment. Participants believe that capital planning is not considering the future demographic trends, nor the most recent advances in facilities planning to guard against infection and ensure the most efficient patient care. Participants understand that the demographic make-up of the province will continuously change, and they encourage planning more flexible facilities to accommodate the consequent shifts in demand.

Participants suggest using other public facilities, such as closed schools or recreation centres, to take the load off of health facilities during busier periods. Some participants suggest more energy efficient practices in hospitals would save in operating costs, and recommend everything from hallway motion switches for lighting to turning off computers, and heat recovery systems. Another common suggestion was to use expensive diagnostic equipment throughout the day and night wherever possible.
Similarly, participants worry that there is little organization around procurement, and the result is that health authorities do not take advantage of their collective purchasing power. There is no provincial-level procurement strategy to ensure cost-savings wherever possible. Procurement of medical technologies was a focus of some participants. They suggest a provincial procurement strategy on medical technologies that would support the purchase of these technologies when they are needed, after studies to determine whether they are the most efficient answer to patient requirements. Similarly, some participants argue that medical technologies should not only be seen as an expense but also as a growth area, and that British Columbia should be investing in the development of medical technology here, for sale elsewhere.

*Health care should not be pigeon-holed in people's minds as a 'social issue' or merely 'public spending.' Health care research and innovation has the potential to be more of an economic generator, returning substantial benefits to the community, and reinforcing and enhancing public health care.*

- Vancouver General Hospital and University of British Columbia Hospital Foundation, Submission

Administration and Management

Administration was often criticized as being too top-heavy, inefficient and unresponsive to patient and front-line requirements. Participants recommend streamlining health care administration and management, from the Ministry of Health through to the health authorities. They also recommend the elimination of departing executive payouts and reduction in executive salaries.

Administrative practices were often criticized as resulting in duplication, wasted effort and poor patient outcomes. Clerical work required by health care practitioners was viewed as both unnecessary and time-consuming, taking away from good patient care. Some participants suggest business process mapping in order to understand the administrative processes, then eliminating waste and duplication. Some also recommend that we undertake external measures of service quality and efficiency to ensure that we have the most efficient management and administrative systems possible. Centralized administrative services, such as human resources and information technology, were recommended to avoid duplication and waste within and between health authorities. Some recommended turning to private delivery of certain services to avoid costly and inefficient administrative practices.
Participants blamed inefficient scheduling practices for poor morale, over-work and inability to retain good personnel and recommended that new and innovative approaches to scheduling be introduced.

Participants expressed frustration with the lack of transparency and efficiency in scheduling and referring to specialists, diagnostic tests and procedures. Many saw the need to return to a general practitioner in order to get a referral to a specialist, even for chronic disease sufferers who return to the same specialist repeatedly for care, as particularly problematic. Participants recommended province-wide referral systems, objective criteria to manage referrals, different rules around specialist referrals and assigning administrative duties to staff.

A surgery that may go overtime is not allowed to start because the hospital would incur extra payment for nurses and support staff. Thus a significant proportion of the operating rooms are not being used efficiently ...lying idle while patients wait. The private surgical clinics are able to work more efficiently and see patients more quickly because they have no such bizarre restraints.

– Online Dialogue, Vancouver

Conclusion

Participants are frustrated with what they see as inefficient administrative and procurement practices and unnecessarily bureaucratic steps in the overall management and administration of the health care system. They also are concerned that the system does not pay enough attention to best practices and evidence when making decisions and introducing new procedures. Their suggestions ranged from the introduction of external review processes designed to seek out and implement best practices from across the globe, to business process reviews that would investigate specific administrative processes and determine ways to make these more efficient. Participants consistently want to ensure that the health care system is delivering care using the most efficient and innovative practices possible.
Innovation and Efficiency

This chapter includes the following topics:

Service Delivery and Innovation
Evidence-Based Decision-Making and Best Practices
Capital Planning, Infrastructure and Equipment
Administration and Management

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

A Vision for 2017
Submitted by the BC College of Family Physicians

Submission to the BC Conversation on Health
Submitted by Society of Specialist Physicians and Surgeons

Physicians Speak Up
Submitted by the British Columbia Medical Association

Submission to the Conversation on Health
Submitted by the BC Cancer Agency

Sunshine Coast Conversations on Health
Submitted by the Women’s Health Advisory Network, the Sunshine Coast Hospital and Health Care Auxiliary and the Seniors Network Advisory Group

Improving Rehabilitation Services for the People of British Columbia
Submitted by the Physician Working Group on Rehabilitation Services

Advancing Healthcare in British Columbia Through Medical Devices and Technologies
Canada’s Medical Device Technology Companies

Advancing Leadership and Innovation In Specialized Health Care in BC
Submitted by the VGH and UBC Hospital Foundation

Recommendations for Better Health Care
Submitted by the British Columbia Optometrists Association

Saving Money By Saving Patients
Submitted by Leta Sinclair

Recommendations for Improvements to Healthcare Services for Seniors
Submitted by Mary McDougall

2020 The Future Without Breast Cancer
Submitted by the Canadian Breast Cancer Foundation
Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Health Spending and Patient Safety.

Service Delivery and Innovation

Concerns and Comments

Quality and Efficiency
Coordinating Patient Care
Access and Demand Management
Service and Facility Availability
Innovation
Information

• Comments on quality and efficiency:
  • Change management in Canadian health care over these past twenty years has largely been focused on trying to create a short-term dramatic shift through the intermediary of a crisis, usually based on financial-sustainability pressures.
  • No simple criteria exist for choosing between the competing use of funds, and the effectiveness and efficiency of different health care interventions.
  • Family physicians find many patients checking to confirm the diagnosis or approach after having seen a walk-in provider: a source of waste and re-work.
  • The health system uses a service delivery model designed to meet the needs of service provision, not to meet the needs of individuals seeking health care. While it is recognized that the goal is person-centred care, we aren’t close to achieving it.
  • By opening hospital laundry services to the competitive bidding process starting back in 2002, service levels have increased, quality has improved and costs have been dramatically reduced.
  • No one solution is without complicating issues that most of us likely haven’t even considered.
  • The major savings in health care expenditures in the past twenty years have been through providing the same care cheaper. Much of health care twenty five years ago consisted of putting the patient to bed, often in hospital and caring for them. Fewer interventions were performed. The patient either recovered or did not. Frequently they suffered complications as a result. This also maintained high
costs. Over the interim we have learned. We do more investigations. We perform more interventions. Length of stay for many routine diagnoses is shortened. More patients are treated at home. Results are improved. We institute more prophylactic measures. Morbidity is reduced. We save money. This compensates to a large extent for increased numbers of interventions.

- How is it possible to understand the need for head injury services without knowing the incident rate in adults and children across the provinces? This should be determined at the Ministry level, not left up to each health authority, which will result in variations across the province in terms of the care offered, as is the case with hip replacements.

- Funding from the provincial government to health authorities should not be based on their level of operating efficiency and patient outcomes. Many areas are not efficient because they do not have the funds to provide the care. Others are not efficient because they have too many patients and not enough money. Other areas are not efficient because they do not have the space or staff or are isolated. Some areas do not have the doctors to provide the type of care that comes in.

- Managers and human resources departments are unable to deter the abuse of the very liberal system regarding overtime and calling in sick from health professionals.

- The cleanliness is so poor because the cleaning is only being done once a day and everything is left dirty in the meantime. This is part of the reason why contagious diseases are being spread in the hospitals.

- The food is bad and the parking is a racket.

- Private sector involvement in support services is gaining popularity because it does save money and it does improve services.

- Health authorities are trying to get legal arrangements in place to allow families to pray for family members during operations. This can lead to faster recoveries and healing.

- Blanket testing over a certain age is expensive, time consuming, leads to many false positives and is generally useless.

- Using BC Ambulance Service helicopters for routine transfers of patients is a gross waste of money. They should only be used in cases of multi-trauma patients more than one hour from a trauma centre, as they were originally mandated for. Their continued misuse is due to poor management. Land transport should be used in most cases.
A heart patient may need stents in one or more arteries. The rules require a certain percentage of arterial blockage before insertion can take place. The result is that a patient may get two stents put in on one occasion, but have to return in a short period of time for a third or fourth insertion to be made. This is ridiculous expense, and also bad medicine. It should be stopped.

Do you think we need to introduce a system of patient accountability? The system is currently abused by many and there is very little incentive for the user to save the system money. So often we hear that health care is free in Canada, so why spend my own money to keep healthy, when I can simply check in at the local clinic if I get sick?

Lack of competition prevents efficient delivery of services, better quality service and sustainable wage structures.

There is a concern that some health tests, such as mammograms, may have unintended negative side effects. Similarly, some pharmacological treatments have negative side effects costing the system and the patient in resources and health.

The health care system must find a way to track the expensive practice of some people who go from doctor to doctor and make repeated appointments, when they do not have illness, chronic or otherwise. A quota system on number of visits annually in this category, perhaps?

There are four system levels at which change is needed: the experience of patients and communities (True North); the functioning of small units of care delivery-microsystems; the functioning of the organizations that house or otherwise support microsystems; and, the environment of policy, payment, or regulation, and accreditation, and so on.

Compare health care to the private sector: the big three auto companies are going broke while Europe and Asia are expanding. Why? Because they pay attention to quality, not to lip service. Paying attention to quality results in a decrease in shortages of health professionals and reasonable wait lists.

If we have a focus on service quality, we will improve Indigenous health. It is a separate and additional pathway to improving Indigenous health. The word under-serving is very close to undeserving, and we need to re-orient health services, especially those that are not Indigenous-based health services, so that they audit themselves to ensure that they provide best practice according to guidelines for the care that they provide to Indigenous clients.

As there is no TPA treatment (TPA is a thrombolytic or clot buster drug) available in the Province for ischemic stroke victims, a patient living in the Kootenays
should immediately have been transported by air ambulance to Calgary, where the TPA treatment is available. This would be a less costly method of handling a person who has been diagnosed as having had a stroke, rather than all the hospitalization, therapy, counselling, and home assistance costs which are the result of palliative care. If both hemorrhagic and serious ischemic strokes were transported to Calgary, the Computed Axial Tomography (CT or CAT Scan) could be done on arrival in Calgary, therefore avoiding time delays with trips back and forth between Trail, Nelson and the airport.

- Unions prevent volunteer work in the hospital.

- Why are test results not given over the phone? This would save the time required to make another appointment. If the doctor wishes to see the patient again as a result of the test, this could still be done.

- Why is it necessary to space out the test requests? The option of getting them all on the same day could save time off work for some people, and speeds up the doctor's diagnosis and recommendations.

- Some readmissions may be related to disease progression, but might some of it be related to not dealing with the root cause of the patient's issues? There is research evidence to suggest that predictors of re-hospitalization include the following: lack of adequate support, premature discharge from hospital, non-adherence to medication and follow up procedures, substance abuse, and delay in seeking treatment. On the same unit, we have also job shadowed nurses. And we found that they were not attending to any of these predictors of re-hospitalization. Nurses are spending minimal time on patient and family coping, social support, and increasing patient self-care capacity.

- There are no standard diagnostic procedures in the Province. In addition, there are too many procedures ordered to test for the same condition.

- Blame is issued with no means for correction. The system becomes reactive and covers problems, but does not correct them.

- Achieving efficiencies is best achieved in an environment sheltered from fluctuations in clinical pressure. Some redundancy must be built into the system.

- We, in healthcare, have not looked at all our processes with anything like the scrutiny that most other industries have, and there is a lot that we are doing that we do not need to do, and which is wasteful. You could probably give higher quality health care at half the cost and give it to everybody on time.
• Richmond’s Hip and Knee project has been very successful in reducing the wait times for hip and knee replacements, and has resulted in such efficiency that we are now the provincial if not national benchmark for length of stay and other measures.

• Patients have to stop at a pharmacy on the way home when they are released from the hospital. This is a hardship for single people who do not have help.

• Patients are being discharged too soon and are not able to care for themselves at home.

• What is really jamming the system is that there is a small percentage of people that require a lot of attention and resources. If you can deal with them with a dedicated group of people, that frees up the rest of the doctors and nurses and nurse practitioners to be more efficient, and to deal with the broader population that does not need as much. You then get a specialization in dealing with those people, rather than it being a rare occurrence, so that you are not learning as much as you would in a more specialized setting.

• There is duplication of programs and strategies.

• Visits to the doctor are always necessary for prescription re-fills, even in cases of chronic illness.

• In-patient priority encourages inefficiencies.

• Innovative programs in several provinces have shown that simply organizing hospitals’ work better, introducing more specialized facilities (that is, hospitals that only do one type of surgery), and by using technology more effectively, public hospitals can become much more efficient and better at what they do. And these public solutions can drastically cut wait times.

• Comments on coordinating patient care:
  
  • Who speaks for the citizens having problems with the health care system? Patients do not have a collective voice or an ombudsman. Current patient advocates are health authority employees, so they are part of the system and therefore biased.

  • Of the key strategies that have underlined the development approach in Australia, the most significant probably is maximizing Aboriginal participation in policy, planning and delivery.

  • I am of the trans-gender community going through a transition over the next three years. I am appalled that I have no control over my own body in this process. The government mandates onerous counselling sessions that give assessors total control over me. The Province places trans-gendered people in harm’s way with
their unreasonable demands for a two year real life experience (RLE). These are third-world medical practices. If I was a woman looking for an abortion on demand, it would happen, no questions asked. Why the double standard? The government’s policy is overwhelmingly anti-trans-gendered care. We have no voice here.

- The procedure of going into the hospital a day or two prior to surgery for a pre-surgery meeting is flawed. Although they do tests, they know the results will not be available for four or five days, yet the surgery is scheduled in two days.

- After-operation care was very good. Nurses were available as needed and stuck to a timely schedule. The tools they needed to perform their tasks were close at hand. So this was good.

- Unfortunately, the historical emphasis on physician and hospital medical services has resulted in a fragmentation of vision care in British Columbia and other provinces, as services covered and degree of coverage varies depending on the patient and provider. In addition, there has been a disturbing trend towards separating the refractive and health components of eye care, especially as the level of publicly funded coverage for primary eye care services has been eroded, even though there is compelling evidence that considering refractive findings in isolation poses significant public health risks.

- Patients are spending their whole life running back and forth to various clinics to treat specific problems.

- When I make a hair appointment a month in advance, I get a phone call reminding me that I have to turn up tomorrow to my hair cut. Some of these medical procedures, tests and examinations are booked months in advance. There is no phone call to remind you, and there is no penalty if you miss that appointment.

- I pay if I am not there if somebody comes to fix my dishwasher. I think we are missing a huge section here that we need to examine, on how people take it all for granted and they do not feel it is important to turn up to some of these appointments.

- People are forced into the acute care system because the Medical Services Plan does not recognize the value of preventative care and complementary medicine (such as naturopaths or chiropractors).

- Doctors are only hearing one symptom or complaint per visit.

- Individuals are going to three or four professionals to treat one issue.

- Family doctors do not have access to good triage for specific complaints.

- How can we treat better to avoid repeat treatment?
• Comments on access and demand management:
  
  • Patient expectations are completely different now than they were before. Patients are much more forward and do not always have the best information, so their demands increase.

  • In New Zealand they have very rigorous clinical protocols around surgery. If you want a surgical procedure, you are going to be evaluated against a very clear protocol as to what the expected outcomes are: life expectancy, quality of life, and a whole range of criteria. If at the end of the day a panel has the authority to accept you as a surgical candidate. If you do not meet the criteria, you get a letter saying thank you for your request, and you are referred back to your clinical practitioner for follow-up. The public has come to understand that not everyone is going to get it because they ask for it. Decisions are based on very clear, defendable, clinical evidence and protocols.

  • The thresholds of illness are changing. For instance, a systolic blood pressure of 140 used to be quite acceptable but now this threshold triggers a diagnosis of hypertension and the prescription of drugs.

  • The other side of health disparities is privilege. So whenever we are spending our time looking at inequities, we should spend as much time talking about the problem of non-Indigenous privilege, because if someone is getting not enough of the service, someone else is getting more than enough.

  • Access to outpatient rehabilitation services is unacceptably long even in tertiary facilities in Vancouver. There are no standards for rehabilitation services.

  • When changes were made to out-patient care and discharges, the workload for both home care and outpatient therapy increased immensely. There is difficulty keeping up with demand. Longer wait lists for rehabilitation mean later intervention and poorer outcomes. Consider and plan for downstream effects of change.

  • Why do doctors’ offices charge $100 for the transfer of my file?

  • There are different care levels at different health care facilities.

  • We need to focus on expediency and timeliness of care. The physicians have been called at three o’clock in the morning for years to ask if the patient can take a laxative. Now that is silly. It is not about professions trying to increase their scope of practice, it is about efficiency and effectiveness of care.

• Comments on service and facility availability:

  • Walk-in clinics have turned into a non-accountable, stand-alone, limited opening times alternative to family doctors.
Richmond Hospital has specialized in hip replacement with great success.

There is not enough patient education offered, nor is there access to technology and terminology.

Another area worth examining is the provision of intra-cellular X-ray spectroscopy testing in high risk populations to provide reliable quantitative measures of the relationship between specific types of food consumption and magnesium deficiencies in the population. If a significant number of cases of magnesium deficiency could be resolved through simple testing, nutritional counselling and supplementation, a considerable dent could be made in reducing down-stream costs to the publicly funded medical system.

Research has demonstrated that prenatal ultrasounds are generally unnecessary in normally healthy pregnant women and yet many of these women will undergo at least one or more of these tests.

Why are we using ultrasounds at a drop of the hat for pregnancy? Babies have been born for centuries without the use of a scan and I know moms with no apparent problem having five.

One participant had sixteen radiation treatments, but since the hospital would not do it on the weekend, it took a month.

Clinical practice guidelines are not always adopted or enforced for accessing diagnostic tests.

A system whose discourse is dominated by interests will end up catering to those interests. Whether it is the pharmaceutical companies or the unions or the doctors or any other group, even though their interests may be legitimate, they are competing among themselves and it becomes a brokerage model. Well you cannot broker the public interest. You cannot broker fairness. If physicians get to practice wherever they want, why would you ever expect rural areas to be served?

Comments on innovation:

We are told there is no funding, but then we see it spent elsewhere than on innovative ideas presented.

Innovation is not encouraged. When new ideas are presented, there is no funding mechanism to make them happen.

Currently, health care does not have discretionary funding to develop new programs.

Our systems, whether they are health or social or criminal justice, they are a product of bureaucracy, meaning you incrementally add and develop the system
over time and you rarely go back and fundamentally re-think it. So you are simply layering on top of it and gaining knowledge and improving. But you are never coming back to the big question: would you create a healthcare system based on dealing with the outcomes of the lack of intervention in the front? You would actually do something entirely different if you were going to start from scratch.

- Too often we let a jurisdictional debate stop us from doing the things that we need to do for the people that all of the jurisdictions are supposed to be serving.

- At the core of any concept of a sustainable system is the idea of adaptability. And at the core of the idea of adaptability is the ability to change. How do you recognize what is happening? How do you facilitate the appropriate direction of change? And how do you do so in a way that is actually enduring so that it is not a kind of a one-off flavour of the month.

- The generation that is currently in management is stuck in the nursing model. This creates burn-out and sick days which stresses our budget. Then we cannot afford a healthy workplace to reduce sick days. Management tries but is not successful at developing innovation in care because staff and management are nursing-focused.

- Successful change initiatives in culturally significant organizations are those that recognize the importance of culture and use its forces in the mutual interests of its stakeholders.

- Comments on information:
  - There is very limited information available prior to accessing the health care system, so we do not know who to contact.
  - People from different cultural communities will go to their own social contacts to get information in their own language.
  - There are huge cohorts of the population who do not know that they can self-refer to a physiotherapist, a massage therapist, a chiropractor, or any of those professionals. They do not understand that they have a choice and that there are different things that can happen for them when they make that choice. There are lots of people who are not informed consumers.
  - The media has played an education role in what interacting with health care system is like.
  - Health care is delivered broadly by the community and by other ministries as well. However, we are not allowed to know the mental health status of our clients, or share the application form for disability assistance. So we do not know whether the clients need to be treated differently or accommodated.
I do not know if patients necessarily need more choices because they do not already know what is available. We really asked the larger population if they feel that they need more choices. When we have done some research around patient journeys, they already find the system very complex to navigate, and no one gives them an understanding of the whole system.

The public tends to be captured by vested interests more than the public interest view, which is government's view. The public is motivated by fear and figures that if the government says one thing and a health care interest group says another, the healthcare interest group gets more credit. Government has lost the public relations communications battle. If you don't have a strategy for capturing the public mind to a different way of doing business and not to fear that change in the face of a predictable backlash from vested interests, then you will not succeed. When, at election time in Saskatchewan, the Nurses' Union puts up billboards that say that it is unsafe to be a patient in Saskatchewan hospitals, this is just fear mongering and hysteria. The government does not fight back. When neurologists in Saskatoon say you should go to Calgary for a neurological exam because you will die here, the system does not actually answer.

Many of us do not know what our rights are, what our health care insurance pays for, or what we can expect the doctor to do for us. We need to be educated. We need to know how to maximize our time and make the most of our visit with the doctor. We need to know more about how the health care system works.

**Ideas and Suggestions**

**Quality and Efficiency**
**Coordinating Patient Care**
**Access and Demand Management**
**Service and Facility Availability**
**Innovation**
**Information**

- Ideas about quality and efficiency:
  - Turmoil related to negative change management outcomes affecting surgeons or operating room structures and sterile processing support could lead to service gaps and the exacerbation of existing integration challenges and system-culture conflict. More importantly, service gaps inconvenience the patient and introduce avoidable risk. Our duty of care requires that we design and implement changes properly and with due diligence to transition issues.
  - Chronic care patients should be able to have prescriptions refilled by pharmacists.
• If we can control the small things, the larger vision of healthcare in British Columbia would be more efficient delivery of services.

• Group specialists into hospitals. This works well in large population areas.

• Savings from contracting out the laundry can go directly to patient care and reducing waitlists.

• Eliminate recorded messages. We need a human to talk to.

• The Interior Health Authority meal program should be cut out.

• Improve emphasis on process-based treatment protocols.

• There should be a watch dog committee that oversees the use of medical testing to ensure we are not doing too many tests.

• WorkSafe BC gives way more support than does the health plan. This should be corrected so that all the plans offer the same services. There are too many plans out there under different ministries. Why is administration in multiple ministries doing the same jobs and asking for the same information when you could have one program that covers everyone?

• Eliminate waste in usage of paper for filling out forms, including unnecessary forms.

• Health care should not be pigeon-holed in people’s minds as a social issue or merely about public spending. Health care research and innovation has the potential to be more of an economic generator, returning substantial benefits to the community, and reinforcing and enhancing public health care.

• When you have a blood test you should be able to phone your clinic and get the results and if you need a prescription refilled you should be able to phone your doctor and have it refilled by phone.

• Pay for diagnostic screening tests to avoid expensive downstream effects of long-term illnesses.

• Liaise between facilities to ensure that tests are not duplicated.

• If regular blood pressure tests are required for a patient, issue them equipment so the tests can be done in the home. Results can be faxed, phoned or emailed into the doctor’s office.

• Cholesterol testing in pharmacies takes the load off physicians and makes mass testing easier.

• We have made incredible strides in efficiency especially with home care and shortening hospital stays. There are no more efficiencies to be found.
- X-rays are ordered for fear of lawsuit and to get patients out the door, sometimes multiple times. Because they are free, orders are usually for larger portions of the body than are necessary.

- It is said that we do not know what a procedure costs and how much time it takes. This smacks of a poor management team. So tighten up and streamline making the system more cost efficient.

- In Vancouver most of the hospitals have their own sterilization facility. For all bulk sterilization, one central facility should be established to take care of the needs of all the major hospitals in Vancouver and the surrounding areas. This kind of facility could reduce costs drastically and increase the efficiency while eliminating duplication.

- A waste management and quality control agency should be set up in every hospital to police the amount of waste that takes place in the hospital, and to see that quality control is maintained for all the goods and services that are used. This Agency should also be responsible for any fraud and theft that may prevail in the hospital.

- Issue hospital and physician report cards.

- Avoid discrimination based on risk factors. Instead, the health care system should take responsibility to help individuals change.

- To reduce infection rates, all staff should wear uniforms and be trained in cleaning adequately. Cleaning standards should be returned to the pre-2000 level.

- Free up the ambulance attendants from having to remain at the hospital until the patient is seen by the doctor; then they can attend to the next patient's transport to hospital faster. It may turn out to be more of an emergency.

- We have no capacity for independent oversight of our health care system, and we are one of the few jurisdictions in the world that does not have any. We have no ombudsman, we have no quality health council, we have nothing, and most of the jurisdictions in Canada have got something. We have zero.

- Focus more on quality of care and less on the budget or bottom line. Re-orient to what is important to individuals and their families.

- You can do quite a bit about changing the current system we have within our budgets, and there are a lot of inefficiencies in that system that you can still capitalize on, not necessarily transferring money from one budget to another but in doing it better. So the homeless outreach we are doing we are funding internally because it actually does save some effort in our office. We have long ago given up on the idea that the money tree will grow, but if our success is only
measured by volume, by the number of bodies that are processed through a system and by how large or how small our deficit is, those are the only things we are going to do, and we need to start measuring other things.

- Our health care system has all the resources it needs: it is just that we are very wasteful.
- New technologies will expedite many routine medicals.
- There is a real need for unions and health authorities to sit down and collaborate and talk through what they are doing. We can work things out together and develop processes and procedures to work more efficiently.
- The Ministry of Health should be the program evaluation body. They would oversee the health authorities. The issue of quality would be left to an independent body set up for that purpose.
- We need to actually take some units, whether they are acute care or residential care or community health units, and bring some experts in who understand job re-design and actually say, we are really going to take a look at what the patient population is that comes in here, and we are going to take a look at what those people need and we are going to say on this unit these are the competencies that are required, therefore this is what we need.
- Sell three days' worth of drugs to patients on release from hospital, which would save the patient time and trauma and the cost of having to stop to purchase medications on the way home. This allows the hospitals to earn money from selling the drugs, but three days' worth is not enough to take the business away from the pharmacies. It also allows patients to go directly home.
- Simplify the system so that people do not have to go to so many places for services, tests, and so on. It is too bureaucratic.
- More sittings of the Legislature should be implemented in order to deal with important issues.
- Health care should be removed from political influence and become a permanent infrastructure with funding based on best practices.
- Bring in outside evaluation consultants to re-organize and streamline processes.
- Existing wastes must be located and corrected. Front line professionals can tell you where those wastes are and how they could be corrected.
- Efficiency in operating rooms needs to improve. Start operations on time. Do a time and motion study to monitor physician behaviour.
• Develop a system of routine audits to pinpoint inefficiencies and highlight best practices. Report the audit results so that the public, providers and government are equally aware of what is working and what problems exist.

• Maybe we need to close some beds for a week or ten days and get the people on the unit to work with a job re-design expert who will start over rather than trying to fix what is there.

• Core capabilities should be identified within the infrastructure to identify opportunities for improved products, processes and outcomes. Improvements and solutions, however, should be looked for inside and outside of British Columbia.

• Competition will drive choice and efficiencies.

• Create efficiencies in system administration.

• Establish acceptable levels of service by first getting input from front line staff. Administrators need to understand front line jobs. Then take a common sense approach to establishing acceptable levels of service.

• Create quality assurance programs.

• Focus on prevention, partnership, treatment and education.

• Reinforce basic service delivery processes and administration, such as record keeping, continuity of care and complementary support.

• Review delivery of service and financial compensation to find efficiencies in system.

• Develop a screening reminder system like the one used for mammograms. It works well and should be used for other screening.

• Comment cards should be more readily available to patients. All patients should be asked at least once a week how their stay has been. All patients should be given the opportunity to fill out an exit survey.

• There should be a forum in place to ensure that when patients do actually write a letter to health officials expressing concerns, there is at minimum a response acknowledging the letter has been received.

• Have a patient advocate that is not connected to the health system.

• Facilitate the establishment of a good consumer representation process.
- Individual patients should have an information sheet given to them as soon as a diagnosis is mandatory. There should also be a care plan for survivorship and guidelines for health surveillance, and these should be given to the patient, caregiver, and doctor.

- Develop a breast cancer awareness kit, distributed by surgeons.

- The Cancer Agency needs to give patients direction and the ability to research other avenues.

- Create an accountable entity within the provincial health care system with the mandate to provide a vision and strategic plan for rehabilitation services that meets the needs of payers, administrators, service providers and consumers. Develop minimum standards for rehabilitation services at the provincial, regional and community levels. Develop standardized outcome and performance measures for rehabilitation services. Develop a human resources plan for rehabilitation providers.

- Patients and their families should be encouraged to report experiences regarding treatment or services they received while in hospital. These reports would be made directly to a department within the health ministry. Additionally, all front line health care staff should be encouraged to anonymously participate in a yearly survey facilitated by the same department. Who better than patients and front line health care staff to provide information of what is really is going on in the hospitals? Utilizing the data received, government would be in an ideal position to bring forth the concerns (and praises) that have been expressed with the health authorities. This in turn would allow the health authorities to bring these issues to the individual hospitals and give them the opportunity to address them.

- Have a patient bill of rights.

- Draw from the experience of patients.

- We need whistle blower legislation to protect staff and families who push for answers regarding quality of care and patient safety. It needs to be an official and easily accessible avenue of communication.

- Develop an understandable feedback loop to inform doctors, government, the general public, patients, administration, nurses, and so on how to improve the use of our health care system.

- Issue report cards by patients about doctors and emergency care and customer service cards to comment on service.
• Ideas about coordinating patient care:
  • Undertake a policy review regarding transfers between facilities.
  • A ministry dedicated to provide services and healthcare to seniors and committed to ensuring collaboration between branches of the Ministry of Health, the health authorities and community organizations would support greater opportunity for collaboration, an end to duplication, and accountability for funds expended through tax dollars.
  • Somebody mentioned that something is initiated and nobody knows what happens. If you go to the Mayo Clinic there is somebody who is put in charge of your file when you walk in the door. Somebody follows your file all the way through. You might only be there two days. But when you are finished, they make sure that you have seen everybody, that all the tests are back, and the consultation note is out.
  • We need investigative experts or a team to act as soon as there is a suspicion of cancer.
  • There should be a breast cancer diagnosis to plan in one week.
  • Adopt over-capacity 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.
  • Direct people to where there is less wait.
  • You need continuity from diagnosis to treatment, including coordination between practitioners and improved information flow.
  • We need to include a rehabilitation perspective in the emergency room.
  • Using community nursing, take groups of patients and walk them through the system.
  • Group patients and the types of care to be delivered in a coordinated way.
  • Streamline the integration and coordination of services for both seniors and the chronically ill.
  • Increase the interaction between hospitals and family doctors.
  • Good discharge planning is required.
  • Involve more ethnic organizations to help patients cope with language and cultural differences.
• Implement a middle person between the doctor and patient to improve communication. People will organize visits to the doctor, medications, personal care, tests and so on.

• One of our problems is publicizing and then rolling out what is working well. For example, there has been a lab callback program in Kelowna that has been very successful, and it has been in place probably about four years but has not been rolled out to any other labs yet. This is a private lab and they have got all their physicians signed on, and they have got their patients signed on. If you have diabetes, every three months you get a notice to come in and get a A1C test and results get sent to both you and your physician. And if there is a problem, there is a little note that says that you should book an appointment. The patient then needs to call to book an appointment. So it works in terms of managing the secondary prevention piece, that somebody else is actually doing that coordination rather than the physician.

• Merge the Ministries of Health, Social Services and Children and Families because integration leads to communication.

• Flag at-risk and heavy-use patients and provide them with a care co-ordinator.

• Try to combine lab test requests into as few separate visits as possible, thereby aiding in a faster diagnosis.

• Early diagnosis can improve treatment, efficiency and effectiveness.

• An independent panel could review decisions made by specialists and hospitals, investigate conflicts of interest and review manipulation of wait lists.

• Ideas about access and demand management:

  • Go back to addressing the sources and causes of demand through a systems orientation.

  • We should look at innovations that manage demand.

  • Educate people so that their expectations of the medical system are lower.

  • With the pressure on the healthcare system, we are going to have to make sure that whoever gets access to the public purse is providing clinically effective and cost effective treatment.

  • Close acute care beds, stop hangnail surgery, lump and bump removal and all the unnecessary procedures that cost the system so much and contribute so little to health care.

  • Our goal should be to make the best use of all the community resources in the health care system.
• Mobilize laboratory services.
• Create specialized clinics to push through high volume operations and speed up wait lines.
• More mental health clinics are required.
• There should be a colonoscopy program for those over 50 and more screening for skin cancer.

• Ideas about service and facility availability:
  • Provide treatment options and training for physicians to allow treatment to be decentralized.
  • Implement a northern regional health centre with specialists.
  • Why not let the testing units be used in off-hours by private practitioners, for a fee per hour for the lease of the equipment, to perform tests on people who are prepared to pay.
  • Why do we not have mobile screening and testing facilities as they do in Washington?
  • More diagnostic facilities should be made available at clinics.
  • Utilize specialty medical or surgical centers where equipment and health care people can be more efficient with much improved results.
  • Make Medical Resonance Imaging machines (MRIs) available. Have them privately-owned, but the service paid for by public funds.
  • It would be helpful to have an experienced soccer Mom scheduling the specialist's time. No one should have to wait two hours in a cast clinic when they have an appointment. Yet everyone does wait. It turns out they book three patients for every 15 minute time slot and they get delayed every day as they take emergency room patients first. If it happens this way everyday why not change the way this is scheduled? The patient's time is just as valuable as the doctor's.
  • Implement a leadership role for the G.F. Strong Rehab Centre (or its future replacement) as the Province's main provider of tertiary adult rehabilitation services, including: transparent and equitable access for citizens of all regions in the province based on need and appropriateness; leadership in rehabilitation research, education and professional training; and, support for regions through outreach, education and dissemination of information.
• With regard to the suggestion that walk-in clinics extend hours of operation to 24 hours a day and seven days a week, do we have a sense what the peak times are? Could we adjust hours to accommodate peak demand, rather than jumping to 24 hours a day and seven days a week?

• Health services need to work beyond business hours.

• Increase services and equipment available.

• Look at having surgeries and services working later and on the weekend.

• Implement specialty hospitals or licensed facilities to take care of chronically ill seniors and those near death.

• Make available a direct phone line in emergency departments to the nurse hotline.

• We need more and smaller options for health care rather than hospitals.

• Implement clinics for pap tests, sexually transmitted diseases (STDs), and sexual health. These would be open in the evenings and provide information on options for sexual health.

• Until a fully-staffed, centrally-located regional hospital is built in the West Kootenays, transport the stroke patient by air ambulance to a center that offers TPA (a thrombolytic medication or clot buster) treatment or, arrange for a patient to receive a Computer Axial Tomography (CAT or CT) Scan and necessary examination and treatment in the Kootenay area.

• Put the nurse hotline on the back of CareCards.

• Separate acute care and chronic care facilities.

• Create more global non-profit clinics with a prevention approach.

• Urgent care would have diagnostic facilities located in a hospital with a large and well-organized triage system.

• Implement streamlined emergency clinics operating 24 hours a day and seven days a week for basic services.

• 24 hours a day for clinic operating hours is unnecessary. Four o’clock to ten o’clock in the evening are the peak hours.

• Ideas about innovation:

  • Implement start up funds for reengineering systems. Funds should be available for programs with a solid three year payback and ongoing savings. Initiatives should demonstrate the ability to improve outcomes.
The Ministry's innovation awards are really good, but not very well publicized. They recognize innovations, but no one is aware of the awards or who receives them.

Frequent changes in leadership reduce the ability to follow through on working, effective initiatives.

Implement a rehabilitation secretariat or a health care professional secretariat that provides advice to the minister before money is given out so that nothing is overlooked.

With regards to improving the system, we need to start small with initiatives that are proven and have been shown to make a difference and begin to utilize those in pockets within the health authorities to influence how people operate differently and change their practice.

They figured out in the United States, in intensive care units, that if you control the blood sugars, your death rate plummets and the length of stay plummets. With all of these $5,000 a day services, it is amazing how sometimes the simple things will get you such a huge payoff.

Establish a blue ribbon panel for health care that would be a decision making body that could make recommendations to government. It would be composed of experts from across the health field and also include cross-provincial representation. The panel would report to the Minister of Health. It would address the issue of costs in health care. The notion of having a non-political, but strong evidentiary base of experts to help shape and guide the development and delivery of older adult services for British Columbians is still what we are looking for. You need the ability in that group to analyze everything and to come up with the best case scenario, not just based on feeling or wants, or this is best so we should do that. It has to be a group that can be questioned at any level and be able to substantiate what they recommend.

What we need to do is have more leadership and strategic direction at the provincial level: some kind of innovations council, a body that has a governance structure that is very broad-based, that has a lot of legitimacy that looks at best practices and evidence, that does teaching that looks at what is really working out there. It would really look at the cost effectiveness issues with a lot more focused attention. This is not happening in the individual health authorities because there are not enough resources.

The experience of Alberta is a good one. Over the years they have had ongoing blue ribbon panels advising their government around services for seniors. They are not perfect, but they do some things very well. In Alberta long term care,
there was a quality crisis that then caused the Auditor General to come in and do a report on all long-term care facilities in Alberta, which then caused a whole bunch of recommendations. I do not want to have to wait until we have the quality crisis before somebody says we had better do a review of this.

- I think that innovators in hospitals should not be made to feel like they have to creep around the walls of the hospital and be termed a maverick. We have discouraged innovation because we have tried to make people toe the party-line and do the right thing because we are all concerned about safety.

- We need to encourage and resource innovation. That innovation could be as basic as a palm-pilot type of tool that collects information at the point of care, to all kinds of other operational and technological innovations.

- The system has to be prepared for ambiguity and messiness because you are going to have the very traditional stuff that is not going to shift and you do not go there first. Then you have this really engaged group and you have got to be ready to shift parts of the system. That is where the tension starts emerging and it gets complicated to know how far to go while at the same time allowing it to be a voluntary grassroots process.

- Targets, incentives and battles are the determinants of change. In this country, we never set targets and if we do we set them nine years out and we are careful not to define what they mean. It lets people know they can relax, that the change is not serious.

- Create an arm's length group that approves innovative ideas and programs. They could evaluate the data and evidence and encourage sharing of programs and innovations.

- Implement a performance management system that drives behaviours based on client satisfaction and a social model of care (complemented by the traditional and somewhat existing medical monitoring and measures).

- Ideas about information:
  - Government should provide a report on where the cut-backs ($2.2 million) benefited the system. For example, how did they benefit home care? Do we have improvements in acute care as a result?
  - Develop a directory of services in the phone book and have a general information phone line.
  - Generate a central database of services across regions.
  - Electronically track patients between services such as walk-in clinics or NurseLine to emergency rooms using tracking identification.
• There are confidentiality issues. If a primary care physician wants to get their data from the hospital, whether their patients were admitted or not, there are hoops to go through as a result of rules around confidentiality.

• Educate the public about available resources.

• Develop a set of standards that must be adhered to regarding the release of information to patients and families.

• Have more communication with the families of patients.

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

**Concerns and Comments**

**Evidence-Based Programs and Studies**

**Pilot Projects, Best Practices and Implementing Success**

• Comments on evidence-based programs and studies:

  • There is a need to stop the advertising and impressions people get from studies and reports that are so-called scientifically proven. Then a month later another scientifically proven study reports the opposite.

  • There is a lack of Aboriginal mentoring support to develop evidence-based products and increase research report capacity.

  • If we are going to be moving ahead and making major changes in our thinking, one of the overlays we really want on that is a strong evidence-based scientific evaluation before and after we implement ideas. They should be evaluated to a high standard.

  • We talk about evidence-based decision-making as in determining what everybody else has done about a particular problem. But the other type of evidence is needs assessments. We used to examine what were the problems people were having, what were the needs, what were some of the dynamics that were part of it, and then you went to solution-based approaches, looking at the resources that we had. So we addressed those needs with the most effective way to responding to them. And what would be the desired outcome. If it is works, which it does sometimes, then you have your own evidence-base. But there are other models for how you can get at the solution, other than waiting to see what somebody else does.
• Comments on pilot projects, best practices and implementing success:

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

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

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

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

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

  • Royal Inland Hospital in Kamloops should be examined closely, for I have never encountered a better run or more efficient hospital. Appointments happen on time, there is little waiting. Someone has that hospital very well organized. Perhaps put that person in charge of more hospitals!
• We do an absolutely awful job of collating and pulling together peer-reviewed best practices that can be shared across our country.

• If we keep doing the same things and expect better outcomes and better results, we will be sorely disappointed.

• What is clearly evident is that we do not understand the research that is already out there. We are not distributing or disseminating that information to everybody. We are not applying it very well in the decisions we are making. We are not evaluating what we are doing in the system. And there is, actually, a strong resistance by many professional groups and by government groups to undertaking evaluation.

• These days, you cannot get a project up and running in the developing world unless you have a formal evaluator on your team and formal evaluation processes in place. These are absolutely essential. And yet here we are, the clever developed world, where we rarely include evaluation in most of our policy decisions.

**Ideas and Suggestions**

Evidence-Based Programs and Studies
Pilot Projects, Best Practices and Implementing Success

• Ideas about evidence-based programs and studies:

  • We need to work towards a system that runs itself by encouraging a creative environment that identifies its own needs and finds solutions.

  • Promote rehabilitation research and training to improve the availability of evidence based, cost effective, and high quality rehabilitation care to citizens of British Columbia. Encourage world class innovation that will bring economic benefits to British Columbia.

  • Create evidence-based and best practice programs.

  • Look at the model in the United Kingdom, namely, delivery councils, which are multi-disciplinary teams that operationalize various initiatives. These councils gather budget from different levels of government to implement initiatives. While one level or delivery arm is the lead, delivery and operations are at the local level.

  • Research needs to be re-focused so it is not just about the current medical model, which is only a pharmacological model. Do not focus on technological solutions. Think outside the box.
• We are committed to the current public health care system and to strengthening it to include evidence-based complementary medicine and preventative medicine.

• Encourage behaviour change research.

• We need more health policy based on health research which is evidence-based.

• Make clinical phase three data public.

• If we have ideas that we want to bring to the table, no matter from what political end you come from, be prepared to come to the table with factual evidence that what you are saying has worked somewhere else.

• Adopt a national best-demonstrated efficiency-sharing symposium and repository.

• Ideas about pilot projects, best practices and implementing success:
  • Release more information on positive experiences.
  • Implement a return to honest, factual scientific integrity to replace present public relations propaganda.
  • It is important to focus not only on innovation, but on making innovative ideas available to everyone so it does not need to be re-invented.
  • We need to celebrate innovation and success.
  • Search out the best practices and have the intestinal fortitude to implement them regardless of vested interests.
  • Look carefully at the studies that have been done by the Senate, because the recommendations that have come forth are non-partisan and seek to find solutions, rather than seeking political gain.
  • Change the mandate of the Ministry of Health to invest in research that has practical outcomes for health care in the province.
  • Academic centres should be assigned responsibility to identify and translate best practices across all health authorities.
  • Health authorities could collaborate on evidence-based care, and could be given the mandate to develop best practices in a certain area, and disseminate the information to other health authorities.
  • Pay the best ten physicians to travel around the Province to rotate the excellent physicians.
• The Ministry of Health should work with the British Columbia College of Family Physicians and other groups to develop a British Columbia Quality Outcomes Framework, followed by the institution of pilot programs for assessing and recognizing quality in practices, with a view to raising the profile of the elements of quality, acknowledging those who have committed to addressing quality and meeting defined standards, as with accreditation in other health sectors.

• Set deadlines for implementing policies systems-wide based on successful demonstration projects.

• Look in British Columbia first (the world comes to us now).

• Develop innovation around a defined need.

• Assign funding backed up by strong evidence-based information.

• Match demand with access (both the type of care setting and the type of health care provider) across the continuum of services through prevention, resource management, trend analysis (demographic, age, ethnicity, gender, disease and health profile) and collaborative care models.

• Planning about best practices is not the work we do today. We must invest in learning environments and change.

• Make sure it is evidence-based and has a real life application to any ideas for access.

• We need to stop treating the application of new knowledge into the health care system as a project. To be sustainable, ongoing and long-term efforts and focus are required.

• Recognize our best practices and resource them to spread them out in a useable format. Research entities need to be linked, smart, accessible, timely, and funded appropriately.

• Form a centre for best practices. This can be under the Canadian Institute for Health Information, or the Canadian Institute for Health Research.

• Implement specialized surgical services within the public health system.

• Centers of Excellence for certain types of care can work well at the tertiary level.

• Use studies and pilot projects to test new approaches.
Capital Planning, Infrastructure and Equipment

Concerns and Comments

Planning
Facilities and Equipment Management
Procurement

• Comments on planning:
  • There is a lack of accountability in the cost of construction. An evaluation of the actual costing during and at completion of a project should be performed to determine if the actual construction was in line with the proposal.
  • They are building hospitals without kitchens, and trucking in airline food.
  • We need to look to real estate professionals to assist with managing valuable assets. It is possible that the university model for infrastructure management and revenue generation may offer some possibilities.
  • We should encourage increased collaboration provincially and federally in the area of capital asset and infrastructure planning and management. In addition, there should be defined protocols and standards between health authorities.
  • We see that hospitals are built and used with the 98 per cent occupancy rate as guidance for administrators. This is an unrealistic figure when it comes to influenza and other sudden illnesses. Everyone shakes their heads when people are harboured in halls and storage rooms while the administrators shine with a fantastically efficient operation.
  • There are more meeting rooms in hospitals than there are wards.
  • Physical facilities for delivery of rehabilitation services are aging and there has been no capital planning for replacement.
  • Look at models like Australia, where a non-urgent care clinic is included in the hospital. In one case, the emergency room admission and non-urgent care admission were across the hall from each other.

• Comments on facilities and equipment management:
  • Facilities are out-dated.
  • Medical Resonance Imaging scanners (MRIs) are not always needed for diagnosis.
  • It doesn't make sense to me to have empty operating rooms, beds and down time on expensive diagnostic equipment that could be running around the clock but for the fact that we don't have the public funding to staff and operate. Surely with
careful consideration and planning there is a way to utilize our full potential for
the betterment of all public access to health care.

- We have no automated lifting. Vancouver Coastal Health needs $30 million to put
  in more ceiling lifts, and if we do that we will have only just managed to cover our
  high-risk beds, not our low-risk beds. The City here has just automated garbage
  collection so that garbage men do not have to lift those big containers. And yet,
  we have still got ninety pound nurses attempting to lift patients that are over two
  hundred pounds.

- In terms of the standard of maternity care at Lion's Gate Hospital, the staff is great,
  but the physical aspect of the department is very poor and can add to the stress of
  a labouring woman.

- Our health system is very frustrating especially with all of the money that seems to
  be being wasted in the management end of things. We need to have smart,
  accountable, innovative, and experienced people running our health system, not
  people who think it is a good idea to bring in pre-cooked food from another
  province and reheat it for the patients, or who think it is smart to send our hospital
  laundry to Alberta.

- I think St. Paul's hospital charging money for Medical Resonance Imaging scanner
  (MRIs) usage after hours is an excellent idea. If the resources are there, why not
  use them to bring in badly needed funds.

- Medical Resonance Imaging machines (MRIs) are difficult to access and are not
  available 24 hours a day and seven days a week.

- There is a legacy of huge hospital complexes that have been shown from a
  number of points of view to be inefficient, sometimes actually dangerous in
  concentrating certain pathogens, and rigid in the expression of professional
  leeway in making medically sound judgments. In short, large hospitals suffer from
  the same impediments that can be seen in all bureaucracies; moreover, other
  models exist that provide the same services in a less centralized way, better and
  cheaper, but this can only be co-ordinated under a public medical care model.

- Hospital administration costs far too much. I have seen a $15,000 fish tank (with a
  weekly maintenance contract to accumulate more costs) installed at a human
  resources office to calm the staff.

- Comments on procurement:

  - A local private surgery outfitted its recovery room (tables, lamps, care carts,
    blankets, linens, curtains and so on) and even some of its operating room items
    (for example, carts and storage bins and the like) with items from IKEA. They did
this at a mere fraction of what the hospitals pay. The hospitals purchase from approved medical companies who charge five and six times the real value of the same items.

- Our daughter, who is an intensive care unit nurse in the United States, told us the hospital she works in does not use dressing packages that are as expensive as the ones we were getting. Half of the items in that dressing package were not used. That seems to be such a waste as those sterile dressing packages must be expensive.

- It is important to provide the market in British Columbia with access to the latest developed technologies and devices, which are more easily adopted and propagated in other jurisdictions. Barriers in British Columbia are mostly due to the current funding structure and actual disincentives that exist around adopting new technology.

- Should we be purchasing costly designer drugs rather than generic ones?

**Ideas and Suggestions**

**Planning**

**Facilities and Equipment Management**

**Procurement**

- Ideas about planning:
  
  - Infrastructure should be built for the future, understanding the need for flexibility while still meeting standards. For example, flexible and modular designs may enable health authorities to respond to changing needs and technology using their same infrastructure.

  - Match the needs of patients with the capacity of facilities.

  - Re-visit hospital layouts.

  - The clinic under construction in Lytton could be expanded.

  - The cycle time from planning to occupancy of new facilities should be reduced by half.

  - Minimum care facilities on hospital properties can be connected by tunnels and electric carts can be used to transport patients between buildings.

  - We need to look at both funding and the availability of providers when we are developing capital and operating plans. You could build a $100,000 million hospital but not have anybody to actually delivery service there.
• Develop a long-term plan for capital investment in rehabilitation facilities at the provincial, regional, and community level.

• Ideas about facilities and equipment management:
  • Re-use public facilities (such as schools and hospitals) that are closing down for retirement centres and wellness or seniors’ facilities.
  • There should be a centralized record system for medical equipment.
  • Our society tends to focus on what is big, expensive and dramatic, like the latest wonder drug or piece of medical machinery. Often the things that are cheaper and less fancy are more effective.
  • By investing in more cost-efficient, less invasive care, we can not only save lives, but save money.
  • Diagnostics must be controlled within the public system with national guidelines about when it is appropriate to use each kind of diagnostic test or machine, followed by quick access to the specialist so tests will not need to be repeated.
  • We need to take into consideration all the newest research and technologies, and we need to make new treatments and methods available and consistent across Canada.
  • Equipment needs to be standard so all staff know how to work it and it should not be user-specific.
  • Get rid of private food and housekeeping in institutions: it is inefficient.
  • The main focus here is hospitals since they use constant power 24 hours per day, every day of the year. The amount saved could be re-directed to other areas of the healthcare systems including staffing. Use wind power, with electricity from the city grid as the backup. Install motion sensors equipped with bypass switches in rooms or hallways where vacancies could occur. Turn off all computers or set them to sleep mode when they are not in use. Use energy saving washers and dryers. Install heat recovery systems. Explore new telephone systems. Seek volume discounts at couriers.
  • Evidence clearly supports the contention that there is testing equipment sitting idle in hospitals (and would most likely be made available in clinics) that could be made available for those willing to step out of endless cues to purchase testing services. This provides more timely medical service to all concerned.
Currently there are facilities for mammograms. Expand this department to include Pap Tests and other female related tests. This would assist physicians by eliminating these tests from their daily routines, resulting in reduced costs and assisting the doctor’s office to run more efficiently.

Implement specialised services clinics for types of surgery, such as hips, knees, and hearts (similar to cancer treatment centers). These would be co-ordinated by the public health care system.

We need different kinds of health centres, leaving the hospitals for long term care or for major health issues.

Non-urgent care centres, similar to the one at University of British Columbia Hospital, should be installed in walk-in clinics central to each neighbourhood. The key is visibility and the capacity to treat all non-urgent conditions. This will assist people in choosing that option over going to the emergency room. Should their situation require a trip to emergency the Nurse Practitioner or doctor at the walk in clinic can advise this, and call the closest emergency room to smooth the way for the patient.

Get up-to-date equipment in hospitals.

British Columbia has the opportunity to create a regionally based health technology assessment system led by the provincial health region. The individual regions could be the assessment arm for provincial medical device funding decisions.

Implement more efficient utilization of equipment and facilities (24 hours a day).

Undertake a per-use-per-day study on equipment such as X-ray machines and scanners, and on operating rooms in all major hospital facilities in order to maximize usage of public investments.

Move away from tendency to use the equipment just because it is there, and create guidelines for the use of diagnostic equipment.

Train diagnostic equipment operators so the equipment can be made available twenty-four hours a day and seven days a week.

Mobile services could address demand issues:

Instead of using hospitals for care and services, provide suitable services delivered by nurses and technicians in a mobile unit.

Implement mobile units equipped with up-to-date diagnostic tools.

Implement mobile medical services that can provide some non-life threatening, non-emergency services.
• Ideas about procurement:
  
  • Develop a new $60 million fund, not restricted to major capital purchases, but also used to acquire any medical device technology that would improve the health of British Columbians. Create accountability in monitoring the fund’s distribution and the technology assessment that is built into the medical device technology fund. The provincial government would provide templates and frameworks developed by the Canadian Agency for Drugs and Technologies in Health (CADTH). These templates would be used by the clinician to enrol patients in the field study program that measures the effectiveness of the technology over the period of that program. Upon completion of these assessments, the government would have evidence as to the value of the technology and could then determine continued funding. In effect, create conditional reimbursement. The Ministry of Health should establish a consultative process with the MEDEC (Canada’s Medical Device Technology Companies) to develop the parameters for an ongoing program to help British Columbians receive the technologies that they and their healthcare providers have determined as best for them and to maximize the offset to the PharmaCare Program and regional budgets due to use of device technologies. In addition, the fund would alleviate clinicians' concerns and their patient care decisions that are based solely on cost. Finally, the fund would stimulate the home-grown medical device industry in British Columbia.

  • There is an opportunity to be more strategic in adopting medical device technologies that would be beneficial to patients in British Columbia through funds made available for technologies that come to market outside of the normal budget cycle.

  • Save money and time by purchasing used equipment.

  • Technology should be centralized to lower costs.

  • Get portable equipment not tied to hospitals.

  • Government should be bulk purchasing software programs for people with disabilities.

  • Items such as hip protectors, which cost $100 plus per pair when bought in small quantities from medical supply outlets, could probably be purchased in bulk from suppliers at greatly reduced costs so that all residents would then be able to purchase them from the facility at reduced costs.

  • British Columbia has the opportunity to create a regionally based health technology assessment system led by the provincial health region. The individual regions could be the assessment arm for provincial medical device funding decisions.
Administration and Management

Concerns and Comments

General System Administration
Administrative Processes
Administrative Personnel
Scheduling and Personnel Management
Referral System

- Comments on general system administration:
  - There are too many jurisdictional layers in the Canadian health care system.
  - I feel that the financial chaos, person-power deficiencies that our medical system has developed to date along with the thrust to privatization is primarily due to political government management and controls set forth to basically protect a system process that is clearly not working to maximize human health, thus facilitating a no-win scenario.
  - There is too much costly administration.
  - Doctors spend time on generic administrative tasks.
  - The focus is on the bureaucracy rather than on service to the public. As a result, there is very little reporting on efficiency in the system.

- Comments on administrative processes:
  - Between five and ten per cent of consumable items that carry a use-by date were wasted due to poor stock control processes. If appropriate logistics (inventory control), stock rotation (first in first out) and moving items appropriately within each department or establishment were used, much of this wastage could be eliminated.
  - The administrative workload is huge. There are six layers from the frontline to the top. Administrators should be supporting the clinicians, but right now it is the other way around.
  - Even the most routine services involve a multitude of steps, forms and people. All of these steps consume valuable staff time, which could be better spent delivering patient care. These steps compromise quality and create opportunities for mistakes.
  - Interior Health uses different lab forms at different locations. Standardize forms at least within health authorities. The different forms are confusing to staff.
• Hospital procedures are ridiculous. You have to be interviewed by admissions people a day or so before surgery. Then you have to answer questions when you are admitted. Then someone comes around and asks you the same stuff in the operating room. Then they give you the wrong medications anyway.

• After the colonoscopy, my wife was wheeled out in front of that area to wait for a porter to come and return her to the emergency room. We waited for nearly half an hour while porters were paged several times. I asked if I or anyone else could take her, but I was informed that they would get in trouble from the union representing the porters if that happened.

• Clinics need to operate differently. You are always treated as a new patient, even you have been there for years. As a result, you are always waiting and signing in.

• In the past 15 years we have gone from individual hospital boards to Community Health Councils, to Health Regions, to Health Authorities. Money, time and energy were spent on each re-organization.

• There are employers that require medical forms to be filled out by the attending physician every two weeks, even if the doctor has specifically stated that the patient will be off for a month or for an indefinite amount of time pending tests and their results.

• When pre-paying MSP billing, a statement is still mailed out. This is a waste of resources and clearly shows the levels of bureaucracy that need to be readjusted.

• The amount of clerical work done by nurses needs to be addressed. At the moment, far too much time is taken doing these tasks. This needs to be transferred down to clerical workers.

• Resources are being put into making hospital policy and protocols in the name of better patient care that can potentially make simple procedures frustrating for staff and thereby taking time and energy away from the patients.

• Because there is no sharing of information between public and private labs, blood test often have to be done twice, double billing the medical plan.

• As an undergraduate nurse working in acute care, I find some simple procedures are made extremely complex and time-consuming through hospital procedures. For example, a referral for a patient to see a wound care nurse consists of requisitioning the referral through the computer, calling the wound care specialist on their pager, office and voice mail and then recording that a wound care consult has been requested in the chart, kardex, care plan and various other forms. This takes away the time nurses can spend caring for their patients and contributes to frustration and burn-out of nurses.
• Business process mapping gets everyone who is affected in the room to go through the business process, and then you look for your efficiencies. And by looking through the efficiencies you can re-direct that energy elsewhere. So you actually build capacity in the system because there is no duplication of efforts.

• I have witnessed and prevented many examples of errors in the timing and application of medications which arose from poor quality records, disorganized chains of command, a lack of management supervision and follow-up, clumsy manual record keeping systems and tired frustrated staff.

• Initial contact screening would be assisted by accessible records. Initial contact with a health care professional is currently subject to too many delays and leads to overuse of emergency.

• Tests not utilized or lost is the most unacceptable waste of resources (financial, human and equipment).

• Diagnosing can be inefficient as a result of over-testing, and turf protection and arrogance by health practitioners.

• One of the things that other industries have done is use the business review process. They literally undertake a very detailed review of what gets done, who touches it, how do they touch it, when do they touch it, and why do they touch it. These are all things that need to be reviewed in order to encourage improvement and innovation.

• Regarding prevention of lost or stolen wheelchairs, affix a six-foot pole to the back of the wheelchair. This will make it difficult for citizens to place the wheelchairs in cars, buses or SkyTrains. Also, position volunteers at entrances and exits of the hospital to interact with patients and monitor wheelchairs as they come and go.

• One of the most powerful sessions in the north was in Quesnel when physicians, the diabetes educators, and home care workers got together with some patients. They were led through the patient journey. The service providers could not believe the journey of the patients.

• There is duplication and misuse of health cards.

• The ongoing paperwork for disability, Fair PharmaCare and the Medical Services Plan subsidy is onerous and unnecessary.

• Comments on administrative personnel:
  • Administration is top-heavy.
  • There are too many costly golden handshake departures.
  • Administrators are desk-bound.
• There is no transparency or accountability on hiring standards.

• How much of the various health authority budgets are made up of administrative and public relations costs? Surely senior administrative staff could handle the odd public relations assignment or have an assistant do it to save costs.

• There is no one managing on the floors or even the operating rooms. There is no one in charge.

• Management has not signed on to regular report cards on their performance and how they compare with their peers here and in other western countries.

• There is too much management in the system, poor communication and power struggles that cause money being wasted and poor utilization of resources. I have worked in the heath system for 30 years and have seen it eroded and made more dysfunctional with administrative changes and managers protecting their turf.

• Administrative personnel drain money from front-line health care.

• Too much time is wasted in meetings, planning sessions and conversations, and not enough time spent in implementing the solutions. The managers are out of touch with what is happening.

• In the business world when problems of this extent occur it is a common practice to change leadership. This means replacing the administration staff starting from the top executives. These people have had plenty of time to resolve the situation, so it is time for new leadership.

• Cars are provided for managers to travel to and from meetings and meals are catered in the meetings. Is this fiscally responsible?

• There have been jobs invented which are not needed. Clinical Nurse Managers do nothing besides sit in their office: they cannot answer questions for you!

• There have been resignations of middle managers due to unrealistic expectations.

• Comments on scheduling and personnel management:

  • There is resistance to the introduction of surgical technicians to assist at the table in place of Registered Nurses. For the cost of two Registered Nurses, we would be able to hire three operating room scrub technicians.

  • When receiving pre-operative physiotherapy in a warm water pool, there were only three of us in a pool that was meant for ten. This calls for a more efficient booking system so that the facility can be fully utilized.

  • Doctors or their secretaries should be trained with a program to schedule patients in for future visits. The system should alert the doctor so that they are aware of the
scheduled appointment and if they need to contact the patient, the patient should be contacted.

- You have got to get more staff into the Medical Services Plan office. There is no way we should be out reimbursement money for over eight months. The people who are submitting receipts for reimbursements are the ones who can least afford to be out that money, and shame on you for not doing something about this very serious problem.

- Compare twenty-four hour or even twelve or sixteen hour home care to round the clock acute care bed.

- Comments on the referral system:
  - A visit to a general practitioner is required in order to receive a referral to a specialist, even when the visit to the general practitioner may not have been necessary.
  - Patients who visit their optometrist for diagnosis of simple eye diseases, often at the request of a general practitioner, must then be referred back to a physician for further diagnostic tests or a prescription to initiate treatment. This inefficient process delays treatment, inconveniences patients, and is wasteful of health care resources.
  - There are long waits to see family doctors followed by long wait times to get the appropriate laboratory and diagnostic testing and then a long wait to see a specialist.
  - There is no accountability for cancellations, rescheduling, authorisations for appointments or surgical procedures.
  - There is no transparency in the process of referrals between practitioners.
  - Infrastructure and access to facilities is inadequate for specialists to be able to perform surgeries.
  - In addition to an inefficient referral system there is too much bureaucracy in the health authorities resulting in unnecessary travel and additional assessments by new doctors.
  - Patients have to go to a family physician each time they need a referral to a specialist, even when the specialist advises the patient that they must return on an annual basis.
  - It is a waste of time and resources to require a family doctor to write referrals to specialists when the patient knows what is wrong.
  - There is a lack of rehabilitation services post-surgery.
• The pre-requisite to seeing a specialist that has had a patient under their care for a number of years is a recommendation from the patient’s General Practitioner.

• The current system of tracking referrals is very poor.

Ideas and Suggestions

General System Administration
Administrative Processes
Administrative Personnel
Scheduling and Personnel Management
Referral System

• Ideas about general system administration:
  
  • Use a quality improvement approach to managing the system, thereby improving administrative practices and service delivery.

  • Use energy saving washers and dryers and a lower water temperature. Install heat recovery systems to re-direct lost heat from ducts and boiler exhausts. Install motion sensors equipped with bypass switches in rooms or hallways. One or two ceiling lights can be running constantly, bypassing the sensor, if safety is a concern. Purchase and install wind turbine(s), with the city grid as the backup. If we generate more power than we need, we can sell it!

  • Build in continuous efficiency reviews of the entire health care system.

  • We need to be able to look for those innovations and trust the people charged with implementation to be able to make those innovations happen. Though process like this can help facilitate that, they can also interfere with it. We have to distinguish between governance, management and service delivery. It is worth reminding government that political leadership includes setting direction. They are not being elected to micromanage.

  • We require easier transfer and portability of health records between health authorities.

  • Set up a proper purchasing office in hospitals or provincially.

  • Address the bed shortage by utilizing off-site more appropriate beds and supports.

  • Standardize services offered by walk-in clinics, and improve available information about services offered.
• Look at the BC Cancer agency triage model to see if the template could be applied elsewhere.
• Create a system to refer seniors to available programs.
• Health care professionals need to be provided with the tools that enable them to make proper and quick diagnoses.
• Link existing small programs to increase efficiency.
• A triage person should make the first stage diagnosis. There is no fast tracking happening in emergency and no consistent assessment in emergency. Nurse Practitioners could perform this task in emergency.
• Employ video conference specialists to assess patients and assist with rural care.
• Some clinics are doing triage before sending people to hospital emergencies. This should probably be the rule rather than an exception.

• Ideas about administrative processes:
  • Use a management program such as ISO or Q-Base. This would move the health care system towards addressing non-conformities in employee training, dealing with vendors, dealing with patients and other customers, and putting in a system of continual improvement.
  • Health care is a service business, so it should be administered like one: be efficient, be practical, and meet the goals of the plan and the needs of those who pay for it first and foremost.
  • Offer annual awards for medical workers who offer ideas that result in substantial savings for health care. These workers know the systems the best.
  • We need a more efficient management system to free up funds for health care workers.
  • Legislation should be implemented to limit hospital liability. Nursing staff currently spend more time than necessary checking up on patients, and recording same, in order to protect the hospitals against possible liability.
  • Naturopathic doctors and doctors of chiropractic should be able to order tests.
  • Develop a form for the patient to fill out before visiting a physician that would ask for the medical reason for the visit along with a list of current symptoms. It could either be electronic or on paper (for those without computers). This would assist the doctor and the patient to find the medical problem, and would expedite visits.
  • Establish an on-line system to allow patients to compare time for elective surgery at various hospitals. Patients who are healthy enough, and have adequate
financial resources, can go to facilities where waiting times are less, which would help to balance out the workload of institutions.

- Perhaps Pharmanet or some other information system could be utilized to streamline protocol around the issue of maintenance medications for hospital patients.

- Bring a business focus to health care management.

- We need to create centralized services for non-care support, such as information technology. These services, including technical expertise around human resources, should be provided provincial wide.

- Bulk purchasing of pharmaceuticals. Bulk purchasing of all hospital supplies.

- Stop theft in hospitals.

- Assign case numbers, track doctors recommendations and follow up. Focus on complex care instead of acute care.

- Make health care practitioners accountable for the supplies they use.

- Streamline paperwork in the acute care setting for minor or less severe cases.

- Eliminate translation services in 130 languages and focus on the two official languages.

- Stop reorganizing the administrative framework and focus on patient care.

- Patients should sign an acknowledgement of the receipt of test results, so we will know if they got to where they needed to go.

- Give doctors greater access to diagnostic tests.

- Allow the public to make suggestions for planning and spending. Ensure greater openness as to how decisions have been made.

- Every single health insurance card would have the picture of the cardholder, as well as a computer-readable identification strip.

- Ideas about administrative personnel:

  - Re-organize the health ministry under two Assistant Deputy Ministers. One responsible for sick care, which is virtually most things you do now, the other responsible for real health care (promotion, education and legislation). Cap spending on sick care at present levels and target expected budget reductions of one per cent per annum over the next 20 years. As people begin to take more personal responsibility for their own health, demands on the system will be dramatically reduced. State clearly how and where you will re-invest savings.
• Streamline transfer functions so physicians are used for their expertise and others can do more minor functions.

• Senior administrators seem to have just do what they want and when things are not successful, they get pay outs. It is rewarding inefficiency.

• Consider persons trained in hotel management for hospital administrators.

• Reduce bureaucracy, and put more resources into delivering real care for senior members of society.

• Control the bureaucracy in order to fund the system.

• Invest more in management training.

• Decrease the administrative burden in order to lower costs, but ensure that we have better qualified and sensitive administrators.

• Re-organize to eliminate costly top-level administrative positions.

• Develop well-trained, well-mentored, and efficient administration.

• When management is fired, there should be no payouts.

• Hire people that know the job and have pride in their work. That is the bottom line. Stop hiring your friends.

• Managers provide their own vehicles and meals, as is expected of their staff.

• Reduce the numbers of health care managers and then the remaining managers must be given the authority and support to efficiently manage, and that includes the best utilization of workers and resources.

• The Chief Executive Officers of hospitals will be rated and evaluated once a year on efficiency and care delivery.

• No more political patronage jobs for Chief Executive Officers of hospitals.

• Manage hospitals efficiently by hiring independent consulting company to dig out loopholes and inefficient methods.

• Ideas about scheduling and personnel:

  • Operating room scheduling could be more efficient and be on time. For example, administer anaesthesia in the holding room to save time. Do not allow empty operating rooms. Have a separate operating room for emergencies.

  • Government and health authorities should expand operating room capacity in public hospitals by: a) designating new Scheduled Procedures Only operating rooms in each health authority for chronic lengthy wait time procedures; b) conducting efficiency reviews of current operating room scheduling and logistics
that include input from all staff (including booking clerks, porters, nurses and surgeons); and, c) where feasible, eliminating hospital corporate days that involve closures of clinics, operating rooms and ward staffing.

- Improve utilisation and scheduling of the existing facilities and services.
- Implement a Radio Frequency Identification (RFID) monitoring system to track missing wheelchairs.
- A surgery that may go overtime is not allowed to start because the hospital would incur extra payment for nurses and support staff. Thus a significant proportion of the operating rooms are not being used efficiently: they are lying idle while patients wait. The private surgical clinics are able to work more efficiently and see patients more quickly because they have no such bizarre restraints.
- If people on long wait lists for tests would agree to go for tests in the middle of the night or early morning it would very much shorten the lists. The medical machinery for all tests is in the hospitals 24 hours a day. All that is required is to hire technicians to work night shifts.
- We need a responsive screening system that anticipates a number of abnormal results and related scheduling needs and develops a fast-track system to access services.

- Ideas about the referral system:
  - Create one-stop evaluation and treatment clinics as pioneered in Alberta for orthopaedic and hip replacement procedures.
  - Stop letting specialists waste time by calling patient two weeks before an operation; this duty should be handled by a trained receptionist or licensed practical nurse.
  - We need more efficient protocols for referrals. Revamp the referral system to save money.
  - Implement a graduated referral and treatment regime by using other health care professionals to make referrals to nurses, nurse practitioners and doctors.
  - We need standard of care of specialists to make sure that practicing specialists are staying current and providing a consistent standard of care to patients.
  - Require competency-based evaluations of specialists.
  - Accountability and quality assurance has to be implemented to ensure that the general practitioner and specialist follow through with their assigned responsibilities.
• British Columbia needs a transparent process to provide the public with information regarding treatment options and the risk associated with each option.

• Look at ways of stream-lining the referral system, such as having the family physician less involved once a specialist starts handling a case.

• We need a province-wide referral base that divides patients based on their ability to travel. Are they able to travel anywhere in the Province; can they travel anywhere in the health authority or are they only able to travel locally? Each patient would then be assigned a triage number and the next available appointment would be offered based on the patient’s indicated level of need and ability to travel.

• Establish criteria for some surgeries as we cannot all afford to have a hip replaced.
Information Technology, E-Health and Electronic Health Records

E-Health and Electronic Health Records were frequently raised as opportunities to introduce innovation and efficiencies into the health care system. Information technology planning, a common health information database, the introduction of electronic health records for British Columbians and the more common use of e-health technologies were all discussed in the Conversation on Health. Here is a selection of what British Columbians had to say on the subject of E-Health and Electronic Health Records.

Information Technology Planning

The key issue raised by participants around information technology is the need for both integrated planning and an integrated information system that would bring together all of the health authorities and the Ministry of Health. Participants are concerned that there is very little consistency now on information technology standards and applications, resulting in different technology platforms that do not talk to one another. While participants understand that costs are associated with introducing new technologies, particularly on a large scale, they argue that proper planning and analysis can result in savings over the long-term.

Some participants suggest that, in the absence of a clear plan, the frequent introduction of new technologies has had undue impact on employees and burdened the system with significant costs, while not substantially improving operations. Others caution that some people may be looking to information technology to solve all the challenges of integrating services and facilities. They warn that, even with these new technologies, people in the health care system still need to work hard to integrate health services: technology alone is not the answer.

Participants recommend that there be a centralized information technology planning process with clear guidelines around the purchase and implementation of new information technology. They suggest an initial investment to achieve integration across the system, which would provide the tools for more efficient health care delivery. They also argue that, whatever the process, there should be a centrally managed short-term and long-term plans. This will ensure that the investment continues to pay off in years to come.
Participants support an overall strategic vision for information technology, developed by the Province and by health authorities. The vision needs to move away from old style information technology conservatism, which is preventing health authorities from achieving its goals, to use of information technology as an enabler of change.

– Health Authority Board Workshop, Vancouver

Health Information Database

Participants criticize the health care system for its lack of sound data on everything from population health to health human resources. This, they argue, means that there can be little evidence-based health care planning, including planning of services, delivery mechanisms or recruitment needs. Some participants suggest that if the system gave general practitioners information about the health of the population they serve, they would be much better able to adjust their services to improve the overall health of that community.

Aboriginal participants argue that, in the absence of sound data about First Nations community needs, they will continually be left out of the mix. The common phrase was: if you do not count it, it does not count.

One suggestion was that the province move to a geographic information system (GIS), which would graphically demonstrate health data, allowing for easy analysis.

Electronic Health Records

The most frequently discussed information technology tool was the electronic health record. Participants are frustrated with the lack of communication between health practitioners and facilities as a result of the inability to transfer or access individual health records easily. While some participants are concerned with the protection of their privacy, most believe that the electronic health record would result in efficiencies in the system and improved patient care. They also argue that privacy concerns could be addressed through security measures that are at least comparable to the measures we have in a paper-based system.

Many participants argued that an electronic health record would make their own health more accessible to them. They would be able to look at their files, for example through a web link, and better understand their condition and how to cope with it. This, they argue, could be a key tool to empower individuals to take control of their own health care.
Encourage the provincial government to develop a closed and secure electronic network system for maintaining patient history, distributing medicine, tracking services, and tracking inquiries to avoid duplications, make treating patients more efficient and therefore make treating patients more cost efficient.

- Regional Public Forum, Burnaby

E-Health Technology

Like the electronic health record, participants look to all sorts of e-health technology to introduce efficiencies in the health care system. They praise existing tools like the NurseLine or the online BC HealthGuide as being effective methods of empowering British Columbians to take care of themselves. At the same time, they encourage the government to better advertise these tools to make them more accessible. Pharmanet was another topic for discussion. Participants criticize this tool for not taking advantage of the possibilities it presents to patients and practitioners, for example, around e-prescriptions.

One idea put forward in a Focused Workshop in Vancouver was the development of an interactive website, named Health Quest, which would provide health care information and coordinate services for patients. The site would provide links to community information and resources based on the inquirer’s area of interest. It would also be able to link inquirers to help lines when necessary. It would consolidate information and be based on sound principles and evidence-based practices. Physicians will therefore know it is reliable. The site would encourage self-care and provide the patient with more control over their own care.

Participants who have been exposed to e-health technologies argue strongly in their favour. In particular, British Columbians from rural areas believe these technologies are the answer to improving services for rural and remote communities. Often, e-health technologies can bring the health care service or procedure to the patient, rather than the patient spending time, money and energy, travelling to specialists. This kind of access for rural British Columbians means timely diagnostic testing, efficient consultations with specialists and less stress on the patient through travel. Participants believe these and other benefits mean keeping more British Columbians out of the acute care system.

I once saw a surgeon operate on a patient, and the doctor’s scalpel was approximately 2.0 centimetres from the patient’s heart. [This was] no big deal. I’m sure that this is done every day in Vancouver. However, in this instance, the surgeon was 1,000 kilometres [away] from the patient.

- Email
Conclusion

Participants in the Conversation on Health, for the most part, agreed that the introduction of integrated information and data systems, electronic health records and new e-health technologies would substantially improve patient outcomes and the efficiency of health service delivery in British Columbia. While there are lingering concerns around protecting patient privacy, the vast majority of participants encourage government to move forward on an agenda that brings electronic innovation to health care in everything from health information databases to remote surgeries.
Information Technology, E-Health and Electronic Health Records

This chapter includes the following topics:

- Information Technology Planning
- Health Information Database
- Electronic Health Records
- E-Health Technology
- Pharmanet and Technology

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Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Innovation and Efficiency; Collaboration in the System; Primary Health Care and Health Care Models.

Information Technology Planning

Comments and Concerns

Current State of Information Technology
Integrated Information Technology and Planning
Investment in Information Technology

• Comments on current state of information technology:
  • The information management technology is archaic and run by highly fragmented organizations, leading to significant safety issues and inefficiencies.
  • You need to do a cost benefit analysis around putting in the necessary information technology. You can save huge amounts of money down the road. Then you get your data and you actually know the health outcomes on so many different levels. We just have to get that.
  • The management system and tools lag private industry. There has to be a better model. Much more efficient computer-based management systems are available.
  • I think we need to be thinking about how our society ought to structure itself in the future and how it will structure itself as information technologies become more and more integral to how we live and work.
  • The use of technology is replacing human caring.
  • All quality improvement gurus will tell you a fundamental core of quality improvement is information technology, and particularly patient-centered information technology.
  • Here is a cautionary note regarding the magical feeling we have about information technology. If we came away with a lesson from the first round of health innovation funding, it was that it is very easy to spend a lot of money on computers and it is very easy to spend a lot of time thinking that we do not have to do the hard slogging work of working together because if we just had an electronic medical record, the gates would open and the future would be set.
• Government could play a role in inspecting some reputable health related websites. They could have a committee that looks very carefully at them, whether they are pamphlets, other kinds of advertising, social marketing, television programs and so on around these sites. The first of all 62 per cent of people of all ages used the internet for health information last year. Even though not all seniors use the internet, it is now getting up to 50 per cent. Then there is their family members who collect information. So it is an area that we can look at and there is real cost benefit here. Although there is need for more research, the cost benefit looks pretty good. It is not that expensive to develop a site for everybody. If you divide up the cost per person, then it is probably pretty low.

• We are actually going backwards as a country in terms of data availability. The movement to alternate funding plans has resulted in a data loss in primary health care. It has never been clarified whether or not the data captured by electronic health records or by practitioners actually belongs to the public system and can be used for secondary data analysis.

• A part of the challenge is you can put technology in place, but the users are the challenge, both in terms of the professionals who have to learn how to work this stuff and consumers who need to understand what the limits of the technology are.

• It is a real benefit in some ways that Canada has such a low uptake of information technology. Now you have a clean slate: you can start from scratch. So you can put in place systems that will work and that are inter-operable.

• Denmark is the most e-health wired country in the world. Everybody in Denmark can log on, look at their health record, see what test they have done, and know when their last surgery was. Their doctors can look at the latest x-rays. Everything is digital. The challenge with it is the cost benefit. Information technology is not cheap. Our struggle in the health care system is the balance between things that are really nice to have, and those things that are simpler, less expensive and can do the job just as well.

• They have a fabulous information system in California that was done by a foundation in the universities. You can find out about every long-term care or community health facility. It tells you what kind of staff they have and what kind of services they offer. They can also tell you about patient satisfaction and whether there have been problems. It would be quite expensive, but it is quite an amazing system because it becomes self-serve.

• In New Zealand there was a rapid movement into patient management software and information systems and primary care. Ten years later, the government is now pushing a much more primary care oriented model and it also wants a
national information system, but it cannot do it because of the embedded systems developed in the nineteen nineties. All of the general practices and primary care organizations have different electronic systems in place and now it is an absolute nightmare. There is a high uptake in New Zealand: up to 90 per cent of general practitioners and primary care organizations use electronic records, however few of them can actually talk with one another.

• Information technology is an area where Canada has a lot to learn from other countries. A recent survey showed Canadian doctors are in last place in a Group of Seven Organization of Economic Co-operation and Development (OECD) countries in the uptake of the electronic health record.

• Comments on integrated information technology and planning:

  • Health authorities support a move to an integrated information technology environment. To do this, leadership at a provincial level is required and collaboration provincially and federally must be improved. Furthermore, within health authorities there should be a focus on integration.

  • We have six health authorities with different computer systems. They are not even integrated. The government provided the funding, but did not say that health authorities have to agree on one and buy one so that they will all talk to each other.

  • Currently, there are different planning processes within health authorities. More consistency is required and the Ministry of Health has a clear role in making this happen, including setting common ground rules and standards, providing provincial funding assessments based on need, and improving strategic planning. Some effort needs to be undertaken to understand those information technology planning processes, which need to be managed provincially.

  • We need better planning on the efficient roll-out of technology. The federal and provincial governments are spending oodles of money on the Electronic Health Record, but there is no coordinated approach.

  • As knowledge expands (including management approaches) and society evolves (particularly the development of information technologies) there is a need for health care and health care disciplines to move from a gradual evolution to major transformations to align with these changes. It is not a time to be timid; a strong commitment to meaningful and effective change is required.

  • There is little or no standardization and compatibility of systems and technology.
• A group was doing some research at the University of Victoria, and said that you can have health care collaboratives, but if you do not have accessible information through technology, then you actually get a bunch of people who are trying to collaborate but they do not have the information. The information technology is fundamental if these collaboratives are to work. That is one of the things that fundamentally holds some of this collaboration back, access to information.

• Networked access to diagnostics, especially radiology, between remote sites of Vancouver General Hospital is excellent. Broaden this electronic access.

• In Canada, we rely on a regional health authority approach. Yet the regional health authorities are investing in different technologies, which mean that there is no standardization of programs, suppliers or software.

• Improved and integrated health information systems can support: coordination of services and continuity of care among providers support evidence-based decision-making; coordination of services and continuity of care among providers facilitate audit and outcome measurement; coordination of services and continuity of care among providers assist in planning, management and resource allocation decisions; coordination of services and continuity of care among providers provide tools and information to support health professionals in their clinical decision-making; and coordination of services and continuity of care among providers.

• Comments on investment in information technology:

  • Health care is a business and successful businesses invest in technology and education. The health system creates a framework for services and deliverables.

  • Why is the province spending up to $200 million building the Provincial Laboratory Information System (PLIS) from scratch rather than working with the established, proven and cost-effective systems already in place?

  • There will never be enough money for health care. Technology becomes increasingly expensive, and seems to be given free reign to dominate all aspects of health care. New software programs are purchased and used by health authorities with nominal review and at significant cost to the public purse. Some of these have had incredible impacts on the lives of employees, with morale at its lowest due to overload of work, and short notice demands by health authorities and the Ministry.

  • We have adopted an electronic record system and it is web-based. So it means you can access it from anywhere. It cost a lot of money and it took quite a while to hone the thing, but now the efficiency has just gone through the roof.
• Funding and confidentiality issues have blocked movement on information access initiatives.

• We do not invest as much as others. Infoway has about $1.5 billion. You are going to have to add zero to get the Pan Canadian electronic health record done. If we do not do it, we will not measure up, know what performance is, be able to compress variations, or report confidently in real time how well the system is actually doing.

• Health authorities acknowledge that when the budget is tight, information technology investment and planning are the first to get cut. Dedicated funding might alleviate this problem.

Ideas and Suggestions

Current State of Information Technology
Integrated Information Technology and Planning
Investment in Information Technology

• Ideas about the current state of information technology:
  • Start by prescribing standards, programs, suppliers and software.
  • Develop guidelines for use of new technology.
  • Create a standard for information sharing.
  • Establish electronic connectivity standards for communicating patient information between family doctors, hospitals and other health professionals.
  • Everything should be under one single umbrella coordinated by the Minister of Health in collaboration with doctors and nurses.
  • Develop standards for health information and reporting. Development should include interested parties such as representatives of primary care health organizations in British Columbia, along with research organizations and relevant divisions of the Ministry of Health. The process should include the development, testing and refinement of systems, including reporting systems, which are fully adequate to sufficiently answer the care, development and reporting needs of primary care in the province.

• Ideas about integrated information technology and planning:
  • Use technology to improve communication.
  • Develop a collaborative system with other organizations outside of government.
• We need an electronic system for communication across the network and providers, standardized across Canada so that it is inter-operable.

• The government needs to be proactive and do better long term planning of how all the health authorities, physicians and other provinces will integrate electronic health records.

• Technology needs to be used and funded to drive change to prescribed standards and protocols.

• Health authorities require overall strategic vision for information technology, developed by the Province and by health authorities collaboratively. The vision needs to move away from old style information technology conservatism, which is preventing health authorities from achieving its goal to use information technology as an enabler of change.

• Ideas about investment in information technology:

  • Implement a Geographic Information System (GIS) to improve the ability to demonstrate health information graphically.

  • Government must put a priority on funding for information technology, including electronic health records.

  • Make a major one-time investment to support the rapid development of a province wide medical records system and do not let political and turf issues get in the way of getting it done.

  • Subsidize hardware and software acquisition and ongoing support required by family doctors to maintain electronic connectivity with hospitals and other health professionals.

  • We require an initial investment to get information so that we know where to spend money. The electronic health record is a good place to start.

  • Provide increased funding to technology to streamline the public system.

  • In Canada most jurisdictions do not have good health electronic records. So if you need to make an initial investment, then maybe that is where to start. Then you have the information necessary to identify where you are going to move your pockets of money around. Because, to be honest, there is always more money needed in health care, especially because we have moved from health care that is needs-based to quality-based. That is what the rising cost of technology is from: it is not necessarily a need thing. We are no longer providing needed health care, we are providing health care that improves quality of life, and for that type of decision you need information as to where you want to spend your money, or you can just keep spending all your money on improving quality at what cost?
• Investment in electronic health records and automation of task is huge because often 40 per cent of staff time is spent in documentation. We are spending about $1 billion, but we have to spend $10 to $15 billion in Canada.

**Health Information Databases**

**Comments and Concerns**

_Databases to Monitor Health_

_Administrative Systems_

_Public Information_

• Comments on databases to monitor health:

  • We are not tracking public health care trends.

  • Government information sources need to be current, accurate and accessible.

  • The technical capability exists (for example in linked data analyses, using information from existing databases) for the Ministry of Health to assist each primary care physician to better understand the population health profile of their patient population. Such information could improve a physician's ability to focus their clinical prevention practices.

  • One of my big frustrations with government right now is with the Knowledge Management and Technology branch in the Ministry of Health. Their perspective is that we are there to serve them. That is a very sensitive issue. It is very frustrating, because they should be serving the outcomes of the goals of other branches of health, instead of the reverse.

  • We need to acquire good data, and understand the context with minimal lag times between acquisition of data and interpretation.

  • A good information system would support whether we are achieving health outcomes, and would also link health authorities.

  • There is software out that we use in health, and broadly in government, called Geographic Information Systems (GIS). We have a booklet that will show you the incidents of measles by communities around the province. You can click on the electronic version of that, and you can see how many cases there were for a couple of years, as reported by physicians.

  • There are silos of information, and therefore no integrated health information.
• We need health data strategies. If it is not counted, then you cannot do something about it. This is so fundamentally important and is something which we have actually done reasonably well in Australia. There is a National Health Information plan, which has a significant strategy for Indigenous health data, and a governance strategy which enables Indigenous people to take a lead role in the Indigenous primary healthcare service. Indigenous academics and other people actually take a lead role in deciding where the priorities are for health data development.

• Comments on administrative systems:
  • Health authority payroll systems do not operate in the same way from one health authority to another, so you cannot analyze your health human resource data from looking across the payroll systems because you have got different payroll systems.
  • We have no real-time information in Canadian health care except billing.
  • Communication between ministries in government causes an unnecessary level of redundant paper work. There needs to be a computerized system.
  • We need a prescription drug system to report problems with medications and to provide information.
  • We need more information systems so that managers can use staff effectively. They cannot get overtime data on a daily basis. They cannot get sick leave data. Our systems are not at the point where they are delivering daily information that people need to run the system effectively.
  • Use Geographic Information Systems as a platform for a road map, to identify where health services lie, like MapQuest. This service could also have a phone number attached to it and not just be a web based application. People living in Campbell River can click on that map and determine where the mental health office, the hospice, and the regional hospital are. We can do that now with physician offices, we can click on the map and find any physician office in the province.

• Comments on public information:
  • Given the well-recognized issue with lower joint care, there should be a dedicated link on Health Authority websites that leads citizens to information and resources for lower joint care.
  • We need increased public awareness of health issues facilitated by access data from a source that can be trusted.
Ideas and Suggestions

Databases to Monitor Health
Administrative Systems
Public Information

• Ideas about databases to monitor health:
  - Provide physicians access to population health statistics along with electronic health records so that the family physicians could actually invest in long term research to see what the impact was down the road of their practice has been. We cannot do that now because of the lack of access to epidemiological data.
  - We need to be able to share information between health authorities, other ministries and community services.
  - We need to take a representative body within First Nations communities in order to gather an accurate database from which we can accurately measure progress.
  - Health information systems should be linked to assess socio-economic position, sex, age, race, and geographic position. They should track flows of health resources, access utilisation and financing, and providing better understanding of the extent to which investments in health care improve health.

• Ideas about administrative systems:
  - A significant cost savings could be made if we were to create a secure medical database on a mainframe that can be accessed by the medical establishment. The database could be backed up in different facilities across the province keeping the data safe from fire, theft and even natural disasters.
  - An information system would assist in the analysis of demographic information, tracking pharmaceutical use and prescriptions, providing information on health care costs, and tracking users through the system.
  - We require implementation of technology to manage a database, integrated across the province and all health care services. A Master Patient Index (EMPI) would be the first step. Set targets at the local (health authority) level. We need global data to identify benchmarks. Look at local targets and management.
  - We need an effective central registry of availability of resources diagnostics, and specialists for queue management. This would be accessible to all family physicians to refer their patients. We need a data base so that we can, on an annual basis, see what progress the First Nations communities have made, to be able to see where the gaps are and what we need to do to make the necessary
alterations to achieve our objectives. For that to be done, we need to go into the communities.

- Create a centralised database, like PharmaCare, to keep track of diagnostic tests.
- We need a regular audit of the wait-list by a body that monitors a database that contains wait-list information.
- We need a centralized criteria-based wait-list management system per type of service (including surgical care) that is regularly audited and is supported through a provincial database and staff that is properly resourced.
- Implement an improved management information system to track supplies and costs.
- A national information system would link everyone with set medical protocols.

- Ideas about public information:
  - Using an electronic health information system, you could individually input lifestyle factors like what you eat, whether you smoke, and how much you exercise, along with your electronic health record which contains your vital statistics information. The system would then use some time-generated graphics and see what you would look like in ten years.
  - Share information.
  - Improved information technology and information tracking would allow the government to track health care expenditures by patient, and permit the issuance of statements to citizens about how much their use of the health care system cost annually.

**Electronic Health Records**

**Comments and Concerns**

**Efficiencies and Patient Management**

**Implementation**

**Monitoring Population Health**

**Protection of and Public Access to Information**

- Comments on efficiencies and patient management:
  - Too many doctors and hospitals are still using paper files.
• In Europe, medical records are part of integrated tracking system for clinical information which is interconnected to a central data base that allows tracking of medical procedures, prescriptions, and so on.

• The electronic health record process is fairly well underway. It has not actually delivered a lot yet, will create accessibility by all health practitioners and patients themselves to patient records, which will eliminate duplication and increase efficiencies.

• Test results are not available electronically, which requires manual transfer of images and files. We have to wait more than a week and up to a month to get results to a general practitioner.

• Current disparate paper-based systems are costly and ineffective.

• In New Zealand, the integrated electronic charting system works well and has resulted in enormous cost savings, a great reduction in drug misuses and a benefit to proper diagnosis and treatment.

• We need better sharing of patient information amongst the health care sector to better manage a person's health.

• European doctors use computerized alerts about potential prescribing problems.

• There is no adequate sharing of information with other practitioners and an adequate database does not exist.

• Informational continuity may assist in reducing repeat testing, and ensure follow-up on critical issues of health promotion, prevention or care.

• WorkSafe BC created a program called e-File in which every piece of paper received regarding claim information was scanned onto the computer. Then, when you needed to look something up regarding a client, you simply punched in their claim number or last name and you got a list of everything scanned. There was an area for writing claim notes as well. This system was ingenious because it meant that everyone could have access to the same information without waiting for a file clerk to retrieve the file. Do you want to go one step further? Create a central database system with all government agencies that are directly related.

• The initiative that will probably yield the best results is the electronic health record. If you are going to have patient-centered care and you are working with multidisciplinary groups and multi-practitioners, that is the consistent way of getting information out, rather than relying on referrals which is time consuming and expensive. Instantaneous, correct information will eliminate duplication of records, duplication of tests and adverse reactions to drugs.
In the State of Denmark, there is one thing that is definitely not rotten, and that is information technology. In contrast to our situation, virtually 100 per cent of Danish physicians use electronic health records, and they report themselves that having this electronic health record saves them about an hour a day in chasing down information from hospitals, in making telephone calls, in reviewing records, in finding out things, again, that they could find out with one keystroke with the electronic health record. It is also a very patient centered system. Patients have access to their own electronic health records on the web, and not only can they understand their own conditions and follow their own treatment and manage themselves better to a certain extent, but they can also see who has had access to their record. So the people who have had access to your record are identified on your screen. If you have a problem with it you can tell them. This is a solution that is available. But it took a lot of time. They had to do a lot of training. There is a lot of support for physicians and others to learn the system well, and there are careful strategies for ensuring that the reports are useful to practice, management and resource allocation.

We would save time, energy and money if all tests and services were recorded and accessed by swiping our CareCards. All of the information would be centralized.

There is a lack of access to information for decision making.

There are no integrated patient health records.

Better information equals better health care.

The hospital admission process would be streamlined if CareCards included patient history.

When a patient changes primary care physicians the records do not automatically transfer to the new primary care physician. This results in fragmentation of medical information.

An electronic health record system would allow general practitioners to keep and transfer records efficiently. It can also be used to queue people with available surgeons, and reduce and handle patient no-shows (including reminding patients of scheduled procedures).

One implication of the electronic record is to ease the administrative burden. When you enter the system, it will log your time, and if you have your tracking built right into your electronic record keeping, you are not filling out more forms.

There is a real push and pull going on in terms of what information should be shared with providers through the electronic health record. It is a big issue because right now with Pharmanet and hospital records. They now have a tracking system to see who accessed the system and did they have a good reason.
The pharmacists are doing it already. So there is a risk for privacy, but on the other hand it is balanced with improving people's health. Consent legislation on the privacy side is trying to find that balance. In the case of dentists we are going to be asking for full disclosure of the electronic health record, but that does not mean we are going to get it. It is a long road of negotiations that still have to happen.

- Often dentists rely on the patient for information about diabetes, which has an effect on oral health. Some conditions, like diabetes, can be diagnosed by a dentist and referred on. And that is where the electronic health record can help. If that core information can contain the critical information, there can be greater integration of all healthcare providers, as well as reducing the number of lab results and eliminate duplication of prescriptions.

- You cannot manage patient flow properly without an integrated information system.

- In the Fraser Health Authority there is a partnership between the NurseLine, a provincial tele-triage and health information call centre, and the Fraser Health Hospice Palliative Care Program. It allows for after-hours access to care and information for dying patients and their families. This program has improved outcomes of symptoms management, cut down on the number of visits to our overloaded emergency rooms, and enhanced the support for families of the dying.

- The NurseLine is not integrated with the rest of the health system. In part this is because the information technology infrastructure for primary health care is years slower in development than other jurisdictions, so the information is not available to the nurse on line. However, neither is there any effort to convey the nature of the call and recommendations shared with the family physician. None of the investigations or hospitalization information is available (some good work is afoot with the CareConnect project). For this reason, it is not appropriate for the NurseLine to initiate referrals.

- You need e-prescribing to make the best use of an electronic health record. It has to, at the minimum, be hooked up to PharmaNet.

- The potential benefits of a robust electronic medical record include: patient access to a practice website (which includes patient management of appointment bookings; patient access to approved (by relevant health provider) laboratory and diagnostic test results; personalised information when logging on with information pertinent to the age and gender and health conditions of the patient; a patient problem list accessible to other providers with patient provided permissions; many patients will have their own health record on line, which may
or may not link to their physician’s electronic medical records; automated reminders of pre-scheduled appointments by provider (any of the clinic staff or consultant referrals, and so on) by automated calls to home phone, cell phone, text message, email, and so on, as preferred by patient; automated reminders of follow-ups, including lab tests (with instructions), repeat imaging, next pap or mammogram, and so on. These are often to be done before an appointment, enabling the encounter, by whatever means, to build on the information from the results.

- MDS metro has pioneered the secure electronic transmission of lab test information through PathNet, now known as Excelleris.

- Comments on monitoring population health:
  - Dutch doctors have a very effective computer-based reporting system which is shared with other doctors via a central registry. During the Severe Acute Respiratory Syndrome (SARS) crisis in Toronto, they tracked cases using index cards.
  - What do we need to do to make the electronic health record effective at changing health outcomes? You could identify registries or subsets of patients who have specific needs. You can include chronic disease management in that so that people who present need to be reassessed at some point. If it is a pap smear, you need to reassess them every couple of years. If it is a mammogram, you have not been doing them at all until they get to be 50 and then you have to see that they are getting it done every year or two. If it is hypertensive, then you need to probably have a check on the blood pressure every four to six months, at least. If it is congestive heart failure, then you probably want to talk to them at least every month. So there are cycles like this that can be tracked through value added processes tied to and dependent upon the electronic medical record.
  - There is no list of home-bound seniors and those with medical needs in case of a natural disaster (such as an earthquake).

- Comments on implementation:
  - The provincial e-health strategy has quite clearly articulated the future, and the option of having a CareCard with your electronic health record on it is probably not on the table.
  - Physicians and other clinicians can go paperless with greater ease, thanks to low-cost wireless networks, powerful and portable electronic devices, a wide range of data input options, and increasingly intuitive software.
• It is not the tool, rather it is how you implement it, train staff, and use that tool. You could do an electronic health record and you could have no impact on patients or on health outcomes.

• Meditech records contain detailed mental health records if the patient had counseling through a mental health centre. These records can contain information about child abuse, incest, molestation, rape, spousal abuse, drug abuse, criminal charges (patient as victim) or criminal records, ongoing criminal actions and other police involvement. This would include names and dates. Some of this information, especially involving children, is held in the strictest confidence with the police. Under Meditech, this information is available to a wide range of medical staff including receptionists and secretaries at the physicians’ offices.

• The piece that is missing is that we keep talking about the successful implementation of this tool versus the goal. We need to be saying that the goal is the improvement of the health management, and so if it is presented to a physician’s office saying that we want to have successful implementation of this tool then that ultimate goal can be lost. There needs to be accountabilities in place around having that as the final measurement of success.

• Between seven and eight per cent of doctors in British Columbia have e-records. It is a complicated and time-consuming procurement process, with a steep learning curve and a resulting drop in production during the first year of implementation.

• Doctors are reluctant to enter information into computers, so they require incentives.

• There is difficulty with high speed internet access across the Province.

• According to a 2006 survey by the Commonwealth Fund, electronic medical record use by American primary care physicians is just 28 per cent, compared with 79 per cent in Australia, 89 per cent in the United Kingdom, 92 per cent in New Zealand, and 98 per cent in the Netherlands and nearly 100 per cent in Denmark even though the Danish government provided a relatively small amount of funding.

• Comments on protection of and public access to information:
  • Nothing frustrates me more than the fact that I can go on the internet and I know everything about my financial situation, I know what bonds I have invested in, I know everything, but I do not know what my blood type is.
• It is a waste of time to deliver a statement of costs to patients. It confuses them. Alberta tried that a few years ago. It did not go well. People did think it was a bill.

• People could access their records when they have questions. For example, they may read about a new study on high blood pressure then they could check their record to see what their blood pressure is.

• Privacy concerns have gone too far and get in the way of electronic health records.

• Patients do not have access to their own laboratory tests, Medical Resonance Imaging (MRI), x-ray reports, and so on.

• The protection of patients' medical records is not going well. The privacy system requires rigorous maintenance.

• Doctors own patient records and many are reluctant to transfer knowledge to enable patients to take control.

• My doctor's office has access to information recorded by the NurseLine as a test project.

• The elderly find it difficult to navigate electronic systems.

### Ideas and Suggestions

#### Efficiencies and Patient Management

Implementation

Monitoring Population Health

Protection of and Public Access to Information

• Ideas about efficiencies and patient management:

  • There is better use of dollars and resources by utilizing advanced technology to support the digital health care card system (patient medical history) and streamline and prioritize point of entry into the health care system.

  • Encourage the provincial government to develop a closed and secure electronic network system for maintaining patients' history, distributing medicine and services, and tracking inquiries to avoid duplications and to treat patients more effectively. This will make treating patients more cost efficient.

  • There is a need for electronic records to ensure continuity of care and utilisation management.
• Hire community wellness managers with hubs that are linked by a database. They could manage a wellness plan for each patient and act as a bridge between various health and community services.

• Implement a Medic Alert Bracelet with a memory chip that can be plugged into the computer at the hospital with all the health records already on it.

• Vital statistics and medical records need to reflect positive qualities, gifts, and talents of all people so that health practitioners see the person as whole person, not just an illness.

• Have a website run by the Cancer Agency with personal information, chart condition, personal log in identification, access by health care providers and the patient, and the ability to ask doctors questions.

• Have longitudinal health records for everyone, that is, a record, easily accessed, of health information on each person from birth to death.

• There should be full access to patient records and histories for all health professionals whether they are working in the public or private system and regardless of which facility they serve. This information would be accessible through the CareCard.

• Develop electronic patient charts that follow the patient.

• Look at closing the gap between changing medications and having the new information show up on the computer.

• When a patient is in need of repeated emergency visits, a computer-generated patient history could be available to more efficiently communicate and move towards quick diagnosis and treatment.

• Address the electronic health records for First Nations.

• Create an electronic scheduling system to book appointments.

• Advanced care directives and organ donor information should be included on electronic health records and accessible through CareCards.

• Ideas about implementation:
  
  • Sponsor computer technology students to work in hospitals and develop and maintain medical record programs.

  • Develop a partnership between the provincial government and the Victorian Order of Nurses (VON) Canada Caregiver Portal to extend access to the electronic drug recording system to caregivers. This would improve client safety and reduce medication errors.
- A computer station should be made available in each hospital room on which you would record the patient activity. This would go a long way to defining who is directly responsible for specific activities in supporting the patient’s care.
- There should be electronic health records that permit centralized access to patient charts.
- Doctors should be offered tax deductible computers and training to assist them to get on the system.
- Hire coordinators to develop databases with health records and plans.
- If a physician’s concern about expanding the scope of practice of other health care providers is that they would not know what others are prescribing, then give them the electronic record and their whole argument falls apart.

- Ideas about monitoring population health:
  - The e-health record should be linked to all social services to ensure that records are complete and patients are effectively treated. This would reduce duplication in treatment and services, and ensure that practitioners are aware of all aspects of the patient’s condition before designing treatment options and working with other service providers and practitioners on a holistic treatment plan.
• Ideas about protection of and public access to information:
  
  • Develop secure electronic records by having health care numbers identify patients and patient information stored on a computer system which could be accessed by authorized physicians and surgeons.
  
  • Only confirmed psychiatrist diagnoses should be on Meditech records. No other mental health reports should be on Meditech. Family physician and specialists' reports can only be released on Meditech with the signed consent of the patient. Doctors and other medical staff can only access Meditech information with permission from the patient.
  
  • Improve sharing of information (test results, imaging, medical information) while maintaining privacy.
  
  • Create a secure health record network, which would include health records, laboratory information, reports, Pharmanet, consultant reports, hospital discharge records, and so on.
  
  • Improve access to medical information, especially for remote areas.
  
  • Once a patient enters a hospital for treatment, they must consent for all caregivers to access their records.
  
  • Create a personal access code to allow individuals to access their health records.
  
  • Patients will welcome and use an internet portal to make appointments, access their health record, contribute to their health record and access health information tailored to their health conditions.

**E-Health Technology**

**Comments and Concerns**

**Service Delivery**

**Administrative Efficiencies**

• Comments on service delivery:
  
  • We have been trying to expand tele-health. This would alleviate the need to move people: you can move information as opposed to people. This will enhance the quality of care that we provide to people as well.
  
  • There is a potential significant gain through e-health in family practice. A third or more of what is currently office-based care could be delivered through e-mail and telephone. But we have structured our current system to halt that kind of shift.
Tele-health can actually televise the patient, and you can ask to see different areas of the body, or you can look at it. You can even do surgery remotely. It may be possible in future to do some of those surgical procedures remotely or at least regionalize that so you don't have to go to Vancouver.

The health care system needs new technologies and innovations. These can save money and time.

Creating the opportunity to use technology is important. Couple our resources with others, such as Health-Link (Alberta's one phone number for all information).

E-health provides automated services that do not require a health professional present.

NurseLine is a positive and efficient service.

There is technology that monitors the house. But would this isolate seniors?

There are tele-health projects that could bring any specialists to any patient with a webcam and immediately have a consultation.

There are 80 communities in British Columbia that are wired for tele-health consultations.

There is a growing awareness of the potential for technology to improve delivery. New and innovative technologies are available with decreasing cost.

Technology offers some new options, such as remote viewing of medical images, consultation with specialists via video, and so on.

In the last two years, five family members have traveled at different times from the Prince George area to the Kamloops/Kelowna area for health care assessments. All of these assessments were not urgent and could have been done through video- or tele-conferencing methods.

Consider that many medical diagnostic procedures are routine and can be mechanized, that is, done by machine with no more than basic guidance on the use of the machine.

I once saw a surgeon operate on a patient, and the doctor's scalpel was approximately two centimetres from the patient's heart. This was no big deal, as I am sure that this is done every day in Vancouver. However, in this instance, the surgeon was 1,000 kilometres from the patient. This is currently a viable alternative in Ontario, so perhaps British Columbia could follow suit.

Has the time come for electronics and specialised programs to deliver some of the medical services we need to out-lying areas?
• Comments on administrative efficiencies:
  
  • Do all the community health nurses walk around with laptops? If not, they should have at least a personal device? You can dramatically improve productivity through certain parts of a health care system through technology and automation, reduce unnecessary administrative tasks, as well as do some clinical tasks safely.

  • If a team collaborates in an assessment of a patient in an asynchronous way, then the doctor looks at all of the findings, prescribes a prevention plan which includes pre-scheduled recalls and coming in for blood pressure checks or whatever is required. Technology can help too because if you try to do collaborative care with sticky notes and file folders it does not work.

  • There is an urbandoc network, and they have a web site and they cross cover for each other so that using this web system they come together on a regular basis. They have separate offices that are working together using this urbandoc.net framework, and then patients can get on there and find out what other doctors are going to cover when somebody is away and so on and so forth. So that again is an example of taking some time and putting a little bit of money into developing a more responsive system.

  • It is difficult to get practitioners together in person. Online access is useful for primary care team meetings.

  • Front line staff manually record information from electronic devices to turn around and re-enter it into computers. This sort of practice is time-consuming and wasteful. These should be automated. This would also improve cost accounting capabilities and improve our ability to compare practices between hospitals and regions.

**Ideas and Suggestions**

**Service Delivery**

**Administrative Efficiencies**

• Ideas about service delivery:

  • Look at e-health options as a way of keeping people out of hospitals.

  • Invest in robotic nurses.

  • Align e-health strategies with chronic disease management, tele-health and web technology.
• We need a user-friendly electronic navigation system to guide patients through their journey in the health care system.

• Increase e-health initiatives.

• Use technology: have doctors using palm pilots to update records and connect with roving health care teams. Restaurants do it to communicate between kitchens and servers, why not health care?

• Use tele-health to bring specialist care to rural and remote communities and to transfer innovative practices.

• Increase the capacity of NurseLine.

• There should be in-home equipment with information transmitted electronically or by phone to physicians or telephone help lines.

• We need a 211 service to access all community and health resources.

• Use alternative technology approaches for service delivery.

• Develop HealthQuest, an online health care information and service delivery interactive site which would be the responsibility of the Ministry of Health. The site would need to be maintained and updated regularly and would provide links to community information and resources based on the inquirer’s area of interest. The site would also be able to link inquirers to help lines when necessary. Health Quest is a one stop web model of health care delivery that addresses the complexity of the system. It would result in improved management of illness, anticipate needs and prevent crises. It would consolidate information and be based on sound principles and evidence-based practices. Physicians will know it is reliable. The site would encourage self-care and provide the patient with more control over their own care.

• Use technologies to allow for long distance diagnosis and treatment.

• Put a direct line in emergency rooms to the NurseLine so those waiting can call that number to get more information on their condition, and perhaps even be directed to another facility or service.

• The International Normalized Ratio testing should be revisited despite turf war issues.

• Patients should be offered the alternative of communicating by telephone and (secure) email instead of office visits. Either patients or clinical providers might initiate health care interactions using these methods.

• Specialists should be set up in the hospital for video conferencing so that patients do not have to travel so much. Technology could help cut costs here.
• Develop a chat-line. It would be a great way for patients and caregivers alike to learn from each other and feel a part of the group with ongoing care and support.

• Implement a mobile public health van. There could be a computer in the van to look up an individual’s health issues and inform the person to whom they should be directed.

• Ideas about administrative efficiencies:
  • Create an urbandoc.net online resource for patients to see if their doctor is backed up.
  • Install computers in pharmacies, libraries, and seniors centres.
  • There should be telephone and video conferencing to support rural areas.
  • Through technology such as hand-held computers connected to a wireless network, nurses could cut down the amount of time consumed with paper work and have more time to spend with patients. The initial costs of such technology would be recouped through efficiencies and would result in better patient care.
  • Create an electronic drug recording system. As the only province in Canada to have an electronic drug system available to pharmacists, physicians and clinicians, there is a unique opportunity to work together to support seniors and their caregivers. By extending the availability of the electronic drug recording system to caregivers, through the Victorian Order of Nurses (VON) Canada Caregiver Portal, polypharmacy, adverse side effects and reactions to drugs would be reduced, thereby improving client safety and reducing costs to the health care system by reduced visits to emergency rooms and doctor’s offices.

PharmaNet and Technology

Comments and Concerns

• When you talk about Pharmanet, our general practitioners can read it, but they do not have access to go in and do anything with it, so it is not a really helpful tool.

• The electronic tracking of medications is one way to better manage health care.

• We have copious evidence of poor prescribing in Canada. One obvious solution is to have electronic prescribing assisted by decision support software. Canada has the lowest uptake of any Organization of Economic Cooperation and Development (OECD) country in terms of medical technology and medical practice, and we are paying a price for it.
• Provincial computer records (Pharmanet) allow for pharmacists to have a consistent and good record of pharmaceutical usage.

**Ideas and Suggestions**

• E-prescribing is becoming a reality.

• We need the digital infrastructure to link into e-records and e-prescriptions.

• Who is going to do the monitoring? The monitoring comes out of PharmaNet. The data are there. So it really is a matter of mandating some part of that organization or some separate organization, because you should not always monitor yourself. It should be some separate organization whose job it is to find out how much impact it is having.

• Pharmacies are linked through PharmaNet to prevent drug overuse or misuse.
Health Financing

Financing of the health care system was a frequent topic for discussion during the Conversation on Health. A variety of sources of funding, funding models, and tax incentives and disincentives were highlighted in discussions and submissions. Here is a selection of what British Columbians had to say on the subject of financing health care.

Sources of Funding

Many participants emphasize that they are open to exploring a variety of sources for funding health care. Many consider taxation to be the most equitable means of funding. Taxation options include increases in income tax rates or dedicated health care taxes. Some participants suggest using Registered Retirement Savings accounts to help people save for their future health care needs. Some propose user fees as a solution to addressing funding issues and to reduce misuse of the health care system. However, some participants are not persuaded that over-utilization is truly a major cost factor or that user fees would generate much revenue, and others oppose the introduction of user fees due to concerns related to equity of access.

Many participants cite the federal cut backs in the early 1990s as the point where health care in British Columbia began to decline in quality. They recommend that the federal health care transfers to the provinces return to historic levels. Others emphasize that British Columbia has not effectively used the recent increases in federal transfer payments and that shifting the blame between the federal and provincial governments will not solve the issues facing health care.
Funding Models

Many British Columbians see the global budget funding model as inefficient and a deterrent to solving access issues. Participants are looking for a mechanism to encourage the health care system to utilize its resources to their fullest potential in an environment of accountability where progress can be measured. Activity based funding, as practiced in the United Kingdom, is suggested by some participants as a means of achieving accountability and creating incentives for improving the efficiency of service delivery. Some participants look to funding based on patient outcomes or other objective measures of performance to achieve the same goals. Regardless of the approach, there is general agreement that funding models should encourage longer term planning. Short budget cycles are seen as a source of inefficiency and poor spending decisions.

*We talk about things being under funded but, really, we’ve never examined what that funding was intended for and whether the original scope of that funding was realistic or not and the accountability around it. So at the end of the day, you can’t throw money at a problem and say, ‘Fix this.’ Well, what am I fixing exactly and with what outcome?*

– Focused Workshop on Delivery Models, Vancouver

Tax Incentives and Disincentives

Tax policy is described as a means to encourage changes in behaviour. Increased taxes on items deemed to be unhealthy, such as junk food, cigarettes and alcohol are suggested to reduce their use and generate revenues that could fund health care. Many British Columbians are also concerned that their efforts to live healthy lives are not rewarded. Participants suggested that health and fitness products and services should be tax free or tax deductible. Many British Columbians support making fees for complementary and alternative medicine tax deductible to encourage their use. Some participants caution that tax incentives reward those who already have the ability to afford health care and request that the socio-economic disparity in health outcomes not be increased by benefits that exclude those with low incomes.

*Hey, I drink a [tonne] of beer, but I understand that could come back to haunt me and the health-care system down the road. I would pay extra tax for the privilege of drinking beer - and I think people who sit … eating chips and watching TV all night should pay more for their junk food.*

– Web Dialogue, Vancouver
Conclusion

Many participants see adjusting the source, amount and mechanisms, of health care funding as a means to achieving sustainability in the health care system. There are numerous solutions proposed and references made to international examples. The common features of many of these recommendations are improved accountability, efficiency and outcomes. Many British Columbians are willing to accept increased personal and collective financial responsibility in return for a health care system they can rely on. While increased funding is often seen as a requirement for positive change, there is an understanding that money alone will not solve the issues facing health care in British Columbia.

One of the things we learned at the Romanow dialogues… was that [citizens] would accept higher taxes if you could demonstrate that there was going to be a different healthcare system…

– International Symposium, Vancouver
Health Financing

This chapter contains the following topics:

- Funding Models
- Hospital Funding Models
- Federal/Provincial Financing
- User Fees
- Tax Policy
- Tax Incentives and Disincentives

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

Submission to the BC Conversation on Health
Submitted by the Society of Specialist Physicians and Surgeons

Smoke Free BC - Healthy People, Healthy Place
Submitted by Dr. Roland Guasparini

A Summary of the Public Forum on Health Care Organized by the Kamloops Citizens Concerned About Public Health Care
Submitted by the Kamloops Citizens

Submission to the Conversation on Health
Submitted by the BC Cancer Agency

Advancing Leadership and Innovation In Specialized Health Care in BC
Submitted by the VGH and UBC Hospital Foundation

Why Wait ? Public Solutions to Cure Surgical Waitlists
Submitted by the Canadian Centre for Policy Alternatives

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

A Vision for Better Health
Submitted by British Columbia Dental Association

Submission to the Conversation on Health
Submitted by the BC Nurses' Union
Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Innovation and Efficiency; Health Care Models; Environmental Determinants of Health and Food Quality; Health Spending; Lifestyle and Personal Responsibility; Health Financing and Public Private Debate.

Funding Models

Comments and Concerns

International Funding Models
Funding Linked to Improved Efficiency
Funding Challenges
International Funding Models

- Comments on international funding models:
  
  - When they implemented the physician funding system in England there were all kinds of problems. Basically, doctors got up to 1000 points. They got points for reaching designated targets and they got a certain amount of money per point. Doctors could get 25,000 pounds if they hit 900 out of 1000 points. All kinds of things happened because of that, for example, doctors stopped working after hours because they were already making more money. Doctors were spending a lot more time on diabetes and did not spend time on things that did not have points. The nurses thought they were doing all the work and did not get any more of the money. One of the things I heard decision makers say there is that it is no longer a topic that you have to measure your outcomes, and that value for outcomes has become part of the system. No doctors are saying, I am not going to tell you how I am doing or I do not want you to know what the quality of care is, that debate is over.

  - The United Kingdom made fundamental changes to their funding model, so that the cash follows the patients. Instead of facilities receiving money and doing what they can, which is what we do now and what they used to do, providers are paid for the services they provide. Patients can receive services at either private or public facilities, with no cost to themselves. The result was competition among providers to put patients first and to earn their patronage. Apparently patient satisfaction went up, waitlists went down and costs did not go up; the money was simply spent differently. I think it is a concept worth considering because the model already exists and from everything I have heard it works.
The system in the United Kingdom is entirely tax funded. Over the last few years private insurance has slightly declined in the United Kingdom. Ninety per cent of the people in the United Kingdom just use the National Health Service.

The United Kingdom uses a population-based funding model. These funds are used to hire doctors, nurses, managers and other professionals. They also looked at improving quality in a variety of areas by providing bonus points for reaching specific targets. Some of them are process targets rather than outcome targets at least to start with because they have a much better information system.

One of the ways the European countries have re-structured health is by having the health care dollars that are now spent on me actually follow me, almost like a voucher system. This way you take the dollars away from the huge bureaucracies that build up around hospitals and health regions and use them to cover individual medical costs that the patient purchases. This way it allows the individual to select the most efficient, effective and wait-time efficient hospital or doctor within the region and province.

A 2005 study published in the British Medical Journal on, the implications of the payment by results financing system, warned of the potential danger of over servicing. In a comparison of short-stay emergency admissions between hospitals, that had introduced the new funding arrangement and those that had not, researchers found more admission in hospitals with results-based funding. This is because short stay admissions attract higher payments under the new system than outpatient emergency care, so hospitals have an incentive to increase admissions.

I am going to sound the alarm that the road that our Government is heading down with respect to pay for results funding, a failed competitive model imported from Britain, is likely only to make things worse. The chair of the British Medical Association Consultants Committee said that political modeling has brought the National Health Service (NHS) to its knees. The Government diverted billions of pounds from improving efficiency to create an internal market in which hospitals compete for patients. The excessive use of private firms to provide NHS services has been costly, disruptive and has fragmented care. The independent sector should be used only where the NHS needs it, not thrust into its midst like a carelessly placed hand grenade.

The money the United Kingdom is spent, and gets into the system, through primary care trusts. The health authorities and health boards are responsible for public health/population health and are responsible for spending the money on individual health care and for providing primary care. They bring together
primary care, public health and all the money that flows into the acute sector. It is about putting the incentive and the power into primary care.

- Canada publicly finances 70 per cent of health care. European countries average about 76 and some countries are well into the 80’s. Europe funds a high percentage of health care and a wider range of services than Canada but rarely 100 per cent of any service. Canada funds almost 100 per cent of hospital and physician services but less than 50 per cent and sometimes zero of other services. Europeans also have some supplementary insurance to make up the gap between the direct charge and the total cost, so out of pocket expenses may be lower. Canada has decided to put all of its social capital into the hospital medical basket and not fund a whole lot of anything else.

- In the developed East Asian systems there are much lower levels of public expenditure, with the exception of Japan, and very low levels of Gross Domestic Product expenditure. The funding levels appear low but this is something of an artifact of the developmental state of the health care systems. The universal health systems of both Taiwan and Korea are much newer than western counterparts or Japan. Both Taiwan and Korea have experienced considerable cost growth in recent years. Korea’s year on year growth rate has been over eight per cent since around 2000 when they put their national social insurer in place. All three countries face an uncertain future due to the demographic changes that they are going through.

- None of the systems in Japan, Korea and Taiwan have waiting lists due to the unrestricted access policies. None of the systems have a wide emphasis on quality assurance or improvement, nor are they underpinned by population health ideals or goals. Although it does need to be recognized that these western ideas of population health are in some ways counter to the strong belief within many Asian societies that health is actually a family and an individual responsibility, not that of the state.

- In all three countries, Japan, Korea and Taiwan, co-payments provide a core funding mechanism and patients will pay about 30 per cent of the costs whether in hospital or primary care in Japan. In Korea co-payments are about 40 per cent of costs; hence quite large sums of money are going into patient co-payments. In none of the three is there a tradition of private insurance so patients will in some cases personally pay quite large sums of money. That said, all three do have safety nets and there are limits on catastrophic payments. In Taiwan, for instance, a patient will pay no more than ten per cent of their annual income in health care payments. Despite the co-payments and the relatively low present costs of these systems, all three systems face cost growth pressures.
Japan has kept costs at around the average for the Organization for Economic Co-operation and Development (OECD) largely been through active fee schedule management. However, it faces problems of population aging and does not necessarily have a solution to stem cost growth. It also has a significant problem, in terms of funding long term care, because of population aging. Taiwan and Korea face quite serious problems because insurance premiums have simply not kept pace with service demand and their fee schedules have also led to quite distorted service delivery patterns.

Diagnosis related grouping (DRG) payments, case payments and global budgets have been the key means for cost control in the health care systems of Korea, Taiwan and Japan. Each country has experimented variously with them. In Korea a DRG pilot has been found to control costs with marginal impact on service quality while in Taiwan case payments have been linked to the off-loading of high cost patients.

In Taiwan, there has been an incentive to over provide high tech hospital services which has led to the growth in very large high tech hospitals over the last ten to fifteen years and to under provide ambulatory and basic hospital services. This was because of the structure of their social insurance fee schedule. In Korea certain services are over provided, for example, the caesarean rate in Korea is 43 per cent and specialties such as ophthalmology and dermatology attract much higher levels of funding than do many others. And so, among medical graduates, this has skewed the demand for training places in certain specialties.

The Japanese system has a few thousand social insurance organizations. This might appear to, and does to some degree, offer considerable choice to the population but the system is otherwise quite strictly structured around three tiers of insurance that cover different groups within the population which the government pays different subsidy levels to. Often referred to as the valve that regulates the Japanese system is the fee schedule that insurers pay to service providers. This fee schedule serves to unify the Japanese health system because it mandates a common pay rate for listed services on that schedule. That pay rate is the same regardless of which tier or insurer a person is covered by. In this way it insures equitable and universal service access. The fee schedule is revised every two years by the Health Ministry and the main player in that process outside of the ministry is the Japan Medical Association. Every item on the fee schedule is scrutinized in the process and costs are controlled by reducing the fee for services that are over utilized and raising the fee for services that have been under utilized. This fee schedule serves as the only rationing mechanism within the Japanese health care system.
The American medical system, designed in the late 40s, depends to a large extent on employer contributions as a way of avoiding a national health care system similar to our own. This system of employer contributions to employee health costs adds an average of 1,400 dollars to the cost of an American made automobile but is not recognized in any tax-based measure of medical costs. This major source of money spent on medicine but not counted in any measure of government expense will obviously skew any comparisons made between our health system and those in the United States.

The Puget Sound Medical services encourage wellness and pays according to wellness. They pay their providers a flat rate per year per patient and cover a broader range of services.

In theory the Oregon Plan and Medical Savings Accounts are good ideas. In practice, neither of these concepts has been shown to improve service or reduce costs. The Oregon Plan is the most direct method because 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 cut-off 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. In Oregon, the Oregon 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 per cent of patients consume less than 600 dollars a year in health care) and might only produce modest savings by severely rationing care for the sickest patients (the one per cent who account for more than 25 per cent of annual health care costs).

Comments and concerns about funding being linked to improved efficiency:

I do not agree that funding from the provincial government to health authorities should be based, at least in part, on their level of operating efficiency and patient outcomes because ultimately patients would be the ones that pay the price in the
end when funding is cut. Cutbacks in funding are not the answer! Correcting the problem is.

- This measure, of funding based on operating efficiency and patient outcomes, would be very difficult to determine and could be very subjective leaving some health authorities unable to deal with the health needs of their region. There is no way to determine the health needs of a given population vis-à-vis another under differing circumstances.

- I absolutely disagree with this idea that funding from the provincial government to health authorities should be based on their level of operating efficiency and patient outcomes. There are many reasons that this would create a disparity in the delivery of health care. The fundamental basis of this idea is that all areas and people delivering health care services are equal and this simply is not true.

- I believe we have to be careful to not confuse operating efficiency with best practices, which have to be based on evidence or patient outcomes.

- Payments by results schemes are not appropriate for improving Medicare. They would make current problems much worse and would destabilize the acute care sector by eliminating any certainty for budgeting or long term planning.

- Let us work at making the existing system work more efficiently. Pilot projects could be used to try out new ways of doing things.

- Pilot projects are disruptive and lack multi-year commitments, so they are difficult to measure.

- Comments on funding challenges:

  - If we make the political decision that there is probably already enough money in the system, the challenge in achieving better performance must lie in improving leadership, priority-setting, decision-making and management at all levels. We must do better on health promotion, public health and preventive medicine. On the other hand, there are many in society and among the ranks of the health professions who believe that the system we have is already doing very well and while its underlying principles seem secure we would adjust its design and the way it is working at our peril.

  - The existing budget is by definition aligned with the status quo, which is mostly a legacy of thinking of the early 1970s. Does it necessarily follow that this is the only model or formulation we are capable of or has the time come, especially in light of yet another massive budget surplus, to consider whether to expand the scope of health services to more within currently under-financed sub-sectors such as PharmaCare and dentistry.
• The choosing and the paying are always separated by great distances and time. The chooser often is not the payer. The equation is results over cost equals value. We do not know what the results are. We do not know what the cost is. So how do we get to value?

• The biggest challenge in health care is that if you conceive it as a public good and a public service, it is built on a huge juggernaut of entrepreneurial activity that increasingly views it as a commodity. Keeping public costs reasonable and keeping utilization to the effective end of it actually conflicts with an entrepreneurial marketing agenda, which is why this tension exists in perpetuity.

• Our public system is based on a 1960s model when it was possible to pay for an entirely publicly funded system. It is not possible to do this any more. There are simply too many demands on the system.

• The current lump sum funding environment of the health authorities is not conducive to a fully public/private operation system.

• A mix of direct taxation (including income taxes and premiums), indirect taxation (federal and provincial sales taxes), private insurance and out-of-pocket payments finance the health care system in British Columbia. Physician and hospital services are covered almost entirely by the first two sources, which in British Columbia turn out to be more or less proportionate to incomes. Pharmaceutical sector financing is quite regressive, as one would expect, since about half of British Columbia’s drug bill is financed by out-of-pocket payments or private insurance. The relatively high proportion of private payment for home and nursing home sectors would suggest that financing for these sectors is also regressive.

• Our system has a similar per capita cost to France, the number one rated system, while ours is ranked 30th- there must be a large productivity gap.

• Health care systems that rely more heavily on direct taxes as a source of finance tend to be more progressive because income and other direct taxes are usually designed to be progressive, with tax rates being a direct function of income levels. Indirect taxes, such as consumption taxes, tend to be regressive, with a greater proportionate burden of payment falling on lower income individuals. Indirect taxes tend to consume a greater portion of income at the lower end of the income scale; a direct result of the fact that these taxes are often levied on non-discretionary goods. These goods are purchased out of necessity by poor and rich alike but obviously account for a greater share of the disposable income of those less well off. Out-of-pocket payments tend to be the most regressive form of health care financing because they represent a much larger proportion of the income of lower-income individuals. In addition, a higher proportion of lower-
income individuals have poorer health, making the impact even more pronounced.

- 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 precludes 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 needs to be addressed.

- There are three opportunities to substantially shift the culture of health care delivery in British Columbia: the primary care partnership with the British Columbia Medical Association (BCMA), the health innovation fund and the primary care charter. This is an opportunity to challenge thinking. But the primary care charter is physician focused whereas primary care is not solely physician based; it is multi-disciplinary, inter-disciplinary care. However, the politics and the power in the province have created a document around primary health care that is physician centric. Almost everyone who is not a physician is actually quite disappointed in the direction we are heading.

- There is no recognition that the services non-profits provide are cost efficient.

- I feel that allowing donations to fund operating costs as well as equipment could lead to private individuals to seek treatment at a public hospital, contrary to the Canada Health Act.

- While health care costs continue to go up so does the value of the St. Paul's Hospital asset. This is an asset we have no control or say over right now but an asset that could help pay for our health care.

- The north has experience a culture of innovation that must be preserved and encouraged.

- The St. Paul's and St Joseph affair is an excellent example of poor administration because they did not even know that this misuse of public resources was happening when a private contractor was renting out time on their diagnostic equipment.

- The private surgical clinic has been given access to public resources ostensibly since December 2006. That access, whether intended or not, has included use of publicly-funded labour (the Sterile Processing Technicians, of which I am one) and on-site resources (the autoclaves in the Sterile Processing Department) in
processing the equipment of a private surgical clinic. Such work has been conducted fully and completely on the public purse.

- We need to have government move away from direct delivery of health care and instead focus on providing funding. This would streamline the delivery of health care. Government does not farm or build homes and these services are delivered to everybody regardless of the ability to pay. Government does a good job of ensuring that the poor are taken care of in these fields without the intervention seen in health care.

**Ideas and Suggestions**

- **Alternate Funding Models**
- **Funding Health Authorities**
- **Activity Based Funding**
- **Revenue Sources and Generation**
- **Funding Challenges**
- **Improving Efficiency through Funding**

- Ideas about alternative funding models:
  - Each resident should have an annual health care account, modelled after the Employment Insurance program. Unused funds in these accounts could be carried forward into subsequent years to fund future health care needs.
  - British Columbians should be allowed to spend money they have saved in Registered Retirement Savings Plans on health care needs and have these payments be tax deductible. Many seniors have a great deal of money in Registered Retirement Savings Plans and would want to pay for services if it got them faster service that was tax deductible.
  - A system should be established similar to Registered Retirement Savings Accounts to allow British Columbians to save for future health care expenses. These funds could be withdrawn tax free after the age of 65 to be used to pay for services not covered by the Medical Services Plan. Anyone can contribute this health care plan, including employers.
  - Medical Savings Accounts where everyone is given a certain amount of funds to spend on health care combined with insurance with a deductible equal to the balance of the Medical Services Plan would provide people with full coverage and incentive to use the funds judiciously because unused balances are carried forward.
• An annual health budget for each resident could be created with unused dollars saved by the individual for future use. The exhaustion of the budget would be a problem solved by that individual.

• We should pay for all our health services through one insurance plan, funded through our income taxes and based on our ability to pay.

• Our system should be organized like an insurance company, with compulsory participation and everyone paying premiums based on actual cost to deliver the service.

• We should create a three-tiered system. Tier three will be for welfare recipients and people in need but not the handicapped. There will be minimal emergency services with a yearly limit of money for each patient. Tier two will be similar to the existing health care system with increased insurance premiums and should be consistent in all provinces and territories. User fees for all services must be paid to 20 per cent of the yearly earning of each patient. There should be a life-time limit or maximum for each patient’s spending on his insurance. Tier one will be an extended version of Tier two coupled with additional private insurance. The life-time limit of money will depend on the type of private insurance. There will be the possibility to get a voucher for the cost of services in government hospitals, which can be used everywhere in the world for treatment.

• The provincial government should create an open-ended account specifically for health care, guaranteed by the Government and separated from general revenues. All of British Columbians’ medical expenses would be paid from this account. As the funds in the account are depleted the tax payers would replenish the account to sustain the health system through fees or a dedicated tax.

• I like the idea of changing the model so that the patient is viewed as a revenue source as opposed to a cost line item. A caution to that is the general move towards a density driven decision making model as our province and country become more urbanized.

• Restructure funding to involve all four levels of Government in health initiatives that are cost-shared, such as affordable housing, low barrier housing, harm reduction, safe clinics, community-based clinics, protective services, safe cities, mental health and addictions.

• There is a lot of funding available in the form of gifts, donations and contributions but we need improved mechanisms to allow the giving of gifts to the health care system.

• Grants and donations must be energetically sought from those in this aging population who have no-one to leave their estate to.
• Government has capital sitting unused, such as closed post offices and schools. Sell these assets and put money into health care.

• Maintain a government system and use strategies similar to rewards for careful drivers. Substantially increase annual health care premiums to reflect true costs but offer significant discounts to people who work actively to achieve and maintain positive health. The more people stay healthy the more resources become available to treat those people who are really sick.

• Link funding to income. In other words, those that can more than afford top quality medical care might possibly pay a little more for their procedures, whereas those with meagre incomes would pay considerably less.

• The next three decades of cost increases can be supported by health bonds. These are issued like the war bonds and are only intended to help pay for the cost of care of the baby boomers for the short term, until attrition reduces their numbers.

• Define health care core services for the public system and non-core at 80 per cent of the capacity of the existing system. The private system would then provide publicly funded services over top of the core services.

• We should negotiate with large suppliers of goods or services for higher discounts or partial/fully donated goods and services. In return, a large and tasteful form of sponsor advertising could be displayed on the building with the highest value sponsor in the top position. A large electronic display (pixel board or Jumbo-Tron television) mounted on the most visible area that includes a thank you, the sponsor’s log and company names informing the passers-by of who sponsors the hospital. This type of board would be easily updated from a user inside the hospital and will constantly keep regular passers-by interested as the sponsors may change. Short television or radio ads can also be considered a method of thanking sponsors. These ads could be purchased at a small percentage taken from the savings.

• Consider pay for performance through the use of a funding secretariat with some dedicated resources and some commitment over a few years to manage it.

• A national spending account for each individual would result in more individual control and incentives for not abusing the system.

• For all our working lives we have taken care of our health and our finances in the expectation that when we became older, and increasingly need health care, we would be able to receive and pay for timely and effective care. Now we find that there are a substantial number of people who are determined to have a system
which penalizes those who have been responsible in favour of those who have chosen to depend on others for their health care.

- What about giving patients money that they can use to shop around internationally.

- Making sure that money follows the patients and rewarding the best gives others the incentive to improve.

- We should use a medical credit system like they have in Singapore and South Africa.

- Ideas about funding health authorities:
  - Funding to health authorities should be based on the population they serve and the particular services and expertise they provide. Vancouver hospitals provide specialized medical services to the whole province not just to Vancouver residents and their funding should reflect that.
  - Let hospitals and their boards handle the money and get rid of Health Authorities.
  - We need to put in place processes to tie funding directly to productivity. These are automatically built into successful private business models as they go out of business if they are not productive.
  - The funding for health authorities needs to be based in part on outcomes and patient satisfaction surveys. This information should be based on services provided at hospitals and clinics; staff attitudes, including clerical staff, towards patients; response times from health authority officials to public inquires and how closely the health authority follows guidelines, mandates and direction from the Ministry of Health.

- Ideas about activity based funding:
  - The reality in countries like Britain that use activity based funding or payment by results is that there are no waits. We need to learn from this.
  - In a system such as ours, geographically organized, activity-based funding makes little sense.
  - Activity based funding is a basic economic principle. It is an internal market. It is where the patient going to the hospital is a source of delight to the finance department of the hospital instead of a cost.
  - Activity based funding is something that could take place within the public system. Even if you wanted to have a pure public monopoly, you can still do that with activity based funding. It is simply a way of paying the hospitals.
• Ideas about sources of revenue and revenue generation:
  
  • There should be a single source of revenue for all health care. Multiple sources increase administration and lead to the break down of the system.
  
  • We have to recognize that the North generates lots of provincial wealth. We should spend more on health care in the North to recognize this fact.
  
  • We need an economic development strategy that will primarily deal with development in remote areas of the province. It may be natural resources but we have got to start to look at where these populations are and how we can affect them positively through better living circumstances that are funded through economic development.
  
  • A huge increase in energy production would mean a huge boost to our economy. If we could create a surplus like Alberta has, our health care system would be in much better shape than it is.
  
  • I believe the excess billions of dollars from the Insurance Corporation of British Columbia (ICBC) should be diverted to health care to fund the hospitals properly.
  
  • Revenue for core services should remain a blend of premiums, general revenue and co-payment.
  
  • Loosening the Canada Health Act to get more private funding is not a real answer. That is basically not looking at finding out why costs are rising but simply trying to push costs elsewhere.
  
  • We could create a co-insurance program which is tax-payer based.
  
  • A solution to the funding problem may come from public-private partnership projects.
  
  • Government has a better credit rating and can secure cheaper loans than private enterprise. For this reason alone, government should continue to build infrastructure.
  
• Ideas about funding challenges:
  
  • The current problems in the health care system cannot be solved with better management and efficiencies when our ability to provide care is being cut. It will take a different attitude in Government and a willingness to raise taxes to correct this.
  
  • The Ministry of Health needs to get out of paying doctors and into funding the health authorities to provide all medical services. In this way health authorities could ensure that all residents in their area have access to care by funding clinics per patient served. Each clinic would have a registry, with a minimum number
and possibly a maximum, of patients to be registered for the clinic to receive funding.

- One of the reasons why British Columbia is so much better off than some of the other provinces is because we believe in boutiques. Children’s Hospital and the Cancer Agency are boutiques. They are provincial resources. They are in different locations but our rates are better because they are centrally controlled. You have the expertise, the efficiency and the effectiveness. We are not duplicating services.

- There is a need for some other kind of funding because of the stranglehold that physicians have over the Medical Services Plan. It could be called the allied health services plan. It would allow health professionals other than physicians to tap into a fee-for-service type structure. As an organization delivering sexual health services, we subsidize the system to the tune of thousands of dollars a year doing pap tests for which we cannot get reimbursement because they are not being done by a physician. This new fund could fund services such as this.

- Allow people to buy better care. Set a minimum standard that is universal and allow those that can to buy more.

- I hope that our Government will find ways to continue a system that provides all essential medical services, financed by our taxes.

- Ideas about improving efficiency through funding:
  - Use report cards to link funding to efficiencies by increasing funding for successful programs and decreasing funding for poor programs.
  - Once procedures and methodologies have been put in place to assess operating efficiency and health outcomes, much of the resources for health will be spent demonstrating value for money. The cure may be worse than the disease.
  - Start mirroring other industries that have taken a lean production approach to costly production processes within their industries.
  - Increase competition on the employer and labour side of the model.
  - We should shift ambulatory care delivery from hospitals to efficient facilities such as home care and other home based programs.
  - Study alternative delivery models to improve efficiency.
  - We need to look at the most efficient and effective service delivery model that focuses on broader criteria, rather than just costs.
· Budget for need after a thorough assessment. We need to know how many x-ray machines, hip surgeries, cancer radiation treatments we need based on demographics and experience.

· Introduce patient-based performance metrics for hospital services.

· Patient health outcomes are based mostly on the level of funding and the availability of doctors and nurses. A lack of doctors and nurses and lower levels of funding contribute to decreased health outcomes. Health care is not a business and can not be treated as such. It makes absolutely no sense to reduce funding to a health authority that has bad patient health outcomes. Penalizing a health authority is a false economy and will only make a bad situation worse.

**Outstanding Questions**

- Are our funding mechanisms and incentives matched to what we want to achieve?

- Would it be feasible if an escalator increase was adopted for health funding based on the Cost of Living (COLA) index?

- With activity-based funding how will rural hospitals compete?

**Hospital Funding Models**

**Comments and Concerns**

**Shortages of Hospital Resources**

**Hospital Budgeting**

**Funding Hospital Infrastructure**

- Comments on efficiency of hospitals:
  - Have a separate hospital or clinic for cosmetic surgery.
  - There should be a standardization of equipment between hospitals to ensure equipment can be used everywhere and that staff anywhere know how to use the equipment properly.
  - Hospitals need a clear mandate to have fewer administrative staff. Enforced budgeting clearly does not work.
  - We should support the expansion of surgical centres that specialize in high volume procedures.
Cardiovascular disease is the leading cause of death in British Columbia. Other provinces have realized this fact and have established Heart Institutes.

We should have more facilities distributed throughout the province to reduce travel for patients.

We need more resources for triage and fast tracking.

The contracting out of services is definitely not working, and is not as financially lucrative as was envisioned. We have to accept that this experiment failed.

Fund and resource community care to reduce the pressures on ambulance care, emergency care and even police response to elderly calls.

We should support infrastructure improvements for hospitals.

It would be a good use of resources to convert closed schools into community health clinics and seniors facilities.

Small facilities embedded in communities and neighbourhoods should be funded to reduce pressures on central hospitals.

Do not compare hospitals to hotels.

Hospitals suffer from operating inefficiencies. Most departments work in silos and yet very much depend on other departments or external resources to make things work. It is a complex environment that has loose standards, methods and procedures.

The cluster model of hospice care is less expensive than hospital care and provides opportunities to partner with non-profit organizations.

All renovations and new hospital construction should be power smart to save money.

One focus of cost cutting could be energy consumption of hospitals. Conservation could save 10 per cent of the monthly bill or higher depending on the solution used.

There is no incentive for hospitals to act like a business.

Too much is being wasted in hospitals. We need to increase accountability and transparency.

The way that hospitals are funded encourages inefficiency. Block funding means that the managers are scared of both overspending and under spending their monies. Both sins are penalized, so limits are placed on services until they realize that a surplus will be created, resulting in a reduced allowance for the next year and what follows is frivolous and urgent expenditures.
Smaller hospitals may only be able to support part-time health care staff. This makes attracting and retaining staff difficult.

Hospital policies that discontinued the option for a patient to request and pay for a semi-private or private room have resulted in less income for the hospital.

Hospitals in other countries keep track of their expenditures and control inventory. Our hospitals do not. Equipment and supplies are handed out without being purchased by the patient. When supplies come in they are not being matched to the packing slips and they are stored in places that anyone could access. These practices would cause most business to run in the red pretty quickly.

The efficiency of a hospital should not be used to affect eligibility for patient care. It could and should be used to monitor and modify performance of health care providers.

There is a surprising lack of accountability in the operations of the health authorities and hospitals. Nobody knows what it costs to do a procedure in one hospital compared to the next. Endless meetings with highly paid participants occur without measurable results. Consultants galore are writing thick reports that simply gather dust. The administrators have no incentive to improve on that because they can spend the money as they see fit.

• Comments on shortages of hospital resources:
  • There is a lack of operating room capacity and surgeons.
  • Equipment such as echocardiography and carotid duplex ultrasound machines are relatively inexpensive and in wide use across the country in other facilities but are in short supply in British Columbia.
  • There is a lack of equipment and lack of storage in hospital.
  • The supplies used in the hospitals are not accounted for, leading to potential for theft and misuse.
  • We need more high tech equipment.
  • Multi-million dollar machines stay idle because the hospitals are not receiving funding to keep them staffed.
  • Do not buy more expensive new and improved diagnostic equipment. What we have now should do. Get more of the current models in all areas, rather than some improved version in just a few centers. Bigger and better is not always smarter.
  • Geriatric activation units are needed to meet the needs of weak, debilitated elderly whose acute medical needs have been stabilized.
• Lab services are inefficient.
• There was no oxygen at the hospital when I was having trouble breathing.
• Power drills are a pivotal piece of equipment for surgeons, especially neurosurgeons. Vancouver Hospital has recently decided to buy new drills for the operating room but instead of purchasing the drills, unanimously supported by the surgeons, they have opted to buy a cheaper, less functional device. It is clearly another example that the current health care system prioritizes money savings over patient care.
• Emergency rooms are a major problem and need more resources. There are no magic bullets in utilization management.

• Comments on hospital budgeting:
  • Global budgeting creates a spend it or lose it mentality. Hospitals budget their funding ineffectively as they lack incentive to serve patients efficiently and in fact have incentive to misuse funds.
  • There is a misuse of resources because of the way hospitals must budget with overly high estimates to ensure funding is not cut.
  • The global budget system for funding hospitals results in limiting and rationing health care, closing beds and operating rooms, reducing surgery and simply not treating patients.
  • Hospitals are funded globally, with all the money going into one big hole.
  • I have some real concerns about how hospitals are funded and how that money is handed out. The hospitals do not seem to be fiscally responsible with their money, nor do they have to get the best price for equipment or other products.
  • Global funding encourages people not to do things and instead to keep the money for end of year. Other jurisdictions have funding based on use which encourages hospitals to be competitive and meet a quality standard.
  • During a two-year period the hospital in question came in under budget and found that their efficiency meant nothing because their budget was cut, as obviously they did not need the funding. Later, under new management, pressure was applied to all departments at year end to spend no matter what to come in a little above budget. This caused departments to take the hint and come in much over budget. After squabbling with the health authority over the need for more funding, they eventually got it. They should have been penalized through direct cuts to executive level remuneration at all levels and kept the operating budget the same. The ones coming in under budget should get more
funding consideration to carry on their efficient work and management should get a bonus.

- It seems that in the hospital system you are rewarded when you have spent your entire budget for that year with a bigger budget the next year.

- It seems clear that the problem is that the hospital is not appropriately funded in terms of beds to care for the number of patients that need to be admitted at any one time.

- Comments on funding hospital infrastructure:
  - Women’s Hospital should not ask its employees for money to build a new facility. The funding should come from public money.
  - The hospitals are over crowded. We are ten years behind in building new hospitals, as Government does not spend money in the right places.
  - Health care professionals are available to work but the health care facilities for them to work in have been closed.
  - It is not right that the Government can close down a hospital and remove the equipment. Much of this equipment was purchased through local community fund raisers and should stay in the community.
  - We need a commitment to public funding of hospitals. Hospital closures just lead to line-ups elsewhere.
  - Many hospitals have empty wards that are unopened due to the costs incurred to staff, power, clean, heat and maintain them.
  - We need more funding for beds.
  - With the over crowding of the hospitals we need to fund more buildings, equipment and staff.
  - The voice of the Northwest Regional Hospital district is not being heard during pre-budget meetings.
  - I want to see not only adequate facilities but ample facilities within the public system. When I get inside a hospital I do not want to see the dirty floors I see now.
  - Large hospitals take up very valuable, downtown real estate and must provide large areas for parking and servicing. The larger hospitals also tend to be overly utilized and therefore very expensive to maintain and operate.
  - Patients have to travel to access needed health services due to inconsistent funding from community to community.
The current funding allocation is imbalanced and inconsistent with the needs of patients and communities.

**Ideas and Suggestions**

**Efficiency of Hospitals**

**Revenue Opportunities for Hospitals**

**Improving the Efficiency of Hospitals**

**Hospital Funding Models**

**Hospital Budgeting and Accounting**

- Ideas about revenue opportunities for hospitals:
  - We have hospitals where people spend a lot of time waiting, visiting, recovering and working. The hospital provides very limited services to these people. I think there could be huge potential for revenue if we tapped into this market. In Victoria we allow junk food vending machines, Starbucks and Tim Horton's to sell to the public. The hours of the cafeteria, especially on the weekend, are not satisfactory. A privately owned 24-hour restaurant or coffee shop could lease space and generate income for the hospital.
  - Hospitals should encourage American citizens to come to Canada for operations. We can use the profits to open up operating rooms 24-hours per day and seven days a week.
  - I would like to see the hospitals run a lottery like the Lotto 6/49. I would like to see this administered by the hospitals with all the proceeds going to building new hospitals and purchasing new technologies.
  - Have you thought about corporate sponsorship for items like diagnostic machines? Companies like Telus could sponsor a Magnetic Resonance Imaging machine (MRI) for example. In New Zealand the Children's Hospital has advertising signs up on the roof, which generates needed income.
  - The rules governing charitable fund raising for hospitals are too restrictive.
  - Many patients who leave the hospital require a prescription, quite often these people are elderly, and are discharged after hours. A public pharmacy at the hospital would generate income for the hospital and be a welcome relief to these patients.
  - We could increase the health care budget by allowing more retail and commercial services in hospitals.
• A fee for service gym could be set up at the hospital. It would promote good health in the hospital and generate revenue.

• The hospitals could lease out space for daycare. This would help to reduce staffing issues and help patients out who are having day procedures or diagnostic testing.

• Hospital waiting rooms could be set up with pay televisions similar to those in patient rooms.

• In the past five years, British Columbian biotech companies Angiotech and QLT have returned over 60 million dollars to University of British Columbia (UBC) Hospital as a return on investment. Boston is an example of where complex patient care combined with medical research brings new economic opportunities to hospitals.

• Hospitals in Winnipeg have more services, such as hair salons, to help pay for health services.

• Ideas about improving hospital efficiency:

  • 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.

  • Patients should be able to choose which hospital they go to. This would create healthy competition and improve service.

  • The answer is to allow the doctors and nurses to use the medical facilities efficiently. Allow the municipalities, churches, universities, service clubs such as the Shriners and private companies to supply and operate hospitals and then have a government-controlled insurance system pay for it.

  • I believe there is a way to offer financial incentives to hospitals. There are a number of performance measurements which are objectively based on actual data not patient survey results. These include Length of Stay and re-admission rates. The key is not to compare one hospital to the next but to establish a baseline for each hospital. Each hospital’s baseline should be established from their historical data and then monitored for improvements. Financial rewards should be based on their own delta change.
• It just does not make sense to increase funding to an area that is already efficient; the funding needs to go into the areas that are lacking.
• We should run hospitals like hotels with standard room rates and fees.
• Hospital bureaucracy must be more responsive to change and improve their utilization of current resources.
• More items in hospitals should be re-usable.
• Staff and fund the hospitals properly with full time doctors, nurses, surgeons, specialists and psychiatrists. These professionals must be given the resources required to do the job properly and efficiently.
• It is less expensive to renovate an existing hospital than to build a new one.

• Ideas about hospital funding models:

• In a patient-based funding model the patient becomes an asset to the budget and not a liability. One concern would be that rural areas would have less access to service because they do not have enough patients.
• Privatizing hospital operations could offer substantial savings. Government would still own and build hospitals but existing hospital staff would be terminated and operating contracts tendered to the private sector. This concept has already worked well for highway maintenance in the province.
• Hospital funding should be based in part on patient satisfaction.
• Hospitals should be block funded for the hotel bed costs at a fixed amount. The rest of their funding should be per patient according to disease group and procedures performed.
• My understanding is that currently hospitals are funded by receiving a fixed fee which is intended to cover operating costs. This method of funding may generate the motivation to perform less services and procedures in order to save money and to not consider the number of staff required for each procedure. Has it been considered whether introducing a variable component to the funding equation, so that hospitals are paid a fixed amount for each procedure they perform, would create efficiencies in the system? I feel that this would create the motivation for hospitals to perform as many procedures as they can in the most efficient manner possible.
• Hospitals should be rewarded for keeping their operating rooms busy. Funding should be based in part on treating more patients as a goal, rather than the current system where rooms are closed to meet budget needs.
There is a built-in overhead cost associated with hospitals having the capacity to deal with emergencies. Health authorities try to limit this cost by ensuring facilities remain at maximum capacity, with the result that predictable conflicts coupled with unpredictable ones creates bed shortages and delays. We need to recognize the need for this capacity and fund it accordingly like we do with fire service and civil disaster preparations.

To reduce wait-times and increase productivity the funding of hospitals should be kept under public control and paid by production and not in a per annum lump sum that has no accountability attached to it.

We must not adopt the European method of health care funding where the hospitals are paid by the patient levels. This method results in patients being kept in the hospital until another patient can fill that space.

Patient outcomes are the most important factor. Funding based on patient outcomes for hospitals would encourage more comprehensive and holistic practices.

Philanthropy is a major source of funding for the Children's Hospital. It is clear that this funding is for value-added services and the pursuit of excellence. It is not in place of sufficient funding from the Province. Government must be responsible for the bulk of the funding.

Hospitals should be bidding against one another for the right to do certain procedures.

In China, hospital organizations receive funding for the provision of health care from revenues derived from taxis and buses servicing the region within a given radius of the hospital.

Ideas about hospital budgeting and accounting:

I suggest that all medical departments, including mental health, be audited at the end of a budgetary year to see if there is a sudden surge in expenditures in order not to lose funding in the following budget year. There should be a reward system for coming under budget and not a penalty.

If we knew exactly how much certain operations and procedures cost there could be more accountability at the hospital level for the services provided. There is always an incentive to do things better if rewards are given for outstanding performance and organization. Conversely, penalties ought to be levied against hospital staff that cannot or will not achieve minimum service standards.

The capital budget must be kept separate from the operational budget or else necessary improvements to the physical side will not occur.
Hospital statistics must be made public to increase the responsibility and accountability of managers.

It intrigues me that people are now suggesting that hospitals should receive their funding based on patients. In a previous time, hospitals and health care facilities received a per diem rate on the occupied beds. Administrators worked hard to ensure 100 per cent occupancy. In long term care facilities an empty bed was filled as soon as possible to ensure maximum occupancy and maximum income.

I would like to see hospitals get only half their budgets at one time and then have them work for the remainder of the budget. This would make them less inclined to shut down operating rooms when budgets get tight.

I think hospitals should not be allowed to run in the red and should have a balanced budget. All money spent on capital projects and leasing should be fully audited. There is a real atmosphere of a never-ending supply of cash in the health care system.

Allow departments to carry over any budgetary surpluses to the next fiscal year to help prevent the use it or lose it attitude when it comes to year end spending.

We must expand medical facilities to accommodate the growth in population before it reaches a critical point.

We should increase community resources instead of increasing hospital resources.

May I suggest you get the administrator at the Kamloops hospital in to assess other hospitals and improve their efficiency? I suspect inefficiency rather than lack of money is at the root of many problems at other hospitals.

Local citizens should be asked to sit on hospital boards.

Investing in publicly funded and publicly built facilities will result in long-term sustainability.

Regional centres should receive additional funding.

Acknowledge the enormous job done by volunteers in raising capital for regional hospitals. These volunteers reduce the load on government dollars and should be acknowledged for their achievement.

I think we should buy all the hospitals owned by Providence Health Care or stop funding them. The private, non-profit society of Providence Health Care should be transformed into a public health care co-operative.

British Columbians should buy St. Paul's Hospital and the St. Paul's Hospital Foundation.
• We need to increase the revenue sources for hospitals.

**Outstanding Questions**

• How do hospital authorities allocate resources?

• How are decisions about locations for facilities made?

• Why not only pay hospitals for the work they provide?

• How are hospitals funded?

• Are hospitals paid a lump sum or is the financing based on the number of beds, staff, population growth and other factors? How is it accounted for?

• Why will we not allow organizations like the Shriners’ to build children’s hospitals?

• Why would you reduce funds for services to patients because the people in charge are not delivering the expected operating efficiency and patient outcomes?

• Why is our system not like Great Britain, where a hospital does not get funds unless they have patients and the hospital that works the hardest to get patients gets the most money?

**Federal/Provincial Financing**

**Concerns and Comments**

• The downloading of health care costs onto the Canadian public is due to budget cuts by the Federal Government.

• The massive federal health transfer payment cuts led to less provincial spending on health beginning in 1993. Health care was in fine shape before the cuts.

• In the 1970s, the Federal Government contributed on average 42 per cent of public health care costs. By 1999, the percentage was down to 10.2. As a result, health care is now a smaller percentage of our Gross Domestic Product. The provincial governments were forced to make cuts in response to the reduced federal funding. Residential beds were reduced in the interior region by 29 per cent. Home support spending fell by 13 per cent from 2001-03. Underlying this is the idea that each government should try to achieve a surplus each year, just as every corporation aims to make a profit.
• Since the early 1990’s, the federal government in successive budgets made massive cuts to social transfers to the provinces. The provincial governments in turn passed these cuts on to various social programs, notably health care. So with billions of dollars in cuts to the public health care system, it was no wonder that the system steadily declined and wait times increased significantly.

• Previous cuts to federal transfer payments brought them to 14 per cent. This is the reason we are in the mess we are in.

• Shifting the blame between federal and provincial governments does not solve our health care problems.

• British Columbia is not spending all of its federal transfer payments on health care.

• Canadians pay enough taxes already. If the British Columbian Government used its transfer payments properly there would be enough money to fund public health for all.

• The British Columbian Government has not pushed the issue of federal transfer payments sufficiently with Ottawa.

• Federal/provincial funding agreements can create disparity.

• Since 2000 health care has not improved but transfers from the federal government have increased. I think the Province has a lot of money but just do not know how to spend it well.

• When we were trying to get funding for pregnancy outreach programs Health Canada would give money directly to these tiny little agencies but they had to make these quarterly reports. You may only have one person working at these agencies and these reports were a huge administrative burden. We were trying to have Health Canada give their money directly to us but they cannot do that because they cannot fund health authorities directly.

• The shift from direct federal cash transfers to the provinces to the federal government offering tax points has resulted in a reduction in the federal portion of health care funding. The federal government had historically contributed up to half of the funds for health care. This shift has also allowed the Provinces to use these tax points for other services and tax cuts. This move has hurt health care in Canada.

• Current census figures suggest that British Columbia is not receiving its share of transfer payments from the federal government to fund the health care system.

• The billions of dollars in new federal funding will not be sufficient to save our abused, overused and out-dated health care system.
Ideas and Suggestions

• Federal government should restore transfer payments to their historic levels.

• The provinces need to work to get the federal government back to funding 50 per cent of health care and education.

• Reinstate federal health care funding to the 50/50 formula.

• We should make the federal government more accountable by demanding more direction from them on how the provinces should spend health care funds.

• We need more federal and provincial funding for First Nations health programs.

• Create an Aboriginal financial funding matrix that includes base funding plus a blended formula jointly funded, federally and provincially. Form a framework that eliminates federal and provincial bureaucratic systems, effectively redistributes funds in a way that gets money directly to communities and supports equitable partnerships.

• Transfer funds from Ottawa should not be put into general revenue but kept separate to show that the money is spent on health care.

• With the influx of seniors coming from other provinces there should be a federal grant given to British Columbia to assist with this growing cost.

• Taxation levels must keep pace with need. Health care funding must be a priority for the federal and provincial governments.

• We should end the Federal transfer program and instead give that tax room to the provinces to use for health care.

Outstanding Questions

• Do the federal health transfer payments that British Columbia receives from Ottawa take the person’s age and/or health condition into account?

• Has the federal government has ever restored or given back to the provinces the transfer payments that were previously cut?

• Of the taxes that British Columbians pay to Ottawa, how much is coming back in federal transfer payments?
User Fees

Comments and Concerns

Socio-Economic Impacts
Legal Implications
The Effect of Implementing a User Fee
Applying User Fees

• Comments on socio-economic impacts:
  • User fees could lead to increased severity of illnesses and higher over all costs if people delay seeing the doctor for financial reasons.
  • Access to services will be limited if user fees are introduced.
  • Human rights will suffer if a pay for service structure is allowed.
  • Health care is a fundamental right and should not be based on the ability to pay.
  • User fees have no impact on people with higher levels of income and they discourage people with lower incomes from using the service.
  • When implementing a user fee either you have a system that exempts so many people that it looks a lot like progressive taxation system or you do not, in which case the burden falls disproportionately on the poor. In Sweden analysts have found that there is a slight decrease in equity of access when you impose additional user fees, even in such an egalitarian society.
  • The working poor are always in the most difficult situation. They are the ones that have to buy their own glasses and prescriptions and they would have to pay this user fee. They would almost be better off on welfare where most of these costs are taken care of.

• Comments on legal implications:
  • It is unconstitutional to charge fees for medical services in Canada.
  • The federal government forbids the charging of user fees.

• Comments on the effects of implementing a user fee:
  • I am against the introduction of user fees for any aspect of care within the health system. I have taken personal responsibility for my health and should not be punished when I need to access the health care system.
  • The elderly, people with chronic health problems and the disabled would be the groups most affected by the introduction of user fees.
• It is human nature to exploit goods and services when they appear to be free. If there was a small fee charged to see a doctor, visits will be drastically reduced and the savings will be substantial.

• It is human nature to abuse what is free. We can no longer afford this luxury.

• A user fees cannot punish the sick or this issue will end up in the courts.

• I do not agree with a means test for user fees.

• There used to be a small fee to visit the doctor or go to emergency. This fee stopped a lot of extra visits.

• It would not be my first choice to introduce an emergency room fee but we do need to find a way to divert the non-emergency cases to other health care providers.

• I in no way support the idea of user fees. We should instead encourage people to make donations to support local health care.

• Too many people use emergency services unnecessarily. A user fee would reduce unnecessary use.

• If there was no charge to get your car fixed, can you imagine the line up at the local auto dealerships? Everyone would be there to get every squeak checked, every engine noise investigated and the oil changed every 500 miles. User fees are necessary.

• Family physicians would bear the brunt of having to collect user fees because the majority of patient’s visits are to family physician’s offices. What it would mean for us is that we would have to have two accounting systems, one for the user fees and one for Medical Service Plan billing. If you are a busy family doctor seeing anywhere from 30 to 45 patients in a day, collecting that many user fees is a nightmare logistically. Patient user fees would have to be somewhat discretionary because we know that some of our patients could not afford to pay it. Family physicians are not going to deny patients access to care because of that. I know this has been floated as a means of increasing revenue for health care but I do not think it is a good idea.

• We need to change the public’s perception that health care is free. User fees would probably not produce very much revenue but will make people aware of how much health care costs.

• People do not appreciate anything that is free. If people paid they would think more about why they are using a service.
• Comments on applying a user fee:
  
  • Examine the possibility of user fees being charged to people who can afford them.
  
  • If user fees are going to be considered they must be based on income. To be fair, user fees would have to be accessed progressively like the taxation system.
  
  • Government should balance free access with a small financial disincentive for inappropriate use.
  
  • Countries with co-payments either exempt many groups, which make it look a lot more like a regressive taxation system, or they reduce equity. That is the reality of how far co-payments can go in solving usage problems.
  
  • User fees will not generate very much revenue due to the expense of added administration.
  
  • The assumption is that people go to the doctor because it is fun or that it is a choice to go. You are dealing with a very small percentage that might be going to the doctor more frequently than is actually needed. In order to address a minority’s action, we are overcompensating by suggesting everybody pay a user fee. We are sending the signal that you should be deterred from going to the doctor when, in fact, it might be appropriate.
  
  • Canada is only one of six Organization for Economic Co-operation and Development (OECD) countries that do not use client cost-sharing of some sort.
  
  • It was standard practice at one time to pay two dollars when attending an emergency room. All citizens can afford to pay a few dollars for such a benefit.
  
  • Looking for new sources of revenue though the collection of user fees offers some potential to limit growth in spending but user fees are not a miracle cure for rising health care costs.
  
  • User fees in Denmark resulted in so many fewer visits to the doctor that the physicians demanded they be removed.
  
  • There was a discretionary user fee for emergency services in the 1980s. The admitting clerk determined whether or not the patient was a genuine medical emergency or if it was something that should have gone elsewhere. It was too difficult to make those kinds of decisions. Take the example of a young mother with a sick child who has a viral illness. As a physician, I could look at that child in 20 seconds and decide the child does not need to be here. However, if you put yourself in the position of the young mother who does not have the skills, the training, or the support it might not be so clear.
• If we are going to maintain a reliable public health care system in British Columbia the patient is going to have to begin to pay some portion of the price.

• User fees are already applied to glasses, teeth, prosthetics, acupuncture and other services. User fees were charged in the 1970s and our health care system then had very few of the problems we face today.

• We have to limit health care spending to a fixed percentage of our budget, even if it means the introduction of user fees or restricting access to some services.

Ideas and Suggestions

Models for User Fees
Where and When a User Fee Would Be Appropriate

• Ideas about models for user fees:
  
  • Allow a defined number of visits to the doctor before charging a fee.

  • Determine the average number of doctor’s visits per year per person and then give everyone that many visits free. After you used up your allotted visits you would be charged on a sliding scale. Couples and families could be allowed to pool their visits.

  • I would like to see a system where every Canadian except seniors, children, pregnant women and postnatal for one year and people with a chronic illness or disability, is allowed 12 visits to the doctor per year. If they need to go more they just have to pay for them. If they do not use their visits they can be rolled over into the next year.

  • Doctors’ offices, hospitals and other health care providers could have a small machine that would allow them to swipe your CareCard. The fee for the visit would then be added to the monthly bill from the Medical Service Plan. User fee payments would be remitted along with your monthly insurance premium directly to the Ministry of Health.

  • Establish a once-a-year user fee that would be paid in advance. If that amount is not used, the credit would be put forward to cover the next year’s fee.

  • Charge a small user fee with half of the cost being refunded if the visit was deemed by the doctor to have been necessary.

  • User fees could be refunded through income tax deductions. Deductions can be calculated on a sliding scale, so that those with a lower income will have a greater percentage refunded than those with a higher income.
Anyone who owns property over a certain value should be required to pay a portion of their medical costs.

Everyone who earns over a reasonable income level should pay a user fee for every doctor’s visit. The user fee should be a nominal amount, such as two to five dollars per visit.

Everyone filing a tax return will be given an evaluation number based on their income. Hospitalization, out-patient treatment or a visit to the family physician would be billed based on the taxpayer’s evaluation number. The higher the taxpayer’s income the higher the payment.

User fees must be benchmarked to the minimum wage.

To make health care professionals accountable to their patients everyone should pay a user fee directly to the doctor. If the patient feels that they did not receive proper care they will go to a different doctor the next time rather than paying to see a doctor they were not satisfied with.

If user fees are assessed for physician services there should be a second tier of health professionals, such as registered nurses or nurse practitioners, whom people could visit free of charge. These health professionals could refer the patient to a physician if it was required and no user fee would be charged for these referred services. This would encourage people to use lower cost health care providers first.

Since allopathic medicine is the only mode supported financially by our government people tend to go that route even when it is not the best option. A solution would be a partial user fee for all health service providers including medical doctors, doctors of Chinese medicine and naturopathic doctors. This would level the playing field and allow people to choose what type of care is best for them.

I think that those who use the medical services above a certain limit through their lifetimes should pay a portion of their costs in user fees.

Low income earners and people in special circumstances could apply for an exclusion from user fees.

User fees could be either a set fee or a percentage of the cost of the procedure.

Ideas about where and when a user fee would be appropriate:

- Charge a larger user fee for patients using the ambulance because so many ambulance calls are not emergencies.
- Consider an emergency room user fee but walk-in clinics must be free.
• We should institute a fee for abortion. It is a moral issue.

• Why not have patients pay for meals in hospitals? This could potentially raise the quality of meals and reduce health costs.

• Charge a small user fee for phoning test results to patients.

• Doctors should charge a fee for phone calls to avoid office visits.

• Increase fees for doctor administered tests for driving licenses.

• User fees could be assigned for prescriptions of new drugs.

• All British Columbians should pay the same user fees for a visit at emergency.

• Apply a user fee to reduce unnecessary testing.

• There should be a universal user fee for all health disciplines to limit abuse of the system.

• Visits to the doctor for colds, sore throats and other ailments that simply require time to heal should be charged a user fee.

• British Columbians are willing to pay a fee for better care and timely access.

• We need to charge user fees for access to the system. Too many people are shopping around for health care professionals who will agree to the care that they want, rather than the care they need.

• User fees could be applied for those who go to emergency when they should have gone to their doctor or a clinic.

• Any visitors to the emergency room that are related to drugs, alcohol or tobacco should have to pay 50 per cent of the total cost of the procedure they require.

• Anyone who has enough money for drugs, alcohol and cigarettes should be able to pay a small fee for medical services.

• A user fee should be levied to elderly immigrants or their sponsoring family.

• There should be user fees for any self-inflicted or sports-related sickness or injury.

• User fees should be introduced for people who abuse their health, such as smokers.

• Patients who do not care for themselves should pay for their care and not burden public system.

• A small user fee could be assessed along with a corresponding reduction to Medical Service Plan payments.
• There should be no pay-as-you-go provisions in health care. This includes no reservation fees, no user fees for emergency services and no queue-jumping fees for diagnostic services.

• It is expensive for the Medical Services Plan to bill everyone a token amount each month and then collect on the delinquent token amounts. A token amount would actually serve a purpose and be far cheaper to collect than would a token user fee.

• I do not think people would be opposed to a reasonable fee for emergency and walk-in clinics if it would solve the access problems.

• If public health care is truly in jeopardy, then a user fees for people that come to Canada or transfer between provinces would be appropriate.

• Universal health care was never intended for the rich, they should have to pay a user fee.

• No user fees for seniors.

• User fees are fine as long as they are not required to be paid at the doctor’s office before being seen by doctor.

• Limiting demand through user fees or co-insurance should only be entertained if attempts to achieve value for money and sustainability on the supply side do not work.

Outstanding Questions

• Would user fees work?

• Can you increase user charges without decreasing equity of access?

• What would the administrative costs be for implementing user fees?
**Tax Policy**

**Comments and Concerns**

**Taxes to Change Behaviour**

**Levels of Taxation**

- Comments on taxes to change behaviour:
  
  - The Government has legalized and collects huge revenues from taxes on vices such as alcohol and tobacco. Alcohol and tobacco use cause a huge drain on the health care system.
  
  - There is no link between the revenue generated from tobacco and the scale of prevention that is being undertaken. It is clear what must be done to have to fewer people smoking in society but we are not achieving that outcome.
  
  - It is ironic that governments who make a great deal of money on the taxes collected from alcohol, cigarettes and junk food would consider a surcharge on health care for people who suffer as a result of their use.
  
  - Increasing taxes on junk food will not stop British Columbians from consuming it anymore than the high taxes on cigarettes, drugs and alcohol have limited their use.
  
  - I drink a ton of beer but I understand that could come back to haunt me and the health care system down the road. I would pay extra tax for the privilege of drinking beer. I think people who sit on around eating chips and watching television all night should pay more for their junk food as well.

- Comments on the level of taxation:
  
  - The recent reductions in tax rates have caused some of the pressures on the health care system.
  
  - Corporate taxes are too low to support the health care system.
  
  - There is a social purpose for taxation that seems largely to have been lost in most of the discussions around sustainability and tax cuts.
  
  - Governments are giving tax breaks to the top ten per cent of income earners in society. The top ten per cent can go buy their health care anywhere in the world they want to.
  
  - British Columbia is currently enjoying an economic boom and the provincial government is benefiting from extra tax dollars as a result. This money should be
directed to health care. It is obscene that people sleep in hospital corridors and wait weeks for treatment while the Province has a surplus.

- I am amazed that the only recommendations on funding the health care system all involve people paying more through private insurance, user fees or higher premiums for people with unhealthy lifestyles. How about progressive taxation?

- I am deeply troubled by the emergence of a two-tier system of health care. The second tier, where people pay for health care, indicates to me that those people are capable of paying higher taxes for improved health care for all. I think we should examine our health care taxation capacity because I believe that we can contribute more.

- Current projections of increased spending would be sustainable if we increase taxes. This is a choice open to us as society. We can choose what we value.

- Health care costs are growing faster than the Government’s ability to pay but we can afford tax cuts?

- There is a need for a public system that provides adequate care for all citizens that citizens have to pay for through their income taxes. If there are insufficient tax revenues to pay for such services, why is the Government cutting taxes? It is fine to boast about our low level of taxation but not if it is preventing the provision of adequate health care services.

- The tax cuts have resulted in longer wait-lists.

- British Columbians do not pay enough taxes to properly fund a good health care system.

- I would be happy to spend my own money on health care but I do not want to have it taxed and then have my deductibles increased.

- If you ask British Columbians if they want to pay more taxes they would say no. This is because all they see is a health care system in crisis. Why would we give any more money to a system that is in crisis?

- Health care funding comes from the tax base. There are not enough people being born for the tax base to continue to support health care into the future.

- Health care costs double for individuals once they pass the age of 65 and as we are experiencing an ever shrinking tax base there will be fewer taxpayers to pay for higher health care costs. There will be nowhere to squeeze the needed money from unless you want income taxes to double over the next 30 years.

- There are too few people paying into the system through taxes. For example, people earn tips and do not report them while others report low incomes. Both live wealthy lifestyles while also receiving subsidized medical coverage.
• Taxing pensions takes money away from health services such as fitness classes, prescriptions, quality food and glasses.

• In the 1960s there was a social services tax that was used only to fund hospitals but the government of the day changed that to a sales tax that went into general revenue.

• It is puzzling why health delivery through taxation is such a problem but taxation for roads and highways is not a problem.

• Why not just increase taxes? There are limits to how high taxes can be raised. Beyond a certain point, and we need look no further than the 1990s to see that point, increased taxes affect economic incentives so seriously that the golden goose ceases to lay. This means that the health budget simply cannot grow exponentially at the expense of everything else and must be brought under control.

• British Columbians are being taxed too much already.

• The public must accept the limitations that the public purse has in regards to publicly funded health care. There has to be a limit to the level of taxation that citizens should bear.

• For those who say the public is willing to pay more taxes, who do you think will be paying for most of those? The working class which is getting smaller and smaller. I am not interested in seeing 60 per cent of my income lost due to taxes.

• Public relations initiatives are needed to clearly show what taxation levels would look like if taxes were increased to fund health care.

• There is an underground economy of unscrupulous contractors in the Okanagan Valley who are now handling over 50 per cent of the building industry in the region. As a result, the Government is losing hundreds of thousands of tax dollars that should be going towards health care and drug rehabilitation.

• It is unrealistic of government to expect people over the age of 75 to pay taxes.

• More and more of our budget will go to health care, meaning roads, education and all other budgets will have to be cut. It will be hard to feed our families if our taxes double.

• Medical Services Plan premiums are a flat tax.

• British Columbians do not want taxes over 50 per cent.

• Do not increase taxes because the health system has adequate funds already.
Ideas and Suggestions

Taxes to Change Behaviour
Taxation Levels
Tax Policy

- Ideas about Taxes changing behaviour:
  - Sin taxes on gambling, alcohol, cigarettes and junk foods can be used to support health care.
  - Bad behaviour and habits should be taxed. Poor health and poor lifestyle choices need to have financial consequences.
  - All tax revenue collected from alcohol and tobacco sales should go to the Ministry of Health and not to general revenue.
  - Revenue from tobacco taxes should be used to fund prevention programs.
  - A medical surcharge needs to be added to the price of cigarettes to more accurately reflect their true cost to the health system.
  - The taxes on alcohol and tobacco can be increased to offset increased MediCare costs.
  - New taxes on tobacco should be directed at cigarette manufacturers. This will result in new revenue to help fund health care and an increase in the cost of the cigarettes for the consumer.
  - Tax televisions, video games and other technologies that encourage sedentary behaviour.
  - Junk food should be taxed to discourage people from eating it.
  - Companies that sell fatty foods and junk foods should be penalized through increased taxes.
  - Taxes on unhealthy foods can be used to subsidize healthy alternatives.
  - Increase taxes on high risk activities to offset their costs to the health care system. For example, those who downhill ski should have tax added to equipment and lift tickets to cover the costs of downhill ski accidents.
  - There should be a tax benefit to those who limit the amount of services they use. If someone underutilizes the system, based on an average, per-unit consumption figure, then they would receive a tax break. If they utilized the system more than the average they would receive no benefit.
• Ideas about levels of taxation:
  • Increase taxes to provide a good health care system to all British Columbians.
  • I would be willing to pay more taxes, if I knew they were going to health care.
  • British Columbians are willing and able to pay for a caring public health care system.
  • The Government should implement more stringent enforcement and collection of taxes before increasing taxes.
  • We are all willing to pay more taxes to ensure the system remains public.
  • My husband and I pay 50 per cent of our pay cheques to the government. We do this willingly because we believe strongly in health care, education, highways, transportation and the other important work Government performs.
  • Close loop holes that allow big business to escape taxation. This alone would fund hospitals.
  • Re-instate corporate taxes to pre-1990 levels
  • It can be demonstrated that tax rates in Canada are relatively low compared to other industrialized countries and that those countries with higher tax rates, especially for the business sector, have better health outcomes, higher gross domestic products, economic surpluses and a host of other positive social outcomes.
  • One of the things we learned at the Romanow dialogues was that Canadians would accept higher taxes if you could demonstrate that there was going to be an improved health care system but not for simply maintaining the status quo.
  • Stop cutting taxes.
  • The funding challenges that the public health care system faces, as Canada’s population ages, can easily be met if Canada’s most favoured citizens are asked to contribute a little more. All too often, it is Canada’s wealthiest individuals and corporations, enjoying their tax breaks and tax havens, who seek to undermine public confidence in our system while paying less than their fair share.
  • If the Government stopped cutting taxes for the rich we would have more money to spend on health care.
  • Create a health care surcharge tax.
  • I am willing to pay more taxes for better access and more services.
  • A proportional tax increase would be better than privatization.
• Raise taxes if that is necessary to ensure equal access to quality health care for all.

• Ideas about tax policy:
  • We need to tax the rich and not the poor.
  • We should eliminate premium payments and pay for health care from more equitable taxation.
  • I strongly believe that a health tax should be developed and kept separate from the general revenues and it should be used exclusively for health care.
  • Collect an Employee Health Tax (EHT) to support health care of about two per cent of the payroll.
  • Establish a payroll tax instead of Medical Services premiums.
  • The benefit of a designated tax for health is that it lets the individual know how much of their tax dollar is going to health, prevents governments from allocating the monies to other uses and provides a degree of accountability related to taxation and service provided.
  • A large tax should be assessed to industrial polluters.
  • Seniors over 90 should have the right to stop paying income taxes.
  • We should allow premiums to be deducted from income taxes.
  • Tax non-resident citizens.
  • The cost of privately paid operations should be tax deductible.
  • Those who have paid for private care should not be able to get a refund back through their taxes.
  • Exempt the public health care sector from paying the Goods and Services Tax (GST) and the Provincial Sales Tax (PST).
  • Registered Retirement Savings Plan (RRSP) withdrawals for medical purposes should be tax exempt.
  • Find a new model for raising health care funds for our aging population and do not use general revenues.
  • Lottery funds could be used to fund health care.
  • People who do not pay taxes should not be eligible for health care. Many people do not pay taxes as a result of fraud. Limiting their access to health care could be one way to get rid of the underground economy.
  • Institute a small health care tax on all users of the health care system that would go into the annual health care budget to fund specific health care goals.
• A referendum should be called to determine the direction people would like to see the taxes being spent.

• Property taxes are used to fund the education system and could be adjusted to fund the health care sector as well.

• British Columbians should be asked to pay for all medical expenses upfront and then be refunded through the income tax system on sliding scale dependent on income. Residents whose income is below a certain threshold would be able to claim the full amount of their medical expenses on their annual income tax and receive a refund. Those above the threshold would receive a progressively decreasing portion of their paid amount back on their tax. Residents whose income was below the threshold would receive a card with their income tax return valid for the tax year. With the card they could take their doctor's receipt to an outlet, such as a bank or lotto store, for a full refund on the same day they received the service. Those less fortunate financially would only be out of pocket a few hours, if need be, but a payment would still be made to remind those of the cost of their treatment.

• I would like a flat tax just for the health care component of our income taxes. Government would determine the tax rate necessary to cover all current health care costs and assess all residents on that basis. The rate would change annually to reflect the increasing or decreasing costs of health care. There should also be a credit system devised to reward those individuals who do not use the system. The credit would be applied against their annual flat tax assessment.

• I propose a negative tax health care system where residents would be refunded for health expenses based on their income; a lower income would get a higher refund and a higher income might not get any refund.

• There should be a 0.5 to one per cent income tax surcharge added on to corporate and personal income tax. These funds would be used to fund incentives for people to change their life styles and live healthier. Tax payers who participated in these programs would get their contributions back and those who do not participate would be penalized by having paid the extra tax.

• Capital equipment purchased by community fund raising should be tax free.

• Lab testing costs should be 100 per cent tax deductible, including testing requested by alternative medical practitioners.

• A portion of the gas tax can be put towards those injured in automobile accidents.

• A sizable levy on gas would be positive as it would cover some of the cost to health care and encourage people to drive less.
The gun industry should be taxed heavily due to the increased cost to the medical system resulting from gun crime.

Impose a tax on all cosmetic surgery to fund training positions for plastic surgeons and dermatologists who want to see patients for medically required treatments.

Provincial sales tax should be charged on all revenue from British Columbia incorporated and licensed medical cannabis suppliers.

**Outstanding Questions**

- Do the countries with the lowest tax rates have the best standards of living and health care outcomes?

- Why are the increased tax revenues from all the new property developments not being used to pay for increased medical services?

- If the health care funding situation is so dire, why does the Government have a surplus and why do they keep talking about cutting taxes?

- Why are Medical Service Plan premiums not integrated into the regular tax system?

- Why is the Government insisting that Provincial Sales Taxes be paid on capital equipment being purchased with donated dollars?

- How much revenue is generated through tobacco taxes?

**Tax Incentives and Disincentives**

**Comments and Concerns**

- Health status stratifies according to socio-economic conditions. Using tax incentives to promote health will benefit people at the higher end of the socio-economic scale who already have good health. The issue should be redistribution of income so that socio-economic disparities in health status are not widened further.

- Naturopathic doctors are not covered by our medical plan and the fees for their services are not tax-deductible as other health care expenses are. This discourages people from using their services.

- If the provincial government would like to improve the physical fitness of all British Columbians by 20 per cent by 2010, why would they tax exercise equipment which is the aid to improving the situation? We do not pay tax on bicycles and it would be prudent to extend the sales tax relief to exercise equipment as well.
• Alternative health care, vitamins and minerals and natural health products should not be taxed. Natural health products are better and safer for people's bodies than chemical-laden prescriptions.

• Healthy foods should not be taxed.

• It is not right to write off drugs but not vitamins. The use of vitamins could save the medical system millions of dollars.

**Ideas and Suggestions**

**Healthy Eating**  
**Healthy Living**

• Ideas about tax incentives for eating well:
  
  • Tax incentives could be used to encourage restaurants to advertise and offer healthier meals to their customers.
  
  • Food producers and processors can be encouraged to use healthier ingredients through tax incentives.
  
  • Vitamins and herbal remedies should not be taxed and their costs should be tax deductible.
  
  • Remove provincial taxes on health foods.
  
  • Whole foods need to be subsidized so that they are less expensive than unhealthy foods.
  
  • British Columbians should be encouraged to eat more vegetables, fruits and whole grains by subsidizing their costs.
  
  • We should not tax fruits and vegetables at all.
  
  • Salads should be tax free in restaurants.
  
  • People who suffer from diseases and conditions that require specific diets should be given tax relief. Many of these foods are more expensive than regular foods.

• Ideas about tax incentives for healthy living:
  
  • Tax incentives should be available for all individuals and corporations to encourage healthy living.
  
  • Government should offer incentives to corporations that provide gyms and fitness classes for their employees.
• Families enrolling kids in physical activities and sports should receive a tax deduction.

• The 500 dollar tax credit for children’s activities needs to be available to everyone.

• Tax credits to encourage children’s physical and mental health are a good first step.

• All costs related to improving health, including yoga, meditation, and gym memberships should be tax deductible.

• Any fees paid by British Columbians to participate in recreational programs should be tax deductible.

• Re-introduce tax incentives for individuals that invest in their health by purchasing approved programs for weight-loss, smoking cessation and other lifestyle-related disease prevention.

• A tax break should be offered to everyone who can prove on a yearly basis that their heart rate and blood pressure are at healthy levels. This would encourage exercise and healthy living.

• British Columbians who take personal responsibility for living healthy lives and minimizing their use of the health care system should be given a tax break as a positive incentive to continue and to set an example for others.

• It is important that incentives for healthy living are available for all levels of income, not just for the rich. Offering community centres tax credits to pass on to lower income populations have been shown to work by the World Health Organization.

• Lower taxes on physical activity equipment.

• All taxes on health related items should be eliminated.

• Parents who enrol in approved nutrition and health education courses should receive a tax credit.

• More tax incentives need to be available for stay-at-home mothers.

• Government should encourage people to have mammograms, check-ups, immunizations and other preventative procedures through tax deductions and tax credits.

• A system of tax incentives is needed to encourage British Columbians to use the health system appropriately and wisely.

• Tax incentives should be put in place for those families that assist in a home care role for a elderly family member.
• The child tax benefit could be a model for a system to encourage families to stay home to care for a relative.

• Renovations should be tax deductible if they enable an elderly person to continue to live at home.

• Volunteers should be offered tax incentives, such as a reduction in the tax on Registered Retirement Saving Plan withdrawals.

• The costs of accommodations after a surgery should be tax deductible.

• Tax incentives should be available for users of alternative health care as they save the health care system money.

• Norway gives a tax credit back to people who do not use the medical system for a complete year but pay into it. This would be a great incentive to stop people from going in every month just because they sneezed or because the doctor is cute.

• Government should offer a tax credit for bus riders.

• Encourage citizens to leave part of or all of their estate to the medical plan through a tax incentive.

**Outstanding Questions**

• I pay tax for health care I do not use. I pay after-tax dollars to see a registered massage therapist or naturopathic doctor with no compensation. Why can the Government not compensate me in some way for taking care of my overall health and not being a burden on the health care system?

• Why is the Goods and Services tax (GST) charged on alternative medical services such as naturopathic doctors, massage therapy and chiropractic care?

• Why are all natural supplements such as herbs, vitamins, minerals, homeopathic and food supplements charged the Goods and Services Tax (GST) when pharmaceutical drugs are not taxed?
Health Care Spending

Spending on health care was a contentious topic during the Conversation on Health. The sustainability and the amount of health care spending, spending pressures and accounting for health care costs, were areas that were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of Health Care Spending.

Sustainability of Health Care Spending

There is a great deal of debate about the sustainability of the health care system. Some British Columbians are concerned that health care spending is consuming an increasingly large portion of the provincial budget. Many of these participants feel that current expenditures cannot be sustained and that some services will have to be reduced or eliminated if we are to preserve the health care system for future generations.

Other participants feel that the sustainability issue is not as dire. They point to tax cuts and reductions in spending elsewhere to account for the increasing percentage of the provincial budget consumed by health care. Many participants argue that health spending as a proportion of Gross Domestic Product is sustainable. They feel that the Government has a number of options available to increase provincial revenues if that is what is required to adequately fund health care and other programs British Columbians depend on.

I think one of the reasons why Canada is so concerned about sustainability of costs is because we have so many governments involved. We have a federal system, which means that 14 governments have this as a preoccupation instead of one, which is the case in non-federal systems. So we seem to be unusually preoccupied with this.

- International Symposium, Vancouver
Health Care Spending

The opinions of British Columbians on the appropriate level of health spending are diverse and conflicting. Many participants are concerned that current spending levels are not sufficient to deliver the health care system that British Columbians want. Others feel there can never be enough money to fund health care and that the recent infusions of funds have resulted in little, if any, improvement. Some argue that the health system is sufficiently funded, but that those funds are not being spent as wisely and efficiently as they could be. Many feel the changes required to improve the health care system and the health status of British Columbians will require short term infusions of funds in order to achieve long-term results.

…all health care systems will absorb all the money they can get near, and all societies or governments… have to find ways of keeping some constraint on that total.

- Focus Workshops on Delivery Models, Vancouver

Spending Pressures

Participants in the Conversation on Health point to a wide variety of causes for spending pressures experienced by health care. Many participants feel that prescription medications are over used. They believe that alternate treatments and lifestyle changes are not explored adequately before a prescription is offered. Other participants discuss increased public awareness of health issues, and the expectations that awareness creates, as important factors in increasing health care demands. For some, the aging population is seen as a source of pressure on health care spending. While most British Columbians agree that the need for health care is greatest near the end of life, there was no consensus that the aging of the population alone leads to increased spending.

There are a number of options presented by participants to reduce health care spending. Some participants recommend increasing home and community care services to address the potential for increased demands arising from an aging population. Administration is another area where participants suggest that savings could be realized through improved accountability, restrictions on compensation for executives and limiting administrative staffing. Others feel that increasing the effectiveness of primary care could help address spending pressures, especially in terms of treating and managing British Columbians with chronic illnesses.
Accounting for Health Care Costs

Most British Columbians believe it is vital that the health care system be able to better account for costs and spending. Many feel that without a clear understanding of costs there is no way to achieve accountability, find efficiencies or improve quality. The current budgeting practices are seen as a contributing factor to this lack of accountability. Participants suggest ending block or silo funding and zero-based accounting. Some participants think that improved accountability could also be achieved through increasing public awareness of costs by providing patients with an invoice listing the costs of services provided.

*Every health authority and every medical care facility within it must be accountable for demonstrating the costs of providing care. Every operation, every procedure, every bed and every person involved should be fully costed so that we can begin to have a clear picture of the value of our health care system.*

- Web Dialogue, Pitt Meadows

Conclusion

Health care spending is a contentious issue for many participants. Some are sceptical that the sustainability situation is as dire as has been suggested, but most agree that changes must be made in the manner that health care funds are spent and accounted for. British Columbians are seeking accountability and measurable results in return for their current and future investments in the health care system. Participants are aware of many of the challenges facing health care, but believe that focused spending and long-term planning will lead to solutions.
Health Spending

This chapter contains the following topics:

**Sustainability**
**Pressures on Health Care Spending**
**Administrative Costs**
**Efficiencies**
**Health Spending**
**Spending Priorities**
**Capital Costs and Technology**
**Accounting for Health Care Costs**

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Submitted by the Canadian Centre for Policy Alternatives
Submitted by the Society of General Practitioners of British Columbia
Submitted by The BC Healthy Living Alliance
Submitted by the Kamloops Citizens Concerned About Public Health Care
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Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

A Submission to the Conversation on Health
Submitted by Canada Cancer Society
Maximizing Value for Health Care Investments
Submitted by ABBOTT
British Columbia’s Conversation on Health
Submitted by GlaxoSmithKline
Submission to the Conversation on Health
Submitted by the British Columbia Government and Service Employees’ Union

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Health Care Models and Innovation and Efficiency.

Sustainability

Comments and Concerns

Sustainability as a Value or Concept
Sustainability of Health Care Spending
Lack of Sustainability of Health Care Spending

- Comments on sustainability as a value or concept:
- Much is being said about how the system is not sustainable but little is being said how we define sustainability as a society.
- Sustainability should mean planning today to meet the needs of future generations.
- Sustainability is a characteristic of a process or a system that can be maintained at a certain level indefinitely.
- Sustainability is about how much we value something and not about economics.
- I think the reasons why Canada is so concerned about sustainability is because we have so many levels of government involved. We have a federal system and a
provincial system, which means that 14 governments have sustainability as a preoccupation instead of just one.

• There is evidence that financial sustainability is not the issue this conversation needs to focus on. There are also sustainability issues around service delivery and human resources.

• Sustainability can be a code word for cost control, user fees, private surgical centres, delisting of services and increased Medical Services Plan (MSP) fees.

• Sustainability is a poor foundation for any system if there is no way to ascertain measure or guarantee that efficiency is part of the equation.

• If we fail to achieve sustainability, our generation will be looked back upon as being so selfish that our lack of responsibility may have led to the downfall of Canadian society.

• The health care system must be socially, economically and environmentally sustainable.

• It is unfortunate that much of the discussion on sustainability is based on personal opinion and political bias. Unless we can move past uninformed or illogical statements of supposed fact the discussion becomes a shouting match.

• There is an enormous amount of inertia resisting change in the health care system. It appears that a sustainability crisis is being created in health care to encourage a sense of real urgency for change.

• This focus on sustainability needs to apply to everything that we do as our resources are finite and will be depleted if we do not find a way to sustain them.

• The fundamental issue is not a growing government health ministry budget but the growing overall cost of health care, regardless of where the revenues come from to pay for that growing cost.

• We need a Medicare renaissance in Canada where we go back to the roots of the Medicare system and re-examine whether we have achieved the goal of insuring families against catastrophic financial loss across the board. Has the system devolved or evolved over time to become what it is today? What is it that we are trying to sustain?

• Comments on the sustainability of health care spending:
  • The claim of health care spending approaching 70 per cent of government revenues is based on an unsubstantiated estimation of future health care expenditures increasing at eight per cent and an under-estimation of government revenues by three per cent. 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 only 40 per cent of the provincial budget in 2017.

- The Finance Minister’s assertion that by 2017 health care will consume over 70 per cent of the provincial budget is not based on a measurement of the correct data. What matters are the share of our total income or Gross Domestic Product that we spend on health care and not the share of the provincial budget.

- The estimate of eight per cent annual increases in health spending is effectively a three per cent annual enrichment rate, which is almost double the historical rate.

- Provincial spending on health care is under eight per cent of the Gross Domestic Product. This is the same range as consumer spending on bars and restaurants, which no one characterizes as out of control.

- If future economic growth rates are consistent with those over the past quarter-century they will lead to health care expenditures falling as a share of the Gross Domestic Product. In medium- and high-growth scenarios there is scope to further expand the coverage of public health care.

- We had the Health Accords of 2000, 2003 and 2004 and an escalator clause built in that goes way past 2011. We have guaranteed that health spending would rise because we said it would. We have decided collectively as a society to put a whole lot more money into health care at much higher than the rate of inflation. It has nothing to do with an inexorable trend in health costs. It has to do with a conscious decision negotiated by governments.

- Viewing recent increases in health care spending that resulted from new federal-provincial agreements to restore health care funding, after cutbacks in the mid-1990s, as unsustainable is questionable methodology. Taking this as its starting point to project further unsustainable increases in spending is unrealistic and ignores longer-term trends.

- According to Roy Romanow, we're not spending more real dollars on health care than we did 25 years ago despite the perception that we are.

- The Organization for Economic Co-operation and Development (OECD) averages about four per cent real growth in spending and we are at three per cent. We are trailing the pack in growth of health spending. There is no obvious reason that we should be so concerned with the sustainability of the rate of increases in health spending.

- Canada has kept costs reasonable as a percentage of the Gross Domestic Product of just under ten per cent, which is comparable with Switzerland, France and Germany, and much less than the United States where they spend 15.3 per cent.
• The argument that the health care budget is rising unsustainably is faulty. The budget set by the Government is a representation of public priorities and health care is a top priority.

• The measure of health care spending as a percentage of the governmental budget is not objective.

• Statistics are being misused in the sustainability debate.

• Government is trying to mislead and frighten people with the use of global health care costs instead of per capita costs.

• Health costs only $8.14 per day per British Columbian. It is affordable to increase the cost to ten dollars per day to keep the health care system public. Per person costs are sustainable.

• Business groups are suggesting that our health care system is unsustainable by exaggerating projections of large increases in health care costs to convince the public to privatize the health care system.

• The health care system is sustainable because it is funded with tax revenues. Tax revenues are a sustainable source of funding.

• Health spending consuming 42 per cent of the provincial budget is a reflection of reduced revenues due to tax cuts and lower spending in other ministries and not unsustainable increases in health spending.

• Slashing education and social services expenditures results in the health care portion of the budget to appear to be rising.

• British Columbia has the third lowest health spending in Canada.

• Government should stop closing hospitals and long-term care facilities and then telling the public the health care system is unsustainable because there are not enough beds to meet the demand.

• Sustainable, universal health care is possible and with proper engagement and utilization of our resources British Columbia can provide a leadership model for the rest of Canada.

• The health care system is providing a broader range of services than it did in the past. The possibilities offered by new technology have to date been accommodated by the public system. While some cracks are apparent, it is important to note that the health care system has expanded a great deal from its early days.

• Health Care in British Columbia is being delivered adequately in spite of media buzz and the occasional disgruntled individual who does not understand the
complexities of delivering health care in a rapidly changing environment where costs, services, demands and technology interplay to create a challenge beyond anything faced before in the health care milieu.

- There is a difference between affordability and value. The value this system may bring to society would not only lead to a better quality of life for people but ultimately it may end up saving money elsewhere. You have to look at it more holistically rather than at the system itself.

- The Minister of Finance is concerned about how much health care costs but at the end of the day there still has to be a coherent, comprehensive and cogent health care system.

- Comments on the lack of sustainability of health care spending:

  - Our health care system costs too much and is not sustainable.

  - Since 2001/02 our population has increased by approximately four per cent. Our health care costs have increased at ten times that rate.

  - There is no question that health care costs are increasing. Between 1990 and 2005 British Columbia’s provincial health care expenditures increased by 138 per cent. Inflation over that period was only 36 per cent.

  - Health spending has doubled every decade for the last 30 years. The share of budget has gone up to 42 per cent. If we continue on this track, 70 per cent of British Columbia’s budget will be going to health care. That is not something the province can afford to do.

  - The cost of health care is increasing relative to the cost of living.

  - Some have suggested that health spending has not changed as a percentage of the Gross Domestic Product but the Gross Domestic Product is not revenue and governments cannot invest Gross Domestic Product.

  - To suggest that health spending can be maintained as a percentage of the Gross Domestic Product is to suggest that the status quo is sufficient.

  - British Columbian 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.

  - Growth in the economy has not kept pace with growth in health expenditures.
• British Columbia cannot afford the current health expenditures and when the baby boomers pass through the health care system it will create a debt that future generations will have to pay.

• Some British Columbians will continue to pretend there is enough untaxed money out there to pay for an increasingly expensive health care system. They would rather we all suffer together than find a solution.

• The design of the health care system is a recipe for an unsustainable system. Those who consume the service do not pay for it. Those who provide the services do not charge for it. Those who finance it do not control it.

• The expectation of full government funding for all health care services is as unrealistic as it is unachievable.

• Statistics suggest we are facing a crisis as our population ages. If we do not make some dramatic changes to the way we deliver health care the system will collapse.

• Quality of human life has an economic value. No one wants anything less than the most advanced care. However, British Columbia cannot continue to increase the health budget year after year. This is a road to bankruptcy.

• The public has to accept that the status quo is not sustainable. We have to determine what we are willing to forego in order to ensure access to health care for life threatening illness and injury.

• It is clear that the current health care system cannot meet the needs of the population and the Government cannot keep on increasing spending.

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

• Our present healthcare system is financially unsustainable and as such endangers our ability to provide acceptable universal healthcare. The entire health care system is trapped in a series of segregated budgeted functions that need to be cross-linked in not just planning but also cause and effect outcome budgeting.

• The health care system is unsustainable due to:
  o the growing demand for hip and knee surgeries;
  o the aging population;
  o organ transplants;
  o increased spending for mental health;
  o substance abuse;
• Increasingly expensive technology;
• Increasing administrative costs, and
• Facilities that are at and above their capacity.

• We cannot continue to pour all our resources into one sector of our society. If we do not make changes now, we will end up with free health care for everyone but access for no one.

• The health care system cannot afford all of the services it is providing. We need to look at what should be covered under Medicare and what should be paid for by the patient.

• There is no way to have sustainable health care unless we stop taking our personal health and our public health system for granted.

• Health care should be sustainable because it meets one of our basic needs and makes it possible for people to contribute to society. Given the current trend of cutbacks, waiting lists and bed shortages the current system is not sustainable enough to be a reliable resource for future generations.

• The health care system cannot help but collapse as long as people are not supported in maintaining healthy lifestyles.

• When universal health care was introduced it was never anticipated that it would be used to fund ever-more-expensive ways of keeping people alive.

• I do not think people understand that sustainability, in the sense of affordability forever, is a completely insoluble problem. We are on treadmill and will not get off until it collapses as a result of our resources being exhausted.

• We absolutely should build our health care system on a foundation of sustainability.

• Innovation is critical to the preservation of a sustainable healthcare system in British Columbia as this may be the first generation in 100 years who can expect worse health outcomes than their parents. We need to adopt a new business model for healthcare which incorporates innovation and focuses on chronic disease prevention and management. Innovation is one of the foundations of a sustainable system and there needs to be an environment where the Government both values innovation and embraces partnership with industry.

• If we want to achieve the goal of sustainability, the greatest challenge we face is the need for innovation in expectations and attitudes toward the health care system and what we expect from it in the future. That will require changes in behaviour and in thinking. Our challenge is how to address that and to build into the system a new kind of environment that supports people sustaining change.
behaviour in how they use the health system and how they think about health for
themselves.

• By introducing a culture of accountability, re-engaging doctors in the system, re-
aligning the public’s expectations for health services and introducing additional
payer sources we may find our way clear to a sustainable and more robust system
for today and into the future.

Outstanding Questions

• What do we mean by sustainability?
• What is driving the unsustainable nature of our health care?
• Why should cost escalation be a reason for shifting costs from public to private
budgets?
• Do health care costs become more sustainable if paid by patients themselves, rather
than from public budgets?
• Would health care be more sustainable if we went in the direction of preventing
disease rather than treating it?

Pressures on Health Care Spending

Comments and Concerns

Pharmaceuticals
Social Determinants of Health
The Aging Population
Demand Management
End-of-life Care
Chronic Illnesses
Medical Practitioners and Practices
Technology and Equipment
Private Health Care Delivery
Lifestyle Choices

• Comments on pharmaceuticals:

• The medicalization of everyday life and the drive to diagnose disease early create
pressure on the health care system. Illnesses are being identified in patients with
no symptoms. The definitions of diseases are expanding. This epidemic of
diagnoses has in turn led to an epidemic of treatments. Diagnoses mean more
money for drug manufacturers, hospitals, physicians and disease advocacy groups. The key contributor is the pharmaceutical industry.

- Over-prescription and inappropriate prescriptions are a source of costly hospital admissions.

- The health care system is being burdened by medical and pharmaceutical costs that could have been avoided.

- Drug costs and unnecessary use of technology are increasing costs.

- Drug company’s excessive profits are driving up the costs of health care.

- Pharmaceutical expenditures across Canada are rising faster than the rest of the health care sector. Pharmaceuticals are not covered entirely under Medicare but split between public funds, private insurance and out-of-pocket payments. This parallels the American pattern of health care funding and yields the same uncontrollable cost escalation one finds in the American health care system.

- Medications that only maintain and do not cure increase costs.

- New and better drugs and vaccines are a cost effective means to ensure the overall sustainability of the health care system. Thanks in part to new drugs, hospitalization rates have dropped dramatically.

- Pharmaceuticals and vaccines, when used effectively and appropriately, are not simply commodities to be positioned as cost drivers or barriers to a sustainable health care system. The public investment in this area is a key contributor to improved treatment of patients and improved health outcomes.

- Comments on social determinants of health:

  - Poverty directly affects the health system.

  - It is estimated that the health care costs that result from violence against women are approximately $1.5 billion per year. Abused women use a higher proportion of health care services compared to non-abused women.

  - The police are using the health care system as a means of policing. The public deserves to know the real cost of health care and police practices are pushing up those costs.

  - The primary determinants of health and the health care system demand lie outside the health care system. Health care has a great deal to do with caring for, and sometimes curing, people who have become ill or injured but it has much less to do with why they became ill or injured in the first place.

  - While it is expensive to build and staff prisons, it is even more costly to deal with substance abuse related illness and injury both in financial and social terms.
• Comments on the impacts of an aging population:

  • An aging population and people living longer are increasing costs on the health care system.

  • The use of the health care system as a comfort service by the elderly is increasing costs.

  • Senior immigrants create pressure on the health care system. People are admitted to Canada each year that will never contribute to our medical infrastructure through taxes, yet they use the health services.

  • In 2003, British Columbia seniors over age 65 accounted for 13.5 per cent of the population but were responsible for 44 per cent of the total public health care budget.

  • Over the next 25 years the population of British Columbia that is greater than 65 years of age is going to go up by 100 per cent. The population itself is going to go up only 30 per cent. These population shifts are going to put incredible pressure on the health care system.

  • Stop blaming senior citizens as the reason for an unsustainable system. Actual usage costs are only $550 more per year for people over 40 years of age.

  • It seems to me from the literature that the aging of the population is one fairly moderate, modest component in the increase in costs.

  • Older people, on average, use more health care and generate more expenditures than younger people. All else being equal, an aging population will generate increasing use and costs per capita. This myth arises from the presumption that this process explains the past escalation of health care costs and that a future acceleration will make public health care unsustainable. The argument is logically flawed and empirically erroneous.

  • The aging of the population is a great Canadian health care success story. It is amazing that we have enabled so many Canadians to live long, healthy and active lives.

  • Population aging is a contributor to rising cost pressures in the health care system but a relatively small one. Based on current projections there is little to suggest a demographic time-bomb about to go off.

  • Injuries to seniors who are trying to stay active should not be included in the statistics as part of the high costs of services to seniors but as part of the cost of services to a community with active lifestyles.

  • The baby boomers are being unfairly blamed for rising costs when it was their generation that paid the lion’s share of Medical Service Plan Premiums and taxes.
• The baby boomers are living healthier lives than their parents and will not cost the health system as much as has been estimated.

Comments on health services demand management:

• The quantity and quality of information available to the public drives patients to demand the best and most expensive care and treatments medicine has to offer.

• British Columbians think the health system is free and use it accordingly.

• The lack of cost born by the individual for health care allows people to act irresponsibly and increase costs for the entire system.

• The public's expectation that all new treatments that come along will be available to them for free creates pressure on the health care system. Many new treatments are very expensive and beyond our ability to fund.

• Everyone believes it is their right to be treated, no matter how old they are, how futile the treatment is or how expensive the treatment is.

• Some women are abusing the health care system by seeking abortions for the second and third time.

• People are not aware of the costs for emergency services or doctor visits.

• The presumption that significant amounts of care are being used by people frivolously, simply because it is free, is false. Studies of actual use patterns show that care is heavily concentrated on a small number of people, people who are in fact quite ill. They are typically elderly and/or chronically ill and suffering from several different illnesses.

Comments on end-of-life care:

• Keeping patients alive who have little or no hope of recovery is a great expense for the health care system.

• A large proportion of health care expenditures occur in the last year of life. What is important is the impact on the margin of additional health care dollars spent. For example, billions could disappear into extremely expensive end-of-life treatments that prolong life by days or weeks but do little to restore health or enhance quality of life. This raises some deep ethical questions about opportunity costs. This money might be better spent, from a population perspective, on prevention and public health measures or on public dental.

• The implication for future health care expenditures is different if high costs of dying are predominant. If expenditures increase as a matter of course as people get older, there will be upward cost pressures associated with an aging
population. If people live longer and healthier lives and the big costs are really associated with dying, the real issues relate to end-of-life care options.

• Comments on chronic illnesses:

  • Chronic disease affects 34 per cent of British Columbia’s population and accounts for 80 per cent of the health care budget.

  • The Ministry of Health estimates the direct cost of providing health care services for people with complications related to diabetes at approximately $776 million each year. By 2016, predicted direct health care costs to treat patients with diabetes in British Columbia will increase by 78 per cent to an estimated cost of 1.38 billion dollars. It is highly likely that the indirect costs of diabetes to British Columbia’s Gross Domestic Product will increase at a similar rate.

  • An estimated 1 in 100 Canadian babies (about 4,000 per year) is born with Fetal Alcohol Spectrum Disorder. The 2003 Provincial Fetal Alcohol Spectrum Disorder Strategic Plan for British Columbia states that, "Each child affected by Fetal Alcohol Spectrum Disorder may require an estimated $1 million to $2 million over the course of their lifetime to support remedial medical, educational and social costs. Pregnancy Outreach Programs work with at-risk women to reduce/eliminate alcohol intake during pregnancy and thereby lower the rates of Fetal Alcohol Spectrum Disorder.

  • Arthritis and musculoskeletal diseases cost the Canadian health care system 16 billion dollars per year and represent the nation’s second most costly group of diseases.

  • Greater value for money will require improving the effectiveness of care for the chronically ill with multiple co-morbidities, through better application of evidence on what works and what does not. Shifting costs from the public to patients will simply penalize the sick financially, thus adding to the burden of illness itself.

  • Evidence-based care and practice are not fully maximized. A Danish study demonstrated that evidence based care in Type II diabetes can have a significant impact on costs and savings.

  • The prevention of cancer has the greatest potential to reduce the burden of cancer, which will help reduce the incidence of chronic disease and lead to a healthier population and a sustainable health care system.

  • The incidence of cancer is expected to increase 60 per cent over the next 20 years due to our aging and growing population. This will place added strain on our health care system and result in the loss of productivity of British Columbians.
• Comments on medical practitioners and practices:
  • Improper diagnosis often leads to unnecessary surgeries, which contribute to making the Medicare system too costly.
  • Surgery is an over utilized solution when problems could be easier and better treated through alternative care.
  • Doctors who make errors are not accountable for their mistakes.
  • There are no cost controls placed on doctors by the primary payer for services, the Government. Doctors are therefore in a position to recommend increased utilization and are guaranteed payment by the Government.
  • The fee for service structure is not efficient and creates incentives for increased utilization.
  • If clinical guidelines are rigorously rooted in evidence from clinical trials, and are in fact followed by clinicians, they are a powerful tool for improving value for money. However, when clinical guidelines are significantly influenced by current practice and convention rather than trial evidence they become a floor from which clinical practice expands.
  • Growth in servicing intensity is being driven not by patients asking for more interventions but by physicians recommending them. The majority of these recommendations are undoubtedly based on the belief that patients will benefit but these beliefs often lack a secure base in evidence.
  • The increases in intensity of servicing that are the major drivers of cost escalation have several sources. One of these is changes is in formal and informal clinical guidelines, which significantly re-defined the proportion of the population in need of treatment. Expanded diagnostic capacity and use leads to the discovery of an increasing degree of clinical abnormality that is treatable but that treatment may have little or no impact on health.
  • Doctors are not the cause of rising health care costs. Many other factors are contributing to the rising costs including an aging population, a greater need for expensive investigations and treatments, the consumption of cigarettes, expensive drugs that are not that effective and too many bureaucrats.
  • Government has signed a $400 million contract with the physicians to address primary health care. I think that is the biggest waste of money I have ever seen. Physicians in general practice alone will not provide good primary health care. They are not conscious of the population or society and all this contract would do is allow doctors more billing. It is not multi-disciplinary nor is it spread evenly across the province because of the way physicians are distributed.
• The current specialist referral system is inefficient, very expensive and needs to be addressed.

• Family doctors and emergency rooms are the main entry points to the health care system for most British Columbians and both are very costly.

• The lack of a family doctor leads many British Columbians to over utilize the health care system.

• The Government should take a more active role in discouraging double doctoring. They used to write letter to people who did this but not any more. The costs of this practice should be better explained to the public.

• Non-professional overtime is where all our money is going.

• Comments on technology and equipment:
  
  • Missing, lost or stolen wheelchairs and other equipment is a great expense to the health care system.

  • Between 2001/02 and 2005/06, the number of diagnostic machines in British Columbia available increased at a pace much faster than population growth or aging would require.

  • While some innovations will save money, technology can also create cost pressures. In a constrained budget environment there is a risk that new technological innovations will crowd out other services.

  • Medical knowledge, procedures and equipment have developed to such an extent that we now have the technology to bankrupt ourselves, unless we are willing to put limits on that spending. Rather than avoiding the question by allowing private care, I believe we should take the responsibility of making these decisions.

  • It must be recognized that new and innovative medical devices are not a cost driver to the system. There is a significant body of evidence internationally to show that the use of innovative medical devices can substantially reduce requirements for pharmaceuticals, reduce emergency room visits and reduce hospitals stays.

• Comments on private health care delivery:
  
  • Walk in and private clinics cost the health care system a great deal and there are only so many dollars to go around.

  • Treatment centres are draining the health care budget.
• It is a concern that the proliferation of private facilities will increase capacity for service delivery past the point where it is affordable for the taxpayer.

• The pressures facing the public health care system would equally challenge the sustainability of private health care.

• The areas where health costs are growing fastest are those with the most private involvement, such as pharmaceuticals, medical technologies and private health care premiums.

• Private sector suppliers are driving up the costs, not the public facilities.

• Privatization increases cost because of the need for profits. Profit will result in escalating the costs of health care.

• Comments on lifestyle choices:
  • Preventable car accidents are a huge cost to the health care system.
  • It is estimated that the cost of smoking and unhealthy eating amounts to double the annual cost of the average otherwise-healthy individual's health care costs.
  • There is an upward trend in childhood obesity-related health care costs burdening the health care system.
  • British Columbians whose lifestyles include unhealthy eating and smoking are estimated to cost the health care system double that of a healthy individual.
  • If we could convince the population as a whole to quit smoking, to lose weight, to walk to work, to bicycle where appropriate, to eat proper foods, avoid trans fats, to not drink alcohol, to not use other substances of abuse, to not get into cars and race, to not take up paragliding and all the things that we all do or many of have done in the past and think that simply by focusing on prevention and health care promotion that we are going to lower health care costs we are mistaken. All we would be doing is delaying the inevitable. Instead of getting into congestive heart failure at age 70 and having a five year life expectancy, you are going to live 7 or 10 years longer but at the end of the day our health care system is still going to be faced with the same problems. All you are going to have done is shifted the problems five to ten years down the road but you are still dealing with the same subset of people who need lots of medical care in the last years of their life.
  • Our health care system has been enriched and expanded by the addition of new surgical procedures, new pharmaceuticals and the public coverage of services of additional health care sectors.
  • More surgeries are done today than a few years ago. However, hospitals must live within global budgets when 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 British Columbia cut costs by reducing production, for example, by closing operating rooms. As a consequence, waiting lists continue to grow.

- I think the evidence is pretty clear that if we make a strong investment in the primary care system you can decrease overall system costs because health outcomes go up for the entire population.

- Ambulance costs are increasing due to the closure of so many hospitals.

- The health care unions are attempting to continually raise the ante in salary and benefits. This is a major factor in the escalating costs of health care. I do not think the rising cost of salaries and benefits is sustainable.

- Resources are wasted because British Columbia purchased an ambulance dispatch system that sends fire trucks and two ambulances to far too many calls for assistance when clearly they are not needed

- There is inflation in health care costs, that is, an ongoing rise in the price of purchasing the same level of health care services. This includes the rising salaries of professionals and other workers and higher costs for supplies and equipment.

- The biggest cost driver is inflation, with increases averaging 10.7 per cent per year, if you include the period of high inflation from the mid-1970s to the mid-1980s. If we look just at the 1995 to 2005 period, the impact of inflation is less at 2.4 per cent per year. Population growth is responsible for increases of 2.3 per cent per year over the 1975 to 2005 period and 1.2 per cent per year over the 1995 to 2005 period. However, it is notable that increases in population are generally offset by increases in economic activity and thus increases in tax revenues to fund services. Population aging is the smallest factor of the three, responsible for increases of only 0.7 per cent per year between 1975 and 2005 and rising to 0.9 per cent per year for 1995 to 2005. Projecting cost pressures forward, aging adds 1.1 per cent per year to the cost of maintaining the status quo of health care services.

- I am concerned over refugee families entering Canada and the potential costs to the Canadian health care system.

- Patients who catch infections while in the hospital add to our health care costs.

- Feedback loops are pushing the system in wrong directions. Methods of payments, amounts paid for various procedures and drugs and the constant lack of evaluating system measurements all result in increased costs.
• The lack of warnings on products containing sunscreen result in a cost to the health care system because of doctor visits and medications for those who have allergies.

• Too many caesarean births are performed in British Columbia at a great cost to the health care system.

• The health care costs that are rising in comparison to the Gross Domestic Product are diagnostics and medications.

• In some areas, Aboriginal people are provided with three meals a day free of charge at the hospitals. That creates a real drain on the hospital budgets and allows less funding for meals for the people who are admitted for care. Hospitals are not restaurants.

• Off-site storage for patient records, that can no longer be destroyed, must cost an absolute fortune and the costs will rise with every successive year.

• WorkSafe uses their legal system to get you off benefits and into the public health care system, thereby saving WorkSafe money.

• Health human resource shortages translate into high rates of increase in pay packets.

Ideas and Suggestions

Alternative and Complementary Health Care
Spending on Technology
Prevention and Health Promotion
Home and Community Care
PharmaCare
Social Determinants
Health Care Delivery
Education and Personal Responsibility

• Ideas about alternative and complementary health care providers:

  • If naturopathic medicines were fully covered under the Medical Services Plan a significant burden would be taken off the mainstream system.

  • Dental assistants can play a key role in improving the sustainability and accessibility of health care but not under the current regulatory framework.

  • The health care system must be cost efficient if it is to be sustainable. It seems we must intelligently investigate and implement the use of less costly alternatives to an increasingly expensive, technological and drug-oriented approach to health
care. Massage therapy can contribute by providing a therapy for many soft tissue conditions that is safe, effective and cost-effective.

- Look for the most effective and economical way to deal with disease or illness, including natural remedies.

- Chiropractic care has been shown to be more cost-effective for the health care system than medical management of back problems thus saving the Government and tax-payers money.

- British Columbia must adopt and administer medical cannabis distribution and licensing. This will generate a great deal of revenue for the health care system.

- We should look for alternate care availability before surgery is offered. Build in a second opinion in serious cases concerning the ways to help the patient.

- The British Columbia Association of Optometrists (BCAO) strongly urges the Government to recognize the benefits of preventive eye care in minimizing costs to the health care system by permitting timely intervention to prevent acute and devastating disease.

- The Government discontinued coverage of chiropractic, massage therapy, naturopathy, physiotherapy and podiatry. People willingly paid user fee to access these services. When coverage was discontinued, people went to their general practitioner for treatment. This resulted in the Medical Service Plan covering the full cost of the visit plus drug costs in many instances.

- Ideas about home and community care:
  - Support community-based wellness programs that involve fitness programs, education and counselling enable older British Columbians to remain independent in their homes for as long as possible. Wellness programs also help to ensure a sustainable health care system by keeping seniors healthy and out of institutions.
  - We must 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 in patients' homes. How we manage the increase in chronic diseases among our growing population and aging seniors will be a critical factor in ensuring that the system functions effectively.
  - The cost of caring for each resident in long-term care can be in excess of $10,000 per month. I feel many family members would be willing to take a leave of absence from their work to care for an elderly family member for half of what it is
costing the health care system. Even if some respite care and home nursing support was provided to these families it would still result in large savings.

- Keeping seniors in their homes saves the system a great deal of money.

- We should do more outreach and monitoring of frail seniors in their residence. This is likely to reduce costs and overloading of beds in the acute care system.

- To respond to the changing needs and demands in this province and to sustain the health care system more consideration must be given to expanding the role of home and community care, integrating all sectors within the health system and innovations that ensure fiscal sustainability of the British Columbian health system.

- Community workers prevent numerous hospital trips that would have cost millions.

- Ideas about PharmaCare:
  
  - Moving to first-dollar public coverage through a national Pharmacare program would deepen incentives for cost-control. A national PharmaCare program would cost between three billion and four billion more than existing public expenditures. A recent report for Health Ministers under the National Pharmaceutical Strategy set additional costs to the public sector for a catastrophic drug coverage plan as ranging between $1 billion and $4 billion, depending on the formula used.

  - Numerous policy initiatives could be implemented to better control drug costs as part of a coordinated national pharmaceutical plan. The federal government could restore compulsory licensing to enable greater generic drug production for the Canadian market, enhance funding for new drug development that would be put in the public domain, engage in bulk purchasing and determine a common formulary that would be covered in all provinces. It could also limit the challenges posed by direct-to-consumer advertising of drugs.

  - The cost of nutritional treatments is much lower than the cost of drugs and has long lasting effects which can only benefit our health system while also reducing costs.

  - Consider buying out the major drug companies in conjunction with other countries who have similar health plans and support new drug research in the universities of the countries that participate.

- Ideas about spending on technology:
• The increasing cost of new technological interventions must be weighed against their benefits. Not every new technology will be justified and there may be significantly diminishing returns to advances in technology. This discussion quickly becomes one of ethics because how much does society expend on an individual's care when the sky is the limit? This topic is deserving of thorough public discussion and debate.

• The Romanow report concludes that health technology assessment is a comprehensive and systematic assessment of the conditions for and the consequences of using health care technology. It provides relevant information to managers, decision makers and health care providers on the safety, economic efficiency, clinical effectiveness, as well as the social, legal and ethical implications of using new and existing technologies. Indeed, health technology assessment should be about what is best for the patient, both medically and economically and not about technology for technology's sake.

• A review of new technology for the Romanow Commission argued for an enhanced health technology assessment and a renewed federal role in technology regulation to ensure the appropriate application of new technologies and to shape the development of new technologies at an early stage. This approach is common in European health care systems.

• We rather uncritically buy new technologies before their time. There are a whole lot of new technologies implemented, particularly drugs that are no better than the older effective products, at twice, triple and quadruple the cost.

• The challenge will be to ensure that new money in the system is directed to areas with the highest marginal benefit. While new technologies are sexy, in many cases we have little empirical data on whether they are effective or whether they justify their cost. The capacity to come up with new technological innovations may be limitless, although only a few may prove to be worthwhile additions.

• There are also important ethical and social considerations with regard to new technology that must be considered. This context will be important in the future in order to balance innovation with cost-containment.

• Technology that quickly leads to diagnosis will reduce pressure on the system.

• Ideas about prevention and health promotion:
  • Increased health care spending has been attributed, in part, to poor coordination of patient centred care and lack of attention to preventative care. Physicians note that many of their patients have had multiple visits to multiple specialists, expensive diagnostic tests, often repeated by different specialists over a long
period of time and still have no clear diagnosis or improvement in health. Multidisciplinary clinics would save the system a lot of money in this regard.

- Preventative health care, which includes disease prevention, is about needing to get to the root causes around health determinants. It is not effective to invest all of our money in the acute health care system. Both preventative and acute health care need to be funded but continuing to short shrift prevention is not the way to go.

- There should be a graduated shift to more money into promotion and prevention, from three to six per cent. It is not so much just rewarding primary care teams as it is recognizing that if you are going to change the numbers on the back end of how many people are accessing the health care system, at some point you have to invest more money on the front end. The whole range of services, including media campaigns, Act Now, and primary care teams need to be more broadly funded. You cannot flip the switch overnight because there are people just waiting longer in the emergency room. We need to deal with wait-lists first before you start shifting people’s behaviours because you need the trust in the system.

- When engaged in public debate about health care we tend to focus on the high cost items that preoccupy institutional administrators, while overlooking the powerful forces that preserve our health, including healthy living environments and workplaces, primary prevention (for example, nutrition education, childhood immunization, ante-natal care, physical activity and smoking prevention) and social policies (affecting literacy, employment, crime, housing quality and community wellbeing). These are the upstream factors. We also become so preoccupied with acute care issues, which are crisis-prone and sometimes glamorized, forgetting not only the upstream factors but also the downstream ones (for example, long-term care and home care) whose availability determines the speed with which acute care patients may move on to more appropriate levels of care.

- Consider the costs of education on healthy lifestyles as way to offset to costs.

- We should encourage people to buy cars with electronic stability control systems. These can reduce accidents by 30 per cent and automobile accidents account for a large amount of health spending.

- We have generations of people who already have cancer and have had heart attacks and they are still going to need care. Also, everybody has an end to their life so we are always going to need end-of-life care and we are always going to need birthing care. So we cannot cut the acute system into nothing because we will always need it, even if we have a healthy population and a model of healthy communities and health promotion.
• We need to invest in healthy pregnancy care and health care for young children in order to save future costs that result from the increasingly poor health of children.

• Encouraging hand washing is inexpensive but will save the health care system over time.

• Medicare costs could be saved if more people knew about and used things like the NurseLine and the British Columbia Health Guide.

• Provide new money to support prevention, which in the long run may decrease the need for acute care and result in savings.

• Educate chronic disease patients on the cost of services they receive to encourage them to better manage their conditions, which will save the health care system money.

• Ideas about addressing social determinants:
  
  • Increase the funding for housing and raise the welfare rate to reduce chronic disease. Dieticians should help set tax policy guidelines.
  
  • We need to increase awareness and begin to address the social issues that lead to health problems. We need to invest across the board to help the overloaded health care system.

• Ideas about health care delivery:
  
  • The goals of the health care system need to include sustainability and timely access to quality healthcare interventions. In order to achieve these goals it will be mandatory to continue to invest in health care interventions that provide the most value and improve both the quality of care and patient outcomes. At this time, the structure and incentives in the health care system need to be modified so that value and quality of health care interventions can be measured. Once relative value is understood, it will be clear which health care interventions should be funded in order to deliver high quality that can be sustained into the future.

  • The private sector can bring core competencies that will generate service innovation, process excellence and cost savings to the challenge of solving the health care puzzle.

  • High quality health care systems cost about 30 per cent less than poor quality systems. The cost of a re-admission is huge. The cost of an avoidable infection that ends up in hospitalization or an extended stay in hospital is huge. The cost of an adverse drug reaction that sends an elderly frail person to the hospital for two weeks is huge. We can do things on quality improvement that should blow a big
hole in whatever you think the sustainability debate is. I think we can crank back the baseline rate of health spending if we had a quality revolution.

- High quality care should be less costly but how do you get to high quality? You get high quality by examining every process in the same way you get to lower cost. Experience shows that in health care, high quality and low cost go together.

- A principal focus for efforts to improve the effectiveness of care for the chronically ill with multiple co-morbidities has been the restructuring and strengthening of primary care. It is widely accepted, on the basis of good supporting evidence, that a strong and well-coordinated primary care system both improves patient outcomes and saves costs.

- If we are effective at the primary care level the result is a cheaper health care system. With more investment in primary care you are going to reduce the cost of overall health care. That is why the systems that are built on sound primary care have lower health care costs. For some populations it may actually increase health costs because it brings more vulnerable groups into the health care system.

- The Primary Health Care Charter, recently released by the Ministry of Health, is a welcome attempt to formulate a long-term vision for a strong and sustainable primary health care system.

- Set up working groups that span different health authorities and other organizational entities, specifically charged with identifying areas where investments in one area will result in substantial improvements in quality of care and cost effectiveness in other area.

- I think the centralization of acute care facilities is a good idea and good for cost saving.

- 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. Leading health policy analysts, researchers and economists have been putting these solutions forward for years. They are at the core of the latest national commission on health care, which was headed by Roy Romanow in 2002.

- Learn from small non-profit social service agencies that are in more contact with their community and also make the most of limited funds.

- Managing costs in isolation not only leads to cost shifting, it creates a downward spiral. It de-emphasizes quality and shifts costs from the near term to the long term. The emphasis on short-term cost containment provides incentive to delay
aggressive, proactive treatment. The objective quality care goes down. The delay in treatment can multiply the overall costs to our society of the patient's illness, resulting in lower productivity for our society.

- Re-open rural hospitals which were closed as cost-cutting measures. The closure of rural hospitals does not save costs in the long run because severe winter road conditions and distances also need to be factored into the costs. People unable to access a hospital become more seriously ill and end up costing the system more.

- Billing surgeons appropriately for the use of public operating rooms and other facilities for elective operations could generate revenue for the health care system. The rates charged currently are below cost and below market rates.

- Re-allocate resources into services such as home care, long-term care facilities and mental health so that more expensive acute care and emergency care resources are not used when other solutions could have been available.

- Ideas about education and personal responsibility:
  
  - Penalize people for taxing our health care system if it can be proven that they are directly responsible for their illness.
  
  - Educate the public and professionals about what health care costs on a per person basis.
  
  - Construct a list of examples of unnecessary procedures and health system usage to educate the public and health care providers.
  
  - Users should receive an annual statement of what services they used in the health system and their costs.
  
  - The public should have their expectation of service lowered to better match the system's ability to deliver services.
  
  - Once a year publish the cost of all types of surgeries and treatments to bring public awareness to health care costs.
  
  - We all have a role to play in reducing health care spending.
  
  - I think that hip and knee surgeries for the chronically obese are a poor use of tax dollars. The replacement joints have a very limited life which is negatively impacted by excess weight. Instead, public fitness memberships could be provided free of charge to those who need to lose weight and do not have the funds to pay for access. If there is no weight loss over the course of six months the passes would be revoked and no surgery booked.

- The focus should be on value for patients, not just cutting costs.
• We should direct science to focus on developing our abilities to do things faster and cheaper without the objective of generating profits.

• Seven Oaks Hospital found motels and hotels that offer three meals a day for $130 per day to house patients. Compare that to keeping people in a full care facility at $1500 per day.

• The federal government allowed corporations and sole proprietors to deduct all of their employee’s expenses by utilizing a third party trust. This arrangement would greatly reduce the ongoing financial strain on the public system, while allowing the employer to switch from costly group plans to a cost controlled internal system. This will benefit both the corporation and the government. Unfortunately, I do not find this information on your Public Health Timeline (Conversation on Health website). If we are going to be able to provide a viable medical system for those who need it, while still retaining our care professionals, we must urge all Canadian companies to switch from a private sector group insurance plan to a government entitled health care solution.

• Increased democratic participation in health care based on more participatory models from other countries could be applicable to health care in British Columbia and could lead to reduced costs.

• The combination of health benefits and economic savings provide powerful incentives to set targets for risk factor reduction, all aimed towards improving the chronic disease profile in the province. Focused implementation is the key to success. Setting targets is one thing but achieving them is another.

• Better utilization and funding of non-profit groups, with some accountability, can relieve pressure on the health care system.

• Institute a province-wide procurement system, which hospitals have the option of joining. This would result in savings for the institution, the government and ultimately the taxpayer.

• If we were able to provide kidney transplants to most of the people on dialysis we could save billions.

• In order to begin acceptable reform in our health care system, I think it is critically important to stop using terms like single-payer or publicly-funded, which are too abstract, and to start correctly identifying them as tax-payer funded services.

• Staff should not be burdened with having to consider the bottom line but be reassured that there is good management at each level with all participants in the system having the same objective of a competent, efficient and caring medical system that respects the public's demand for a public health system.
• Maybe limits should be placed on how much we spend on each person. The people expect too much.
• Re-direct funding to areas with more positive outcomes.
• As the population of working people decreases and retired persons increase, look at increasing the number of working, tax paying people through increased immigration.
• Increase the fees for practitioners in private practices and then re-invest the money into the public system.
• Developing cost sharing teams to deliver common services with WorkSafe and the Insurance Corporation of British Columbia.
• Re-open facilities that were closed.
• Employ health care economists to better describe the true costs of health care and where to achieve efficiencies.
• We must have the political will to begin a process to define limitations on what services can be provided.
• The Insurance Corporation of British Columbia (ICBC) must be responsible for the medical treatment of injuries caused by vehicular accidents.
• Allow corporations and disability insurers to pay for medical procedures in both the public and private systems to bring more money into the health care system.
• Look for lots of small savings at the front-line instead of large program cuts.
• Treat conditions early and rapidly. Regular screening and monitor trends will help to catch problems early.

**Outstanding Questions**

• Is malpractice insurance a cost that is indirectly borne by the public health system?
• Seniors are cited as a primary cause for medical expenses but how much is being spent on children’s medical and hospital expenses?
• What factors control demand for health care services?
• Is there any evidence that smokers or obese people actually cost the health care system more over their lifetime than healthy people?
• What is the biggest cause of health expenditures?
• The American Academy of Orthopaedic Surgeons projected that within the next several years that knee replacement surgeries are going to rise by 670 per cent. How are we going to pay for this?

**Administrative Costs**

**Comments and Concerns**

• Twice as much is being spent on administration by the health authorities as is being spent on public health and prevention and 75 per cent more than on mental health and addictions.

• Too many people in government are involved in deciding how to spend money.

• The Ministry of Health suggests that ten per cent of all health care operating costs are allocated to administration. Being Canada's largest service sector, employing 2.6 per cent of the total population, ten per cent could be considered excessive.

• In a single-payer system, ten per cent administration costs may be average but that represents $1.29 billion in administrative spending.

• I recently paid the Goods and Services Tax (GST) on the administrative portion of my annual physical performed at a private clinic. Based on the amount of tax, it appears that administration costs are 37 per cent of our overall health care costs. If this is correct, it seems very high.

• Far too much money has been thrown at health care without much meaningful progress. Part of the problem stems from the fact that too large of a percentage is spent on administration at the expense of the actual provision of health care.

• We can afford health care but we cannot afford the current level of administration.

• Too much money is wasted on bureaucracy and propaganda. There is no accountability at the highest corporate levels.

• The cost of the administration of our health care system is out of control.

• Management should not receive any bonuses if health regions forecast deficits, make cuts or reduce programs or services to stay within budget,

• If you look at the amount of meetings that managers have then you can see at once the waste in the system.

• Managers are managing to budgets and not to best care practices.
• A recent Fraser Institute report indicated that the number of hospital workers in Ontario earning over $100,000 per annum has tripled since 1996, with executive pay growing twice as fast as non-executive pay. The report indicates that only three per cent of the recent billions of dollars that has flowed into health care have actually been spent on you and me. The balance has gone to wages and salaries.

• They keep closing beds, losing nurses and hiring more administrators.

• We certainly need no more paper work, committees and quality assurance departments with all of the accompanying administration costs.

• There are administrators with huge salaries who are pointing out that we need a review of the system. It is not hard to see that the system is too expensive.

• Regional health management costs eat up all sorts of money that should be spent on special equipment and trained providers.

• My perception of the health care system is that there is a huge duplication in administrative and professional positions. We seem to have departments at the federal, provincial and regional levels and in the hospitals themselves. Surely some of these positions or departments could be eliminated to reduce costs without compromising the efficient operation of our health care system.

**Ideas and Suggestions**

• The health care system can save dollars by trimming the top heavy administration.

• There is no crisis in the health care system. The problem is with management and the unwillingness of politicians to act in the public good.

• The managers should be compensated based on the facility's service and efficiency.

• Reorganize finances so spending benefits the patients and is not focused on administration and bureaucracy.

• Reduce huge payouts to administrators for severance.

• Understanding the costs of service would allow us to judge the efficiency of our administration.

• Administration of hospitals and health authorities must be reduced and should not exceed six per cent of the total health expenditures, which would create a potential savings of $516 million.
Outstanding Questions

- How much do we spend on administration as compared to delivery?
- Where can I find figures on the salaries and perks of the administrators?
- What percentage of the funds spent on health care is spent on administration?

Efficiencies

Comments and Concerns

- It is a waste to purchase expensive equipment when cheaper equipment is available. Other areas of wasteful spending include disposable supplies, underutilization of equipment and facilities, and duplicate testing.
- The use and cost of health care supplies in hospitals are rising at a rate in excess of the national inflation rate. In the average public operating room, every item which could potentially be required in a surgical case is brought into the operating room and opened. This means that single use disposables are opened and ready for use, regardless of their need. This is wasteful.
- Supplies from Canada are the same quality as those in India but at a much higher cost.
- There is a lack of competitive pricing in health care purchasing.
- The health care system wastes money on the inefficient use of electricity, equipment and supplies.
- Supplies and equipment are purchased by non-accountable employees. It is not their money! Chairs for the ward took six months to arrive, cost $180 each and broke very quickly. Replacements took another three months to arrive. These chairs could have been purchased locally for $90 each. Budgets are being used up quickly to retain next year’s funding.
- The present health care system is cumbersome, costly and fragmented.
- We are getting poor value for the money spent.
- Canada is not getting our money’s worth. We are ranked 30th in the world.
- No amount of money will ever fix our health care problems. We must reduce the tremendous waste we now have.
- Large amounts of money are going into health care with a relatively low efficiency on its return.
• Information technology projects and contractor wages are two sources of wasted spending.

• Cost control is a low priority for doctors, nurses and administrators.

• The budget process is politicized, short-term and restricted in silos. This leads to inefficient spending.

• There is no accountability of how money is spent.

• If you cannot follow how the money's used, you cannot question if you are using the money in the most appropriate way. That lack of accountability has to do a lot with the way that we fund health care.

• Budgeting rules are forcing health organizations to spend money unwisely, such as spending before year end.

• There is too much targeted, one time money and not enough consistent and stable funding.

• There is no financial encouragement to do more. It is easier to get 50 surgeries out of a budget than 70.

• There is no incentive or alternative means to resource or benefit from innovation in the current health care system.

• Compartmentalization of health care funding is an issue creating barriers to innovation throughout the system.

• We are wasting tax payers' money and patients’ energies by not recognizing naturopathic doctors’ skills and training.

• Ignorance, biases, prejudices, political philosophy and in house thinking are resulting in unwise expenditures.

• We have two ministries: one pays for education and the other pays for health. The Ministry of Advanced Education gives you money for educational seats but if Vancouver Coastal asks for money for practicum seats the Ministry of Advanced Education cannot give it to them. Money for practicum seats must be approved through the Ministry of Health. We have this dichotomy of reporting structures. We have a health human resource crisis that has been identified that needs inter-ministerial cooperation, funding and dialogue.

• Tests are often reordered because the results of the last test are not readily available because we do not have an efficient means of sharing results.

• Doctors are paid by the number of patients visits, which is an incentive is to have a large patient turnover each day to cover overhead costs and to spend as little time as possible with each patient.
• Governments and taxpayers have no idea how much of their money is wasted hourly by the present system that has become too union driven, administratively heavy and incredibly poorly organized. The costs of covering one’s posterior against liability and accountability have become more important than the patient who we are there to care for.

Ideas and Suggestions

• Wind power holds the possibility of saving the health care system a great deal of money. The technology exists and can be implemented for a short-term cost, with long-term savings. Purchase and install wind turbines as alternative power sources, mounted at the highest points of the hospital or on a tower on the grounds. Electricity from the city grid would be considered the backup uninterrupted electricity if the wind is too weak.

• We should create self-contained energy sources for hospitals, such as wind power and solar power, and negotiate with suppliers and manufacturers to create lower voltage devices for use in hospitals.

• Institute a mandatory discount system for all suppliers to only allow a certain percentage of profits on hospital contracts.

• Province-wide bulk purchasing of medical supplies would save a great deal of money.

• I feel by making better use of telephone, e-mail and other on-line services it would streamline the process for patients and doctors and save money in the long run.

• Change the law to allow hospitals to destroy records rather than having to ship and store them.

• While it is essential that many tools, instruments and bandages be sterile to reduce the possibility of infections, I have noticed that many hospital products are extremely over-packaged.

• A recycling program for rehabilitative tools, such as neck braces, should be established because they are easy to sterilize and expensive to replace.

• We could reduce hospital expenditures by not contracting out food services and laundry and by making our own dressing trays.

• We need a health professions council to make sure that what is promised is actually getting delivered.
• Ensure that accounts receivable gets the money from Worksafe and other insurance providers. Too much money is lost by not getting bills paid by the responsible insurer.

• It would be great to find the motivation to build a more effective and efficient public system.

• 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 that results in significant decreases in wait times. British Columbia should consider a few pilot projects to see if similar improvements in productivity can be achieved here by delivering more services without corresponding increases in costs.

• Physicians should be given a finite budget for costly investigations and tests. They should only be conducted where there was already a tentative diagnosis established and where the outcome of the test would clearly influence the pattern of treatment.

**Outstanding Questions**

• Are we getting the maximum efficiency out of our hospitals in terms of productivity and health care delivery?

**Health Spending**

**Comments and Concerns**

*Increasing Public Health Care Spending*

*Limiting Public Health Care Spending*

• Comments on increasing public health care spending:
  
  • There are never enough health care dollars to spend effectively.
  
  • The current health care funding is inadequate to maintain the health care system.
  
  • The will of Government is not there to adequately fund public health care.
  
  • We may not be paying enough individually for health care.
  
  • Too much money has been diverted to other programs away from health. The health budget must be increased in correlation with population growth and the age of the population.
  
  • If public health expenditures are adjusted for population growth, aging and inflation, then the remainder is for enrichment. There has been a continual
expansion of health care services in British Columbia over the past three decades. The total increase in spending due to enrichment in 2005 is 48 per cent above 1975 levels. That means the average British Columbian receives almost one and a half times more health care services as their equivalent did 30 years ago. Enrichment is beneficial in the sense of more nursing homes, more comprehensive drug coverage and new technologies but health care services are not a typical economic good. They are a response to ill health. More health care services are only good if they lead to improved health outcomes.

- The health authorities are running deficits at a time when we have a robust economy and are throwing billions of dollars at the Olympics. The overruns on the RAV-line, are ten times what our health care overruns are and yet we think we are in a health care funding crisis.

- Over the last 20 years we have seen health ministry spending almost quadruple. The demographic and other cost pressures that we face are only going to increase and that is going to be something that we all have to deal with.

- Everywhere in the developed western world, as individuals, provinces and countries become more affluent and people live longer, more is spent on health care.

- We can expect total public health care spending to rise by more than three times current levels by 2031. This is a convenient end-point as this represents approximately the peak year of seniors as a share of the population. Long-run demographic projections suggest a period of declining share of the population over 65 after 2031.

- It is important to look at health spending on the whole and not just to focus on public health spending.

- Health care in British Columbia costs every person $8.40 per day. Most of our government representatives spend twice that on their espresso cappuccino coffee every day.

Comments on limiting health care spending:

- We talk about things being under-funded but we have never examined what that funding was intended for and whether the original scope of that funding was realistic or not. You cannot just throw money at a problem if you do not know what you are trying to achieve.

- The most difficult future policy choice will be the determination of what proportion of expenditures the public is prepared to support with the general tax base versus an increase in co-payments.
• Increasing funding will not resolve the issues facing the health care system.

• There is no relationship between huge expenditures on health care and the health status of society.

• Throwing billions of dollars at our health care system will not solve the ongoing problems. The real problem is the Canada Health Act and the totally uncontrolled and obstructive health care bureaucracy.

• There has been billions poured into the medical system over the last few years with no improvement and as of yet I have not heard anyone, be they politician, administrator, health care authority or private provider give a good explanation of how it has been spent without producing any positive results.

• Trying to manage demand by rationing is not working because it just causes cost to escalate. We need to try something different.

• I recommend that you abandon the idea of health services for everybody, funded from general taxation, regardless of personal circumstances.

• The public system rations service and payments to practitioners and hospitals. If the Government opened the purse strings and allowed the backlog to clear itself as quickly as possible, it would be fascinating to see how quickly that would happen and how much it would cost you and I in taxes. We would have all our medical issues addressed but we might not have schools.

• The United States demonstrates perfectly that satisfying the public demand for health care is impossible.

• Containing costs in the health care sector is a permanent, bruising, nasty business that every government has to be involved in. It is not the case however that we are running beyond our ability to pay.

• I think there should be a cap on health care spending in British Columbia. The cap should be a percentage of provincial revenues. The rest of the money for health care would have to come from premium payments. If people want more hospitals, more specialists and more surgeries, then they should be willing to shoulder more of the costs.

• The current funding methods are unsustainable.

• The solutions being brought forward are always about providing more money or arguing that costs will come down somewhere else later. Only they do not ever come down. If we just found a way of getting more money from the public through user charges, higher taxes or whatever, then we would not have to worry about the problems of allocation or management. Well, no you would not, until next year. Then you would be back into the same old cycle. I think a lot of what is
suggested here is in fact thinly disguised ways of asking whether we can get more money out of somebody else to get ourselves off the hook? The answer is no.

- The simplistic solution is more money. Anyone involved in health care can attest to the fact that although money can purchase beds, it does not solve the problem of the physical lack of trained staff, an aging population, the dramatic rise in obesity and its affect on health and the myriad of other issues that must be addressed.

- It really is a zero-sum game because if you move more money to education then it is out of the health care budget. If you move it to health care it is out of the education budget.

- We ought to not celebrate adding more money to the health budget but instead celebrate if we need less money in the budget.

- Putting more money into sick care is robbing other areas like schools and forestry.

- The Government cannot afford to just keep on pumping money into the health care system. To continue to do so would require a raise in the tax rates which is a no-win situation for any party.

- It would be worse and cause a greater deficit in our overall budget if the recommendations to expand the system to include other therapies were to be followed through. The solution to health care is not to put more money into it or to expand it.

- What is measured and what is paid attention to is the only thing that gets done and in our system for some valid reasons, at least in health, we are mainly concerned with cost. Often our concern with cost will outweigh our concern for outcomes, so we are in a situation where we have lots of evidence and lots of great business cases that are focussed on saving money in the long-term and improving outcomes. However, if we only focus on saving money you could close a number of acute care beds in one year, but that can never happen when our acute care facilities have all the hallways and lounges and the ambulances in the driveways filled with people waiting to get in. If you empty 13 beds there are 13 people just waiting to fill them up. So what we are measuring needs to change and the priorities need to change or at least be weighted differently.

- The law of medical money is that all health care systems will absorb all the money they can get near. All societies and governments have to find ways of maintaining some constraint.

- First Nations are getting crumbs compared to the billions that everyone thinks they are getting.
The spiralling costs of health care certainly afflict the First Nations community more since we have fewer resources to deal with all of these terrible statistics.

Government is de-listing services to save money but many of the cuts are to preventative services and will increase costs over time.

55 per cent of spending goes to acute care versus only five per cent to prevention.

Ideas and Suggestions

Increasing Health Care Spending
Value of Health Care Spending
Limiting Health Care Spending

Ideas about increasing health care spending:

- Health spending is an expression of our concern for and support of our fellow citizens. It is not and should not be money siphoned off in profits to the businesses most inventive in misleading us through advertising or fleecing us through sharp practices. So, let us celebrate every tick of the Health Care clock as an indication of our intent to improve the lives of our fellow citizens, both those who work in the health care fields and those who have need of health services.

- Voters in Kamloops do not mind sharing the cost for public health care, education and prevention.

- We should increase the percentage of Gross Domestic Product/Gross National Product committed to the public health system.

- If the system needs more money, and if people value the system, then they should be willing to pay more taxes to support the system.

- If everybody helps pay, it is a lot less per person than if we all tried to do it by ourselves.

- Sometimes the only way to get costs under control is to spend more upgrading an inefficient system and to do that takes foresight, dedication, risk and guts, especially when politics enter the mix.

- We do not often look at the long-term assessment of costs but sometimes when you invest it costs a bit of money upfront to get long-term benefits. Unfortunately the system is not set up to appreciate that. We often look only at short-term numbers and efficiencies. For example, early diagnosis would mean greater costs in the short-term but in the long-term better outcomes for the patient.
• We need to get over the notion that we are spending too much already and start to think about strategic investment in change. And that is where we are going to produce the most for the money.

• Government needs to balance spending on health care with other needs.

• Allocate surplus money to health care where it is needed most.

• None of the money used in the system should be allowed to leave the system for profits and shareholders.

• Tell us what the increased cost will be to maintain our present health care system and I can guarantee it will still be less than the same standard of private health care in the United States. I am willing to pay the cost of not seeing our old and sick dying in the streets, as they do in other third world countries, including the one south of our border.

• The health budget should be based on the cost of what we need.

• Create health budgets that are realistic and related to performance measurements.

• The health care system required consistent core funding based on the client need not statistics.

• Consistent sustainable funding is needed to allow for longer-term planning and reforms.

• We should not always have to be competing for little pots of money. Core funding and the need for consistency of core funding is a priority for all the health communities.

• The Province should set funding levels but allow the option for communities to raise extra money for local projects and services.

• We should determine a level of basic spending for health care.

• 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.

• The World Bank published a Report providing an estimate of the net worth of Canada's hard natural resource base such as gold, copper, nickel, zinc etc. The net worth at raw state at 1997 market value was estimated at $2,500 Trillion. That works out to over $83 billion per person in Canada. We are definitely the most resource rich country in the world and that was before the rising price of oil made extraction from the Tar Sands viable. There is 70 trillion barrels of oil available there. Yes, I said trillion twice in this paragraph, so what possible excuse could
there be for denying people their right to a functioning health care system and a just society?

- Ideas about the value of health spending:
  - Every dollar that is spent anywhere in this system becomes a dollar of somebody’s income. When we are talking about savings always ask yourself, corresponding to these savings, whose income is going to be reduced.
  - When you look at the expenditures on the health care system, what is the best measure of tracking how provincial spending on health care has changed over the years? The best way to track it is the relationship with the amount of money that federal governments have provided. When they increase the money, then the provincial governments spend more money. That is not a good thing because when you increase spending you should be putting money into the system so that you can make changes in the future, not just because more money is available to spend.
  - The money we put into health care does not just end up in some black hole north of Dawson Creek never to be seen again. The dollars we invest in health care pay for infrastructure and salaries, equipment and new technologies. Many businesses are health care suppliers and thrive through health care dollars. Doctors and other health care practitioners and staff spend much of their salaries locally and in doing so support businesses that pay taxes. Just because it is public does not mean the health care system is not a huge source of revenue for the economy.
  - We should note that a great deal of the costs of health care are recycled immediately into the economy. This is limited by foolish attempts to farm out services to other providers outside the province. We want our dollars to be used in support of our own citizens.
  - Lots of money is being poured in but it is being put into things that in actual fact do not add value.
  - I think the challenge that we have only begun to address seriously is value for money. We talk a lot about total spending and we talk much less about what we are getting for that total spending.
  - The issue is not how much we spend but what value we get. The reality is that all high spending countries experience, in gross terms, severe diminishing returns at the margin. Our assumption that all service is essential and value added, I think, is quite definitively disproved by the data. The lesson here is that we have to shift the focus from how much we are spending to what for and to what end.
• The medical system should become a crown corporation not unlike the Insurance
Corporation of British Columbia (ICBC). Crown corporations are far better at
controlling costs than the general government or the private sector. ICBC has
given British Columbia the lowest automobile insurance rates in Canada for
equivalent coverage. Why not do the same for our beloved medical system?

• Ideas about limiting health care spending:
  • Allowing private payments for services would free up money from the health
    budget to pay for other services.
  • 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 Canada has less to do with a lack of
    funds as it does with how those funds are used.
  • Some cost cutting decisions have been good for health care, such as earlier
    discharge and home care. Not all cost cutting measures result in worse health
    care.
  • Instead of more money there should be more incentives to find solutions in the
    community.
  • Foster ingenuity and creativity in the delivery of services. This does not mean
    more money but the ability to allocate funding at the health authority and
    hospital level to areas they feel it is most needed.
  • Financing is not the problem but how that money is being used. I do not mind
    paying taxes for a publicly funded health care system but I do mind that money is
    being wasted.
  • There must be limits on spending established, such as an average health budget
    per person.
  • I would recommend the Government put a cap on health spending of 45 per cent
    of the total budget. This would send shock waves through the system and
    demonstrate the serious leadership necessary to tackle these problems.

**Outstanding Questions**

• We really need to ask why we pay more per capita than citizens of most countries
  that have similar health systems and yet our service levels rank at the bottom?
Spending Priorities

Comments and Concerns

Olympics and Sports
Budget Reductions
Prevention and Health Promotion
Youth

• Comments on spending for the Olympics and sports:
  • Stop pumping money into the 2010 games.
  • Government has higher priority for the Olympics and roads than health care.
  • We should not be hosting the Olympics when we cannot even look after the basic needs of our citizens
  • The Government knew the population was aging so why did it not plan for it instead of squandering tax dollars on things like the Olympics and high salaries for elected officials?
  • I resent the way in which child services, education, medical access, beds and services have been cut in favour of roads to Whistler, the Olympics, endless expensive dialogues and the RAV Line (Canada Line, formerly known as the Richmond-Airport-Vancouver Line) going to the airport instead of into the places where people now live and to which they commute by car as a necessity.
  • I was afraid that the 2010 Olympics would jeopardize Health Care in British Columbia and it already has.
  • It is really painful to see the money spent in government advertising and the 2010 Olympics while our Government displays a callous, uncaring attitude toward its own people with regard to health care funding.
  • The first thing the Government needs to understand is that there needs to be better priorities when it comes to spending money. Giving money to sports venues is not an essential part of life because no one ever died from not playing or watching sports.
  • They are spending all the money in all the wrong places. The working people pay for the Olympics but only the rich can afford to go. Spend the money on health and education instead.
  • British Columbia would have money to put into the health care sector if it was not giving it away to sports. British Columbia lotteries were started 30 years ago to help with the money problems the health care sector was having. When it was
deemed that health care was on track the money was then diverted to sports. What a big mistake.

- Comments on budget reductions:
  - Slashing publicly funded services, such as vision exams, physiotherapy and chiropractic treatment only shift the costs away from prevention and treatment onto private insurance and private individuals.
  - Out-patient cuts are short sighted and often create a domino effect.
  - We must acknowledge the impact of cuts and how the current system has become unresponsive to the needs of British Columbians.
  - Health care will be a bigger burden to families as they are required to do more for themselves and their members in all aspects of health care.
  - There is a lack of awareness and understanding about what the family responsibility is going to be in light of the withdrawal of services.
  - The Government should stop cutting funding and the manufacturing of wait-lists.
  - I believe that these cuts have been pre-meditated, forcing British Columbians to choose private care out of frustration due to the lack of services.
  - The only reason our public system looks flawed at this time is because of strategic funding misallocations to make the public think the system cannot work without private health care.
  - Government has withdrawn resources that used to assist primary care givers, such as integrated medical teams, social services, support workers and respite.
  - Most seniors and disabled patients cannot afford to pay out-of-pocket for services there were provided by home support, so they live at risk, in filth and without the ability to shop for healthy food and attend necessary appointments.
  - Downloading and de-listing not only changes who pays, it means poorer people do not get these services that may result in higher costs to the system when they go to the emergency sicker.
  - The problem is that cuts were made without determining the problem and possible solutions.
  - The cuts to acute care beds and home support services since 2001 were a mistake.
  - Under funding leaves the weak, poor, disabled and mentally ill behind.
  - Inadequate home support funding is a false economy.
  - The increased reliance on charities for service delivery is not a solution.
• 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.

• Comments on prevention and health promotion:

  • This province has got it backwards by cutting measures which would aid in prevention and then whining about the money you have to spend at the back end in curing.

  • Governments have ceased funding the Society for Clinical Preventive Health Care that has developed preventive-health care programs that, if implemented, could save the Government and the taxpayer millions of health care dollars.

  • We need to continue the relative emphasis on both health services and health promotion in our spending. If we shift all of our money to providing services then the stress on nurses and family caregivers will create more health problems. If we do not put sufficient emphasis on health promotion then health problems will again increase.

  • The majority of our health care dollars and our own focus is more reactive than proactive and this is going to bankrupt the entire health care system.

  • It makes sense to do everything possible to reduce demands on health care services through preventive measures and strategies. It is ridiculous that government funding for the Therapeutic Activation Program for Seniors (TAPS) has been discontinued. Seniors who participate in this program make fewer demands on medical and hospital services than others in their age group.

  • If the focus is on prevention, then the other end of the care scale will lose out. Critically ill people will miss out of funding that may extend their lives.

  • Government is going to use our tax dollars in the amount of $22 million to educate already intelligent people about issues such as smoking, exercising and healthy eating. This is not a good use of tax dollars.

  • We have observed Vancouver Coastal Health spending substantial sums supporting Insite, a safe injection site, and leaving non-profit prevention programs with nothing. This leaves the impression that drug addicts receive more attention and assistance than regular citizens and that is not fair.

  • If I look at how large our health care expenses are relative to preventative expenses, it leaves a lot of room for improvement.
• Comments on youth:
  • The Board of Directors for the Children’s Hospital Foundation requests that child health be a key priority emerging from the provincial government's Conversation on Health. Our specific concern is that the health demands of our aging population, though urgent and substantial, must not divert resources and funding from paediatric care and that demands of the aging population should not supersede the needs of future generations.
  • Do not forget about the youth, the young adults, the families, the children and the middle-aged adults who carry this society on their shoulders. Their needs must also be considered for the future.
  • Funding for urban Aboriginal health services and resources needs to match the younger Aboriginal demographics.

• My issue is with the phenomenal amount of money spent on translating brochures.

• Stop using public funds for research by private drug companies.

• Government should not be giving themselves raises when they are unable to maintain health care services.

• Get away from fancy corporate offices that waste our money.

• Too much money is spent on slick public relations campaigns about how well we are doing, when the average citizen of this province knows it is not the case. Stop this abuse of public funds.

• Eye care for those who cannot provide it financially for themselves will reduce the need for expensive care for the blind or sight impaired further down the road.

• We should not have a surplus when there are health and environment problems. The surplus should go into increased health care and cleaning up the environment.

• Balancing the budget is a good thing to do but not at the expense of the health of thousands of people.

• There must be an increase to pay for crisis intervention and grief counselling.

• With an aging population and a slightly increased average life span, we are going to have to make decisions about how and when we spend our precious health care dollars. If British Columbians do not take the opportunity the Conversation on Health provides to offer some direction, the decisions will be made for them. Take the de-listing of services such as physiotherapy, chiropractic and massage care as an example. All of these services were uninsured during one of the last health care realignments in the 1990's.
• Health Care does not mean everyone is treated regardless of cost. We have to make hard choices about who receives what treatment, something our doctors will not do, so the state must do it for them.

• Conditions and illnesses which do not cause a disability or suffering should be only partially funded.

• 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, which include 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.

• Stop talking about giving the public more choices unless you are prepared to talk about how much those choices are going to cost and who will be able to afford the preferred services.

• Governments should not waste the taxpayers' money on Associations like the Canadian Cancer Association and the Canadian Diabetic Association.

• It is no wonder the Government is broke from paying all the bills of court cases and giving money to foreign governments for relief.

• New technologies cost a lot of money, so maybe we have to decide what is important.

• Our pattern of funding by crisis is not the way to determine health care spending priorities. Right now, knees are the flavour of the day.

• The way that funding is structured makes it difficult for the Health Authorities to predict what the consumer wants and needs.

• It is absurd to duplicate efforts to test new drugs when it has already been done in other countries.

• Nurses with a Bachelor of Science in Nursing (BSN) do not improve productivity and cost much more to employ than diploma Registered Nurses (RN).

• We manage the health industry in the interest of business. Until we get off this road we will never balance the health budget and become healthy.

• It is estimated that less than 35 cents out of every health care dollar actually go to patient care.
Ideas and Suggestions

Establishing Criteria for Spending

- Ideas about establishing criteria for spending priorities:
  - There needs to be discussion on government priorities across British Columbia.
  - Funding directives must be evidence-based, research-based and based on the knowledge of actual front-line workers’ issues and experiences.
  - Funding priorities should be targeting key groups that you want to make a difference to initially. That means some of the dollars that would have gone to broader uses would be more focused.
  - Fund projects of small to medium sizes that have immediate tangible results and strive to create independence and self-reliance in patients.
  - According to many leading economists, the value of human life is $10 million. This means that if a stop-light were to be installed on a road to save just one life, it should be installed as long as its cost is less than $10 million. A costs-benefit analysis in medicine would have to determine whether or not the Government should subsidize the expensive alternative treatment, based on this formula.
  - Set priorities for spending, such as innocent accident victims first and drug, alcohol and tobacco users last. Do not worry about the these cases going to court because users of these products will be dead before their case is heard.
  - Spending needs to be balanced between supporting research-based medicines and social programs. We must realize that the health care system does not exist in a vacuum and requires more support.
  - Measure the social value and impact of limited funding within the health care budget. Are we getting value for our spending?
  - I think we have to be honest with British Columbians and tell them, this is where we are at right now, this is where we want to go and this is how much money we are going to invest in the system to get us there.
  - Greater collaboration is needed between health, education and the Treasury Board. The Treasury Board must be part of the conversation and part of the solution. There needs to be consensus between the funders, the suppliers and the users.
  - We need to be spending money on making sure children have the best possible chance to be healthy socially, emotionally and physically.
• We have to limit the amount of money spent on premature infants. Considerable resources are dedicated to premature infants who have little chance of survival without serious birth defects.

• We spend lavishly on people in the last moments of life, yet the most efficient and effective place to invest is early in life.

• We cannot let the demands placed on the health care system of the aging population take away from paediatric care.

• Continue funding patients’ rights, workshops, education and advocacy work done by non-profit organizations like the Vancouver Women’s Health Collective.

• Fund non-profit care centres.

• Adequately fund non-profit health care organizations.

• Develop financing strategies to ensure that Aboriginal people are able to access resources according to need.

• There must be adequate funding for home care and hospice in all communities.

• A second level of care, covering life enhancing and life prolonging services could be funded through private health insurance plans.

• For every $1 million net increase in operating revenue there will be an estimated additional 1,000 surgical and other procedures to be performed each year.

• Increase funding for prevention and public education.

• We should re-institute funding to crisis services and mental health centres in order to expand the Assertive Case Management model.

• The funding for mental health should not be lower than funding for cancer research.

• British Columbia should spend more on cancer treatment than other provinces.

• The Government should help fund successful religious treatment centres for addicts.

• Public financing of Insite, where illegal drugs are administered safely to drug addicts, should be stopped.

• Money should be put into the health system instead of going to tax cuts.

• No elected officials should receive increases in pay or benefits until the health system is fixed.

• Covering a wider range of services is not necessarily going to raise the cost to the public because if you are actually covering the most effective range of services you may reduce your aggregate cost, even though people have more options.
• Politicians need to be educated about the actual cost of traditional and alternative health care methods, versus the Government approved method.

• We have got this dynamite ambulance service at the bottom of the cliff. What we need is a fence at the top of the cliff but you know what, you cannot do away with the ambulance service until you get the fence built. So you will have to double fund for a while.

**Outstanding Questions**

- What percentage of the total health budget is spent on prevention?
- What does the Government do with the money from the lottery?
- How do we decide which procedures and treatments the tax dollar will fund?

**Capital Costs and Technology**

**Comments and Concerns**

**Spending on Technology**

• Comments on spending on technology:
  - Medical equipment is very expensive and those who make purchasing decisions lack the qualifications and experience to make these decisions, resulting in the purchase of major equipment before ready for it coupled with insufficient staff training or a shortage of personnel and resources to operate it. Group buying saves money but most are not happy with what they get.
  - Computed tomography (CT) machines are being purchased and installed which are inferior to Magnetic Resonance Imaging (MRI) and produce 1,000 to 10,000 the amount of radiation that an MRI emits.
  - It is the role of government to pay for things like Computerized Axial Tomography (CAT) scans. It should not be left to the public to raise the monies for these needed machines on their own.
  - 3-D ultrasound technology produces a higher resolution image for monitoring fetal development that most parents would presumably want over a traditional ultrasound. However, in most situations, 3-D imaging would provide sufficient additional information to justify the higher cost.
While technological developments will almost surely be more costly, they may not provide more information that older technologies and may be used more widely than specific cases that would actually benefit most from the new technology.

While greater availability of Magnetic Resonance Imaging (MRI) machines and Positron Emission Tomography (PET) scanners opens up new possibilities in assessing disease, which is a positive development, it is also another case of technology driving demand for services previously unavailable or much harder to access.

The potential for a whole new suite of genetic testing and screening technologies raises additional ethical as well as economic and health issues about how the public system needs to address technological advances.

We assume that the price that is offered is the price that we ought to accept and we rather uncritically buy new technologies before their time.

Our medical equipment is old and in need of repair at all levels.

Increasingly expensive machines and physical structures associated with them are a large drain on the budget.

Operating equipment donated by private individuals can only lead to those individuals seeking treatment at public hospitals.

Capital spending on new equipment and hospitals is a major issue affecting service delivery. After years of restraint, recent new spending on diagnostic imaging has increased the number of scanners in British Columbia. However, we still have far fewer than the Organization for Economic Co-operation and Development (OECD) average, ranking 18th among 20 countries.

People want access to new health technology but refuse to face the realities of the increased costs. Canada is lacking in every one of those tools because it has only public funds to pay for them and not private funds as well.

We continue to expand facilities yet the monies could be spent better in other areas.

Stop spending money on old hospital when a new one is coming.

The health care system promotes expensive (and potentially unnecessary) capital redevelopment as the effectiveness of facilities is measured solely on physical, quantitative comparators and fails to recognize the quality of life indicators that can exist regardless of the surroundings.

There is a disconnect between capital and operating budgets.

Capital budgets do not take into account amortization of the building, the hotel costs and the amortization of equipment.
• There is a lack of opportunity for philanthropic fund-raising except for capital assets.

• It is ludicrous to suggest that government can provide all health care services plus the capital costs of hospitals.

• One thing that has always bothered me from a taxpayer perspective is concerning capital equipment purchases. Every year come February or March I would get phone calls from purchasing saying they needed to buy this piece or that piece of equipment before March 31st because they would lose those capital funds if they waited. I have always thought there was something wrong with a system that worked that way. In other words their next year’s budget would be affected if they did not show they needed X amount of dollars to run the hospital. They may not have even really needed that additional equipment.

Ideas and Suggestions

Standardization

Spending on Technology

Funding Technology Purchases

• Ideas about standardization:
  
  • British Columbia and Canada could save hundreds of millions of dollars by creating a standard hospital design and using construction products that have proven to be durable and require low maintenance. Standards of care should be established for infrastructure design. Processes must be developed that understand needs and match needs with capacity.

  • Standardize equipment across the province so everyone knows how to use it and then purchasing could be done province wide.

  • Joint purchasing of common items would save the system a great deal of money.

• Ideas about spending on technology:

  • The high costs of hi-tech equipment should be thoroughly reviewed.

  • We should closely examine the costs and benefits of technology spending.

  • When considering new technology we should demand evidence of its efficiency before committing funds.

  • The abundance of new machines entering hospitals appear to be very similar to existing machines. They may be faster or have sharper images but the existing machinery is already adequate. Eliminating this buying could save funds.

  • Multi-year capital funding would encourage better use of public money.
• I would rather see a hospital rewarded for coming in under budget by providing them with additional funding for the next year for equipment or projects they feel are needed in their situation instead of hospitals spending to ensure they do not lose their capital funds.

• Claims that the system cannot keep up with all the new technologies is nonsense.

• There must be more local participation in the buying decisions. Purchasing decisions should be made by people who understand the needs and understand the equipment.

• We need better public accountability for federal capital funding given to the province.

• There should be better training for those people involved in capital purchasing and more consultation between the buyers and the users.

• The capital budget should be spread out over more, smaller projects.

• Do not buy equipment without providing a 24 hour operating budget.

• Health care equipment funded by communities should be exempt from taxes.

• Ideas about ways to fund technology purchases:

  • Issue a bond to British Columbians to fund the purchase of money saving diagnostic machines.

  • We should repair equipment rather than replace when it is possible.

  • Magnetic Resonance Imaging (MRI) equipment can and is leased. Leasing saves the high cost of capital and would allow more equipment to be obtained.

  • We should look at borrowing money to buy machines that in the end save the system money.

• We should purchase the very best equipment, just like a private provider would, and sell all of our old equipment.

• Innovations and technology tend to increase costs in the short-term and reduce costs long-term.

• Find ways to make Computerized Axial Tomography (CAT) scanners and Magnetic Resonance Imaging (MRI) machines less expensive. Communities have to raise millions to buy a CAT scanner; surely in this day and age they can be built for less money.

• New hospitals should be built by the private sector and leased back to health authorities. Hospitals would not pay taxes on top of the lease and would have clear, transparent and fixed construction costs, with the only variable being interest rates.
• We can not build our way out of this mess but if we prevent the influx of seniors in the first place we may be able to keep the facilities open for those who really need them and it will cost less too.

**Accounting for health care costs**

**Comments and Concerns**

Health Care Budgeting Practices

**Determining Costs**

• Concerns and comments about health care budgeting practices:
  
  • Budget for seven to ten year funding allocations.  Short-term funding is not working.
  
  • There is too much secrecy in health care budgeting.
  
  • There has been a four decade breakdown in the satisfaction of health care in Canada and 25 years of erosion here.  The source of this erosion can be traced back to when line-by-line budgeting was replaced with global budgeting.
  
  • Twenty years ago the hospitals were given a budget and required to report monthly on the number of patient days that had occurred every month.  We managed the money. Now, when there is a surplus in some section of health authority's activities you never see the money.  A new service is started or the money disappears into a black hole.  We need to go back to managing the money.
  
  • The project based funding for only new programs is not effective.  You cannot sustain ongoing services with this formula.
  
  • Sufferers of respectable illnesses organize effective lobby groups that attract unreasonable proportions of the health budget pie not linked to the amount of disability or suffering caused.
  
  • When the public hospitals exceed their case expectation for the year and do better than expected they get penalized by the Government for over spending and not congratulated for trying to decrease the waiting list.
  
  • The official process of budgeting is to go by last year’s expenses.  It is common knowledge that the hospitals and other publicly funded institutions spend every last cent, especially at the end of their fiscal year-end. Often these expenditures at year-end are on trivial items in an effort to spend every last cent and to prove that they need that large a budget next year.
• Comments on determining costs:
  
  • What does it actually cost to provide a service? How much does it cost for a General Practitioner visit, in a global sense, not just per visit but, generally speaking? How much does it cost to fund a hip operation? How much does it cost to fund on a case-mix basis, taking into account various factors that might surround an average case of surgical or medical treatment? We need to understand this with a view to defining really how much it costs so that you can start to weed out the variation in costs that might be happening across the system and finding out where various services might be under funded and therefore quality impacted.
  
  • We do not know the costs of procedures in hospitals.
  
  • Before health care can be reformed, we need to determine the cost of procedures, health professionals and even medical supplies.
  
  • There is lack of transparency on what our tax dollars are purchasing in health care.
  
  • The budget analysts do not know what an hour of operating room time costs or the cost of a hospital bed for a day.
  
  • It is useless to discuss our health care system if we do not know where the costs come from.
  
  • We do not know the costs of medical mistakes.
  
  • There is a lack of understanding of the full costs of any service in the health care system.
  
  • There are no priority indicators and no relationship on outcomes. We need to know what gets results and what those results are.
  
  • Health care costs are unclear to citizens.
  
  • We can tell you about some procedures and some cost. We know what we pay various medical practitioners for over three thousand different procedures but the total cost of it is something of a mystery and that makes managing it a lot more difficult. There are lots of hidden costs that we do not talk about.
  
  • We do not have an integration of costs.
  
  • There is no understanding of the total costs of service.
  
  • We artificially compartmentalize the costs. We actually pay health care costs in the policing budget, the social services budget and the correctional services budget.
  
  • There is no clear information on costs and a lack of communication between service providers on this issue.
• At St. Paul's we look at every dollar we get and we break it down based on the funding. Much of our funding goes to drugs, wages and supplies. It does not go into superfluous stuff. We have already outsourced security, housekeeping, and food services. If you said to me, "St. Paul's, we want you to reduce your budget by three per cent," I would have to cut service. I need guidance from the public. What do you want me to stop doing? Who do you not want me to see? So when the 15 mental health patients who require admission in our emergency room that we actually cannot put in a bed because we do not have enough beds and they are sitting in our emergency room for four days, what do you want me to do? I need some guidance from somebody to tell me what to stop doing.

• There is no relationship between cost per case or cost per capita and quality and outcome. Zero relationship. This is not a good thing. This relationship should be pretty linear in a system that actually takes quality and efficiency seriously.

• Our accounting system is really bizarre. For example, they decided to take capital expense out of the asset column and put it into the negative column, when most people consider capital assets as an asset. A building is an asset. Property is an asset. Somehow, in health care, it goes to the negative balance.

• There is no measure for accountability or effectiveness.

• Numbers get cherry-picked to meet an agenda.

• Funding needs to go directly to the communities to recognize the uniqueness and diversity of British Columbia.

• The system provides no invoice or receipt showing what their service has cost and no effort is made to give information on the extent of the service provided. Providers are totally unaccountable for any of the services they provide or the financial impact of their decisions. They have a budget to follow but they have no idea what the acceptable cost of their service is and make little effort to have performance based results.

### Ideas and Suggestions

**Budgeting and Accounting**

**Accountability**

- Ideas about budgeting:
  - End of year spending must stop.
  - End zero-based budgeting.
• Get rid of block-funding to increase productivity and reduce costs.

• Budgets should be allowed to carry over from year to year to eliminate ridiculous last minute spending. This idea of use it or lose it needs to go. Let the health care system decide where the funds need to go.

• Activity based accounting and budgeting based on need rather than lobbying are two solutions to our current health care problems.

• We should use a zero based budget system.

• Budgets are annual but the solutions and the cost savings take years before we can realize them. That is the problem in dealing with budgets because you know that great things are happening but by the time it actually occurs it has been buried in additional cost elsewhere.

• We need to do a thorough and comprehensive report of how much procedures cost right down to the cost of cleaning the room afterwards and the electrical and cooling costs. This would allow for a real cost-benefit analysis to take place.

• Nobody knows how much anything costs in our health care system. This could be solved simply by providing doctors with a booklet with current costs for visits and procedures. This list could be updated annually or semi-annually using email or the internet.

• In Australia, there has been a long argument about actually having the allocation of Indigenous health occurring within the health portfolio and the health budget and not within the Aboriginal affairs budget. If you have it within the Aboriginal affairs budget then the relative importance of Aboriginal housing and Aboriginal education has to be assessed against Aboriginal health. It is far more important to actually have that question being addressed against the larger health budget process.

• Institute an independent audit on health care. The auditor would reports on spending and waste and make recommendations.

• Use Generally Accepted Accounting Practices (GAAP) in accounting for health care system spending.

• Implement forensic accounting of the health system.

• Ideas about accountability in health spending:

  • Government spending needs to be monitored by a non-partisan watch dog. Maybe then we could begin to trust Government again.

  • The Government must have direct control over monies spent and knowledge that these funds are accountable.
• We must create incentives for measurable efficiency gains within the various health care departments.

• Health care contracts must be transparent and publicly accountable.

• The public health care system must be fully accountable so that it can be compared accurately against private delivery costs.

• Private facilities know their costs exactly. Public facilities need to be held to the same standard.

• Detailed financial statements need to be made public each year.

• There is a need for more transparency on public spending across the board.

• If private companies such as Air Miles can track every dollar we spend on gas or groceries then our CareCard should be able to provide us with similar details. Knowing that their usage was being tracked might make people use the system more responsibly.

• Our health care professionals need to be accountable for the dollars they spend.

• There needs to be more longitudinal data to assist in tracking the effectiveness of health interventions.

• Increase the capacity of the Medical Services Plan to analyze cost pressures so that solutions can be identified to save money and increase the focus on patient needs.

• The Medical Services Plan is able to provide a detailed listing of costs but that only covers the privately provided services, such as doctors and laboratories.

• We need a health care ombudsman to monitor health spending.

• The solution to fixing the public health care system is very simple: accountability and full disclosure. This can be achieved by having two separate public health budgets. One budget for all the administrative costs and a second budget for medical service delivery.

• Every health authority and every medical facility within it must be accountable for demonstrating the costs of providing care. Every operation, every procedure, every bed and every person involved should be fully costed so that we can begin to have a clear picture of the value of our health care system.

• A culture of accountability must become a cornerstone of public health care. An Accountability Office should be established to create system-wide changes.
• We have talked about needs-based funding for 25 years but never really done it. Nobody has gotten off the fixation with volumes being the measure of accountability and I think we have to get the off the volume stuff. In a goal-oriented system there should be some flexibility because the accountability is to the goals not to the instruments. So the requirement, then, is to meet the goals and not be volume based.

Outstanding Questions

• I would like to know why private clinics, doctors offices, dentists and other private services can state how much each surgery or other procedure they provide costs but our hospitals cannot?

• How can you prepare a hospital budget if you do not know your actual cost of service?

• What are the effectiveness measures in the health care system?

• Do we get what we pay for in health care?

• Who is auditing the accounts and financial transactions in the health care system?
Medical Services Plan

The Medical Services Plan was a topic for discussion in the Conversation on Health. Medical Service Plan coverage, usage and premiums were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of The Medical Services Plan.

Medical Services Plan Coverage

British Columbians presented a long list of services that they felt should be covered by the Medical Services Plan. One of the most common suggestions is restoring and enhancing coverage of alternative and complementary services. Many participants see these services reducing pressures on the health care system through their role in prevention and as a cost-effective treatment option for British Columbians suffering from a variety of conditions. Many recommend including other preventative services such as check-ups, prostate exams, eye exams and counselling for diet, addictions, and mental health in the Medical Services Plan. Many participants suggest that the Medical Services Plan cover some dental care, with most focusing on the needs of children, low-income British Columbians and the elderly. Some express concerns that rural British Columbians are not adequately covered for the additional travel expenses they incur when accessing medical services.

Some British Columbians feel that the Medical Service Plan makes coverage decisions for the wrong reasons, looking only at their costs and not the effect the decision has on patient health and patient costs. Many believe that more information about the reasons behind coverage decisions must be made public and that the decision making process should be more transparent and accountable.

…there is no way… that we can provide first dollar coverage for all of these services across the continuum of care that goes beyond hospital based care and physician care. So how do we deal with that as we move forward, how do we create a rationalization in our system…? How important is that to Canadians to protect that core basket of services? Who makes the decisions about what's in, what's out, what's de-insured... I think that's the fundamental question as we move forward.

– Delivery Models Focus Workshop
Medical Service Plan Usage

Some British Columbians feel that the Medical Services Plan needs to do more to prevent abuse of the health care system by both health care users and health care providers. Participants are concerned that too many British Columbians feel entitled to free health care and that this perception of entitlement leads to abuse of the system. Many participants suggest reducing fraudulent access by including an up to date picture and improving other security features on CareCards. Increased auditing of health professional billing is suggested by some participants as a means of reducing inappropriate practices and reducing costs. Some participants feel that those immigrating to British Columbia from elsewhere in Canada and from outside of the country should be made more responsible for what they cost the health care system through increased premiums or user fees.

Medical Service Plan Premiums

Many British Columbians express concerns about Medical Services Plan premiums. Some feel the equality of access to health care is affected as British Columbia is one of the few provinces to assess premiums for health insurance. Some participants suggest reducing premiums in favour of a payroll deduction or increased taxation to reduce the administration required to adjust, assess and collect premiums. Other participants are concerned that premium rates do not reflect the true cost of health care, as the Medical Services Plan does not consider factors that increase insurance premiums in the private sector. To address this concern they recommend linking premium rates to lifestyle factors and usage of the health care system.

Participants are concerned that the Premium Assistance program is not responsive enough to sudden changes in income and that there is little consideration of exceptional circumstances. Some request that more effort be made to inform the public, especially young people, about the Premium Assistance program to ensure all British Columbians who are eligible are covered.

*Can we please put an end to the pointless and costly practise of [Medical Services Plan] premiums? It is expensive to bill everyone a token amount and then collect on the delinquent token amounts.*

–Penticton Web Dialogue
Conclusion

Many participants want the Medical Services Plan to offer more choice in health care services and health care providers. They feel the Medical Services Plan should focus more on maintaining health and preventing illness, while still maintaining the principle of protecting British Columbians from the costs of medically necessary treatments. Participants believe British Columbians should have more input in coverage decisions and feel that the Medical Services Plan needs to be more responsive and receptive to advancements in treatment options.

I would appreciate the right to apply whatever premium I pay towards what I deem appropriate to my needs, including alternative therapies. Should my needs change as I age, I would appreciate having a "medical" program that was flexible enough to adjust to my needs. As it stands, I feel it does not.

– Nanoose Bay, Web submission
Medical Services Plan

This chapter includes the following topics:

- **Medical Services Plan Coverage**
- **Medical Services Plan Policies**
- **Medical Services Plan Administration**

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**Related Chapters**

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Complementary and Alternative Medicines; Canada Health Act and its Principles; Health Spending and PharmaCare.
Medical Services Plan Coverage

Covering Complementary and Alternative Medicine
Covering Dental Care
Coverage Decisions

- Comments on the coverage of alternate and complementary services under the Medical Services Plan:

  - It seems attractive to include alternative medicine, but we first need to decide what that means, which areas of alternate or complementary medicine we include and how will we pay for it. Will it be higher premiums and taxes or from our limited pot do other areas of health coverage have to be cut? This could lead to an even wider gap between the health care of those with and without resources.

  - Medicine is, and should be based on clinical evidence from large, randomized, clinical trials. Any alternative therapy that is to be funded through universal health care should be held to this same standard. If it meets this standard, absolutely it should be funded, but it has to be proven to be better than a placebo before my tax dollars pay for it.

  - There is no such thing as alternative medicine, simply good, evidence based medicine and bad, unproven medicine. Complementary therapies are just that, complementary, and should only be funded where evidence exists for their efficacy. Non-evidenced based therapies should not be funded from the public purse.

  - Traditional medicine is evidence-based. Alternative medicine is not. That is why it is called alternative. If my tax dollars are going to pay for someone else’s medical bill, I believe that I am entitled to insist that the efficacy of the treatment is scientifically demonstrated.

  - I strongly support the inclusion of alternative and complementary medicine in Medicare. I have received tremendous benefits from regular visits to my health care practitioners: naturopathic doctor, chiropractor, and registered massage therapist. I think a set number of appointments per year should be covered in order to support preventative care.

  - I strongly oppose the Medical Services Plan covering alternative, holistic, naturopathic, or complementary medicine. I would be very concerned that if funds are allocated to fund these treatments, the funding of scientifically proven and clinically recognized treatments would suffer.

  - Increasing the complementary medicine funding schedule would reduce pressure on allopathic system.
• De-listing chiropractic, podiatry and optometry has proven to save taxpayers money, even if it contravenes the *Canada Health Act*.

• We should not include traditional Chinese medicine (TCM) and herbs in the Medical Services Plan. Covering TCM would only drive up health spending.

• The current medical system does not support alternative modalities which are the basis for preventative health.

• British Columbians should have a choice as to where their medical coverage may be applied, be it acupuncture, traditional Chinese medicine, homeopathic, chiropractic, or naturopathic care, as they each have their place.

• Chiropractic treatments are a lot less expensive than carpal tunnel and other surgeries, but the patient is charged a fee for saving the health care system money. This does not make any sense.

• I have had chronic back pain since childhood. I have found that the only way to keep the pain under control is to go regularly to the chiropractor, massage therapist and the physiotherapist. Since the cuts to these services, I am only allowed ten visits a year for all three treatment types combined. This adds up to a considerable expense for me. Over the year I have paid over $1000 to stay pain free. This hardly seems fair to those of us who have a low income yet have to have these treatments for chronic conditions. I would like to see more benefits available to lower income people.

• When I go to a medical doctor, it is free. When I go to the naturopath, I pay. Naturopaths are doctors too, and I think basic health care should cover a wider selection of health practitioners. I would like to have a choice of who I see and not be penalized with large fees.

• Many homeopathic therapies are valueless, but they are promoted by the powerful herb and vitamin lobby.

• Doctors treat diseases; naturopathic doctors prevent diseases. Naturopathic doctors should be paid the same as regular doctors under the Medical Services Plan.

• I like to see my naturopath because she takes the time to listen and explain things to me. If naturopaths were to be covered, I hope they would still be able to offer the same level of service. If the government paid them, I worry that they would become like Medical Doctors and spend less time with patients.

• The substantial improvement in my health over the past 18 months can be attributed to supplements prescribed by a naturopath. None of these helpful
treatments is covered under our health care plan. My naturopath is a medical doctor, so I do not understand why these valuable services would not be covered.

• We can only bill the Medical Services Plan to counsel patients about topics that require discussion, support and advice, such as depression, anxiety and drug addiction for four, 20 minute sessions each year. This is hardly enough time to see a patient through a relationship break-up or job loss, never mind more serious issues. Our medical plan needs to recognize that preventative counseling and education are invaluable for improving the health of the public.

• We have to increase the number of tobacco cessation counselors and remunerate physicians to counsel on this topic. Even limited physician counseling has been shown to reduce smoking prevalence in patient populations by five per cent or more. We should promote this important physician function by introducing a specific fee code for addiction counseling. Dental offices, pharmacies and other public health settings are logical locations where rapid assessments and referrals could also be done.

• Nutrition counseling by a registered dietitian should be covered by the Medical Services Plan.

• There is no fee schedule in the Medical Services Plan for psychotherapy, except for psychiatrists and most of them do not practice it.

• For my annual eye checkup, I am seeing an optometrist. The Medicare supplied eye doctor runs a completely inferior and dangerously inadequate checkup, compared to that of the optometrist.

• The cuts to funding for eye exams have put more pressure on other areas of the health care system.

• Funding for lactation support has been cut, reducing the availability of this needed service to two days per week. This is entirely inadequate for mothers needing assistance. Even waiting a few hours can be excruciating for mothers and a wait of days could have dire consequences for newborns.

• It is a mistake that health promotion is no longer funded.

• People who post surgery can not afford to go to their physiotherapy appointments will have wasted the surgery because rehabilitation is crucial to the success of many procedures.

• I have recently had breast cancer and I am going to physiotherapy for problems with my arm resulting from the surgery. I have been referred by my doctor, so why is this not covered?
• The lack of full coverage for physiotherapy is a barrier to good health for many British Columbians.

• I would like to be able to choose from the full menu of health practices such as chelation, massage, chiropractic, homeopathy, herbal, acupuncture, reiki, reflexology, iridology, pranic healing and healing touch, cranial sacral therapy and, preventative practices, like yoga, Tai Chi, meditation which all have a role in a healthy society.

• The Fraser Institute polled on the use of complementary and alternative medicine in Canada and British Columbia and found that many of people who were using these services did not want them to be covered by the Medical Services Plan system. What they wanted was access to the system so they could do all their primary care with referrals to diagnostic imaging, specialists and pharmaceutical rights. The users of alternate and complementary health care were concerned that if these services were to come under Medical Services Plan coverage, their availability would be restricted.

• Comments on dental coverage:

  • Private dental coverage is too expensive for most. There can be serious complications from neglecting dental care that are more costly in the long run than providing basic coverage for all British Columbians.

  • The system will pay hundreds of thousands of dollars to repair or replace a smoker's lungs, an alcoholic's liver, and obesity-caused diabetes or related ailments and will not pay $1 of any dental examinations or dental work whatsoever until rotting teeth cause disease elsewhere in the body.

  • It does not make sense to cover dental surgery, while office appointments that prevent the need for expensive surgery are not covered.

  • Basic dental services, such as teeth cleaning and checkups, should be covered. The teeth are a part of our body and can cause great discomfort and even illness if not properly cared for.

  • I would like to see a dental plan included in the Medical Services Plan. Dental coverage could be optional. Those who are interested could pay separate premiums for the dental coverage. I really think it is a good idea, as it would help to reduce the inequality in dental health between wealthy and less fortunate people.

  • Change the regulations affecting dental hygiene to allow seniors more access. Good teeth are important, but 75 per cent of home bound seniors do not see a dentist. Dental hygienists should not be restricted by the 365 day rule.
By increasing access to services provided by dental hygienists the health of British Columbians would improve over all and it in turn would lower health costs to the current health care system.

Many individuals working for $8 to $12 per hour would have to use an average of a full year’s savings to afford minimal dental care for just one damaged tooth. Many students and minimum income earners can only sit back and suffer as dental issues can send us through the medical system with not one of the medical professionals able to help or even direct us towards a solution.

There is no access to dental care without the funds to pay for treatment. This is a concern for low-income people with chronic conditions like diabetes.

Even those who do receive some coverage through the government for dental care cannot afford the extra billing and so have their teeth pulled instead. The appeals process is too complicated, so people do not fight it.

The Ministry of Health needs to pay up to the general dentist fee guide for Ministry of Health patients.

The Healthy Kids Plan, which assists low-income families with some dental coverage for their children, pays at such reduced fee rates that many children still cannot access dental care because the families cannot pay the difference between the Healthy Kids Plan fee rates and the full British Columbia Dental Association Fee Guide rates.

I suggest that the Healthy Kids Plan keep the same ceiling on how much coverage each child would receive per year, but pay the current full British Columbia Dental Association Fee Guide rate.

Comments on coverage decisions:

British Columbians want first dollar coverage for complete home care services, residential care services, glasses, dentures, occupational therapy related items, motorized wheelchairs, scooters, and so on. There is no way that we can provide first dollar coverage for all of these services across the continuum of care that goes beyond hospital based care and physician care. So how do we deal with that as we move forward, how do we create a rationalization in our system? Should physician services and hospital based services continue to be fully funded through the core basket of services? How important is that to Canadians to protect that core basket of services? Who makes the decisions about what is in, what is out, what is de-insured? I think that is the fundamental question as we move forward.
· Some coverage decisions seem to only offer short-term savings with higher long-term costs for both for the system and the patient. Less control by the government and more competition for the public dollars would be a major step forward.

· It is my opinion that the Medical Services Plan only benefits few and penalizes those who would opt for preventative care through healthy food and food supplements.

· Immunization of children, hospitalization following accidental trauma, and life-threatening diseases are obviously examples of services that should be covered. However, dialysis for an 85 year old person and keeping a premature baby on life support indefinitely are examples of services that probably should not be covered.

· Our health plan needs to re-examine what is covered and what is not covered. Many of the exclusions are archaic.

· Two-tier medical exists here and always has. The most glaring areas we commonly see are for alternative, complementary care, dentists and eye doctors.

· The Medical Services Plan should cover all medical needs. People who cannot afford complementary health care are placed at a disadvantage.

· I do not understand why new procedures that are less invasive and safer are not covered by the Medical Services Plan? My doctor has said the two procedures would cost about the same, but the Medical Services Plan only covers the out-of-date procedure. The decision to only fund the out-of-date procedure will result in me being off work for eight to ten months, sitting at home waiting and recovering.

· When I was a child, all medical services were paid for by the medical system. Now, I am responsible for paying for many services. I believe that the system is no longer offering good service.

· The exorbitant costs for sustaining the present system are due to the universality of the system. 50 years ago the list of medical procedures covered by government comprised only a fraction of what is covered today.

· We need to collectively make decisions about what will be funded and what won't. I believe that coverage decisions should be based on the following questions. What is the probability that the intervention will produce the desired result? If the intervention is successful, what is the individual's prognosis in terms of quality of life? Are there other benefits that would result from funding this intervention? If this intervention is funded, what will be the future requirements for funded interventions? I don't think we can continue to advocate universal care without putting some limits on what that care covers.
· De-listed services increase employer benefit costs.

· Our Provincial Government has removed annual medical checkups from the Medical System Plan, while people who are on social assistance and welfare are enjoying this privilege. Should government’s first priority not be to look after the taxpayers of this great nation?

· Those who can afford choices and non-necessary medical services receive them and those that do not have the means do without these services.

· Newer technologies and therapies are not covered by the Medical Services Plan, even when they are proven to be effective and cheaper.

· The current system of paying for medical services is fraught with discrepancies. For our family, dental, hearing and optical care commands a major portion of our family’s budget. These services are every bit as important to us as day-care for seniors and prescriptions are for others in our community whose services are supported by the Medical Services Plan.

· It is unfair that men have to pay for prostate blood tests when women do not pay for mammograms and Pap-smear tests.

· I am concerned that some of the population has a sense of entitlement to any medical help that is out there regardless of the cost or what their contribution to society has been. There is no way that any society could afford the endless and expensive procedures, techniques and new drugs that are available.

· I would like to know why the Medical Services Plan pays for injuries that are sustained while doing illegal activities such as skiing out of bounds, drinking and driving or joy riding. If you are doing something that is against the law, you should be held legally responsible. Why are we paying the medical bills for these law breakers?

· If we allow private insurance to cover medically necessary procedures it will escalate the existing inequality in the system. If the Medical Services Plan was providing the service people deserve, there would be no call for private health care. This is an issue of how the public system is managed and the commitment of those in charge to deliver what the public demands.

· We should have a choice where our health care dollars go and be able to purchase individual plans that reflect our distinctive philosophies- rather than one size fits all.

· Government cutbacks to coverage result in the deregulation of parts of our bodies, such as eyes and teeth.
• I am very angry that I pay over $1,200 a year for Medical Services Plan for my family, yet when we need a doctor we must resort to a walk-in clinic and take whoever we can get.

• Although I pay my premiums, presumably to insure my health care, government has been forced to reduce medical services to the point that little of what I need is covered.

• We need to discuss what changes we need to bring full health care coverage back.

• If you have chronic fatigue, none of the services you require are covered by government.

• Morbid obesity needs to be recognized as a disease and an epidemic that will sooner or later kill those who are suffering from it.

• Many of the costs of acquired brain injuries are not covered, other than through private funding or if services occur in a hospital. The programs offered vary from region to region, but are all under funded and have long wait lists. Family Doctors do not have the time to devote to these types of injuries.

• Technological innovations can change the lives of many diabetics, but the Medical Services Plan will not pay for them.

• Some people have access in their local facility and it is covered by Medicare. For osteoarthritis I must travel 60 kilometers and pay out of pocket for the service.

• Autism treatment is not covered by Medicare. It should be covered because it is necessary.

• People with diabetes (and other chronic diseases) have to pay fees for preventative care, such as that of a podiatrist. If you beg, sometimes health care providers will waive fees.

I ideas and Suggestions

Services that Should Be Covered
Services that Should Not Be Covered
Coverage Decisions

• British Columbians suggested that the Medical Services Plan should provide coverage for the following services, procedures and equipment:
  • Oxygen;
  • Mobility aides;
  • Personal care in assisted living facilities;
• Adaptive devices to allow seniors to stay in their homes;
• Lifeline services for seniors;
• Appliances for colostomies;
• Glasses and lens replacements when required due to new prescriptions;
• Hand braces;
• Crutches;
• Walkers and canes;
• Wheelchairs;
• Prosthetic legs;
• Prosthesis and assistive devices;
• Hearing aids;
• Dentures;
• Pain management medications and services;
• Alternative stage IV cancer treatments;
• Tinnitus treatments;
• Treatment to prevent the impact of ischemic strokes;
• In-vitro fertilization therapy;
• Lymphatic drainage treatment;
• Test strips for diabetics;
• Lantus long acting insulin;
• Insulin pumps for diabetics;
• All costs for children with type one diabetes;
• Prostate Specific Antigen (PSA) screening and routine;
• Regular colonoscopies;
• Annual check-ups;
• Physician prescribed elastic compression stockings;
• Dental care for seniors;
• Universal dental care for children under 18 and vulnerable populations;
• Full vision services for children under sixteen;
• Free ambulance rides;
• Lap-band surgery;
• Compensation for those with bursitis;
• Interpreters at hospitals;
• Traditional healer practitioner in communities;
• Chelation treatment;
• All diagnostic testing, including:
  • Tests to detect nutritional imbalances;
  • Hair analysis;
  • Complete examination costs;
  • Positron emission tomography (PET) scans for cancer patients;
  • Open Magnetic Resonance Imaging (MRI) tests;
• Marriage counseling;
• Mental health counseling;
• Medically required travel;
• Smoking cessation treatments;
• Clinical nicotine replacement therapies;
• Herbalists services and natural health products;
• Homeopaths;
• Traditional Chinese Medicine (TCM);
• Chiropractors;
• Massage Therapy;
• Naturopathy;
• Acupuncture;
• Ayurvedic Medicine;
• Osteopathic therapy;
• Energy Healers;
• Athletic therapy;
• Podiatry;
• Weight loss programs;
• Adult stem cell treatment to re-grow knee/hip meniscus;
• All newborns should be screened for 28-30 metabolic disorders;
• Alternate birthing services, such as the South Community Birth Program in Vancouver;
• Midwifery care also needs to be supported, encouraged and promoted;
• Prenatal and perinatal support for all mothers;
• Lactation supports;
• Doula services;
• Speech therapy services;
• Mental health related services;
• Counseling, including lifestyle counseling;
• Primary care doctors compensated for lifestyle counseling;
• Psychiatry;
• Psychologists;
• Repetitive trans-cranial brain stimulation;
• Applied Behavior Analysis (ABA) therapy;
• Health clubs;
• Yoga classes;
• Life skills training;
• Nutrition education;
• Holistic treatments for addictions recovery;
• Harm reduction services;
• Injections with sodium hyaluronate to avoid knee replacement surgery;
• Yearly influenza vaccinations;
• Immunization protection against the human papilloma virus for all girls in the 9 to 18 year age range;
• Operations for hair-lips or correction of other disfigurements such as severe burns;
• Prevention work done by community care nurses;
• Soft lenses for cataract surgeries;
• Hip resurfacing;
• Home visits for patients with mobility limitations;
• Free access to recreation centres exercise facilities;
• Dental hygiene services;
• All travel costs required to access medical services;
• All medically necessary costs paid for by the province;
• Elders and anyone else who identifies finances as a barrier should receive services for chronic illnesses (preventative and maintenance) free of charge; and,
• Elective procedures should be covered under an optional extended care Medical Services Plan policy.

• Ideas about services which should not be covered:
  • The Medical Services Plan should not provide joint surgeries to people who are excessively overweight.
  • Ultra-sounds during pregnancy should not be covered unless medically necessary. Every parent-to-be wants one of these just so they can have a picture to put into the baby book.
  • Make optional surgeries like hip and knee replacement, and certain heart surgeries subject to user pay.
  • There should be an age limit for expensive surgeries, such as heart bypass.
  • Place limits on heroic treatments. Considerable resources are expended on patients who clearly have only a limited time left to live. Treatment should be limited to palliative care.
  • Physiotherapy should only be covered for extreme cases, like burn victims, broken backs and people who cannot walk. Anyone who can walk should not be included in paid for physiotherapy.
  • I do not think that Medicare should pay for alternative or complementary medicine because so many of these services are either not scientifically proven to be beneficial or are based on religious theories and practices from other cultures. Our medical system would become very costly were all these items to be covered.
  • People who commit crimes and are injured as a result should not be covered.
  • We should not cover extreme sports accidents.
  • Birth control should not be funded. We can and should manage this for ourselves.
  • Gender change surgery should not be funded.
Abortion is used as birth control by too many women and should not be paid for with tax revenues.

Abortions used to only be performed when there is a danger to the mother. Now, they are performed as a form of birth control and should not be covered.

The Medical Services Plan should not cover expensive one-of-a-kind procedures.

Ideas about coverage decisions:

- A transparent decision making body is needed to make decisions on coverage.
- Establish a citizen's assembly for defining the Medicare basket of services to be covered.
- Insured services as described in the Canada Health Act should be determined by the people and not by politicians.
- British Columbians will have to take this Conversation on Health process to establish what the status quo for service will be, or else face de-listing similar to that of the early 90's of physiotherapy, chiropractic and massage therapy.
- Let people choose the services that should be publicly funded.

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.

We do take a very careful look at evidence in terms of trying to make decisions about what does get funded and what does not and that the evidence is constantly being reviewed.

The province adequately assesses new procedures and treatments. Considerable testing is required before new procedures are covered.

Medically necessary should be defined as: to preserve life; or treat and cure an illness, injury, disease or disorder; or to relieve suffering caused by illness, injury, disease or disorder.

How is it right that terrible diseases can be treated with drugs that are not paid for, but I can take a sore arm to a hospital whenever I want? We should not cover the day-to-day and instead pay for essential operations and drugs.
• The Medical Services Plan should not put limits on therapies without a doctor’s verification of need.

• Every other insurance system requires a certain amount of personal responsibility for coverage to continue. If I do not replace the brake pads in my car, and get into an accident because of it, the Insurance Corporation of British Columbia (ICBC) is not legally required to cover me. Why should health care insurance be any different?

• There should be information sessions to explain the health benefits system. What is covered, what is not covered; how services are reimbursed in a culturally appropriate manner.

• Supplement the federal compassionate leave provisions, and offer additional support (in terms of extending the eligible period beyond 6 weeks and supplementing federal benefits during the first 6 weeks), to people caring for family members with cancer and other major illnesses.

• A possible solution to the complex dilemma arising from the private urgent care facility opening today in Vancouver, is for the Medical Services Plan to pay the $199 fee that the facility is charging patients for each visit. This way the integrity of a single-tier, universal, public health system is preserved and patients receive timely service. If the private care facility is able to provide the same care in less time, pressure on hospitals, equipment, doctors and nurses will be relieved while our treasured Medicare system will remain intact. Perhaps public money can be saved through more efficient use of facilities.

• Did you know medical insurance companies in the United States are starting to use alternative medicine as a way to reduce their costs by shortening hospital stays, preventing illness and reducing complications during procedures?

• For services no longer covered, such as massage therapy and chiropractic, create a reimbursement structure to support individuals who take responsibility for their own care.

• Health care should pay for alternative treatments and medicines to decrease demands on hospitals.

• Investigate how private insurers could work with the public system.

**Outstanding Questions**

• There are no explanations as to why things are or are not covered by basic health care. What is the criteria behind these decisions?

• Who decides what is medically necessary?
• Why does the Medical Services Plan not offer extended health care as well as the basic insurance?

• Why are mammograms free of charge but men have to pay for a prostate examination?

• Why does the government not fund regional centres modeled on the Centre for Integrated Healing?

• How do we as a society establish what the public’s expectations are on eligible services?

• Does broadening the Medical Services Plan coverage for chronic disease management eliminate the possibility of more multidisciplinary involvement?

Medical Services Plan Policies

Comments and Concerns

Premium Assistance
Travel Policy
Differences in Coverage across Canada
Out of Country Coverage

• Comments on Medical Services Plan premiums:
  
  • I am concerned about the premium assessment for the Medical Services Plan. British Columbia, Alberta and Ontario are the only provinces that collect health premiums.

  • Premiums can amount to almost $1200 per year, while seniors in Ontario pay nothing and have better health care.

  • I think it is outrageous that British Columbians are expected to pay premiums for health care that they are entitled to receive for free as Canadians. I do not understand it. In Manitoba you get your health card in the mail one day and on you go with your life, here they bill you for it. I think it is time British Columbians demand the free health care they are entitled to.

  • Make it mandatory for employers to cover premiums after three months.

  • British Columbia and Alberta are the only two provinces that pay premiums for their registered and status Indians.

  • Premiums should be the same for all. The current system is too costly for employers to administer.
• The way in which premiums are applied is biased. Single people pay $54, Couples pay $48 each. A single parent pays $48 and another $48 for the first child. Medical Services Plan premiums are too high in relation to wages and when compared to wages and premiums paid in Europe.

• I really resent having to pay so much for my husband and I to have medical coverage when we have been unable to find a regular family doctor for the past three years.

• The premium system as it stands is a regressive tax since it is the same for everyone regardless of income. The rich pay the same as poor, which is a bargain for the rich and a hardship for the not so rich.

• The present health care premiums are ridiculously low.

• The premium bills do not make sense and appear to be sent out in error more often than not.

• The Medical Services Plan has a lien against the house of a diabetic mother with no income. How can you pay your bill if a bank is unable to refinance your mortgage so you can get the money to repay the Medical Services Plan because the Medical Services Plan has a lien on the house?

• Premiums appear to be based only on healthy lifestyle choices. These amounts are fine for those who comply but not for those who do not.

• All smokers should have to take a stop smoking class every year in order to qualify for regular premium rates, or they should pay extra.

• Comments on the Premium Assistance program:
  • As premium assistance is currently administered, it denies access to the poor, burdens emergency rooms, and creates large administrative costs.
  • Premium assistance claims can take up to eight months to process. Without this continuous coverage, doctors can charge a fee or turn patients away.
  • I did not have to pay for my health care until my wife’s minimal income is added in with mine and I must pay the family amount. This does not seem fair.
  • The premium assistance system is not responsive to income change. If your income drops this year, you can still expect a $1200 bill based on your income from three years ago when you were making $40 per hour. Sick people often find that their income drops rapidly. It is not fair that your insurance costs can jump from $0 to $100 per month for a family when your income has dropped.
  • There is no process for looking at exceptions to the rule in the premium assistance program.
• Although there is a sliding scale for health care premiums, up to a point, above a very low income level there is a flat fee for health care.

• I have been on disability for the last three years. I was not informed that the Medical Services Plan should have been covering my prescriptions and premiums for those years and now there is no way to be paid back for what I should have never paid for in the first place.

• Many young people are only notified years after they should have started paying their premiums, that they owe large amounts of money. This is not money that these young people owe, as they should have been covered by premium assistance, but they cannot apply retroactively.

• It is reverse discrimination and entrenches the two tiered health care when the Medical Services Plan subsidizes chiropractic services for low income earners. Everyone should pay the same per visit regardless of income.

• Concerns and comments about the Medical Services Plan travel policies:

  • Travel expenses for tests and treatments create inequalities among rural British Columbians.

  • Traveling to Vancouver from many parts of British Columbia can cost up to $500 for a day trip.

  • It seems that patients who need care outside their own area are penalized by having all these expenses to get the needed treatment.

  • Many specialists do not know about the forms that have to be filled out to apply for travel assistance.

  • The policy for claiming assistance does not help people recover all their costs for medical travel which ends up being a barrier.

  • The Medical Services Plan does not adequately cover travel expenses incurred to receive proper medical attention.

  • Inter-Provincial treatment options and agreements are inconsistent.

  • I do not understand why the Medical Services Plan will only pay $75 for a hospital room if required when visiting my sister in Lethbridge? If I get sick in Langley and need a hospital room it will cost close to $1,000. Why will they not pay what they would have to pay if I was home? The Canada Health Act requires them to cover these expenses.

  • Patients need the ability to phone home or use the internet when they stay at the Cancer Lodge. Right now, they have to pay for these services.
• Comments on differences in coverage between provinces and regions:
  
  • If British Columbians travel to another province they have to purchase travel health insurance. What is universal and portable about that?
  
  • The provinces all have different standards and different coverage for health care services.
  
  • I have just moved here from Ontario and the quality of care in British Columbia lags far behind.
  
  • Magnetic Resonance Imaging (MRI) and emergency services have been opened to private payment in Quebec. Why do we not change our rules to match? I feel like a second class citizen because I live in this province.
  
  • Some provinces do not charge premiums for health insurance.
  
  • Portability means that services offered in one part of the country and/or one health region in the province are the same as those offered in another province or Health region. It just does not make sense for one health region to cover some services that an adjacent Health region does not.
  
  • I should be able to go anywhere in Canada and have the health system treat me as a permanent resident would be treated. Acceptable treatments should be the same in all the provinces.

• Comments on out-of-country coverage:
  
  • There is no coverage to go to out of country for cell replacement surgery for patients with spinal and head injuries. This feels like discrimination.
  
  • The Canadian Snowbirds Association recommends that the amount of money paid for out-of-country expenses needs to be standardized across Canada. British Columbia has the lowest level of coverage for out-of-country care. This should be increased to a more reasonable amount.
  
  • Citizens who live and work outside of Canada while continuing to pay taxes and Medical Services Plan Premiums cannot be insured without a three month waiting period when they return to British Columbia.
  
  • After being out of Canada for more then six months, you cannot leave again without losing Medical Services Plan coverage.
  
  • Immigrants working in British Columbia are not covered by the Medical Services Plan or WorkSafe BC, and if hurt are sent home.
  
  • Reimbursement from the Medical Services Plan can take up to 16 months.
  
  • The difference in fees for residents and non-residents in British Columbia is unjust.
• The department that adjudicates health care claims for those living on disability should not second guess the specialists, doctors and dentists. Those are the people who are dealing with the patient and know whether or not the test or treatment is necessary.

• I think it is disgusting that the Members of the Legislative Assembly and civil servants that have the luxury of a funded health care package are making policy and decisions in this area when they do not understand what it is like to be middle aged, have worked all your life, been laid off and cut off from access to health care insurance at a reasonable cost.

• If you are really poor you get coverage through income assistance. If you are on income assistance at 65 you are lucky because your coverage is paid for. It is those that are not that poor, or did not go onto income assistance that are really struggling.

• Doctors only discuss one item per visit resulting in many unneeded repeat visits.

• There is no routine process for correctly billing either the Medical Services Plan or WorkSafe BC when medical costs arise as a result of a work injury? Currently, many medical costs that should be the responsibility of Worksafe are wrongly being paid by the Medical Services Plan, driving up costs for the public system.

• Seniors do not understand the health insurance plan and often do not have any coverage for this reason.

Ideas and Suggestions

Premiums
Premium Assistance
Out of Province and Out of Country Coverage
Travel Policy

• Ideas about Medical Services Plan premiums:
  • Lower premiums for healthy lifestyle choices.
  • Charge smokers higher health premiums.
  • Premiums should to be based on the health of the individual.
  • The premiums for every other type of insurance, whether private or public, are graded according to risk. I see no problem with charging much more to people who refuse to stop doing things that are bad for their health.
- The same factors that increase life insurance premiums should be applied to determine each British Columbians health insurance rate.

- People who participate in high risk sports or activities should have to pay more for their insurance.

- Factors that increase the Insurance Corporation of British Columbia (ICBC) premiums should equally apply to health insurance, such as speeding, dangerous driving and driving under the influence of alcohol or drugs. The ICBC records should be provided to British Columbia Medical.

- Premium increases should be tied to the inflation rate.

- Phase in the Medical Services Plan Premium increases on a straight 20 per cent per year basis. Provincial tax should be offset in the same amount and a refund offered if someone’s income is low. Tax credits should remain fixed at these levels and as Medical Services Plan premiums increase, absorb the premium payers group through increasing premium payments, just like any other group plan operates.

- If you increased health care fees by three dollars per month, you could cover all the costs of these services.

- Insurance premiums paid should relate to the real costs of the health care system, as it should not be funded through general tax revenue.

- The Medical Services Plan must be self funded by premiums. All health care services over and above the Medical Services Plan should move to a partial premium based system whereby premiums are charged to recover 10 per cent of the annual costs.

- The Medical Services Plan must be self funded by premiums to ensure an adequate supply of medical resources and health care services could move to a partial premium based systems to recover 10 per cent of annual costs.

- Medical premiums must be raised to more accurately reflect true costs. Compare British Columbia where a couple pay $96 per month and Germany where they pay $350 per month.

- Everyone should pay a bit more monthly to ensure health care remains viable.

- British Columbians would pay higher premiums in order to maintain the public system and would be even happier to pay more if the service improved.

- Premiums should be collected at the time of taxes and scaled according to net taxable income. This could allow more funds to be collected and is based on the same principle of scaled tax structure that pays for other essential services such as fire and police. One should have to pay more if they have a larger income, but
there should be no difference in health coverage. Awards should be used to reduce usage and abuse.

- All working people should pay into health insurance through a payroll deduction, according to income, similar to our Employment Insurance premiums. Self-employed people and all others on fixed income also have to pay into this fund according to their income as long as their income is above the poverty line. The rate of deductions and payments needed could easily be figured out by our financial gurus.

- Look at the Ontario Health Insurance Plan. They use payroll deductions based on monthly income, not annual. This change would eliminate the cost of administering Premium payments and collection of those premiums.

- Premiums should be more closely referenced to salary.

- Eliminate Medical Services Plan premiums. Increase our progressive tax rates to make up the loss in revenues.

- Eliminate the monthly premium payment and instead charged a per visit fee on a sliding scale according to income, on each visit to the doctor, dentist, or other health care provider.

- Reduce health premiums and charge a small user fee.

- Premiums should be reduced or eliminated and each individual asked to pay for their own health care costs up to a maximum annual amount.

- Reduce premium costs for those people who make little use of the health care system. Such a reduction would provide a clear incentive to become healthier.

- The prospects of paying a relatively small monthly premium and funding health care collectively instead of incurring a potentially large doctor’s bill when paying for it personally holds a natural attraction for those whose cost of living normally absorbs virtually all of their income.

- If you have been contributing your whole life to the health care system you should have full priority and 100 per cent coverage. If you have just started paying into the system, you should have a lower priority and pay a certain percentage of coverage.

- Extend the graduated payment of medical premiums so that those earning $100,000 pay more than they are now.

- Health premiums must be reflective of the ability of people with chronic illness to pay.
The use of health care premiums to generate revenue should also be examined. While there are many points of view about the value of a premium system, the doctors of British Columbia believe that premiums should be retained. Premiums impart a degree of cost consciousness. Currently, premiums cover less than 15 per cent 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 needs to be closely examined.

Premiums should be per person and not include family groups.

- Ideas about the Premium Assistance program:
  - Premium assistance should be a pay-cheque deductible.
  - Restructure premium assistance to provide vulnerable individuals with better health care and increased access.
  - Eliminate the subsidies to low income people.
  - A notice should be put on every premium bill stating that if your income is below the cut-off to call a number to have it resolved.
  - Premium assistance should not be available to immigrants.

- Ideas about the Medical Services Plan travel policy:
  - Make patient travel expenses part of the health care budget not the Ministry of Human Resources.
  - The ferries should be free to those traveling to access medical services in the lower mainland.
  - If residents want coverage for travel outside of the Province, above what is already provided, they should pay an amount dependent on a number of situations, such as age, medical condition and number of days travelled.

- Ideas about out-of-province and out-of-country coverage:
  - Patients should be able to access services outside of the Province and have it covered by British Columbia’s insurance plan.
  - In Australia, citizens can travel throughout the country under one medical plan.
  - Canadians should be able to travel within Canada without having to buy travel insurance.
  - Citizens should be able to access any public facility anywhere in Canada for free.
• All health care services should be available in British Columbia. No one should have to leave the Province for treatment.

• No Canadian should be sent to the United States for medical treatment.

• A cost-benefit analysis could be used to determine if a person should leave the Province, or even the country to receive medical care.

• The six month restriction on Medical Services Plan coverage while outside the province, should be extended or eliminated. This change would encourage people to use other insurance plans while outside British Columbia and not burden our health care system.

• The Medical Services Plan should pay the cost of travel and treatment to other countries where the total cost of treatment is less than the cost in British Columbia. India, Malaysia, Thailand and many other countries could offer quality medical care faster for the patient and at a lower cost for tax-payers.

• Out-of-country specialist care needs to be an option for Canadians who can afford to travel and pay for it. An individual who uses approved services over seas should be able to subtract the expenses from their taxable income.

• The Province should not cover the costs of traveling outside Canada for treatment.

• Health care should be covered 100 per cent in neighboring provinces to allow people to access the closest specialized services regardless of provincial borders.

• Instead of the government paying for people to cross the border for services they cannot get here, they should put the money into ensuring services can be provided in British Columbia.

• Snowbirds should be paying more for Medical Services Plan coverage as they do not live here full-time. We cannot afford to subsidize their lifestyles.

• The out-of-country hospital per diem charge should be raised as traveling to the United States assists in keeping the elderly healthy because of the climate.

• Out-of-country coverage should not be increased, but individual cases should be considered for higher payments under special circumstances.

• Change the billing rules to allow physicians and specialists to bill for longer appointments for people with complex needs.

• Put a cap on yearly spending per person to keep people from taking advantage of the system. Children under the age of 12 should not have a cap.

• The Medical Services Plan should accept credit cards for premium payments. Not doing so is costing the government a substantial amount every year as premium
debts are not charged any interest or penalties and medical services cannot be withheld on delinquent accounts. Your collection agent, NCO Financial Services, is so rude and upsetting that nothing short of a court order would convince me to deal with them. If you reward delinquent accounts by allowing them to use their credit cards and collect Air Miles or other bonuses, more people will pay on time.

- There should be a residency requirement of 20 years to qualify for coverage.

- The Medical Services Plan should be run as a group health insurance.

- We should have the option of an alternative insurance provider to the Medical Services Plan.

- Any insurance policy exists to protect the policy holder from devastating financial costs. Health insurance should be no different. The Medical Services Plan should pay for the big bills and have the policy holder pay for the lesser costs. This could be in the form of a deductible, user fee or a more unique approach. The system needs to return the payment for services rendered feature back into health care. It would change public perception that the system is free, while still protecting those who cannot afford to pay.

- Offer an optional Enhanced Medical Services Plan where subscribers may pay an extra monthly fee. The enhanced plan could include a routine eye exam every two years, subsidized prescription drugs, limited extended medical coverage, an enhanced extended travel medical coverage as well as limited dental procedures.

- Institute a system of points whereby people could choose to use their allotted points at the chiropractor, physiotherapist, acupuncturist or other provider that can treat their condition.

- Patients should be asked if they are a Worksafe BC or Insurance Corporation of British Columbia (ICBC) claim before the Medical Services Plan is billed.

**Outstanding Questions**

- Why are there not “Healthstars” similar to “Roadstars” for auto insurance?

- What percentage of British Columbians pay premiums?

- Why are premiums not part of the income tax system?

- Why do we subsidize international students on our medical?

- Why do some provinces charge a premium and others not?

- How do the other provinces finance their health care systems?
• Should we support those who have chosen to travel elsewhere for medical treatment?

**Medical Services Plan Administration**

**Comments and Concerns**

**CareCard Usage**

**Health Professional Conduct**

**Health Care Usage**

**Visitors, Temporary Residents and Dual Citizens**

**Seniors Moving to British Columbia**

**Immigration**

• Comments on use of CareCards
  
  • CareCards have no security features and can be shared and counterfeited very easily.
  
  • Family members can share CareCards, creating a potentially dangerous situation.
  
  • There is a discrepancy between the number of British Columbians and the number of CareCards in circulation.
  
  • Each person who accesses health care in British Columbia has a unique personal health number which can be used to access medical services, even after the number is no longer valid.

• Comments on health professional conduct:
  
  • Doctors billing for services such as telephone consultations is an abuse of the system.
  
  • Some doctors refuse to take telephone calls but insist the patient come in for an office visit.
  
  • When doctors see other doctors commit fraud and/or malpractice they do not report them.
  
  • Duplicate and unnecessary billing of services by health care providers is a major concern.
  
  • Some physicians book patients for unnecessary visits.
  
  • Physicians who bill patients when they do nothing more than say hello to them in the waiting room are abusing the system.
  
  • It is fraud when doctors and clinicians bill for services not provided.
• Some doctors refuse to see patients but still charge the Medical Services Plan.
• Some health care professionals bill the Medical Services Plan and private clinics simultaneously.
• Theft of equipment, supplies and patient’s personal belongings is a serious problem.

• Comments on health care system usage:
  • Funding the health care system out of tax revenue removes accountability from the patient or user thereby allowing overuse of the health care system.
  • The belief that the health care system is free leads to abuse.
  • It is too easy to take advantage of the current health care system.
  • There is no incentive for an individual to limit their use the health care system.
  • People can go to multiple walk-in clinics in a day until they get the answer they are looking for from a doctor.
  • Many British Columbians do not understand the cost difference between the services of the emergency room and those of a walk in clinic.
  • The Medical Services Plan is the only insurance plan that does not use investigators or recognize the extensive amount of fraud committed by policy holders.
  • The health care system has been abused for years.
  • If the situation involving abuse of the health care system is left unchecked, instead of a free-for-use system it will become a pay-for-all system.
  • Frequent abusers of the system should be identified by their personal health number and subjected to additional scrutiny when accessing services.
  • Many seniors go to their doctor because they are lonely; this is a waste of money.
  • There is considerable abuse of the system by our aged population.
  • It is an abuse of the health care system to go to the doctor just because you are uncomfortable.
  • Women may put more pressure on the health care system than men do.
  • It is an abuse of the system for people to go to their doctor to obtain a note for their employer.
• Comments on visitors, temporary residents and dual citizens:
  • Many non-residents use the British Columbian health care system and do not pay
    the whole bill before leaving the Province.
  • The Ministry of Health lacks the resources to go after individuals who do not pay
    before leaving the Province or country.
  • Visitors and students often come to Canada with insufficient health insurance and
    do not reimburse the health care system for bills that their insurance does not
    cover.
  • Some citizens not living or paying taxes in Canada, use the health care system.
  • Part-time residents spending six months of the year outside Canada can still retain
    their health care coverage.
  • Canadians living in the USA come across the border to use our Medicare.
  • Many citizens not living or working in Canada obtain premium assistance as they
    do not have to declare any income in Canada.
  • People from all over the world use our health care system but we need to look
    after Canadians first.
  • People from other provinces or countries put additional pressures our health care
    system.

• Comments on seniors moving to British Columbia:
  • American seniors move to British Columbia to take advantage of our cheap health
    care.
  • Many seniors move here from elsewhere in Canada and have not contributed to
    our health care system or paid taxes in British Columbia yet their most expensive
    years of health care usage are paid for by British Columbians.

• Comments on immigration:
  • Elderly people immigrating to Canada to join their families do not contribute to
    the tax base, yet access British Columbia’s social services.
  • Many immigrants to Canada may use relatives’ CareCards to access the health
    system.
  • Immigrants may increase the pressures on our health care system.
  • Immigrants arriving to British Columbia from the third world may have medical
    conditions which can negatively impact the health care system.
Mental illnesses are often overlooked in the immigration process.

Immigrants should speak English before being allowed to immigrate to Canada as it is difficult and expensive when a translator is required for them to receive medical treatment.

It is not right that older people can immigrate to British Columbia needing the medical system and they don't have to wait three months for coverage.

In some cases, non working family members remain in Canada and continue to receive health care benefits while the wage earner returns to work in their country of origin.

Immigrants and BC residents should receive equal treatment. New residents to British Columbia, without a family physician, must use the emergency departments for non-emergency health care.

### Ideas and Suggestions

- **CareCard Usage**
  - Having the subscriber’s picture on their CareCard could prevent fraud.
  - Encode biometrics on CareCards. Personal information such as retinal scan, photo, blood type, thumb print and height and weight should be on CareCards.
  - The Medical Services Plan should issue new CareCards with more security features to those entitled to health care coverage to eliminate the illegal and fraudulent use of our health care system.
  - CareCards could be issued and renewed by the Insurance Corporation of British Columbia (ICBC) along with driver’s licenses using the same photo and information.
  - CareCards should have subscribers’ home addresses on them.
  - CareCards should be reissued every ten years with up to date personal information.
  - Put an expiry date on CareCards.
• CareCards could have a PIN number like a bank card to minimize fraud.
• If a CareCard is lost or stolen, the new card should have a new number to ensure that the old card is not usable.
• Everyone should have to present their CareCard before receiving health care.
• Individuals lending CareCards to non-residents and those borrowing cards should have to face legal consequences.
• Patients not presenting CareCards or phoning the number in after receiving medical services, should be screened to ensure there is no fraud or illegal usage occurring.
• The Medical Services Plan must make it more difficult to obtain a CareCard as documents and cards are easily falsified.

• Ideas about health professional conduct:
  • Patients should be required to sign their bill to certify they received the service before the doctor is paid by the Medical Services Plan.
  • Patients should receive a printout of services used to check for fraud and improper billing.
  • Patients should have the regular opportunity to review costs paid on their behalf, to ensure that the charges are correct.
  • Send patients a list of the doctors billing their CareCard.
  • Random audits of doctor’s billings to the Medical Services Plan and health authorities would catch and help deter fraud.
  • The health authorities should do random checks on doctor’s billings.
  • Doctors whose billing profiles raise concerns with the Medical Services Plan should be audited on an individual basis.
  • Doctors caught fraudulently billing should have their billing number revoked.
  • There should be a monitoring body that advocates for patients and holds health professionals accountable for their billings.
  • Doctors’ billing should be more transparent.
  • If patients can receive a bill from dentists and eye doctors then doctors should also have to send patients a statement or receipt of the cost of the procedures being billed.
  • Doctors should supervise their peers to ensure they are practicing and billing appropriately.
• A new smart CareCard should be issued that could be swiped, like a credit card, displaying all the services the doctor charges for.

• Ideas about health care system usage:
  • Incentives need to be in place to ensure users of the health care system value and appreciate it more, while reducing abuse.
  • The public must be made aware of the financial drain on the health care system that results from abuse and overuse.
  • British Columbians should have to pay directly for abusing the system.
  • Penalties should be used to discourage abuse of the system by patients.
  • Medical billing statements should be sent to all users informing them of their incurred costs to the health care system.
  • Make the public aware of the cost of basic services by publishing a list.
  • Patients should be required to present photo identification before obtaining medical services.
  • Charging a user fee would reduce abuse and overuse of the health care system.
  • Triple the Ministry of Health staff so abuse of the system can be investigated.
  • There should be a toll free telephone number to call to report fraud, with rewards given for good tips.

• Ideas about visitors, temporary residents and dual citizens:
  • Non-residents should have to pay up front for health care services.
  • Only residents of British Columbia should be covered by the Medical Services Plan.
  • Non-citizens should not be eligible for health care coverage.
  • Dual citizens should not be covered by our health care system.
  • Spot checks should be done to ensure that residency rules are being respected.
  • The Medical Services Plan should require proof of residency before granting coverage.
  • Only those who pay Medical Services Plan premiums and file taxes in British Columbia should be given coverage.
  • Those not paying taxes in Canada should not be covered for health care.
  • You should not receive Medical Services Plan coverage until you start to pay into the system.
• New residents should not be allowed to access the health care system until they have paid premiums for a period of time.

• New residents should pay premiums on a sliding scale until sufficient funds are paid before being allowed access to the same services as British Columbians.

• There needs to be a measurement of how much a new resident to British Columbia has contributed to the economy, before they can be covered by the Medical Services Plan.

• We need to have tighter limitations on what we give away to people who are not really Canadians.

• Immigration Canada should be notified that a visitor to British Columbia has sought medical attention but not paid the bill in full so that efforts can be made to recover monies before they leave the country.

• The Health Authorities should send Immigration Canada a list of all visitors to the country with outstanding medical bills to prevent them from re-entering Canada before this debt is paid.

• The federal government should monitor landed immigrants not residing in Canada, who return to receive expensive health care services.

• If you are a citizen and leave the country you should be required to purchase private insurance or pay out of pocket for health care coverage upon returning to British Columbia.

• We must ensure that those using the Health Care system are actually Canadians and not just here to take advantage of our system.

• Visitors and students should not be allowed to enter Canada unless they have adequate health insurance.

• Ideas about seniors moving to British Columbia:

  • Residents who have not contributed to the Medical Services Plan for an extended period of time should pay higher premiums.

  • Start charging seniors retiring to British Columbia from out of the province for medical services.

  • New residents should pay a one time deductible of $2,500 to the health region they reside in.

  • Establish an inter-provincial fund which follows senior Canadians when they move from province to province.
• Seniors who relocate to British Columbia should pay a surcharge to enjoy the same benefits as those who have been paying premiums for many years.

• Ideas about immigration:
  • New immigrants and visitors should agree to pay all their medical expenses or be denied entry to Canada.
  • People who immigrate to Canada should not be covered by our health care system.
  • All immigration must stop until all British Columbians are well cared for.
  • After reviewing their medical history and conducting a physical examination, immigrants discovered to have chronic conditions, should pay a premium to cover additional costs of treatment.
  • Immigrants who arrive in Canada with a chronic condition should have a portion of their medical expenses covered by their home country.
  • New immigrants should have to purchase private insurance.
  • Sponsors of new immigrants should be required to obtain a bond for each person sponsored in an amount sufficient to cover their estimated health costs.
  • Immigration laws concerning reunification of elderly parents should make the sponsor liable for the health care costs their parents incur.
  • Immigration policies should ensure that new residents do not burden the health care system.
  • British Columbia should bill the federal government for all expenses elderly immigrants incur.
  • There should be limitations on which services are immediately covered for new immigrants.
  • Those working their whole lives in another country and retiring to British Columbia should not qualify for the Medical Services Plan after only three months.

**Outstanding Questions**

• Once a card holder dies or leaves BC what safeguards or steps are in place to ensure that their card is not used by someone else?

• Do we have insurance investigators who investigate allegations of fraudulent billing by doctors?

• What systems do we have in place to monitor employee theft in medical facilities?
• At what point do we draw the line to indicate allocation of resources to an individual must be finite?
• Should we focus attention on extremely heavy users or is it more efficient to focus on the larger group that moderately over use the system?
PharmaCare

PharmaCare was a topic for discussion in the Conversation on Health. PharmaCare coverage, the use of prescription medications and cost pressures were topics highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of PharmaCare.

PharmaCare Coverage

Many participants express concern that the PharmaCare plan is not responsive enough to the needs of British Columbians. Some feel that PharmaCare is too slow to approve new medications and that the approval process lacks transparency. There is also concern that the referenced based pricing system limits treatment options and is not flexible enough to meet patient needs.

Many participants feel PharmaCare leaves too much of the cost of prescriptions on the patient. They point to high deductibles, dispensing fees and prescriptions for drugs that are not covered, as costs that can limit access to medications for many British Columbians. Others express frustration that alternative medications and supplements are not covered, even if prescribed by a doctor, and do not count towards the PharmaCare deductible.

> Drug formulary decisions should be based on scientific evidence, clinical expertise and the health experiences of patients, not based on economies which are hidden behind the guise of Pharmacare “sustainability”.

– Online Dialogue, Coquitlum

Use of Prescription Medications

Some British Columbians feel that prescription medications are over-used, and frequently mis-used. They feel that non pharmaceutical options are often not adequately explored before a prescription is offered and that too often symptoms are medicated instead of determining the underlying problem. Participants are hopeful that improved public education and prescription supports for health professionals could address these concerns.
Every one of us has got a drug cupboard at home in [our] bathroom for the medicines you didn’t take. And a lot of the evidence suggests that's because people weren't really involved with the doctor and they took the pills 'cause the doctor told them to take it and they stopped them after two days.

–International Symposium, Vancouver

Many participants are troubled that prescriptions can only be renewed for a maximum of three months. Many see this practice as an added burden on patients and doctors and unnecessary for British Columbians on long-term or maintenance medications.

PharmaCare Cost Pressures

Participants express concerns about the rate at which PharmaCare costs are increasing. Many British Columbians feel that the Pharmaceutical industry is in part responsible for escalating drug costs, suggesting that the marketing of prescription medications and the extended length of patents are two of the leading causes of increasing costs. Some also question how we regulate the relationship between the manufacturers of prescription medication and those who prescribe to the public, and the effect that relationship has on drug usage.

A number of solutions are suggested to address increasing costs. Many participants express interest in a national formulary that would allow bulk purchasing, increased federal funding and consistent coverage across the country, as a means to limit increases in spending. Building on the existing referenced-based pricing system, many recommend including therapeutic and generic substitution as another way to control costs. Some participants feel that prescription medications are responsible for many of the recent gains in health outcomes and that further limiting spending and choice in drugs will lead to cost increases elsewhere in the health care system. They suggest that increasing spending on prescription medications will save the health care system money overall.

[We] have to learn something from New Zealand… a national formulary that is consistent right across the country, so that every province has the same package of drugs that are covered by the public system, and you have bulk purchasing power. Imagine, if you had ten provinces and three territories all getting together and saying, we are going to negotiate with big pharma… as a nation, right across the country.

– Focused Work Shop on Delivery Models, Vancouver
Conclusion

The PharmaCare plan and the role of pharmaceuticals in health care were the source of much debate during the Conversation on Health. Some British Columbians feel that, when used appropriately, pharmaceuticals can offer a non-invasive way to address many illnesses and conditions. However, they are concerned that the costs of pharmaceuticals are becoming an increasingly large burden for patients and the PharmaCare plan. There are a number of solutions proposed to address this concern, but there was no consensus on the best way to balance providing treatment options while controlling costs.
PharmaCare

This sub-theme includes the following topics:

PharmaCare Administration and Regulations
Costs of Prescriptions
Use of Prescription Medications
PharmaCare Coverage
Reference-Based Pricing and Generic Drugs
Pressures on PharmaCare
Pharmaceutical Industry

Related Electronic Written Submissions
(www.bccconversationonhealth.ca/EN/electronic_written_submissions)

Contribution to the BC Conversation on Health
Submitted by Merck Frosst Canada Ltd.

Is BC’s Health Care System Sustainable?
Submitted by Canadian Centre fo Policy Alternatives

Submission to the BC Conversation on Health
Submitted by the Summit on the Value of Medicine

Innovation our Passion: Better Health our Mission
Submitted by the Rx & D Canada’s Research-Based Pharmaceutical Companies

A Summary of the Public Forum on Health Care Organized by the Kamloops Citizens Concerned About Public Health Care
Submitted by Kamloops Citizens

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

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Salaries; Medical Services Plan and Seniors.
PharmaCare Administration and Regulations

Comments and Concerns

PharmaCare Deductible
Special Authorities

- Comments on the PharmaCare deductible system:
  - The PharmaCare deductible is too onerous for people on fixed income.
  - When Registered Retirement Savings Plans (RRSP) are cashed in, their value is added to your annual income and increases your PharmaCare deductible.
  - PharmaCare deductibles are too high for most British Columbians.
  - Through Fair PharmaCare, I subsidize the less fortunate with my family deductible of $1,900 before my family qualifies for drug assistance. Fair PharmaCare then imposes another financial restriction or fine as it pays only 70 per cent of my drug costs over $1,900 until I reach a second plateau of $2,550.
  - The PharmaCare deductible is based on the previous year’s income tax return and is a form of double taxation, which is unethical if not illegal.
  - With the PharmaCare family, maximum deductible set at $3,000, most patients will end up paying for their prescriptions and in so doing, subsidize other users. This is not equality and is unfair.
  - Fair PharmaCare is prejudiced against some people. Seniors should be entitled to equality with everyone else in terms of the PharmaCare deductible and not penalized because they worked hard, spent many years of their lives in university and saved money.
  - I am not able to work due to illness and I require many prescriptions but because I was able to save and have a Registered Retirement Savings Plan (RRSP) I am required to pay a large deductible.
  - It does not make any sense that the threshold for PharmaCare deductible is $15,000 when the threshold for Premium Assistance is $24,000. The thresholds should be set at $24,000 for both plans and an individual should be able to sign one form to qualify for both programs.
  - Keeping track of the PharmaCare deductible for those with many prescriptions is a headache.

- Comments on Special Authorities:
  - Special Authority criteria are outdated. We often get different advice and cannot rely on it from Maximus.
• We should not be paying someone at PharmaNET to reject or approve a Special Authority when the community pharmacist has the same information, if not more.
• The special authority system is too slow in responding to requests.

• PharmaCare is too focused on the cost, not the value.
• The PharmaCare program is the only program left over from the previous administration that the current government has not made more responsive to patient needs.
• The system is set up for safety and price but the customer or patient has been forgotten.
• PharmaCare will not pay for more than three months of prescriptions at a time.
• The provincial government encourages those on Vancouver Island and in the Lower Mainland to prepare for earthquakes, which includes having prescriptions on hand. However, the Government prevents earthquake preparedness for those who need longer-term medication, as prescriptions are only available in three month spans.
• Income testing for services is not realistic. The threshold for coverage should be just over the poverty rate.
• I had a coverage issue and was told to write PharmaCare to get a letter of exception from my Doctor so I could continue to use the same drug I have always used. No one ever responded to the letter that I wrote.
• The PharmaCare program is deteriorating. It is increasingly working against patients rather than for patients.
• The Ministry of Health does not have meaningful ongoing consultation with one of its principal interests, Canada's Research-Based Pharmaceutical Companies. The Ministry of Health projects and manages the PharmaCare budget without in-depth analysis and involvement from industry.
• It is unfair that every January I need to be re-assessed for Fair PharmaCare.
• We recently moved back to Alberta and now the Government says they cannot reimburse us for our heart medications we needed while waiting to get health care insurance in our new province. We have worked hard all our lives and now we cannot live in dignity because of this rule.
• I also believe that the 1941 birth year cut-off for PharmaCare coverage grandfathering is simply unfair. Everyone over 65 should have the same coverage.
• The more my health care costs rise the more money I need to withdraw from my Registered Retirement Savings Plan (RRSP) but doing so increases my PharmaCare deductible, which then costs me more. It is a vicious circle.
• In the east once you reach 65 years of age your prescriptions are taken care of. The PharmaCare system seems like a poor reward for working hard to earn a pension.

• Many pharmacies deliver dispensed prescriptions on a weekly basis. So someone taking three prescriptions gets a weekly pack delivered for free and PharmaCare is billed for seven days of each prescription, plus a dispensing fee for each one. For a 90 day prescription, pharmacies are charging at least 11 more dispensing fees, which is approximately $77 more per prescription, than if they delivered all the 90 day supply in one trip. There needs to be a rule that says only one dispensing fee may be charged per written prescription.

• Too many laboratory tests are required to receive medication. In the past, people were able to have one annual test and receive a prescription for one year of medication.

• Fair PharmaCare is not working for me and I doubt if it is even understood by most people. The financial burden for prescription drugs was shifted by the provincial government to the private insurance companies. My PharmaCare deductible is so ridiculously high that I will never receive any government help and I have no extended health care insurance.

• There is too much paperwork for Fair PharmaCare.

I ideas and Suggestions

Deductible

• Ideas about the PharmaCare deductible system:
  - Deductibles should be lower for people who live below poverty level.
  - Seniors have already paid their dues and should not have any deductible.
  - PharmaCare should be provided free for people with an income under $35,000 per year.
  - Create a pro-rated scale of coverage for those between low-income and higher income brackets, especially if they are married or have dependents.
  - We should base the PharmaCare deductible on personal, not family income. Children could be covered automatically.
  - Use a three to five year average income to determine the PharmaCare deductible.
  - Lower the allowable income level for people suffering from chronic illnesses.
  - Fair PharmaCare is already fair.
  - PharmaCare deductibles should be based on several years of income and there must be provision in case of a sudden drop in income.
• The PharmaCare system is a prime example of a system working well. People use discretion in their prescription usage because they must also make their own contribution.

• PharmaCare should support the purchase of six months of prescriptions at a time, especially for out of country travelers and those with managed, chronic illnesses.

• There must be more advocates to help people deal with PharmaCare.

• Allow prescriptions written by a doctor who has moved to remain valid.

• Eliminate handwritten prescriptions.

• If it is possible to have a system of special authority pharmaceutical drug approval, surely it should not be too difficult to institute a similar program for those suffering from chronic diseases, which would prevent the abuse of such treatment modalities, and benefit many, while saving on the cost of pharmaceutical products.

**Outstanding Questions**

• Why are static prescriptions not available for twelve months, instead of only three months?

• When will the Government recognize naturopathic medicine by allowing the cost of supplements and other remedies to count as part our Fair PharmaCare deductible?

• Why have special authorities if 98 per cent of all special authorities are approved and only doctors can apply?

**Costs of Prescriptions**

**Comments and Concerns**

• PharmaCare will cover the costs of drugs only up to a certain point. If a pharmacy charges more than that, either the overcharges are absorbed by that pharmacy or if one is not paying the PharmaCare deductible, the patient absorbs that cost.

• The current PharmaCare program still costs too much for the working poor. We need a National PharmaCare plan.

• The cost of drugs is still prohibitive in many instances.

• Patients on lower incomes must make impossible choices between satisfying fundamental human needs and buying expensive drugs that have not been approved by the PharmaCare drug formulary.

• I require certain prescriptions to maintain my good health and not be a burden on the hospitals. I find myself having to spend a great deal of money annually, when
others are able to obtain the same prescriptions free. Under a true one-tier system prescriptions and all other medical expenses should be available to everyone, equally, at the same cost.

• I am a pharmacist and I am puzzled by the manner that PharmaCare gives away Air Miles to patients. I understand if the patient pays for their own prescription then they are entitled to the Air Miles which they have earned. What puzzles me is when a patient is over their deductible and PharmaCare is paying for the prescription, why is the patient still receiving the Air miles? These Air Miles belong to the Government and could be put towards travel costs for government employees and ministers. They would amass huge savings to the Government and to the taxpayers.

• With 46 per cent of total prescription drug costs funded out of the public purse and 54 per cent funded privately, I think governments would love nothing more than to offload more of those costs.

• The specialists can prescribe any medicine but when a family has to try and pay out $300 a month for it, because it is not covered, the whole family suffers. It can become a choice between putting food into our mouths and paying a medical bill.

• The cost of drugs has to be addressed. So many find it a real financial hardship to keep paying for medications that they must take, often for the rest of their life. All of the costs of research and experimentation by the drug companies cannot be passed on to the consumer.

• With Fair PharmaCare, patients with extended coverage piggyback their plan and then when the deductible is reached, the extended plans are off the hook for the cost of drugs.

• The PharmaCare formulary and the hospital based formulary are not harmonized. This causes problems for patients when they leave the hospital and have to pay for medications they had been receiving for free while hospitalized.

**Ideas and Suggestions**

• There must be more public transparency in drug pricing and dispensing fees.

• More price transparency of drugs for patients and doctors. For example, pharmacies need to advertise or make easily available their current prices, dispensing fees and policies.

• We should empower consumers with the knowledge of the costs of medicine to enable them to make informed choices.

• Prescriptions should be free for people on welfare and for seniors.

• More funding is required to help people on disability who need to be on medication.
• Drugs should be the same price throughout the province.
• The dispensing fee from drug stores should be the same from store to store.
• A catastrophic drug program seems to be an easy solution but is bad policy.
• Charge people for medication received in Emergency Departments.
• Not-for-profit medications should be produced.
• Government should offer generic medications at cost to patients.
• Access to drugs should not be contingent on what job you have, if your employer has a good benefits package or if you have enough money for drugs and the other necessities of life.
• The Government should lower the cost of prescriptions with legislation.
• There should be rebates on the price of prescriptions for non-smokers.
• PharmaCare is a good system that is helping low-income people afford drugs.
• Drugs are readily available at accessible prices.
• I would like to see access to medications for all British Columbians of any age, on an equal footing.
• You are going to get two kinds of benefits from a PharmaCare program where you have the federal government or the provinces deciding to pay a high percentage of the cost of prescription drugs. You are going to get equity and, while you will have shifted cost onto the taxpayer, you give government the vehicle for trying to push global costs down. You give yourself the opportunity and the mechanism to bring prices under control. It is a trade off but it is a trade off that says we as Canadians will pay less through the private insurance system and more through taxation. This also means that it will shift along the income distribution because people at higher incomes will be taxable. It will push more of the costs onto people with higher incomes and take them off people with lower incomes, which is part of the political dynamic.
• Place a yearly limit on drug coverage for British Columbians.
• There should be catastrophic drug insurance for people that have drug bills over a certain limit each year.
• Allow tax breaks or credits for non-prescription medicines.
• The Government should fund all medications for all residents in long-term care.
• Institute full PharmaCare coverage so that people are not held hostage by private insurance companies. I recently tried to upgrade my private health care insurance to increase coverage of my prescription costs. The carrier refused to do so because of my medical history. Their profit margin would have been reduced.
Use of Prescription Medications

Comments and Concerns

Side Effects

- Comments on the side effects of prescription medications:
  - People are getting sicker on drugs which do not have well documented benefits.
  - Some drugs have side affects that can cause incurable disabilities. These drugs should be banned.
  - On three occasions the drugs I have been prescribed have been recalled because they can cause heart attacks.
  - The fourth leading cause of death after cancer, heart disease and stroke is taking properly prescribed prescription drugs.
  - There is a concern that doctors at walk-in clinics are overlooking drug allergies that are stated on a patient’s chart or mentioned at the time of a visit.
  - I have only heard of one person dying from using vitamins but in the United States thousands of people die every year from taking Tylenol which is an over-the-counter drug. Who knows how much is covered up about the side effects of prescribed drugs for the sake of corporate profit.
  - Nearly all drugs have side effects that are often worse than the original problem.
  - There is no way to search for up-to-the-minute information on drug interactions or negative side effects before prescribing a drug.
  - So many prescription drugs create side effects that in turn require more intervention with other drugs to counteract the illness created by the first drug.
  - Conventional medicine has a horrible dependence on a cocktail of drugs, most of which actually weaken the body further and end up being more harmful than the disease itself.
  - The human body cannot endure the barrage of pharmaceuticals that is so commonplace in today’s society. There are better ways to treat illness.
  - Drugs for chronic problems such as back pain, migraines and arthritis often end up causing more health problems in the long run than they help with the original problem.
  - The health care system looks for easy, prescribed solutions.
  - Every one of us has a drug cupboard at home in the bathroom for the medicines we did not take. The evidence suggests that is because the patients were not really
involved with the doctor and they took the pills only because the doctor told them to take them and then they stopped after two days.

- Doctors treat symptoms with drugs and/or antibiotics when it is not necessary or without exploring all of the underlying issues.
- We are not offering preventative alternatives to drugs.
- Drugs are subsidized by the system but persons looking to reverse or prevent illness are punished by having to pay full costs for supplements and other preventative treatments.
- Pharmaceuticals can enhance and extend our lives but they are also overused and over prescribed.
- There is a concern surrounding pharmaceutical-abuse by First Nations Elders. Prescription drugs that contain codeine and tranquilizers are over-prescribed to people in First Nations communities.
- The PharmaNet data shows a pattern similar to the Medical Service Plan data: children in continuing care were prescribed more medications much more frequently and for longer periods of time than were children who had never been in care.
- In North America, the prevailing notion seems to be that a pill manufactured by a large pharmaceutical company and prescribed by a doctor is the only way to treat conditions. This approach is reactive rather than preventative.
- Doctors must be held responsible for being experts in regards to the drugs they prescribe. They should not be allowed to prescribe medications unless they know what the minimum overdose quantity is and how to recognize symptoms of overdose.
- Pharmaceutical companies have conned patients and doctors into believing that drugs are the answer to everything.
- Most drugs are worthless at best and potentially very dangerous. This is well documented with solid evidence.
- There is concern regarding over-prescription and addiction to pharmaceuticals by seniors.
- Addiction from prescribed medication in young people is on the rise. These addictions lead to adverse changes in personality.
- British Columbians have little or no education in prescription use.
- Fair PharmaCare has not stopped the over prescription of medications that can make the elderly sick and can result in numerous younger people being over medicated on anti-anxiety and anti-depressant medications.
• Pharmaceuticals are being prescribed for problems outside of the operational scope of that drug. For instance, Prozac is being prescribed for patients with angina pain, with fatal results.

• The over reliance on antibiotics for both bacterial and viral infections has very rapidly made these miracle drugs useless.

Ideas and Suggestions

Side Effects

• Ideas about the side effects of prescription medication:
  • Alternative care methods largely have no side effects while the opposite is true when dealing with pharmaceuticals.
  • Pharmacists should be able to catch drug errors.
  • Prescription drugs should be very carefully considered, as to their side effects, as each patient has different reactions.
  • Samples of drugs should be prescribed until it is known if patients can tolerate them.
  • Manufacturers of drugs need to be responsible and pay for the damage they do.

• Alternative medicines should be used. I realize that the drug companies have a stranglehold over the regulatory bodies, hospitals and doctors and that natural medicine and practices do not make money for the drug companies as they cannot normally be patented. The use of alternative medicines should be encouraged instead of more expensive and often dangerous drugs.

• Reduce drug use by encouraging alternative medicines and lifestyle changes.

• Make doctors accountable for the medication they prescribe by periodically auditing them.

• Doctors should not rush through appointments because simple diagnoses are then often missed and the patient ends up with a prescription.

• People should be weaned off pharmaceutical drugs.

• Provide more consumer education on pharmaceutical drugs and alternatives to them.

• Homeopathic remedies should be covered by PharmaCare.

• The Government should not increase the budget to cover pharmaceuticals.

• Launch Government awareness campaigns to educate the public on the use of pharmaceuticals only as a last resort option.
- Stop prescribing drugs for viruses because they do not respond to medication.
- Implement an electronic medication profile that is available to doctors and pharmacists in order to efficiently track drug use.
- Prescription drug users should have periodic reassessments to reduce over-prescription.
- Ensure health professionals are clearly communicating the proper use of medications to their patients.

**Outstanding Questions**

- Why does our medical only cover drugs? What about the thousands of British Columbians who are using natural supplements and paying out of their own pockets?

**PharmaCare Drug Coverage**

**Comments and Concerns**

**Plan G and Treatments for Mental Illnesses**

**PharmaCare Approval Process**

- Comments on the No-Charge Psychiatric Medication Plan (Plan G) and coverage of treatments for mental illnesses:
  - If an adult makes a very low income their medication is covered by Plan G but for those making slightly more, they must cover the cost of their medications that are absolutely necessary to maintain or improve their health. This essentially reduces their standard of living.
  - Pharmacies are shifting costs to the client. This is especially a problem in the area of mental health.
  - Some medications may cost $900 per month and must be paid for by the patient or client.
  - General practitioners should not rely on anti-depressants to treat depression without first ensuring that there has been a proper diagnosis and a thorough consideration of alternative forms of treatment.
  - Patients cannot afford the prescriptions so they do not follow the treatments and get sicker.
• Over prescription of anti-depressants is a major concern. Many emotional imbalances leading to the prescription of medications could be addressed through diet, vitamin and mineral supplementation.

• There are a number of new psychotropic medications available as first-line treatment, and when they work, they improve the client’s and family’s well being. New treatments mean better opportunity for receiving a chance for recovery.

• Comments on the PharmaCare approval process:
  • Decisions on drug coverage seem to be based on economics, not patient needs.
  • In the British Columbia PharmaCare Annual Performance Report, pharmacoeconomics are not associated with the introduction of the new drug evaluated or considered; therefore cost savings to other parts of the health care system are not taken into account. It appears that the only economics considered are the direct impact on the immediate PharmaCare budget of the next year with no consideration for the savings that could be reaped from other parts of our burdened health care system.
  • The Ministry of Health projects and manages the Pharmacare budget with little involvement from the pharmaceutical industry. Other industries, such as those engaged in the extraction of natural resources, have ongoing relationships and dialogues with their regulatory agencies.
  • The process for the approval of innovative medicines is conducted behind closed doors and all advising parties, such as the Therapeutic Initiative, are equally restricted. No stakeholders, including health care professionals, patients or the innovative medicine sponsor, are ever provided with any data around the process of approval or non-approval.
  • Very little of the information on why drugs are approved or not is shared with the public.
  • British Columbia’s Therapeutics Initiative does not make public the rationale behind its listing decisions and often does not call on the advice of disease-specific experts and consumers in making decisions.
  • The Executive Director of the Arthritis society states that, the way in which chronic disease medication is approved and covered is not working in the best interest of the patients. Timely access to the right medication is needed. PharmaCare should be seen as a strategic investment in our health and not as another expense to be cut.
  • It is important that PharmaCare increases transparency and improves governance to ensure that there is a better understanding of the decision making process and that we can be assured that the coverage decisions are based on evidence and not made on political ideology.
Drugs are approved for use in Canada through a process called the Common Drug Review (CDR). Once drugs are approved, it is up to each province to decide whether to add them as a benefit under their respective drug plans. British Columbia takes longer than other provinces to make a listing decision and often that decision is to deny coverage. British Columbia has a parallel process to the CDR called the Therapeutics Initiative (TI). The duplicate system results in a backlog of much needed drugs waiting for listing in British Columbia.

The backlog of drugs under review in British Columbia has grown from 22 to 60 in the past two years. It takes an average of 503 days to list a drug on the provincial formulary. British Columbia is the second slowest of all the provinces to list a new drug.

Politicians should not have the right to pick the medications that PharmaCare pays for.

It takes too long for new drugs to be covered by PharmaCare.

Certain drugs are restricted because they are very expensive but if they are used in the short-term, you may prevent a major complication.

In listing drugs, British Columbia is ninth out of 10 provinces in total listings, ninth out of 10 provinces in full listings and eighth out of 10 provinces in partial listings.

We all want better and timelier access to medications routinely available to most Canadians through a publicly funded system. This is denied to us in British Columbia.

PharmaCare is limiting treatment options for patients. Rather than striving for excellence and facilitating the delivery of better treatment options, PharmaCare is fostering mediocrity by limiting treatment options.

PharmaCare does not cover over the counter drugs for residents in long-term care and the fact that a pharmacist has to dispense them in blister packs only adds to their cost.

Medications are not covered in other provinces, even if a patient is sent there for treatment.

PharmaCare does not cover all the drugs approved by the federal government.

Doctors have outdated information and are prescribing drugs that are no longer covered by PharmaCare.

Doctors write prescriptions for drugs that are not covered.

People need to have both PharmaCare and private coverage to afford treatment. Too many drugs are de-listed.

Insurance companies refuse to cover drugs when they are prescribed too often.
• Politicians and bureaucrats are given preferential treatment when it comes to drugs. Health Canada’s Common Drug Review (CDR) committee recommended that 28 new drugs be covered in provincial and federal drug plans. Of the 28, only 15 are reimbursed by PharmaCare, yet politicians and bureaucrats are covered for all.

• PharmaCare only pays for the slow acting type of insulin that came out in 1946 (MPH).

• PharmaCare is already too generous in its coverage.

• The policy on drug treatments for Hepatitis B needs to be made fairer. The drug I need to be on is not covered and this will force me to take a second job and put my health at risk.

• Some diabetic medications are deemed to be ineffective and are therefore not covered. This is outrageous and untrue based on my experience and makes it too expensive to pay for fully out-of-pocket.

• It is frustrating that the Government funds abortions but not birth control pills.

• Can anyone explain to me why Alzheimer medication is not on the formulary of PharmaCare and those in power continue to steadfastly deny its inclusion. These drugs have a proven track record of slowing the progression of the disease.

• PharmaCare does not fund drugs to treat Alzheimer’s because they are not cures.

• I feel strongly that a review needs to be done on the accessibility of HIV Post-Exposure Prophylaxis (PEP) medication in our emergency room hospitals.

• I am upset because the government is unable to help a cancer patient who will have to pay $7,000 per month for an anti-Cancer drug that is not yet approved in Canada.

• There is only one medication for Osteoporosis being covered by PharmaCare and it is not very effective.

• PharmaCare does not cover programs, medications or services to help people quit smoking or to lose weight.

• Orthomolecular low cost medicine is not being used because most Medical Doctors are not familiar with the huge amount of scientific studies that are out there that show how it works for certain diseases.

• PharmaCare’s coverage of test strips accounts for 3.7 per cent or $29 million of the PharmaCare budget. They are looking to reduce its glucose strip costs by approximately 20 per cent. If this happens, tendering of strips will see British Columbians forced into using a certain product. If experience tells us anything, it is likely that patients will ultimately be left with the oldest (cheapest) version of the product. Patients will be forced backwards in time and technology.
• The demand for the use of Compounding Pharmacists is on the increase, yet the prescriptions they fill are not allowed as part of the PharmaCare system. This is not the only example of what seems to be penalization of the proactive person who takes ownership of their health.

Ideas and Suggestions

Plan G and Treatments for Mental Illnesses
PharmaCare Approval Process

• Ideas about the No-Charge Psychiatric Medication Plan (Plan G) and coverage of treatments for mental illnesses:
  • We need to reduce the role of drugs in the treatment of mental illness.
  • Provide free drugs, as needed, for those dealing with mental illness.
  • We should offer drugs at no charge to all mental health patients. Allow access to alternative drugs, such as cannabis at no charge.
  • Do not prescribe drugs for mental issues at walk-in clinics.
  • Allow complete access to all psychotropic medications as first-line treatment so the client is not burdened with secondary outcome. The costs of medications are not so high when compared to the costs of hospitalization, especially repeated stays.
  • Prescribe fewer pharmaceuticals and do more counselling and patient interaction with those suffering from mental illnesses.

• Ideas about the PharmaCare approval process:
  • The Government is refusing to admit the need for a PharmaCare program on a national level with a national formulary.
  • New drugs should be covered and formularies dealt with at the federal level, not the patchwork of provincial regulation we have today.
  • The therapeutics initiative is a group that gets some funding from the Government to look at new medications as they come out to see if they are worth the money and if they actually work. It has saved a very large amount of money for PharmaCare by not recommending coverage for new drugs with limited usefulness.
  • The effectiveness and uniqueness of a drug, from the standpoint of reducing risk to life or supporting reasonable health, should be considered when deciding whether to cover the costs of a drug. The cost of the drug and its generic alternatives should also be considered.
• The approval of new drugs must be sped up.

• Use a regional approach and let hospital pharmacists evaluate medications.

• If one of the purposes of the review process is to have a high quality review of submissions, then highly qualified and objective experts should be expected to participate in the process. The need for practicing specialists and experts who have been involved in the development of pharmaceuticals and biotechnology treatments should be welcomed into the system in order to ensure the Government has access to the most experienced and knowledgeable experts in a given field.

• In Quebec, citizens and clinicians, through their respective associations or groups, who want to submit their comments, have the opportunity to do so for a 30 day period after a file has been accepted for review. In Saskatchewan, residents or groups who disagree with decisions because they feel vital scientific information was missed have the ability to appeal in writing to the Province's Formulary Committee.

• Involve Pharmacists more in developing provincial medication formularies.

• Medications that are proven effective should be funded.

• We should require blind studies prior to having drugs approved.

• Prescription medications should be included as a PharmaCare benefit when the following criteria are met: an individual cannot reasonably afford the medication, there is no low cost alternative and failure to take the medication will result in a substantial increase in hospital admissions.

• Pharmaceutical selection is adequate. Product information sheets on pharmaceuticals are adequate.

• It should be easier to get patient-friendly drugs such as methadone.

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

• Our income sensitive Fair PharmaCare Program is recognized across the country for its scope and its breadth.

• Support the use of traditional medicines in First Nations communities.

• The reason behind drug listing decisions should be public knowledge.

• If we think drugs are expensive then we should compare it to the long-term costs of under treated or untreated chronic disease. The long-term costs are going to be a lot more expensive.

• A study has been done that shows it is cheaper to pay for seniors prescriptions than to have them show up at the hospital because they did not take their medication.
• PharmaCare should cover newer Type I diabetes drugs to stabilize patients and prevent further medical costs down the line.

• Cancer drugs should be paid for by the Province as soon as they are approved.

• PharmaCare should cover a certain level of dental services to those using blood thinners or auto-immune suppressing drugs because these people have to avoid infection at all costs.

• British Columbians are entitled to the same prescription coverage as our politicians have.

• Traditional and herbal medicine should be recognized.

• PharmaCare should cover drugs that help in the prevention of illness.

• Life saving, catastrophic drug costs should be uniformly covered by public health care.

• We should not have universal drug coverage. Drugs should only be covered when you are in a hospital or other facility for a specific treatment, otherwise they should be the responsibility of the patient.

**Outstanding Questions**

• Why are all new drugs automatically not covered by PharmaCare?

**Reference-based Pricing and Generic Drugs**

**Comments and Concerns**

• The reference-based drugs program is not based on scientific research.

• Generic drugs drive the cost of health care through the roof and lead to increased spending.

• Generic drug prices in Canada are more expensive than they should be. In fact, Canadian generics are approximately 115 per cent higher than the equivalent products in America.

• Drugs are being removed from the formularies that are effective because of their costs.

• Restrictive policies like reference-based pricing and therapeutic substitutions do not provide patients with access to the latest, most effective drug therapies and creates a negative investment environment for companies.

• The Reference Drug Program in British Columbia is the one policy that is most emblematic of silo policy thinking at PharmaCare.
• Most health systems that have implemented Reference Drug Program and Therapeutic Substitution have abandoned the policy or are not expanding it to new therapeutic classes and a vast number of others have considered this policy only to reject it. This is because the balance of evidence shows that Reference Drug Program and Therapeutic Substitution does not succeed in lowering health care or drug costs, it is complex and costly to administer and it may actually harm patients.

• New Zealand’s experiment began in the early 1990s as part of their experiment with competition within their health system. The four purchasing organizations, created a subsidiary company known as PHARMAC which aggressively managed the schedule of around 3,000 publicly subsidized drugs, using techniques such as reference pricing and funding generics. PHARMAC claims to have kept the public funding of drugs in check and you can see that it would have been two and a half times as much in the absence of PHARMAC. The organization, however, has been controversial as the incentive with them is really to prescribe only drugs that are listed on the public’s schedule. Drug companies deeply dislike the organization and doctors and patients often challenge PHARMAC decisions. Most recently PHARMAC chose to fund Herceptin, the breast cancer drug for nine weeks instead of the fifty-two that most governments fund, and another very recent study found that New Zealand had some of the poorest access in Organization for Economic Co-operation and Development (OECD) countries to cancer drugs.

• Generic drugs take too long to go onto market.

• Our single payer system has not helped to keep generic drug prices down. What that tells you is it is not just the patent system that is keeping our prices up, it is the way in which the generic market place in Canada manages not to be competitive, and some of that has to do with kickbacks to pharmacists.

• Over 30 international studies have concluded that the primary effect of drug plan restrictions was to shift, not to reduce, health care costs.

• Reference-based pharmaceutical pricing means that the price of a drug will be determined by what the customer is willing to pay in order to live without the pain or the illness, rather than the actual production value of the drug.

• PharmaCare maintains that they have saved millions while providing no objective data to support their claims or the actual cost of policies transferred or created in other parts of our health care system.

• There is concern with reference based drug pricing in British Columbia. Doctors do not get paid for the extra time to fill out the necessary forms, but if you pay physicians to fill out the forms, then there is a dual incentive to bypass the reference pricing system. An e-prescribing process would make it easier to mitigate this dual incentive but at the same time clinical judgment and clinical professional autonomy needs to be preserved.
• Ironically, generic drug prices in Canada have been distorted by the drug pricing policies of federal and provincial governments. Pricing policies virtually preclude patented drug companies from competing with the generic versions of our innovation due to the structure of Canada's price control policies. The policies use the highest price of an existing drug in a therapeutic class as the price for setting the maximum allowable price for any new or future innovative medicine in that therapeutic drug class. No rational business would reduce the price of their now-off-patent drug to compete with the generics, as it would endanger any pricing of a future patented drug.

• Too many doctors are prescribing more expensive drugs when generics will do the same job. Government has allowed brand-name drug manufacturers increased time to maintain copyrights and prevent generic companies from saving the public money.

• The government should not force generic drugs on people.

• The cheap, generic drug is more expensive in the long run because the more expensive drug works better. The cheap option can mean more ambulance and hospitalization costs.

• Doctors should be able to prescribe the pharmaceuticals that will help the patient, not just what is approved by PharmaCare.

**Ideas and Suggestions**

• In the British Columbian context, it is worth noting that the provincial reference drug program has been successful in containing costs for a very limited number of drug categories by paying only for the lowest cost drug that is therapeutically equivalent. Annual savings as a result of the program are in the $24 million to $42 million range from the time the program was introduced in 1995 up to the end of the decade.

• Only about six per cent of the new drugs that come on the market are novel drugs for new conditions where they are stand alone agents.

• The pharmaceutical companies launched Vioxx with a huge marketing campaign as a treatment for arthritis. It was supposed to be the big save-all and it ended up having all kinds of problems after the fact. PharmaCare did not fund it. It was one of the cases that proved that reference-based pricing and the therapeutics initiative really works, because they had not found enough evidence to support the fact that this drug should be funded on the PharmaCare system.

• The reference-based pricing model is working well.
• The province's initiative of evaluating new drugs for their benefit over existing drugs seems to be going well.

• There are solutions to rising drug costs. The 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.

• If a patient has had years of success on a pharmaceutical, leave them alone. More money is wasted with repeat visits to the doctor and drugs being thrown away then it would probably have cost to provide the original medication. New prescriptions should be generic, but we should grandfather existing prescriptions and not ask people to change drugs that are working for them.

• Doctors should be asked to rationalize why a patient needs a certain drug that is not on PharmaCare’s formulary.

• Doctors on the front line, working with a pharmacist, will be in the best position to determine the efficiency of a medication.

• Mandate the prescription of generic drugs whenever possible.

• There must be some leeway and some ability for each individual’s case to be reviewed if the generic option is not working.

• It has been shown that there are no negative consequences to patients from switching to reference based drugs. It was suggested that switching drugs was leading to increased hospital utilization rates. That might be true for the first prescription, but over the long term it did not lead to increased hospitalization rates and did not lead to more co-morbidity or other perverse effects.

• The best medications, not the cheapest, need to be covered by PharmaCare.

• We could save $30 million annually if British Columbia paid the same rate as Ontario does for generic drugs.

• Today in Ontario, the first generic medicine in a category must be priced at 50% of the listed branded equivalent. In BC, there is no set policy. The first generic typically enters the market at a 10% -20% discount with the following entrants driving the discount down, depending on the number of entrants.

• We should move beyond medicine rationing policies such as reference-based pricing and therapeutic substitution and embrace the positive impact innovative medicines have on the system and on development of the knowledge-based economy.

• Once regulators and politicians recognize and understand pharmaceutical innovations decrease costs in other areas of the health care system, they can move beyond medicine rationing policies as cost containment vehicles and instead make
spending decisions that reflect the wisdom of investing in medicines as a means to achieve health care sustainability.

- Until such time as rigorous, high quality research, covering long-term impacts on health outcomes, is conducted to provide reliable guidelines to assist policy-makers; one should not consider expanding the implementation of such restrictive reimbursement policies as Reference Drug Program /Therapeutic Substitution

- Pharmaceuticals should be crossed referenced with the equivalent generic drug so that these may be matched with the idiosyncrasies of the patient's conditions. If this information was available in a database it could save the patient and society a great deal of money.

**Pressures on PharmaCare**

**Comments and Concerns**

**Drug Pricing and Demand**

**Effectiveness of Drug Spending**

- Comments on drug pricing and demand:
  - One of the fastest growing costs in health care is the use of pharmaceuticals. More than $1.16 billion a year is now spent on prescription drugs. When we looked at the data, 80 per cent of the increase from 1995 to 2003 was due to the use of heavily marketed drugs. That is drugs that do not represent a real breakthrough in terms of value for money. They do not make you any better than some of the things that are already existing, but they cost more.

- When a new treatment becomes available, we have what is called a 'treatment substitution effect' where old treatments are replaced by innovations. This can have two different results. It can reduce the number of patients needing treatment and the cost of treatment per patient (that is, vaccines that can reduce or virtually eradicate some diseases) which may result in significant cost savings for the health care system. The other possible result is that the new treatments are more expensive than the old ones and the immediate cost to the health care system increases. What is important to note is that in this case, academic evidence shows that the quality-adjusted price of medical care will still fall over time as new technologies and processes are adopted.

- Marketing by drug companies make people think that more expensive drugs are more effective when they are not.

- Advertisements marketing drugs and diseases lead to increased consumption.

- The pharmaceutical industry is inflating demand.
• The out of control PharmaCare costs are due to the drug companies.

• We are exposed more and more to drugs being advertised on the television. Where are the Canadian Radio and Television Commission (CRTC) in this respect? It is illegal in Canada for the drug companies to do this, but it is being allowed to continue. For some people, if you tell them often enough about a condition, real or not, and the drug for it, they will believe it is reasonable to expect treatment. It is a matter of creating a market that does not exist.

• Drug companies are marketing drugs to doctors, resulting in the prescription of unnecessarily expensive proprietary drugs.

• The price increases of patented drugs are not cost drivers of the health care system. Canada ranks fourth lowest of eight countries on patented drug prices.

• The Canadian government controls Canadian drug costs. Suppliers adhere to these cost controls in order to sell to the Canadian market. Canadian consumers enjoy lower costs than their American counterparts and this keeps medical costs lower.

• The drug company’s agendas are being promoted as medical advice.

• I am concerned that the profit mark-up on prescription drugs can be as much as 200 to 500,000 per cent.

• Comments on the effectiveness of drug spending:
  • Every time PharmaCare refuses to list a drug, they are spending money, not saving it.
  • Cost containment within PharmaCare focuses on limiting supply rather than ensuring appropriate utilization and measurement of the value that medicines provide to patients, to the healthcare system and to society.
  • The health care system is not structured nor is there incentive to measure the value of health care interventions. As such, it is difficult to understand the relative value provided by investments in most health care interventions. In the absence of this knowledge, cost containment becomes an exercise of controlling expenditures in the silos whose rate of growth is the highest. The concern with this approach is that health care investments cannot be strategic and therefore have the potential to undermine both the quality and the cost-effectiveness of health care interventions.
  • Prescription drugs are in fact a very cost-effective tool to manage disease. When used effectively and appropriately they become key contributors to improved treatment of patients, improved health outcomes and the sustainability of the health care system.
• PharmaCare grows at least ten per cent year over year. If we take the brakes off, we could easily see it grow by over 25 per cent.

• Of the 5,200 new drugs that are available in Canada, the World Health Organization (WHO) lists 326 as essential. Most of the new drugs emerging on the market are not new therapies, but new versions of old therapies. Of about 100 new drugs emerging per year, only five could be classified as new, true breakthroughs in drug therapy.

• The extension of patents to drug companies has increased costs for the PharmaCare program.

• The North American Free Trade Agreement (NAFTA) has implications on pharmaceutical costs.

• Technology and the development costs of new pharmaceuticals have stretched the system’s ability to cope.

• There are three factors in the increases in the PharmaCare budget: volume, therapeutic choices and prices. The biggest cost pressure is volume.

• Drugs are now the second highest cost item in the whole health care system. That is due to higher levels of prescription drug use and the large price tag that comes with new pharmaceuticals.

• Drugs are an important component of the health care budget and have been increasing in cost as a result of a number of factors, including: demographic pressures; high public expectations; effective chronic disease management; a focus on primary prevention; the shift to outpatient care; increases in drug utilization; new therapies and emerging technologies; new diseases and areas of pharmacology; increases in overall fiscal pressures; professional fees; and, wholesale mark-ups.

• Not fixing a medical problem surgically and just putting the patients on a drug for life costs the system more money than getting the problem fixed in the first place would have.

• The production of pills costs pennies, yet the mark up is sky high. I would guess the profit margin is 10,000 per cent.

• One of biggest driving forces behind the pharmaceutical problem is the behaviour of the federal government. What we have in pharmaceuticals is a situation where the federal government makes a lot of the key policy decisions and the provincial governments pays for it.

• The prices of patented medicines have not been a factor in driving up health care budgets due to price regulation by the Patented Medicines Prices Review Board, price controls, and overall cost pressures in the health care system.

• 2004 was the 12th consecutive year that the patented medicine price level has either decreased or remained relatively unchanged.
Ideas and Suggestions

National Formulary
Bulk Purchasing
Role of the Provincial Government
Value of Drugs

- Ideas about a national formulary:
  - What would happen if the federal government contributed ten per cent of the costs of any drug that was on a national formulary? Governments could agree on the set of drugs that would be covered and provinces could opt in or not participate. You need a certain ideology of a government to go in that direction, but it is in their best interest to work cooperatively with the ten provinces and the territories to ensure that their overall debt load is as little as possible.
  - Imagine having ten provinces and three territories negotiating collectively with the pharmaceutical companies on cheapest cost of a particular drug. To make your negotiation effective you have go to be able to steer your purchasing. If that national committee has no influence over what is actually purchased, then the producers will just laughs at you. It has to be backed up by bulk buying and the ability to shift the contracts from one supplier to another.
  - New Zealand has had virtually no cost escalation in their drug plan in the last ten to 15 years. The whole New Zealand market is a bidding market that forces the pharmaceutical companies worldwide to get into a negotiation process over prices. Not only do the brand name drugs come in cheaper but the generics are a lot cheaper in New Zealand than they are in this country.
  - We should implement a national PharmaCare system, with reference-based pricing, bulk purchasing and the use of generics.
  - The Government should be responsible for acquiring pharmaceuticals in order to assure fair prices.
  - A national formulary creates two things; purchasing power and consistency. It is cost and efficiency and comparability. Harmonization would also really get to the issue of standardizing drug treatment in hospitals and in the community to ensure that patient safety is a big issue.

- Ideas about bulk purchasing and other purchasing strategies:
  - The British Columbia Cancer Agency has established a centralized purchasing system for cancer drugs, which has allowed negotiation of reduced prices for both oral and IV cancer therapies.
• There may be savings through group purchasing and more purchasing clout, if the provinces would agree on the various drugs that they collectively approve for their PharmaCare programs.

• The individual health authorities are trying to stay within their budget so they are negotiating with the drug producers on a much smaller scale, but nonetheless they are into bulk buying for their hospitals.

• The Province needs to adopt tendering, bulk buying and other measures to decrease manufacturer’s costs.

• Establish a province-wide single buyer system to purchase drugs needed by British Columbians.

• Bulk purchasing would reduce the costs of drugs.

• All else being equal, we should purchase drugs made by Canadian companies who pay taxes and buy drugs from companies having the lowest profit margin built into their cost. Cost alone should not be a factor.

• Low-cost alternatives should be tried before more expensive options are considered.

• Ideas about the role of the provincial government:

  • Allow the rights to certain drugs to be owned by government and allow production of these drugs to be sustained by sales with no profit element.

  • The Provincial Government should set up their own pharmacy to help cut the costs of PharmaCare.

  • We should build a facility in this province that could produce generic drugs of high quality and much lower costs that would not only save dollars, but put the quality control in the hands of the government of the province.

  • Form a British Columbia pharmacy company to develop new drugs that operates on a not-for-profit basis.

• Ideas about the value of drugs to the health of British Columbians:

  • Research-based medicine is a part of a sustainable health care system. Innovative drugs, that better manage health issues, keep people out of hospitals, reduce wait times and enable people to manage their health outside institutions.

  • While expenditures on prescription medicines have increased, it is also true that innovative medicines have been responsible for improving the health outcomes of the citizens of British Columbia and the world, each year, for over a century. The global innovative medicine industry is responsible for developing more than 90 per cent of all medicines and vaccines in the world. The presumption that the
increased cost of public spending on innovative medicines is the primary cause of financial distress on our health system is at best misguided.

- Cost containment within PharmaCare focuses on limiting supply rather than ensuring appropriate utilization and measurement of the value that medicines provide to patients, to the healthcare system and to society.
- Data from the latest Canadian Institute for Health Information (CIHI) report on drug expenditures in Canada and the more recent PharmaCare 2005 Annual Performance report clearly show that while the overall cost of pharmaceuticals is increasing, the cost of prescription drugs does not represent a major component of the health care budget. The average cost of a prescription in British Columbia has also decreased in the past five years.
- Half of the gains in life expectancy over the last 50 years have come from drugs. If you rely on drugs more heavily, you save money.
- Drugs that are preventative and curative can save health care money.
- The PharmaCare program in British Columbia should not be focused on cost containment but focused on what can be done to enhance health.

- Stop all drug advertising.
- PharmaCare costs have increased by 25 per cent since 2001. New Zealand has alleviated this problem by having pharmacies compete with one another.
- The testing of new drugs is too onerous and increases the costs.
- We need to amend the federal acts that give such long protection to new drugs. The current situation of cost escalations was predicted when the Federal Government extended the drug companies’ monopoly. The revenue we might lose in drug company research and development is a drop in the bucket compared to the increased costs we have been experiencing.
- If a drug or remedy is being researched with public money, no patent can be taken out by a company or individual.
- PharmaCare should pay for experimental drugs if the patient is willing to sign a liability waiver.
- A tandem change in prescribing costs would also be beneficial and save chronic care patients such as asthmatics going without medications. A baseline dispensing charge to the patient of, for example, $35 for every prescription, regardless of cost, for medications approved by PharmaCare would control prescribing and ensure very few could argue cost as a reason not to take medication. This would pay for itself as cheaper medications would subsidize the more expensive ones. It would also encourage drug companies to look carefully at pricing as there would be more
to gain in sales from keeping prices down when negotiations for inclusion in an approved list took place on a larger scale.

- The alternatives to pharmaceutical medicine cost less.

- Drugs should be supplied to Canadians at a lower price and then sold to other countries at a higher price.

- A Columbia University study showed that every dollar invested in new medicines relieves the health care system of expenses seven times greater than in other medical areas.

- PharmaCare should only fund a small number of quality drugs.

- Educating elderly patients on proper drug use would lower their drug use.

- Prohibit or severely limit the quantity of drugs exported to the United States.

- Promoting healthy life styles would help lower our use of pharmaceuticals.

- The academic detailing initiative educates doctors directly about the costs and benefits of brand-name and generic pharmaceuticals, making them less reliant on Drug Company advertising. This initiative saves $1.50 for each dollar spent to run the program. There is no reason it could not be expanded to reach more doctors across the province.

- Charge Doctors a fee per prescription written to help limit drug use.

**Outstanding Questions**

- It would be interesting to know how much of the PharmaCare expenditures are associated with waste?

- Cuba makes its own drugs, so why not Canada?
Pharmaceutical Industry

Comments and Concerns

Health Care Professionals and the Pharmaceutical Industry

Government and the Pharmaceutical Industry

The Pharmaceutical Industry and Rising Costs

• Comments on the relationship between health care professionals and the pharmaceutical industry:
  • Pharmaceutical companies provide physicians with free samples in order to influence prescribing. The ability for pharmaceutical companies to provide samples should be eliminated.
  • Frequently, a doctor’s main education about a drug is what a pharmaceutical representative tells them in a social setting, usually involving the serving of alcohol.
  • Doctors get their only information from studies done by the drug companies that are biased.
  • The doctors have become sales representatives for the drug companies and our Government endorses this relationship.
  • Pharmaceutical sales people take doctors time away from patient care and only provide information that promotes the pharmaceutical industries interest.
  • Many prescribers have been co-opted, influenced inappropriately and pressured by the drug companies.
  • The Canadian Medical Association has a very strong, clear policy on relationship between physicians and industry, not only for drugs but for infant formulas, medical supplies and other ethical considerations.

• Comments on the relationship between government and the pharmaceutical industry:
  • The government allows drug companies to control the testing of new drugs, designing trials to suit their interests, not the consumers.
  • The patent system for the pharmaceutical industry and the pressure to generate profit does not serve the public interest, particularly on the research side and with the availability of university research information to the public.
  • PharmaNet is one of British Columbia’s great health care resources and it is underutilized. PharmaNet is a province-wide network that links all British Columbia pharmacies to a central set of data systems. This database is one of few in the developed world and provides researchers with a great resource to study
patient outcomes and medicine efficacy as well as to improve upon treatment protocols. It could also be a significant resource for monitoring patient safety in a real world setting. Unfortunately, it has been the experience of independent academic researchers sponsored by industry that access to PharmaNet is denied by PharmaCare. The same is not the case for academic researchers sponsored by the Ministry of Health. The double standard is unacceptable to all British Columbians. More importantly, British Columbians should know that the utility of PharmaNet is one of the reasons that industry can be attracted to invest in British Columbia’s chronic disease management requirements, as it allows true evidence based medicine on a large scale. PharmaNet is a truly underutilized asset.

- Competition for international industry investment in research and development, even within a corporation is fierce and investment logically flows to jurisdictions where industry is welcomed. Investment in British Columbia has been minimal.

- British Columbians should understand that in order for their life science industry to contribute to the health care system, there must be an enabling environment and an environment where the health care system collaborates with industry to bring innovation to its consumers. Today, the Ministry of Health does not promote collaboration with industry. In fact, the Ministry of Health and in particular PharmaCare openly shun collaboration with local and international industry.

- The drug companies make contributions to political parties to ensure their patents are protected.

- The unwillingness to use these alternative resources creates the impression of collusion with the drug companies. The drug companies are running the system, not the government.

- British Columbia is eighth among provinces in per capita university-based research funding.

- Comments on the Pharmaceutical industry and rising costs:
  - Drug and treatment researchers know that they have a guaranteed market if they come up with what is perceived to be an effective treatment.
  - Pharmaceutical companies manipulate the public through advertisements and misinformation.
  - The major pharmaceutical companies have turned symptoms into diseases. One example of this is Acid Reflux Disease, which is in normal cases a reaction to a bad diet.
  - Pharmaceutical companies use pressure tactics to introduce a new drug, knowing they have patent protection. Generic drug makers have to wait years to bring their products to the market.
There are seven or eight pharmaceutical companies, each trying to develop their own version of the Cadillac drug for a particular category. This results in these upward cost pressures and is diverting a lot of money for Research and Development. If your competitor has a blockbuster drug, you could spend a lot of money at high risk trying to find some other blockbuster drug, or you could spend less money at lower risk to find a related molecule that enables you to compete in the already established successful market. What are you going to do? It is not a difficult choice.

I am disgusted that our system allows pharmaceutical companies to pad their pockets. On the street this would be illegal.

Our politicians need to realize that the drug companies spend two dollars on advertising for every one dollar they spend on research and development. They would spend even more if we allowed direct-to-consumer advertising.

The monopoly of pharmaceutical companies is resulting in huge profits.

Virtually all medical research is done by private companies and only on medicine that is profitable. This can only make costs go up.

We know that pharmaceutical companies are not going to try to save the PharmaCare plan any money. Old drugs disappear to be replaced by patentable new versions in order to make good returns for the shareholders.

The drug Thalidomide, which caused birth deformities some 30 to 40 years ago, has now been found to help cure some forms of cancer and that drug companies have increased the cost to consumers by 1,000 per cent. This unconscionable price increase has led health insurers to not cover the cost, making it affordable only to the wealthy. I think the government should be able to intervene and prevent this price gouging.

Pharmaceutical companies base the costs of new drugs on the price an individual is willing to pay to live without the pain, rather than the actual production value of the drug.

Extended patent laws and the North American Free Trade Agreement (NAFTA) prevent the government from truly controlling the cost of drugs.

We should not be paying drugs companies to treat symptoms instead of searching for cures.

A large number of herbal medications have been banned in Canada because of the constant pressure and lobbying of the government by the pharmaceutical industries.

Many very good cures, treatment and prevention protocols exist already, but conventional medicine and corporations suppress them.
• Diseases are not being recognized or treated as quickly as developments could allow, due to commercial interests.

• Nutrients that the public wants and needs are being severely restricted in order to protect pharmaceutical dominance.

• The British Columbia Biotechnology industry is breaking new ground in research and development that has the potential to not only improve the health outcomes of British Columbians, but also to diversify the province's natural resource oriented economic base.

• Life expectancy is increasing in large measure due to innovative medicines.

• The pharmaceutical industry is investing over $60 billion per year in research and development globally and has over 5,000 compounds in active development. Only 20 to 30 compounds are expected to reach the market in a given year.

Ideas and Suggestions

Health Care Professionals and the Pharmaceutical Industry

Patents

• Ideas about the relationship between health care professionals and the pharmaceutical industry:
  • Get pharmaceutical companies out of doctor’s offices and medical schools.
  • We should ban pharmaceutical companies from marketing drugs directly to doctors.
  • The prescribing of drugs should not have perks for doctors
  • Stop the kickbacks to doctors for prescribing certain medications. Doctors caught receiving kickbacks should lose their license.
  • Drug companies should not be allowed to incentivize doctors.
  • Increase the drug education of doctors using science-based information instead of brand-name information.
  • There is clear evidence that educating physicians is the most effective way of changing prescribing patterns and looking at the whole issue of appropriateness of drug prescribing.
  • There must be stricter ethical guidelines governing interactions between doctors and drug companies.
  • Reduce the power of pharmaceutical companies to determine criteria for treatment.
• Doctors should not be allowed to endorse pharmaceuticals.

• Ideas about patents:
  • Get rid of 23 year patent protection which leads to gross profits for multi-national companies at the expense of the public health care.
  • All cancer treatments, cures and drugs should belong to humanity and nobody should be allowed to make any profit.
  • We should have legislation for a more reasonable seven year drug patent protection.
  • We need to amend the federal acts that give such long protection to new drugs. The money we might lose in drug company research and development is a drop in the bucket compared to the increased costs in even one province, like British Columbia.

• The Government should draft legislation to stop the practice of inflating drug costs.
• Drug costs are a pittance compared to the cost of surgery and treatment.
• Drug companies do make money, but they also provide us the drugs that keep us from keeling over.
• Pharmaceutical companies need to stop their symptom-control approach to disease. It generates a lot of income, but creates more problems than it solves by ignoring the source of disease
• Create an independent board to oversee the pharmaceutical industry.
• The Government could provide other tax incentives for the companies to encourage development without styming creativity.
• Institute stricter guidelines on ethical behaviour for drug companies involved in research and development.
• The federal government should control the cost of production and profit percentages of drugs.
• Drug companies must make all of their research results public.
• Our government should ensure that a drug company does not bury a potential cure in favor of a drug that offers results only when taken on an ongoing basis.
• The regulation of the pharmaceutical industry or even the nationalization of the industry would reduce the costs dramatically.
• Government should fund drug research in the correct areas, such as population health as opposed to anti-aging.
• There must be better recognition of independent drug study reviews with more oversight on studies and true independent evaluation.
• We should create a forum for industry and government to dialogue based on mutual respect. Formal and regular interaction could provide comprehensive information for forecasting purposes related to PharmaCare expenditures and the means to explore options to optimize the use of medicines and other effective initiatives.

• Knowledge-based industries such as innovative pharmaceuticals are the growth engines of modern economies. The health care system must not be seen as a cost to be borne but as an opportunity for economic growth.

**Outstanding Questions**

• Why is something not done to limit the profits of the drug companies?

• Are there published, unbiased studies available that were not funded by the big drug companies?

• How much are BC doctors paid and what sort of incentives are they receiving from the pharmaceutical salesman that frequent doctor's offices?
Access to health care was a prevalent topic during the Conversation on Health. Issues raised on this topic included: access to primary health care and clinics; specialists; emergency departments; acute and long-term care facilities; and ambulance services. Here is a selection of what British Columbians had to say on the topic of access to health care.

Primary Health Care and Clinics

Access to primary health care was a prominent topic during the Conversation on Health. Participants discussed primary care suggesting that most often doctors are the first point of contact, or gatekeepers to the public health care system. They also suggest that this contributes to long wait-times and delays in receiving medical care. Other participant concerns include: a lack of doctors and availability of their services after hours; long wait times; and a lack of incentives for doctors to attend to non-urgent needs such as preventative care. To improve access to primary health care, many believe that Government needs to give patients more choice on the types of primary health care providers they can access as well as educating and attracting more primary health care providers and looking at their scope of practice. There was also considerable support for both expanding the role of complementary medicine practitioners and promoting multi-disciplinary clinics.

The majority of participants support multi-disciplinary clinics to improve access to primary health care, although the details related to the operation of these clinics are widely debated. Suggestions include: walk-in clinics that are open 24 hours a day and seven days a week; mobile clinics, especially for rural communities; clinics that specialize in a community defined care need such as diabetes or cancer; and stand alone surgical clinics that are dedicated to one speciality such as orthopaedics. Some participants raise concerns about walk in clinics and the continuity of care and preventative care that these clinics deliver. Others emphasize that the focus should be finding alternative ways to access primary health care within the existing system. They suggest this may include providing more community support services, increasing the scope of practice for certain health care professionals, and expanding the role of the BC NurseLine.
Access to Specialists

Discussions on access to health care often include some discussion on access to specialists. The common view is that the wait-times in moving from primary care to specialized care are too long. Many participants suggest that this is due to inefficiencies in the referral system. One example often cited is having to see a general physician for every referral to a specialist regardless of whether it is for an initial or follow-up visit. Others voice concerns related to receiving faster access to specialists through emergency departments, placing limits on the number of surgeries that surgeons can perform, and having a burdensome process for general physicians to follow when referring patients to specialists. Participants provide many recommendations, including: enabling patients to have direct access to specialists through a self-referral process; allowing other health care professionals such as physiotherapists, chiropractors and naturopathic doctors to have the authority to refer patients to specialists; and extending the time period for when a referral is required.

Efficiencies need to be encouraged. For instance, re-referrals to specialists for continued monitoring of a condition that required their expertise is a waste of health resources. The specialist should keep the relationship with the patient until it is no longer needed.

– Online Dialogue, Vancouver

Emergency Departments

The topic of emergency departments was very popular during our consultations. Many participants are concerned that there are a lack of alternatives to emergency rooms. Others focus on the issues of poor patient flow and mismanagement, staff shortages, a lack of beds, and funding cutbacks. The fundamental issue for many is that emergency departments are over-used and congested.

Emergency departments are loaded down with admitted patients and the staffing is depleted to the point that they cannot give good care to these patients and have no space or resources to examine or treat the Emergencies that come in.

– Online Dialogue, Errington

Some participants emphasize supporting a shift in the public perception of emergency care and re-defining urgent and non-urgent care. Others suggest establishing benchmarks for emergency room wait times or expanding triage capacities. Many support bolstering the staffing infrastructure by allowing professionals to work within their full scope of practice and providing in-hospital training as well as providing suitable alternatives that have diagnostic equipment.
Acute Care Facilities

The majority of participants advocate for more funding and resources for the acute care system. Many believe that the reduction of acute care facilities and beds over the last 20 years has placed considerable pressure on the acute care system and has contributed to staff burnout, long wait-lists, and poor quality of care. They also believe that these pressures make emergency departments the default for care, which contributes to overcrowding and congestion in emergency care.

*The shortage of acute care beds is a primary factor for emergency department overcrowding which has become a significant patient safety and quality of care concern in British Columbia.*

– British Columbia Medical Association, Submission

Long-Term, Residential and Extended Care Facilities

During our consultations, there was strong support to build more long term, residential and extended care facilities to accommodate the current, as well as future needs of the elderly. Participants widely agree that British Columbia needs more long-term care beds in both rural and urban communities.

Many participants voice concerns related to specific long-term and residential facilities that are located in their community. The underlying theme of these concerns is that community facilities need more resources. Many recommend increasing long term care facility intake and stopping the closure of long term and residential care facilities. Other suggestions include increasing bed capacity and providing the resources to help local communities take care of geriatric and palliative patients.

Ambulance Services

Many participants feel that ambulance crews are doing a good job, but that there needs to be faster access and increased availability of ambulance services in British Columbia, especially in rural communities. A common concern is the lack of resources in staff, crew skills and ambulance fleets (including air, ground, and sea). Some suggest that this lack of resources does not make the field attractive to new recruits. Many believe staff are not compensated fairly, particularly for being on-call, and that the system does not efficiently use the knowledge and skills of existing staff. This is seen as contributing to inefficiencies in the dispatch process and negatively impacting the quality of patient care and response times. Participants also raise concerns that complex care patients are often transferred over large distances and suggested these
inefficiencies increase the time it takes to get rural patients to tertiary centres. Many discussions focus on the current centralized/regionalized model, which some suggest increases the demands on the system. They also suggest that there is not a corresponding increase in resources or expansion of scope of practices to meet these demands. Participants recommend providing ambulance crews with assessment training to avoid transporting patients to hospitals if possible, and giving more authority to paramedics to treat patients in the field.

Conclusion

The majority of participants believe that changing the way we think about health and health care is fundamental to improving access to care. To do so, most want Government to support a health care model that responds to patient needs. They also want a system that gives patients a number of ways to access different types of health professionals and health services. Many believe that access issues can only be resolved by shifting the public perception of emergency care, providing alternatives to emergency departments, and alleviating pressures on the acute care system.
Access

This chapter includes the following topics:

Demand Management
Primary Health Care and Walk-in Clinics
Specialists
Emergency Departments
Acute Care
Long-Term and Residential Care
Ambulance Services
Comments on Specific Communities and Facilities

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

Primary Health Care
Submitted by the BC College of Family Physicians
Submission to the BC Conversation on Health
Submitted by the Society of Specialist Physicians and Surgeons
Physicians Speak Up
Submitted by the British Columbia Medical Association
Sunshine Coast Conversations on Health
Submitted by the Women’s Health Advisory Network, the Sunshine Coast Hospital and Health Care Auxiliary and the Seniors Network Advisory Group
UBC College and Inter-professional Network
Submitted by the UBC College of Health Disciplines and the Inter-professional Network of BC
A Summary of the Public Forum on Health Care Organized by the Kamloops Citizens Concerned About Public Health Care
Submitted by the Kamloops Citizens Concerned About Public Health Care
The Health Benefits of Electronic Stability Control
Submitted by Glen Nicholson
From the Beginning to the End
Submitted by the Bella Coola Discussions on Health

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Innovation and Efficiency; Primary Health Care; Health Care Models; Health Spending;
Demand Management

Comments and Concerns

Access to Health Care
Public Expectations on Accessing Health Care
Choice and Coverage
Sustainability
Information and Public Education

• Comments on access to health care:
  • British Columbians overuse health services because they do not have any other options.
  • The health care system does not promote individual accountability, especially in terms of using health care services appropriately.
  • Our system has turned into a patient drive-through, due to the inefficient one symptom or issue per doctors’ appointment system.
  • Treating petty ailments in the public health system blocks up services that should be available for those that truly need them.
  • Pharmaceutical advertisements on television and in magazines are terrifying people (especially older more vulnerable people) and are leading to increased burden the health care system beyond capacity.
  • Unnecessary tests are a strain on the system.
  • Using the health care system unnecessarily clogs up the system and causes long waits for people who really need the care.
  • Delisting health services such as physiotherapists, chiropractors, naturopaths and massage therapists limits access to appropriate care.
  • Just providing funding does not get to the root of the problem of access to care. We need to focus on accountability, staff retention, appropriate staffing, innovative scheduling, respect for workers and ongoing education.
• A study on the social isolation of older people showed that the more knowledge, engagement and involvement they had with their health care, the more they tended to seek appropriate treatment from an appropriate health professional.

• Most seniors do not have enough choices or control over their health care. Those that do, have it because they have the money.

• British Columbia has a very open-ended system whose cost is driven by unbridled and uncontrolled input. Input is the desire of the public to access care, and the output is the capacity of the doctor to see and serve the public.

• Canada has equal access to health care without discrimination.

• The current system takes care of cancer patients effectively and efficiently.

• Canada has one of the finest health care systems in the world if you can access it.

• Generally, the care given in British Columbia is excellent, but we need to increase access to medications and diagnostic tools.

• I am generally pleased with the service I have had from all areas of health care. I am healthy and have not needed the system often, but when I did it was there.

• One of the biggest problems is access to the system including primary care access, access to laboratory results and public consultation on access to health care.

• There is a bias in the system about who gets treatment based on geography, demographics, and so on.

• The bulk of our votes and decision making happens in highly dense populations where density driven decision-making models actually work and make sense. However, these models do not fit if you are in other less densely populated areas of British Columbia, like Dawson Creek.

• Public and policy debates often focus on questions of wait-times, but it is clear that geography, cultural differences, cost, knowledge base and other factors are important barriers to achieving appropriate access.

• My daughter and I spent three weeks in the children’s ward of a hospital and we were treated very well. We were given a private room and both had a proper bed and three meals a day.

• The system works well and is accessible for certain special interest groups, but not for the common person.

• Access is limited due to awareness, cost, support and political engagement.
The current health care system will treat life and death type afflictions, but those that are suffering from non-life threatening situations are treated without urgency.

Equal access has to be traded off against both quantity and quality of care. Equal access means access to services that are fewer in quantity and poorer in quality than are available in most other Organization for Economic Co-operation and Development (OECD) countries and the United States. Canadians have equal access to getting in line, but they do not all stay in line.

The current system of having a single payer is fairest, as need, not ability to pay is what gets you to the front of the line.

Health care is a necessity like clean water and should be accessible to all.

If the Government could only provide one service to its citizens, then it should be health care. There is nothing more important than access to state-supported, free health care. Not only should this be guaranteed, but we should be moving forward with a free dental and drug plan.

The current funding model for dental care widens the gap between rich and poor. The poor tend to have worse dental health and it is exacerbated by our policy decisions. In general, the Government needs to make policy decisions that could lessen the inequities in health not widen them.

There is a lack of operating facilities especially for joint replacements.

There is concern about equal access to health care as British Columbians already pay for health care services. Those who can afford it go elsewhere, so they must effectively pay more.

British Columbia has a good children's hospital system.

In discussing health care, too often the assumption is that all British Columbians have equal access to extended health benefits either through their employers, unions or government sponsored plans such as that provided to clients by the Ministry of Employment and Income Assistance. Unfortunately, this is not the case.

If our facilities cannot handle the number of suspected cancer cases, then should we not be proactive and co-ordinate a system with other provinces and countries to provide the tests and surgery needed?

Perhaps we need to help pay costs (reasonably) for tests and so on in order that we all receive timely care.
• Comments on public expectations on accessing health care:
  - People have been convinced that there is no need to put up with a minor ache or irritation if it can be remedied by a drug or treatment.
  - People expect everything for free.
  - One doctor comments that he has a six month wait-list for cancellations for which he feels he is the brunt of public frustration. He feels that the general public should take on some responsibility and stop looking at health care as free.
  - People need to understand that everything is not free and not every illness requires surgery.
  - The barriers to reform are the unrealistic expectations that we have given the public. The public has a poor understanding of what the system is and what it can deliver.
  - Societal expectations of health care are becoming unrealistic.
  - We have to stop treating health care as an all-you-can-eat smorgasbord where there is no physician and consumer accountability for resource use.
  - The public sees primary and preventive care as a visit to the doctor for a quick fix.
  - British Columbia has a very generous and high quality health care system. However, our system is simply overtaxed by unreasonable expectations that are far beyond anything ever envisioned for the general public.
  - There are over 20 million visits to family physicians offices annually in the province. That is a big shift from the past when we had lower expectations of our health care system.
  - It is part of today’s culture to expect and ask for too many tests and prescriptions.
  - The system has failed us for many reasons. The biggest problem is that most Canadians expect service for nothing. Wake up Canada and pay for your services. Let us not become like the United States, but at least be like the Europeans and pay more for what is needed.
  - I have worked and paid taxes since I was fifteen years old. It is my right to expect that there will be public health care available should I need it.
  - It is sad to be aging and have something that you have invested in all your life, like health care, not be available when you need it.
• Comments on choice and coverage:
  • If the customer cannot choose on the basis of who is best and what it cost, it will always cost too much. It will never be as good as it can be and there will never be enough of it. A customer is defined as one who makes the choice and pays the bill. In health care, the customer is the patient, family, caregivers, and people around the patient, but it is also the referring physician, the Ministry of Health, Ottawa, the voters, and the political side. There are disparate customers and they all need to be satisfied.
  • There can be universal health care, but it should be prioritized. If we want other countries to look at Canada as a model for health care, then we have to build customer choice into the system. Decades of social experiments with equality-for-all have failed in dozens of forms.
  • If services are to be provided for all, then not all services can be provided.
  • Whatever you do, the public needs to know for sure what services are covered and what services are not. It should be the same for all.
  • Lack of access is a bigger cost driver than medications and human rights. We do not want to make a choice between money and time or wait-lists.
  • If the goal is to optimize the health of both the individual and the population, then we need to radically change how health services are designed and determine our options and priorities. This includes making choices about what we are not going to fund so that we can start moving the funding upstream.
  • Where or how surgery is obtained does not matter as long as quality of care is assured.

• Comments on sustainability:
  • In order to create a sustainable health care system we must reduce the demand for services placed on the system. This is particularly critical as the baby boomers enter the system.
  • The system is costing too much so we need to peel away services.
  • People are waiting too long for services such as surgery and the most urgent case is not necessarily the next case. We can do much more to make our system the best it can be for those who need it. Sustainability has been redefined to mean meeting the customers' service needs.
  • Global aging and longer life expectancies put pressures on our health care resources.
• Comments on information and public education:
  • People do not know where to go to get tests and treatment other than hospitals.
  • We need to do more to encourage seniors to use health care services other than their doctor’s office.
  • People do not know where to go for primary health care.
  • The 24 hour BC NurseLine is an extremely useful, but poorly advertised service.
  • Many people are uninformed and/or uneducated on what health services are currently available.
  • Translated health care brochures have mistakes and do not reach their intended audience.
  • Some television advertisements incorrectly direct people to their doctors when other health care providers would be more appropriate.

**Ideas and Suggestions**

*Access to Health Care*

*Clinics and Access to Health Care*

*Choice and Coverage*

*Sustainability*

*Information and Public Education*

• Ideas about access to health care:
  • Build a dynamic health care system that is responsive to the needs of British Columbians in place of the existing rigid system we have today.
  • Avoid unnecessary examinations and tests.
  • Set health care priorities through consultations with a panel of qualified health care professionals.
  • Use trained consultants to conduct a provincial health care review and make recommendations for improvements.
  • Integrate population health and acute care management to improve patient services.
  • Focus on prevention and increase coordination between home support, home nursing and primary care to manage demand and avoid use of more expensive long-term care and hospital services.
  • Increase resources to care for patients in communities.
• Have a seniority clause in health care where those people that have lived and worked all their lives in British Columbia are first when it comes to treatment.

• Increase access to medications and diagnostic tools.

• Provide services closer to home.

• Allow for freedom of choice.

• Focus on access to physician care and services and continuity of care both on and off reserve.

• Support an Open Access or same day appointment approach, which increases opportunities to address health concerns by phone and email.

• In the United Kingdom the root cause of delay was variability and high utilization, so the British Government proposed some short term strategies to optimize its current capacity such as reducing steps and queues, using first in, first out principles, planning discharges, maximizing skill use, pooling capacity and stopping rework. In the longer term, the British Government’s goal is to plan for a system with no queues, which includes measuring and shaping demand, planning capacity and reducing variation. These strategies are at the core of their plans to achieve their next target.

• Follow the New Zealand approach to reduce wait-lists by introducing clinical prioritization for elective surgery. In this case, if the patient does not meet certain criteria, then they do not qualify for publicly-funded treatment. This strategy is based on three fundamental principles: clarity, timeliness and equitable access to assessment and treatment. For clarity, patients know whether or not they will receive publicly-funded elective assessment or treatment to provide certainty on their plan for care. For timeliness, if a patient is deemed eligible for publicly-funded services then a request for access to a doctor is responded to within ten days and assessment or treatment within six months. Equitable access to assessment and treatment means similar access for similar need, based on transparent, consistent and systematic criteria.

• Close the open door and introduce a system of personal responsibility. Otherwise the enormous demand for health care will overwhelm the system and bankrupt the country.

• Improve availability to tests to catch cancer early and improve mortality rates.

• Focus on improving outcomes versus cutting costs - get better value from what we spend by assuring appropriate use and adherence. The right intervention for the right patient at the right time.
Canadians want everything that modern medical science can offer and to have it delivered equally and quickly. We have to tell patients and the population that this is impossible.

Start a primary care pilot project that is dedicated to surgical procedures to eliminate wait-lists that is publicly owned and funded.

Ideas about clinics and access to health care:

- Establish more specialized short stay surgical clinics within the public system.
- Establish alternate practice settings such as mobile clinics, clinics in group homes for developmentally disabled, private hygiene clinics, visits to the home for home-bound patients, and visits to children’s facilities and daycares.
- Establish Centres of Excellence for orthopaedics, cardiac care and so on.
- Reframe the idea for having a 24 hours seven days a week clinic to providing a responsive primary care system, which could be achieved by increasing: same day access, the number of people who actually have an identified primary care provider, and the ways and mechanisms for accessing primary care such as phone, email, group visits and extended hours.
- Create a centre for specialists so that all specialists are used effectively and patients do not wait one year for treatment.
- Create stand alone clinics that focus on one group of procedures such as joint, knee, hip, eye, back and so on.
- Create and support stand-alone public clinics that are specialized and focus on short stays. These clinics are geared for low-risk elective surgery, allow for better patient flow, increase efficiency and ultimately have shorter wait-times. They also achieve the efficiency benefits of specialization and innovation often ascribed exclusively to the private sector, while maintaining the public sector advantage of low overall administrative costs and broader societal benefits.
- Support one-stop, multidisciplinary pre-surgery centres to consolidate as many services as possible under one roof.

Ideas about choice and coverage:

- The state of Oregon has a list of 85 to 90 procedures that have been established as priorities for the health care system. The higher on the list, the more of a priority that condition is. Establishing a list like this for British Columbia could settle issues such as what is and is not covered, as we cannot provide every thing to everyone.
• There should be mandatory minimal health care services available for everyone regardless of location. Services above this mandatory minimum should be reasonably defined locally.

• Subsidize all new medical procedures and all new medications that are not currently covered by the Medical Services Plan on a graduated net income basis: the lower the income, the greater the percentage of subsidy.

• Guard publicly-funded services to ensure health care for all.

• When the health care system was set-up, it was to cover high hospitalization costs that people could not afford. We have to go back to that goal and examine the things that have been added, which are now burdening on the system.

• Define what is medically necessary and provide that to everyone.

• We need to establish a public body that sets the criteria for decisions concerning when highly expensive medical interventions will be made and when they will not.

• Until everyone has basic health and dental care, no one should get extra care or treatment.

• Ideas about sustainability:
  
  • Identify long-term elements that put more demand on the health system and then prevent and manage those elements.

  • Do health care planning that emphasizes:
    
    a. demand management including primary care, health promotion and prevention, proactive planning, and efficacy review;
    
    b. network development including internal processes, bridging processes, case management, best practices and triage; and
    
    c. human resource management including seasonal flexibility, staff retention and recruitment, staffing models, and education and training.

• Ideas about public information and education:
  
  • Encourage people to use the BC NurseLine and the British Columbia Health Guide.

  • Advertise the BC NurseLine more. For instance, send fridge magnet's with the BC NurseLine to everyone.

  • Find a collaborative solution that gets health care professionals get together to feed information to the BC NurseLine.

  • A dial-a-nurse line should be available 24 hours seven days a week.
• Provide more information to public on how to use the health care system appropriately.
• Provide more outreach programs to target those that overuse health care services.
• Produce public information campaigns on some basic life threatening situations to help educate the public on when they need to call 911.
• Teach first aid and basic health care in schools.
• High school students should learn about how the health care system works, how to stay healthy and how to access health care services.
• Support injury prevention and safety education such as the use of seat belts, child car restraints and bicycle helmets to decrease emergency visits and hospital admissions.
• Improve how we estimate wait periods and provide patients with frequent updates.
• Require that doctor offices have videos on patient etiquette and information on what services the doctor can and cannot provide, as well as other ways to obtain those services. Patients could watch these videos while in the doctor’s waiting room.

Primary Health Care and Walk-in Clinics

Comments and Concerns

General Practitioners and Access to Primary Care
Walk-in and Community Clinics

• Comments on general practitioners and access to primary care:
  • The shortage of general practitioners restricts access to primary health care and preventative care. It also breaks the continuity of care for too many British Columbians.
  • We cannot book appointments with our doctor unless we are willing to wait a week and can get time off work to go during office hours.
  • Limitations on the numbers of patient visits per day for family practice clinics results in general practitioners restricting their office hours. As soon as the doctor’s allotted 44 visits are over, the doors close because there is no point being open and working for free.
• It is so difficult for the public to get a family physician that more and more patients are forced to go to walk-in clinics for their care. If there is no access to a walk-in clinic, the emergency room becomes their default health care provider.

• Most doctor offices are akin to assembly lines, where patients have 12 minutes maximum to state their case and get an intelligent response.

• It is not right that patients can only discuss one problem per visit to the doctor.

• It is perceived as multi doctoring when a patient meets with a number of doctors in order to identify which one they wish to stay with.

• Family doctors spend too much of their day refilling prescriptions, doing basic check-ups on healthy people, talking about the weather and writing referrals.

• Medical Doctors are the only entry point to the health care system because the services of other health professionals are not covered.

• At one time general practitioners and nurses would have attended to non-urgent needs. Today, the general practitioner service delivery option is withering because Medical Services Plan policies have made it less attractive for doctors and they have failed to reward those who may be willing to work evenings and weekends.

• Patients with no family doctors are 3.5 times more likely to end up in an emergency room.

• People do not tend to access primary care physicians after hours. Emergency room data supports this analysis, showing that the peak in demand for low urgency care is during daylight hours.

• Most repeat visits are for the most common conditions such as the common cold and generally do not require a physician's attention. Instead, nurses could perform simple diagnostic measures and direct care over the phone.

• Too many visits to the doctor are more for social reasons than medical reasons.

• Many patient visits are unnecessary. For instance, many family physicians will call back patients into the office to discuss lab results, which were negative. This is a waste of health care money and causes unnecessary emotional stress for the patient.

• There is absolutely no incentive for patients to not visit their family physician. In fact, many family physicians encourage more visits because that is how they are paid.

• Making an appointment to get a laboratory requisition for on-going and routine blood work for patients with a chronic condition is wasteful.
- People do not want to have to take two or three hours off work when they have to go see a doctor to get a simple thing done.

- Under our present system, physicians are motivated to ask for return visits because they are limited in what they can charge for a visit and therefore are inclined to have the client return again at another time. This is inefficient in terms of office overhead, Medical Services Plan payments to physicians, and often paid lost employee time in the work place. Unnecessary return visits are wasteful in terms of travel time, gas consumption and other inefficiencies.

- The current method that we have to access our own physician is excellent. We are never turned away and when critical situations arose our physician acted in our best interests in an expedient manner.

- People seek primary care at hospitals rather than through doctors, public health nurses or mental health nurses.

- Too many patients are admitted to hospitals that could otherwise be treated in the community.

- Some people contact the BC NurseLine, go to a walk in clinic, and then the next day go to their regular physician to see if the physician agrees with the prescription that they got from the walk-in clinic. We need to discuss how to integrate services to deal with issues like this and reduce the duplication of services.

- The current structure of the health care system results in gaps in service coordination and lacks the flexibility to respond to these challenges.

- Primary health care is not available on weekends.

- There is no connection or co-ordination between the BC NurseLine, emergency departments or walk-in clinics.

- The suggestion of having 24 hour clinics near hospitals sounds great, but activities have to coordinated between the two organizations. There is no use going to the clinic first and then being referred to the emergency department if doctors in emergency do not trust the clinic's diagnosis.

- Primary health care is not available when people need it on weekends and evenings.

- There is lack of funding for preventative health care and alternative health care professionals.

- There is a lack of incentives to provide after hours care.
• British Columbia has done some innovative things like the BC NurseLine, but the NurseLine does not have the authority or experience to make diagnoses.

• There is a lack of communication between physicians and other health care professionals.

• We are not utilizing public facilities to their fullest potential due to staffing shortages.

• There is too much segregation of medical staff and patients.

• Protocols require a range of diagnostic tests before patients can get to the equipment or tests that their doctor thinks they actually need.

• Comments on walk-in and community clinics:

  • Walk-in clinics may leave emergency rooms for real emergencies but they do not actually provide quality primary healthcare.

  • Walk-in clinics take the easy issues leaving the general practitioners with the more complex issues that take more time to deal with.

  • Walk-in clinics have a group of doctors and they are often open 24 hours seven days a week. But there are problems with these clinics such as continuity of care.

  • Walk-in clinics create an attitude amongst the physicians that they do not have any real investment in you as a patient.

  • People sometimes go to more than one doctor in different walk-in clinics until they either get the answers they want to hear or get the prescription they want to take.

  • Walk-in clinics do not include enough diversity of health practitioners.

  • Walk-in clinics are not being utilised to their full capacity.

  • There is a perception that people will get better care in emergency departments than walk-in clinics because in the emergency department patients can get all of their tests done at once, have access to specialists and get admitted if required.

  • Walk-in clinics do not employ a diverse enough range of health practitioners.

  • There is scope of practice and turf protection issues with walk-in clinics.

  • Walk-in clinics tend to close early because of having already met their quota.

  • The quota system for doctors in walk-in clinics curtails the usefulness of walk-in clinics.

  • There are not enough community clinics.

  • Walk in clinics have not met their purpose of decreasing emergency room visits.
Walk-in clinics are replacing general practitioners. Government has not fully considered the impact of this change in health care delivery.

Walk-in clinics that are open 24 hours seven days a week will not work unless people accept the fact that unnecessary visits are a drain on resources.

The care at walk-in clinics provides no emphasis on prevention.

People are suggesting 24 hours seven days a week walk-in clinics with no specificity of what that really means. For instance, the number of emergency room visits and non-urgent clients generally increases when people come home from work until about 10:30 pm and then they drop after 11:30 pm at night.

If we have 24 hour private clinics close to hospitals, who would pay for these clinics? There is concern that the cost would fall to patients and that most patients could not afford this.

Continuity of care is an essential part of good primary care. However, 15 per cent of Canadians, and likely the same percentage of British Columbians have to depend on episodic care from walk-in clinics, because they are unable to find a family doctor who will take them as patients. If all these 'orphan' patients were young and healthy it may not matter much, but they likely represent a cross-section of society from the very young to the very old and from the healthy to those with several chronic conditions.

Walk-in clinics that are open 24 hours seven days a week are not a good idea. Rather the focus should be on providing responsive primary care that people want. This may mean all night doctor phone lines, increasing same day access to someone’s own physician or team member, or emailing the doctor or a walk-in clinic with a concern. We need to increase the ways to ask the question and extending the available time to actually access a live person.

Walk-in clinics are a waste of money. Investing in community health care would be a better use of money.

An increasing number of newly graduated general practitioners are choosing to work shorter hours in walk-in clinics to provide 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.

Walk-in clinics are a licence to print money for the doctors. Because they are free, the public drop in for every minor issue that comes up.
• The advent of walk-in clinics has only added to the distress of the system. One can go to any mall or shopping center and find a drop in clinic very handy. It is free so why not check out that sore finger or sore throat or whatever. Once in the clinic the doctor is obliged to send the patient with something such as an X-ray requisition, a lab requisition or a prescription.

• Centralized non-urgent care clinics struggle to respond to demand in an efficient way. There are sometimes long waits and at other times when walk-in traffic is low professional resources are ill-used.

• Walk-in clinics provide quick fixes, but are ill equipped to follow up complicated cases and provide poor continuity of care. This often results in patients returning to hospital emergency departments or a family physician for re-examination and re-testing.

• We already have walk-in medical clinics in most urban areas of British Columbia. The challenge is that many people going to emergency wards with colds, flu, sprains and other non life threatening health issues instead of using these clinics.

• Public walk-in clinics are good value for money.

• Walk-in clinics work well. Locums and part-time doctors often staff them, which is a good use of resources.

• Walk-in clinics provide a temporary solution for those unable to secure a family physician.

Ideas and Suggestions

Walk-in and Community Clinics
Reducing Emergency Room Usage
Family Practice
Community Health Care Clinics and Centres
Role of Health Professionals in Primary Care
Primary Health Care Practices and Models

• Ideas about walk-in and community clinics:

  • Provide more walk-in clinics that are open 24 hours seven days a week.

  • Provide more multi-disciplinary walk-in clinics that emphasize prevention.

  • Have more Nurse Practitioners and physician assistants at clinics to help screen patients.

  • Connect 24 hours seven days a week clinics and pharmacies at hospitals.
• Exempt walk-in clinics from the quota system. Pay physicians until the end of their shift.

• In Sparwood, people can accept that acute care facilities are not located in the region. However, there is strong need for 24 hours seven days a week staffed facility. This is important because mining draws a young labour demographic with young families to the region so there needs to be more care close to home.

• Implement a franchised system of private 24 hours seven days a week medical centres in every city in British Columbia.

• Provide 24 hours seven days a week pharmacies to fill prescriptions written by walk-in clinic doctors.

• Provide high class first aid station 24 hours a day.

• We do not need clinics open for 24 hours seven days a week, but we do need a clinic provided for peak periods. Locate clinics for peak periods in the hospital itself where the hospital and the clinic can share triage.

• Allot a space in every hospital to accommodate a group of doctors in a clinic environment and then pay them a salary.

• Standardize the services available at walk-in clinics.

• Move day surgeries and less complicated procedures out of hospitals and into clinics.

• Provide access to diagnostic equipment at walk-in clinics.

• We need stand alone clinics dedicated to one specialty such as orthopaedics.

• Create Centres of Excellence that specialize in community defined needs, such as diabetes.

• It would be much better to divert if heart failure patients to a weekly community clinic in which health professionals such as nurses, dieticians and pharmacists could advise them on nutrition and other issues important in monitoring their health.

• Provide more primary care options in rural communities through walk-in clinics.

• Follow the Swedish model for walk-in clinics.

• Consider the Masset Health Centre model to increase services at clinics.

• Government should offer funding to the owners of existing walk-in clinics for extended hours.

• Increase the use of mobile clinics.
- Offer free or reduced square foot rental to independent walk-in clinics.
- Provide more multi-media information about clinics aimed at different ethnic groups.
- Put signage on bus routes to advertise walk-in clinics.
- It is good to have clinics available through the public health care system, especially in light of the shortage of doctors.
- A walk-in clinic using Nurse Practitioners to assess or triage and assign a patient to either the emergency room or to the clinic for service is a great idea.
- The British Columbia Government should subcontract the non-urgent or less urgent medical conditions to 24 hours seven days a week medical clinics.

**Ideas about reducing emergency room usage:**

- Attach 24 hours seven days a week clinics to emergency departments.
- Educate the public on when to use the emergency room and when to use a 24 hours seven days a week walk-in clinic.
- Support more private 24 hours seven days a week emergency facilities such as the False Creek Care Centre in Vancouver.
- Have 24 hours seven days a week clinics with doctors or Nurse Practitioners that would act as a triage center to deal with patients and refer to emergency if needed.
- Train paramedics in the Canadian Triage and Acuity Scale to determine whether a patient could go to a clinic or if it is a true emergency case.
- A community clinic system would help solve emergency problems. Ensure the community clinic fits in with the vision of the community by studying the growth and demographics patterns.
- Augment emergency departments with a separate out-patient clinic. Operate these clinics the same way that family physicians operate their own clinics. This means that doctors could bill the Medical Services Plan in the same way as any other walk-in clinic with a Medical Services Plan card.
- Have staggered hours for clinics to help with emergency overload.
- Support models such as that found in Kamloops where a group of physicians formed a non-emergent, after hour walk-in clinic to try and help decongest the emergency room at the Royal Inland Hospital.
- Give triage nurses in the emergency room the authority to turn people away that do not need to be in the emergency room.
• Have a specified triage nurse assess patients who enter requesting services and have a walk-in clinic on site at the hospital to divert non-urgent patients. Doctors who were on salary and could work in both the emergency room and the walk-in clinic.

• Only treat certain medical issues at emergency departments, such as severe bleeding, heart attack, severe burn, stroke, or industrial/road accident. Walk-in clinics close to the hospital could handle all the other issues.

• Extend the Wound Clinic formula to at least the two big hospitals that have overloaded and overcrowded emergency departments. This formula includes specially trained emergency nurses who first assess a patient and send the true emergency cases to the doctors, and treating less serious cases themselves.

• Restructure the business model for clinics so they are a precursor to emergency room services.

• We should be able to get referrals from walk-in clinics or general practitioners for specific machines in emergency departments and then to be sent back to the original doctor with the findings.

• An integrated team of nurses, nurse practitioners, pharmacists and doctors could solve many of the so-called emergencies that appear at the emergency department.

• Provide urgent care clinics next to emergency with mental health practitioners on site.

• Open as many ambulance stations as possible as first aid post. In large metro areas, have ambulances designated as first aid posts situated in high call volume locations to treat the walking wounded.

• Ideas about family practice:

  • Create an environment where family practitioners can profitably exist to serve patients in a proactive health care model.

  • Facilitate a renewed interest in family practice and expand the role of Nurse Practitioners.

  • The family physician gets to know you and your family members and can see health patterns because they have your health history. This is so important in obtaining correct diagnoses.

  • Get rid of the old family doctor system and replace it with centralized clinics with good computer-based record keeping.
• Ideas about community health care clinics and centres:
  • Use our local community health centres more effectively.
  • Have 24 hours seven days a week community health centres where people could access primary health care practitioners plus emergency care for minor things.
  • Ensure all communities have a clinic.
  • Provide more community clinics along the lines of REACH and MidMain Health Clinic, both in Vancouver.
  • Provide urgent care at community health care centres and private medical centres.
  • Expand community services to deal with more issues.
  • Support community clinics where there is care available around the clock from a multi-disciplinary team of health care providers.
  • Real progress has been made on reducing wait times in emergency departments in several Canadian jurisdictions by using community clinics. In Sault St. Marie, members of the community health centre uses emergency services just one fifth as much as the rest of the population does.
  • Provide a health van with a public health worker that can triage at shopping malls and other public places.

• Ideas about the role of health professionals in primary care:
  • Encourage the use of Nurse Practitioners to help shift the current public perception that they have to see a physician.
  • Encourage the use of multi-disciplinary teams.
  • Use doctors for initial reviews of patients rather than emergency department staff.
  • Increase the number of house calls from all health professionals such as doctors, nurses and Nurse Practitioners.
  • Allow others to be gatekeepers for the health care system, not just the general practitioners.
  • Encourage more telephone consultation for the doctor/patient relationship, particularly when there are long distances to travel for ongoing consultation with specialists. In this case, the specialist would still get paid, but at a lower rate than in person visits. A bonus side effect would be savings on transportation and the environment.
• Pay physicians to make house calls. Perform more procedures to be in the patient's home to reduce the pressure on hospitals, clinics and care facilities.

• Stop one problem visits to doctors. Patients need more time at the doctor's offices to talk about issues and get more information about services.

• Encourage the role of midwives. They keep labouring women at home longer thus preventing unnecessary intervention in hospitals.

• Give naturopathic doctors the same privileges as medical doctors to lighten their load.

• Make it mandatory for doctors that work in a walk-in clinic to get hospital privileges.

• Provide onsite translators or require second languages for nursing staff.

• Ideas about primary health care practices and models:
  
  • The British Columbia Medical Association should be responsible for rotating medical doctors so that they can handle the normal and/or excess patient loads.

  • Consider the long term connection to primary care as practiced in the Kaiser Permanente non-profit model in the United States.

  • Consider the model in the United Kingdom that uses something called see and treat, which says that the most senior person will deal with people much more quickly.

  • General physicians should receive a greater fee for service so that additional visits are not the means of insuring adequate salary. A fair fee for service review could perhaps solve the present practice of return visits to achieve sufficient time with the physician and save the time and effort of all concerned.

  • Give incentives to physicians to keep their clinics open on the weekends and/or have extended hours.

  • Introduce user fees for walk-in clinics and doctor office visits to cut down on unnecessary visits with exemptions for low-income individuals or families.

  • Take the therapy to the patient such as long term care patients receiving IV treatment by creating treatment teams that travel to the patients. This is better than moving the patient multiple times in an ambulance.

  • Provide more incentives for new medical graduates to work in northern communities in British Columbia and in clinics not paid via the fee-for-service model.
• The Children’s Hospital has a much better system. The patient sees every necessary practitioner in one visit.

Specialists

Comments and Concerns

Access to Specialists
Referrals to Specialists
Efficiencies
Accountability

• Comments on access to specialists:
  • Specialists can refuse a consultation with a patient, which can delay treatment.
  • The availability of specialists and certain procedures should not be regionally limited.
  • If a specialist does not care for the questions that a patient asks, then they can advise the family physician that they will no longer see that patient.
  • It is stressful to wait months for a specialist to interpret test results when they may be especially concerning.
  • Pensioners should not have to wait to see a specialist for their problem. They should be looked after instead of being left on medication while their condition worsens.
  • There is up to a two week wait in hospital to see specialist, but patients arriving in the emergency department see a specialist immediately.
  • It is physically, mentally and emotionally stressful for a patient to try and convince their doctor that an appointment with a specialist is necessary.
  • There are too few specialists in British Columbia.
  • It is very difficult and expensive to see a specialist for women’s health issues such as early onset menopause
  • Specialists are available, but there is a long wait.
  • The number of unnecessary visits from patients only seeking reassurance is staggering. They see it as their right to see a specialist whenever they want.
  • Nurse practitioners refer to specialists at much higher rates than family physicians do.
• Comments on referrals to specialists:
  • General practitioners are hesitant to refer patients to specialists because they want to keep the patient’s treatment within their own practice.
  • General practitioners do not spend enough time with patients to make a proper diagnosis as they are inclined to refer them to a specialist.
  • Patients are sent to specialists unnecessarily. Often a family physician could have dealt with the issue at a much cheaper cost to the system.
  • Centralized referral clinics centred in public facilities have reduced waiting times for key procedures.
  • People must make an appointment with their doctor every time that they want to see a specialist. This now requires the Government to pay for the appointment plus the cost of a letter to see a specialist.
  • Specialists are asking doctors to cease their referrals in order to spend more time in the operating room.
  • Most doctors now refer patients with anything other than basic problems to specialists, causing increasingly long wait lists. The family doctor does not have the time, nor are they paid, to be the old fashioned doctor that was able to solve a host of problems.
  • Jurisdictions that allow patients self-referral privileges must deal with abuse of the system. For example, some people want to see a specialist when a general practitioner could have dealt with the issue. Also, patients may seek out the advice of numerous practitioners and specialists until they hear a diagnosis that they feel is correct.
  • The process of referral to a psychiatrist is wasteful and ineffective. Even if a patient is diagnosed as having mental health issues, they need a referral from the Ministry of Children, Families, and Development or the Adult Mental Health department to visit a psychiatrist.

• Comments on efficiencies:
  • The wait-time between primary care and specialized care is long, drawn out, and very expensive.
  • There is a lack of communication between primary care physicians and specialists for diagnostic screening and testing.
  • The amount of unused and underused surgical capacity in British Columbia hospitals, even in daytime hours, vastly exceeded the number of additional hours
physicians said they needed to eliminate waiting lists for some key elective procedures - hip and knee replacements and cataract surgery.

- Specialists require the patient to return multiple times when they could have dealt with the issue at hand on the first visit.
- The paperwork required for specialist consultations is burdensome.
- Only specialists can order medical Resonance Imaging (MRI) exams. It is challenging to receive these tests due to specialists’ long wait lists.

- Comments on accountability:
  - We do not give family physicians enough training or authority to try and diagnose ailments, so instead they send people to specialists who in turn order tests and send the patient back to the family physician.
  - Too often, specialists offer inadequate advice during follow up appointments.

**Ideas and Suggestions**

Access to Specialists
Referrals to Specialists
Efficiencies
Accountability

- Ideas about access to specialists:
  - Provide quicker and easier access to specialists.
  - We should consider dentists as specialists that everyone needs to see twice a year.
  - Have all specialists in the same building where the population warrants this kind of set-up.
  - Australia increased operating room utilization 5.1 per cent by reducing the number of last minute cancellations.
  - Return to specialist services in Nelson, not just Trail, until a new hospital located in a central area.

- Ideas about referrals to specialists:
  - After an initial assessment by a specialist, there may be a requirement for follow-up appointments. These appointments should not require referral from a family physician.
  - Reduce the amount of referrals necessary for provider services.
People should have direct access to specialists through a self-referral process.

If a specialist requests a patient to get an annual test, then the patient should not have to go back to the general practitioner to get an annual requisition.

Allow people direct access to health care providers such as nurses, dieticians, physiotherapists and specialists without a referral.

When a doctor refers a patient to a specialist, that referral should stay valid for the duration of the treatment.

Allow patients to have access to a specialist for one year without a further need for referral from a physician.

If a patient has a chronic medical condition, they should not have to visit their general practitioner first to get a referral.

Screening tests should be available to anyone on a self-referral basis with a reasonable fee.

Specialists should maintain a relationship with the patient until their services are no longer needed.

If a patient has seen a specialist in the past three to five years, then they should be able to book their own appointment with that specialist without referral.

People should be able book an appointment with a specialist over the phone and not have to go through a doctor.

Provide more education to general practitioners regarding referral practices.

Stop charging referral fees for access to specialists.

Encourage general practitioners to consider other alternatives before referring to a specialist.

Give physiotherapists, chiropractors, and naturopathic doctors the authority to refer patients to specialists.

When being referred to a specialist, the patient's complete medical history should be available.

Raise the quota for general practitioners to make referrals.

Allow family practitioners to refer patients with mental health issues directly to a specialist.

Encourage doctors to refer their patients to specialists, as some doctors may be reluctant to lose their patients business to specialists.
• Ideas about efficiencies:
  • Increase the length of time that a specialist has with each patient to reduce the need for repeat visits.
  • Doctors need to learn which specialists are available and ensure that the chosen specialist is appropriate for their patient case.
  • Hold a case conference between patient, patient support, general practitioner, surgeon and oncologist in the presence of a serious disease to develop plans and discuss available alternates.
  • Only specialists can order Magnetic Resonance Imaging (MRI) tests. Grant general practitioners the authority to order these tests too.
  • Second opinions should be required in order to reduce unnecessary surgical procedures. This may cut down on the large number of caesarean procedures being prescribed.
  • Mammography clinics should book follow-up appointments with patients when the results of their exam require a re-check within six to twelve months.
  • Ensure that specialists hire appropriate staff to meet their workload needs.
  • End the requirement for a patient to be present when a phone call would suffice. Let the doctors charge a fee for the call rather than hold up clinic time with useless re-referrals to specialists.
  • Replace individual specialist wait-lists with service category wait-lists.

• Ideas about accountability:
  • Require surgeons to provide information to patients about the options for surgical care in British Columbia.
  • Improve the bureaucracy so pertinent information passes between doctors and specialists faster.
  • Complaints about specialists should go to the Provincial Government not the College of Physicians and Surgeons, who have a vested self interest.
Emergency Departments

Comments and Concerns

**Access to Treatment in Emergency Departments**

**General Physicians and Emergency Departments**

**Overuse and Misuse of Emergency Departments**

**Staffing Emergency Departments**

**Impacts of Congested Emergency Departments**

**Beds and Resources in Emergency Departments**

**Costs and Efficiencies**

- Comments on access to treatment in emergency departments:
  - The health system is great at providing emergency care when the situation is life threatening.
  - The triage system is going well; we are doing the right thing.
  - The care we get in emergency rooms is good. If it is a real problem, then the emergency staff take you right in.
  - The emergency department is working very efficiently, particularly for true emergencies. Once the patient sees an emergency room physician, the care is good and the problem is usually fixed.
  - Why can a person obtain faster and often much better emergency care for their dog or cat from a veterinarian, than one can receive at a hospital emergency wards?
  - The nursing centre in Courtenay is a good example of how to deliver services in the community as an alternative to people going to emergency ward during the day.
  - I was taken to an emergency room in China by ambulance with food poisoning and was treated by a doctor, nurse and technician within two minutes after arrival.
  - There is ageism in emergency departments.
  - Patients may languish for many hours in emergency and then be moved or admitted to a floor where there are several empty beds.
  - Emergency departments are getting worse especially Surrey Memorial.

- Comments on general practitioners and emergency departments:
  - Physicians use the emergency room as an office.
Family doctors should not be able to use emergency rooms as their locum when they are not available, nor should they encourage their patients to go to emergency in order to jump the queue and get surgery quicker.

One participant writes that their family doctor would not take their visiting grandchild because they were not the child’s patient, so they had to take their grandchild to the emergency room.

Doctors can only admit patients to the hospital through emergency departments, they cannot admit directly to any unit.

Patients are sent to emergency rooms when they are unable to see primary care physicians in a timely manner.

Doctors are telling their post-operative patients to go to the emergency room if there is a problem, but then the emergency room does not understand the situation.

People are going to the emergency department instead of going to a family physician.

There is seldom a time in emergency rooms when the waiting room is not filled with the elderly and those needing sutures or a bone set. Thirty years ago people would have gone to their family doctor for suturing, eye exams, rashes, sore throats and strains or sprains. Nowadays, family doctors are too busy to do these or other traditional tasks (like home visits). And with so many women in the work force, we no longer have a cheap supply of caregivers in the community for our elderly.

Great numbers of seniors are coming into emergency rooms because doctors do not visit care facilities.

Seniors in long term care have no access to physicians during off hours. Often long term care facilities have to send seniors to the emergency room for attention.

Comments on overuse and misuse of emergency departments:

Funding cuts to rural hospitals put pressure on emergency departments.

One of the problems is the closure of the emergency rooms in some of the smaller hospitals. The concentration of emergency care to just a few hospitals ensures that there will be unacceptable wait times and potential for disasters.

There is an increase in emergency room visits because there is a lack of ongoing support for people with chronic conditions, an increase in seniors’ health needs, a lack of coordination of services for seniors and inappropriate use by some.
There are a lot of elderly females in emergency departments because care providers do not know where else to get help for them.

Elderly patients with complex healthcare needs and disease management go to emergency departments because they have nowhere else to go. We need an infrastructure where these types of patients can be housed for two or three days in an environment that is only for them.

Too many elderly people end up in emergency because they are having a scared or lonely moment.

Elders increasingly show up at emergency departments when their families cannot cope any longer.

There are too many patients with non-emergency issues in the emergency room.

There is a general lack of understanding of when to use emergency room services.

Overuse and misuse of emergency departments is actually a public awareness and education issue.

Information on alternatives to emergency departments is not available or advertised.

Some people are using emergency rooms and walk-in clinic visits for problems that could be solved by the patient if they were better informed about how to take care of minor health care situations.

Artificial regional divisions create congestion in emergency rooms.

There are not enough community resources for families to look after their elders. As a direct result, emergency rooms are backlogged with elders waiting for acute care beds.

There is misuse of ambulance services in an effort to jump the queue in the emergency room or short circuit triage.

Welfare recipients use ambulances because they are free and ambulances transport to hospitals, not to doctor offices.

Walk-in clinics send people to emergency for things that perhaps they could do such as stitches.

If the emergency room will not turn you away and the Care Point medical clinic will charge you $50, where do you think poor people go?

People think emergency is free and go there.

Emergency rooms are misused because of cultural expectations of how end-of-life should be managed.
Triage does not have authority to turn those patients away who have minor injury or illness.

We need to stop using our emergency rooms as overflow for social services that have been cut or no longer exist.

There is an increased use of the emergency room by persons diagnosed with psychiatric disorders and substance use, which is overwhelming staff.

Emergency doubles as first point of contact for homeless, sex-trade workers, mental health and low income individuals, because there is nowhere else to go.

Some mental health patients are discharged from hospital too early so they end up going back to emergency, which ends up costing the tax payer more. This is due to pressure placed on psychiatrists and nurses to discharge mental health patients to make room for new admissions from emergency departments.

Much of the costs for emergency services and ambulances may be due to addictions. People with addictions need to be placed in long-term recovery centres. There need to be more and improved counsellors and the counselling services. These services cost money but would reduce the costs incurred in emergency.

A third of emergency room patients have no fixed address (those with mental/drug addiction) and can be better served by specialized treatment centres. Another third of patients is over 65 years old with complex medical issues that could be better served by properly equipped extended care facilities. The remaining third are there for what emergency rooms are designed for, healthy individuals who have an unanticipated health crisis or trauma.

People without health care coverage are likely to be served in emergency rooms rather than walk-in clinics.

Emergency rooms are administering ongoing care rather than short term emergency care.

Parents with young children need more counselling about childhood sniffles and communicable diseases, rather than running to emergency care.

Many musculoskeletal complaints end up in the emergency room when they are less urgent or non-urgent conditions. One of the most common musculoskeletal complaints in emergency departments is back pain.

There is a concern that new immigrants to Canada use the emergency department because they do not know the alternatives or feel safer in the emergency department rather than a walk-in clinic.

People go to emergency rooms to get their prescriptions free.
The problem is not that too many people are carelessly using the health care system or the emergency departments because most people who seek help need it. The problem is that the capacity has been exceeded.

Too often there are patients such as people with Multiple Sclerosis who must go to emergency to get steroids intravenously when they have an exacerbation. Why cannot this service be done in a clinic under a doctor’s care?

There is concern that many single mothers without family support are using emergency, as they have no one to call and share their concerns.

Nurses on the BC NurseLine seem to be afraid of litigation and therefore tell many people who call that they should go to the emergency department.

The emergency department is not the issue. It is a through put problem where demand is exceeding supply and there is no where to go.

People use emergency departments as walk-in clinics.

Cuts to acute care lead to increased demands on emergency rooms that now have to provide some of these acute care services.

Emergency room overcrowding is due to inpatients.

Government literature indicates that emergency visits increased significantly more than the population increased between 2001 and 2005. However, there is no indication as to how many visits result from no other medical assistance being available; therefore leaving the emergency ward as the only choice. It can safely be assumed that many emergency visits are not emergencies and are a result from a shortage of doctors.

Emergency room congestion has nothing to do with the running of the department so building new emergency departments is not the answer.

Inappropriate use of emergency has been an issue for over 20 years. Past initiatives to address this issue include better triaging, user fees and fast tracking.

A recent report has outlined that 25 per cent of all Emergency Department visits are unnecessary and could have been avoided if the patient simply undertook common-sense self-care measures or a visit to the drug store for over the counter remedies such as cough syrup, aspirin and vitamins.

There has been constant pressure from the Government to reduce visits to the emergency room. The patient and staff are constantly asked whether the visit is necessary. That decision can only be made by the patient before they present. It depends on their medical experience, education and insight.
• Comments about staffing emergency departments:
  • Staff in emergency rooms use up too much of their time answering repeated questions.
  • Emergency departments in hospitals are understaffed.
  • There is not enough emergency room staff. For example, at Langley Memorial there is only one doctor on in emergency at night time. This is the same amount of doctors we had 20 years ago and our population has increased, so you can imagine the wait.
  • There is lack of communication between staff in emergency departments and patients as staff do not have time to explain things to patients.
  • There is an issue with liability for volunteers in emergency departments.
  • Emergency departments are loaded down with admitted patients. The staffing level has been reduced to the point that they cannot give good care to these patients and have no space or resources to examine or treat the emergencies cases that do come in.
  • By law, once you walk into the door of a hospital a doctor has to see you.
  • Emergency physicians are trying to decompress emergency rooms, but at the same time most of these physicians are only paid until they reach a certain threshold of patients. So the incentive for emergency physicians is to see as many patients as possible, while at the same time we ask those physicians to keep emergency departments for emergency cases only and to decompress patients so they can focus on the more acute patients.
  • People with cancer problems need to be triaged better by someone who understands cancer. They need some way to be flagged as a cancer patient rather than wait for an hour for triage, and be exposed to others in waiting room.
  • The triage system in emergency departments is inappropriate. There is an absence of staff at triage stations, superficial medical cases going to emergency rooms, understaffing of Emergency Physicians and an inappropriate ratio of physicians to nurses and beds.
  • Emergency room health care professionals are facing burnout because they are bearing the brunt of an angry public.

• Comments on the impacts of congested emergency departments:
  • When the emergency room is full there is a problem with prioritising patients.
• Waiting in the emergency department for a long time can lead to more serious health issues and higher costs.

• Patients exposed to gruesome injuries while waiting for care in emergency departments raises safety issues.

• Emergency room wait rooms are uncomfortable, especially for clients who may want or need to lie down.

• Emergency rooms cannot cope with the volumes of patients, the waits are unacceptable, and seeing patients on gurneys in hallways is insulting and undignified to those relying on our health care system to care for them in a dignified and appropriate manner.

• The inability to receive reasonably prompt emergency care in hospitals is a serious concern.

• One participant questions how overcrowded emergency rooms actually are, as they have seen an emergency room physician’s time being wasted while he examined a toddler’s red marks only to diagnose mosquito bites. They have also seen a very elderly senior citizen coughing up blood while waiting to see the emergency room physician who was occupied in dealing with a convulsing drug abuser presented to him by paramedics who picked up the drug abuser off the street.

• Emergency departments are overcrowded.

• Comments on beds and resources in emergency departments:
  • Finding beds to transfer admitted emergency room patients to is a problem. There are often no available beds so transfer to in-patient setting is blocked.
  • There is concern that most of the patients in beds in the hallways are elderly people.
  • There is a lot of frustration of having for a long period of time for medical attention in emergency rooms.
  • Emergency does not have enough diagnostic equipment available and the equipment it does have is not utilized fully.
  • With the closure of the University of British Columbia Emergency Department in 2003 the volume and level of acuity went up at St. Paul’s Hospital and the Vancouver General Hospital. This necessitated hallway stretchers which were lettered "A" through "J" in the hallway just outside of the emergency room at the Vancouver General Hospital. In uncountable occasions many critical patients were in those stretchers because they could not get a bed inside the emergency
room. Furthermore, on one occasion I had to insert a central venous catheter in one of the family waiting rooms to resuscitate a patient going into renal failure with fluids. He was about to get a bed in the emergency room but this was taken by another patient having an acute myocardial infarction (heart attack). It would have been hours before getting a bed on the ward. He may have died before then. (He ended up surviving, getting the surgery he needed and leaving hospital). The beds in the emergency room were not full of people with non-urgent conditions. They were either admitted patients that could not get a bed on the ward because the ward was full of patients that were waiting for non-existent long term beds in the community.

- Beds in emergency departments are used as acute care beds.
- There is recent evidence published that refutes the notion that non-urgent patients tie up beds in emergency departments.
- There are no acute hospital beds in emergency.

- Comments on costs and efficiencies:
  - There is no incentive for emergency rooms to limit non-emergency use and therefore try to be more efficient.
  - Basing hospital funding on each fully processed emergency room patient that is treated in less than 10 hours would only lead to mistakes and rushed decisions.
  - Emergency rooms are not efficient and do not have access to patients medical histories.
  - There is concern about budget management for emergency departments and that some emergency issues are considered to cost the system less but in fact they will end up being very expensive. For example, non-urgent patients waiting for long periods of time may be less expensive in financial terms, but they are actually very expensive in other terms such as using up nursing resources.
  - Patients should be able to get their medication administered at the emergency room and should not be pressured to administer it at home.
  - If you take the average cost of a patient in an emergency ward, then you are considering the person who came in with terminal contusions and the person who came in with minor ailments. If the costs are not separated for different levels of care required then you are grossly overestimating what it may cost to look at somebody in the emergency room.
  - I would be happy to pay the going rate for professional private health care rather than wait for hours in the emergency room.
Ideas and Suggestions

Access to Treatment in Emergency Departments
Availability and Misuse of Emergency Departments
Emergency Department Staffing
Beds and Resources in Emergency Departments
Costs and Efficiencies

• Ideas about access to treatment in emergency departments:
  • A person should not be able to walk off the street for emergency care. A clinic located in the proximity of the hospital should do all the triaging and refer patients to a non-emergency 24 hour clinic if possible.
  • Pass legislation to limit use of emergency rooms to 911 ambulance emergency calls only. Send all other minor cases to local walk in clinics or local storefront emergency services operated by local general practitioners.
  • Provide triage outside hospital emergency rooms like the Canadian Army model.
  • Provide suitable alternatives to emergency departments that have diagnostic equipment.
  • Use aggressive monitoring of patient needs for queuing for treatment.
  • Change the way that the health care system treats emergency departments as a backup.
  • Establish benchmarks so that patients do not stay in emergency departments for more than a few hours.
  • Provide geriatric assessment in emergency departments.
  • Advertise and market alternatives to the emergency department that are based on patient needs.
  • Have patient advocates in emergency rooms.
  • Bring children to emergency through a different area and separate out problematic patients.
  • Provide ways for greater use of telephone consultation before going to emergency to reduce the number of emergency visits and to help people know what to expect when arriving at emergency.
  • Government’s one-size fits all solution for emergency departments and after hours care in rural communities does not work. Look at publicly funded alternatives that relieve pressure on emergency departments such as walk-in clinics and secondary diagnostic centers.
• The emergency room should not be the entry point into the health care system.
• Put seriously disabled and chronically ill patient needs first on the priority list.
• Provide intravenous therapy in walk-in clinics instead of the current practice of having to go to the emergency room to have it done.
• Have an infant and child clinic connected to paediatrics in the hospital to free up room in the emergency departments.
• Have a gerontology clinic attached to the emergency department.
• Designate hospitals or care centres for the elderly.
• Provide comprehensive, longitudinal and holistic care at the community level with extended hours provided.
• Admission to the emergency ward should be by ambulance or by a doctor’s reference.
• Implement a numbering system for each patient to help track patients.
• Have a first aid room at each hospital and major shopping centers taking enormous pressure off our over crowded emergency rooms.
• Encourage the establishment of both private and public emergency clinics for non-life-threatening injuries.
• Provide more respite care in home so families do not leave their family member in the emergency department, as they do not have any other choice.
• Solutions to the emergency room problems need to be proactive, not reactive.
• We need legislation to protect the hospital from any potential liability for the one in a million chance that an urgent case is referred to a clinic by mistake.
• Fund nursing centres and public health units to provide emergency services from 7:00 am to 11:00 pm to take pressure off the emergency department.
• Emergency departments should have many separate units such as a trauma unit, a stroke and cardiac unit, a mental health unit and an isolation unit.
• Provide services like a library, food vendors and video rental in emergency rooms.
• Build a new facility for emergency department issues in Castlegar and elective surgeries in Trail.
• As one enters the emergency room, it could be the triage Registered Nurse’s responsibility to assess the patient and determine the level of urgency. For instance, level 1 is you are dead and require immediate intervention (like CPR) and level 5 means that you can sit in the emergency room all day and live to see
another day. In this case, patients need to be advised that they are a level 5 and will have the choice to remain in the emergency room and be charged a user fee or they can leave and see their physician the next day. Sounds risky as we are then relying upon the triage nurses judgment but it has to start somewhere.

- The room layout of waiting rooms in emergency rooms should allow for small grouping instead of one long line of chairs or benches. Patients need to be able to lie down if they need to.

- Implement a five-part strategy to reduce Emergency Department waits and incorporate it into the performance agreements with Health Authorities:
  a. Implement a 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 emergency department in British Columbia;
  b. Adopt overcapacity protocols province wide.
  c. Expand triage capacity immediately for emergency departments experiencing volume beyond their physical plant capacity, using portables if necessary;
  d. Create regionally based pools of Emergency Department physicians and General practitioner’s with Emergency Department experience to provide float coverage in demand overload situations; and
  e. Introduce urgent care centres (with access to lab and x-ray services) that are in close proximity (or in hospital) to emergency departments that are routinely overcapacity.

- Ideas about availability and misuse of emergency departments:
  - Consider a third strike system, which gives the option to the medical centre to give a fine on the third strike.
  - Give hospitals in British Columbia the right to refuse those people who do not have medical emergencies.
  - Follow the 911 model in France that has in home acute care to prevent emergency admission.
  - Government needs to establish a maximum emergency department length of stay benchmark of less than six hours (from arrival to emergency department exit).
  - Government needs to require that all admitted patients must be transferred out of an emergency department to an inpatient area within two hours following a decision to admit.
• We need definitions for what constitutes urgent and non-urgent care. Otherwise it is like we asking patients to make the judgements of a triage nurse when deciding whether or not to go to the emergency Room.

• Offer more services for homeless people who end up in emergency.

• The public needs to take some responsibility for clogging up emergency rooms.

• Look at the reasons why people are using the emergency room and not walk-in clinics. One example of this was in the Royal Hospital London that studied why there was escalating attendance at emergency for minor complaints. Results showed that one immigrant community in particular went to emergency because they did not feel that the doctors at the walk-in clinics were professional because they were not wearing white coats.

• Many emergency visits are unnecessary. If the patient had to pay, then they might be more prudent in the use of the service.

• People who abuse emergency care should be billed for it.

• Track an individual's use of emergency services and charge those people who abuse emergency room services.

• Survey the self inflicted ailments like drugs and alcohol that end up in the emergency room to see if there is need build a separate clinic for these cases.

• Encourage new immigrants to use doctors and clinics instead of the emergency department.

• Do not give out free medicine in the emergency room.

• If someone shows up at emergency for a non-emergency have the nurse make an appointment for a non emergency clinic or pay a higher rate.

• Introduce a surcharge for people who use the emergency department. People on social assistance could have a determined number of visits per year without a charge or more if they have serious medical problems, as authorized by their physicians.

• Support a shift in public perception of emergency care to go to a community health centre first.

• Provide a user-friendly information package to all households listing common maladies that frequently result in a visit to the emergency department and other pertinent information.
• Educate people about:
  a. emergency use and overuse;
  b. when to go to a physician and when to go to emergency; and
  c. types of minor ailments that can wait for medical treatment.

• Ideas about emergency department staffing:
  • We need better support for emergency staff.
  • Listen to emergency staff.
  • Allow the use of Nurse Practitioners to clear backlogs of non-emergency cases in emergency rooms.
  • Call in extra staff when the emergency room is busy.
  • Use volunteers in emergency departments.
  • Have alternative health care providers in emergency rooms.
  • Emergency room staff and use of resources needs to be more versatile.
  • Chiropractors are highly trained in musculoskeletal complaints, and have a lot of experience in diagnosis and treatment of back pain in particular. Emergency departments should have a chiropractor on staff so that emergency room physicians have more time to see patients with urgent conditions.
  • Give patients attending the emergency department a choice to be treated by a Nurse Practitioner within one or two hours, or they can wait for longer to see a doctor.

• Ideas about beds and resources in emergency departments:
  • Provide new resources and proper utilization of resources to get patients out of the emergency room.
  • More beds in emergency departments.
  • Have appropriate supplies ready for use in emergency rooms such as vomit bags.
  • Spend more time and resources on cleanliness in emergency wards.
  • Instead of closing hospitals dedicate them to chronic or urgent care to take pressure off emergencies.

• Ideas about costs and efficiencies:
  • Improve the efficiency of admitting repeat patients to the emergency room and/or hospital by improving patient medical records.
• Provide more training to ambulance staff so they can determine whether or not to take the patient to the emergency department.

• Educate the public about costs and alternative services to help prevent utilization of high emergency department costs.

• Remove the limits on how many patients a doctor can see in a day and allow the doctors to set their own limits to cut down on the number of people in emergency departments.

• Consider a combination of public and private funding to help overcrowding in emergency departments.

• Bill doctors for the full cost of using the emergency department for a procedure that could logically be done in their office.

• Send a letter to patients attaching a bill that demonstrates the cost of their visit to the emergency room.

• Amend the Canada Health Act to allow user fees. Waive the fees if it is a real emergency.

• Eliminate health care premiums like Manitoba did, where everyone has a health care number and can go to any clinic or doctor, but they are unable to visit emergency for minor ailments.

• Emergency room funding should be part of global funding.

• Adopt new technology and use different ways of powering the emergency department.

**Acute Care**

**Comments and Concerns**

**Access to Acute Care**  
**Acute Care Bed Shortages**  
**Health Human Resources**  
**Acute Care Administration and Management**  
**Costs and Efficiencies**  
**Transferring Patients**

• Comments on access to acute care
  
  • We have to stop using hospitals as hotels to get diagnostics done. We have to stop using our hospitals as residential care facilities. We need some checks and
balances in place to ensure that hospitals are for there intended purpose, which is acute care.

- When physicians become frustrated with patients that they are having difficulty treating, which is often the elderly who have multiple medical and social issues, physicians admit these patients to acute care because they do not know what else to do.

- The historical expectation that hospitals should continue to provide over night health care for non acute and preoperative care is gradually shifting. We are beginning to accept what the research for years has shown, that it is better to convalesce at home.

- In many cases, the weaker and more debilitated patients eventually die in an acute hospital bed when all they needed was a care home and to be involved in some form of activity, rather than lying in a hospital bed for two to five months.

- Comments on acute care bed shortages:
  - There are not enough beds for the detoxification of patients addicted to drugs and alcohol. More beds for detoxification purposes would relieve pressure on emergency rooms.
  - Bed shortages create bottlenecks in all the major centres of British Columbia.
  - According to a survey, Kelowna General has 87 less beds than it did in 1990. Considering the population increase over the past 17 years, this statistic reflects terrible administration.
  - My father waited more than four months in Memorial Pavilion for an acute care bed in a nursing home when the Gorge Road Hospital was closed. The Vancouver Island Health Authority knew that beds were needed for the residents of the Gorge Road Hospital and also for all the new admissions from the community, but still it stayed closed.
  - Seniors and acquired brain injury patients are the most difficult to place and spend months in acute care beds, which is the worse possible place for them. The activity restrictions escalate their behaviour and they disrupt patients.
  - The traffic on the Sea to Sky Highway can add to the pressures on acute care beds if there are any more accidents.
  - The significant reduction of residential care beds in British Columbia 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. 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.

- British Columbia has a relatively low number of acute care beds. That shortage of beds means that most British Columbia hospitals frequently operate at unsustainable occupancy rates of higher than 90 per cent, 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.

- We need more chronic care beds so that we can use our acute care and our emergency department beds for the purposes for which they were intended.

- The population has doubled, but acute care and long term care beds have closed.

- 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 British Columbians.

- There are not enough beds or placements, but what we do have currently in the system is working well.

- The acute care system does not have enough of the following:
  
  a. publicly funded beds;
  
  b. acute, recovery and long term care beds;
  
  c. transition beds where patients are held prior to proceeding to the next level of care;
  
  d. available staff;
  
  e. facilities and operating rooms;
  
  f. appropriate beds and therefore level of care;
  
  g. beds for assisted living, complex care and social living;
  
  h. community support that creates more demand for acute care and beds;
  
  i. immediate availability of treatment facilities;
  
  j. special care beds such as beds for wandering and dementia patients;
  
  k. transportation to and beds for detoxification centers;
  
  l. specialized staff for acute care beds;
  
  m. child or adolescent psychiatry beds; and,
  
  n. acute care beds for those with developmental delays;
Patients are being admitted to the hospital with one ailment and then leaving the hospital with another ailment. This is because a lack of beds leads to dangerous overcrowding which leads to the cross-contamination of diseases.

When the hospital in Fort St John was built it had three times as many beds as it does now, yet the population has increased by at least four times since the hospital has been built.

There is a giant shell game happening in Prince George, where the status of buildings has changed, but there are no new beds.

There are not enough available beds in major centers in British Columbia such as Prince George, Vancouver and Victoria. In addition, there are not enough staff members in the receiving hospitals to treat the patient.

The lack of beds negatively affects post-hospital care and monitoring. It also causes other problems for patients, such as staying for days in emergency rooms, geriatric patients filling beds and the splitting up of couples and families.

Operating rooms cannot be used because there are not enough beds available in the hospital.

There are too many cardiac patients that are kept in hospital so that they do not lose their bed for bypass or angioplasty surgery. We should allow these patients leave the hospital on day passes, without being discharged so that they lose their place in line for surgery.

Patients often wait a long time for their surgery to be scheduled, but it can be cancelled at the last minute because of a shortage of beds. For example, after seven months of waiting and preparing for surgery, although the patient, the surgical team, the operating room and the nurses were ready for the surgery, there were no beds in the hospital for recovery. These types of dry runs are a waste of taxpayer dollars, not to mention the frustration that this situation creates for all involved.

Acute care beds are plugged up with those needing acute care and there are no community services for patients to access. As a result, people rebound back and need intermediate facilities for respite care and long term care beds.

The single biggest problem facing our hospitals is the fact that so many acute care beds are taken up by chronically ill and elderly patients.

We have had a reduction in our in-patient acute care beds and in our long-term care beds. So now we have seniors at home, but we have little or no home support service available. This leads us to the more expensive options of care for seniors, which include putting them in emergency departments and acute care
beds. Meanwhile, surgeries have to be done on patients that need those acute beds. Nobody has a sense how this impacts families and communities.

- Wait lists for surgeries, specialists and emergency rooms are exacerbated by bed and equipment shortages.
- Discharging patients too early leads to recidivism, but there are not enough beds for convalescence.
- Inadequate numbers of beds force patients to face inhumane conditions.
- How long can someone lie in bed with a broken bone on morphine while they wait to have a bed open up so they can have surgery?
- Many people have had to sleep for two to four nights in a hallway awaiting surgery.
- It is simply not fair for a person who lives a healthy lifestyle to waste time waiting for a bed that is taken up by somebody who chooses to live an unhealthy lifestyle, while both people are paying the same amount of money for care, or lack thereof.
- There is a concern that neonatal patients have to get care outside of British Columbia because of a lack of beds.
- Patients are inappropriately placed in beds because of the backlog in the system.
- British Columbia'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. British Columbia has only 1.8 acute and rehab beds per 1,000 population. This is 35 per cent below the 2.75 that is recommended by the British Columbia Royal Commission and significantly lower than most Organization for Economic Co-operation and Development (OECD) countries. From March 2002 to March 2004, 1,279 hospital beds were closed, which is a 19 per cent reduction in capacity when population increases are taken into account. Between 2001 and 2004, there was a net decrease of 1,464 residential care beds, even after accounting for new assisted living units. As of January 2006, British Columbia had 5.8 publicly and privately funded medical resonance imaging machines per million residents, below that the numbers of Alberta, Quebec, New Brunswick, Manitoba and PEI. All provinces except for Alberta and Ontario had higher numbers of publicly and privately funded cat scans than British Columbia.
- British Columbia does not have enough adolescent psychiatry beds or acute care beds for those with developmental delays. This population actually regresses and does horribly in a general psychiatric hospital environment. We need more appropriate acute care options for these populations.
• A shortage of acute care beds forces hospitals to discharge patients faster and this limits the amount of teaching and preparation that can occur before a patient is sent home to live with their condition. Home care does not adequately replace the in-hospital education a patient should get.

• The Government shut down care homes for the elderly all over British Columbia and now there are elderly people in acute care beds instead of care homes.

• Comments on health human resources:
  • Bed shortages lead to staff burnout, extra overtime costs, greater patient load and sicker patients.
  • There is a nursing shortage not a bed shortage. Two beds are closed on our unit not because we do not have the nurses to care for them.
  • I believe the main cause of long wait lists is the fact that doctors cannot get enough access to existing beds.
  • Many beds are closed because we do not train enough registered nurses.
  • Beds and wards in hospitals around British Columbia are closing because of staff shortages.
  • There is a lack of staff including nurses, administration and technicians, especially during peak season.
  • Health care staff is overworked and patients are delayed in receiving treatment.

• Comments on acute care administration and management:
  • Changing the rules around bed assignments confuses staff and patients.
  • British Columbia has the lowest bed-to-patient ratio in the country.
  • There should not be anymore hallway care.
  • It is a problem when people are told by their doctor that they need to be in the hospital, but the hospital kicks people out because there are no beds.
  • There are too many surgery cancellations because there are no beds.
  • Hospital administration has come up with a hallway nursing protocol, which implies that there is no intention of fixing the bed shortage problem.
  • We have an acute care system that is bursting at the seams, where acute patients often occupy beds that are allocated to long term care. We are not doing enough to move the acute care patients out of these beds.
• The Province needs to be careful because when the baby boomers are gone it will need less hospital beds, in the same manner that we need less schools today.

• With hallway beds, there is no privacy for the doctor, patient or family to discuss personal treatment.

• Too much office space is being set aside for hospital administration when there is such a problem with space for beds.

• There are people occupying beds that do not need hospital care, but the Government does not provide them with other places to go.

• There is a constant push to shorten the length of stay of patients, but outpatient rehabilitation in communities is inadequate so patients ultimately return to acute care.

• Comments on costs and efficiencies:

  • Hospital beds are being used for the infirm because of a lack of institutional beds. This causes patients to become less active, less able to take care of themselves and it ultimately costs the health care system more in the end.

  • While hospital occupancy is over 100 per cent, hospitals are funded based on the premise that only 75 per cent of the beds will be full at any one time.

  • People may check into acute care to avoid extended care fees.

  • It is cheaper for government to get patients out of the system because beds are expensive.

  • Acute care and acute beds can be quantitatively measured in funding dollars received; however, measuring preventative care where care is more qualitative is not so easy. We need to develop a means to measure prevention so that it can receive the same attention as acute care and beds do now.

• Comments on transferring patients:

  • There is concern that patients needing beds in intensive care units (ICUs) are transferred to different institutions because there are no intensive care unit beds at the hospital that performed the surgery. It is traumatic and painful for patients to be transported back and forth between intensive care beds in different hospitals.

  • There is a concern that it is nearly impossible to get an emergency transfer due to a lack of specialists as well as bed shortages.
Patients are held at local hospitals until a transfer can be arranged to another hospital, but often there is a shortage of beds at the receiving hospital so the patient gets worse and may die while waiting.

Bed closures in the Vancouver region affect all other regions because outlying regions send patients to Vancouver for specialized care such as cardiac and orthopaedics.

Emergency patients wait far too long for specialist care while rural doctors are on the phone to the British Columbia BedLine, looking for a hospital with an available bed.

**Ideas and Suggestions**

**Access to Acute Care**

**Acute Care Bed Shortages**

**Acute Care Administration and Management**

**Health Human Resources**

- Ideas about access to acute care:
  - Implement a robust primary care strategy to decrease long term demand on acute care system.
  - Provide transitional guidelines for acute care settings.
  - If we built the required facilities to meet this provinces long term care nursing needs, it would free up so many acute care beds in our hospitals that our hospitals would be able to function as they should.
  - Opening up closed schools as extended care facilities would free-up some hospital beds for acute and short term stays.
  - We need geriatric activation units across British Columbia to get the weak and debilitated elderly out of acute care beds (they do not meet rehabilitation unit criteria).
  - Implement mandatory province wide coding for acute care admissions.
  - When a person’s health starts to go downhill, they want to know that the right help, beds and equipment will be available when they need it.
• Ideas about acute care bed shortages:
  • Stop closing acute care beds and increase funding for discharge planning.
  • A designated transition unit with sufficient beds would make the current allotment of acute, long-term and palliative beds more effective and efficient.
  • Direct our tax dollars to build more long term health care beds and nursing homes, which will in turn free up acute care beds and in the long term be a much more cost effective way to spend our tax dollars in health care.
  • Expand acute care bed capacity, as we are only operating at two-thirds of the Seaton Commission’s recommended number of acute rehabilitation beds per thousand. We have to look at our emergency departments, operating rooms, long term bed capacity and most of all, the whole issue of multidisciplinary care.
  • Reinstate the acute care beds at Delta Hospital.
  • If we closed all the beds used for abortion, then there would be more beds available to everyone.
  • We need more funding for beds and equipment on the Lower Mainland.
  • Increase beds and services across the province.
  • Provide more triage beds and standards.
  • Provide more transitional beds for seniors.
  • Provide more labour, delivery and postpartum care suites as well as nursery and paediatric facilities.
  • Provide more specialized beds so patients are not in the inappropriate bed for the area of care required.
  • Provide more rehabilitation and convalescent type beds and care to reduce congestion within hospitals and emergency rooms.
  • Establish more chronic care beds to open up more acute care beds.
  • Provide more beds in emergency departments.
  • We need more in-patient beds for child and youth mental health
  • For the short term we need more operating rooms, hours and more hospital beds
  • Re-open hospital beds to the numbers that existed in the year 2000 and publicly fund acute care hospital beds.
  • Provide more neonatal beds in British Columbia so mothers do not have to be separated from their newborns or sent to the United States to give birth.
Ideas about acute care administration and management:

- Have a provincial centralized electronic booking system for tests and procedures. This would increase efficiency and keep track of how long people have been waiting and what beds are available.
- Establish maximum wait times for beds for those patients that are admitted to hospitals through emergency departments.
- Protect designated beds such as those for surgery, cardiac care, general care and orthopaedics.
- Surgery wait lists and recovery beds must be coordinated.
- We need to cap the number of hallway beds allowed in the emergency room.
- The BedLine does not work and ties up ambulance crews who are needed elsewhere.
- Transfer the geriatric non-critical patients that are taking up acute care beds and get them into appropriate long term care beds.
- Health Authorities should commit to renewable five year plans that include:
  a. target rates of utilization (per age/gender standardized population) for acute care services;
  b. bed targets (based on funded beds per population) for each clinical service provided in a Health Authority; and
  c. strict guidelines that all acute care hospitals in British Columbia not exceed an average occupancy rate of 85 per cent to allow for surge-capacity situations.
- The shortage of acute care beds is a primary factor for emergency department overcrowding which has become a significant patient safety and quality of care concern in British Columbia. The British Columbia Medical Association recommends setting a provincial benchmark for total emergency department length of stay that is measurable and linked to an accountability framework for performance assessment.
- While health authorities agree that more beds are needed, they are not necessarily required in hospitals. For example, health authorities could investigate the expansion of services at existing facilities such as expanded elderly care facilities rather than moving the elderly to the emergency department for treatment.
- Prioritize patient needs so that the greater the patient’s need the higher priority it is for them to get a bed.
• Base bed management on recognizing that patients have different needs at different stages of life.

• There is a need to prioritise care according to patient need not just the needs of special interest groups such as the WorkSafeBC.

• We need criteria for wait lists for beds such as severity of illness and family and work responsibilities. For example, whether or not you will lose your job if there is not a bed available for you to have a procedure versus a retiree that may have more time.

• First take a look at how available beds are currently utilized before directing financial and staff resources to increasing the number of beds.

• Quality control would ensure that there is more attention given to the reform of primary care beds

• Address the problem of patients who over-stay in hospital beds. We need better bed utilization practices including effective discharge criteria.

• Fund beds in areas with bed shortages and where occupancy is over 100 per cent.

• Accelerate the creation of areas of excellence in each of the major hospitals in order to create efficiencies.

• Ideas about health human resources:

  • As a priority, carry out human resources planning to staff the 5,000 bed strategy.

  • Provide incentives to interns to discharge patients on time so that beds are available to other patients.

  • Post operative beds need to be funded to support good nursing care.

  • All beds should be converted to electric three position beds so nurses do not have to run to a room six times a day to crank a bed up or down.

  • Although more beds are clearly needed, simply opening more beds is not a viable solution, as there are not enough nurses to staff these beds. There is a shortage of nurses, but there is also a long wait list for students to enrol in nursing school. To train more nurses now, go back to on the job training for nurses.
Long-Term and Residential Care

Comments and Concerns

Long-term and Residential Care Facilities

Long-term Care Bed Shortages

Facilities in Specific Communities

- Comments on long-term and residential care facilities:
  - Hospitals are treated as long-term care facilities because there is a lack of alternatives, resources and education.
  - Long-term care patients strain hospital staff in short-term facilities.
  - Bureaucratic decisions have resulted in the demolition of many long-term care facilities without plans to rebuild facilities, such as the closure of Saint Mary's Hospital.
  - I firmly believe that our hospitals and emergency rooms are overcrowded because there are not enough long-term care facilities available for our aging population. We all know that a hospital bed costs much more than long-term care and it is a waste of tax dollars to keep patients inappropriately in a hospital bed.
  - The Interior Health Authority has closed extended care facilities in anticipation of private facilities filling this void. Our hospitals are over run with seniors who now have to depend on emergency facilities for their needs.
  - Patients do not receive the attention and care that they would have gotten in a long-term care facility while they are waiting in a hospital bed. This means that recovery is delayed or does not happen due to neglect.

- Comments on long-term care bed shortages:
  - There is a shortage of residential care beds so patients are placed in already overcrowded emergency rooms.
  - We were promised 5,000 more long-term beds, but instead we lost 3,000 long-term care beds.
  - Long-term care patients remain in acute care beds and the Intensive Care Unit is crowded.
  - Too many long-term care beds are closed and replaced with supportive housing.
  - There are adequate long-term beds available, but they are closed because they are inadequate or not up to today's standards.
- We cannot transfer patients out of the emergency room because beds on other floors are filled with patients waiting for placement to a long-term care facility.

- I recognize that the Government is taking steps to create more extended care beds to move patients requiring long-term care out of hospitals; however, this appears to be happening at a slow pace. I urge the government not to be distracted by the media focus on individual incidents relating to emergency room waits.

- We need to create more long-term beds. It is the elderly who tend to most be languishing in the hallways because there is nowhere for them to go. This is where the major backlog is being created.

- There is concern that the Government of British Columbia promised more long-term care beds but is not providing them rather it is focusing on providing assisting living buildings.

- Families naturally want loved ones nearby when institutional care is required. However, bed availability for the most part usually means that someone must die for a vacancy to occur. The preferred care facility cannot always be provided upon the immediate request of a family, as someone else would have to be moved out for that to happen if a bed is not available through the death of a resident. Those people that complain that they cannot immediately move their loved one into the care centre of choice must understand that an alternative location may be the only answer in the short run. An alternative would be to care for the loved one at home rather than drive the extra miles to an alternative facility. Most people are not willing to do that and some complain loudly and gain media support. So seniors end up in hospitals rather than long-term care facilities and then end up using all of the available beds.

- Comments on facilities in specific communities:
  - We need more hospital and long-term care beds in the Cranbrook Regional Hospital. This hospital now serves all of the East Kootenays, which includes approximately 80,000 people, but it was only built to serve approximately 20,000 people.

  - Long-term care beds have not increased in Kamloops despite the fact that those who need them have increased. The backlog in the hospital exists because we have nowhere to put these people.

  - The Ministry of Health said that Trail needed more transition and respite beds. However, the community saw that only 11 residential beds were then funded in the area (10 to a private facility in Castlegar and one to Trail). Several community members with health care, engineering and cost analyst backgrounds proposed a
22 bed Transition Unit as a solution to our problem of up to 18 acute beds being occupied by elderly people waiting for assessment, transition to home, or care facilities. (We also had a problem with our elderly being sent out of town for residential care and then family unable to travel to visit because of the mountainous area). Transferring an adult day care program to the unit would have made the 22 beds economically feasible. The site was a former care home so amenities already existed.

- There are promises to upgrade the Kelowna Hospital, but this does not include increasing long-term and extended care beds.
- Patients from 100 mile house went to four different hospitals in need of an Intensive Care Unit bed. Why is the BedLine unable to identify where the available beds are?
- Masset is combining acute and extended community care.
- Burns Lake is adding transition beds to help transition from acute care to extended care.
- The Comox Valley Hospital has trouble finding beds for all of its patients.
- Increase the number of operational beds at Mills Memorial Hospital to be more in line with the numbers at other hospitals with regional responsibilities.
- Provide a recovery area at Dawson Creek Hospital for surgery patients, rather than sending patients home early.
- Do consultation and business planning to provide resources to rural and Northern British Columbia. Realize the differences in providing health care in these areas and that it costs more to deliver this care.
- Provide beds and build for growth in Fort St. John, one of the fastest growing northern communities.
- Increase beds in the Jubilee Hospital in Victoria.
- The immediate construction of a 1000-bed hospital in Surrey is needed.
- Build more primary health centres and long-term care beds in the West Kootenays.
- Provide more diagnostic services, and long-term and transitional care in Kelowna.
- Build another hospital in the Fraser Health Region because the Royal Columbian Hospital is overwhelmed.
- There are unacceptable wait-times due to bed shortages at the Royal Inland Hospital.
• The shutdown of the Sparwood Acute Care Center means that people needing those facilities now go to the Elk Valley Center. However, there are stories of people lining up in beds in hallways there, as they wait to be admitted to a room.

• There are issues finding space for new equipment within the Comox Valley hospital.

• Emergency rooms in Penticton General, Kelowna are overrun because beds have been too heavily cut.

Ideas and Suggestions

Long-term and Residential Care Facilities

Long-term Care Bed Shortages

Resources

Costs and Funding

• Ideas about long-term and residential care facilities:
  • Increase long-term care facility intake.
  • Stop closing long-term care facilities.
  • Reopen long-term care facilities that have been closed.
  • Put less stress on acute care by increasing the supply of long-term care and extended care beds and facilities.
  • Use existing but closed hospital beds for rehabilitation, convalescence, awaiting interim and long-term care beds.
  • Provide satellite services to senior centres or residential care facilities.
  • Use closed down facilities for other uses, such as community health and wellness centres.

• Ideas about long-term care bed shortages:
  • Increase bed capacity, especially for assisted living and residential.
  • Reopen at least 4,000 of the long term care beds that have been closed.
  • Plan, build and implement policies for the future now. This includes recognizing the aging population and addressing the lack of chronic care beds.
  • More chronic care beds for seniors would reduce the so called burden on the system by seniors.
• Government needs to fund more long-term beds so that major hospitals can discharge chronically ill people to the long term homes and free up the hospital beds for critical care patients.

• Open more publicly funded respite units, assisted living beds, long-term care beds, palliative care and extended care beds.

• Double the number of long-term care beds in communities.

• The Government has focused on increasing the number of assisted living units, rather than residential care beds. However, residential care beds and assisted living units are not interchangeable because of the differing care needs between residential and assisted living patients. 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.

• Ideas about resources:
  • Increase resources to allow patients to remain in residential care versus being sent to emergency.
  • Help local communities to take care of geriatric and palliative patients and support long term care homes so these patients do not have stay in acute care hospital beds.
  • Utilize more ideas on the home care front in order to take pressure off the hospital system.

• Ideas about costs and funding:
  • The cost of respite and palliative beds is prohibitive for low income seniors. Put a system in place to help low income seniors such as setting a threshold for assistance based on either the Guaranteed Income Supplement or a certain minimum income level. Waivers are currently cumbersome and slow to be approved.
  • Instead of tax cuts, we should put that money back into opening the beds that were closed in hospitals and open the promised long term care beds.
  • Provide publicly funded support for home care services.
  • Build publicly funded long-term care beds in each community that provide proper care for each resident.
  • Provide funding for community education on spiritual and acute care.
  • Move costly non-emergency patients to community facilities.
Ambulance Services

Comments and Concerns

Administration and Dispatch
Human Resource Issues
Availability and Misuse of Ambulance Services
Costs and Funding

• Comments on administration and dispatch:
  • There is a lack in accountability for decisions that dispatch and ambulance staff make.
  • Ambulance service is too centralized. Dispatch and headquarter services are now too far removed from the communities they serve.
  • Ambulance services are not well organized and can be wasteful.
  • Turn around time for ambulance crews are lengthened or delayed, as drivers have to wait with their patients in the emergency rooms.
  • The cost of having ambulance crews stand by while their patient is waiting for a bed is unacceptable.
  • The wait-time for access to an air ambulance is too long. The British Columbia Ambulance Service only operates two air ambulances after 8:00 p.m. in all of British Columbia.
  • The dispatcher decides what cases get priority.
  • Ambulance services mails invoices to people many months after the service was used. In some cases bills are sent to collections agencies without the invoice first being sent to the patient.
  • Ambulance invoices are mailed out months after a patient’s death. This brings back painful memories to family members.

• Comments on human resource issues:
  • The paramedic’s scope is limited because physicians and nurses are no longer available to act as transport escorts.
  • The demand for ambulance services outweighs available human resources, crew skills and an ambulance service that contains air, ground, and see fleet vehicles. Patient transport is currently bottlenecked and it takes too much time to get rural intermediate and critical patients to tertiary centres.
- The level of care that patients receive from ambulance attendants may be inadequate.
- The British Columbia air ambulance service may only have about one-quarter of the number of crews that Alberta possesses.
- The British Columbia Ambulance Service concedes that service has been challenged by labour shortages and a lack of skilled people, but that they will mitigate this challenge by mounting a recruiting drive. Why are they wasting money with a recruiting drive when there is already well-trained staff who wants to work?
- The British Columbia Ambulance Service is the largest ambulance service in Canada and as they approach their 35th anniversary of they are still struggling to address staffing issues that should have been fixed in the late 1980’s and 1990’s.
- Emergency or general duty crew are unable to meet their response time goals due lack of staffing and the geographic placement of stations.
- Due to reductions in paramedical services, the public must rely more on other first responders. Firefighters, who possess only a first aid certificate, would be the primary source of care now as paramedic services are spread too thin.
- When paramedics start they are paid two dollars an hour to be on-call and no more than 20 minutes away from their stations. Their pay does not go up until they receive a call out. Those operating in rural stations may only receive two or three calls a week.

- Comments on availability and misuse of ambulance services:
  - Ambulance services are abused to access emergency departments with a higher priority.
  - There is no reason why a patient’s family should have to drive them to a hospital for emergency or patient transfer reasons. Times of high usage should be taken into consideration so that there are no ambulances on standby during peak hours.
  - Seniors are increasingly calling on ambulance services. This is due to the assumption that they are granted faster entrance into emergency departments than if they were to walk in.
  - Ambulance services are rising but resources for this service are not.
  - There is too heavy reliance on ambulance services to transfer home care residents to emergency rooms.
  - There is no assistance when transporting patients out of the hospital.
• It takes five or more hours to get an emergency patient to specialist care due to a lack of ambulatory service.

• People may be abusing ambulance services by calling them to obtain a free ride into town. This abuse of the system is both costly and endangers those who are experiencing a real emergency.

• Ambulance drivers are not communicating necessary information to patients regarding process and protocol.

• The requirement of ambulance crews to direct all of their patients to emergency only increases the number of calls for ambulance service.

• Comments on costs and funding:
  
  • Closing hospitals leads to higher ambulance costs for the health care system and its patients.

  • Having to pay for ambulances makes this service inaccessible to those living on a lower income.

  • There is inadequate funding for ambulance services including:
    a. Lack of staff to service ambulance stations;
    b. Poor wages;
    c. Lack of training for staff; and
    d. Staff shortages in smaller communities.

  • There is too much transportation between major hospitals for different kinds of treatments. This shuffling around is not cost effective and is traumatic to the patient.

  • Seniors in residential and long term care facilities are forced to pay ambulance costs for transportation to their appointments.

  • The Greater Vancouver Regional District’s firefighting budget is roughly the same as the entire provincial budget allocated to paramedical services.

  • An ambulance trip costs $500.00; however the patient is only billed $54.00.
Ideas and Suggestions

Administration, Management and Dispatch
Human Resource Issues
Availability and Misuse of Ambulance Services
Costs and Funding

- Ideas about administration, management and dispatch:
  - Review the British Columbia Ambulance Service’s dispatch service.
  - Stop requiring that ambulance crews wait at the hospital until their patient is seen by a doctor, they should be able to leave to attend to the next dispatch call as soon as the patient is admitted.
  - Communications and dispatch services should be located in the most populated regional centres.
  - Adopt an ambulatory model similar to that being used in Alberta.
  - Heliports are not a routine part of a hospital emergency-ward in new facilities. Hospitals should be retro-fitted and reinforced to allow for the weight of a helicopter and a roof-top elevator to lower the patient directly to an emergency care area or operating room.
  - Merge police, fire and ambulance services into one emergency response resource.
  - Use global positioning systems (GPS) technology to better coordinate ambulances.
  - Ensure better communication between fire trucks and ambulances to prevent over-response.
  - Eliminate the overlap of emergency, ambulatory and fire services when being called-out to a first response situation.
  - British Columbia Ambulance Service management must set the criteria for the use of air evacuation helicopters.
  - Follow examples in other jurisdictions such as the United States where 911 calls can be made over the internet using voice over internet protocol (VoIP) technology.
  - Allow paramedics to access a patient’s electronic medical records.
  - Encourage ActNow measures to reduce the need for ambulance service calls.
  - Partner with communities to develop first responder programs.
  - Design and build smaller ambulances for transportation purposes only.
• Ensure that ambulances are in good running order.

• The ambulance service requires more stations and staff to achieve Emergency Medical Service industry accepted standards if they expect to improve patient outcomes which would ultimately save health care dollars.

• Ideas about human resource issues:
  - Implement an intermediate-level paramedic to substantially reduce transport times to tertiary centres.
  - Empower paramedics to treat patients in the field.
  - Give ambulance personnel the authority to deliver a patient to the nearest available treatment centre. Do not allow the patient to decide where they are to be delivered.
  - Make it mandatory that dispatchers have local geographic knowledge of their area of responsibilities.
  - Ensure that the right people possessing the right skills are the ones that are transporting patients between facilities.
  - Expand ambulatory scopes of practice. Centralize or strategically locate expert crews, or implement a combination of critical teams versus intermediate teams. Intermediate patients represent the greatest bottleneck so we need a solution that focuses on the transport of type of patient. These options require a change in the Emergency Health Act to expand the scope of practice to account for the appropriate skills needed to transport patients.
  - Ambulance attendants should have an on-line hospital connection.
  - Give paramedics the authority to treat the elderly in their own homes.
  - Provide the First Responder Certification Program free of charge or at a reduced rate to small volunteer departments.
  - Provide ambulance crews with assessment training so that they can avoid the transport of patients to hospitals when possible.
  - The new service at the Royal Columbia Hospital has hired full and part-time ambulance personnel to assist in emergencies and to relieve the crews who have to wait around.
  - Paramedic and ambulance crew should all receive the same level of training.
  - Training firefighters as first responders is beneficial. They are often the first to arrive at the scene.
  - Negotiate a new contract with ambulance service staff.
Ideas about availability and misuse of ambulance services:

- Increase ambulance service in areas that receive a huge influx of people in the summer.

- In the event of arterial fibrillation, send a doctor and a nurse in a large van equipped with portable equipment and anti-arrhythmia medication. If these measures do not stabilize the patient in the home, then transport them to emergency room.

- Investigate and encourage meaningful partnerships with local industry.

- Implement a pilot project with the British Columbia Ambulance Service that would see a sedan passenger vehicle with one crew member and one social worker for all calls in the downtown core of Vancouver.

- Use ambulatory patient vans in the place of regular stretcher ambulances to take patients to local clinics instead of emergency departments. This would have many benefits and could be coordinated using the British Columbia Ambulance Service’s Advanced Medical Priority Dispatch protocol.

- Residents in some smaller communities do not mind which hospital they end up in as long as they arrive alive.

Ideas about costs and funding:

- Keeping ambulance crews on duty in rural areas would cost less due to being able to immediately administer care to those in need.

- Additional ambulance and helicopter units are necessary, especially for highway traffic accident and collision victims.

- Purchase more helicopters for the air ambulance service.

- Increase resources in urban and metropolitan areas to reduce response times.

- Require that all ambulances charge a fee that is well in excess of what a taxi might cost. Make the fee refundable after a doctor’s visit and confirmation of a true medical emergency. Add this fee to medical insurance premiums or take it off welfare checks.

- Provide more funding and guidance for the Municipal Emergency Preparedness Program.

- Provide more funding for extrication training programs.

- Allocate more resources, funding and equipment to the British Columbia Ambulance Service.

- Consider contracting out ambulance services.
Comments on Specific Communities and Facilities

Comments and Concerns

Access to Health Care in Specific Communities
Access to Health Care and Specific Facilities

• Comments on access to health care in specific communities:
  • Campbell River needs a new facility and the Comox Valley hospital needs
    upgrading to sustain the growing population.
  • The Vancouver Island Health Authority voted to build a new hospital between
    Campbell River and Courtenay, but this will cost more money than it would to
    renew the existing Campbell River and Comox (Courtenay) hospitals.
  • There is concern that hospitals and facilities are being closed in the Vancouver
    area yet the demand to handle tertiary referrals from other areas in British
    Columbia continues to increase.
  • $25 million in funding was provided to the University of British Columbia Hospital
    for hip replacement surgeries, but no funding was provided for residents in the
    Interior of British Columbia.
  • New hospitals in Quesnel and Masset are good things.

• Comments on access to health care for specific facilities:
  • I am appreciative and thankful to be living in British Columbia as the wonderful
    medical staff at Vancouver General Hospital saved my life in 2002 with a smoothly
    run operation via a quick transition into emergency surgery.
  • I had a heart attack four years ago and an angioplasty procedure. I received
    prompt and excellent service in the cardiac ward at the Vancouver General
    Hospital.
  • There is concern about the food quality and need for expansion at the Kelowna
    Hospital.
  • There is concern about overcrowding at the Vernon Jubilee Hospital and Kelowna
    General Hospital.
  • They are building a new hospital in a hurricane zone near Massett and Port
    Clements.
  • The White Rock Hospital will be overcapacity soon and they have no plans as to
    how to deal with this flow of patients.
• There is concern about the quality and money spent on the hospital renovations in Revelstoke.
• There is concern about accessing the Trail Hospital in bad weather conditions.
• The operating room at the Oliver Hospital was closed, which makes residents go to the Penticton Hospital.
• Local residents argue that Deni House was safe and presented a petition to Government to keep it open. This facility was closed over concerns of its condition.
• Health authorities need to upgrade the Langley Memorial Hospital.
• There is concern that patients closer to the Langley Memorial Hospital have to go to St. Paul’s Hospital because there are no available beds at Langley Memorial.
• Prince Rupert Regional Hospital requires an adequate equipment budget as there is a service obligation to surrounding communities.
• The Vancouver General Hospital has a lot going for it such as its evolution as a major complex care centre and research hub. The creation of the Conversation on Health was itself an acknowledgement that there are choices to be made in the delivery of public health care. There are two paths that can be taken to move to the next level and continue to develop the Vancouver General Hospital as a world leader that generates advances in patient care for British Columbians, or, alternatively, to stall and lose momentum.
• There is concern over the closing of the Delta Hospital, as it was the only hospital had been supported by the citizens of the Ladner/Tsawwassen area.
• The Lion’s Gate Hospital in Vancouver has a very good garden for patients but it needs to be enclosed.
• The Sacred Dove Hospital has provided good service.
• There is concern that the St Vincent’s Hospital had an excellent hip surgery program, but the hospital was torn down to make way for a sky train.
• Wait-time in Kamloops has decreased due to new equipment and additional staff.
• People teaching about Type 2 diabetes at Burnaby Hospital are great, but there was a five month wait-list to get in the course.
Ideas and Suggestions

Access to Health Care in Specific Communities
Access to Health Care and Specific Facilities

- Ideas about access to health care in specific communities:
  - Provide another hospital to receive trauma patients in the Fraser Health Authority.
  - Fundraise for the Sunshine Coast hospitals through lotteries.
  - Give specialists in the Comox Valley more access to operating rooms.
  - Build a new hospital for the West End of Vancouver.
  - Do an analysis of the hot spots that need mobile attention in the Vancouver area.

- Ideas about access to health care for specific facilities:
  - Maximize the potential of the Vancouver General Hospital as a coordinated complex care center, as this hospital has the capacity to grow and already draws thousands of workers and patients to its precinct every day. It would also make the most of the potential to increase the interaction between specialists and researchers at this site.
  - Increase the size of the Royal Columbian Hospital to meet demands of a growing population.
  - Maintain the existing functions of the McBride and District Hospital, including emergency, acute and long-term care, laboratory, x-ray and outreach to the community.
  - Create a cardiac center for the interior of British Columbia such as in Kelowna.
  - Expand the St Mary’s Hospital including the emergency department.
  - Make a provision for a dental surgical suite at the Kootenay Boundary Regional Hospital with appropriate equipment and on-call staff.
  - Mount Saint Joseph Hospital should be kept open as a full service hospital and 24 hour Emergency room.
Wait-Lists and Wait-Times

Wait-lists and wait-times are important issues to many British Columbians and figured prominently during the Conversation on Health. Some of the concerns raised included the demands placed on the health care system, equality of access to care, the negative effects that waiting can have on patients, and wait-list management. Here is a selection of what British Columbians had to say on the subject of wait-lists and wait-times.

Demand Management

Participants indicate that a universal health care system is a good model, but if it is to be sustainable, then it is important to find ways to manage the demands placed on it. Participants are concerned that public expectations are overburdening the health care system and go far beyond what was originally envisioned when Medicare was created. Others would like to see more accountability on how resources are used by health care providers and consumers, as well as more public education on the design, capacity and cost of the health care system. Participants, for the most part, agree that we need to inform the public about what the system is and what it can provide.

Participants talked about managing demand by defining the level of services that the health care system should provide. They offer a range of ideas on how to determine this, including: offering no extra care until everyone has basic health and dental care; setting a minimal level and anything over and above this level would be defined locally; setting priorities either by defining what is medically necessary; or, establishing a list of clinical priorities. While there is no consensus, most agree that in order to determine the level of services that the system should provide, Government needs a coordinated approach to health care planning that focuses on demand management, facilities management, and human resource management.
General Comments on Access

Throughout our consultations, there were many discussions on wait-list management, equality of access to care, and the effects that waiting can have on patients and their families. The majority of participants think that wait-lists are too long and are symptomatic of a problem with equality of access to care. They suggest that queue jumping occurs when patients seek private care or if they belong to special organizations such as the Insurance Corporation of British Columbia and WorkSafe BC. To address these concerns, most participants believe that Government needs to focus on providing a more responsive primary care system that is delivered in a holistic and integrated manner. Participants recommend: delivering health care services through alternate practice settings such as mobile or 24 hours a day and seven days a week clinics, finding ways to increase the number of primary care providers, and increasing the ways that we can access providers such as by phone, email, group visits and extended hours.

When you apply early intervention and address health concerns in a timely, holistic and coordinated manner, you reduce waitlists, better manage illness and achieve wellness faster.
- Health Professional Meeting, Prince George

Participants widely agree that long wait-lists lead to further health issues, chronic problems, and result in a poorer quality of life. To mitigate these effects, they suggest Government should find ways to offer care to waiting patients before their affliction becomes disabling or causes further damage.

Funding and Health Care Models

Participants want funding increases in areas that they see would have the greatest effect on improving wait-lists. Facilities, equipment and human resources were the most commonly suggested areas for funding increases. Others want funding to target rural communities in order to meet the needs and priorities of local populations.

Participants widely debated the role of the private sector in addressing the length of wait-lists. Some participants feel that a two tier system would exacerbate multiple wait-lists while others believe that we should use private clinics to shorten wait-lists. Some support a mixed model of public and private delivery to shorten wait-lists. A number of participants believe that discussions around delivery models and the public private mix should continue.
Administration of Wait-lists

Many participants voiced concerns on the efficiency and accountability of wait-list management, and others focused on the need for improved access to wait-list information. A number of participants are aware of the Provincial Surgical Services Project that tracks patients waiting for elective surgeries in British Columbia, but many participants either question the accuracy and comprehensiveness of this site or do not know that it existed. The Saskatchewan Surgical Care Network is highlighted as a good model of a comprehensive surgical database. Alberta is also recognized for its efforts to reduce wait-times for certain surgical procedures as it implemented a standardized referral tool and developed a single point of entry.

Many participants said that long wait-times for medical care and attention were unacceptable. To identify and track wait-times, participants argue for more accountability in the system, primarily by setting meaningful guarantees and benchmarks based on medical outcome evidence.

*Establish 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. This fund should be created to support patient care costs as part of the introduction of wait time benchmarks.*

– British Columbia Medical Association, Submission

Innovation

Participants widely recommend that Government learn from and build on Canadian projects and international primary care systems that have successfully reduced wait-lists and wait-times. Participants cite examples such as the University of British Columbia’s Centre for Surgical Innovation, the Richmond Hip and Knee Reconstruction Project, the Alberta Hip and Knee Replacement Project, the North Shore Joint Replacement Access Clinic, and Mount Saint Joseph Hospital’s cataract and corneal transplant program. Participants also look to some international primary care systems such as the approach taken in New Zealand, which introduced clinical prioritization for elective surgery as a way to reduce wait-lists.
Conclusion

Over the course of the Conversation on Health, many participants advocated for a reduction in wait-lists and wait-times. They also voiced concerns related to the apparent queue jumping facilitated by private sector service provision or through other avenues of access to care, such as the Insurance Corporation of British Columbia and WorkSafe BC. Many participants also expressed a strong desire to reduce inefficiencies in the system and emphasized the value of taking a collaborative approach in meeting the health care needs of British Columbians such as sharing facilities, targeting funding, and learning from innovative projects and systems. Others emphasized increasing access to wait-list information, suggesting this would provide clarity to patients around their expectations and tools to Government and doctors for better management of wait-lists.

*Wait times are really the result of a complex interplay between needs for care, the capacity and organization of services and public preferences and expectations. They are rarely simple, silver bullets, much as we might all like one. The answers tend to be multifaceted and implementation usually requires hard work and often difficult choices.*

– International Symposium, Vancouver
Wait-lists and Wait-times

This chapter includes the following topics:

- Wait-lists and Access to Health Care
- Management and Administration of Wait-lists
- Health Impacts of Wait-lists
- Funding and Health Care Models
- Innovation

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

- Four Initiatives for Health Care Change in BC
  Submitted by the Cogentis Health Group
- Is BC’s Health Care System Sustainable?
  Submitted by the Canadian Centre for Policy Alternatives
- Physicians Speak Up
  Submitted by the British Columbia Medical Association
- Why Wait? Public Solutions to Cure Surgical Waitlists
  Submitted by the Canadian Centre for Policy Alternatives
- Sunshine Coast Conversations on Health
  Submitted by the Women’s Health Advisory Network, the Sunshine Coast Hospital and Health Care Auxiliary and the Seniors Network Advisory Group
- Conversation on Health Submission
  Submitted by The UBC College of Health Disciplines and The Interprofessional Network of BC
- HEU Submission to the Conversation on Health
  Submitted by the Hospital Employees Union
- Report to the Conversation on Health
  Submitted by the BC Cancer Agency
- A Vision for Better Health
  Submitted by the British Columbia Dental Association
- Submission to the Conversation on Health
  Submitted by the British Columbia Nurses’ Union
Wait-lists and Access to Health Care

Comments and Concerns

Leadership and Structure of the Health Care System
Wait-lists and Access to Health Care
Wait-lists and Access to Health Care for Specific Populations

- Comments on leadership and structure of the health care system:
  - While there are a number of outstanding initiatives in British Columbia to reduce wait-times for elective surgeries, Provincial leadership has not appeared. Many of these projects exist in pockets of the system rather than throughout its entire fabric.
  - Long waits for hip and knee surgeries over the last few years reflects both a lack of resources and a lack of political will on the part of Government to pay for the work being done in a timely manner.
  - Long wait-times do not exist in isolation, but are symptomatic of deeply entrenched dysfunctions within the system. Drastically reducing and in some cases ending unreasonable wait-times requires transforming the system to put patients at the centre of the action.
  - Canada has one of the most expensive systems in the world, but one which delivers some of the worst wait-times and care when compared to other developed countries.
  - Lengthy wait-times for elective surgeries are at the core of many British Columbians' frustrations with public health care. Until public solutions are implemented province-wide, Medicare will not reach its true capacity to meet our health needs.
  - There is nothing wrong with our health care system right now. Long wait-times are propaganda from the media and people who are not critically ill. As a cardiac patient, I have always had reasonable wait-times.
  - Although close to 85 per cent of Canadians say they are very satisfied or somewhat satisfied with the overall way health care services are delivered, too many are anxious, frustrated and angered by untimely waits to see a specialist, get diagnostic tests or undergo elective surgery.
• The Conference Board of Canada reports that British Columbians register a high level of dissatisfaction with service delivery (especially hospital wait-times) even though the Conference Board ranks British Columbia’s health care system first in Canada.

• Wait-times are the result of a complex interplay between needs for care, the capacity and organization of services as well as public preferences and expectations. There is no easy single answer. Answers tend to be multifaceted and implementation of them usually requires hard work often with difficult choices.

• To a significant degree, the health care system is asked to perform more surgeries simply because it is more capable than ever of relieving a patient’s pain and suffering and increasing their quality of life. Of course, this is a good thing, but the effect of more people demanding more surgery is longer wait-lists.

• We do not pay enough attention to the signal problem in Canadian health care, which is more quality related then it is access. This does not mean that there are no access problems and we do need to address them, but quality is the bigger problem.

• Too often we cannot get care for a small health problem until it becomes a life or death situation, which costs significantly more money than the small problem would have cost.

• 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 and actually increase waits in non-targeted areas.

• All technologies and services should be available immediately for the management of health. However, it is the wait-list that throttles the insatiable demand for these resources. In other jurisdictions, out of pocket expenses and Health Maintenance Organizations take care of throttling demand. Wait-lists work to solve this problem, but they are inefficient, as waiting for treatment can incur all sorts of tracked and hidden expenses on the health care system and society as a whole.
Comments on wait-lists and access to health care:

- Across a number of key areas, the British Columbia health care system is performing substantially more surgeries than it would from population growth or aging alone. Yet despite the increase in surgeries, wait-lists are still an issue because technology has increased demand as well as the number of people who can avail themselves of such surgeries.

- Long wait-lists deny citizens prompt emergency attention.

- People on wait-lists are basically held hostage by the medical system and cannot do anything. This is because they wait in eager expectation for the call to confirm their procedure, but the schedule keeps changing and the scheduled date keeps being pushed farther away.

- Wait-lists have improved so critical patients can get what they need.

- All you ever hear about in public discussions are wait-lists.

- The sole determinants of a population’s health is not, as many would suggest, the wait-lists for Medical Resonance Imaging (MRI) and joint arthroplasties.

- I found out that I had an inguinal hernia but I was informed that there was a nine month wait-list. I did not want to wait so I went to the United Kingdom where I had the procedure in one week.

- I am currently off work due to an injury and my insurance company will only pay for three months. During these three months I must see a specialist and submit a Magnetic Resonance Imaging (MRI) report. However, I have to wait five months to see the specialist and six months for Magnetic Resonance Imaging (MRI). I am now forced into making a choice to wait or pay for it privately.

- There are wait-lists for elective surgeries but none for abortions.

- Many people wait far too long for services, yet are denied the right to do anything about it.

- There are no wait-lists if you are a Member of the Legislature, as you get immediate medical assistance. This is wrong.

- Are there any professional sports players or labour union members on a wait-list for procedures?
There is too much queue jumping by people going to other countries to get surgical procedures done, or through affiliation with special groups such as Worker's Compensation Board, Department of National Defence, the RCMP and well placed individuals within the system.

The serious problem of wait-lists means that accessibility to health services varies by problem area and by region. The principle of equal access is violated in practice every day in every province.

There is a one year wait for most procedures, but if you are a nurse, laboratory technician or even just know someone in the hospital you can have the procedure much sooner.

What consideration is given to people who are on medical wait-lists and are the sole providers for their families? For example, a self-employed businessman can be financially ruined by having to wait for a medical procedure, not to mention the aggravation of seeing their livelihood and business destroyed and not being physically able to do anything. The willpower is there but because of a medically necessary procedure that is wait-listed they cannot physically do anything.

Access to health care is wonderful despite wait-times.

Here is a sampling of the types of wait-lists that many consider too long:

a. assessments and access to primary care;
b. referral and access to specialists;
c. surgeries such as joint replacements and cataracts;
d. diagnostic procedures such as Cat Scans and Magnetic Resonance Imaging (MRI);
e. care services such as home support, adult day care programs and day hospital programs;
f. assisted living, residential care and extended care provisions for the disabled and elderly;
g. assisted devices such as wheel chairs and walkers;
h. beds, including respite, emergency and crisis from home;
i. medical attention and treatment in emergency departments;
j. mental health services and counselling; and for
k. rehabilitation services.
Comments on wait-lists and access to health care for specific populations:

- The current system is not working for marginalized and rural communities such as the homeless, First Nations, rural, and so on.
- Women have special needs for health care such as needing:
  a. to see a female doctor;
  b. to have medical procedures that are less intrusive;
  c. access to community-based alcohol and drug addiction treatment services;
  d. greater awareness surrounding post-partum depression;
  e. homeopathy to be covered and free prescription medications;
  f. access to unbiased information about pharmaceuticals;
  g. a women-only emergency shelter in the Downtown Eastside of Vancouver, British Columbia;
  h. more income and housing assistance;
  i. more hiring of First Nations women; and
  j. more education for doctors on violence against women.

- The current wait-time initiatives ignore children. For example, 65 per cent of children in this country are waiting a medically unacceptable period of time for health care.

There is concern that elderly people waiting to have medical treatment or attention will have to return to work or find other funding sources to pay for necessary medical procedures and transportation to the hospital.

- There is a concern that elderly people are taken to emergency in an ambulance and scheduled for a diagnostic test but are then sent home to wait for the test.

The dentists’ drafted bylaws made reference to the practice of certified Dental Assistants within Government public health programs. The draft dentists' bylaws reference certified dental assisting practice within government public health programs. These bylaws do not address the needs of specific target groups such as the homeless, working poor, the disadvantaged, new immigrants, and First Nations. These are marginalized populations who have little or no access to oral health promotion and preventive services.

Additionally, the draft omits protocols and delivery of service in long-term care, seniors' residential care institutions, and home care despite a growing need for professional assistance in all of these chronic care situations.

**Ideas and Suggestions**

**Leadership and Structure of the Health Care System**

**Wait-lists and Access to Health Care**
Wait-lists for Specific Groups and Marginalized Populations

- Ideas about leadership and structure of the health care system:
  - Ensure there is a fair system for wait-times that are similar province wide.
  - Ask the public how long they think they should wait for a particular service as a starting point.
  - Initiate a public awareness campaign that helps people understand that some waiting for certain procedures is not unreasonable.
  - Set up an accountability system set up to ensure that people receive quality care in a timely manner.
  - Solutions for long wait-lists exist in our public system and include applying new technology and techniques, using public clinics, and improving work conditions and decreasing overtime to retain staff.
  - Have a wait-time advocate to engage politicians and inspire care providers to address wait-times.
  - To reduce wait-lists focus on improving efficiency and ensuring appropriateness and equity of care need. Knee-jerk reactions which throw more money at the system in the hope of increasing patient flow will not remove the problem.
  - Better management of wait-lists requires physicians to make the shift from working individually to working in teams with their specialty group, with primary care physicians, and other members of the health care team. These changes would require leadership from the Provincial Government which to date has not been 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.
  - Give the public the opportunity to share their thoughts, comments, concerns, ideas and solutions on wait-lists.
• Ideas about waitlists and access to health care:
  • Identify areas around British Columbia that are most in need and hire staff from
    other provinces on a limited basis to clear the backlog.
  • To reduce wait-lists we need the equivalent of 24 hours seven days a week walk-in
    clinics associated with emergency departments because many people do not
    know whether their problem is urgent or not, do not have access to a family
    doctor or cannot schedule their illnesses for convenience.
  • Extend the hours of medical clinics and triage centers to provide medical
    attention to people after hours and reduce wait-lists and visits to emergency
    wards.
  • Apply early intervention and address health concerns in a timely, holistic and
    coordinated manner to reduce wait-lists, better manage illness, and achieve
    wellness faster.
  • Reduce wait-times by defining medically necessary procedures.

• Ideas about specific groups and marginalized populations:
  • Provide resources and create more awareness for sufferers of chronic health
    diseases. This includes increasing affordability of medications and vaccinations
    for chronic health disease clients and hiring a chronic health disease advocate to
    put these things in place.
  • Ensure youth have access to medicine, a decent health care system, and
    information.
  • Share knowledge and best practices to improve wait-list management,
    particularly those wait-lists that affect children and families.
  • Change legislation that says that low income families who do not qualify for any
    provincial subsidized programs but may be able to afford one visit per year per
    family member with a dental hygienist, must be examined by a dentist before
    they can have preventative health services by a dental hygienist. This is an
    additional expense which makes access to preventative dental care prohibitive.
Management and Administration of Wait-lists

Comments and Concerns

**Quality and Efficiency of Wait-list Management**
**Wait-list Management for Specific Illnesses and Procedures**
**Wait-list Management in Other Jurisdictions**
**Bed Management**
**Surgical Wait-list Databases and Registries**
**Wait-list Measurement, Benchmarks and Guarantees**
**Wait-lists and Wait-times and Health Care Professionals**

- Comments on quality and efficiency of wait-list management:
  - Wait-lists do not appear to be well managed or organised.
  - Wait-lists are unmanageable and overwhelm doctors and nurses.
  - Wait-lists are determined by categorising the procedure into elective or life-threatening, but the elective category includes such a broad scope of care that it plugs up the system.
  - There is little debate that long waits are unacceptable for certain surgical procedures. There is less agreement regarding what to do about it. Some researchers describe waiting lists as a function of a funnel and spout. Wait-times depend both on how many people are told that they need a service (the funnel) and how many people are regularly receiving it (the spout). Increasing capacity for one service can increase the size of the spout, but without other changes, may make the spout for another service smaller. At the same time, increasing capacity can cause physicians to refer more patients for that service, thereby increasing the size of the funnel. If both of these occur, more people may well be receiving the service, but wait-times may not be affected at all, or may even increase.
  - Wait-times and delays for care are not usually due to a lack of resources, but to poorly organized services. Shoddy or non-existent coordination, lack of flow and lack of consistency are some of the organizational problems contributing to health care bottlenecks. Inconsistencies or variations slow the flow and delay needed interventions. For example, every day valuable operating room time is taken up by the re-making and re-supplying of operating rooms according to the individual preferences of surgeons, even those doing identical procedures. Variation on any point along the continuum of care slows the system down. Most
variation, however, arises from inefficiencies in the system and not from unpredictable elements such as changes in a patient’s condition.

- The recent agreement between the British Columbia Ministry of Health and Health Authorities may significantly limit the Province’s ability to rectify the wait-list problem. This agreement appears to leave much of the wait-list management and coordination to individual physicians. It also appears to restrict the ability of Health Authorities to re-direct patients.

- Wait-times cannot be effectively reduced without substantive improvements to the province’s operating room strategy.

- The issue is getting the best service when needed without having to pay for that service out of your own pocket. If the health services were managed correctly there would not be an issue of wait-lists and extra costs.

- Wait-lists are lengthening due to a lack of preventative measures.

- Wait-times are due to a lack of solid, hard-nosed management of hospitals.

- Regionalisation has improved wait-list times.

- People with priorities get quick treatment.

- Length of stay data has shown huge decreases due to improved technology and moving people quicker.

- The focus on wait-time priority areas has not crowded out other types of surgery, although trends do vary across the country for specific types of surgery. There is a concern that the public’s information indicates British Columbia has doctors available, available operating rooms, and diagnostic equipment but we do not have an operational management system in place to co-ordinate it all.

- There is a lot of skepticism concerning the information provided about wait-lists.

- Wait-times for some services such as laboratory tests and radiology are done quickly and locally, but there are long waits for diagnosis and treatment.

- If wait-lists are getting longer we need to be able to do a blitz to reduce them and then go back to normal procedures.

- There is no average patient and no average wait-time, as we are dealing with situations that vary by the type of care needed, the sense of urgency, which wait-list the patient is on and what organization manages that wait-list, as well as other factors related to an individual patient’s conditions.

- Comments on wait-list management for specific illnesses and procedures:
• Wait-lists for hips and knees are down from two years to about 12 to 14 months. This is still not good, but it is better. The protocol and wait-lists for diabetics to receive pancreatic surgery is too restrictive in British Columbia.

• Lower-joint care is currently delivered on a position-in-cue not need basis. The system must provide people the care that they need when they need it, not in relation to their position in the cue.

• There are short wait-times to treat breast cancer.

• Comments on wait-list management in other jurisdictions:

  • An Irish study converted a time-based waiting list to one based on clinical need resulting in a substantial decrease in the waiting list.

  • One Toronto hospital reduced wait-times for lung cancer by making changes to scheduling and referral practices, adopting performance standards and improving multi-disciplinary communication. As a result, wait-times were reduced by 71 per cent.

  • In 2004, Ontario launched its Wait-Time Strategy, a multi-pronged effort to reduce wait-times that cost almost a billion dollars. Ontario targeted five high demand areas: cardiac revascularization procedures, cancer surgery, cataract surgery, hip and knee joint replacements, Magnetic Resonance Imaging and Cat Sans. The strategy's first goal was to reduce times for 90 per cent of patients waiting for treatment in those areas by December 2006. That goal has been achieved, albeit more successfully in some areas than others. According to the government's latest update (September 2006), it met all targets for cancer and cardiac bypass surgery, but has not yet for other areas

  • Alberta reduced wait-times for hip and knee replacements by implementing a standardized referral tool, a single point of entry as well as other organizational changes. As a result, wait-time to see a specialist has fallen from eight months to six weeks. Alberta has also decreased the time required to go from decision to operate to actual surgery by optimizing patients' conditions and implementing alternative plans for care.
• Comments on bed management:
  
  Poor bed management leads to longer wait-times. A sampling of British Columbians concerns on this include:
  
  a. poor exit planning so patients occupy beds longer than necessary;
  
  b. blocking beds to indicate that they are full when they are not;
  
  c. patients using beds while waiting for beds in other areas;
  
  d. lack of recovery beds; and
  
  e. patients occupy beds who would be better off in a long-term care facility or at home with quality home care.

• Comments on surgical wait-list databases and registries:
  
  British Columbia's current internet wait-list registry is inaccurate, inconsistent and difficult to use as a management tool. On the whole, information on surgical services in British Columbia is out-dated, as it is elsewhere.

  At the base of the wait list discussion and the proposed provincial surgical registry is the unwritten concern that some may view specialist services as interchangeable; that both quality and outcomes are similar for patients and their agent, their family physician. The traditional model has reinforced a different relationship; the system regulator prefers to have the quality of this specialist services observed by another physician through referral by a primary care physician. At the centre of the wait list discussion we therefore find an attempt to change the pattern of referrals raising questions for change managers and policy makers in a number of areas: costs of developing referrals, issues of ownership of waiting lists, list sharing, valuation (goodwill), cost recovery for maintaining lists, and access to surgery to the extent that the length of wait lists are factors in determining surgical block allocations. All of these open issues are change related and until resolved create system-culture tension.

  The new Surgical Patient Registry is way too comprehensive and not accepted by all physicians.

  There is not one source for the general public to find wait-list information for both private and public facilities for certain services in British Columbia. This information seems to be scattered on the internet amongst various web sites.
There is concern about the accuracy of the provincial wait-list website. According to this website, the median wait for the surgeon that I have is 11 weeks. However, I have already been waiting nine weeks and was informed that it will take up to at least 12 more weeks.

The Saskatchewan Surgical Care Network (SSCN) is the most comprehensive surgical database in Canada and the foundation for several other provinces currently implementing their registries, as it is a pro-active rather than passive system. Pro-active registries start with firm and daily updated data gathered in a consistent and standardized way. This information can then be used by patients, physicians and more importantly health authorities to shorten wait-times for care. Active registries are more about managing wait-times than they are about reporting wait-times. It must be emphasized, however, that no registry and no wait-list whether it is active or passive prevents patients from choosing a specific surgeon. Patients always have the right to choose who will perform their particular procedure; however, depending on their choice they may have to wait longer.

Two years ago, the Province launched the Provincial Surgical Services Project, an ambitious collaborative effort between the Ministry of Health, the Province’s six health authorities, practicing surgeons, the British Columbia Medical Association, the University of British Columbia’s Faculty of Medicine and the British Columbia Medical Services Commission. The goal of the Provincial Surgical Services Project is to reorganize surgical care to make it fairer, timelier and more appropriate for patients. After more than two years and five million dollars in capital funding, its new British Columbia Surgical Patient Registry is approaching completion. This real-time, web-based registry is capable of reliably tracking all patients waiting for all elective surgeries in British Columbia.

The provincial surgical wait-list is difficult to understand, as it has no common definition, criteria or rules.

Comments on wait-list measurement, benchmarks and guarantees:

- There is no comprehensive and consistent measurement for wait-lists.
- People want a hard number to inspire confidence. It is the uncertainty that puts people off, not the length of time. We know that the overall number of surgeries is up in priority areas, but we do not actually know what effect this is having on wait-times because we do not have comparable data to track wait-times and trends across the country.
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. 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. British Columbia is to implement an eight week guarantee for radiation therapy for cancer by 2010. However, the average wait-time for radiation therapy in British Columbia 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 British Columbia Government does not meet this mark.

Government imposed wait-list guarantees for a few procedures simply do not measure up. With inflexible funds and health care human resources, wait-list guarantees simply serve to reallocate precious health care resources to issues at the top of the political agenda.

The doctor or health care provider is the first person to visit so represents the first wait-list. The referral to the specialist is the second wait-list. We need to agree on a true standard wait-list.

Comments on wait-lists and wait-times and health care professionals:

- Long wait-lists cause inefficiencies in the system such as nurses performing administrative tasks.

- The surgical process before, during and after an operation is technically complex and multi-faceted. It includes preparation for surgery, hospital admission, anaesthesia, surgical procedure, recovery and involves a wide range of health professionals working in different areas in a hospital and community. Traditionally, the system has relied on individual physicians and their office staff to manage and direct the many steps in this process. For example, it is up to surgeons and their office staff to make multiple appointments for patients with specialists, laboratories, radiology facilities and operating rooms. Because one appointment is often dependent on the outcome of another and because no one is organizing patient traffic as a whole, congestion can occur at every stage.

- Currently within health care delivery systems, it is not in the interest of patients or medical practitioners to spend time screening for and treating those issues which can be addressed expeditiously and effectively with routine, non-invasive, cost effective chiropractic treatment.
• Doctors that retire leave orphaned patients who have to wait a long time to find another doctor and receive medical attention.

• Wait-lists are long because there are not enough health care professionals, especially specialists and anaesthesiologists.

• Government could open operating rooms, but surgeons only have so much time to spare to do the procedure. This is because they are just as concerned about operating an office to generate the wait-list.

• People want to visit their family doctor instead of a walk-in clinic so they do not have to wait. However, people have to wait one week or more to see their doctor and then wait again in the doctor’s office because the doctor is so backlogged.

• To make wait-lists shorter doctors need to ensure that the right patient has the right procedure. This may mean not having the procedure at all. Although seldom discussed in the media some medical interventions are inappropriate because they are needless or may actually do harm. If those patients who would not benefit from a surgery were screened out, then wait-lists would be shorter.

• There is a concern that people have to wait for many months to see a surgeon and then they still have to wait for the necessary procedure.

• I work for a rheumatologist. Our referrals to orthopaedic surgeons, Magnetic Resonance Imaging (MRI), cat scans and bone scans are unacceptable. A one year wait for Magnetic Resonance Imaging (MRI) and a two-year wait to see an Orthopaedic Surgeon are unreasonable.

• The present system used for surgery wait-lists has a patient assigned to a specific surgeon’s wait-list. If this surgeon stops practicing then the wait-listed patient is moved to the bottom of a new surgeons list. This is an unfair and potentially dangerous situation since a person can be lost in the system and have their wait-time extended because of circumstances beyond their control.

• There is a concern that doctors double book patients (two patients per five minute time slots) so doctors can maximize their income and force patients to wait over an hour to see them for less than two minutes.

• Wait-times must take into account the time that one has to wait to obtain a doctor’s services, get the necessary investigations and then wait to see a specialist.

• Wait-lists to see specialists will increase by additional referrals from Nurse Practitioners.
Ideas and Suggestions

Quality and Efficiency of Wait-list Management
Priority Wait-lists and Patient Flow
Wait-list Management for Specific Illnesses and Procedures
Bed Management
Surgical Wait-list Databases and Registries
Information Systems
Wait-list Measurement, Benchmarks and Guarantees
Wait-lists and Wait-times and Health Care Professionals

- Ideas about quality and efficiency of wait-list management:
  - Make all wait-lists public.
  - Ensure patients receive their test results in a more timely fashion.
  - Review referral processes, manage schedules more effectively and utilize community for more traditional tertiary services to shorten wait-lists.
  - Create two wait-lists, one that elective and one for non-elective surgery.
  - There needs to be strategic and objective planning to reduce wait-lists.
  - Wait-list management should start with diagnosis.
  - A third party such as the Health Authority or a committee should take over wait-list management.
  - Go back to three care diagnosis: life-threatening; necessary care (not immediate but required to assist in quality of life); and elective but not medically necessary.
  - Understand the clues contributing to long wait-lists to enable them to be reduced. For instance, patients transferred between hospitals and those who arrive at hospital on a week day rather than a weekend will likely have a longer wait-time, while those admitted to large community or teaching hospitals may have less of a wait-time.
  - Reduce wait-lists by ensuring that tests and procedures are done in one visit.
  - Ensure comprehensive utilization of resources from home to facility and back to home including human resources, equipment, beds, home care and support without spending more.
  - The Health Authorities should maintain wait-lists on a single, coordinated list.
• Adopt a single common waiting list rather than a multitude of lists managed by individual doctors or facilities.

• Adopt queuing strategies to improve current organizational processes.

• Eliminate wait-times for Medical Resonance Imaging (MRI) by offering this service in the communities, like x-rays and ultrasounds are.

• Reduce wait-lists by identifying certain hospitals as having operating or diagnostic testing services that cannot be bumped by emergencies.

• Jumping a surgery wait-list for medically covered services should not be allowed unless the service is provided by a physician that is not enrolled or has de-enrolled from the British Columbia Medical Services Plan.

• Before services are provided to those on wait-lists there should be a medical evaluations and advice to determine a patient’s degree of pain, discomfort, and inability to lead a normal life.

• Find out how much time doctors can safely spend in surgery each week and then provide them the operating room time to be able to do it.

• Have an impartial board of health care professionals determine wait-time guarantees then find the resources for a publicly funded health care system to meet those guarantees.

• Reduce wait-lists by focusing on health promotion like subsidising gym memberships, providing support to help people quit smoking, and providing information and cooking lessons in schools to promote healthy lifestyles.

• Patients who are bumped from scheduled surgery for emergencies should not go to the bottom of the list, but should be rescheduled as a priority.

• Remove the waiting room in emergency departments. If there is no waiting room, then perhaps people may shift toward information centers where people could be educated while they wait.

• Analyse what the statistics on wait-times are really saying. One person wrote that they waited for one year for eye cataract surgery because he wanted a specific surgeon. He said that he could have had the surgery sooner by going to a different doctor.

• Focus on how many surgeries should be done in this population, rather than how many surgeries have been done.
• Redefine what an elective surgery is. When a patient is in pain 24 hours and seven days a week, it is not elective.

• Make hospitals that are in close proximity to each other specialize in certain areas.

• It has been mandated that urgent cataract surgery should be done within four months. One specialist writes that he is unable to come close to maintaining this standard due to the chronic lack of operating room time available.

• The question of what are safe wait-times can only be answered by doctors and they are currently working to establish those times.

• Ideas about priority wait-lists and patient flow:
  • We need variation in processes and patient flow to reduce wait-lists not just to provide more access.
  • Eliminate priorities for special groups such as Worker's Compensation Board, Department of National Defence, the RCMP and prisoners.
  • Adopt pre-surgical programs that prepare patients physically and mentally for surgery.
  • Create a priority wait-list for patients who have had previous diagnosis and surgery because doctors have access to their previous medical history.
  • Prioritize wait-lists based on need and personal actions. This would include a point system where smokers and obese people get fewer points for their lifestyle choices and therefore would have to wait longer for services.
  • Prioritize patients on wait-lists according to the level of care that they require.
  • Implement and support the effective solutions that can reduce bottlenecks and improve patient flow for elective surgeries, these include:
    a. pooling patients onto a common wait-list;
    b. pre-screening and educating all patients facing surgery;
    c. discharge planning before surgery;
    d. ensuring that home care arrangements are in place to decrease the chance patients will need re-admission;
    e. begin all surgeries on time to lessen the chance of backup;
    f. standardize surgical equipment by procedure rather than by surgeon preference to assist operations to be done more efficiently and to enable bulk buying of equipment;
g. when appropriate, physician preference information needs to be current and easily accessible;

h. booking groups of similar procedures together;

i. modernizing electronic information systems;

j. standardize patient care protocols to ensure all patients receive the best post-operative care; and

k. support advanced practice Registered Nurses and Nurse Practitioners who can be trained for such roles as anaesthetist or surgical assistants.

• Ideas about wait-list management for specific illnesses and procedures:
  • Reduce wait-lists for drug addiction treatment centers.
  • Patients who are waiting for cancer treatment should be prioritized to a maximum wait-time thought to be reasonable for that disease.

• Ideas about bed management:
  • Patients who are discharged early for bed utilization do not lose procedural priority.
  • A British report noted that the single most important way to improve wait-times in emergency and to reduce the number of cancelled surgeries is to ensure more beds are available. One of the main ways to guarantee more beds is to improve community care, yet British Columbia has moved in the opposite direction. According to a 2005 report by the Canadian Centre for Policy Alternatives, access to long-term care and home health services decreased significantly between 2001 and 2004, in spite of an aging population and cuts to the acute care system. Thus, expanding community health care represents another vital means of taking pressure off the more expensive acute care system and enhancing the flow of elective surgeries.
  • Improve bed management to reduce wait-lists.
  • Provide more long term-beds outside of hospitals.

• Ideas about information systems:
  • Create a Province-wide referral system for surgery and diagnostic testing to reduce wait-times.
  • Implement a common system for reporting with common definitions such as the Calgary data system.
• Implement a system to evaluate wait-list status.
• Hospitals need to create a booking system to manage wait-lists collectively and use electronic health records.
• Faster reporting of test results such as by electronic reporting would reduce waiting time.
• Allow patients transparent access to existing assessment diagnostic and treatment options.
• Educate people on the facts of wait-lists, so they have more than the emotional media hype on the fear and/or loss of services.
• Wait-list management is about developing a global approach driven by fair, transparent and commonly defined data that meets the local patient population needs, not provincial targets, and focuses on improved triage systems.
• Give patients waiting in emergency rooms an idea of where they were on the list by using a numbering system or something similar.
• Institute a wait-time information system, similar to the system in Ontario, that hospitals have the option of joining.

• Ideas about surgical wait-list databases and registries:
  • Provide patients the ability to see what the wait-list times are for individual surgeons.
  • Coordinate universal and standardized assessment for surgery wait-lists.
  • Establish an on-line system to allow patients to compare time for elective surgery at various hospitals. This would allow those patients who are healthy enough and have adequate financial resources to travel to other facilities thereby helping to balance out the workload of institutions.
  • Reducing wait-times requires a set of enhanced management tools such as central registries like the Surgical Waitlist Registry, clinical guidelines, best practices, information technology, financial incentives, overcapacity protocols and clinical prioritization tools. For instance, the Surgical Waitlist Registry provides a standardized tool for surgeons to prioritize patients on wait-lists, so British Columbia has a more consistent and accurate approach to managing wait-lists for all surgeries. This registry improves the accuracy and reporting of wait-list data to ensure that patients with the highest urgency are served first.
- Reduce surgery wait-lists and wait-times in emergency departments by introducing heavy performance-based financial penalties and bonuses for medical administrators.

- Identify maximum timeframes for meeting the medical needs of our population. For instance, if it is critical, it should be dealt with in a specific amount of time, if it is surgery, such as a hip replacement, it should be dealt in a specific amount of time and so on. Without a base line, people are waiting years for surgeries that would improve their quality of life.

- Review the new Surgical Patient Registry and scale it back to a manageable product.

- Ideas about wait-list measurement, benchmarks and guarantees:
  - British Columbia should establish maximum wait-times and then abide by them.
  - If British Columbia truly wants to better define accessibility in law, then it must have the courage to implement meaningful guarantees.
  - Set performance measures and benchmarks in the system to promote accountability.
  - Implement overall monitoring and benchmarking based on best practices to get wait-list management data that government can trust.
  - Follow the British model to set hard targets for maximum wait-times.
  - Set realistic targets for elective and urgent procedures.
  - Define and communicate targets for wait-lists and track performance in meeting targets.
  - Set specific timeframes for particular processes such as blood tests and injections.
  - The British Columbia Government should establish evidence based wait-time benchmarks that 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.
  - Continue and expand the work of the Canadian Wait-Time Alliance, which is preparing clinically driven benchmarks in the areas of emergency, psychiatric care and reconstructive surgery. These benchmarks will extend the focus beyond the
five priority clinical areas and begin to provide benchmarks across the continuum of health care services.

- Educate and support patient knowledge about wait-lists so the patient is part of the team.


- 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, whose members include eleven medical specialty societies and the Canadian Medical Association. In 2005, the Wait-Time Alliance established evidence-based benchmarks in the following five priority areas: radiology, nuclear medicine such as diagnostic imaging, joint replacement, cancer care, sight restoration and cardiac care. These areas were outlined in the 2004 First Ministers 10-Year Plan to Strengthen Health Care. The Wait-Time Alliance 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.

- Make the ten key benchmarks that the health ministers across Canada unveiled in December 2005 legally binding. 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.

- The British Columbia Government should commit to implementing wait-time guarantees. 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 British Columbia is scheduled to receive as part of the ten year Wait-Time Reduction Fund announced in 2004.

- If any Province cannot meet the wait-time target, then it must offer the option of having the procedure done elsewhere in Canada or the United States, at no cost to the patient.
• Establish maximum wait-time guarantees for the more common surgical and diagnostic procedures and be prepared to have these procedures delivered in private facilities and funded by the Government in order to stay within these guarantees.

• Define reasonable access that includes wait-list guarantees so that there are set and firm time limits as to how long a patient needs to wait and/or travel in order to get access to health care.

• The National Health System web site in the United Kingdom provides weekly, monthly and annual wait-times and identifies wait-time targets, which ensures accountability.

• Ideas about wait-lists and wait-times and health professionals:
  • Keep doctors up-to-date as to the status of wait-lists and current literature on criteria for ordering tests.
  • Adopt team based care that enables providers such as nurses to assume broader clinical tasks while working within their scope of practice.
  • Pass legislation that doctor appointments are at least 10 minutes.
  • Find a way to enable all practitioners to know a patient’s history.
  • To decrease wait-lists for specialists give doctors more time to think, investigate and talk to patients so referrals may not be necessary.
  • There needs to be a system in place for doctors and specialists to be accountable for excessive long wait-times for appointments.
  • Model an Albertan pilot project where a nurse and physiotherapist triage joint replacement candidates and refer them to orthopaedic surgeons. The Alberta pilot project successfully decreased wait-times to see orthopaedic surgeons from eight or more months to weeks.
  • Provide temporary assistance to family doctors to clear their backlog of appointments.
  • Make greater use of nurses and nurse practitioners.
  • Facilitate cooperation between specialists and find ways for them to combine wait-lists.
  • Require follow-up on patients that are on wait-lists and involve local physicians in patient care.
• Effective triage can reduce treatment and wait-times and improve utilization of resources.

• Reduce wait-lists by looking at scope of practice such as using operating technicians instead of doctors.

• Patients should be put on wait-lists for the hospital that is close to where they reside. The patient would then be assigned to the next available surgeon on the list for treatment. If the patient is bumped then they should be scheduled into the surgeons next surgical slot and the other patients surgical times moved back one surgical slot.

• Ensure health professionals have the proper diagnostic tools to be able to expedite diagnosis to alleviate bottlenecks in various health areas.

• Wait-times which are dependant on a physician's availability to see patients could be lessened with the involvement of Nurse Practitioners in our health care system.

• Provide an incentive to surgeons to do more operations. In Ontario, the more procedures surgeons do the more money they make and as a result wait-times are slashed.

• Limit wait-lists for all surgeons to three months, as there are other surgeons with low volumes who could do more work.

• Reduce wait-times by covering chiropractic care and help to avoid more serious, unnecessary surgeries and other related costly interventions.

• Having more health care professionals, such as nurses, nurse practitioners, doctors, physiotherapists, dieticians, etcetera, available in a community in an easily-accessible setting would decrease wait-times for appropriate services.

• Ensure more efficient utilization of health human resources so it is more cost effective for the public.
Health Impacts of Wait-lists

Comments and Concerns

Negative Impacts of Wait-Lists

- Comments on the negative health impacts of wait-lists:
  - Long wait-times in waiting rooms can end up giving you more problems than you went in with, as well as exposing others to your illness or disease.
  - Waiting too long to get test results from your doctor can delay getting definitive treatment.
  - Governments still fail to recognize the June 9, 2005 Supreme Court of Canada ruling that stated that delays in the public health care system are widespread and patients die as a result of waiting for public health care.
  - The Canadian Institute for Health Information (2003) data tells us that we know very little about wait times: how they compare across the country, what percentages fall within the recommended guidelines, and in particular what is the emotional and physical impact of waiting for care.
  - Too many people are off work due to some ailment or illness while waiting for months or years for diagnosis and treatment. This is a huge problem and causes sick people to become worse. People off work costs us more money in employment insurance, insurance claims, lost business and training temporary help.
  - Long wait-lists lead to further health issues, chronic problems and result in a poorer quality of life. Here are some concerns from British Columbians on this issue:
    a. I had to wait on a four month wait-list for my eye surgery which would have helped or slowed down early onset macular degeneration.
    b. I was on a three year wait-list for a 20 minute operation. This led to losing my job, a lack of mobility and extra costs to the system.
    c. A long wait-list to see a psychiatrist was very stressful for the entire family.
    d. By the time people find out what really is wrong, they have had cancer for five to six years without knowing it;
    e. Patients who are waiting for care become progressively sicker and care becomes more difficult, longer and more expensive.
f. Extended wait-times (over six months) for diagnosis and treatment increases the complexity of the health problem and reduces the possibility for resolution.

g. There is a lack of organs available, which causes very long wait-times and high medical costs as a patient’s acuity escalates, some even dying.

h. Peripheral costs to being on a wait-list include waiting in pain, poor mental health, stress on work and family life, and damage to other body parts.

i. Delays to surgery cause patients to make more visits to their doctor to ask for more prescriptions. Wait-lists encourage doctors to prescribe more.

j. Waiting in the emergency department for long periods of time for simple procedures takes a toll on patients and can sometimes cause shortened life spans.

k. I had to pay privately for Magnetic Resonance Imaging (MRI) because I was not willing to wait another four months for one to determine whether or not I had a brain tumour. I found out that I have Multiple Sclerosis and now I face long wait-lists for continuing care by my neurologist.

l. It is cruel to make people wait many months and in many cases years, when they are in pain. Whatever the person is suffering from may well be incurable or inoperable by the time they are seen by a specialist and/or operated on.

m. One should not have to wait three months for day surgery. The long wait is causing deterioration in my husband's health.

n. My 58 year old sister's knee replacement is nowhere in sight, neither is her knee cap, as it is somewhere on the side of her leg. Waiting for her knee replacement is becoming extremely difficult as she sometimes falls due to her swollen damaged knee. Do you recommend welfare and pain killers when she can no longer work.

o. Long waiting lists for high profile procedures such as cataract surgery and hip and knee replacements have caught the attention of the media, public and governments. People can wait many months, in some cases more than a year, for surgery that could have an enormous affect on their quality of life. Replacement of a painful knee can improve or reinstate basic mobility, reduce or even eliminate constant pain, and can allow patients to return to long abandoned activities. Removal of a cataract can have similarly dramatic effects, allowing people to retain (or regain) their independence.
p. It will take me four months to see a gynecologist. Although my condition is not life threatening I am suffering from symptoms and cannot understand why there would be a four month waiting list.

q. I have recently been diagnosed with Arterial Fibrillation and my cardiologist suggested a procedure called Pulmonary Vein Ablation. The cardiologist placed my name on the list in August 2006 and I may get a consultation with him in the fall 2007. The procedure itself will be approximately one year after that. By that time I will be 67 years old. The bonus is that the longer I wait, the less likely the procedure will be successful and so I may be disqualified as a candidate for this procedure.

r. My father has been waiting for a heart operation since the fall 2006. Although the surgeon is ready to operate he cannot due to hospital cutbacks.

s. It took me from February to October to finally be scheduled for a much needed surgery to drain a cyst that was attached to my pancreas from another ailment. This operation should have been done in three or four months, but I waited nine months.

t. I had the unfortunate experience of witnessing my 94-year old patient’s frustration of having to wait for hip surgery. The patient could not eat for two days (protocol for undergoing surgery) and was transferred to and from his bed to a stretcher for endless hip x-rays, making him scream in pain. It is simply ridiculous.

u. I am currently waiting for total knee replacements and have been waiting for over two years.

v. After waiting four years for an orthopaedic surgery, I am going to Ottawa to have it done.

w. I know an active healthy senior who requires knee surgery. He has been waiting for two years and his surgeon said he should not expect the surgery anytime soon because there is such limited operating time available and he has to prioritise patients.

x. It took almost two years for me to see a surgeon. The two year waiting list that the British Columbia Government thinks is okay has destroyed my life.

y. I have just waited five months for a mammogram appointment even though I have in fact had breast cancer and have been advised to have a mammogram every year.

z. I must wait one year before I can see an ear, nose and throat specialist. This delay may result in the loss of my other ear drum and I will become deaf.
aa. It took 18 months to get to an appointment in a chronic pain management centre in Kelowna. It also took 12 months to get an appointment with a sleep disorder specialist where sleep apnea was suspected, which is life threatening.

bb. I was in excellent physical health but had an injury. I was disabled for nine months due to long wait-lists in the medical treatment system. Thank goodness I had the option to pay for the procedure privately even though I had to pay for it on my credit card.

c. My mother was diagnosed with cancer, but by the time she sees an oncologist it will have been six weeks since diagnosis without any action taken to arrest or treat her condition.

dd. Our son had a bad shoulder injury, but because we did not have knowledge and the doctor did not give it due attention and he is now disabled (after three operations). The fact that he had to wait nine months for surgery was wrong.

e. My husband had an electrocardiogram, blood test and stress test this summer, all of which indicated an urgent cardiac disease. He was then put on a five and one half month wait-list for a diagnostic angiogram in Kelowna. We ended up going to Seattle for the angiogram, which only had a one week wait. Good thing we did as he had to undergo emergency life saving open heart surgery the next day. Now our wonderful British Columbia medical system will not pay any part of it, as they say that acceptable and appropriate care was available in British Columbia. He would have died if we had not gone outside the Province.

ff. My wife and I just paid over $2,000 for her to have her knee operated on because she could not wait another year for the medical system to get around to her; and

gg. My surgeon has an elective waiting time of over five years. Patients with tumours and so on are fast-tracked for surgery, but patients with benign diseases have long waits to access the public system, even though these diseases greatly affect their quality of life.

**Ideas and Suggestions**

- Provide care to patients before their health affliction or concern becomes disabling or causes other damage.
- Pay for in-home care for patients on wait-lists for surgery.
- Reinstate family and support services for patients on wait-lists.

**Funding and Health Care Models**

**Comments and Concerns**

**Capacity**

**Costs and Funding**

**Health Care Models**

- Comments on capacity:
  - Expanding capacity has been a focus for governments across Canada in recent years, with particular attention paid to priority areas such as hip and knee replacements, cardiac, cataract and cancer surgery. The result has been significant increases in volumes of surgery in each of these areas across the board. The number of cases was up 12 per cent over five years, even after adjusting for population growth and aging.
  - Long wait-lists are due to a lack of testing facilities.
  - Operating room availability (7:00 am to 3:00 pm) means that equipment is only used part-time.
  - Three years ago, the Interior Health Authority region had six operating room booking systems at nine sites. Now one system serves 11 sites.
  - The private use of Vancouver Hospital scanning systems is in violation of the *Canada Health Act*. We are now faced with the reality that these hugely expensive resources will sit idle for a good percentage of their lives. This means that at least 1,100 patients over three years will have to be slotted into the already lengthy wait-lists for scans, and our economy has been robbed of 1,100 patients times $1,400 or $1.54 million.
Comments on costs and funding:

- Wait-lists and wait-times for sonograms, procedures, tests, scans, and so on, are under-funded to promote private treatment and care.

- Treating someone quickly saves money. This is evidenced by the Worker’s Compensation Board, which is the only organization in Canada with flat health care costs.

- Wait-lists cost more money because of the huge overtime wages paid out to keep shifts covered.

- The longer the wait-list the more it costs the system. These costs include more prescription medications while patients wait for surgeries, more invasive surgeries and more intensive treatments as a result of the delay. Closing hospitals and surgery rooms actually end up costing more through complications in the long run.

- It is much cheaper for the Government to pay for the needed surgery quickly in order to save money. Although the same argument cannot be made for a senior citizen who suffers from an affliction, as they are unlikely to qualify for employment insurance or welfare and their tax base is unlikely to go up or down whether they have the surgery or not. However, the costs for medication and possible costs associated with needing to provide a higher level of care for those seniors may show a similar result (shorter wait-times = less costs).

- Technology testing equipment made available by Hospital Foundation funding has improved wait-list times.

- A major reason for wait-lists is that the public hospitals have to accurately budget each year. They are penalised if they go over budget and also if they are under budget because the extra money is recaptured and a smaller allowance is allocated for the next year. The demand for health care especially surgeries is hard to predict so the hospital manages by controlling the access to operating theatres.

- Government withholds funding that is required and then it appropriates $20 million to pay towards private clinics for providing services and reducing waiting lists. Government ideology is creating wait-lists.

- Mental health wait-lists and counselling are tragically under-funded, especially in rural and small areas.
• Ministry funding may not meet local priorities.

• My cardiologist advises me to have an ablation operation, but I have to wait months for the procedure because he is only able to operate one week per month even though a second operating theatre at his hospital sits vacant due to under-funding.

• Waiting time for elective surgeries, such as knee and hip surgery, has been increasing because there is not enough funding given to the Interior Health Authority to reduce waiting times.

• The present health care delivery model is ignored and under-funded leaving people to suffer needlessly and sometimes even die while on wait-lists.

• There is a problem that physicians are available to do surgeries and the space to do them is available, but Government imposes limitations on the number of surgeries that they pay for. This limits the options of patients to either go on a wait-list or to a private clinic.

• Comments on health care models:

  • Health Care Commissioner, Roy Romanow reported to the federal government in 2002 that long waiting times are the main reason why some Canadians say they would be willing to pay for treatments outside of the public health care system.

  • I personally would be willing to pay a reasonable amount (based on income) towards timely care in another location rather than suffer on a wait list again.

  • Wait-lists are far too long and force the average person to have no choice but to take part in the extremely lucrative private sector options.

  • I accept wait-lists for certain procedures if it means staying true to the principles of universal access and public health care.

  • Do not discriminate on the ability to pay in relation to wait-times.

  • A two tier system exacerbates multiple wait-lists. The British experience has not been good with a public and private mixed model.

  • Although private interests may be able to establish a health clinic quicker than their counterparts in the public system, the existence of such a clinic creates several problems. First, it lures precious health care workers, in particular nurses, away from the public system where they are desperately needed. Second, depending on the clinic’s contract, its existence could compromise the effective management of the wait-lists of doctors who practice in both public and private
facilities. Finally, a privately run surgical centre will likely serve only low risk patients, leaving the more complex and acutely ill patients for the public system to care for. Yet if the private clinic is paid the standard rate per case, the public system could end up overpaying the clinic for its services.

- Doctors sometimes cancel procedures to work for profit or wait a long time before ordering tests, even when the person has been having symptoms for months or sometimes years.
- People are often told by doctors that they can have their surgery done sooner with the same doctor if they pay for it.
- Privatization is not the way to go to shorten wait-times. No matter if it is private or public there are not enough doctors to supply either system.
- Countries that have gone to a private system have reported that the quality of care has declined.
- Removing the ten people from the public waiting list may make the public list shorter in numbers, but it does nothing to shorten the wait-time. The doctors will service their private clients first and then spend their remaining time on the public clients.
- My daughter has been going to physiotherapy for months and is in pain while waiting for a Magnetic Resonance Imaging (MRI) test to diagnose her injury. There is a wait of three to six months for Magnetic Resonance Imaging (MRI) through the public system, but it is available the next day through private care if you have $1,200.
- Private clinics only do elective surgeries, not emergency surgeries. This means that patients do not get bumped to make way for emergencies.
- Several European countries have shorter or no wait-lists with excellent outcomes at lower cost per capita than Canada.
- One key issue to wait-times involve patients who do not attend appointments and who cannot be effectively charged for the time wasted. One doctor’s wait-lists are several weeks longer than they have to be because of patient no-shows. There should be a penalty to teach people the value of these free visits.
- Private care is queue jumping and makes other wait-times longer.
- Wait-lists are being used as a ploy by government to introduce private care.
Ideas and Suggestions

Capacity
Costs and Funding
Health Care Models

- Ideas about capacity:
  
  - Audit hospital clinics as many are operating far from capacity.
  - Build more public surgical centers to decrease surgical wait-lists.
  - Dedicate operating room time to orthopaedic surgery.
  - Provide more medical support for long-term care facilities.
  - Increase access to areas and facilities that are currently underutilised.
  - Allocate a specific building to be used for intermediate care in transitional beds.
  - Create more access choices such as more walk-in clinics.
  - Provide more operating room capacity and more surgeons, nurses, health professional support staff to reduce wait-lists.
  - Provide more emergency and operating room staff.
  - Increasing capacity is not the only way to reduce wait-lists and narrow the gap between available capacity and demand. We also need to focus on areas to increase efficiencies, develop plans to do things differently, develop different scopes of practice or care plans, and reduce demand by preventing disease or by improving quality to reduce complications.
  - Run diagnostic and imaging equipment at full capacity 24 hours a day.
  - Reduce wait-times by investing in infrastructure to build more operating rooms.
  - Upgrade medical infrastructure in local communities such as Vancouver’s downtown area to help alleviate wait-times for tests.
  - Increase the available operating room time in the Fraser Health North Region.
  - Allocate one hospital in certain areas that is just for surgery. That means no Emergency Department, palliative care, patients or anything else that exists in a normal hospital setting. This hospital would be just for doctors to operate and perhaps have some wards where patients could spend some recovery time before being moved to other hospitals if more recovery time is required.
• Ideas about costs and funding:
  
  • Speed up the process for surgery and provide appropriate funding allocations.
  
  • Provide more public sector hours to reduce wait-times even though this may increase costs for labour and resources.
  
  • Establish 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. Such a fund should be created to support patient care costs as part of the introduction of wait-time benchmarks.
  
  • The Government of British Columbia is not looking at the big footprint cost of providing health care. For example, a teacher that requires surgery has a nine week absence for convalescence. For this absence, the school board is required to post a temporary position to replace the teacher, interview candidates, hire someone and then bring the successful candidate in to acquaint them with the students. Then, the teacher arrives for surgery only to have it cancelled so the whole posting, interviewing and hiring process is repeated six weeks later when the procedure is rescheduled. No cost to the health care budget, but certainly to the school board and taxpayer.
  
  • Work with the West Kootenays Health Endowment Trust that will be an investment and granting agency to fund health care services, projects and programs not financed by the British Columbia Government.
  
  • Properly fund and make available the latest and best diagnostic tools to reduce wait-lists, misdiagnosis and inadvertent death.
  
  • Support more local fundraising and grant applications to bring specialised testing equipment to smaller communities.
  
  • Fund the public system and reduce backlog as promised.

• Ideas about health care models:
  
  • Shorten wait-lists by creating one shop stops in the public system for common surgical procedures.
  
  • Reinstate the practice to send patients to other areas for treatment. For instance, years ago if a patient was on a wait-list for radiation they were sent to Bellingham for treatment and the medical plan paid for it.
· Development of a model for surgery that is like a mass-repair surgical assembly line would reduce wait-lists to almost zero.

· If wait-times are longer than one month, then people should be allowed to go wherever there are no wait-lists and the health-care system should pay for everything.

· Use private facilities to manage and/or reduce wait-lists.

· To improve wait-lists bolster existing operating room capacity in the public sector and consider more effective use of the private sector.

· Allow a mixed care model of public and private so people can pay for private care to shorten the wait-lists and free up funds for those who cannot.

· Establish concrete guidelines for queue-jumping and a paid or reimbursement referral plan to private facilities in the event of priority needs for scans that the public system cannot provide in a timely manner.

· Use the budget surplus to have the waiting list reduced by half, by contracting out any procedure that the patient agrees to have done to private clinics or the United States.

· To reduce wait-lists for a Medical Resonance Imaging (MRI) test, the Government should pay the fees to private clinics that have facilities available until the wait-list is shortened.

· Encourage the establishment of both private and public emergency clinics for non-life-threatening injuries so people with non-life-threatening ailments can get quicker care as they will not be bumped by more urgent cases.

· Expand the contracting out of daycare surgeries to private centers.

· Encourage a two-tier system to take pressure off the public system and allow for shorter wait-times.

· Open up pay clinics for specific surgeries. This does not mean that these surgeries would be taken out of the public health care system, but providing the option of pay clinics would ease a lot of hospital bed congestion.

· Create one stop shops for treatment, existing in Hamburg, which offer follow-up care at the time of treatment.

· Charge a no show fee to those who do not cancel scheduled medical test appointments if they are unable to attend.
Maternity leave covers people for one year. Medical employment insurance should cover people waiting for surgeries in the same way.

**Innovation**

**Comments and Concerns**

**Canadian Models**

- Comments on Canadian models:

  - Alberta Hip and Knee Replacement Project, a joint effort by the Alberta Bone and Joint Health Institute, orthopaedic surgeons, health regions and the Alberta government is a prime example of how relatively simple, common sense changes can solve seemingly intractable problems. The Alberta project combined elements of North Vancouver’s North Shore Joint Replacement Access Clinic and the Richmond and University of British Columbia hip and knee reconstruction projects and adds even more progressive ideas. The project is now the standard of care for hip and knee replacement in the Calgary, Capital and David Thompson health regions, and three other regions have expressed interest in adopting the model.

  - In April 2006, the University of British Columbia Hospital opened its Centre for Surgical Innovation, a $25 million, one-year Provincial pilot project dedicated to fast tracking patients for hip and knee replacement surgery. The Centre for Surgical Innovation is specifically geared to serve low-risk patients who have been on a waiting list for more than 26 weeks. The project has two dedicated operating rooms and 38 inpatient beds, and aims to perform 1,600 surgeries a year. As of January 2008, the Centre for Surgical Innovation had carried out more than 1,100 procedures.

  - The Richmond Hip and Knee Reconstruction Project had dedicated funding of $1.3 million, which meant that the project had a full-time manager, equipment, research and evaluation tools, a newly renovated operating room and new operating equipment. Funding came from the Provincial Government, the Vancouver Coastal Health Authority and the Richmond Hospital Foundation. But as numerous health care analysts know, money alone cannot buy success. In this case, however, money combined with numerous surgical efficiencies did. Operation start times were staggered and scheduled between two rooms, so...
surgeons could swing between rooms as their patients were ready. This allowed operating teams to complete eight joint replacements or reconstructions per day instead of six. Surgical procedures and clinical practices were standardized, eliminating previous idiosyncratic variations. The move also resulted in significant savings for the hospital as it could negotiate better deals on bulk purchases.

- The North Shore Joint Replacement Access Clinic exemplifies an effective way to decrease wait-times for hip and knee replacement surgery by focusing on the preparatory work that must be done before patients undergo surgery. As a result, the North Shore Joint Replacement Access Clinic has dramatically reduced wait-times both before a first surgical consult and before the surgery. The North Shore Joint Replacement Access Clinic is a one-stop, centralized booking service for pre- and post-operative appointments and procedures. It opened as a pilot project in May 2005 and is now a permanent facility at Lions Gate Hospital.

- Mount Saint Joseph Hospital is a 140-bed, acute-care, community-based hospital in East Vancouver best known for its multicultural approach to care delivery, especially for the city's large Chinese community. Over the past three years it has become renowned for a cataract and corneal transplant program that outperforms every hospital in the Province. By completing more than 6,300 procedures a year, the program has cut wait-times in half (from six to eight months to three to four months), with many patients having the procedure within 10 weeks. Because there is little variation with cataract surgery, it lends itself well to production-line efficiencies without loss of quality. A decision to invest in the best technology and in more equipment so that surgeons do not wait for tools to be sterilized, allowed them to immediately get up to speed.

**Ideas and Suggestions**

**Canadian Models**

**International Models**

- Ideas about Canadian models:
  - Follow the model in Saskatchewan that posts surgical wait-lists with the surgical care network.
  - Have more clinical trials to shorten wait-lists.
• Look to innovation in the public health system to improve service such as consolidating waitlists.

• The Ministry of Health should consider the nationally recognized best practices that the Vancouver Coastal Health Authority implements to reduce wait-lists.

• Create a centralized surgical wait-list system such as the Joint Rapid Access Clinics that were created in Alberta. These clinics engage people on wait-lists well ahead of surgery to improve their health and knowledge for better surgical outcomes and less acute care bed days. These clinics also support accurate, bare minimum diagnostic procedures done prior to seeing specialists.

• Contract out joint surgeries to the Fraser Surgical Clinic or other clinics.

• Public clinics with one stop service can decrease wait-times. For instance, there are breast health centres in Canada and elsewhere that perform follow-up tests immediately on the women who have positive mammograms.

• Follow Ontario that has an emergency patient referral system called CritiCall that allows admitting clerks, hospital administrators and even physicians to track beds, emergency department status and other medical resources. This allows for the direction of patients to facilities that can help them quickly and thus reduce wait-times.

• Ontario research is in the preliminary stages, but it suggests that there is little conclusive variation in impact among existing Canadian models. In other words, we do not know which model absolutely will produce the best care. But we do not have a whole lot of data either. We do know that some primary care systems in other jurisdictions have managed to achieve triumphs in access such as same day access in England, Australia and New Zealand. In this case, when you phone up for an appointment your chances of getting in that day are pretty high, and your chances of getting in within 48 hours are virtually 100 per cent.

• Ideas about international models:

  • Learn from the improvements that have been made in parts of Europe where progressive policies have substantially reduced wait-lists.

  • Learn about best practices on health care from the Netherlands.
Patient Safety

Patient Safety was among the issues raised by many participants during the Conversation on Health. Food quality, hygiene practices and patient care in hospital and hospital administration were topics highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of patient safety.

Food Quality in Hospital

Participants voiced general concern that food in hospital does not assist patients in the healing process. They suggest hospital food is too high in sugar and salt and too low in nutritional value to be of any benefit, emphasizing that patients lack adequate meal choices. Specific opinions cite high servings of meat and potatoes, frozen vegetables and overly-sweet deserts as problematic.

Hospital meals are inadequate for patients. The food is overcooked, greasy, fried and batter crusted. Nutrition seems to be of low priority. The vegetables are canned. The food is highly processed and no whole grains are present at all.

– Regional Forum, Vancouver

Most submissions related to hospital food call for greater variety and choice: instead of just coffee, provide green or other mild teas; instead of only processed foods, provide organic fare as well. Others think that more vegetarian choices and culturally sensitive foods on hospital menus are desirable. This would ensure that patients get the nutrients they need to heal fully and avoid another trip to hospital.

Hygiene Practices in Hospital

Conversation on Health participants generally agreed that hygiene in hospitals is poor. Though several state that health professionals perform their work without due care to sanitation, many also feel that housekeeping staff are not well-trained and do not adequately clean the facilities. Some cite a lack of supervision for both health professionals and cleaners as the reason for this situation.
The suggestions to improve hospital hygiene were numerous. They include: providing better training for housekeeping staff; preventing health professionals from wearing their uniforms in public places; increasing the use of disinfectant spray; setting up hand sanitizing stations and; advertising the benefits of hand-washing. One submission also suggests that an independent inspector should be appointed to monitor hygiene standards in health care facilities.

Patient Care in Hospital

Patient safety is also comprised of concerns about staffing, treatment and discharge practices in hospital. Participants feel that there are too few staff available to treat patients, resulting in reduced quality of care. They also believe that there is no accountability for misdiagnosis and that patients are often discharged too soon, which leads to subsequent, ongoing hospital visits and increased pressure on the health care system.

Patients are being sent home from surgery too early, often resulting in complications or delayed recoveries which add to the medical costs.

– Email, Maple Ridge

Prescription drug use also receives attention. The majority feel that doctors over-prescribe medication rather than treat their patients. This also contributes to preventable drug interactions and increased hospital admissions.

Participants argue that hospital care should centre more on the patient. Several feel that hospitals should develop a comprehensive discharge team to assist patient transition back into the community or, at the very least, that patients should stay in hospital longer. They also focus on providing advocates to help patients navigate through the health care system and creating an ombudsman as an oversight body on medical treatment. Some participants suggest patients should have more time with health professionals.
Hospital Administration

Several submissions identify the quality of facilities and equipment and the privatization of services as cause for patient concern. Some believe that elevators, ventilation systems and assistive devices, like wheelchairs, are out of date. Others say that increasing infection rates were the result of unsafe procedures and techniques practiced at private clinics. They suggest that, by updating facilities and equipment, and by monitoring hospital policies and procedures, the system may decrease capital costs for infrastructure and improve patient outcomes.

While I was in the operating room, the door fell out of the track and hit a nurse. When replaced, it fell again and broke medications. While I was in the ward for four days, the hot water was not working and I could not be bathed until the fourth day. The ice maker to provide ice for trauma, was out of order for the entire four days.

– Regional Forum, Fort St. John

Conclusion

Patient safety received a lot of attention in the Conversation on Health. Participants think that hospitals, in general, have an opportunity to improve the care that patients receive. They emphasize that food quality and hygiene practices are integral parts of the healing process and note that administrative practices could be revised to provide more timely, cost-effective service. These factors have the potential to improve patient outcomes and prevent a return to hospital. Overall, the message from forums, online dialogue, email and all other submissions regarding patient safety was clear: focus care on the patient and, thereby, reduce cost to the health care system.
Patient Safety

This chapter contains the following topics:

- **Food Quality**
- **Legal Implications**
- **Prescription Drug Use**
- **Hospital Administration**
- **Hygiene Practices in Hospitals**
- **Patient Care in Hospital**

**Related Electronic Written Submissions**
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

Electronic Stability Control
Submitted by Glen Nicholson

Do Not Harm: A Submission to the Conversation on Health
Submitted by the AD-AV Society of British Columbia

Report to the Conversation on Health
Submitted by the BC Cancer Agency

Research on Child Health – Final Report
Submitted by BC Children’s Hospital

Submission to the Conversation in Health
Submitted by Office of the Advocates for Seniors’ Care - Vernon

**Related Chapters**

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Public Private Debate; Access to Hospitals in Rural Areas; Environmental Determinants of Health and Food Quality; Training and Morale.
Food Quality in Hospitals

Comments and Concerns

- Since food services were contracted out, hospital food is no longer nutritious.
- There is a lack of vegetarian options in hospital cafeterias.
- Serving white bread, sweet puddings, watery soups, and frozen vegetables in hospitals is not acceptable.
- There is too much sugar, white flour and meat being served in hospitals.
- Hospital food is highly processed and no whole grains are present at all.
- There is no way that an egg cooked in Toronto is safe to eat in BC. The food service is horrible.
- Hospitals should not have a Tim Horton’s.
- Staffing levels are too low and often no one checks to ensure that patients get the food trays that are dropped at their doors.
- Cleaning staff and food servers are the main transmitters of disease.
- Did those people making the decisions eat the food that was delivered to patients each and every meal? No.
- For diabetics, a snack is sometimes necessary when waiting for another patient in the hospital and the cafeteria is not always available.

Ideas and Suggestions

- Provide nourishing food to patients.
- Why can composting not be set up for hospital food and organic gardens set up as close as possible to the hospital to supplement patients' diets?
- Hospitals need to serve green or mild teas with healthy foods, and serve patients less coffee, red meat and potatoes in the first week after surgery.
- Ethnic food that is appropriate for different cultures should be served in hospitals.
- Get rid of the current food service providers and put some decent cooks in charge.
- Adopt the Hazard Analysis Critical Control Point Plan (HACCP) principles to create a food safe program in the food industry.
- Hospital food is currently an impediment to the healing process.
Legal Implications

Comments and Concerns

- There are no regulations in place to enable dentists to treat mercury amalgam fillings as hazardous material.

- There is a sense among health professionals that they cannot undertake treatment for a patient because they would cross some legal line; this creates a culture of fear in hospitals.

- Reviews of medical treatment, conducted by health authorities or the College of Physicians and Surgeons, often have no outside independent reviewers.

- The present legal and institutional infrastructure tends to prevent open examination of the treatment in question and does not encourage quality improvement.

- The Canadian Medical Protective Association has so much financial clout that patients have difficulty addressing treatment errors in court.

- Patients have no help in the health care system if their families are not able to be involved.

- Different medical specialties have different rates for malpractice and liability insurance.

- Information about new medicines or treatments should not be released prematurely as patients often rely on this information, only to find out the treatment was not good or possibly harmful.

- The medically necessity of a service must be determined by impartial medical professionals, not by politicians, lawyers or insurance companies.

- There is nowhere to go to ask questions regarding quality of care, ethics, and medical necessity or to question the advice given by professionals.

- Deaths in hospitals are not properly investigated.

Ideas and Suggestions

- Look at Ontario’s legislation for curbing Elder abuse.

- Develop safeguards to ensure quality of care via accreditation standards and complaints-based investigations.

- An independent body should investigate complaints about physicians.
• Multidisciplinary care 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.

• Create a registry for health care workers convicted of abuse who are working with individuals in long-term care.

• Look at the Patients Bill of Rights in the Scottish National Health Service, which includes legislated minimum wait-times for certain treatments and guarantees of confidentiality and access to information.

• Every case of death not occurring in a health centre should be sent for autopsy.

**Prescription Drug Use**

**Comments and Concerns**

• Prescription drugs are over-prescribed.

• Medicine has become far too reliant on prescribing pharmaceutical drugs without first trying alternatives.

• Changing prescription amounts can endanger health.

• Managing multiple drug prescriptions is confusing for families. This may lead to health emergencies.

• Fungal infections may occur in the brain, lungs, gut, kidneys, and skin, and are increasingly common since the anti-biotics kill the bacteria which normally inhibit the growth of fungi.

• There is no reference book listing the side effects for anyone taking multiple drugs.

• Many of the admissions to Vancouver General Hospital were assessed as being medication misadventures and the majority of those were completely preventable.

• Some research suggests that one-quarter to one-half of prescriptions filled are not necessary and could potentially harm the patient.

• In care homes, medication errors have become increasingly common and, in addition, the problem of poly-pharmacy is well known, as is the failure to recognize adverse medication effects.

• Many people are not told about all the side-effects of treatment because doctors worry about non-compliance.
• Tested as safe on animals, a number of arthritis drugs were subsequently removed from the market following serious side effects. It is dangerous to assume that something that has tested as safe for any animal is therefore likely to be safe for a human. It may be just as dangerous to assume that promising new drugs may be overlooked because they cause disease in rats.

• Penicillin was almost discarded when research showed it to be highly toxic to guinea pigs, and to cats. Fortunately, Dr. Fleming did not wait for the results of his animal experiments before trying it out on human patients.

• Animal studies failed to reveal heart abnormalities, but clinical usage showed the danger of heart valve defects from combining the approved prescription drugs Fenduramine and Dexfenfluramine, both withdrawn in 1997.

• Over 30,000 people were seriously damaged in Japan after taking the diarrhea medication Clioquinol. Rats and mice had suffered no effects during testing. It is now known that they metabolize the drug differently from humans.

• New drugs can be developed exclusively using human tissues and computer technologies - we can investigate how the drugs affect the actions of human genes or the proteins they make.

• Effective anti-HIV drugs were conceived and developed using in-vitro and in-silico (computer) methods, without reliance on animal models.

• Prescription drugs must be used with a great deal of discretion, especially when dealing with issues concerning mental health.

• Vaccinations are not being tested; they are declared safe before they have tested as being safe.

• When it is claimed that animal research resulted in the prevention of diseases such as polio, measles, whooping cough and diptheria through the development of vaccine, it must also be noted that the same vaccine may have presented drawbacks equally as devastating as the disease it targeted.

• Since 1952, the British Public Health Laboratories have acknowledged that approximately half the cases of polio in Britain have been caused by the animal-based vaccine itself. Similarly in the United States, the pertussis vaccine tested well in rats and mice for over 40 years. But its makers have since paid out more than $12 million in claims for children who died or were brain-damaged by its use.

• A Danish study showed that people who had measles vaccine-induced antibodies in the bloodstream later developed more arthritic and bone problems, skin diseases and cancer than those who had had the measles.
• Drugs are being prescribed for everything when a simple habit adjustment or improved diet could lead to improvement.

**Ideas and Suggestions**

• Take more care in putting new drugs on the market.

• There should be better public education regarding disposal of unused drugs and alternative treatments to prescriptions.

• Doctors need to ask new patient what medications in what doses they are taking.

• Stop vaccinating infants for so many diseases at such a young age. Their immune systems are not developed enough to handle the vaccines and can result in problems in later life.

• Change the current billing system in order that doctors not receive financial compensation for prescribing more drugs.

• Doctors should have check clients existing prescriptions before new ones given.

• Put daily prescriptions in blister packs for Elders.

**Hospital Administration**

**Comments and Concerns**

*Facilities and Equipment*

*Public/Private Models*

• Comments about Facilities and Equipment:
  - Hospital administration costs far too much. I have seen a $15,000 fish tank installed at a human resources office for the benefit of the staff. There are many other examples of over-spending by hospital administration.
  - St. Paul’s needs to spend more money on basic facilities: intravenous poles are rusty, elevators need to be updated, and modern ventilation systems installed.
  - As part of the upgrade to Mills Memorial paediatrics, the thirty-one year old, unsafe paediatric cots should be replaced.
  - Since the Royal Columbian Hospital lacks bed pans, patients are forced to wear adult diapers. This can cause skin breakdown and infection.
  - The wheelchairs available at hospitals are decrepit.
• While I was in the hospital ward for four days, the hot water was not working and I could not be bathed until the fourth day and the ice maker to provide ice for trauma patients was out of order.

• Old and aging infrastructure is creating undue operating expenses and some of these investments are not conducive to safe practices.

• Brick and mortar structures filled with antibiotic-resistant strains of bacteria are not appropriate places to warehouse sick and frail seniors.

• Comments about Public/Private Models:

  • Private facilities where general anaesthesia is used are not as safe for the patient because of the inevitable lack of an on-call independent cardio-pulmonary resuscitation team, which is the norm in any properly functioning public hospital.

  • When the motive for a company's operation is profit, patient health may be jeopardized.

  • Do a random audit of the sterilizing techniques of the operating room instruments at the private surgical clinics. Why is there an increase in infection rates? There is no regulating body that checks on these clinics.

  • When private contractors attempt to cut costs we get the sort of situation we have now where hospital food is disgusting and cleanliness is not a priority.

### Ideas and Suggestions

• The chair used for dialysis is very uncomfortable. There is a need for something solid, but more comfortable.

• Create facilities that contain various levels of care so seniors can stay in their retirement home; rooms should not be set up like hospital wards (have single occupancy or at most double rooms- like children’s wards).

• Particularly in the north, parking-lot and walkway areas around the hospital should be routinely heated with sub-surface electrical conduits during snow-falls since many of the people using these walkways are already infirm.

• The health care system should give patients equivalent protection to that of individuals on the job who are covered under workers compensation provisions. This would include:

  • Required reporting of errors;

  • Error investigations;
• Dissemination of information to prevent or reduce common errors; and,
• Compensation and rehabilitation for those killed or injured in hospitals.
• Establish a group of influential business people to address patient safety and quality issues in Canada like the Leapfrog Group does in the United States.
• Reward hospitals based on their performance and their achievements in continuous improvements in service and care.
• Link patients to non-profit groups who can help them navigate the medical system when they are suffering through a post-accident process; create medical advocates and an ombudsman for patients.
• People should have free access to medical information such as their blood type.
• Curtail visiting hours and the number of visitors allowed per patient.
• Proper neonatal security would be provided with the reintroduction of a nursery at Mills Memorial.

Hygiene Practices in Hospitals

Comments and Concerns

Health Professionals
Housekeeping Services

• Comments about the practices of health professionals:
  • There is no hand washing in hospitals, which can cause infectious diseases to spread.
  • Doctors perform their rounds in the same garment.
  • Hospital staff arrive at and leave the hospital in their uniforms. What are they bringing in to patients? What are they taking home on their car seat and finally to their house? What sickness are patients getting from staff this way?
  • Many health professionals visit public places in the hospital while still in full uniform.
  • A lack of adequate supervision causes an unsanitary work environment, which results in poor care and super bugs.
  • Nurses and doctors do not change their gloves when moving between patients or after cleaning up a mess.
• Comments about housekeeping services:
  
  • Hospitals are unhealthy places because hygiene is not paramount.
  
  • Contracting out housekeeping services in hospitals and care facilities was not a good idea.
  
  • Private housekeepers are poorly trained, resulting in a rise in hospital infections.
  
  • While I was at the hospital, I heard the nurses talking about the cleaning job performed by the housekeeping department. It seems the staff ignored the mess on the floor in the Colonoscopy ward.
  
  • I found the hospital quite dirty. The morning after my surgery, a soiled sheet and gown were still lying on the floor beside my bed. There were soiled Kleenex and emesis basins lying under my bed for 4 days.
  
  • As a recent patient in Victoria General Hospital, I was appalled that my room was only surface cleaned twice and that the bathroom was not cleaned daily.
  
  • Hospitals are not sterilized and could cause yeast infections.
  
  • Kitty litter was sprinkled under the beds to lower the smell in the Burnaby Hospital.
  
  • Residential care homes often are not maintained properly in cleanliness or repairs and often have rodents.

**Ideas and Suggestions**

**Health Professionals**

**Housekeeping Services**

• Ideas about the practices of health professionals:
  
  • Teach all the appropriate staff proper cleaning techniques.
  
  • Set up hand sanitizing stations for people to use as they enter and leave the hospitals. Install dispensers on the walls near entrances, and put up signs asking people to disinfect their hands.
  
  • Health care providers should not wear their uniforms in public and must put them on in the hospital, in a clean area.
  
  • Surgeons should have to change clothes or put on coveralls or a lab coats over if they leave the operating area.
  
  • Safety needles are a great idea.


- There should be more in-home care for minor illnesses.
- Mobile nursing units would cut down on the spread of illness.
- Gloves should be changed.

- Ideas about housekeeping services:
  - Reinstate properly trained housekeeping staff in hospitals and care facilities.
  - If there is to be more emphasis put on keeping conditions sanitary in hospitals, simple tools need to be available, like hand towels, which are missing in hospitals such as Penticton.
  - The use of a disinfectant spray in common areas of hospitals could reduce the spread of antibiotic-resistant bacteria.
  - Develop regulations for cleaning staff and monitor their daily cleaning practices.
  - Standards need to be uniform. Independent inspectors should be hired to see that cleanliness is enforced. Soap and water is very effective. Cleaning in hospitals is currently contracted out, as are laundry services.
  - Increase safety standards and carry out regular cleanliness inspections.
  - Establish acceptable and measurable standards for cleanliness, and infection control.

**Patient Care in Hospital**

**Comments and Concerns**

**Staffing**
**Diagnosis and Treatment**
**Discharge Practices**
**Infection Control**

- Comments about staffing:
  - Staff shortages are a risk to patient safety, cause patient care to suffer and lead to decreased productivity.
  - Multiple doctors per patient is not a good thing.
  - Good nursing is not being practiced because no one is in charge to organise the floors as a whole, which encourages lazy nurses, some of whom lack appropriate knowledge and supervision.
• There is no head nurse, so there is no updating between nurses on shifts and monitoring is quite haphazard.

• There were a number of occasions where my wife needed a nurse and none walked by for extended periods of time.

• Nurses do not respond to the buzzer when a patient calls for help.

• Interpreters often put their own twist on information. There are language barriers in the Williams Lake area.

• He waited three days in the Delta Hospital emergency room for a bed and surgeon to be available to treat him.

• There were not enough nurses on the floor to maintain proper care and the ones who were there were run off their feet.

• Don’t tell me you’re "training" when new staff are learning new procedures.

• There is a hospital that is 37 kilometres away from where I am and I don’t use it because the doctors that come in there are just students doing their practicums.

• The malnutrition of patients in acute care settings increases health problems. For example, a patient waits four days for surgery that keeps getting cancelled and, meanwhile, continues to deteriorate.

• Making patients wait can result in low-level problems developing into more critical situations which then leads to more pressure on emergency rooms. This can then increase waiting times for those still on the list.

• Comments about diagnosis and treatment:

  • Diagnostic doctors seem competent; unfortunately, there is no accountability when they are not.

  • A health survey showed misdiagnosis or late diagnosis are at epidemic levels.

  • It seems likely that episodic care, especially where doctor and patient have never met before, may cause more misdiagnoses and medication errors, resulting in unnecessary hospitalizations and increased health system costs.

  • Screening for diseases fails at times. There also are sometimes errors in recording test results.

  • Poor medical assessments lead to missed diagnoses.

  • Osteoporosis fractures are often left undiagnosed.

  • During an emergency visit, the doctor provided an inadequate examination.
• The day surgery staff were not responsive to my needs as a diabetic; I had to push myself out of hospital in a wheelchair.

• Doctors are not forthcoming when explaining the whole problem to patients, even when asked.

• Those patients who do not receive continuity of care are at greater risk of worse health outcomes.

• Discrimination by doctors towards Elders is a concern. Often they don't get the proper care, and treatments are not explained properly.

• Comments about discharge practices:
  • Hospitals coerce patients into allowing themselves to be discharged.
  • People are being discharged too soon and are not given proper care instructions.
  • When I had my kids, I was in the hospital for five days; now, new mothers are sometimes in for seven or eight hours, and then released with a new baby and no support.
  • My sister was discharged from hospital without proper clothes and my family was not contacted.
  • Patients are being sent home from surgery too early, often resulting in complications or delayed recoveries, which adds to the medical costs.
  • Paying bonus money to emergency departments for processing patients in less than 10 hours will lead to dangerous errors and premature discharges.
  • If patients are air-ambulanced to the lower mainland, treated, and released, they have to find some way to travel home, no matter what condition they are in. I was released from Vancouver General with very high blood pressure, no money and no way home.
  • Doctors who work off-reserve should work and communicate with Community Health Representatives on-reserve.

• Comments about infection control:
  • I picked up a staphylococcus infection in the Dawson Creek hospital; the staff seemed not to be surprised. There have to be better controls around the patients that actually have these contagious infections.
  • I have had four friends who have had surgery in the past 18 months and they have all acquired infections in their surgical sites following their surgeries.
Given the post-operative infection rate in Canadian hospitals and my susceptibility to infection, I am considering skipping the surgery and taking my chances and living with this health issue.

Many visitors bring infections into hospitals.

Ideas and Suggestions

Discharge Practices
Diagnosis and Treatment

- Ideas about discharge practices:
  - In-patients who have complex needs or few supports when discharged should stay in hospital a little longer to ensure that they do not need to return to the hospital.
  - Perform a fundamental review of our discharge process and links to community resources.
  - Initiate a discharge planning team for each area comprising one nurse, a physiotherapist, and an occupational therapist who will collaborate with the physician.
  - Improve continuity of care to prevent people leaving the hospital from having access to follow-up treatment. This would include transition from hospital to home, to chronic care facilities or to assisted living.

- Ideas about diagnosis and treatment:
  - Doctors need more time to get a patient’s medical background.
  - Physiotherapy staff should monitor patients who are connected to machines and not leave them unattended.
  - Create patient satisfaction forms. Remember that the patient is a person, not a case.
  - Trainees should not be administering IVs to patients.
  - Once a surgery is decided upon, the health professionals must establish that it is the last possible route to health and healing. The least intrusive method must always be the first step.
  - Patients who suffer from a fracture should be checked thoroughly for osteoporosis.
• Disclose primary conditions and treat them before they develop into secondary conditions such as cancer or organ failure.

• Keep people mobile when in hospital; provide more Physiotherapists and Licensed Practical Nurses.

• Have more locally based Nurse Practitioners working with doctors.

• Due to the high risk of cancer, eliminate the use of radiation as an image tool. This includes x-rays.

• Replace patients’ dental mercury amalgams, which are unsafe, at public expense.

• Remove children and pregnant women to a separate and safe location while they are waiting to be seen in the hospital.

• Put personal health information, including personal health plans, on Care Cards. In case of emergencies, the ambulance crew could call ahead with the information rather than having to wait for tests after arrival in emergency.

**Outstanding Questions**

• Do doctors know what services or programs are available to refer their patients to?
Rural Health Care

During the Conversation on Health, rural health care was a frequent topic of discussion. Participants emphasized the importance of meeting the needs of rural communities and highlighted some of the unique challenges that they face, such as transportation and ambulance services, access to health care professionals, and access to health care facilities. Here is a selection of what participants had to say on the topic of rural health care.

Transportation

Participants widely agree that in rural communities, transportation is a barrier to receiving timely health care. Concerns related to this topic include: having to travel long distances to urban centres for medical care; driving on dangerous rural roads or mountain highways to reach a hospital; and a lack of public transit. Participants have mixed views of the Health Bus system that exists to take patients in rural communities to specialist appointments. Some suggest that it is working well, while others say service is inconsistent and does not reach enough communities.

Participants emphasize the impact of access to transportation on elderly people. They voice concerns that many elderly people do not have access to a vehicle or public transportation. They also suggest travel costs are expensive for elderly people on fixed incomes, as well as for their families who often take time off work and pay for their own travel and accommodation.

*A lot of our community members do not have access to transportation so it is expensive and troublesome to have to travel outside the community for medical services.*

– Email, Lytton

For many, it is important to ensure that there are equitable transportation options in all communities regardless of location or population size. Some recommend providing subsidies, mileage reimbursement, ferry discounts or travel vouchers for patients that have to travel for medical care. Others suggest providing additional funding when a patient requires a travel escort. Promoting the Health Bus and extending the service to more communities as well as increasing funding for road maintenance are discussed as mechanisms to facilitate patient travel.
Ambulance Services

Many participants raise a number of concerns related to ambulance services. Some discuss the lack of ambulance services in rural areas and the high costs associated with expanding services. Others focus on long response times for ambulances to arrive to rural areas, the shortage of ambulance crews, and the vast distances that the ambulance stations must cover. Many participants would like to see ambulance services provide more primary health care by expanding their scope of practice. Other recommendations include: decentralizing ambulance dispatch services; initiating active recruitment in small and rural communities; increasing paramedics’ standby wages; and providing more funding to the British Columbia Ambulance Services.

Access to Health Care Professionals

There is widespread agreement that there is a shortage of health care professionals in rural communities such as doctors, specialists, pharmacists, and nurses. Participants suggest it is very difficult to find a doctor in rural areas and especially in rural First Nations communities. They also express concern that people in rural communities do not have equal access to specialized care. Many emphasize that where there are doctors practicing in rural areas, they are often over-burdened.

The majority of participants believe that providing more resources to attract and retain health care professionals to rural areas is essential to improving access to health care in rural areas. They also believe that Government should focus on bringing health care providers to rural areas rather than sending patients to urban centres for medical care. Other recommendations include providing financial assistance to health care professionals working in rural areas and implementing a rotation system for doctors and specialists to visit rural areas. Some suggest using video-conferencing while others supported creating multi-disciplinary teams who use mobile clinics.

Access to Health Care Facilities

Many participants from rural communities are frustrated with their access to health care and some feel that there is an inequity in the quality of care that is provided to rural communities versus urban centres. Others express concern over the closure of rural hospitals and comment that regional hospitals are not adequately servicing surrounding communities. Some suggest that regional hospitals do not have up-to-date equipment to take advantage of technological advances in diagnosis and treatment.
Many participants support the idea of increasing the number of health care facilities in rural areas and some suggest that these facilities should have more local government control to meet the unique and diverse health needs of communities. Some suggest opening emergency facilities at walk-in clinics if hospitals are not close by or re-opening some of the closed hospitals. Many recommend supporting mobile health services, while others suggest implementing a patient advocate system to support patients who have to travel to urban centres for treatment. Some support using private providers and clinics to provide services in rural areas.

Conclusion

Some of the participants in the Conversation on Health believe that if British Columbians choose to live in isolated communities, then they should accept some reasonable challenges in accessing health care. However, many suggest that the challenges facing residents of rural areas are extreme. Other participants believe that rural communities are under-serviced and do not receive the same standard of care as larger communities. Most suggest that providing sufficient resources targeted to transportation and ambulance services as well as increasing health care professionals and facilities would improve access to health care for rural communities.
Rural Health Care

This chapter includes the following topics:

Equal Access to Health Care
Access to Health Care Facilities and Equipment
Access to Health Care Professionals
Transportation
Ambulance Services in Rural Communities

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

- From the Beginning to the End
  Submitted by the Bella Coola Discussion on Health

- BC Physicians Speak Up
  Submitted by the British Columbia Medical Association

- Aboriginal Conversation on Health
  Submitted by the Vancouver Coastal Health Authority

- Sunshine Coast Conversations on Health
  Submitted by the Women’s Health Advisory Network, the Sunshine Coast Hospital and Health Care Auxiliary and the Seniors Network Advisory Group

- Submission to the Conversation on Health
  Submitted by the UBC Centre for Health Services and Policy Research

- Report to the Conversation on Health
  Submitted by the British Columbia Cancer Agency

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

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Wait Lists/Wait times; Patient Safety and Health Human Resources.
Equal Access to Health Care

Comments and Concerns

- Comments on equal access to health care:
  - People in rural communities do not have equal access to specialized care and do not get the same standard of care as larger communities do.
  - There is a disparity between southern British Columbia health care and what is available to the north.
  - It should not matter where people live; everyone deserves to receive the same health care services.
  - Services are centralized in urban areas.
  - The health system is failing northern areas of the province. When people are ill in rural areas, they sometimes have to travel to a hospital that is hours away.
  - There should be local access to all health services.
  - It appears that there is sometimes an unfair distribution of travelling services between rural communities.
  - Paying for transportation, accommodation and meals can add up, and for some families it is just too much to afford. Included in expenses is the time it takes (sometimes days) to get to the centre where the care will be provided. Ultimately, this means some people cannot afford care.
  - Hospitals and health services in large centres are being used and are fully funded. Rural services are diminishing.
  - Universal health care does not exist. There are large differences in the quality of care that is received in rural and urban hospitals.
  - The bigger areas such as Prince George are getting much more than smaller areas. The smaller communities get forgotten about.
  - Rural communities may have to design their own strategies to meet their unique and diverse health needs.
  - Because regionalization worked in the Okanagan that does not mean it will work in the West Kootenays. One problem is the outlying geography of the regional hospital in Trail, meaning that all people do not have equal access.
• It violates the Canada Health Act to buy medical care, however when a community is in need, the government encourages them to fundraise. Small communities are often struggling for the same level of care that is available in larger centres, not superior care.

• Centralization in larger urban areas has a negative effect on rural communities.

• Accessibility to health care varies from region to region; equal access varies within the province.

• There are wide disparities between funding and services for rural communities.

• There is a two tiered system between rural and urban centres.

• Living in small communities has become dangerous, as the health care in these communities being withdrawn.

• Distance and weather create inequalities in access to care in rural communities.

• The cost to the health care system and to the individuals living in smaller communities is unsustainable.

• When the population of British Columbia is so unevenly dispersed, it is not possible to deliver equal care to everyone.

• The health care decisions made in Victoria do not work in rural communities.

• People choose to live in the remote communities of the province and demand that health services come to them. It is the patients’ responsibility to come the regional health centers.

• Seniors living in rural communities are moving to cities as they age to ensure they can receive medical care.

• Making health care more accessible to rural communities should be a top priority of the government.

• Those who choose to live in isolated communities should accept some of the negatives of that choice, but this does not mean the burden should be extreme.

• When there is little access to health care in a rural community, it is a deterrent for people who are considering relocating upon retirement.

• Stop the misguided and disastrous policy of centralization of inpatient health care, especially in the rural areas of BC.

• Living in a rural community, I accept the fact that I do not have nor expect to have health services that are available in centers sustained by a larger population base. I am thankful to have specialized services in locations within an hour or so and access to Vancouver Hospitals if necessary. I do not expect all services to be
available in my local community. It is not reasonable for every community to have the astronomical capital expense, operating costs and staffing overhead of all the specialized services that are available in large centres.

- I have lived in the same area on the Sunshine Coast for 40 years, during which time I have had numerous family doctors. Not because I have changed them, but because they have left the area. For the last three years I have not been able to get a permanent replacement, being forced to take whichever doctor is available at the walk-in clinic in time of an emergency. And very often the last thing I want to do at such a time is to wait two hours in the walk-in clinic. I feel that this sort of alienation is not ideal for the promotion of a person's good health.

- Many rural First Nations communities have limited access to health facilities, outreach programs and funding.

**Ideas and Suggestions**

- Provide more research into needs assessment for rural communities. For instance, there needs to be a cost analysis to determine how much money could be saved by limiting travel to Vancouver by putting additional services in rural communities.

- We are expected in a small rural aboriginal community to function like a larger community.

- Build community capacity for health care.

- Provide more health care options on-reserve to ensure that residents have access to services.

- The funding structure for rural health service delivery needs to be changed. Supply and demand should be determined and services provided to meet the needs.

- The Ministry of Health should work with Northern Health and the BC Cancer Agency to implement the Northern Cancer Control Strategy, and ensure that Northern Health provides financial assistance to northern cancer patients for travel and accommodation related to cancer treatment.

- A review to determine what medical procedures and treatments are presently available within each community should be done. Once a list has been established, services can be expanded to accommodate projected growth in the region.
Access to Health Care Facilities and Equipment

Comments and Concerns

Access to Health Care Facilities
Access to Laboratories and Diagnostic Equipment
Emergency Departments
Travelling for Health Care and Treatment
Impact of Travel on Family Members
Home, Acute and Long-term Care
Specific Communities and Facilities

• Comments on access to health care facilities:

  • Hospital parking lots are too small for the number and often the elderly must walk long way in difficult weather to reach the hospital doors.

  • Mining and forestry communities have many accidents, but not all fall in the time frame of working hours when the clinics are open.

  • Services like detoxification centres are often hours away from rural communities.

  • There are few counselling and rehabilitation services available in rural communities.

  • Many small rural hospitals have been closed. The extra ten or fifteen minutes drive to the next closest hospital may be a difference between life and death.

  • Hospitals in small communities have been closed, leaving the closest hospital sometimes hours away.

  • Communities that have hospitals that are clean and efficient are very appreciative.

  • Centralised hospitals are not helpful to people who live in rural areas.

  • The results of shutting down hospitals in rural areas are extra costs to patients and taxpayers.

  • Small rural hospitals and health units are competing against monster-sized hospitals for the same funding.

  • Hospitals have been promised to several rural communities, but they are still waiting years later. That is not fair.

  • Cancer is a critical issue for Northern British Columbians. Northern British Columbia has the highest mortality rate in the province from all forms of cancer, and cancers are the second leading cause of death among northerners.
• Regional hospitals do not properly service the cities, let alone the surrounding communities.
• Rural hospitals are declining in bed capacity.
• There are very few drug and alcohol rehabilitation centres in the interior.
• There are not enough services for spinal cord injuries in rural areas.
• Very little has been directed to specialty care and trauma care delivery in rural northern communities.
• Some rural communities have excellent health care centres, but often do not have facilities for acute care, twenty-four hour service, palliative care, or maternity care.
• There are not enough services for pregnant women or new parents in rural communities.
• The number of health facilities in remote areas in decreasing as health care becomes more centralized. This is occurring even though there is an increasing population in the rural communities.
• We applaud the Ministry of Health for recently expanding oncology services in the north. The recent opening of a new community cancer unit at the Quesnel hospital will improve access to cancer care for northern region residents.
• Some remote communities do not have cell phone reception, which is dangerous when an emergency occurs.
• There is no 24 hour, seven days a week service in rural areas.

• Comments on access to laboratories and diagnostic equipment:
  • Laboratory service is limited in most rural communities.
  • Travelling Magnetic Resonance Imaging (MRI) machines are not accurate, and rural communities should have their own.
  • In the rural areas not all regional hospitals have up to date equipment and people often have to go to a larger city to receive treatment.
  • Mobile Magnetic Resonance Imaging (MRI) units still only visit select communities, and it is difficult for senior to access, especially in the winter months.
  • Specialists do not have proper equipment in rural areas.
  • Rural physicians should have access to Magnetic Resonance Imaging (MRI) scans.
• Comments on emergency departments:
  • Emergency departments are being used as a medical clinics because no options other then driving a long distance.
  • Regional emergency rooms are overcrowded.
  • Emergency rooms in rural areas are closed at night and on weekends.
  • There is too much stress on rural emergency rooms.
  • Many hospitals are understaffed and thousands of people are without a family doctor and many small communities do not have walk-in clinics, so the only other way to get medical care is through the emergency room.
  • Emergency rooms at regional hospitals were already busy before rural communities were diverted there.
  • Emergency room services have been cut, and people have been transferred to larger regional hospitals, which have become overcrowded as a result.

• Comments on travelling for health care and treatment:
  • It is not fair to expect someone to travel long distances to get treatment.
  • Patients should not have to travel for surgery or treatments when they can be administered locally.
  • When someone is treated as an outpatient in an urban centre, they need to be there for four to six weeks, which can become very costly.
  • Patients in need of acute care are often sent to the nearest city.
  • Equity in accessing cancer care services in Northern British Columbia will only be feasible if travel and accommodation assistance is provided. Referral patterns will not change if these challenges are not addressed effectively.
  • Many cancer patients living in the interior have to receive treatments in Alberta and remain away from home for weeks because the distance is too great to do daily.
  • Health care workers in urban areas consider the travel distances when making recommendations to patients for additional services.
  • Women have to travel to have an abortion. This is makes an already stressful situation worse.
  • Follow-up appointments often mean more, often difficult, travel back to major centres.
• Many residents of rural communities have to drive and wait for hours to receive medical attention at a walk-in clinic.

• Patients have to travel for many procedures, and travel costs are not compensated. Sometimes cash must be paid at the time of the procedure in addition to time, transportation, meals and accommodation.

• Flying a patient from a northern community to Vancouver is an expensive and time consuming process that may be held back by weather and equipment shortages.

• Some hospitals in smaller communities have been closed, which has left many seniors having to travel to receive treatment.

• Having to travel for care is expensive for seniors on fixed income.

• Elderly people, especially those who live by themselves, find it stressful to travel to other cities and hospitals for surgeries or treatment.

• It is wrong to make seniors travel so far for services.

• Patients need more funding for having to travel. Just having a tax deduction at end of the year is not good enough.

• Trauma patients are often airlifted out to surrounding areas, and sometimes wait days for a bed.

• Comments on impact of travel on family members:

  • Family members should be able to be close to a loved one who is sick, but sometimes cannot afford to be there.

  • Patients often have to travel alone which puts their health in jeopardy and families are left to worry.

  • Time away from home is frustrating and expensive. Many times patients have to go back for follow-up visits, which puts additional stress on the family and patient.

  • People suffer emotional and financial hardships when they have to spend time away from home when they are ill. Some patients have spent little time away from their communities prior to their treatment. They become stressed and homesick as a result, which worsens their condition.

  • Some seniors find travel confusing and need to have an escort to navigate.

• Comments on home, acute and long-term care:

  • Rural areas are not able to get home care support or volunteers so patient can die at home
• Long-term care facilities are being closed and causing people to be transferred to out-of-town facilities away from their home and loved ones.

• Palliative care is different in smaller communities. Ending life in a hospital bed is not acceptable.

• There needs to be acute and palliative care available in rural communities. When the elderly are sent away from their families they suffer.

• Comments on specific communities and facilities:
  • The regional hospital in Castlegar was closed. It was central to the population, and now twenty-four hour emergency services are not available there. The West Kootenays need a fully staffed centrally located regional hospital.
  • Access to virtually all medical services in the Interior is limited by geography.
  • The health care system is failing the people of Trail and Rossland.
  • The city of Kelowna has more than doubled over the past ten years, and the hospital that serves Kelowna has become overcrowded.
  • Regional Hospitals should not have been so drastically cut. In Princeton, people have to drive to Penticton which is over an hour away to get to the hospital.
  • There are not proper emergency services north of Victoria on Vancouver Island.
  • Most children in the East Kootenays obtain specialist care through the Children’s Hospital in Alberta. It is easily accessible and the services have been excellent.
  • In a small city like Dawson Creek, there are only two options when immediate medical attention is needed. Either try to see your general practitioner, or go to the emergency room at the hospital.
  • Having a regional hospital in Courtenay-Comox is not a good idea. There needs to be a hospital in Campbell River as well.
  • The hospital in Comox is overburdened with the population influx to the community. Because many of the residents are over sixty, this also means a greater need for more surgeries in the future.
  • Cortes Island was turned down for funding, so the community had to raise money to buy space to accommodate mental health services.
  • The Vancouver Island Health Authority is not responsive to health care needs at community level.
  • Rural does not include Comox. Rural programs located in mid- Vancouver Island do not have credibility.
There is a proposal to re-classify the Port Alice Health Centre from a site offering emergency care to one offering only urgent care, which means no laboratory or x-ray services.

Tofino needs more in the way of palliative and respite care. Currently, there is one privately funded palliative care room in the hospital, and more is needed.

**Ideas and Suggestions**

**Access to Health Care Facilities**
**Access to Laboratories and Diagnostic Equipment**
**Emergency Departments**
**Travelling for Health Care and Treatment**
**Impact of Travel on Family Members**
**Home, Acute and Long-term Care**
**Specific Communities and Facilities**

- Ideas about access to health care facilities:
  - There needs to be more hospitals in rural communities because sometimes the travel time is life-threatening.
  - There should be clinics set up to perform prostate examinations in the interior to avoid transportation costs to Alberta.
  - There needs to be more treatment facilities in rural areas.
  - The hours of medical centres should be expanded to evenings and weekends. This would stop needless travel to the neighbouring hospital emergency room.
  - Government should re-open some of the closed hospitals.
  - Provide more rehabilitation centres accessible to rural communities.
  - Open a hospital in every rural community.
  - Increase mobile health services to rural communities.
  - Provide more women’s health services in rural communities.
  - There needs to be a minimum radial distance between hospitals in rural communities.
  - The right of the Medical Services Commission to allocate billing numbers where doctors are needed should be re-instated.
  - Rural communities should have the option of private health care and facilities.
• When building new health facilities, there should be more planning. Birthrates and new residents should be considered.

• Community recreational facilities could be used to set up small clinics with emergency equipment. These clinics could be equipped with a direct line to the British Columbia nurse help line, which would direct the caller on whether their symptoms needed urgent attention. Portable medical units could be used and moved easily if the need arose.

• Private providers and clinics should be considered to fill the health care needs in underserved rural communities.

• More walk-in clinics available would help with the shortage of general practitioners in rural communities.

• Provide more health services to rural communities to accommodate the influx of retirees.

• There needs to be properly equipped and staffed facilities open twenty-four hours a day, seven days a week in all communities with populations over five thousand people.

• Extend hours to evenings and weekends for clinics, hospitals, and doctors offices.

• Rural hospitals should continue to operate and take the stress off the larger regional hospitals.

• Ideas about access to laboratories and diagnostic equipment:
  • Rural hospitals should provide more comprehensive diagnostics and follow-up care.
  • Diagnostic facilities in hospitals should be available all of the time.
  • Upgrade equipment in rural hospitals so visiting specialists can do their job effectively.
  • There is sophisticated technology that could be brought into rural communities if the hospitals were built to equip them. It is not that the hospitals have to be big; they just have to have right equipment in them.
  • Video-conferencing could be implemented in remote areas where the patient, doctor and specialist can exchange information.

• Ideas about emergency departments:
  • Open emergency rooms 24 hours a day, seven days a week.
There are rural communities whose main industries are logging, where there is a high incidence of serious accidents. It is essential that these communities have hospitals with emergency services.

Create emergency facilities at walk-in clinics if hospitals are not close by.

**Ideas about travelling for health care and treatment:**

- There should be a patient advocate system to support patients who have to travel to urban centres for treatment.
- Those living in isolated communities should be able to access health services by traveling to centres where the appropriate care is available.
- Patients who have been transferred out of the area must not be stranded after treatment. Patient discharge must be conducted sensibly, with provisions to return patients to their homes in a timely manner. Discharge planning and communications are vital so patients know what is going on, and are able to plan accordingly.
- Schedule consultations and appointments closer together for patients who have to travel.
- Credits should be given to patients for plane tickets to Vancouver when they have to travel there for care.
- Provide financial assistance to northern cancer patients for travel and accommodation related to cancer treatment.
- There are programs that have been set up to assist with costs. Included in these programs are reduced hotel fees, and reduced or free air travel. Although these are great programs, they are still underutilized and need to be better advertised.
- When a patient is released from hospital, they are in a compromised position yet they are responsible for their own transportation home.
- More money needs to be put into travel assistance programs.
- Government should provide free transportation and subsidies for necessary travel expenses to patients.
- There should be a comfortable reimbursement for transportation costs, as it is expensive and time consuming to travel. This could be a mileage reimbursement for the distance travelled for care.
- There should be ferry discounts for patients who live on the smaller islands.
- There should be no costs at all for patients who have to travel for medical treatment.
• There should be some sort of loan or bursary that is offered to patients who are airlifted into major city centres and have no time to make necessary financial arrangements.

• Travel assistance should be provided to low and middle income individuals.

• Ideas about impact of travel on family members:
  • There needs to be space allocated for affordable accommodation for families to stay when a loved one is in the hospital. Somewhere that is close by and affordable.
  • Patients should be able to have medical treatment in their own communities with their family close by.
  • Provide more funding for families to travel with patients.
  • There should be additional funding when a patient requires a travel escort or when their family accompanies them. There should also be affordable family housing while they are away, similar to the Ronald McDonald House model.

• Ideas about home, acute and long-term care:
  • Provide more acute and palliative care in rural communities.
  • Expand end of life care and facilities in rural communities.
  • Focus on providing community services that can help maintain people in their homes and provide respite to family members who are providing care.
  • Intensive Care Units in rural communities should remain active to care for acute patients.
  • Small community hospitals should be re-opened to house the seniors waiting for placement, and to accommodate convalescing patients.

• Ideas about specific communities and facilities:
  • Make Kelowna General Hospital a teaching hospital in partnership with the University of British Columbia’s medical school.
  • A tripartite agreement should be developed between the Nelson, Trail and Castlegar hospitals to work together to provide the best care possible.
  • The north island should retain and expand the two local hospitals into state of the art facilities; these hospitals have been allowed to deteriorate for too long.
  • The west coast of Vancouver Island needs more long term care facilities and hospice spaces so that patients do not have to be sent to Port Alberni.
Create a second air health transport centre at the Campbell River Airport to:
  a. Allow easier access to remote already marginalized First Nation Communities;
  b. Avoid the congestion in the south air corridors; and
  c. Allow a second option if the weather is poor.

Utilize Prince George as a regional centre for health care in the northern parts of British Columbia.

The Red Cross outpost nurses were very helpful and should be re-instated on the small islands along the coast.

Access to Health Care Professionals

Comments and Concerns

- General comments on access to health care professionals:
  - There is no back-up relief in remote areas, or staff available to allow for professionals to upgrade their skills and training.
  - There are not enough services available in communities that are large enough to support them, because many are geographically undesirable for medical professionals.
  - Lack of funding for mental health issues and counsellors in rural communities.
  - A lack of medical professionals leads to misdiagnosis and mistakes in medications.
  - The restrictions placed on the British Columbia Dental Hygienists Association puts pressure on our healthcare system especially in rural areas. No hygienist can see a client without the patient first seeing a dentist. In Northern areas it is rare that a dentist chooses to practice rurally so therefore there is no dental health that can be provided thus increasing healthcare through poor oral health. Sometimes entire rural communities are denied oral healthcare because of the regulations.
  - Referrals to services in centres such as Dawson Creek, Fort St. John, Grande Prairie, Edmonton, Prince George, and Vancouver from the North are exceptional in most cases.
• Comments on access to specialists:
  • Timing of specialist appointments is not well coordinated with bus routes.
  • People in rural communities often have to travel at least 150 miles to receive a fifteen-minute service. This short service usually has to be repeated and can be extremely expensive as people have to pay for travel, accommodation and meals.
  • Transportation, socio-economic status and age make access to specialists even more difficult.
  • Specialised doctors are not readily available and do not want to travel to rural locations.
  • Very ill people may have to travel to long distances at their own expense to see specialists. Often, the specialist has all of the pertinent information, files and films to form an opinion without having the patient present.
  • With such limited access to specialists in rural areas, patients lose control over their care and the health professionals develop a monopoly.
  • Appointments with specialists often require multiple trips to major centres.
  • Patients must travel long distances to see specialists.
  • There are some specialists now visiting rural communities up to twice a month and seeing a large number of patients.
  • We get good daily care in Pemberton from our doctors with easy and quick access but get referred to a specialist or go for diagnostic test and you wait. Even if your need is urgent there is just too much delay.
  • There is a lack of experts and specialists in rural communities in the area of chronic diseases.
  • Working conditions are often stressful for visiting specialists.
  • When visiting specialists do come to rural areas there are too many patients to spend enough time with each one.

• Comments on access to doctors and nurse practitioners:
  • It is very difficult to find a general practitioner that is accepting new patients in rural areas, especially for those who are new to the area. Even when residents do have a general practitioner, it is difficult to get an appointment.
  • It is difficult to retain doctors in rural areas.
  • General practitioners in rural or remote communities often have large waitlists.
  • Doctors in rural areas have the highest patient load in the province.
In some rural communities there is one nurse and one doctor, and people were healthy.

It is difficult to find a doctor’s office open on a weekend.

There are often locums in rural communities, which tend to disrupt the continuity of care.

There is little access to physicians in First Nations communities.

British Columbia cannot ensure that medical services are allocated where they are needed which is one reason we have physician shortages in some areas.

It is nearly impossible to see a family doctor on short notice because they are always already booked solid with appointments, and on some days each week these doctors are taking their turns at the hospital emergency room or performing surgery, so they are not available for appointments.

Medical students sometimes get placed in rural communities, and some of the students have gone back once they have graduated.

It is not possible to get doctors to live in remote communities. A nurse practitioner would be ideal in those locations if they could be sent in on a rotation with other nurse practitioners.

Comments on access to nurses:

- Intensive care units are limited because there is a lack of nurses.
- Nurses are flown into some communities for a set time each month, but this is not enough.

Ideas and Suggestions

Access to Health Care Professionals
Access to Specialists
Access to Doctors and Nurse Practitioners
Access to Nurses

Ideas about access to health care professionals:

- Financial assistance should be provided for health care professionals willing to work in remote areas.
- Medical staff in rural communities need to be trained in all areas of health and medicine.
• Lodging expenses should be covered for medical professionals living in remote areas.
• There should be wage incentives for medical professionals to come to, and stay in, rural communities.
• Medical professionals in rural communities should receive education on cultural sensitivity.
• There should be health professionals that cater specifically to the needs of First Nations in rural areas.

• Ideas about access to specialists:
  • Travel to specialists needs to be reduced or made more affordable.
  • Specialists should be brought to the patients. It is a better option to have visiting specialists than having patients travel out of the community.
  • There should be surgeons at the smaller rural hospitals so that more surgeries can be performed closer to home.
  • Provide roaming specialists in mobile clinics to rural communities. Support regular travelling specialists that are on salary and travel to communities as needed.
  • Provide and coordinate transportation for patients who require testing or treatments with a specialist located outside of British Columbia.
  • Specialists should visit rural communities twice a month.
  • Make out-of-town specialists more accessible.
  • Rural communities need to have resident specialists (anaesthesiologists, dentists, heart specialists, chiropractors, surgeons, oncologists, et cetera), or at least have specialists that visit on a regular rotation.
  • Communities should support local physicians to provide temporary care in the absence of a specialist.

• Ideas about access to doctors and nurse practitioners:
  • Physicians in smaller communities should be salaried with incentives to keep them there. Government should implement a similar system to the one in the thirties in Saskatchewan.
  • Have a physician and clinic in every rural community.
  • Utilize doctors coming to British Columbia from other countries.
• Government could increase the number of physicians in the rural areas by granting scholarships to medical school to students who agree to practice in rural areas for a minimum number of years.

• Expand the role of nurse practitioners.

• Recruit foreign trained specialists to come and practice in rural British Columbia.

• Doctors should spend a mandatory time with First Nations or remote communities.

• We should have a rotation system where a doctor must spend time in a rural facility every few years.

• Emergency room doctors in rural communities should be on salary to ensure emergency services.

• Ideas about access to nurses:

  • There needs to be sleeping rooms for nurses who travel to rural areas.

  • Rural communities need more nurses.

Transportation

Comments and Concerns

Lack of Transportation
Road Conditions
Bus Systems in Rural Communities

• Comments on lack of transportation:

  • Sometimes the closest hospital is hours away with no reliable transportation available.

  • When people have limited funds and no transportation, their access to care is restricted.

  • There is a lack of transportation vehicles on-reserve to get clients to medical appointments.

  • In some small communities there is no medical service outside of regular office hours. Because of this, residents have to travel to the nearest hospital or call an ambulance. If they are admitted to hospital, they often have no way of getting home other then taxi which can be expensive.
• Comments on road conditions:
  • Driving on rural roads or mountain highways to reach a hospital can be extremely dangerous in winter months.
  • It can be dangerous to drive at night when immediate medical attention is required.
  • Winter travel is dangerous and difficult for seniors.
  • There is a large population of seniors who prefer not to drive long distances or in the dark.

• Comments on bus systems in rural communities
  • There are bus systems specifically for patients travelling to specialist appointments throughout the province. The cost is reasonable, they are wheelchair accessible and it appears to be working well.
  • Northern Health Authority Buses can be inconsistent, inconvenient, take a long time, and they do not always follow a direct route.
  • Some rural communities do not have public transit.
  • Patients without vehicles or someone to drive them have to take buses and taxis to their medical appointments or the hospital.
  • The Northern Health Authority bus is not utilized.
  • There are many seniors in remote communities with no public transportation.

Ideas and Suggestions

Lack of Transportation
Road Conditions
Bus Systems in Rural Communities

• Ideas about lack of transportation:
  • Transportation should be provided to rural patients when they need to go to urban centres for treatment.
  • Hospitals that are close to each other could share the responsibility of providing transportation for patients.
  • Increase resources for medical transportation for patients on and off reserve.
  • There needs to be equitable transportation options in all communities regardless of the population.
Part II: Summary of Input on the Conversation on Health

- Partnerships with companies may be an option to provide inexpensive transportation for patients.
- Service clubs may be willing to help coordinate transportation for patients.
- Build transportation capacity on reserve.
- The handyDART services should be expanded for wheelchair-bound patients and people with disabilities.

- Ideas about road conditions:
  - Government should increase funding for road maintenance.

- Ideas about bus systems in rural communities
  - Bus services should be available in rural areas to bring people to the regional health facilities.
  - Revise the schedule for buses to meet the needs of patients having to travel.
  - Patients should be encouraged to use public rural transportation.
  - There needs to be more public information available about the Health Bus so patients can maximize the service.
  - The schedule of the Health Bus needs to be more flexible and extended to cover more communities.
  - Money should be allotted for patients to use the bus system when they have to travel for treatment.
  - Band manager or Community Health Representative should work with transit (HandyDart coverage).
  - There needs to be more qualified drivers to transfer people that have knowledge of locations of specialists and services.
Ambulance Services in Rural Communities

Comments and Concerns

Access to Ambulance Services
Ambulance Costs
Dispatch
Response Times
Resources

• Comments on access to ambulance services:

  • No small British Columbian village or town should be deprived of ambulance or other emergency service.

  • People need to able to get the services they need where they live. There needs to be access to emergency response teams throughout the province.

• Comments on ambulance costs:

  • There is a concern about the high cost of ambulance service in the north.

  • Growing rural communities are concerned about a lack of ambulatory services and the costs associated with expanding the service.

  • More money is being wasted since small regional hospitals have been closed and patients now have to be ambulanced hundreds of kilometres for treatment.

  • With an ageing population, we need more money put into our ambulance services.

  • Many ambulance trips and thousands of dollars are used to transport cardiac patients from the interior to Vancouver General Hospital for surgeries, either by ground or air. If they could have the surgery at Kelowna General Hospital, the transport and wait times would be less, the patient’s family could be much closer and we would not have to risk ambulance trips over the Coquihalla in the winter.

• Comments on dispatch:

  • Dispatchers are often not familiar with local condition so sometimes ambulance crews are sent to the wrong area. The topography of the East Kootenay area especially provides a challenge to some dispatchers.

  • 911 staff in smaller communities volunteer their time and only receive a nominal honorarium for their work. In order to receive further training the staff members must take leave without salary from their jobs and pay for travel and
accommodation expenses out-of-pocket. This must be improved to successfully recruit new staff members.

• Dispatchers are not available for local areas.

• Comments on response times:
  • Patients must wait a long time for ambulances and first responders to arrive from the larger neighbouring communities.
  • Ambulances take a long time to respond to calls in rural areas.
  • It can take up to three hours or more for an ordinary medical evacuation and up to three days for evacuation by air in northern British Columbia.
  • Castlegar has no ambulance service whatsoever.
  • It can take up to three hours for response by ambulatory services in Dease lake.
  • It takes at least 90 minutes for an ambulance to arrive in an area located 30 miles outside of Fort St. John.

• Comments on resources:
  • The shortage of ambulance crew and vast distances that the ambulance station must cover in rural communities is a significant concern.
  • In Bella Coola, the ambulance crew is down to five or six staff, most of whom have full time jobs, as well as family and community responsibilities. Most crew members in these communities begin working as first responders as a community service and are generally not interested in working full-time or working in any other communities. During the last few years, the Bella Coola crew is being asked to cover Anahim Lake, Bella Bella and serve as back-up for Alexis Creek because of the extreme shortage of crew in those communities. This has meant that the Bella Coola crew travels to Klemtu, Bella Bella, Port Hardy, Anahim Lake and even into Williams Lake. When one crew, which is comprised of two people, is out of the valley due to holiday, business or on another ambulance call, the remaining members have to cover shifts in the valley or put the ambulance out of service. Both the downturn in the local economy due to a loss of jobs in the forestry industry and a lack of incentive to join the British Columbia Ambulance Service are leading to human resource issues in rural communities.
  • Public policy around training costs and remuneration for those on call are actively discouraging recruitment and retention of ambulance volunteers. As a result, the number of volunteers in rural areas is declining drastically to the point where service is seriously threatened.
Ambulances are often absent from their home communities when required to cover service gaps in other regions. An efficient, equipped, and properly staffed ambulance service can make the difference in a patient’s survival.

Fewer hospitals mean more ambulance trips.

**Ideas and Suggestions**

- Transport patients from rural communities to hospitals located in the interior rather than in the Vancouver area.
- Implement and/or upgrade access to ambulance services in the north.
- Decentralize ambulance dispatch services.
- 911 services should be tailored more to suit the needs of the community or region.
- Initiate active recruitment in small and rural communities to help alleviate the shortage of ambulance crew.
- Increase paramedics’ standby wages, often called pager pay.
- Ensure that ambulance crews receive training within the community at little to no cost.
- Increase access to helicopter ambulance service in rural areas.
- Ambulance service should be enhanced so responders are qualified paramedics with the capability to start an IV and use defibrillators.
- In rural areas, there should be a medical clinic service adjacent to the ambulance dispatch center. When the paramedics are not on calls, they could assist with patients.
- There needs to be at least one medical team, ambulance or helicopter in rural areas to respond to emergencies.
- The maintenance of a multi-ambulance service in Tumbler Ridge is critical as active oil and gas exploration leads to multiple emergency calls at the same time.
Community-Based Care

Community-based care was a topic for discussion in the Conversation on Health. The importance of addressing issues related to accessing and funding care at the community level, and service delivery in communities were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of community-based care.

Accessibility of Care

Many participants suggest there is too much focus on acute care and too little on community-based care. Participants believe that community-based care would both be cost effective and provide quality care; however, it would need significant up-front funding in order to work properly. Many support the idea of community members having input in defining what a community has, what it has the potential to deliver and what is needed to improve access to services. Several respondents emphasize that centralizing services instead of supporting outreach programs does not solve access problems since this increases demands for transportation. Others suggest that sending people from northern communities to the south is sometimes appropriate, and that the Interior Health Authority bus is a good solution to transportation issues. Vulnerable populations are at greater risk when community services are cut back and many supported providing basic services to particular communities, like the Downtown Eastside, to decrease ambulance fees and other health costs.

Funding and Costs

Many participants are concerned that health authorities download costs to the community. Many emphasize that some communities do not have the numbers to qualify for government-funded programs or support outreach programs. Many recommend investing in communities to help set healthy goals and action plans. Some suggest that, although the health authorities are supposed to be informed by communities, the amount of consultation that actually happens varies significantly across the province because there is little funding available at the community level. Participants emphasize the importance of ensuring that community health and social service agencies have adequate resources to deliver on-the-ground support services.
Community-Based Service Delivery

Participants suggest that communities need to build greater capacity with a specific focus on community services. Many believe that communities must become involved in health service delivery. Many of the participants who took part in Aboriginal community engagements suggest that First Nation communities need to be empowered to take action, and figure out what they need to improve their health status. Recommendations to improve community-based service delivery include: supporting those who chose to return to smaller communities through access to housing, employment, consistent medical services and education; expanding community services to allow for earlier discharge from hospitals; and making community living and services available to those with disabilities. To provide the impetus for focused health promotion and prevention programs, participants also suggest providing communities with information that describes where they stand in relation to provincial statistics related to health status.

*We should think about communities as well as individuals. It is what we do as a community that will make a difference as we move ahead. There is a tendency for us to think about individuals doing things. I think that community response is important.*

- Provincial Congress, Vancouver

Many participants discussed the development of community health centres or community clinics, collaboratively run by service providers. They recommend these health centres be accessible 24 hours a day, seven days a week, and that they be staffed by salaried, multi-disciplinary health teams appropriate to the needs of the community. Many believe community health centres decrease the demands on emergency services and could host a vast number of health professionals including: physicians, nurses, physiotherapists, outreach workers, community support workers, pharmacists, counsellors and nutritionists. Participants emphasize that community clinics are needed across the province, not just in major centres.

**Conclusion**

Many participants highlight the need for accessible, community health services based on community needs. The majority of participants involved in the discussion believe that investment in community care will result in decreased costs and demands in other parts of the health care system.

*With what we've done with rural communities the last couple of years, I am absolutely convinced when you give people the opportunity to come together, the answer is there. The problem is they've not had the opportunity*

- International Symposium, Vancouver
Community-Based Care

This chapter includes the following topics:

Access to Care at the Community Level
Funding of Care at the Community Level
Community-based Service Delivery

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

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

Report to the Conversation on Health
Submitted by the BC Cancer Agency

Proposed Final Submission to the Conversation on Health
Submitted by the Advocates for Seniors Care - Vernon

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Access to Hospitals in Rural Areas; Home Care or Support; Health Care Models; First Nations and Seniors.

Access to Care at the Community Level

Comments and Concerns

Access for Marginalized Communities
Accessibility of Community-Based Models

- Comments on access for marginalized or vulnerable communities:
  - Urban Aboriginal people are in a different situation than someone who lives on an Aboriginal Reserve.
  - Looking at the Downtown East Side, which is the poorest postal code in Canada, the health needs there are startling. These people are largely ignored because
they live in a marginalized community, yet they know what they need to access health care. These residents live in single occupancy hotel rooms, shelters and under bridges so their needs are different than people who live in higher-income neighbourhoods.

- Vulnerable populations are at greater risk when community services are cut back.
- If we went to Alert Bay then we could learn something about how the Aboriginal and non-Aboriginal groups within that community work together.
- Some of the existing support systems, that place people back into their community after they have been in hospital, are very good and culturally sensitive.
- Access to basic health is limited by a lack of health professionals in small communities. This means that larger communities have better basic health care access than smaller communities.

• Comments on the accessibility of community-based models of care:
  • There can be negative consequences of changing from institutional care to community-based care when communities do not have the necessary resources.
  • There is now less community-level interaction, which has been partly created by walled communities.
  • There is no community support program in place for post-cancer treatment.
  • Both the public and health care providers lack knowledge in available services in communities.
  • Community-based services are easier to access.
  • Some community co-ops are in place and facilitate access.
  • Centralizing services instead of supporting outreach programs does not solve access problems. This is because centralization of services requires additional funding and resources to meet the increased demand for transportation.
Ideas and Suggestions

Access for Marginalized Communities
Accessibility of Community-Based Models

• Ideas about access for marginalized or vulnerable communities:
  
  • Remote communities or social service organisations within smaller communities should be able to hire a certified dental assistant to provide preventive services.
  
  • Providing basic services in the Downtown East Side would decrease ambulance fees and other health costs.
  
  • Communities have lost the feelings of ownership, empowerment and responsibility for the delivery of services. In Ontario this was resolved through the creation of District Health Councils, which engages seniors and community groups.
  
  • It is sometimes appropriate to send people from northern communities to the south and the Interior Health Authority bus is a great idea and the operators are excellent.
  
  • If you empower Aboriginal communities to take action, then they can figure out what they need to improve their health status.
  
  • Support sustainable interactive community and community outreach.
  
  • Community living and services should be available for people with disabilities such as Foetal Alcohol Syndrome.

• Ideas about accessibility and community-based models of care:
  
  • There has been talk, for ten years or more, about a community model of care being the easiest way to provide integrated community level care. People perceive that this type of care would be cost effective and provide quality care; however, it would need significant up-front funding in order to work properly.
  
  • There is a need for a community integration model or a community development model where community members give input into the services and programs developed.
  
  • In a community based primary healthcare network with community governance, members from the community should be involved with their needs assessment. Local community members would be the best ones to ascertain the different capacities and needs of their community.
  
  • Boosting the continuum of services available at the community level for seniors and aging has proven cost effective.
Community health care should be local and accessible.

We need to develop a community of practice in the form of a learning community that might be made up of a number of navigators, a number of occupational therapists or a number of clients who meet. This learning community would talk about what their experience was in their community, what they learned, what they struggled with and how they resolved their issues. This process could be carried out through teleconferences, web discussions and should be endorsed and funded by government.

We need to do an asset assessment in order to define what a community has, what it has the potential to deliver and what people need to improve their access to health services.

Provide follow-up with outreach clinics in the community.

Bring health services to the outlying communities.

Encourage young Aboriginal people to volunteer in their communities.

Funding of Care at the Community Level

Comments and Concerns

- Health Authorities are currently downloading costs to the community.
- Our community does not have the numbers to qualify for government funded programs and facilities.
- Community care groups do not have money for outreach.

Ideas and Suggestions

- Increase funding to community care. Put health care money into communities to help them set healthy goals and action plans to get to root issues. Provide funding to get communities talking proactively about responsibilities in health service delivery.
- Public and/or private funds are needed support community health programs.
- Ensure community health and community social service agencies are adequately resourced to deliver on-the-ground support services.
- Redirect funding from new technology to community support.
The regional health authorities are supposed to be informed by community counselling, community participation, but the amount of consultation that actually happens varies significantly across health authorities and across regions or communities. You get some communities that are much more active and interested, and therefore are able to lobby for services. However, there is not a lot of money at the community level. There are lots of tools, and lots of resources out there, but there is nothing to mobilize the grassroots level.

The health budget and community economic development budgets do not meet. Use the Union of British Columbia Municipalities as a body to coordinate and administer funding for communities.

Focus on improving outcomes versus cutting costs - get better value from what we spend by assuring appropriate use and adherence. The right intervention for the right patient at the right time. Improve continuity of care - so when people leave the hospital they do not get lost to follow-up and appropriate guidelines to care are followed - includes transition from hospital to home, to chronic care facilities or to assisted living.

To promote maximum choice and decision-making, encourage private investment in additional services, and ensure living costs are paid by the user. A system that distributes 'care credits' (or client vouchers) could evolve. Specifically, the client would direct their 'care credits' (i.e. designated/qualified funds) towards specified organizations ' depending on a wide variety of choices. For example, they could consider home support, adult day programs, or community living options.

**Community Based Service Delivery**

**Comments and Concerns**

- Communities are responsible for people with mental health issues and addictions.
- Community based support programs can be effective.
- Assertive community treatment such as in Ontario is effective for mental health issues.
- Community court takes a holistic approach to delivering justice and is a good innovation.
- We do not accurately look at evidence related to community health care.
- There is too much focus on acute care and too little focus on community-based care.
Ideas and Solutions

Community Based Health Centres
Partnerships and Linkages
Capacity Building

- Ideas about community health centres or clinics:
  - Develop community health centres or community clinics that are collaboratively run by service providers.
  - Community Health Centres should be accessible 24 hours a day, seven days a week.
  - Community Health Centres work to decrease the demands on emergency services (ambulances, emergency rooms etc.).
  - There is a need for more salaried, small clinics with a health team that is appropriate to the needs of the community.
  - Multidisciplinary integrated care services should be available that are based in the community. Focus on education and recruitment for staff for these programs.
  - Community Health Care Centres should be established and run by a local non-profit board made up of community members and health care professionals elected by the community in which they operate. The Centres should host a vast number of health related professionals including: physicians, nurses, physiotherapists, outreach workers, community support workers, pharmacists, counsellors and nutritionists. These professionals should be paid on a salary basis allowing for more time and care to be given to patients which will result in better care being delivered and thus will be cheaper to the system in the long run.
  - The Ministry of Health should standardize community health centre models and staffing.
  - Every community needs to have a primary health centre that would support prevention, diagnosis and treatment, staffed with nurse practitioners. These health centres should be housed with other services such as seniors housing.
  - There is a need for community-style facilities as an alternative to home care or institutional care.
  - Community clinics are needed across the province, not just in major centres.
  - The Mid-Main Community Clinic, the Reach Community Clinic, Tahsis Medical Clinic, and the Native Health Clinic all provide examples of effective community health centres with salaried doctors.
Ideas about partnerships and linkages:

- Use rural communities to test the healthy community strategy. The Province needs to partner with communities while supporting community driven strategies, act as the steward of all data and statistics and monitor performance.

- Communities could form medical neighbourhoods that would work along the same principles as a Block Watch.

- Links between paediatricians and community support workers are essential in detecting, managing and preventing chronic disease.

- Students from leadership classes in schools should be used as a resource in communities. School systems can be integrated with community needs: high school kids volunteer to help disabled, to cut lawns, take out garbage. This is a win/win situation that develops compassion in youth and could help recruit them into the health care system.

- Introduce care programs for chronic disease in home and community care. Develop systems for shared information between facilities and health care professionals and fund programs to meet these needs. Support innovation in acute care with appropriate services in the community. Continue to support individuals to care for family at home for end of life care. Expand funding for family members.

- Link Health/Activity Programs related to chronic disease management with existing Community Centres.

- Encourage greater ongoing constructive dialogue with all of the important stakeholders involved in the healthcare system, including patients.

- Recognizing and incorporating innovation is the key to improving healthcare and to getting the best value for the dollars we spend. Recognizing and utilizing innovations and working with the stakeholders involved in the system will lead to greater cooperation and improve outcomes - the ultimate goal is to improve the health and well being of all British Columbians.

- Innovations in Health Care Delivery and Health Services - recognize the role the private sector and citizens can play in helping deliver care. Coordinate and utilize the many participants in the health care continuum.

- Use the resources the province has in the linked health care database (including PharmaNet) to improve utilization management and identify care gaps in managing the health of people in BC.
• Ideas about capacity building:
  • We have to focus on building the capacity in the community so that the
    community again starts to look after itself.
  • Communities need to have the capacity to support seniors. There is a need for
    local community services.
  • Communities must become involved in health service delivery, as it is not just the
    responsibility of Government.
  • People who chose to return to smaller communities need to be supported
    through access to housing, employment, consistent medical services and
    education.
  • More support is needed for community care facilitators to find solutions to
    community health issues, decreasing the amount of control held by government
    and health authorities.
  • There is a need to tap into resources available to help non-profit organizations.
  • Recognize positive community models and replicate/support them.
  • Promote whole community senior care and encourage school kids to interact with
    seniors.
  • Provide communities with information that describes where they stand in relation
    to provincial statistics related to health status to draw attention to issues and
    provide the impetus for focused health promotion or prevention programs.
  • Expand community services to allow for earlier discharge from hospitals.
  • Continue to support innovations through support for research in the life sciences.
    This includes basic research in mechanisms of disease pathogenesis and targets
    for prevention and treatment, development of new therapeutic modalities, new
    vaccines, new models for prevention, clinical trials and health outcomes and
    health economic research. We have great universities, top notch medical schools
    and schools of pharmacy. Look at the healthcare system as whole, not in
    individual silos within health care. Look at the impact on the economy as well.
Home Care and Support

The topic of home care and support has been very popular among our participants, generating much discussion around sustainability and the future of caring for seniors and those with mental and physical disabilities. The importance of addressing issues related to accessibility, service delivery and safety, funding and costs, caregiver support and health human resources were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of home care and support.

Accessibility of Home Care

Participants have a number of concerns with the lack of home care services, both for the disabled and the elderly, which they suggest increases hospital admissions and costs. Many describe barriers to accessing home care including: a shortage of information available pertaining to types of services available and how they are delivered; people being intimidated by the criteria that have been set out for accessing home support programs; and a lack of transportation in rural areas to help patients attend to personal needs. Many emphasize that isolated rural retirement communities in the province often do not have access to services.

Participants have several suggestions to improve the accessibility of home care. They suggest creating a policy that clearly defines the eligibility requirements for home care benefits to ensure that the elderly get appropriate care. A number of participants focus on the need for long-term planning around home and community care and recommended providing patient advocates and public education on home support options. Many suggest expanding mobile health services to serve seniors in their local community, as well as increasing transportation options and support for community programs. Some emphasize the need for the integration of home care, hospice, community and hospital services. Others encourage multi-generational living to reduce the isolation of seniors while also strengthening families.

Delivery of Services & Patient Safety

Despite suggestions that there has been a gradual recognition of the growing need to provide services to the aging at home, many participants voice concerns about cuts and restrictions placed on the delivery of home care services. Many believe these cuts, including cuts to personal care time and services such as light housekeeping, meal
preparation and driving, negatively impact the safety of many home care recipients. Participants suggest expanding the flexibility of personal care services to respond to fluctuating or emergency needs and assigning regular clients to individual home support workers. For many, making care available 24/7, expanding the eligibility criteria for subsidized services, and increasing the speed and frequency of assessments was also important. Several participants mention that patients with mental illness need home support. Some suggest that the lack of discharge planning in the current system exacerbates gaps in service delivery. They feel this planning should take a team approach, with home care providers having the authority to decide when discharge is inappropriate or not enough in-home support is available. Participants also recommend supporting home adaptations and modifications that would allow seniors to stay at home safely, rather than moving to facilities.

*Increase home support so that people who need it, but cannot afford it, will have help with cleaning of home, cooking, shopping etc this would help prevent falls, eating unhealthily, thereby cutting down on visits to emergency*

- Regional Public Forum, Castlegar

A number of recommendations involve delivering home care services through cluster care and providing coordinated services to all seniors living in one apartment building to increase the time available to the home care workers. Other suggestions encourage individuals to place caregivers in homes that would work like a co-operative, with two or three seniors living together. While some believe that the distinction between home and in-place care has to be better defined, many support increasing supportive housing and support programs to allow people to live independently for as long as possible.

**Funding and Costs**

Due to lack of funding, many participants are concerned that home care can result in a considerable financial burden for the patient and their families. Many believe there is not enough funding for home care workers and that services that allow aging-in-place should receive more funding. Participants recommend stable government funding to provide 24/7 community and home support based on individual patient needs. Some believe home support needs funding on a program by program basis. This would ensure longer term planning, while supporting regular scheduling for workers and ensuring the targeted delivery of health care services when and where they are needed. Many suggest the Government needs to follow through with the data already
collected, which demonstrates the cost effectiveness of keeping seniors in their own homes. Although statistics may be showing an increase in the cost of home support, they feel this is balanced by the high cost of having these patients in the hospital.

Participants suggest new funding and delivery models for home care. These include: placing the home support system outside of the Ministry of Health; making social housing programs the responsibility of municipalities; supporting home care through both federal and provincial funding; supporting more collaboration between private and public service providers and, separating home support for seniors from other parts of home care. Others suggest that money would be better invested in supporting families who care for their elderly as opposed to building additional seniors housing.

Another viable option for home care is the expansion of… program[s] that provide[s] 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

- Submission, British Columbia Medical Association

Caregivers and Support

There is widespread recognition that caregivers play an important role in our health care system and that they need to be provided with adequate supports. Participants feel that providing resources to support caregivers would result in an economic burden and an emotional and physical strain on them. Many recognize the importance of respite and suggested that counting on families, friends and volunteers to provide for complex medical needs can be unrealistic. Some suggest that not all caregivers are aware of the resources, supports and services available to help them.

Recommendations to increase caregiver supports include providing mentoring and a communication plan and creating financial support or tax credits for caregivers. Others are concerned that these supports may be of limited benefit to low income families. Recognizing that all families have unique needs, participants suggest providing various supports to families providing care and being flexible in service delivery.
Support must be provided to this group of people that save the taxpayers so much money and provide the care and supports needed by their loved ones. We must learn to care for the caregiver…Respite care can be considered a health promotion and protective factor for caregivers, potentially leading to better care and reduced institutionalization

- Victoria Order of Nurses, Submission

Health Human Resources

Many participants indicate that there are shortages of trained home care providers, particularly in rural communities. As travel between clients can take a significant amount of time, many explain the difficulties of organizing schedules and the resulting lack of continuity of care for the client. Although participants acknowledge that home support workers can be very helpful, they describe the amount of time workers are allocated for an individual as insufficient. Many emphasize the strength of the voluntary sector in some communities. However, they suggest volunteers are not coordinated and, in many areas, there is no awareness of what services are actually available.

Working conditions for home support workers are also a focus in the Conversation on Health. Participants recommend making home support shifts a set number of hours, rather than sporadic time blocks over the course of a day and enticing new home support workers with increased compensation. Recommendations also include: providing education for home care support workers on diverse cultures; and changing job description to allow workers to provide housekeeping services as a form of preventative care. Many also discuss the importance of physician support and expanded roles for registered nurses in home care.

Conclusion

Many participants believe there is a need for a broader, more accessible home support system with increased hours per client. Participants identify increasing supportive housing and home care programs and the availability of community options as important areas for improvement. These steps would allow people to live independently for as long as possible and ensure caregivers receive the supports they need. Many believe improving homecare will also decrease costs and demands in the acute and long term care sectors.
Home Care and Support

This chapter includes the following topics:

Health Human Resources
Care Giver Support
Funding and Costs
Accessibility
Service Delivery
Safety

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

Addressing the Home Care Nutrition Care Gap in BC
Submitted by the Dieticians of Canada, BC Region and the Community Nutritionists Council of BC

Family Practice Recommendations For British Columbia’s Health Care System
Submitted by the Society of General Practitioners of British Columbia

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

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

Keeping The Elderly Safe And Well At Home: A Case For Assistive Technology Including Telecare
Submitted by Bob Schutte

Saving Money By Saving Patients
Submitted by Leta Sinclair

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

Submission to the Conversation on Health
Submitted by the BC Cancer Agency

Submission to the Conversation on Health
British Columbia Government and Service Employee's Union

Proposed Final Submission To The Conversation On Health
Advocates for Seniors Care - Vernon
Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Seniors; Community Care and Wait Lists/Wait times.

Health Human Resources

Problems, Issues and Concerns Identified

Hours and Salaries of Home Care Workers
Accreditation and Training
Demands and Shortages
The Voluntary Sector

- Comments on hours, contracts and salaries home care workers:
  - For many home care professionals there is a disparity in the hours worked and hours paid. Staff members get paid for eight hour days when they are in fact working many extra hours.
  - In many cases a care worker is only allowed 15 minutes with each client.
  - Home support workers can be very helpful, however the amount of time that is allowed to an individual can amount to as little as 15 to 20 minutes. Workers are no longer expected to prepare meals from scratch, only reheat food in the microwave.
  - Community care is limited in how many hours a day can be spent in a person’s home, and by how many registered nurses or other practitioners may attend to patients. The visits are further limited by the skills of the registered nurse and the orders obtained from the doctors, so that the registered nurse is unable to carry out effective symptom or issue management.
  - Travel between clients can take a significant amount of time. Therefore it is difficult regulating the schedules and the client often does not know when the worker is going to arrive.
  - The number of hours allotted to home care providers per week is too low.
  - Home support should include assistance with personal care, cooking, cleaning, medication management, social and recreational activities. Currently this is not happening.
• The contracts of home support workers are inefficient and do not meet the needs of the clients or the workers.

• The hourly wage rate for Independent Living staff is below the agency rate, making staffing difficult. Independent Living is being used as a cost-saving mechanism for the Vancouver Island Health Authority which is not how it was intended to be used.

• There is a shortage of hours for home support workers, especially those workers who help elders and chronically ill people within the First Nations community.

• There is a lack of continuity in home care providers; patients often do not know who is coming and when.

• Comments on accreditation and training of home care workers:
  • There is little regulation of private home care providers. Operators meet minimum criteria and there are currently no controls on who can operate in this field.
  • There are not enough paid support workers to enable seniors to stay in their homes.

• Comments on demands on and shortages of home care workers:
  • Working with seniors is not always easy; there can be fights and arguments along with a lack of respect and care from family members.
  • Care to seniors should be available 24 hours, 7 days a week if needed. A shortage of home support workers and funding means that there are not enough resources available to provide the appropriate care.
  • There is a shortage of home care workers in Barriere, and in most small communities.
  • Many home care services are contracted out to agencies that are short staffed.
  • There are many staffing issues in home care, with staff performing at low standards, for example: not completing duties required for the client, missed appointments, and a lack of clarity in the roles and responsibilities of staff, from management to front-line workers.
  • Maternity Community Nurses do not have adequate resources for home visits.
  • There is increased pressure and demand on home care nurses, physiotherapists, and occupational therapists as patients are more ill due to early discharge from hospital. Early discharge results in a lack of early interventions and prevention oriented care.
The home support workers are dealing with many chronic disease issues, but all the funding for chronic disease management and prevention is currently going to physicians.

Home care practitioners perform an amazing role in providing care in difficult situations.

The fundamental decision that needs to be made related to home care is who is going to manage the care? Who is going to be the coordinator and the facilitator and the negotiator? The question is, does the public want to go to a physician driven system where they coordinate or run everything, or do people want to have a system that recognizes that there are some professional services needed and some non-professional services, where a case manager could actively coordinate with a physician?

Many home care providers are motivated, caring and want to help.

The infrastructure is there to support an effective home care system and it will work well after certain issues are addressed.

The lack of trust that Aboriginal Elders have for home support workers can be a barrier to treatment.

Comments on the involvement of the voluntary sector:

Some services are provided by volunteers, however these volunteers are seniors themselves and the next decade may experience a overtaxed volunteer system.

The voluntary sector is very strong in some communities and can provide excellent services to the elderly. However, it is not coordinated and in many areas there is no awareness of what services are actually available.

**Ideas and Suggestions**

**Hours and Salaries of Home Care Workers**

**Accreditation and Training**

**Demands and Shortages**

**The Voluntary Sector**

Ideas about hours, contracts and salaries of home care workers:

There is a need to support consistent home care services, with care scheduled on a regular basis and provided consistently by the same caregiver.

More time is needed for the home care workers to be in the home.
• Alter job descriptions to allow for flexibility of service delivery within the boundary of common sense.

• Remuneration of home support workers should be increased to a rate that would allow them to live comfortably; the current rates are shockingly low.

• Improve working conditions so that home support shifts are a set number of hours, rather than sporadic time blocks over the course of a day.

• Efforts should be made to entice new home support workers with increased compensation.

• Increase salary and permanent positions in home support. Focus on retention and resources.

• Job descriptions for home support workers should be changed to allow workers to provide housekeeping services as a form of preventative care.

• Provide full-time employment versus part-time for home care workers.

• Ideas about accreditation and training of home care workers:

  • Provide education for home care support workers on diverse cultures. Caretakers must respect elders and adapt and be flexible to cultural needs.

  • Enhance the available education for home support workers, for example, range of motion.

  • Retiring professionals could be retrained to join community and help with home care.

  • Encourage staff to work cohesively; carry out team building activities and have some funding attached to this.

  • Home care workers should be bonded and regulated.

  • To alleviate harassment claims from staff a management course should be provided for supervisors to allow them to focus on capacity building and their ability to deal with staff issues effectively.

• Ideas about demands on and shortages of home care workers:

  • Stop cutting home support workers from the system.

  • Hire more home care nurses and home support workers.

  • After-care teams, early psychosis teams and behavioural teams are needed in home care.

  • More home support workers are needed and they should be given flexible hours. More incentives are needed for people to go into the field.
Establish an online network to support home care workers and families in need of home care. A registered care aide job exchange on a web site would be useful.

Action oriented discharge planning is needed with enough staff support to carry it out.

There is a need for more community based registered nurses, licensed practical nurses, and other support workers to help people stay longer in their own homes.

Geriatricians should be included in home care teams.

Physician support is the key to successful home care as are expanded roles for Registered Nurses.

Coordinators should be hired for home care in all communities.

More integration of home support and community health workers with other health services and within the health care team.

Ideas about the involvement of the voluntary sector:

The voluntary sector is a cornerstone of the home care support system and methods should be explored to assist these organizations.

Non-profit societies could hire, screen, and administer criminal record checks to ensure that workers are safe to go into seniors’ homes, to clean, cook, and do laundry services.

Care-givers and Support

Comments and Concerns

Financial Support for Care giving
Family Caregivers
Respite and Support

Comments on financial support for care giving:

The economic burden of care-giving can be considerable.

There is a lack of financial support for family caregivers.

Paid caregivers or respite services are lacking in many communities.

When you talk about home care and so on, one vehicle that governments have looked at and are doing to some degree, is to provide tax credits for stay at home caregivers, but by providing tax credits instead of money they are only providing
tax relief to people who have enough income to be taxed, leaving lower income families in financial difficulty.

- The system is biased towards paying care workers rather than family members who care for long term care patients.

- In the United Kingdom people receive care allowances and there is an increased awareness of employers with regard to seniors' care; for example, employees can take a two-hour lunch hour to go home and care for senior family members.

- In Germany, if someone gives up a full-time job to look after somebody who needs full-time care, they receive an ongoing tax incentive for as long as the patient at home is alive.

- Comments on family caregivers:
  - Families are sometimes intimidated into performing services for patients.
  - Family members are needed to care for elders in the home. This can place a lot of strain on family members when there are few resources or supports available to help them.
  - Caring for a family member can be hard physically and emotionally.
  - 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.
  - It is unrealistic to count on families, friends and volunteers to provide for complex medical needs. With families dispersed across the country it can become even more difficult to care for the elderly. If someone is taking care of a young family as well as aging parents it can be impossible to keep a full-time job.
  - High expectations can be placed on families and their ability to provide care and assistance. These expectations can lead to burnout.
  - If the caregiver of a family member with a chronic illness gets sick and is hospitalized, there is no one left to look after the ill person at home.
  - When somebody has a diagnosis of dementia, all the aspects of care are discussed: the care givers, home care resources, mental health supports and other assistance, that allow families to deal with issues. However, there are often people who don’t receive early diagnoses, resulting in sudden crises that can leave the family unsupported and without the necessary knowledge.
  - As home support has been cut back, the pressure on the family members of people with chronic diseases increases. There are few respite options for patients wanting to give their families a break without taking up a long term care bed.
• Support systems stabilize living situations.

• We know that seniors who are discharged from hospital have better rates of improvement if they have access to community, family, and friend support systems.

• The home care system in Victoria actually functions brilliantly, but only in the presence of an existing stable family structure. If you do not have that, it can be very difficult.

• Comments on respite and support for caregivers and patients:
  • 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 church used to be a good source of networks and support. Now churches are disappearing, although there are still some who are very active.
  • Not all care-givers are aware of the resources, supports and services that do exist and are available to help them.
  • Care-givers are often expected to come up with solutions to medical problems without any consultation with medical professionals.
  • There are some caregiver support groups, but being able to find the time to attend them is challenging.
  • According to Statistics Canada, there are an estimated 3 million care-givers in Canada who day in and day out provide care and support ranging from: arranging resources and community supports, meal preparation, transportation, medicine administration, dressing changes, and emotional and social support.
  • Using any outside help can make seniors too dependent on aids instead of retaining their independence.
  • Did you know that after diagnosis, people with dementia and their caregivers are left on their own to cope, and commonly, for many years, it is only when a crisis occurs that they get back in touch with the system.
Ideas and Suggestions

Financial Support for Care giving
Family Caregivers
Respite and Support

- Ideas about financial support for care giving:
  - In addition to the impact they make on the quality of a care recipient’s life, caregivers provide more than 2 billion hours of care giving, saving the Canadian health care system about $5 billion each year. Simply put, from both a quality and financial perspective, caregivers are vital to ensuring a sustainable health care system.
  - Institute a senior’s allowance, like child allowance, for a family with a dependant elderly member.
  - Tax incentives or payment should be provided to family caregivers. Home care equipment and supplies necessary for providing home care should be funded.
  - Instead of subsidizing elderly Canadians to live in institutionalized homes, our tax dollars can be better spent subsidizing families who live with a senior. This system is successful in Hong Kong, where the government gives mortgage subsidies to families living with at least one grandparent. As elderly care is becoming more costly to Canadians and reservations about the quality of care in facilities have been raised, this solution is clearly advantageous. Moreover, many minority Canadians, such as the Chinese, would support this act.
  - When family or friends opt to care for a family member and enable the patient to stay out of hospital, they should be given tax credits and Canada Pension Plan credits for pension income later in life.
  - Provide leave to look after an elderly member of the family similar to maternity leave.
  - There are a number of published reports on 10 European Countries that have experimented over the last number of years with direct payment to families as opposed to paying agencies for the care of elderly dependents. The results are actually quite impressive. It isn’t without challenges, but the notion of giving families the option and support to provide care to their elderly may be a framework for a solution.

- Ideas about family caregivers:
  - If needs are met at the community level, the family doesn’t have to run around to get the necessary supports.
Families need to advocate and care for their elders.

Bring in adequate government funded home support to help with the constant stress of care giving on families.

Provide day care programs for disabled seniors and seniors living with working families.

Instil family values that encourage looking after one another and providing care to elders.

Provide various supports to families providing care, and be flexible in service delivery. Recognize that all families have unique needs.

Mentoring and guidance should be available to caregivers and family so that everyone has access to the resources and knowledge needed to assist the elderly.

Involve families more in care giving teams.

Involve the whole family in caring for the elderly and have someone available to monitor the care that the elderly are receiving.

Ideas about respite and support for caregivers:

Provide respite options for caregivers, including in-home respite.

Create an environment that welcomes health care providers into the home.

Establish a membership driven provincial health association for smaller care providers and purchases of services. Provide a voice for these people in the system. Smaller care facilities are needed.

Develop communication plans that reach caregivers of seniors regarding information on services and care-giving supports.

Reintroduce the revised *Guardianship Act*.

The Government of British Columbia should undertake pilot studies to support informal caregivers and long-term care patients, including those that: explore tax credits and/or direct compensation to informal caregivers for their work; and, expand province-wide respite relief programs for informal caregivers that provide guaranteed access to respite services in emergency situations.
Funding and Costs

Comments and Concerns

Costs to Families and Patients
Funding
Cost Effectiveness

• Comments on costs to families and patients:
  ・ Home care can result in a considerable financial burden for the patient and their families.
  ・ The family of individuals with chronic diseases, like multiple sclerosis, sometimes have to pay for many necessary aides such as scooters, hospital beds etcetera that allow patients to remain as independent as possible. These expenses can be very difficult on a reduced income or on disability.
  ・ Medical Services Plan premiums should be eliminated for seniors who fall under a certain income bracket.
  ・ There is more room for federal assistance through tax incentives and benefits to encourage people to care for their family at home. The current tax benefit and the compassion care rates are inadequate.
  ・ Right now a lot of the home support is only available if you can pay. There are many economic barriers to receiving sufficient home care.
  ・ Home support requires some private spending and many seniors cannot afford it.
  ・ People are saying that families should provide care and should pay for that themselves. The issue is that clients involved have medically necessary care requirements, as described by the Canada Health Act.
  ・ Many seniors feel that they cannot afford food delivery services.

• Comments on funding:
  ・ There is a lack of funding for home care for seniors.
  ・ Although we are starting to see examples of being able to age in place, there is a need for programs to have proper funding.
  ・ Care home living/assisted living could be more cost effective. The current system is very fragmented between Health Authorities and the private sector.
  ・ In an effort to reduce health care costs, the Health Authority eliminated funding for housekeeping services by the home support workers, which had a negative effect on clients physically and mentally who were unable to keep up with
minimal hygiene and unable to pay for private help. This resulted in steadily
deteriorating health, depression, increased confusion and misery for many
seniors.

- There is not enough funding for home care workers.
- Home support is recognized as being important but as of yet no money has been
  there to support it.
- There are concerns as to how available funding for senior home support is used.

- Comments on cost effectiveness:
  - A shortage of home care results in increased costs of hospital stays and
    admissions.
  - Home care represents more of a quality versus cost issue. The cost of home care
    can eventually be more than facility-based care and also contribute to increasing
    the acuity and complexity of care needed for patients by the time they end up in
    long-term care and hospital care.
  - Hospital beds can be blocked by patients not requiring hospital stays but unable
    to return home due to insufficient home care options.
  - The Premier’s Council on Aging and Seniors’ Issues published its final report, *Aging
    Well in British Columbia*, December 1, 2006. The chapter entitled *Supporting
    Independence* put forward a new vision for home support services, focused on
    prevention, maintaining quality of life, and avoiding the high cost - financial and
    human - of institutional care. The report recommended more government
    assistance for home support services and claimed it would also reduce total
    eldercare costs.
  - Denmark has one of the best systems in the world for seniors care, one of the
    most cost effective and one that is used world wide as an example of how to keep
    seniors in their home longer with proper home support care and with support
    from municipalities. Their system is supported by both the federal and provincial
    governments.
  - Home care is the most cost effective way to provide good and preventative care
    for people.
Ideas and Suggestions

Costs to Families and Patients

Funding

Cost Effectiveness

• Ideas about costs to families and patients:
  
  • Seniors who chose to stay in their own homes in rural areas should have to supply and pay for their own care.
  
  • Seniors who chose to live independently should do so at their own expense.
  
  • Education and instruction on lifestyles should be supplied. Patients and their families should be responsible for day to day care.
  
  • Follow Germany’s example, subsidize children to look after their parents, it is cheaper and better for the family. The same policy is followed in Switzerland and in Holland.
  
  • A viable option for home care is the 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.
  
  • Money would be better invested in families caring for their elderly rather than spending more money on seniors housing.
  
  • Create a policy that clearly defines the eligibility requirements for home care benefits.

• Ideas about funding:
  
  • There is a need for more funding to support aging in place for an increasingly aging population.
  
  • Sliding scale to subsidize care for clients to fund home care. Fund the system to allow family and professional care providers to provide a better service.
  
  • Stable government funding is needed to provide twenty-four hour/seven days a week community and home support based on individual patient need rather than formulas.
  
  • More funding is needed to provide residents accessing home care with assistance for taking medication.
  
  • Any funding that goes into home support saves dollars in the health care system (for example, reduces use of emergency room, acute care, and long-term care).
• Home support needs to be funded on a program by program basis rather than on a client by client basis to stabilize the programs and ensure longer term planning while supporting regular scheduling for workers and ensuring the targeted delivery of health care services when and where they are needed.

• Improve the funding for drugs and medical supplies for patients cared for at home.

• Group homes need funding.

• Implement the recommendations from the Romanow Report related to federal support (national funding) for home care diagnostics.

• Provide funding for non-profit and volunteer agencies that support family members and caregivers.

• More funding is needed to allow social workers to deal with problems as they arise.

• Improve home support services. Restore home support daily living services to focus on prevention and maintenance. Increase funding for home support and develop a global funding formula.

• Expand home care nursing and ensure that it is all publicly funded and delivered.

• Lobby the federal government to transfer payment for community home services under the Canada Health Act.

• The funding model for home care also needs to reflect demand. Currently funding is provided on an hourly basis for specified services, resulting in fragmentation. Changing to a global, core funding model will increase flexibility and stability.

• Ideas about cost effectiveness:

  • Ignoring the preventive aspects of home care may not only lead to increased costs in the overall health system, but may also lead to suffering and emotional distress for individuals.

  • Home support costs significantly less than long term care. Although some people need long term care, in many cases, the entry into the long term care system could be delayed by providing soft supports, such as gardening, shopping and housekeeping. Plan for the future, regardless if current numbers support government funding.

  • Edmonton took the home care and split it into acuity, low acuity, medium acuity and high acuity. They then determined how they were spending time and what the actual costs of care were to ensure that everything was being done as efficiently as possible.
• When planning care, be aware of population shifts, such as the movement of elderly people from the lower mainland to smaller communities.

• Statistics may be showing an increase in the cost of home support, but this is balanced by the high cost of having these patients in the hospital.

• Providing acute care in the patients’ home does not require the construction of new facilities and can be expanded or collapsed quickly as requirements change.

• Government needs to follow through with the data they have already collected that demonstrates the cost effectiveness of keeping seniors in their own homes.

• Support more collaboration between private and public service providers to increase the quality of home care for seniors. The possible solutions will be cheaper than the status quo.

• Minimize costs associated with readmission to hospital and admission to long term care facilities from home care.

Accessibility

Comments and Concerns

Assessment and Public Education
Housing Option and Support Services

• Comments on assessment and public education:
  • People needing care in their homes are intimidated by the criteria that have been set out for accessing home support programs. All home support is determined by income and people resist sharing their personal income info.
  • There is currently too much bureaucracy and levels of administration that do not communicate in the home care system.
  • Home care is not provided until crisis hits.
  • Many seniors are falling through the cracks; people are not aware of the services that are available to them and are therefore not assessed.
  • There is little information available pertaining to types of services available and how they are delivered.
  • When a terminally ill person or someone at the end-of-life experiences a crisis in symptom control (respiratory, pain, nausea, weakness, mental deterioration, caregiver burnout or anxiety), there is a window of opportunity to address the issue so that the person is stabilised and able to stay at home, while time is
bought so that the person can become a direct admit from home rather than going through the emergency room; thus freeing beds.

- Right now, the criteria for home support assessment is flawed.
- No in-home assistance is provided if there are psychological needs that are misdiagnosed.
- There is a shortage of resources allocated to assessment for home care.

- Comments on housing/support options and transportation:
  - There is not enough home support to help our disabled stay in their homes, leading to increased hospital admissions and costs.
  - There is a lack of transportation in rural areas to help patients attend to personal needs.
  - There are not enough government subsidised private care homes.
  - Due to the push for home care and aging in place, elders are remaining in their homes, but are not getting the right care.
  - As Aboriginal people age there is a desire to go home, but there is a lack of accessible housing to accommodate elders on reserve land.
  - The aging in place model provides more home support to people, realizing that people are often more comfortable managing diseases in their homes surrounded by their social support networks.
  - The Choice in Supports for Independent Living program funded by the Vancouver Island Health Authority to encourage adults with disabilities to live independently in the community instead of in a facility is exemplary.

Ideas and Solutions

Assessment and Public Education
Housing Options and Transportation
Models of Service Delivery

- Ideas about assessment and public education:
  - There is a need for a system of assessing how treatment (or delay of treatment) affects quality of life and the overall home care system.
  - Educating people on home support options will save money and free up hospital and long term care beds.
• More co-ordination between jurisdictions is needed.
• Monthly evaluations of home care needs must be accessible to community care centers. Changes and improvements need to be considered and followed up on.
• Ensure that the information available to the public is reflective of what is available and affordable.
• Expand the eligibility criteria for subsidized home support services so that seniors requiring low levels of help can access these services.

• Ideas about housing options/support and transportation:
  • More resources are needed for transportation to and from appointments or services.
  • Increase the use of home care and home support to reduce the need for hospital beds.
  • The active aging plan has five key areas of support for active aging: healthy eating, physical activity, tobacco cessation, injury prevention, in particular falls prevention, and social connections. Social connections are one of those things that will permeate every one of those other areas and should be considered when planning for accessible home care services.
  • Support for seniors that allows aging in the community should be strengthened.
  • Provide a bus service to get seniors out for meals and entertainment.
  • Government funding is needed for volunteers driving home care clients to appointments.
  • Home care needs to be available in smaller centres.
  • Expand home care services.
  • Provide nursing services and home care nurses to First Nations communities.
  • A lot of the responsibility for maintaining seniors in their home is dependent on the available community services and effective urban planning. We need intergenerational homes and higher density living to ensure there is appropriate housing available for seniors.
  • People have to be able to stay in their communities.
  • Home care services are needed in senior complexes.
  • Housing for caregivers and their charges needs to be larger.
• Ideas about models of home care delivery to increase accessibility:
  • Develop and/or expand mobile health services and/or clinics that provide health services to seniors in their local community.
  • Remote care could be provided via the web.
  • We need to look at providing health care services in more appropriate places and using better models, such as step down units or apartments for weak and frail elderly who are too weak to go home but are otherwise stable.
  • There is a need for the integration of services, home care, hospice, hospital as well as a stepped care approach. Stepped care supports taking the least invasive and most cost effective approach which is often collaborative home care to start.
  • Community based programs and hospitals should be integrated to streamline the care and movement of patients.
  • Provide incentives to encourage family members to look after each other, change cultural values and encourage co-habitation with parents/grand parents. Make it affordable to have families live together. Encourage multi-generational living and work to reduce the isolation of seniors while strengthening families.
  • Mobile clinics should be available to come to homes to assess needs.
  • Streamline access to equipment and streamline support, home care, medication management.
  • Support the recommendations in the Aging Well in British Columbia Final Report, which calls for:
    a. a new, broader and more available home support system, increases to the number of hours of home support per client;
    b. increased supportive housing and support programs to allow people - to live independently for as long as possible; and,
    c. an increase in the availability of community based options to ensure caregivers receive the supports they need.
• The Ministry of Health should provide a mediation service to advocate for elderly patients or residents to make the system easier to navigate.
Delivery of Services

Comments and Concerns

Systemic Changes
Delivery and Demands
Dementia

• Comments on systemic changes:
  • The current home care services are inflexible.
  • It is difficult to integrate work when there are two different ministries involved in the delivery of home care services.
  • The home care system in the Interior Health Authority needs to be re-structured and all the associated systems need to be integrated. Currently there is no shared accountability for the delivery of services.
  • Care is more "medicalised" and social living supports are in decline.
  • There is a gray area that has to be defined between home and in-place care.
  • There is too much bureaucracy and too much rigidity in what home support can and cannot do.
  • Changes in policies have created a moving target with regards to what government and home and community care, will pay for (no meal preparation, laundry etcetera). With the current restrictions, home support workers go in to set out meals and then have to leave as opposed to having the time to assess how their client is managing while checking on health care issues.
  • Societal expectations are that chronic care patients go into facilities rather than staying home.
  • Seniors are encouraged to stay at home and use home care but that can shut them out of the rest of the system.
  • The British Columbia Government and Service Employees’ Union (BCGEU) does not agree with the Council’s recommendation to move non-nursing/ non-medical home support services out of the Ministry of Health as this would further reduce the overall integration of home support services.

• Comments on the delivery of home care services and demands:
  • Discharge planning is lacking in the current system, leading to gaps in service delivery.
There is a general lack of home care services in communities.

People are not getting to choose between receiving services in hospital or at home.

Community home support is not available 24/7, so clients end up in the hospital or in a facility.

With the number of hours that food delivery programs works with, there is only so much the coordinators and supervisors can do.

There have been cuts to personal care time, as well as the elimination of services such as light housekeeping, meal preparation, and driving.

Patients who are supposed to have home visits where a physiotherapist comes to check in do not always receive the hands on treatment they need, instead one patient received only two 15 minute visits post-operation.

There is no longer any time for nutritional monitoring or time allotted for meal preparation.

There has been a gradual recognition of the growing need to service the aging at home.

To include travel time in the time allotted for service delivery is unacceptable.

The Danish model of community and home care should be examined, there, all seniors over 75 receive yearly visits from community health workers.

Duncan Manor provides great personal care, with the same people visiting every day to give baths and medicine and they provide help with going to doctors’ appointments.

The Provincial Government should look at the model that Veterans Affairs provides for support services (like meals, housekeeping, etcetera).

Home support is provided directly by Vancouver Coastal Health on the Sunshine Coast, enabling fixed hours, increased flexibility and responsiveness to client needs, and better integration of all members of the health care team, including community health workers. There are other fixed-hour pilot projects in both the Interior and Northern Health Authorities that offer positive and effective innovations.

Over the last decade, more older people are continuing to live independently and the common myth that most older people are in care homes is just not true.

The number of publicly-covered home care clients has been declining although the acuity of home care clients is rising.
• Sometimes patients lack willingness to receive help from outside of the family.
• The shortage of nursing, physiotherapy, and occupational therapy sessions in home care can result in institutionalization.

• Comments on dementia:
  • 1 in 13 Canadians over 65 has Alzheimer's or a related dementia: of particular interest is that over age 74, the prevalence is 1 in 9, and over 85, 1 in 3. The yearly incidence rate (how many people develop the disease in a given year) for B.C. is about 13,640, expected to be over 16,320 by 2011. Currently, at least 63,480 people have dementia in B.C. Each health authority has estimated a growing senior population and has acknowledged being unprepared for the expected care needs.
  • Alzheimer's disease and related dementias are devastating conditions creating huge emotional, financial, and physical challenges for the person, their family and caregiver. But BC is not prepared for the reality of dementia.
  • There are risk factors for dementia, and armed with that knowledge there are risk avoidance activities all of us can utilize. However, with all of the attention on healthy aging and healthy living in B.C., no provincial messaging includes this critically important information. The current focus on self-care is not a real option for most people affected by dementia, which means it is even more important to get this information to people before dementia even develops.

Ideas and Suggestions

Systemic Changes
Delivery and Demands
Dementia

• Ideas about systemic changes:
  • Increase the scope of services for home care workers to reduce the need for acute care services.
  • Integrate home support into health units.
  • Encourage individuals to set up homes with caregivers that would work like a cooperative, with two or three seniors living together to facilitate the delivery of home care services and allow for longer visits.
• In Gibsons, the home support workers or community health workers, are directly employed by the Health Authority. This makes integration easy as they are already part of the system. In this model the Registered Nurse in the home support agency, meets with care givers in the hospital every morning to determine who’s getting discharged and what type of support they’re going to need on discharge.

• Expand the flexibility of personal care services to respond to fluctuating and/or emergency needs.

• Develop quality service measures that promote proactive preventive service delivery and ensure that seniors are accessing and utilizing needed services.

• Incorporate social work and case management into home and community care.

• Assign regular clients to each home support worker so system becomes client based.

• Re-establish homes for senior care that function as a small home based business.

• Support more co-operative government and non-profit activities and facilities for seniors.

• Provide increased home support to seniors to decrease the number of seniors in assisted living care or extended care.

• Reinstate home support to the levels that existed in 1994, including personal care, light housekeeping, shopping and transportation to appointments within the duties that can be performed by home care workers.

• The home support system should be outside of the Ministry of Health. Social housing programs should be the responsibility of municipalities.

• Remove home care from the mandate of health authorities and establish a separate organization.

• Separate home support for seniors from other parts of home care.

• Increase the number of hours of home support per client to appropriately respond to the current need.

• Given the intricacies of home support and continuing care services, the British Columbia Government Service Employees’ Union (BCGEU) recommends that an independent review be undertaken as part of the development of a new plan and approach to home support. This review must include the viewpoints of front-line workers, including community health workers, schedulers and other members of the home support and continuing care team.
Home support services should be amalgamated within all of B.C.’s health authorities. Currently, the delivery of home support is done directly by some health authorities (Northern and Interior) and by contracted affiliated agencies in others (Vancouver Coastal, Fraser and Vancouver Island, although some of these have a mix of direct and affiliated delivery). Amalgamating home support reduces costs and better integrates home support with other community and acute care services. It also provides stability for workers and increased continuity of care for clients.

- Ideas about the delivery of home care services and demands:
  - Utilizing out-post medical stations and holding regular weekly clinics could be an efficient way to deliver services to seniors in rural communities.
  - There is a need for more programs like adult day care and meal delivery as well as general home support with time for relationship-building and the completion of household tasks.
  - Home support should be available twenty-four hours, seven days a week with qualified staff.
  - Bring dentists, hair dressers, and other service providers into care homes.
  - Home care should be expanded to include the delivery or expansion of many other services such as:
    a. the delivery of IV antibiotics;
    b. nutrition programs for in-home care;
    c. household and home maintenance programs offering affordable home and yard cleaning, maintenance and repair services;
    d. home adaptation programs so that more seniors can access the installation of home aides;
    e. a referral service to give seniors information on reliable, trustworthy, affordable providers of home maintenance, cleaning etc;
    f. enhanced shopping assistance programs;
    g. assisted bathing more than once a week;
    h. personal accompaniment for seniors who need personal support to attend medical appointments;
    i. physician home visits and general checkups; and
    j. interim home support for patients waiting for placement in other facilities.
  - Provide home care and home support for patients with mental illness. Follow up on necessary medication.
• Provide annual home visits to everyone over 75.
• Hold discharge planning team meetings that include a hospital liaison and home care worker.
• Develop and implement an action plan which provides for care of acute care patients in a home environment thus creating an alternative to in-hospital beds.
• Provide care through mobile home care teams that include doctors and nurses.
• Provide home care for post operative care and follow-up in general.
• Support the development of personal support centres and social network plans.
• Deliver home care services through cluster care, providing coordinated services to all seniors living in one apartment building or block to increase the time available to the home care workers as well as the efficiency of service delivery.
• Make home care activities more individualized and client centered.
• Reduce hospital services to increase/promote home care.
• Provide more home care in First Nation communities, so that our elders can stay home.

• Comments on dementia:
  • Cognitive Impairment Guidelines for BC physicians have been approved and are on the Ministry of Health web-site, but most family doctors do not know these are available, or do not find they have the time to study them and utilize them in their practice. Physicians need education about their use. It would also be advantageous if fee guidelines provided incentives to family physicians for early recognition, early diagnosis and provision of care to people affected by dementia. It is critical that the medical school curriculum include sufficient attention to health issues affecting the frail elderly, of which dementia is increasingly a major aspect.
  • Incorporate Healthy Brain messaging in Act Now, the Ministry of Health’s Active Aging strategy, BC Healthy Living Alliance, and Healthy Communities programming.
  • BC is experiencing a shortage of family physicians and the ones we do have, do not receive adequate training to recognize that dementia is not a normal part of aging, and that early, and proper diagnosis is critical to ensure positive health care outcomes. People are in a better position to take care of their own health care if they receive the proper diagnosis and health information in a timely way.
The current policy direction towards integrated health networks within the Primary Health Care System for targeted populations, particularly the frail elderly, has the potential to improve health care outcomes. But the Ministry's work needs to ensure that dementia remains a focus. The Ministry is working on a Dementia Strategy, which needs to be funded and implemented if BC is to be in a position to respond appropriately to the increase in people impacted by dementia.

Safety

Comments and Concerns

Technology and Home Modifications

• Comments on technology and home modifications to improve safety:
  • There is a lack of support for home adaptations and modifications that would otherwise allow seniors to stay at home, in their communities rather than moving to facilities.
  • User activated personal emergency response systems and Telecare (automated personal emergency response systems) are noticeably absent from lists of available home care tools and resources and can be very valuable.
  • Due to shortages of home care workers and restrictions placed on time allotted per caregiver per client, many seniors cannot shop for food, cannot get to appointments, and are forced to live in filthy houses, despite accessing home support.
  • A lack of home care can lead to overuse of acute care and can increase the possibility of readmission after surgery.
  • The criteria that clients need to meet to qualify for home care is currently too high.
  • Many seniors suffer from social isolation.
  • There are inconsistent standards of home care throughout the Province.
  • The types of home care services offered are not sufficient and many essential services have been cut. As a result, many seniors are living at risk.
  • Transitions between acute care and home care are happening too early. There is no smooth, planned transition of care for seniors or others who need housing support.
• Assessments for home care assistance take too long.

• Patients are often released from hospital without supports.

• Elderly people often suffer from malnutrition as they are not able to prepare meals on their own.

• Those with a good support system do better when travelling to urban centres.

Ideas and Suggestions

Technology and Home Modifications

• Ideas on technology and home modifications to improve safety:
  
  • Increased government funding for conventional home care and support services, together with safety-related home modifications and a range of stand-alone assistive devices is necessary. Often there is also eventually a need for adequate monitoring of the activities of daily living and home environment conditions to prevent accidents and respond to hazard or injury in a timely way.

  • The Premier's Council on Aging and Seniors' Issues new vision did not emphasize the significant contribution even low-tech assistive devices and home modifications can make to maintain the safety and quality of life of older people who desire to remain living at home. Home modifications for independent living support are available through the Canada Mortgage and Housing Corporation. Their 'Home Adaptations for Senior's Independence (HASI) program provides forgivable loan assistance to eligible seniors.

  • Assistive technology has a burgeoning role in eldercare. In the United Kingdom, several controlled clinical trials and cost-benefit studies have demonstrated the cost effectiveness of pairing home care and support with assistive technology to help keep the elderly safe and well in their homes.

  • Wearable push-button and stationary pull-cord type communication devices already exist to alert an emergency response service. A Canadian study of Personal Emergency Response System(PERS) users found fewer hospital admissions and fewer hospital bed days per user were needed compared to a control group of non-users. Wearable fall-detectors also exist to automatically send an emergency signal should a fall occur.
• Continued, if not increased, support and more local delivery is needed for safety-related home modifications for the elderly including assistive technology, which the government should bulk purchase and make available to all persons over age 65 living alone.

• Regular home inspections should be carried out to ensure clients have access to good food, and are living in a clean house.

• Promote the electronic monitoring of elderly in their homes.

• Provide safety and risk assessments for patients.

• Provide assistance to upgrade bath tubs, making them safe for the elderly.

• Elders with short term memory problems shouldn’t use the stove.

• Informal caregivers cannot always be present and may not be available at all. Paid, full time, live-in caregivers are costly and unwelcome to elderly persons who are used to their independence.

• Don’t push the elderly out of hospitals on a Friday if there is no home support on the weekends.

• Clinics need to have full range of support and assign a post operative home care person to reduce re-admissions.

• Promote and support self-esteem for people in home care. Support people’s independence in their home.

• Standards for home care are needed.

• Increase home support so that people who need it, but cannot afford it, will have help with cleaning of home, cooking, shopping etc this would help prevent falls, eating unhealthily, thereby cutting down on visits to emergency.

• Home care providers should have the authority to say no when discharge is inappropriate or not enough in-home support is available. Discharge should involve a team approach.

• Recognise the limitations of home care and home support to provide adequate care to acutely ill or recent surgery patients.

• Enforce background checks for home support workers.
• After a major health issue patients need a psychological assessment and access to counsellors.

• Community based advocacy groups should be put in place to stand up for long term care and seniors rights.

• Private caregivers should have to be registered with the Province.

• Change the Residential Care Act, to increase the minimum standard of care.

• Assist aging people who want to stay fit, through providing access to specially designed exercises or other activities.

• Review health care service delivery programs to ensure that seniors who are isolated and at-risk in their community are identified and regularly assessed.

• Home support is also a form of preventative health care, with community health workers monitoring the health of their clients and providing a form of early warning system to identify and then deal with serious problems as they emerge.
Residential Care and Assisted Living

Residential care was a common topic for discussion during the Conversation on Health. The importance of addressing issues related to the accessibility of beds and facilities, the delivery of services, patient safety, costs, and health human resources in long term care, were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of residential care and assisted living.

Accessibility of Beds and Facilities
Many believe that there are not enough residential care beds for the number of seniors who need them. There is widespread agreement that the health care system needs additional publicly funded, long-term care beds, and that these beds would relieve pressure on emergency rooms. Stories of people having to leave their home communities for long-term care placements due to bed shortages occur. The lack of assisted living facilities for middle-aged patients who have suffered strokes or other chronic debilitating conditions is also a concern for participants. Many feel younger people with long-term care needs should not be in residential care designed for seniors. Several participants suggest that, to relieve stress on family caregivers, long-term care facilities could also have accessible respite care beds for family care and support.

Many recommend that facilities need to be geographically accessible and flexible to ensure that elderly couples can stay together and that seniors can be close to their families and friends. Family care homes are an alternative that can support aging-in-place (meaning in their home and community). Many also discuss the potential of multi-level care facilities and the Campus of Care model, which allows patients to move from assisted living to complex care in one facility when their needs increase.

Follow through on promise to provide 5000 long-term beds in British Columbia. Have enough staff to provide care for residents
- Regional Public Forum, Cranbrook
Delivery of Services

Participants voice concerns about a lack of transportation and recreation services available to residents of long-term care homes. Some suggest assisted living facilities are sometimes used as an extended care option, but without the resources, which leaves more to be covered by seniors. Many recommend modelling service delivery after facilities that work well, suggesting that better monitoring and medical care provided within facilities will decrease transfer rates to emergency. Others recommend changing assessment tools to ensure that patients receive the appropriate level of care early, decreasing the chances of needing acute care intervention and minimizing complications.

Participants also feel that the long-term care system lacks communication between facilities and clients. Some emphasize the lack of understanding for assisted living, and that people have to be able to direct their own care. Many recognize the importance of addressing the gap between assisted living and extended care. Participants suggest that increasing staff-to-patient ratios and involving family members in facility care are essential steps to improving the delivery of services in long term care.

Patient Safety and Quality of Care

Many discuss the importance of making facilities safe for residents. Some participants perceive that there have been budget cuts and privatization of services have decreased the quality of care in facilities. Concerns related to patient safety in facilities include: the lack of stimulation for residents; psychiatric patients in long-term care as a threat to other residents; poor food quality; outdated facilities not up to standards; and seniors facing potential neglect and abuse.

Quality of care is also a focus of discussion. Many are concerned that there are no systems in place to ensure that facility managers and owners are accountable for the quality of care provided in their facilities. Participants also suggest there needs to be a better transition between independent and residential living. Many feel the criteria for acceptance into long-term care are too high, which results in patients being very ill when they finally enter the system. They also suggest the level of care available in assisted living facilities should be raised. Many commend facilities adhering to a ‘gentle-care’ philosophy for Alzheimer’s patients and those following co-operative housing models. Others focus on the importance of culturally appropriate long-term care facilities for Aboriginal people.
Many agree that long term care facilities have to be more accountable to residents and their families. They believe that facility accreditation or licensing should be mandatory and that advocating for residents is important to help them get the appropriate care. Some recommend creating strict standards for care and an accessible complaints resolution process.

Funding and Costs

Many suggest the funding of long-term care has to change to recognize the complexity of the services needed. They emphasize that while public funding largely appears to cover costs, there is a lack of transparency regarding the range of daily rates, and why one facility enjoys greater funding than another. Participants suggest the shortage of publicly funded beds and the high cost of private care makes long-term care facilities inaccessible for many lower income residents, increasing the pressure on the acute care system. Some feel that mixed public/private funding creates a negative environment in long-term care facilities, and believe that privatization of these services should end. Others suggest encouraging private sector construction of intermediate and long-term facilities with short-term tax incentives. Many believe specific funding is needed to support: non-profits to deliver quality care; more Campus of Care style facilities; rehabilitation services in facilities; and, dental care.

*Allow for tax deductible contributions to co-operative-type funds to finance the building of facilities that those who contributed funding get to live in when they are seniors*

- Regional Public Forum, Richmond

Health Human Resources

Participants emphasize that, though staff in facilities try to provide quality service, they are being overworked and are not responsive to residents’ needs, which negatively affect patient care. Some participants indicate that seniors in facilities have no access to physicians after-hours and that indigenous elders in facilities face racism. Others think that staff in facilities do not address residents’ increasing need for bed-side care and socialization. They also feel that residents in smaller communities also face limited availability of service providers.
The suggestions for improving health human resources in the long-term care system are many and various. Several participants recommend increasing physician support for long-term care facilities. They also recommend hiring more staff and providing them with higher levels of training. Other participants suggest having more recreational care coordinators and care aides to provide bed-side care and socialization. Many believe that multi-disciplinary teams of health professionals in facilities that include doctors, nurse practitioners, pharmacists, rehabilitation personnel and nutritionists, could also reduce trips to acute care.

Conclusion

There is widespread concern that the demands on the long-term care system will continue to increase as the population ages. Participants agree that the system should provide secure, quality, affordable, dignified care to those in long-term care and assisted living to meet all levels of care needs.
Residential Care and Assisted Living

This chapter includes the following topics:

- **Accessibility of beds, facilities and services**
- **Delivery of Services**
- **Patient Safety and Quality Care**
- **Funding and Costs**
- **Health Human Resources**

### Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

- Submission to the BC Conversation on Health  
  Submitted by the Victorian Order of Nurses for Canada
- Submission to the Conversation on Health  
  Submitted by the Certified Dental Assistants of B.C.
- HEU Submission to British Columbia’s Conversation on Health  
  Submitted by the Hospital Employees’ Union
- Report to the Conversation on health  
  Submitted by the BC Cancer Agency
- Advocates for Seniors Care - Vernon  
  Submitted by the Advocates for Seniors Care – Vernon
- Submission to the Conversation on Health  
  British Columbia Government and Service Employee’s Union
- Submission to the Conversation on Health  
  Submitted by the B.C. Nurses’ Union

### Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Wait Lists/Wait times; Home Care or Support; Assisted Living; Euthanasia; Palliative Care; Health Spending and Seniors.
Accessibility of Beds, Facilities and Services

Comments and Concerns

Specific Facilities/Regions
Multi-Level Care Facilities
The Separation of Couples and Moving the Elderly
Assisted Living
Bed and Facility Shortages

- Comments on specific facilities or regions:
  - The Kootenays used to have two seniors facilities with 112 beds, however these facilities have been replaced by one facility with fewer beds despite the aging population and larger area that now falls into the boundaries of the region.
  - There is a shortage of beds and facilities in many areas. In Prince Rupert there are currently not enough beds and although a new facility is planned, by the time it is constructed, it will do very little to address the shortages.
  - There are no private facilities in north eastern British Columbia and public facilities are full.
  - In Williams Lake, as well as other small communities, there are concerns about access to publicly run and funded seniors extended care and assisted living facilities.
  - Residents in the Kamloops Seniors Village cannot go from assisted living to residential care without going to the Interior Health Authority to be assessed and then must wait until their name comes up on the waiting list. This causes stress for patients.
  - In 2003, the closure of Parkholm Lodge in Chilliwack, an 85 bed facility was precipitated by budget restraints in the Fraser Health Authority. This caused a major backup of long-term care patients in the hospital. To this day there are on average fifteen to twenty long-term patients waiting for care.
  - England uses a model that has specialized buildings for elders, with small homes/courtyards.
  - There is a rumour that when the newest construction is complete in the Rotary Manor, the Pouce Coupe and Peace River facilities will be closed. What will be done with these buildings?
  - In Richmond the city is trying to implement universal building standards which would make every living space a potential living space for seniors and disabled people.
The assisted living facilities in Nakusp are wonderful.

• Comments on multi-level care facilities:
  • The Campus of Care model is more challenging in smaller communities.

• Comments on the separation of couples and moving the elderly away from their communities:
  • The separation of couples in facilities due to location or levels of care required is unacceptable.
  • People have to leave their home communities for long-term care placements due to bed shortages.
  • The elderly often have no say in where they are placed.
  • When families try to move their elderly from out of province, there is no availability of treatment or care.
  • At least there is now some acknowledgement that senior couples should not be separated if possible.

• Comments on assisted living:
  • There is a shortage of publicly-funded and affordable assisted living and long-term care residences/beds.
  • Assisted living is not a replacement for long-term care options.
  • There is a lack of assisted living facilities for middle aged patients who have suffered from strokes or other chronic debilitating conditions, multiple sclerosis for example.

• Comments on bed and facility shortages:
  • There is a lack of respite beds in long-term care facilities.
  • 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. Many hospitals beds are occupied by patients who would be better served in nursing homes, convalescent care or at home with the appropriate community supports.
  • There are not enough residential care beds for the number of seniors who need them. 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.
• Bed closures and closures of long-term care homes are causing misery and pain among seniors.
• There are no facilities for intermediate care.
• Specific housing/beds for dementia care is lacking.
• There is a realization that long-term care is necessary, and communities are starting to develop assisted living and complex care facilities.
• Options for chronic and extended care for seniors are limited.
• Geriatric and Assessment Units are not being utilized as intended. They are now being used for acute care beds for long-term patients as there is no room in the community.
• Accessible, affordable public senior housing options are limited.
• We need some long term beds and palliative beds especially in the interior and up north but 5000?
• From 1977-1978, the continuing care, long-term care, and the home care system in BC was put in place from absolutely nothing to being fully implemented.

Ideas and Suggestions

Specific Facilities/Regions
Multi-Level Care Facilities
The Separation of Couples and Moving the Elderly
Assisted Living
Bed and Facility Shortages

• Comments on specific facilities or regions:
  • Campus of Care models exist, such as the Elim facility in Surrey, which will take you from entry into the system through long-term care, and hospice until death.
  • Do not close the Deni House long-term care facility in Williams Lake.
  • Increase options for seniors in Williams Lake.

• Comments on multi-level care facilities or service delivery models:
  • Campus of Care, which allows patients to move from assisted living to complex care in one facility as their needs increase, is an excellent model.
  • There is a need for multi-level care facilities.
• Campus of Care developments should be built so that middle-income seniors can buy into them using a co-op type model. These would incorporate independent living townhouses at market prices through to smaller assisted living apartments and facility-like long-term care options.

• Seniors' residences should ideally be multi-level, with a wing (or floor) for dementia patients, a wing for patients who are pretty much bedridden and need continuous nursing care, and a wing with private rooms for singles and couples who are somewhat independent but need to go to a central dining room for meals. There needs to be a recreational program and an attached (or at least on the same property) complex with low-cost apartments for seniors who are still able to be cook for themselves and be independent.

• In rural areas, rather than a single facility that supplies a continuum of services, there should be a series of small units catering to each particular stage of care.

• More needs to be done to provide facilities throughout the Province that are designed to meet the more complex medical and care needs of those now being placed in residential care and to do so in a truly 'residential' style facility that is a part of the community. Perhaps with a look at integrating residential care facilities within communities; perhaps incorporating onsite day cares (designed well) could meet a need for additional day care spaces for both staff and others in the community as well as provide ready entertainment for residents.

• Having a multi-health-level care-facility on reserve would help limit travel for family. If Elders are close to home, mental health is better.

• Comments on the separation of couples and moving the elderly away from their communities:
  • Facilities need to be geographically accessible and flexible to ensure that elderly couples can stay together and that seniors can be close to their families and friends.
  • Support the construction of graduated facilities to enable continuing relationships. Include end-of-life care within those facilities and support elderly couples to stay together through to the end of their lives.

• Comments on assisted living:
  • Localized assisted living is needed for Aboriginal elders.
  • Assisted living facilities should be community based, in smaller, neighbourhood-based facilities.
  • There is a need for special-living homes for Alzheimer's patients.
• Build low-cost small apartments that are staffed at all times with a caretaker, nurse, first aid attendant, etcetera. Do not build "luxury hotels" that leave most seniors almost destitute.

• Cluster housing for seniors, or group homes where meals, housekeeping services, and on-site care options are available can work well.

• For smaller communities a more amalgamated housing system is needed, lowering the criteria for assisted living or supportive housing options to keep people out of hospital.

• Comments on bed & facility shortages:
  • There is a need for additional long-term care facilities. These would also relieve pressure on emergency rooms.
  • More publicly-funded long-term care beds and assisted living facilities are needed.
  • Recognize that over-crowding in the emergency rooms and surgical wait lists are directly linked to a lack of residential care. Problem solving in these areas should reflect this connection.
  • Reinstitute public care homes.
  • Fulfill the promise of long-term care beds in British Columbia by relieving the congestion of seniors in our hospitals who are taking up acute care beds.
  • Private facilities provide the elderly and their families with choice in long-term care options.
  • Convert closing schools into seniors’ facilities.
  • There is a need for more publicly run nursing homes with different levels of adequately staffed care.
  • Use cruise ships as seniors’ facilities. They cost the same as top of the line care facilities but provide their passengers with better care.
  • Every city of 100,000 or more should have a chronic care facility, public not private, with an emergency room on the ground floor from which patients can be admitted if necessary. If people want to pay to be sent to a nicer, private facility, that is their choice.
  • Enable charities or non-profits to build seniors facilities in urban areas.
  • Family care homes can provide excellent care to frail elderly. would allow the caregiver to be employed in the home while caring for their family member. As our population ages, the demand for residential care and respite services will
outpace our ability to build and fund them. This is an alternative system of care which appears to be not only less costly but more effective than what we now have.

- Long-term care facilities could have accessible respite care beds for family care and support.
- Need active senior living residences, which teach seniors to be active partners in their health care.
- The location of senior care facilities should be in the heart of the community, not pushed to the outskirts, so that seniors can stay active and involved, thus increasing the social capital of communities.

**Delivery of Services**

**Comments and Concerns**

The Coordination of Service Delivery

Service Delivery in Long-Term Care Facilities

- Comments on the coordination of service delivery between levels of care:
  - There is a lack of communications between facilities and clients.
  - Records and medications are not always transferred when patients are moved to another facility.
  - Once assisted living patients move to acute care, they are often not accepted back into assisted living facilities.
  - There is a trend to control health care costs by reducing the length of stay in acute care hospitals as well as making residential care facilities necessary only for the very end of life. Home care services are provided by healthcare agencies in the community or by family, friends and neighbours. Assisted Living provides support for elders wanting to live in congregate settings, but these people must be able to 'direct their own care' and thus are quite independent. For these reasons, the people who now come to live in residential care are truly 'complex', meaning they have multiple illnesses and require round the clock care.
  - Assisted living often does not meet the needs of patients and is frequently used as an extended care option without the resources, leaving more to be covered by seniors, many of whom are already at the poverty line.
• Assisted living is a welcomed component to the mix, but does not replace intermediate care. The shift of care from institution to community must be a true shift, not simply the loss of service in the residential care system.

• Before treatment is over, address survivorship - letting people know that there is a range of post-treatment reactions: emotionally, cognitively, physically.

• Comments on service delivery in long term care facilities:
  • Patients in long-term care beds do not receive adequate services.
  • There is a lack of transportation available to the residents of long-term care homes.
  • Limiting the participation of certified dental assistants to government-approved dental public health programs restricts the public's access to oral health promotion and preventive services.
  • In many facilities there is a lack of privacy, individuality and timeliness of care.
  • There is a lack of understanding of residential care and what we can safely offer families.
  • Some facilities are fabulous and should be used as an example and model for others.
  • There are inconsistent and/or poor standards of care in long-term care facilities.
  • The best way of supplying quality of life to seniors is to have as great a population of seniors as possible within a condensed area or a facility where they can be offered a range of services on a cost effective basis.
  • Measure patient satisfaction first and medical indicators second. By mandating and monitoring measures that first look to satisfaction or quality of life indicators (qualitative) and are balanced by quantitative indicators, a more meaningful assessment of 'value' would be obtained.
  • Establish and communicate the Government's 'guaranteed' services: Healthcare should consider defining clearly what is part of the 'Government guaranteed services' for Residential Care and by default, the industry would be able to establish 'optional extras' that could be purchased privately outside of that guarantee.

• Patients with dementia receive is quality care, but there are not enough facilities available.

• Younger people with long-term care needs are misplaced in residential care that is geared towards seniors.
• Long-term care facilities are not built on a medical model.

• There was a study for Health Canada where we looked at actual systems of care delivery across Canada for the elderly people with disabilities, kids with special needs, and people with chronic mental health issues.

Ideen and Suggestions

The Coordination of Service Delivery
Service Delivery in Long-Term Care Facilities
Service Delivery in Supportive Housing

• Comments on the coordination and movement between levels of care:
  • Better monitoring and medical care provided within seniors’ facilities will decrease transfer rates to emergency and long-term care.
  • The gap between assisted living and extended care needs to be addressed.
  • A lot of people do not understand what assisted living means. People have to be able to direct their own care.
  • Integrate care under one roof. Connect independent living with long-term care.

• Comments on service delivery in long-term care facilities:
  • Ensure that residents of care homes are provided with a variety of recreational activities.
  • Care homes must provide transportation.
  • Music and exercise are important in residential care. Use music therapy for connection to greater community.
  • Provide access to dental hygienists in long-term care facilities.
  • Respite care should be provided in facilities or at the very least the knowledge of available resources.
  • Day care programs should be offered through long-term care facilities.
  • It is important to have culturally relevant care for elders in facilities.
  • Facilities for seniors should not be like a hospital, they should be more home-like.
  • Increase staff to patient ratios, and add social component to senior facilities.
  • More space should be available at care homes for family visits.
• Involvement of family in care of family members in facilities is vital and each caregiver needs support.

• Coordinate and maintain an equipment lending program.

• The establishment of on-site infirmaries in long term care staffed by Registered Nurses assisted by visiting physicians 'with at least one RN on duty around the clock' would go a long way to reducing the number of costly transfers to emergency rooms, and facilitate quicker discharges from the hospital back to long term care.

• Comments on service delivery in supportive housing or assisted living:
  • For safety reasons reinstate funding for housekeeping services. Services to take seniors shopping and to appointments are necessary as private services are too expensive for low-income seniors.
  • Create more affordable housing in settings with communal supports, for example: laundry, emergency pull cords, meals supplied, and activities for physical and social wellness.
  • Respite bathing programs are needed to provide a break for caregivers.
  • Use local non-profit, community-based societies to deliver services such as home support and assisted living.
  • The Government of British Columbia needs to increase the number of supportive housing units and implement the appropriate personal support programs that allow individuals to maintain their independence and remain living independently for as long as possible.
  • Assisted living homes should be registered through the Ministry of Health rather than the Ministry of Forests and Housing.

• The majority of new seniors’ facilities are entrepreneurial ventures and there needs to be quarterly evaluations performed, especially in the first year, to review practices and determine if seniors are receiving proper care.

• There are integrated care facilities in Vancouver, however they are too much a distance to travel for some seniors.
Patient Safety & Quality Care

Comments and Concerns

Physical Safety of Facilities
Quality of Care
Transitions between Care Levels or Facilities

- Comments on physical safety of facilities:
  - Former safety measures, such as bed rails, are now considered restraints and are not allowed.
  - Many facilities are outdated and not up to standards, such as heating and cooling systems, wheelchair access etcetera.
  - Old regulations do not always work with new facilities in terms of size etcetera.
  - Seniors have contributed to their communities in the past, so they should not be stuck in inadequate quarters at this point in their life, even if it is temporary in nature.
  - Seniors are being moved to other communities to fill private care facilities and some of these facilities are not even fully completed.
  - Many of the new assisted living facilities are beautiful and provide the right kind of care.

- Comments on quality of care:
  - In some care homes there is a lack of stimulation, both mental and physical.
  - Psychiatric patients in long-term care can be a threat to the elderly.
  - The average age or residents is increasing and many have older or no families. The incidence of Alzheimer’s is increasing and most require fulltime assistance with feeding, toileting and bathing.
  - There is poor food quality in long-term care.
  - Some facilities for seniors are not looking after residents properly. For example diapers not getting changed enough and they are not welcoming to visitors.
  - Residents that are lower functioning get missed for rehabilitation, recreation and musical therapy.
  - There are many indicators that the care and quality of life provided in facilities is far short of ideal, far short of appropriate, far short of acceptable.
Mixed (both male and female) long-term care facilities could lead to embarrassing situations for residents.

Seniors can face neglect and abuse in care homes and facilities.

The process of long-term care service delivery can be inhuman: isolation, intimidation, disrespect, and harassment can occur and increase the stress and illness of residents.

For the past four years I have witnessed an alarming decrease in the quality of care delivered in long-term care facilities. We are suffering from lack of proper funding to adequately care for the residents in my facility. This lack of funding has caused a shortage of staff, which has lessened time available for each resident, while also cutting into the funding for equipment and services, including laundry and cleaning.

There is regular theft of seniors' jewellery, medication, clothing, etcetera. occurring in facilities.

Abuse and overall poor care in private settings has historically been alarming. Today, these concerns are still there. For example, there is no monitoring as to the quantity of food or liquid that residents are consuming. Dehydration is a problem and premature death may occur as a result. Lack of staff may also be a problem and may result in neglect of patients.

The Deltaview facility is an exemplary facility that incorporates the 'gentle care' philosophy for seniors with Alzheimer's.

Families often complain that their loved one deteriorated after going into care. Sometimes the facility is blamed for the continued downward spiral after admission. The fact of the matter is that often the loved one requires an increase in care because their condition is in the process of deterioration. Although the process continues following admission, families often have expectations that more care will reverse the situation. Usually it does not.

Performance monitoring has become even more prescriptive in nature as can been seen in the direction of Health Authorities, stipulating the minimum number of direct care hours by facility without any specific acknowledgement of client mix and/or acuity levels. As there is a lack of any other accurate and reliable measure for quality, closer controls are needed to be intimately managing the output. The current result is a system that is micromanaged using expensive resources (people, technology, etc.) without any confirmed assurance that the quality of healthcare services, as received by the clients, is even close to satisfactory.
• Comments on transitions between care levels or facilities:
  • The transition from independent living to assisted living can be difficult.
  • Seniors in my town were treated with little respect when existing care facilities were phased out before new assisted living facilities were in place.
  • Seniors are often given no choice as to which home they are placed in.
  • A small pilot project in Salmon Arm tested a document called the 'Passport to Care'. The Passport to Care was something to assist the elderly specifically in the transition from community to residential care. Multiple caregivers were involved: the home and community care, mental health providers, and acute care staff. This passport was put together and given to patients at their initial home care assessment and included everything they needed to know: relevant numbers, people to contact, and little pouches to put in things like their Power of Attorney, and their advanced directives. They are now beginning to come back with the resident as they enter residential care and it seems to make that transition a little bit easier.
  • In the late 1980s and early 1990s the Continuing Care System in British Columbia was viewed by international experts as one of the best, if not the best system in the world at that point in time. In the 1990s there were fiscal pressures and changes in the allocation of resources that started sending things in another direction, but without the proper supports.

**Ideas and Suggestions**

Physical Safety of Facilities
Quality of Care
Transitions between Care Levels or Facilities

• Comments on physical safety of homes, and facilities:
  • Injuries to the elderly are reduced if they are in proper care facilities and have access to proper and better home support.
  • Facility accreditation or licensing should be mandatory. Some strict standards are needed.
  • A complaint resolution process in long-term care facilities that patients and their relatives can easily access is essential.
  • When designing seniors facilities, do not make tiny rooms. In a small suite include a kitchen and a separate bedroom and living room.
- Rest homes need a separate wing for Alzheimer's patients.
- How many facilities will be needed to safely address the needs of the baby boomer generation needs to be determined.
- Build larger areas in extended care units for patients to wander around in. Include activity stations and behavioural cues for patients with dementia (colour, common room themes).
- Have more facilities adhere to the 'gentle-care' philosophy for patients suffering from Alzheimer's (constructed in a circular form so that they can be more mobile independently). Build pathways through gardens in courtyards next to extended care units. Provide a "Love, Hugs, No Drugs" environment for patients.
- Allow seniors to bring belongings with them into facilities and provide them and their families with a supportive and dignified environment for them to age in.
- Renovate long-term care facilities.
- Allocate suites in care homes for out-of-town family members who cannot afford to travel or live without their spouse. In return these family members can take care of the patient twenty-four hours, seven days a week without any monies paid.
- Long-term care facilities should provide total care with secure and non-secure units.
- There should be increased camera surveillance in senior's facilities and increased penalties for people abusing seniors.

- Comments on quality of care:
  - There is a strong need to advocate on behalf of ailing parents because care is no longer up to the standard it used to be.
  - At the care home, quality food should be served.
  - The board of directors in seniors care facilities should include members who live there.
  - Install complaint boxes in senior's facilities.
  - Strong regulation of assisted living homes is needed so that they cannot charge exorbitant fees, but must provide a certain level of medical care using properly trained staff.
  - Have advocates available for those living in care who are unable or do not want to advocate for themselves.
  - Don't warehouse seniors, put them in appropriate homes. It's all about respect.
Government must get involved in regulating the industry, for example standard wages and level of education for workers.

Attach seniors’ facilities to schools to promote intergenerational learning.

Support long-term care facilities for Aboriginal people where they receive the proper diet and proper care. This would benefit both seniors and younger generations.

Provide secure, quality, affordable, dignified care for all levels of our seniors needs.

Implement a robust Performance Management System that prioritizes and focuses strongly on satisfaction. In particular, it would align with the evidence that one’s quality of life is measured by our mental experience and not the physical state.

To ensure quality of care and caring in residential facilities in British Columbia we need mandated and funded Family Councils (independent of facility management or Health Authority control) in all residential care facilities; a network of regional family councils; and ongoing dialogue and consultation with family councils.

We need strengthened inspection and compliance mechanisms. Create a mandatory requirement for all Residential Care facilities in BC to establish an internal Facility process for the receipt and resolution of care concerns.

Comments on transitions between levels of care or facilities:

Physicians can best recommend what level of care a patient needs.

Assisted living costs less than residential care and allows for a higher quality of life for the patient.

Revisit Intermediate Care or increase the level of of care that is available in Assisted Living Facilities.

Co-operative or co-housing can be a good option. The Grandview Seniors Housing Co-Operative in Castlegar provides an excellent model, with apartments getting cheaper as residents move to smaller rooms. These facilities can provide spa-like living with good healthy food, physical activities, problem solving action and support of like-minded people.

The criteria that has to be met before being allowed to access long-term care and home support is too high, resulting in patients being very ill when they are finally permitted to enter the system. These criteria should be lowered.

Something needs to be done to facilitate overnight transitions from acute care to long-term care.
The experience in Holland shows that if we have a multi-disciplinary team of providers and infirmary services in place in long-term care, we can significantly reduce ambulance transfers from long-term care to emergency rooms.

**Funding and Costs**

**Comments and Concerns**

**Costs to the Patient**  
**Funding and Resources**  
**Involvement of the Private Sector**

- Comments on costs to the patient:
  - Care in long-term care facilities is only available at a high cost.
  - There are too many patients with serious recurrent chronic problems who should be in chronic care facilities or have extensive home-care nursing but can't afford either.
  - The responsibility to cover items required by long-term care residents falls on the family, such as: replacing lost dentures, hip protectors and wheelchairs as well as paying for medications not covered by Pharmacare.
  - Seniors and their families are being conned by care homes run for profit by foreign and Canadian companies with their aggressive advertising.
  - Seniors should not have to sell their assets, such as their home, to pay for care of an unknown number of months remaining in their life, in a privately operated care facility.
  - Assisted living costs are getting higher and supporting it is expensive.
  - There are no systems in place to ensure that facility managers and owners are accountable for the operations and quality of care provided in their facilities.
  - New assisted living funding does not cover people with cognitive impairments.
  - The current Client User Fee system does not honor or respect the economic realities of life and the resulting choices we all need to make. The client contribution is determined solely based on their income and bears no reference to the cost of the housing and accommodation service received. In contrast, at all other times of life, people make choices to pay for accommodation that they can afford and accept the options available to them. This system does not acknowledge nor incorporate that fact.
The current Client User Fee rates do not adequately reflect the cost of hospitality and accommodation services in new facilities and the system of placing individuals does not reflect the cost differences associated with capital differences.

Comments on funding and resources:

- More funds are needed to create more long-term care beds. Where can this funding come from?
- The funding allotted for non-profits is not adequate for the provision of quality care.
- Funding for facility care has been reduced.
- Public funding appears to largely cover costs in long-term care, but there is a lack of transparency as to the range of daily rates, and why one facility enjoys greater per resident/day funding than another.
- Facilities have been encouraged to contract out services, but recent resident/day funding increases did not apply to contracts, even though those costs are also rising.
- Public/private funding creates a negative environment in long-term care facilities.
- There is inadequate funding for new Campus of Care housing. The construction standard is too high for what should be simple facilities. That is $250,000 a unit versus $80,000-$100,000 per unit for the new homeless support housing.
- There has been partial acceptance of the idea of Campus of Care by government policy makers and they have started to receive some funding.
- Too much money is wasted by keeping patients who should be in long-term care facilities in acute care beds.
- The Northern Health Authority is frequently informed by other health authorities that they have too many long-term care beds in their area in relation to the population. This is not true.
- Long-term care patients are associated with high emergency room costs.
- The current Client User Fee system does not 'blend' into the private pay system which creates a large gap in costs and therefore, encourages individuals to seek out Government subsidy. Currently, client user fees for Residential Care services are based on a model that establishes the client's hospitality and accommodation contribution to ranges from $28 per diem to $65 per diem, depending on income levels (relative a total service cost that ranges between $160 -$200 per diem.)
contrast, the equivalent private pay rate for Residential Care ranges between $140 per diem to $180 per diem depending on client needs.

- The 'base services' set an extremely high standard and further discourages private pay. As the service provider contracts require the delivery of 'complex care' (which is a very wide band of services) and the definition of these services are not clearly defined publicly, there is tremendous upward pressure to continuously find new ways to respond to increasing demands without additional funds to do so. Through the vague description of service and a limit on what can be an additional charge, clients expect that all needs are met by the system and it works to reinforce the entitlement mentality.

- Comments on the involvement of the private sector:
  - The private sector doesn't understand issues in long-term care and assisted living.

**Ideas and Suggestions**

**Costs to the Patient**

**Funding and Resources**

**Involvement of the Private Sector**

- Comments on costs to the patient:
  - Create Campus of Care to provide support for patients with middle or variable incomes, and increase the capital budget for this model.
  - Considering that long-term care facilities receive a considerable amount of funding per resident, all medications required should be paid for.
  - Increase the accountability of long-term care facilities to the client and their family.
  - Allow for tax deductible contributions to fund co-operative building of facilities. Those who contributed should then get to live in these facilities when they are seniors.
  - Promote the development of alternate facilities for seniors. The provincial government should provide subsidies for individuals to live in alternate facilities, lowering the costs of treating them unnecessarily in the hospital.
  - Make resident day rates available at various facilities.
  - Seniors living in long-term care should be covered for dental care.
• It is recommended that the client user fee model in facilities should extend such that there is marginal difference between a person paying privately and the least subsidized level of Government care (i.e. the maximum user fee). The objective is to create a blended system that inspires individuals to consider private pay as well as motivating private investment in the creation of alternative healthcare services.

• Create a client user fee model that better reflects the true cost of accommodation and introduces choice for the client. It should be reasonable that a newer facility would have an accommodation cost that is higher than its older counterpart. In the new Client User Fee model, a client would still qualify for a particular user fee rate based on income. However, that level would align with various designated facilities that have a corresponding cost of accommodation.

• Comments on funding and resources:
  • The funding of long-term care has to change in recognition of the complexity of services that are needed.
  • Beds for seniors should be allocated based on need not on population.
  • Funding and systems should be put in place to create a home-like facility as opposed to institutional settings.
  • The resident or patient should be funded, not the bed and facility.
  • More strategic planning efforts should be directed towards solving long-term care issues.
  • The money government spends on long-term care beds should be transferred to private care facilities with patients paying the difference.
  • Encourage the marketplace to respond to the need for independent housing and communal health care.
  • Targeted funding is needed for rehabilitation in long-term care facilities. It is important to keep these patients mobile.
  • More core funding is needed for volunteer groups such as tax credits and senior outreach groups.
  • More resources are needed for assisted living.
  • Prepare now for the aging population to come: build facilities with long-term care beds.
  • Allocate funding increases equitably between those who followed government pressure to contract out and those who did not.
  • More funding should be allocated towards chaplaincy services.
• Health Authorities must develop renewable 5-year plans for increasing the number of funded and staffed residential care beds and assisted living units in their region.

• Spend money on education for people with elderly parents to learn about care.

• We need to give proper recognition and resources to continuing care such as home support, assisted living and residential care. With adequate resources and funding, we can reduce pressures on the acute care system. We need seamless, interdisciplinary networking.

• Services received under the Government paid system could be modest and reflect a minimum acceptable level of service while providing the ability for individuals to supplement those levels, if they so choose. Through the process of establishing clearly defined services, this future system would incorporate education and communication to ensure individuals proactively assume responsibility for planning their later years.

• Align funding and incentives with a performance management system. By pairing the monitoring focus with money and/or recognition, there is a clear direction for behaviours to follow. This solution is age-old and well proven: we motivate what we measure and recognize.

• It seems wise to consider some of the sources of the 'cost' of care amid the current practices in residential care to assess their 'cost' and, perhaps, feasible effective and efficient alternatives. This could include comparing the costs of expensive continence products with the cost and benefit of some additional Residential Care Attendants who are clearly responsible for implementing an appropriate resident focused toileting plan. Another common area of cost is food wastage 'unappealing food is often refused and discarded. As a result the residents are not receiving nourishment' although monies are spent.

• Comments on the involvement of the private sector:

  • Care should not be dependent on income. Stop the privatization of these services.
  
  • From an outcome based approach, further the progress of private public partnerships in residential care and assisted living homes.
  
  • Encourage private sector construction of intermediate and long-term facilities with short-term tax incentives.
  
  • The future system will seek out a means of promoting options to funded health services by establishing Government systems and practices that minimize the disruption on 'natural market forces'. By considering new approaches to funding and labour cost management combined with proactively supporting operators
that deliver creative service options, a dynamic, integrated and complimentary system will evolve between private pay and the funded system.

**Health Human Resources**

**Comments and Concerns**

**Staff in Facilities**  
**Community-Based Health Care Providers**

- Comments on staff in facilities:
  - Nurses and care aides in facilities are overworked, which negatively affects the care of patients.
  - There is a lack of physician support for large long-term care facilities.
  - Seniors in long-term care have no access to physicians during off-hours.
  - Racism is a serious concern for indigenous elders in long-term care.
  - 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, results in residents who 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.
  - Because there are fewer long-term beds, the acuity levels of patients in care are rising and there is a need for more staff and higher levels of training for these staff members. However, staffing levels have not kept pace with changes in resident needs.
  - There are staff members in long-term care facilities who have very low levels of training.
  - Many of the staff in facilities work very hard to provide patients with the best care possible.
  - Bill 37, which was introduced in 2004, rolled back wages for thousands of workers in long-term care facilities by 15 per cent. Although there were increases in the last round of bargaining, they did not make up for this cut. The workers affected by this cut in wages are still very unhappy and are not encouraging friends or family members to seek training and employment in the industry. Ongoing staff shortages have created unsafe conditions for both workers and residents,
resulting in increased injury rates and higher instances of work related stress and burnout.

- There is a lack of registered nursing staff in long term care facilities. This limits the amount of nursing time available for residents on a daily basis.

- Comments on community-based health care providers:
  - The availability of service providers in smaller communities is limited.
  - Caregivers, often relatives and friends who are not professionals, are often extremely overloaded which can cause them to have to give up their jobs or get sick.
  - 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.

**Ideas and Suggestions**

**Staff in Facilities**

**Community-Based Health Care Providers**

- Comments on staff in residential facilities:
  - Better use should be made of nurse practitioners and clinical nurse specialists in residential care. Perhaps a practicum in residential care could be a requirement for accreditation for these professionals.
  - More staff are needed to look after patients discharged from acute care. 4 hours of transitional care for a patient moving to long-term care is not enough.
  - Have enough staff to provide care for residents, there are currently not enough people in training to meet the demands. There must be adequate provider/patient ratios, based on the available research and evidence.
  - Have doctors spend more time in residential care homes.
  - Salaried doctors, or nurse practitioners, should work in residential care.
  - Residents need more bed-side care, and socialization. Hire more recreational care coordinators and care aides.
  - Registered nurses need to be brought back into the long-term care system.
• It would be beneficial to have a staff nurse or practical nurse on site to assist individuals with medications, education and their health care needs.

• There should be full-time nurse practitioners and gerontologists in long-term care facilities.

• Human resources are needed to provide quality of life and support for families with members in long-term care.

• More dieticians are needed as well as more staff in senior facilities to help feed patients

• Changes should be made to the Residential Care Act. To increase the quality of services provided, ensure the proper ratio of care providers to patient need, and provide adequate attention to evaluating the needs of patients. A different workload management tool that distributes work in response to an accurate assessment of the needs of each client should be used.

• Retired nurses could be encouraged to help out in care facilities.

• Comments on community-based health care providers:
  
  • In seniors housing complexes, have a staff or practical nurse on site to assist individuals with medications, education, etcetera to result in fewer 911 calls, less ambulance use and shorter hospital stays.

  • Long-term care managers should assess each senior after discharge, on the first day, with a reassessment within two to four days, and another a week later.

  • Maintain or reintroduce the community health nurse to support the seamless delivery of care and to improve communication, quality and continuity of care.
Death and Dying

The cost of end-of-life care and British Columbia’s aging demographic were among the issues raised by many participants during the Conversation on Health. The accessibility of services, need for caregiver support and preparation of the patient for death and dying, as well as health human resources and doctor-patient interactions in end-of-life care, were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of death and dying.

The Cost of End-of-Life Care

Discussions about the cost for end-of-life care focus on the need for more funding to improve available services. Many participants see an investment in home care and hospice as a more cost-effective alternative to the current approach to end-of-life care. Others express concern that there is no reliable long-term funding structure for palliative, hospice or home care. This, some suggest, results in more time being spent on fundraising rather than on patient care.

Others say that if one-third of a person’s health care expenses occur in the last year of person’s life, there are moral and ethical considerations about making large-scale expenditures for a time-limited benefit. Participants question whether spending $100,000 on therapy to extend life for three months is a decision that should be supported with public funding. Other participants question the figure that end-of-life care accounts for 85 per cent of health care costs. Further, they argue that paying more for a 90 year old is quite reasonable since a 90 year old has paid taxes for 40 more years than a 50 year old.

Many participants suggest that the Ministry of Health’s 2006 Provincial Framework for End-of-Life Care addresses many of the issues and concerns they raise. Participants recommend that a detailed accountability structure be set up to ensure health authorities are accountable to the Ministry of Health to follow this Framework. Participants emphasize that if we cannot afford to sustain the system, we need to educate the public about realistic expectations related to end-of-life care. The public requires transparent information, such as publicly available itemized costs related to specific procedures, to make informed decisions related to end-of-life care.
Government should take a leadership role in strengthening, recognizing and promoting living wills, right to die, and palliative care. This includes safeguarding the patient's wishes on how and when to die.

– Public Forum, Richmond

Access to End-of-Life Care

Many participants voice concerns regarding the accessibility of end-of-life care. They think that there should be more options for people with limited or no income to go into care, and that rural communities face additional barriers to accessing services. Most agree that end-of-life services are not reflective of population needs and that options for end-of-life care should be better communicated to the public and more easily accessible.

Some participants see supporting independence for the elderly in a safe environment as another way of recognizing aging and dying as a normal conclusion to life. The majority of participants suggest that what matters most in end-of-life care is avoiding pain, where possible, and providing people with the opportunity to die with dignity. For many participants, this means not prolonging life artificially and providing people with the opportunity to die in their own home with proper support, or in a hospice. Other recommendations from participants include: investing more resources in end-of-life care; increasing the number of dedicated hospice and palliative care beds; improving partnerships with hospice societies and other non-profit organizations that support individuals at end-of-life; and, dedicating education resources for the general public and care providers.

Caregiver Support

Throughout the Conversation, many agree that families who care for a terminally ill family member at home have inadequate support and respite care options. Any education efforts geared at increasing patient awareness of their care options at end-of-life should also target caregivers. Many participants recommend that patient advocates be available to patients and their loved ones to assist when making a decision at end-of-life, or enabling them to stay out of the hospital. Others would like to see caregivers financially compensated for their contribution monetarily, or through tax or pension plan credits.
We’ve been doing such a good job of keeping people alive that that dying process isn’t one of days or weeks. It goes for a long period of time, and it’s unrealistic to expect family to provide what is essentially 24-hour nursing care to individuals.

– International Symposium, Vancouver

Health Human Resources for End-of-Life Care

Patients appreciate frank, open and honest discussions with their health care providers when they near the end-of-life. However, many participants are concerned that the current fee schedule for physicians provides a disincentive for taking time to counsel patients on end-of-life issues. Some see multi-disciplinary health care teams, in a setting that allows more time to discuss concerns, as a solution to this issue and there is widespread agreement that health professionals need more training in end-of-life care.

Everybody dies, but every death is unique. We have a responsibility in health care to provide every patient with a dignified and compassionate death, affording patients and families a full range of choices and levels of support as they need. We also have a responsibility in health care to ensure that staff are well trained and comfortable with the dying process and [are] supported emotionally, physically and spiritually if needed by their supervisors/co-workers when dealing with dying patients.

– Health Professionals Meeting. Burnaby

Advanced Directives

Good communication of options well in advance of the end-of-life situation is critical to ensuring that families are well-equipped to make difficult decisions. Many participants in the Conversation on Health see advanced directives and living wills as important tools in end-of-life care. They suggest that British Columbians need to be educated on the importance of having clear and well documented end-of-life plans and that there should be teams put in place to offer third party help and consultation with these difficult decisions. Many participants believe that taking responsibility for one’s own end-of-life care will be normalized if physicians take the lead in raising awareness about living wills with their patients.
Conclusion

A number of people would like to see continuation of the discussion about end-of-life, within government, between government and British Columbians, and within families and communities. Many voice concerns that our society has a fear of dying and, as a result, does not discuss it openly. Some believe that medical professionals view death as a failure, and, while technological advances prolong life, there needs to be a discussion between health professionals to determine reasonable treatment. Participants perceive the current medical approach to death and dying as often keeping people alive against their will, showing a preference for quantity over quality of life. They discuss the need for individual choice, focussing on maintaining quality of life through end-of-life.

Every human being deserves to die with dignity, comfort and [they deserve to] feel peaceful in the location of their choice, including respect for language, religion and customs.

– Public Forum, North Vancouver
Death and Dying

This sub-theme includes the following topics:

Costs of End-of-Life Care
Access to End-of-Life Care and Services
Caregiver Support and Preparation of the Patient
Human Resources and Doctor-Patient Interactions
Advanced Directives and Living Wills

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

| Sunshine Coast Conversations on Health  
| Submitted by the Women’s Health Advisory Network, the Sunshine Coast Hospital and Health Care Auxiliary and the Seniors Network Advisory Group  

| The Two Standards of End-of-Life Care in British Columbia  
| Submitted by Providence Health Care  

| UBC College and Interprofessional Network  
| Submitted by the UBC College of Health Disciplines and the Interprofessional Network of B.C.  

| Report to the Conversation on Health  
| Submitted by the BC Cancer Agency  

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

Costs of End-of-Life Care

Comments and Concerns

Funding End-of-Life Care
Prolonging Life by Taking Heroic Measures
Accountability
Cost and Personal Choice

- Comments related to funding end-of-life care:
  - There are insufficient funds set aside for activity planning to ensure end-of-life facilities are more enjoyable.
  - There is little funding available for those who want to end their life in a comfortable, non-medical environment.
Most of the health authorities have seen funding cuts to end-of-life care although there are increasing demands in this area.

As funding has gone directly to health authorities for end-of-life care management, there are different models being developed in each health authority, which does not necessarily address the need to provide the right care, at the right place and at the right time.

Comments on prolonging life by taking ‘heroic’ medical measures:

- The exponential growth in medical knowledge and technology makes it possible to keep more premature babies and the very elderly alive and to treat conditions and diseases that were previously untreatable, resulting in increased costs to the health system.
- There are many moral and ethical considerations to take into account, related to large-scale expenditures for limited benefit, if the health care system is to work towards sustainability (e.g. spending $100,000 on therapy to extend life for three months may not be reasonable).
- Medical advances have made it possible to prevent death to the point where it is often debatable whether the intervention is doing anything but prolonging the dying process.

Comments on accountability:

- The *Provincial Framework for End-of-Life Care* does address many of the issues and a more detailed accountability structure must be set up to ensure health authorities are accountable to the Ministry of Health. There must be support for innovation and demonstration projects to ensure we are providing the best care at the right time in the most cost-effective way.
- There is a lack of resources in all settings to provide comprehensive end-of-life care (home, facility and hospital).
- Many insurance companies are cashing in on the concerns that Canadians have resulting from insufficient funds for their funeral costs.
• Comments on cost and personal choice:
  - Patients wanting to end life at home must pay for their own drugs.
  - People should be able to die naturally instead of having money spent to keep them alive against their wishes.
  - It can be cruel and humiliating to keep dying people alive against their will.
  - Health care costs for the end-of-life for terminal cases (for example, late-stage cancer) are exorbitant.

• The majority of health care dollars are spent in the last 10 years of life.

• It is too costly to provide 24/7 care in the community.

Ideas and Suggestions

Funding End-of-Life Care
Prolonging Life by Taking Heroic Measures
Accountability
Cost and Personal Choice
Age and Treatment Priority

• Ideas about funding end-of-life care:
  - There is already a Provincial Framework for End-of-Life Care (May 2006) and there is a good example of end-of-life care in the Hospice House in Prince George. So fund it and get on with it.
  - Is there a plan for the Government of British Columbia to adequately fund the health authorities so that they may effectively carry out the recommendations in the Framework for End-of-Life Care?

• Ideas about prolonging life by taking ‘heroic’ medical measures:
  - There are a lot of interventions that we know in our hearts are futile. If we could have the wherewithal to acknowledge that, step back and stop offering these services, then we would have resources that we could regroup.
  - There is a need to address the ethical issues related to end-of-life care and to determine to what extent our system should perform heroically.
  - The only time people should have to pay for health care is when someone is diagnosed with a terminal disease. Once diagnosed, health care coverage should stop for that person (aside from procedures and medications needed to ensure
basic comfort for the patient). If they choose to pursue new therapies it should be at their own expense.

- We cannot legislate a change to a wiser philosophy but we can vote to limit health care: the technically non-viable unborn need not be born, the life saved by an outrageously expensive treatment need not be saved, the life prolonged by significantly major surgery need not be prolonged, cancerous diseases that threaten our lives need not be defeated.

- Ideas about accountability:
  - Transparent information, such as public, itemized costs related to specific procedures is needed to make informed decisions related to end-of-life care.

- Ideas about costs and personal choice:
  - People should have the right to die naturally and this right should be facilitated by increasing home support in recognition of the savings, as far as costs of home care over hospital care.
  - All people should be organ donors. This would reduce scarcity and would in turn reduce crime related to the need for organs.
  - People are definitely living a greater number of disability-free years which is excellent for all of us.

- Ideas about age and treatment priority:
  - We need to decide if we expect and value better and timelier health care, earlier in life and throughout middle age, or, if we want to have better care in our final years. Clearly, our current system cannot offer us both and with an aging population, things are likely to get worse.
  - Age should not influence decisions made by a hospital or doctor. If health care is a right, then age should not be a factor.
  - There should be an age limit cut-off for expensive surgery, such as heart bypass.
  - Take a look at some of the health care systems in Europe, where they offer no publicly funded surgeries for persons over 75.
  - People are definitely living a greater number of disability-free years which is excellent for all of us.
  - Form a committee of health care workers to provide a means test for operations. For example, determining the pros and cons of providing a hip replacement for a 90 year old.
• The cost of dying from an illness is often higher than the costs of the treatments needed to survive an illness, particularly in acute care.

• Reduce initial costs related to death and dying, by not having end-of-life patients fill acute care beds.

• Tax payers should not have to pay thousands of dollars for the health care of a dying person.

• A funeral benefit, through the Canada Pension Plan, could be provided for everyone who donates a major organ. The consent form could be part of the Canada Pension Plan record and made available, via a database, to all hospitals. This could be financed through the savings brought about by having far fewer people on dialysis etc. This money could only be used for funeral costs and would not benefit surviving relatives. Payment would be forfeit if not spent on funeral costs, and the program would only be in place when there was a dire need for organs and could be instated and dropped as necessary each budget year. Those having signed up would remain on the list until their death and would not have to resign each year.

• Investment must be made to support the infrastructure needed to provide standardized end-of-life care.

**Access to End-of-life Care and Services**

**Comments and Concerns**

**Facilities**

**Acute Care Settings**

• Comments related to accessing end-of-life care facilities:
  • There are not a lot of options for a person with limited or no money to go into care.
  • It is difficult to get the right diet for Aboriginal Elders who are dying in facilities.
  • Our long-term care facilities are full of people in the end stages of life who have no quality of life left, and are often suffering and in a lot of pain.
  • There are not enough complex care facility beds for end-of-life care.
  • The oldest of the old in our society are not served well by the current system. The *Provincial Framework for End-of-Life Care* promises adequate end-of-life care in
residential care but fails to give the health authorities adequate resources to accomplish this. Our older adults with dementia and frailty are some of the most vulnerable people in our society. How we treat them says a lot about what our society values and with our current state of residential care, they are clearly second-class citizens.

• The Provincial Framework mentions quality indicators developed by the Canadian Council on Health Services Accreditation specifically for end-of-life care, but the health authorities are not asked to report on these measures. Currently, none of the measures in place will adequately capture the quality of end-of-life care provided to British Columbians in residential care.

• Comments related to access to end-of-life care in acute care settings:
  • We end up shuttling people into acute care and are missing an opportunity for people to come into an environment that is the more responsive and appropriate for end-of-life.
  • People are dying in the hospitals because they do not have options/services available.
  • The busy and generally under-staffed acute hospital setting is not entirely appropriate to meet the holistic and often complex needs of a dying patient or their family.
  • The Quesnel Hospital has a great end-of-life program.
  • The Intensive Care Unit in Prince George is amazing in their handling of dying patients.
  • The fact that Richmond has a Hospice and a Palliative Care Unit is great.

• Rural areas may not always be able to get home care support or volunteers so patients can die at home.

• Doctors and the government of British Columbia appear to want only those people deemed to be no longer valuable to die.

• Starvation is not an acceptable alternative way to end life particularly when more compassionate means are unavailable.

• People are becoming more aware of their choices in end-of-life care.

• The current health care system is ill-prepared to meet the ensuing needs of people with end stage chronic illnesses leading to death.
• It can be cruel and humiliating to keep dying people alive against their will.
Ideas and Suggestions

Facilities
Public Education on Death and Dying
Cultural Issues and Personal Choice

• Ideas about accessing end-of-life care facilities:
  • Design end-of-life care facilities providing these services for smaller and rural communities.

• Ideas about public education on death and dying:
  • Normalize the end-of-life process much like cancer (charity runs, walks, etc.).
  • There must be better public communication concerning the comfort that end-of-life care can provide. Recognize end-of-life care as a necessary part of health care.
  • Place more emphasis on dying at home.
  • Provide outreach and education around end-of-life issues to multicultural communities through ethnic media, associations, churches, or religious groups to ensure that the appropriate and available services are utilized effectively.
  • Use the media to promote a change in the approach to and understanding of end-of-life.
  • Direct more resources towards advertising end-of-life services.
  • Provide education on end-of-life and the services available. There is currently a lack of awareness in the general public. This information needs to be easily accessible and geared towards specific populations.
  • Teach about issues related to death and dying in schools.
  • If we cannot afford to sustain the system, then we need to educate the public with regards to realistic expectations related to end-of-life care.

• Ideas about cultural issues and personal choice:
  • Acknowledge the cultural component of death and dying. There are some cultures where the whole point is to prolong life as long as possible, regardless of quality of life. For others, it is important to die at home among family.
  • What matters most is the avoidance of pain where possible, and providing people with the chance to die with dignity. This means not prolonging life artificially and providing people with the opportunity to die in their own home with proper support or in a hospice.
  • Remove the ‘no code’ option but support peoples’ choices at the end-of-life.
• Focus on quality of life, versus quantity and respect the choice of the patient.
• Provide quality end of life care for marginalized populations and the homeless, as well as people from various ethnic groups.
• Allow ceremonies in facilities during end-of-life care for First Nations peoples.
• There needs to be equality in care across communities.
• We need to remove religion from the health care system and separate religion from the ethics that guide health care decisions in areas such as abortion and prolonging the life of children with disabilities etc.
• Supporting the elderly to maintain independence in safe environments is another way of recognizing ageing and dying as a normal conclusion to life.

• We need to follow through with outcome scales that not only measure where a person died but also assess the quality of life a patient experiences throughout the dying process:
  • Were pain and shortness of breath controlled?;
  • Was the patient and their family made aware of all they wanted to know about the illness?;
  • Was psychological support provided to the patient and family throughout the process?; and,
  • Was grief support available to the remaining family and friends?

• Hepatitis has to be included in end-of-life planning.

• Establish national standards for home care and hospice palliative end-of-life care delivery programs. These standards will ensure that all British Columbians have access to quality and timely home care services, which will mean improved quality of life, and a dignified death in those situations where death is the only outcome.

• Minimal service level requirements should be defined, and integration between acute and community care is vital. While this would increase access to care and information for cancer patients, their families, and other caregivers, it would obviously help those dying of other diseases.
Caregiver Support and Preparation of Patient for End-of-Life

Comments and Concerns

Support for Caregivers and Families
Death as a Natural Process

- Comments related to support for caregivers and families involved in end-of-life care:
  - There is inadequate support for families who are caretaking for a terminally ill patient at home.
  - Do not overlook the extra strain that end-of-life care can place on the spouse/partner, especially if they are elderly.
  - Family caregivers do not have medical knowledge or experience. They do not know how to access appropriate equipment, methods, practices, services.
  - In dying, time is one of the most important components. The medical system has no process in place to manage families nor is there time to provide adequate care to family members.
  - The end-of-life period had grown from weeks to years, increasing the burden on family caregivers.
  - The Government is downloading end-of-life care to families.
  - Do not overlook the emotional bond/attachment that caregivers can develop with a person who is terminally ill.

- Comments on death as a natural process:
  - Death is inevitable, it cannot be prevented, just postponed. It is the dying process we are afraid of. Our culture does not accept dying even if an individual has specifically expressed their wishes.
  - Physicians are often unwilling to communicate that a patient is dying; some perceived as medical failure.
  - We do not talk about death enough, although it is a natural process.
  - If end-of-life care stays within the medical model system, you will not get engagement at a community level.
  - Medical advances have made it possible to prevent people from dying with major illnesses such as stroke, heart attack or infection, but this does lead to more frail 'survivors', who are living with the chronic consequences of the initial illness that would have killed them previously.

Ideas and Suggestions
Support for Caregivers and Families
Death as a Natural Process
Support for the Patient
Legislation and Regulations for Caregivers and Patients

- Ideas about support for caregivers and families involved in end-of-life care:
  - When a family member is dying, the focus should be on that person and respect paid to their dying. Do not be afraid to talk to a loved one who is dying, while they are dying. So many people suffer a prolonged death because of the family members left behind.
  - Invite the family to be part of the process. Provide individual and unique care when a patient is approaching end-of-life. It is not just about the patient, it is also about the family.
  - Address gender issues in end-of-life care. Historically women have taken on care for family members and this is changing as more women work outside the home.
  - When a person’s time comes, make it as easy on the family as possible.
  - There is a need to support family members after the death of a family member.
  - Explain end-of-life interventions to families.
  - Establish a consulting service for patients and families to learn about options for end-of-life care.
  - Families need to become more involved and better educated on death and dying – start in the schools.
  - Expand grief and bereavement counselling.
  - Options related to compassionate care leave and financial benefits for caregivers need to be increased.
  - Roving nurses and home care nurses could be used to help patients and families dealing with end-of-life care.
  - Respite care has to be available when a family chooses to handle end-of-life care.

- Ideas about death as a natural process:
  - End-of-life does not need to be negative.
  - End-of-life care must be about the patient. Strip away the Medicalization of death.
  - We need to create an atmosphere that allows discussion around death and dying to happen earlier and more often with more active conversations on the issues related to end-of-life.
  - Society needs to be re-educated that dying is not an illness. Care for end-of-life requires a paradigm shift away from acute care models to acceptance and recognition of the dying process with a publicly funded holistic approach.
• Ideas about support for the patient:
  • Assign a grief counsellor/case manager/spiritual counsellor to patients to help
    them navigate the end-of-life care system.
  • Patients need a social worker or counsellor to speak with immediately upon
    receiving the news that they are terminal.
  • Information related to death and dying has to be personalized. It does not work
    very well to put it in television ads. What you need is someone, whether it is the
    family physician or another health professional, to sit down with a patient and
    their family and have a conversation about expectations and options related to
    end-of-life care.
  • Everyone dies in a unique way. We have a responsibility in health care to ensure
    each patient receives a dignified and compassionate death, providing patients and
    families with a full range of choices and supports as needed.
  • A ‘life review’ can be a valuable component to end of life care. This ties into a
    legacy concept and helps people to understand the mortality of their lives, while
    preparing a legacy for inter-generational understanding. There are some
    practitioners in hospice societies that are doing this. It is using technology to mark
    what your life has been and can be a helpful means to validate the life progression.
  • Make the elderly comfortable in the end do not give them procedures to prolong
    their lives for a short time.
  • A vehicle or trailer with a glass top (so the patient can see out but no one can see
    in) could be used to take patients to their homes or to a ranch to allow them to
    enjoy the last few hours of their life.

• Ideas about legislation and regulations for caregivers and patients:
  • Pass legislation related to professional caregivers making end-of-life decisions.
  • Allow patients with a willing caregiver and in-home support to be administered
    pain medication when they decide to die at home.
  • Change Employment Insurance to allow people to take leave to act as a family
    caregiver.
  • Make legal estate counselling available for those without families.

• If the person wants to die at home then the following must be available:
  • professional support i.e. nurses and doctors;
  • pain management even if the patient lives outside of town (The care giver is not
    always able to administer proper pain management); and,
  • continuity in care providers for people using home care or support.
Human Resources and Doctor-Patient Interactions

Problems, Issues and Concerns Identified

Role of Health Professionals

- Comments on the role of health professionals and physicians in end-of-life care:
  - Doctors often do not want to prolong life.
  - Medical professionals can view death as a failure and at end-of-life (or what should be the end-of-life), medical professionals can sometimes take over and not allow a person to die even when the person does not want help.
  - Many physicians find it difficult to broach the subject of dying to patients and relatives.
  - Many doctors simply shrug questions off or do not take the time to ascertain the patients’ feelings.
  - Nurses are and doctors already overworked and the demands of end-of-life care can be burdensome.
  - The current fee schedule for physicians provides disincentives for taking the time to counsel patients on end-of-life issues.
  - The nurses and doctors make every effort to make sure patients are as comfortable as possible until they pass on. Unfortunately, sometimes people do suffer pain in spite of their best efforts.
  - Hospital staff members are good at accommodating requests where possible.
  - It is very hard on professionals when patients die. Often professionals are left with feelings of regret and guilt. If these feelings are not dealt with it can affect how they relate to others.
  
  - The quality of the system is currently dependant on volunteer support.
  
  - It is not an accepted practise to remove death and dying from the medical model.

Ideas and Suggestions

Role of Health Professionals
Education of Health Care Providers
Service Delivery

- Ideas about the role of health practitioners and physicians in end-of-life care:
The physician is in the best position to look down the road and tell the patient and their family what to expect during end-of-life processes.

A lot of it comes down to the differentiation between the science of medicine and the art of medicine. The science of medicine involves treating disease, to do no harm and to try and do everything you can to preserve the life of the individual. The art of medicine is talking with families and having that rapport, that you need to really address the issues and do what is the best, to get the best quality of life for the patient, whether they are aging or in the end of their lives.

At end-of-life doctors should act as advocates to ensure that a patient’s wishes are met.

General Practitioners need to be educated to communicate/hold complex conversations with patients about advanced directives. They should work in collaboration with patients to develop end-of-life scenarios.

Have physicians talk to patients at age 65 to discuss end-of-life options with their family. An ad campaign could help start a light hearted conversation that will get people talking.

Physicians must be more open, honest and compassionate towards their patients.

Patients appreciate frank, open and honest discussions, as well as having a range of options to choose from.

Doctors should not have the power to decide who lives and who dies, who gets what treatment who does not. Obviously they need to have a major input but society needs to have the understanding and ability to set guidelines and to have appropriate expectations.

With regards to premature babies, the medical profession needs to set some boundaries that define the viable point after which a good quality of life for the whole family can be a possibility. Do not leave it to parents to make that decision.

Ideas about the education of health care providers in end-of-life care:

In end-of-life care there is a need to consider cultural factors and offer alternative care options. The inability to carry out cultural rituals can lead to increased stress on the family members, care providers and patients. Health providers need to be educated in cultural sensitivity.

Educate medical professions in end-of-life care issues and options.

The Ministry of Health has a paper on end-of-life, with recommendations for curriculum changes for the medical community.

An inter-professional approach in the contexts of end-of-life/palliative care and geriatric health care, in rural communities, can provide best practice opportunities for collaborative learning sites for students.

End-of-life care should be a specialty area with its own facilities and expert teams.
• There is no clear answer to how end-of-life should be handled; however there are certainly gradients of stability in end-of-life that should perhaps be analyzed. We need more specialists in this field who are at all levels of experience and education.

• Ideas about service delivery:

  • Having better prognostic skills would help us avoid costly investigations and treatments that do not add to the persons’ well-being. This would also better help us to plan effective care for that person through the end-of-life process.

  • If we could solve the end-of-life care problem, we would decrease the workload on our existing health/human resources to the point where the problem would be more manageable.

  • Multi-disciplinary health care teams should be available to patients wanting to go over their end-of-life options in a setting that allows more time to discuss concerns than a short appointment with a General Practitioner would permit. These consultations could be in groups, with those attending having access to web information and other forms of communication, as well as one-on-one communication.

  • Health providers or health authorities should come to agreement on and implement shared clinical tools for end-of-life.

  • Medications to speed up the dying process should be available to patients with terminal cancer; do not let them suffer.

  • What can be done to prevent the abuse of the end of life care system?

  • In assessing each individual case, what standards are there to compare them to? Are there acceptable qualified lists of standards for end-of-life care?

  • Wait a respectful amount of time before sending out questionnaires related to the satisfaction of surviving families with the end-of-life care services received. Do not carry out exit interviews.

• There should be a separate room in hospitals where doctors can talk to terminally ill patients in private.

• Need patient advocates in end-of-life care, especially for the disadvantaged or disabled.

• Use volunteers more in end-of-life care, particularly in smaller communities.

**Advanced Directives and Living Wills**

**Comments and Concerns**
Living Wills
Advanced Directives

- Comments on living wills:
  - Doctors can overrule living wills. A Living will does not force doctors to follow patient wishes and since institutions and medical professionals fear liability they are often not adhered to.
  - The law might take the view that if you did not have a living will, you have consented to everything the system could or would do to you. But generally there is an understanding, that actually the doctor decides what has to happen to the patient, not the family.
  - Living wills do not necessarily follow a patient to where they are receiving care.
  - Living wills allow the patient a degree of control over the end of their life.

- Comments on advanced directives:
  - Do Not Resuscitate orders can place pressure on families. It can be frustrating for families trying to advocate for patients when the doctor no longer involved in ongoing assessment.
  - There are cultural issues around death, Do Not Resuscitate forms, etc. End-of-life has to be patient/family driven.
  - Ambulances and paramedics do not always respect advance directives.
  - There is concern related to legislation for advanced directives.
  - Even when it is clear that a patient wants nothing but palliative care, you may have to call 911 and go to the hospital, and once there it can be difficult to put the brakes on, ensuring that the patient is comfortable but that heroic measures are not taken.
  - If potential death happens when a person is not in hospital or documentation is not at hand, heroic measures can be taken, even if the patient has requested that no such actions be taken.
  - Being able to set out a clear set of wishes and knowing they will be adhered to goes a long way in providing comfort to people. If someone becomes incapable of making their wishes known, it would be comforting to know that their life could be ended mercifully.
  - The path of decline in cancer is often somewhat consistent. This makes it easier to do the Advanced Care Planning that can help prepare the patient and their family for end-of-life.
  - The terminology around end-of-life is misleading. In reality, end-of-life care has to start with advanced planning, which ideally takes place long before end-of-life. It's like planning for retirement; you do not plan for it when you are ready to retire.
• We allow people to become incapacitated without encouraging them to make decisions about their future when they can.

Ideas and Suggestions

Living Wills
Advanced Directives

• Ideas about living wills:
  • Make living wills a common practice. When you go to get a will notarized, you should be asked about a living will.
  • Change legislation to allow doctors to record end-of-life wishes.
  • The Government should take a leadership role in strengthening, recognizing and promoting living wills, the right to die, and palliative care. This includes safeguarding the patient’s wishes on how and when to die.
  • Before a person lapses into un-consciousness he/she should legally appoint someone to have power of attorney and make major decisions for them.
  • Combine end-of-life decisions with estate planning and wills.
  • There should be a central registry of living wills, with these wishes noted on the individuals’ care card to aid paramedics.
  • If physicians take the lead in raising awareness about living wills, the idea of taking responsibility for ones own end-of-life care will become a part of life.
  • Doctors should help their patients prepare living wills and keep advanced directives up to date, revised every five years.

• Ideas about advanced directives:
  • Do not make advanced directives mandatory, only available, should a person wish to document their health care decisions.
  • Advanced Directives should be mandatory, with better and earlier communication between all parties.
  • The Do Not Resuscitate (DNR) system is a mess and is frequently misused, instead, we need to use representation agreements more.
  • Families should have representation agreements that deal with final health issues.
  • People need to advocate for representation agreements.
  • The Intervention Consent Form needs to be updated and patients need to be educated on its contents.
  • The public and health care workers need education about advanced directives.
  • Do Not Resuscitate forms and should be made available to every British Columbian.
• We need to include the patient and family in decisions and advanced planning, starting at diagnosis.

• Information is the key to decision making and the delivery of good data and options well in advance of the end-of-life situation is critical to ensuring that families are well-equipped to make the difficult decisions required.

• Carrying our end-of-life wishes stuck to our MSP Card would help to make the system more efficient.

• There needs to be some way to inform all the necessary medical disciplines of a patient’s wishes to prevent the performance of heroic measures, for example, a medical bracelet.

• People need to be educated to have clear and well documented end-of-life plans. There should be teams trained and put in place so there is third party help and consultation available.

• Improve the quality of life of seniors by removing the fear of a slow, painful, undignified death. Allow people the opportunity to make a well informed, thought out, and planned way of ending their life when they come to the point of not wishing to live anymore.

• Educate people (seminar style) in their options, provide a clear, concise booklet of the options, then have peoples’ wishes recorded somewhere (the CareCard is one possibility) and ensure that doctors offices and hospitals can call up this information quickly and that paramedics out in the field have this information available to them on the spot. These additional costs will pay for themselves in savings by reducing unnecessary care.

• There should be a panel of people to make decisions related to the end-of life care of a patient, unless that person has clearly made the decision.
Palliative Care

Over the course of the Conversation on Health, palliative care was a frequent topic in discussions related to end-of-life care. The importance of addressing issues related to training health professionals and the delivery, accessibility and the costs of palliative care, both in facilities and in communities, was highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of palliative care.

Accessibility and Costs

Participants suggest that there appears to be a new recognition of the value of and need for palliative care and generally supported investment in these services. They argue that this investment would reduce the demand for acute care beds and aid in waitlist management in the acute care system, while offering more choices to dying patients, and reducing health care costs. Many advocate for a multi-disciplinary approach to a patient-directed, palliative care model, supported by long-term sustainable funding.

Participants are concerned that terminally ill patients and their families often find themselves coping with end-of-life issues in acute medical units while waiting for one of the few available hospice or palliative care beds. They emphasize the idea that access to palliative care should be equal, no matter whether it is provided in acute care, complex care, homecare or residential care settings. One suggestion is to undertake an assessment of the accessibility of specialized palliative services in residential care, which is extremely variable throughout the province. There is also concern that the consent process for palliative care is different in different health authorities. Often, families do not understand what services are available to them and many recommended having a palliative care navigator accessible to patients and families.

Health Human Resources and Training

Many participants describe the benefits of supportive palliative care, where staff members are educated on issues such as pain and symptom management and caregiver support. Despite demographic trends and the projected needs for palliative care in the future, participants widely agree that there is a shortage of health professionals trained in palliative care and insufficient opportunities available for
students interested in this field. Some suggest recognizing palliative care as a specialty in general medicine and providing additional training programs as means to meet the demand for more trained palliative care staff.

It concerned some participants that not-for-profits or over-burdened volunteers run many of the palliative care services available to British Columbians. Many participants support the idea of increasing the number of palliative home care teams and 24 hour palliative response teams. Another suggestion recommends a formalized and consistent palliative care team structure, which would include a social worker to address the psycho-social needs of patients and their families.

As difficult as end-of-life care is, we have to humanize it… each case is unique and requires respect. [The] whole [process of] end-of-life care requires specialized training - you can’t just treat those patients like everyone else, along with everyone else.

- Health Professionals Meeting, Burnaby

Palliative Care in Facilities

Some participants suggest that palliative care beds in complex care facilities would not result in quality care and that palliative patients should not be in acute wards. Others state that hospitals or long-term care facilities have a role in the delivery of palliative care. Many propose that the system needs additional palliative and hospice care facilities to meet existing and future demands and that planning for palliative care should be based on demographics.

Although participants voice concerns related to the lack of stable funding for hospices, many recommend them for the delivery of palliative care, suggesting that they provide quality care and decrease demands on the acute care system. Several participants emphasize that one of the most glaring differences between hospices and residential care is that all hospices have access to the palliative care benefits program while not all residential care facilities do. Participants discuss the need for better partnerships between health authorities and hospice societies and other non-profit organizations. They recommend the creation of clear guidelines to ensure that hospice beds are used appropriately and not occupied by long-term palliative care patients.

Hospice Houses have a different atmosphere and purpose than acute care hospitals or even long term care facilities. Staff at hospices are trained not only to care for the dying person… [they] provide support for family and friends as well. This takes an increased number of staff to effectively accomplish…

- Email, Prince George
Palliative Care in Communities and Caregiver Support

Participants recommend supporting those who want to have palliative care in their homes by providing: a home visit nurse; a tax break for caregivers; 24 hour, on-call access to physicians or nurses to relieve stress on family members; income support for families caring for in-home palliative care patients; and some form of compassionate leave for those involved in palliative care. Many also believe the Government should increase the availability of community respite options to ensure that valued caregivers and contributors to the health care system receive the supports they need.

Conclusion

Over the course of the Conversation on Health, there is widespread agreement on the need to focus on allowing patients to die comfortably and with dignity. Many participants describe providing sufficient resources to palliative care as essential to achieving this goal.

We spend a lot of time and energy thinking about the baby boomers and the Olympics, but people have always been dying. We are in a death defying culture…We are talking about preventative issues, but at the end of the day we want to be in a place where we are cared for, through all the components of quality end-of-life care: being psychosocial care, your spiritual dimension, as well as your pain and symptom management…That is the specialized care [we want.]

- Focused Workshop on Seniors and Aging, Vancouver
Palliative Care

This chapter includes the following topics:

Health Human Resources and Training in Palliative Care
Accessibility of Palliative Care
Facility-based Palliative Care
Hospice Care
Palliative Care at the Community Level and Caregiver Support
Assessment and Consent
Funding and Costs of Palliative Care

Related Electronic Written Submissions:
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

The Two Standards of End-of-Life Care in British Columbia
Submitted by Providence Health Care

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

Report to the Conversation on Health
Submitted by the BC Cancer Agency

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Seniors; Home Care or Support; Death and Dying; Euthanasia and Long Term Care.

Human Resources and Training in Palliative Care

Comments and Concerns

- Despite demographic trends and the projected needs for palliative care in the future, no additional training programs have been initiated.
- In general medicine, Canada does not recognize palliative care as a speciality.
- There is a human resource shortage in palliative care.
- Palliative care responsibility is often taken on by staff ‘off the side of their desks.’
Palliative care units are not pleasant places to die, as many of the nurses seem to lack compassion for the patients.

Nurses are often unwilling to administer the pain medication needed to lower the pain threshold of palliative care patients.

When a patient is dying in hospital, staff members are very compassionate and supportive.

Many palliative care services are currently run by not-for-profit or volunteers.

The Provincial Framework for End-of-Life Care released in May 2006 was well received by those working in hospice-based palliative care.

**Ideas and Suggestions**

- There is a need for palliative volunteers in hospitals and a need to channel volunteers into this field.
- Palliative care providers must be informed of the specific needs of individual patients.
- Palliative care should be provided by well coordinated interdisciplinary teams. These could be private, public, or volunteer based.
- More palliative home care teams and 24 hour palliative response teams are needed. There should be a formalized and consistent palliative care team structure which includes a social worker to address the psycho-social needs of patients and their families.
- Change the emphasis of medicine to address the needs of the elderly and those with terminal illnesses through palliative care.
- As difficult as end-of-life care is, we have to humanize it. We are not cattle, each case is unique (culture, family dynamics, religion, etc.) and requires respect. The whole discipline of end-of-life care requires specialized training.
- Pastoral care or chaplains should be available to check in with staff and family during the dying process.
- Connect Phase 1 clinical trial volunteers to palliative care services in Vancouver.
- Doctors and nurses need to be educated about palliative care options and provisions.
- Some remote communities might be willing to offer services for end-of-life patients, since small communities can have personal relationships. Explore this possibility of obtaining local help.
More end-of-life beds are needed in the community. Supportive, palliative care, where the staff is educated on issues such as pain and symptom management and caregiver support, is very beneficial.

Recognize that staff and health care providers are human and should be allowed to grieve and acknowledge their loss when a patient dies.

**Accessibility of Palliative Care**

**Comments and Concerns**

**Palliative Care Bed Shortages**  
**Regional Access Issues**  
**Public Education and Promotion of Services**

- Comments related to palliative care bed shortages:
  - Palliative beds have been closed in some areas, yet are vital to the health care system. These cost cutting measures need to be reconsidered.
  - Too often terminally ill patients and their families find themselves coping with end-of-life issues in acute medical units while waiting for one of the few available hospice or palliative care beds.
  - The amount of palliative care services does not meet population needs. For example, Parksville/Qualicum has one of the largest aging populations, but only one palliative care facility.
  - Some communities do not have palliative care facilities, only beds in hospital.

- Comments on Regional Access:
  - The Tofino area needs more in the way of palliative and respite care. Currently there is one privately funded palliative care room in the hospital, but many more are needed.
  - In Liverpool, England, a study was carried out on end-of-life care, discussing their whole system and all the pathways needed to navigate the palliative care system. They created an amazing road map.
  - Palliative care is still well administered in Cranbrook, despite the fact that the hospice has been de-funded.
  - Fraser Health provides great services in terms of palliative care.
  - The palliative care ward and Vancouver General Hospital provide excellent care.
• Many patients wish to die at home and Victoria Hospice's palliative response team, along with home care support are working together to help achieve the patient's desire by visiting the home as needed. The Palliative Response Team works 24 hours per day, 7 days per week, 365 days per year so that if there is a crisis at the home, the team, comprised of a nurse and a counsellor and at times a physician, can attend quickly to get the pain under control. If a patient is on the palliative care unit, the staff and volunteers attend to the patient’s and family’s needs and it is not uncommon for patients to become stabilized and return home for a time or even for them to die at home, if that is desired.

• Not all communities have access to palliative care, especially for non-cancer patients.

• Comments on public education and promotion of palliative care options:
  • A partnership between the BC NurseLine, a provincial tele-triage and health information call centre, and the Fraser Health Hospice Palliative Care Program allows for after hours access to care and information for dying patients and their families. This program has improved outcomes of symptoms management, cut down on the number of visits to our overloaded Emergency Rooms, and enhanced the support for families of the dying. With the majority of Canadians saying that they want to die at home, it is likely that more of these services will be needed in the future.

• There are some palliative care programs that work well for the patient.

**Ideas and Suggestions**

**Regional Access**
**Public Education and Promotion of Services**
**An Integrated System of Service Delivery**
**Cultural Sensitivity**

• Ideas about regional access to palliative care:
  • Access to palliative care should be equal, no matter if it is provided in acute care, complex care, home care or residential care settings.

• Ideas about education and promotion of palliative care options:
  • Many people are not aware of the palliative care services available to them so doctors should provide this information to everyone.
• Palliative care should be made more accessible for seniors.
• Provide education related to the availability of palliative care for seniors.
• Use the NurseLine to initiate access to palliative care resources for patients.

• Ideas about an integrated system of palliative care delivery:
  • Palliative care needs an integrated, government funded system where quality of care does not depend on ability to pay.
  • Invest in palliative care so people may pass on in a relatively painless way.
  • Provide adequate palliative and hospice care and more choices for patients and families dealing with end-of-life (provide translations of materials to increase accessibility).
  • Palliative care should focus on allowing patients to die comfortably and with dignity.
  • Support a multi-disciplinary approach to a patient directed, palliative care model, including long-term sustainable funding.
  • Options and choices related to the quality of palliative and end-of-life care, including palliative units, hospice, residential care and home care options, should be available and accessible to patients.
  • An assessment of the accessibility of specialized palliative services in residential care is needed. It is currently extremely variable across the province. Specialized palliative care services are teams that can work with residential care and other health care providers, to manage symptoms and improve the quality of life for those with a chronic, unpredictable illness.
  • Recognize the variable needs and levels of palliative care patients (tertiary, hospice, etc).
  • Provide better treatment and palliative care for AIDS patients.
  • Hospice and palliative end-of-life care should be designated as a core service under the BC Ministry of Health. Health Authority performance agreements should include this important and neglected area.

• Ideas about cultural sensitivity:
  • Provide palliative care homes that are quiet, fully staffed, and that support various ethnic beliefs. Accommodate the diversity of cultures in palliative care settings.
  • Provide a room in the palliative care section of the hospital for First Nations families, where there are staff members educated to understand the culture.
Facility-Based Palliative Care (Long Term Care Facilities & Hospitals)

Comments and Concerns

• Palliative beds in complex care facilities will not result in quality care. Palliative patients should not be in acute wards.

• There are inequities in what is provided in the community, hospice/acute care, or palliative units versus residential care.

• Palliative care facilities cannot provide the means for families to live with patients during their stay.

• In residential care, patients do not receive palliative care from staff due to lack of resources and training as well as a lack of access to doctors or other specialists with palliative expertise.

• Palliative care is different in smaller communities. Ending life in a hospital bed is not acceptable.

• To add to services for residential care, the Ministry of Health developed a program called Added Care. This allows residential care managers to request extra staff for a patient who may be near the end-of-life and needs more assistance and companionship. However, other pressures on the system have conspired to the point that this program is now rarely used for patients at the end of their life. Often, Added Care is used for people with dementia who have marked behavioural challenges and are waiting for a place in a special care unit or for older adults who are awaiting transfer to geriatric psychiatry units. Added Care is being used for safety reasons while patients wait for an appropriate bed to become available rather than providing the additional end-of-life services as the program was designed to do.

• Leaving a patient in a palliative care ward is a way for some families to absolve themselves of responsibility for the care of their loved one.

• As a society, we have to accept that we will all die and in palliative situations test results need to be reviewed and accepted. Many times there is no need to do one more cat scan or emergency Magnetic Resonance Imaging (MRI) scan as the doctor already knows the outcome from conducting previous tests. In long-term care facilities these tests are often done just to satisfy families or the doctors and are not of any real value to the patient.
The Delta Hospital does not seem to have a Standards and Procedures Policy in place regarding Palliative Care.

**Ideas and Suggestions**

- Planning for palliative care resources and facilities needs to be based on demographics.
- More palliative and hospice care facilities are needed to meet existing and future demands. More palliative care centres or palliative units in acute care should be supported.
- Reopen palliative units to facilitate continuity of care.
- Hospitals have a role in the delivery of palliative care.
- We need palliative care homes so that palliative patients can be looked after in a less clinical environment. This will also open up much needed hospital beds.
- Areas of hospitals should be set aside for palliative care in a hospice-type setting, with rooms set aside for family members. In these areas providers should have the flexibility to do what they think is needed (candles, music, cultural requirements).
- Two palliative care beds at a hospital are better than none.
- Long-term care facilities should be providing end-of-life care.
- The government should make a commitment to offer palliative and end-of-life care to residents in all the residential care units in British Columbia.
- Turn closed acute facilities into palliative beds.

**Hospice Care**

**Comments and Concerns**

- **Funding of Hospices**
- **Referrals to Hospices**
- **Accessibility of Hospices**

- Comments on funding of hospices:
  - There is a lack of funding and services for hospice care.
  - Hospices spend more money on patients rather than on residential facilities.
Currently one of the most glaring differences between hospices and residential care is that all hospices have access to the palliative care benefits program and not all residential care facilities do. This means that if special medications or equipment are needed for someone who is dying, then that must be applied against the global budget of that facility. This makes it tempting for facility managers to send these patients to acute care when they get complex symptoms as their costs will disappear and the patient will be happy because in acute care they do not have to pay for daily care.

Hospice beds cost half as much as acute care beds.

Hospice is a perfect example of public and private partnership.

Comments on referrals to hospices:

In our current system we tend to refer those with cancer to hospice and those with non-cancer illnesses and particularly those with dementia, to residential care. This is primarily because of the predictability of the disease. Hospice wants people who have an estimated length of life of two to three months and residential care does not have an average length of stay. We all try to avoid sending someone to a new place just before his or her death, however, both with the unpredictability of death, and the pressures in our acute care system, this regrettably still happens.

Doctors and nurses are primarily focused on the preservation of life and are not utilising hospice appropriately.

Referral to hospice is not automatic once a patient is designated to palliative care. Each area sets their own rates for palliative care patients.

Too many people die in acute care in hospital because doctors do not refer to hospice.

If all the patients currently dying in residential care and their families were to understand that there are higher staffing levels and more services available in hospice, and were to prefer this option, we would have many more requests for transfer to hospice from residential care. It would then be clear that this option is not available for everyone.

Comments on accessibility of hospices:

Hospices are overwhelmed.

In reality there are two standards of end-of-life care in British Columbia: The younger patients without cognitive impairment and with cancer die in a hospice. The hospice has higher staffing levels and operates on a larger per diem rate so there are more services and people available to maintain quality of life. The older
patients with cognitive impairment and multiple non-cancer illnesses die in residential care, which has at least $100 per resident, per day less to provide what should be the same care.

- There is stigma associated with accepting care in a hospice instead of acute care.
- There are no hospice homes in rural areas.
- Our system has also evolved alternatives to acute care for those needing chronic ongoing care. We have increasing numbers of hospices, and home-like, small care facilities that provide end-of-life care for those who are estimated to live two to three months or less.
- Hospice is a flexible, coordinated environment. You have the option of moving patients into a hospice where there is care, but also to move them back home when they are feeling better and only need partial care. Hospice can function as sort of broker or buffer, allowing the individual to make their own choices.
- Prince George has an excellent hospice facility.

**Ideas and Suggestions**

**Funding of Hospices**
**Referrals to Hospices**
**Accessibility of Hospices**
**Guidelines for Running Hospices**
**Staffing Hospice**

- Ideas about funding of hospices:
  - Ensure adequate funding for all aspects of hospice care.
  - Free-standing hospice houses are a cost-effective and compassionate solution to the end-of-life care dilemma.
  - More money should be allocated to hospice societies. They are a tremendous help but must spend a good deal of time and effort fund raising in order to stay afloat. With palliative beds already available, why not give them the money needed to keep going.
  - Encourage bequests to hospices.
  - Free-standing hospices should be funded appropriately from public funds. Hospices should not have to be seen as a volunteer effort.
  - It is cheaper to have a dying person in a bed in a hospice house rather than in an acute care hospital bed. There is a volunteer base available to draw from so hospice is cheaper to run, and draws less funds from the hospital.
• Better partnerships are needed between health authorities and hospice societies and other non-profit organisations.

• Ideas about referrals to hospices:
  • We need to educate nurses and doctors with regard to hospice.
  • Create a policy to support the referral of all end-of-life patients to hospice and increase public awareness related to the services they can provide.
  • Home care nurses are good at referring patients to hospice services.

• Ideas about accessibility of hospices:
  • Establish hospice facilities and homes and expand existing programs.
  • Encourage and support hospice care in communities with proper facilities and Palliative Response Teams.
  • Every community should have a hospice house.
  • Encourage hospice societies in small communities where they do not currently exist.
  • Hospice services could be extended to provide some follow-up with the bereaved.
  • There is a need for co-ordinated hospice support systems in the Cranbrook area to service the valley.
  • Somehow, we need to be able to reach out or find a way to bring marginalized people in to hospice care so they are not left behind.
  • Free-standing Hospice Houses shorten waiting lists for acute hospital beds.

• Ideas about guidelines for running hospices:
  • Every hospice is run separately but we need more uniformity.
  • Clear guidelines must be created to ensure that hospice beds are used appropriately and not occupied by long-term, palliative care patients.
  • Targets could be set with regards to the number of hospice beds set up, possibly on a per capita basis and then a project plan carried out, including the roll out of public education related to hospice care and the overall standardization of care.

• Ideas about staffing of hospices:
  • Volunteers can be trained to provide hospice care.
  • Hospice houses have a different atmosphere and purpose than acute care hospitals or even long-term care facilities. Staff members in hospices are trained
not only to care for the dying person, but to provide support for their family and friends as well.

- There doesn’t have to be a sacrifice of quality of life at the end-of-life. If patients register for hospice or palliative care with a hospice society, they will have highly trained and compassionate physicians, nurses, counsellors, therapists and volunteers all working in the patient’s and family’s best interests. The focus in hospice is on dying with as much joy and as little physical and psychological pain as possible.
- Staffing ratios are different in hospice than in hospitals.

**Palliative Care at the Community Level and Caregiver Support**

**Comments and Concerns:**

**Community-Based Care and Home Care**

**Support for Caregivers**

- Comments on community-based care and home care:
  - There is a lack of weekend and after-hours care for community services, that is, palliative care; which would otherwise support those who want to stay at home for as long as possible.
  - There is a lack of home visits by doctors for palliative care patients.
  - There are not enough resources for palliative care in the home.
  - There is no night coverage for palliative care in communities.
  - Palliative Care provides a positive model for community care.
  - There is a new recognition of the value and need for palliative care services as defined by communities.
  - Palliative home care should be regarded and administered as a very effective alternative to acute or even round-the-clock hospice care.
  - There is a growing acceptance in the community of allowing people’s individual choice around when and how to end their life.

- Comments on support for caregivers:
  - The emotional and financial cost of a relative’s end-of-life care can be a heavy burden on families.
Everyone has the right to die with dignity in the care of sympathetic professionals. Family members cannot give the care needed, or anticipate each step along the way or the care needed in the final moments.

Look at veterans benefits (having someone stay overnight so the support person can get a good nights rest) as a model of good supportive services for caregivers.

Having the option of providing palliative end-of-life care to family members at home can be a positive experience for all involved.

### Ideas and Suggestions

#### Community-Based Care and Home Care

**Caregiver Support**

- Ideas about community-based care and home care:
  
  - Expanding home-based palliative care programs is an option and would free up some beds for people who cannot die peacefully at home.
  
  - Develop a community-based palliative care system.

- Ideas about caregiver support:
  
  - If a person is dying at home, give enough help to the spouse and family. There is a lot of strain and work involved. If a person is dying in hospital, move the patient to a quiet room so that family can attend.
  
  - Support those who want to have palliative care in their homes by:
    
    a. providing a home visit nurse;
    b. loaning medical equipment at low rental rates;
    c. providing a tax break for caregivers;
    d. providing 24 hour, on call access to physicians or nurses to relieve stress on family members;
    e. providing income support for families caring for in-home palliative care patients;
    f. providing access to 24 hour nursing support via phone and/or home visits for pain management; and,
    g. granting some form of compassionate leave for those involved in the palliative care or the supportive care of a family member, not unlike maternity leave.
• If we can ensure that those who are bereaved get the appropriate attention and have access to support we can prevent long-term problems.

• Patients and families need support and staff should have the flexibility to take the time to provide support when necessary.

• Have a palliative care worker follow up with the family after the patient dies.

• Caregivers should have training on end-of-life issues including what to expect.

• The _Palliative Care Book_ should be provided to caregivers before the patient leaves the hospital so that they have an understanding of what resources are available and what to expect. Fear is one of the biggest obstacles to feeling comfortable providing the care the patient needs.

• The Government of British Columbia should increase the availability of community-based respite options to ensure that valued caregivers and contributors to the health care system receive the support they need to continue to provide care to their loved ones and reduce the risk of being admitted for care themselves.

### Assessment and Consent for the Provision of Palliative Care Services

#### Comments and Concerns

**Assessment for Palliative Status**

**Consent Processes**

• Comments on assessment for palliative status:
  
  • Many service providers do not consider pain as a vital sign and they do not offer enough counselling for care preferences.
  
  • Patients receive differential treatment from some community organizations depending on whether they have palliative status.

  • People dying with a non-cancer illness tend to lose out on receiving palliative care services because of the difficulty of predicting when they are going to die. Many health care providers see palliative care as a service that is only to be used for the last weeks or last few months of life. Since they do not know when these people will die, and are reluctant to make predictions and be wrong, they hesitate to involve palliative care. The public's perception is also that palliative care is only for
the actively dying and therefore people tend to avoid accessing services in a timely manner.

- Comments on consent processes in palliative care:
  
  · The consent process for palliative care is different in different health authorities. Often families do not understand what services are available to them. Misunderstandings related to the level of intervention consent form can also act as a barrier to providing sufficient care.
  
  · The truth must be told. Palliative care and hospice is euthanasia pure and simple.
  
  · Constantly drugging someone when they are not in pain is a way of sweeping them under the rug and only lifting that rug when the patient has died.

**Ideas and Suggestions**

**Assessment for Palliative Status**

**Consent Processes and Advanced Care Planning**

- Ideas about assessment for palliative status:
  
  · General practitioners who have a patient in palliative care don’t necessarily know how the system works. Therefore, having someone with experience in navigating this system available to make the process less confusing for patients, their families and their physicians can be beneficial.

- Ideas about consent processes in palliative care:
  
  · Advanced care planning goes a long way in helping people understand the notion of the quality of life at end-of-life and makes it something they can prepare for.
  
  · Treatment options should be openly discussed with people who are dying and their families.
  
  · Keep palliative care, living wills and euthanasia as separate types of care.
  
  · Provide the appropriate resources to educate families so that they understand the implications of delaying the appropriate level of treatment and how this can result in the need for acute care.
  
  · Patients and their families need more awareness of the palliative care resources and services available to them.
• Terminally ill individuals who are no longer of sound mind should obtain only palliative care. Using life prolonging measures is inhumane when the patient is terminally ill, and their condition is painful and frightening.

• Develop a policy regarding the transition from long-term palliative care, to end-of-life palliative care.

Funding and Costs Related to Palliative Care

Comments and Concerns
• There is a lack of funding for palliative care

Ideas and Suggestions
• Remove the per diem charges for palliative care patients who go to a hospice house.
• Change the billing system to support more palliative care services for seniors.
• Audits of physician’s end-of-life care decisions for hospitalized care should be performed. Too much expensive and useless care is being provided to dying patients.
• Fund all prescription medications and care for palliative care patients who choose to stay at home in the same way that they would be funded in acute care.
• Sustainable funding is needed for free standing palliative care and hospice facilities.
• Proper palliative care can reduce some acute care costs.
• PharmaCare must give all patients access to the Palliative Care Benefits Program no matter what type of facility they are in. This would eliminate the need for facilities that do not have access to the program to use their global funding to provide adequate pain and symptom management for their patients. It may also reduce the transfer of patients from residential care to acute care.
• Revisit the Added Care program to separate the requests for added care due to behavioural challenges or short-term medical morbidity, and end-of-life care, providing separate and adequate funding for end-of-life care within facilities.
• Provide the same funding per Elder to all facilities. This disparity needs to be corrected if facilities are going to provide adequate end-of-life care. It is not possible to define who is 'palliative' in a facility and then add funding in the last few months because of disease unpredictability and because almost all of these people are in the last months of their life regardless.
• Health dollars and resources need to be allocated to provide a consistent standard of care for hospice, palliative, and end-of-life care.

• Providing affordable, high-quality home care and hospice, palliative end-of-life care to all British Columbians through the publicly-funded health care system can be cost effective and is the right thing to do.

• Costs for the last few months of life care and treatment should be publicized and respite care versus heroic treatment should be the norm. What are the costs and what percentage of these people survive? This should be publicized.

• The Ministry of Health should designate and fund hospice, palliative, end-of-life care as a core service within British Columbia and recommend that the Government of British Columbia contribute to and support national standards for home care and hospice, palliative, end-of-life care delivery programs.
Assisted Suicide

During the Conversation on Health, assisted suicide was a frequent topic of discussion related to end-of-life care. So too, was the importance of addressing issues related to the costs associated with end-of-life care and assisted suicide. Right to die legislation, the importance of choice and control at end-of-life and the role of health professionals in assisted suicide, were also highlighted in many of the discussions and submissions. Here is a selection of what British Columbians had to say on the subject of assisted suicide.

Costs of End-of-Life Care and Assisted Suicide

Many participants are in favour of instituting a process to allow euthanasia or assisted suicide, suggesting this would allow people to die with dignity while also lowering health care costs related to end-of-life care. However, some voice concern that the option of euthanasia introduced the possibility that patients would be pressured into ending their lives. This pressure could result from the inconvenience of continued care to relatives or caregivers, or the cost of maintaining the patient's comfort.

Right to Die Legislation

Participants widely agree that political will to approach the idea of euthanasia must exist. Though some oppose the idea of allowing assisted suicide outright, many suggest initiating some type of public discussion, or province-wide survey on the issue. One specific comment recommends a Royal Commission on right to die legislation. Many believe that the liability issues for institutions and professionals needs to be clarified, with many suggesting that legalizing assisted suicide would require the enforcement of strict guidelines. Participants frequently cite examples from Oregon, the Netherlands and Belgium as supporting a patients’ ability to die with dignity.

*The Netherlands implemented a checkout system. It operates primarily for that country, but significantly (and unexpectedly) there is now a steady trickle of patients with one-way tickets traveling from other European countries to use the system, probably for a fee… No one will ever be forced to use the system, but it should be there for those who choose to use it.*

- Email, Surrey
Choice at the End-of-Life

Many who participated in the Conversation on Health argue for giving patients the choice of when to die. Most participants believe we should support quality of life over quantity, allowing people to die with dignity while ensuring that they are as comfortable as possible. They suggest some tools to support the choice of when to die including: living wills, laws to enable euthanasia, and/or legislation related to advanced directives. Others see patient advocates as a means of aiding patients in choosing the right instrument to communicate their wishes, and advocating for that choice on their behalf.

Support for the right to choose, however, is not unconditional. Some participants suggest the government must have a role in developing clear direction concerning who makes end-of-life decisions about and what criteria are applied to those decisions. Others emphasize the importance of including family members in end-of-life planning and decisions.

_Euthanasia should only be allowed under some circumstances and should be carefully monitored_

- Public Forum, Kamloops

The Role of Health Professionals

Many British Columbians believe physicians are caught in the middle of the larger argument concerning death and dying. One suggestion indicates that the modern physicians’ oath says a doctor should not over-treat a patient and, therefore, a patient should be allowed to die when there is no hope for a better life. Another recommends that a panel of doctors be consulted in setting the criteria and conditions under which euthanasia would be permitted.

Some participants voice concerns about the costs and quality of life for the severely disabled. They suggest that doctors should have the ability to determine if they should use heroic measures to prolong the lives of extremely premature, mentally and physically challenged children who cannot survive without medical assistance.

_Why is it logical to instruct the doctor not to resuscitate and not logical to ask them to pull the plug?_

- Public Forum, Kelowna
Conclusion

While some are against the idea of assisted suicide in any form, many believe that if someone is terminal or completely incapacitated, doctor-assisted suicide should be an option. Regardless of participants’ opinions on the subject, there is widespread agreement on the need for more discussion on this topic and many submissions suggest the Government carry out further consultations related to legislation on end-of-life and assisted suicide.
Assisted Suicide

This sub-theme includes the following topics:

Right to Die Legislation  
Euthanasia and Costs  
Euthanasia and Choice  
Euthanasia and Health Human Resources

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Death and Dying; Health Spending; Palliative Care and Seniors.

Right to Die Legislation

Comments and Concerns

- Debates concerning euthanasia create a moral dilemma.
- According to the modern physician’s oath, a doctor is not supposed to over-treat a patient. When there is no hope for a better life, a patient should be allowed to die.
- Why is it logical to instruct the doctor not to resuscitate and not logical to ask them to pull the plug?

Ideas and Suggestions

- We need right-to-die legislation.
- There has to be political will to approach the idea of euthanasia.
- Bring in legislation similar to that found in Oregon: provide the option of assisted suicide for people who are terminally ill with no hope of recovery.
- Legalize assisted suicide.
- Clear up the liability issues for institutions, and professionals related to euthanasia.
- Hopefully doctors can be easily encouraged to terminate life if they cannot be held criminally accountable.
• The provincial government should promise not to pursue charges, or arrest medical professionals involved in euthanasia given certain provisions.

• Euthanasia should be decriminalized.

• If someone is terminal or completely incapacitated, doctor assisted suicide should be an option.

• Allow legalized, carefully structured and monitored euthanasia when desired.

• Euthanasia should only be allowed under certain, carefully monitored circumstances with family members and a patient advocate involved in the decision making.

• Hold a Royal Commission on right-to-die legislation.

• Start a public discussion about euthanasia (follow the example set in Europe).

• Have a province-wide survey to find out who supports the idea of legalized euthanasia so politicians will have the impetus to act.

• A panel of doctors should be consulted to set the criteria for the conditions under which euthanasia is permitted. The panel could be made up of the family doctor, two independent physicians and psychiatrists as well as a family member of the patient in question.

**Euthanasia and Costs**

**Comments and Concerns**

• Interventions for neo-natal, low birth weight babies can lead to many complications, acting as a long-term drain on resources.

• Euthanasia is actually a gender-based issue. Women comprise the greater percentage of elderly, which needs to be taken into account whenever decisions are made related to euthanasia.

• The issue of euthanasia introduces the possibility of pressuring patients into ending their lives because of inconvenience to relatives or caregivers, or because it is thought the person's life is not worth the dollars to continue comfort care.

• By not allowing euthanasia for the elderly or terminally ill, we are limiting the health care dollars available to younger people who might otherwise be more productive members of society.

• The Government should study the Dutch model which allows people to choose to die by lethal injection.
The Netherlands implemented a checkout system. It operates primarily for that country, but significantly (and unexpectedly) there is now a steady trickle of patients with one-way tickets traveling from other European countries to use the system, probably for a fee. Other European countries are now considering implementing this and one has already done so. No one will ever be forced to use the system, but it would be there for those who choose to use it.

**Ideas and Suggestions**

- Instituting a process to allow euthanasia so people can die with dignity will lower the costs related to end-of-life for the health care system.
- There should be no heroic measures taken, like mechanically assisted feeding or breathing, when a patient is past a certain age or is suffering from a terminal disease.
- Euthanasia and living wills should be legal choices and would alleviate some of the burden of end-of-life health care costs.
- Our long-term care facilities are full of people in the end stages of their lives who have no quality of life left, and are often suffering a lot of pain. Legalizing euthanasia would not only provide people with choice but could alleviate some of the burden on long-term care services and might also address the bed shortage issue.
- Legalizing euthanasia provides a mechanism to address the rising burden on the health care system caused by the elderly.
- The medical profession should have the ability to ensure that heroic measures are not taken to prolong the lives of extremely premature, mentally and physically challenged children who have no quality of life and cannot survive without medical assistance.
- There is a need to prioritize what we are prepared to spend our health care dollars on and we should think twice before supporting decisions concerning extensive and expensive operations on newborns.
- How would this choice (euthanasia) affect payout of insurance policies (would life insurance not pay?, would fraud increase in terms of cause-of-death in order to obtain insurance benefits?)
- How would death certificates be filled out (disease? suicide? euthanasia?) and how would statistics be kept?
- Would tax dollars be collected and spent specifically for euthanasia?
Euthanasia and Choice

Ideas and Suggestions

- Give people the choice of when to end their lives.
- Everyone has a right to die.
- We have no right to determine when a person should die.
- Families and patients need to have input with regards to assisted suicide.
- Euthanasia can provide the family and patient with comfort.
- People have a right to have the option of freedom from pain.
- Allow people to make informed decisions and support them in that decision, including euthanasia.
- Respect wishes for active euthanasia, or at least consider the withdrawal of nutrition and hydration when a patient wishes to die.
- Support peoples’ efforts to die with dignity.
- Terminally ill people who are mentally competent should be able to die on request and be assisted to do so by a physician and a support team.
- Consider quality of life. Life without quality is not always the best option. Quality of life rather than extending life should be paramount.
- After age 65 or 70 you should have the right to request euthanasia. Seniors who suffer a deteriorating quality of life speak about wishing there was an acceptable way "out" without having to wait for some catastrophic event, and without becoming a burden on those they love.
- Euthanasia should be an option for seniors who state their choice in their Advanced Directive, providing insurance policies and pension payments to spouse/families are not jeopardized.

Comments and Concerns

- As a society we are much kinder to animals than to humans. When pets become too old, are constantly suffering or have an incurable disease, we have no qualms about performing euthanasia, yet we hesitate to provide this option for humans.
- Euthanasia may be OK for animals, but not for humans. We have the skills, compassion and medications available to assist a person to die in peace and love.
• The opinion expressed by a Christian in this Conversation on Health, suggesting that euthanasia is the same as suicide is just not sensible.

• The fact that quite a number of people seem to support suicide, assisted suicide and possibly euthanasia, is distressing.

• Doctors, nurses or administration in hospitals may bully patients into making the decision to die if they are disabled or if a patient is comatose, to free up beds.

• Getting rid of old people because they are no longer useful is a sure sign of moral and ethical decline. Making it look like it’s politically correct by using terms such as "Right-to-Die" is unacceptable.

• IF Do Not Resuscitate (DNR) orders, and organ donation decisions can be made in advance, why not euthanasia?

Health Human Resources and Euthanasia

Comments and Concerns

• The stress placed on staff exposed to euthanasia in the workplace can have negative impacts which are rarely discussed.

• Caregivers and medical staff should have the right not to have their own beliefs violated, with regards to performing or assisting with euthanasia.

• If euthanasia became common practice, hiring decisions could be made based on the willingness of a person to participate in euthanasia.

Ideas and Suggestions

• More training should be provided for health care providers and facility staff regarding the human aspect of care and end-of-life care including euthanasia.
Mental Health

Mental Health was among the issues raised by many participants during the Conversation on Health. Access to and the delivery of mental health services, and public perceptions education and awareness were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of Mental Health.

Access to Mental Health Services

Many of those involved in the Conversation on Health think that mental health services should be more available throughout the province. The North, the Kootenay/Boundary region, the Sunshine Coast, the Fraser Valley and Victoria are mentioned as specific areas in need of increased services.

Several contributors also think that British Columbia needs additional services to assist more populations with differing mental disorders. They believe children, women, Aboriginal peoples and the elderly require more access to advocates, mental health workers and psychiatrists. Specific treatment services for Bipolar Disorder, Depression, Anxiety, Post-Traumatic Stress Disorder, Schizophrenia and Autism are also recommended.

Participants also suggest that increased access to supportive housing and job training programs would help people with mental health issues to live in and be productive members of the community.

*We need mental health homes for the chronically ill to make sure that they take their medications, are fed a proper diet and have a clean, warm place to live and sleep.*

–Regional Forum Written Submission, Cranbrook
Delivery of Mental Health Services

Several participants indicate that the delivery of services is not supportive of mental health patients. Some submissions indicate that mental health staff and police are inadequately trained to assist people with mental health concerns, while others note that the rules for accessing treatment are too complicated. Others suggest that these services do not travel to find those in need of treatment where they live. Overall, most of the submissions indicate that delivery of mental health services could be more flexible and better designed to fit the needs of the individual.

Several ideas for the improvement of mental health service delivery came out of the Conversation on Health. Some participants note that staff need more training and more time spent with mental health patients. Others think early diagnosis is the key to treatment and suggest that health professionals work in schools. Many other submissions raise the idea of co-locating medical resources and community services to ensure that mental health patients have easy access to all the necessary treatments.

*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.*

– Health Employees’ Union, Submission

Public Perception, Education and Awareness

There is general consensus that a stigma exists around mental health and that mental health services are poorly publicized. Most participants agree that the public does not have enough information to effectively treat disorders such as Schizophrenia and Bipolar Disorder. Many submissions focus on increasing mental health resources and awareness. Suggestions include creating a 1-800 phone number and a guide to educate the public about existing services as well as increasing education programs in the schools.

*Integrate mental health patients into education programs in schools, the workplace and out in the community in order to provide important information to the public and help to avoid an isolative state these patients may encounter.*

– Mail, Vancouver
Several contributors focus on promoting mental health issues for First Nations people, and on increasing supports for people who deal with domestic abuse and suicide. These submissions indicate that traditional healers and elders can be of great assistance in addressing mental health issues in Aboriginal communities. They also note that people with concerns about domestic abuse and suicide need specific support centres and a better awareness of the available crisis help phone numbers.

Conclusion

From the perspective of the participants in the Conversation on Health, there should be more mental health services and supports available across the province, and more comprehensive care for patients. Some submissions indicate that job training and housing would help people with mental health issues to remain productive members of society. Others add that support programs should be more flexible and mental health staff should be more willing to seek out patients in the community to provide treatment. Overall, participants agree that supports should be better promoted, multi-disciplinary, and more adaptable to ensure the best possible outcomes for mental health patients.
Mental Health

This chapter includes the following topics:

- Access to Mental Health Programs
- Service Delivery
- Delivery Models
- Workplace and Employment
- Housing and Mental Health
- Domestic Abuse
- Suicide
- Prescription Drug Use
- Youth and Mental Health
- First Nations and Mental Health
- Awareness of Mental Health Issues

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

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

| Improving Health Care for Victims of Abuse in British Columbia |
| Submitted by Yuen-Kwun Lam |

| Submission to the Conversation on Health |
| Submitted by the Representative for Children and Youth |

| Submission to the Conversation on Health |
| Submitted by BC Cancer Agency |

| Submission to the Conversation on Health |
| Submitted by the British Columbia Government and Service Employees’ Union |

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Wait Lists/Wait times; Access; Access to Hospitals in Rural Areas; First Nations; Collaboration in the System; Addictions; Health Promotion and Mental Health Facilities and Deinstitutionalization.
Access to Mental Health Programs

Comments and Concerns

• A lack of mental health services was mentioned in the following areas:
  • Specific regions: Smithers and the North, overall; the Kootenay/Boundary region; the Sunshine Coast; Fraser Health Authority; and Victoria;
  • Specific services: mental health advocates; mental health workers; psychotherapists; and psychiatrists;
  • Specific populations: children; the elderly; families; violent mental health patients; First Nations; and women; and,
  • Specific disorders: Attention Deficit Hyperactivity Disorder; Bipolar Disorder; Post-Traumatic Stress Disorder; Depression; Anxiety; Schizophrenia; and Autism.

• The Mental Health and Addictions Branch has no psychiatrist in an advisory or leadership role. Indeed, there is no psychiatrist in-house consultant with any formal, consistent and permanent role attached to the Branch.

• The length of sessions allowed for people in counselling are insufficient.

• There are too many people dealing with each mental health case.

• Mental health programs are too unstructured.

• Mental health services are too expensive.

• Closing beds in psychiatric units at Christmas time is unacceptable. Denying patients access to help only adds to the stress of the police and front-line mental health workers.

• Some British Columbians mentioned receiving good care from mental health services, including: the 24 hour Nanaimo mental health program; non-profit organizations; psychologists; the Cowichan suicide prevention project; and, the Prince George Schizophrenia Society.

• Usually, I am more aware than my doctors are about what I require for adequate care.

Ideas and Suggestions

• British Columbians mentioned a need for more of the following services: mental health advocates; psychologists; counsellors; life skills workers; a 24 hour crisis line;
treatment centres for eating disorders and youth suicide; drop-in social centres; a facility for homeless people with psychological issues living in East Vancouver; and assisted living facilities.

- Psychiatric illnesses reduce the sufferer’s capacity to advocate on themselves and their needs remain out of sight.
- Provide more timely access to mental health to services.
- Use funding for front line workers to assist mentally ill clients.
- The government should convert existing public mental health centres to Health, Wellness and Fitness Centres. These centres could be located in all communities in the province and could include:
  - community nurses;
  - nutritionists;
  - occupational and physiotherapists;
  - health educators, personal trainers;
  - psychiatrists;
  - psychologists;
  - social workers; and early childhood education workers.
- People with psychiatric illnesses should experience care at the same level, with the same degree of sophistication as any other person with an illness of equivalent disability.
- Combine Royal Canadian Mounted Police and mental health workers.
- Mental Health continues to demand that patients come in to the offices; services should be available at the patient’s door.
- Do not close the facility in Shaughnessy, a home for the mentally ill.
- Make programs available to individuals who are willing to travel to other jurisdictions.
- Parents and educators should recognize the characteristics of autism and have children diagnosed early.
- Stronger social services/mental health teams are needed for the Islands.
- The health care system should not support people with mental illness.
- Review how non-profit organizations supply assistance to mental health patients.
- Develop a position for a community director of mental health services.
Outstanding Questions

- What information does the government require to provide services to people with mental health issues?
- What is the government doing about housing and care support for the mentally ill?

Service Delivery

Comments and Concerns

- Mental health programs are disorganized.
- The British Columbia Mental Health and Addiction Services, an agency of the Provincial Health Services Authority, has a 2004 Strategic Plan that was updated in 2005, but not since.
- Staff are not appropriately trained.
- Mental health workers are not supportive when asked for help.
- Mental health services use too many complicated rules.
- The process of obtaining help is too time-consuming and intimidating for mental health patients.
- Treatment options are not made clear to patients.
- We discharge the mentally ill from the hospital too early.
- The outpatient mental health system does not aggressively seek out and engage patients who need services, but are unable to come to a clinic.
- The assessment of mental illness is poor.
- The police are not adequately trained to deal with people suffering from mental health problems or addiction.
- Locating and accessing supports is very difficult.
- Dementia patients do not qualify for assisted living.
- I have reached out to the psychiatric profession for help. I could use a two to three hour session to discuss all that is going on, but my doctor is only allowed to bill for one hour.
- Restraints and seclusion are used for psychiatric patients in the emergency room, which is against all current standards.
- Psychiatry is expensive and awful.
• Mental health workers are great, once you get through system.
• I have had pretty positive responses from people in Kamloops, Kelowna, Prince George and Victoria about the expanding mental health services.

Ideas and Suggestions

• Financial assistance given to mental health patients needs to be monitored to ensure that it is used for its intended purpose.
• There should be after-care programs with community and family support.
• Service providers should spend more time with patients.
• Address the underlying issues affecting mental health; do not just prescribe drugs.
• Provide more training to non-health professionals.
• Diagnose mental illness early to prevent people from going to jail or using the hospitals; provide diagnostic services at schools.
• There should be one front-line worker who stays with a client from the time of the initial assessment to treatment.
• A telephone contact should be available to answer questions; waiting for the next appointment does not always work.
• Alternative therapies should be made available to mental health patients.
• If the provincial government covered the cost of psychotherapy, the burden of disability from depression and mental disorders, and medication costs may be greatly reduced.
• Once suitable treatment is determined, the quality of care is generally good. There is some choice regarding available treatment.
• There should be a special room in the hospital to house mentally unstable patients.
• Some funding intended for mental health may be going to fund other health services.

Delivery Models

Comments and Concerns

• There is too much bureaucracy and management in the delivery of mental health services.
• There is a lack of connection between mental health and other health services.

• The regionalization of mental health services resulted in a shortage of funding for some areas and a lack of local control.

• There cannot be a general way of providing services for mental health consumers; the needs of small communities are not the same as those of large centres.

• The government spends too much money on programs that cater only to people with mental health conditions.

• People not taking their medication can lead to the use of illicit drugs, which in turn impacts the justice system.

• Disability funding is available, but is less than required to maintain a reasonable standard of living.

• Mental health services and addiction treatment are under-funded. None of the funding is dedicated expressly to mental illness and addiction.

• Funding needs to be consistent; there should be core funding, rather than project-based funding, for mental health services.

• Communities resist the construction of care facilities for mentally ill, in part because they do not trust that the government will be able to maintain a quality environment.

• Many people are opposed to mental health facilities being placed in their neighbourhoods.

• Do not sell old hospitals and their land but, rather, redevelop them to be used for mental health and keep people off Vancouver’s Downtown Eastside.

• The responsibility for mental health services has been downloaded on to families and local governments.

• Low incomes preclude many of the patients in the mental health system from seeking legal assistance.

• We do not properly define "harm to self or others" in Section 28 of Mental Health Act. Drug addicts and homeless people are clearly causing self-harm. We do not reach out to people who have no faith in the system.

• Increased mental health funding is not perceived as a priority.

• Admitting mental health patients to hospital rather than proactively treating their illness is expensive and inefficient.
Ideas and Suggestions

- A comprehensive provincial mental health and addictions strategy is urgently needed. It may include street-level counselling services, group homes, structured community care, and institutional care for those having higher safety and care needs.

- Mental health services should be under one ministry.

- A Provincial Mental Health Commission should be established and funded with a membership of not more than 10. Membership should include representatives of the Mental Health and Addictions Branch of the Ministry of Health; the Health Authorities; the University Department of Psychiatry; the British Columbia Psychiatric Association; and other independent advocacy and patient representative organizations.

- Programs need to acknowledge cultural differences.

- Mental health users should be included in policy development considerations and program development.

- Work with First Nations group to develop effective services.

- The provincial government should fund municipalities to deal with mental health issues.

- The recent announcement by the provincial government that a consultant will be hired to develop a 10-year mental health plan is positive. So was the federal announcement on the creation of the Canadian Mental Health Commission, headed up by Michael Kirby, and tasked with developing a national strategy.

- Use the recommendations on mental health reform from the Kirby Commission.

- Alert the public to large cost of mental illness.

- Recognize the rights of mentally ill and their families; revive Bill 22.

- Reform the law to allow a care team to enforce safety for both the patient and the public proactively. Currently, teams cannot act until patients threaten others or harm themselves.

- Enforce Section 28 of Mental Health Act.

- There should be one-stop shopping for mental health outreach and services.

- The available evidence suggests that a properly organised system of care, providing for the clinical needs of the patients at the appropriate location, and in a timely manner, will produce a better clinical result, at no greater cost to the system, than the current system of disorganised, haphazard and ad-hoc care.
• Children and adult mental health services should be under one umbrella.

• Correct the historic imbalance in funding between physical and mental health care.

• The Auditor-General of British Columbia should undertake a comprehensive review of the total amounts received and spent by the provincial treasury for the care of persons with serious mental health and addiction problems.

• There needs to be a straightforward and understandable system of tracking the monies spent on services for the prevention, treatment and rehabilitation of patients from psychiatric illnesses.

• Local voices need to be heard.

**Outstanding Questions**

- Will the Mental Health Act be reviewed to enshrine patient rights and to provide clear legislation for safe, effective and dignified treatment?

**Workplace and Employment**

**Comments and Concerns**

- It is difficult for people with mental health issues to find employment, and available job skills training is inadequate.

- It has been shown in England that improved worker productivity can be achieved through better access to mental health services to facilitate the treatment of ailments such as depression and anxiety.

- The result of an exhausted health care workforce, without deeper support to facilitate wellness, results in a biased view of mental illness.

- People with mental health issues who work are a lot less likely to visit the hospital during any given year, which results in huge savings to the health care system.

**Ideas and Suggestions**

- Adults with mental illness should have work programs.

- Community support is needed to help people be productive. With supports, they may be able to rejoin the work force.
• Create easier access and financial support for employed addicts who bring their problems to work.
• Training, including job and life skills, should be offered for those who are mentally ill or have disabilities.
• Mental health care and addiction should be a priority in the workplace.
• There should be incentives for employers to keep people with mental illness at work.
• Provide more employee assistance programs to support people with stress-related mental illness.

Housing and Mental Health

Comments and Concerns
• Many homeless people also have mental health concerns.
• There is a shortfall in housing, residential care and subsidised rental housing for people with mental illness.
• Homeless people with mental difficulties are being turned back to the streets.
• Cutbacks in recent years have resulted in youth with mental illnesses being rendered homeless.
• Mental health disorders account for 52 per cent of hospital stays among the homeless, compared to five per cent among the general population.

Ideas and Suggestions
• Provide more supported housing for people with mental illness.
• Those with mental illness need support, medication, and living accommodation with others present to prevent loneliness. This gives them stability and could lead to them enter the workforce.
• Provide better housing options for mentally ill prison inmates once they are released.
• Providing adequately funded services, such as assisted living to clients with mental health issues, will reduce the drain on other health care services.
Outstanding Questions

- What per cent of homeless people have a mental illness?

Domestic Abuse

Comments and Concerns

- Exposure to family violence may increase a person’s risk of acquiring chronic physical illnesses.
- Many abused women experience post-traumatic stress syndrome.
- Lack of reporting violence masks occurrences of abuse.
- Reliable victim services are not there when needed. They are too difficult to access.
- Failure to diagnose domestic violence may result in inappropriate treatment, including prescription of sedatives or antidepressants, which may increase the risk of suicide.
- Abuse is an important health care issue because of the vulnerable proportion of the population that is affected, the adverse health effects of abuse, and the high cost to the health care system associated with treating the abused.
- People who experience abuse have a negative perception of health care providers’ response to abuse victims.

Ideas and Suggestions

- We need zero tolerance campaigns towards violence and child abuse.
- There need to be areas where people who suffer mental illness as a result of abuse can go to access support.
- Ensure that domestic violence awareness campaigns, education programs and information are accessible to all persons. Information should be available in multiple languages and awareness campaigns/education programs must be culturally sensitive.
- All health care workers should have access to domestic violence education and training programs.
- Provide a toll free, 24-hour number for victims of abuse.
• Implement electronic health records to track patients with specific injury or behaviour patterns that indicate abuse; have a health professional follow up with these patients.

• Expand the Domestic Violence Program offered by Vancouver Coastal Health to all health authorities.

• Apply the suggestions that are outlined in the document, 'Violence Against Women: Improving the Health Care Response.'

• Place posters about domestic violence in emergency rooms, physician offices, walk-in clinics and midwifery clinics and provide information cards/pamphlets advertising services.

• There should be marriage counselling available in order to manage inter-marital home stress.

**Suicide**

**Comments and Concerns**

• Everywhere we look, whether province-wide or by region, the years of life prematurely lost from heart disease and from suicide are approximately the same.

• We do not detect risk of suicide until it is too late.

• There is concern with the high rate of suicide among people diagnosed with schizophrenia.

• Young males are affected by suicide.

• Abused women are more likely to attempt suicide.

• Suicide is not being effectively dealt with in First Nations communities.

• Suicide is not a priority for doctors.

• Long wait-lists for mental health care result in increased suicide attempts, completed suicides, and the associated costs to the health care system.

**Ideas and Suggestions**

• Develop suicide prevention teams.

• Provide a 24-hour place to go for people who are suicidal.
• I feel it is very important to turn all non-emergency or emotional related calls to crisis centres. Crisis hotline volunteers are very well trained to assist people who feel suicidal.

• There should be more comprehensive assessment of individuals who are admitted to hospital related to suicide.

Prescription Drug Use

Comments and Concerns

• Pharmaceuticals are often over-prescribed for mental illness.

• How are over-prescribing doctors monitored? How do we prevent addictions, which are running rampant in First Nations community?

• Drugs like Ritalin are overused for children suffering from hyperactivity.

• Using anti-depressants long-term, rather than dealing with problems is not a solution.

• Non-compliance with medical treatment is high, especially among people with serious and persistent mental illness, since the time required to observe response to medication can be lengthy.

• There is a dependence on drug therapy rather than psychotherapy.

Ideas and Suggestions

• Implement a very low cap on the number of pills that may be prescribed to those who attempt suicide or have accidental overdoses.

• Prescribe non-pharmacologic interventions for residents with dementia.

• Help people by prescribing lifestyle changes, not just medications.

• Legislation is needed to enforce taking medication for mental health patients who display violence when off their medications.

• Review non-generic drug prescriptions through a panel of peers to ensure that physicians are accountable.
Youth and Mental Health

Comments and Concerns

- How does everyone work together to prevent kids from falling through the cracks?

- Mental health problems among children and youth are predicted to increase substantially over the next 15 years, and are important precursors of adult mental health disorders.

- Children of mothers with limited parenting skills, especially teen mothers, are at greater risk for mental health problems.

- Children in continuing care were prescribed Ritalin-type, antidepressants, tranquilizers and anti-psychotic medications at a much higher rate than children who had never been in care.

- For children in continuing care, mental health disorders were the second most common reason for hospital admission, at a rate almost 15 to 19 times greater than for children who had never been in care.

- Children in care have a higher prevalence of depression, anxiety and hyperkinetic syndrome.

- Infants with insecure attachment to their parents have been shown to be at risk for later adaptation problems such as conduct disorder, aggression, depression and anti-social behaviour.

- Youth have feelings of hopelessness and are peer pressured at school.

- Treatment programs for children end at age 19; they fall through the cracks and are not eligible for any services. The adult system does not provide the same level of support.

- Services that are available in the adult system such as mental health and addiction services are not easily accessible to young people living in destabilized situations who do not have the skill or experience to deal with adult bureaucracies.

- There are no ongoing support services with psychiatrist.

- School counsellors and social workers are stretched since they need to provide services to too many children.

- Staff who work with kids lack specialised training.

- There are no public programs available outside the school system, or at least they are not publicly advertised.
Ideas and Suggestions

- Support pregnancy outreach programs. This will encourage bonding between mother and baby to promote secure parent-infant attachment and help at-risk pregnant and postpartum teens and women to increase their parenting and coping skills. Outreach services could include nutrition and lifestyle counselling, food assistance, prenatal vitamins, peer group support and referrals to community services.
- Take immediate steps to collaborate with academics to conduct research into whether or not children in care are being appropriately medicated with cerebral stimulants.
- Consult with the College of Physicians and Surgeons, and other appropriate professional organizations, about steps that could be taken to determine whether the prescribing practices of physicians treating children in care are appropriate.
- Educate children and youth in care, foster parents and guardianship social workers about anxiety and depression, and the identification and management of them.
- Young people need supportive adults to help them navigate the system. Young people who have been in care often do not have adults who will play this role for them once they reach 19 and the government's guardianship responsibility ends.
- Provide support money, time and energy to keep children participating in activities outside of school.
- Use money spent on individual for family support.
- Spend more money on early childhood development. The first three years of a child’s life are critical.
- Parents need to be sent to a counsellor after filing for divorce in order to protect the welfare of their children.
- Use theatre or music therapy in youth mental health services.
- Obesity is preventable. Parents must be held accountable if it is not due to a mental problem.
- Provide more support for foster parents.
- Provide more family support services and counselling in more languages to assist new families moving to Canada to deal with the stress and depression associated with settlement and integration.
First Nations and Mental Health

Comments and Concerns

- Targeted funding for aboriginal people can cause inequities among available mental health services.
- There should be more focus on children coming into care in First Nations communities.
- Address the inequality between on-reserve and off-reserve case loads.
- Distance and lack of transport have an affect on Aboriginal people’s ability to access services.
- Call for help often is not heard or taken seriously, resulting in suicide.
- First Nations communities require training to recognize the benchmarks of people who need help with mental health issues.
- I am on disability, but am afraid to ask for or do anything because my disability is a mental health issue and I do not want to end up in a psychiatric ward for the rest of my life.

Ideas and Suggestions

- Recognize traditional approaches to medicine and healing.
- Mental health assessments could be done or assisted by traditional healers.
- Youth within the First Nations community should use theatre and music to address mental health concerns.
- Form support groups for teens who suffer trauma, bullying and stereotyping.
- There should be more workshops, cultural or drop in centres and easier functional, low pressure places available to talk 24 hours a day, seven days a week.
- There is a need for a First Nations Elder Advisor for suicide prevention.
- Provide family and community support for those who have suffered loss or suicide.
- Start having social and/or craft nights for all ages to instill feelings of belonging.
- There should be male specific outreach programs for men who experience mental and physical trauma in their lives.
- Increase awareness of resources available to First Nations communities.
- Provide education on recognizing benchmarks of severity for mental illness.
• We need more programs for traumas in First Nations communities, like residential school syndrome.
• We need mental health treatment from people who understand and have experience in the context and culture of First Nations communities.

**Awareness of Mental Health**

**Comments and Concerns**

• Mental illness is not often treated with the same degree of seriousness as physical illness. Achieving equity would mark an important step in combating the stigma and the discrimination against people living with mental illness.
• Services are not well publicized. There is a lack of information about specific illnesses such as Schizophrenia and Bipolar Disorder.
• The stigma of linking mental health and addictions is a barrier to people who are seeking services.
• Despite recent improvement in awareness, the public needs more information to combat the mental illness stereotypes that exist.
• The lack of understanding of mental illness leads to fear and discrimination.
• The stigma of mental health is slowly disappearing.
• Canada is finally looking at mental illness as a significant and substantial health care problem.
Ideas and Suggestions

- Remove the stigma of mental health by developing awareness among the public and health care professionals.
- Establish resource guides for mental health programs and resources in every health authority.
- Create a 1-800 number to let people know about existing services.
- The school system should have education programs on mental health and addiction.
- Focus education on at-risk youth.
- Integrate mental health patients into an education program in schools that will provide important information to the public and help these patients avoid isolation.
- Communicate the results of research on mental disorders.
Mental Health Facilities and De-Institutionalization

Mental health facilities and de-institutionalization were among the issues raised by many participants during the Conversation on Health. Patient care, accessibility of facilities, and out-patient services and community supports were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of mental health facilities and de-institutionalization.

Patient Care

Many British Columbians feel that the closure of mental health facilities resulted in increased pressure on hospitals and municipalities to deliver services to individuals suffering from mental illness. Participants comment that, without support from a facility, mental health patients are more susceptible to homelessness and drug abuse, and that they are more likely to visit the emergency room because they had nowhere else to receive treatment.

The closure of mental health institutions has directly resulted in pressure on emergency rooms as many of these people now on the street and have no supports, many of the people on the streets have mental health issues and should be in long term care facilities.

– Letter, Kelowna

Some believe that a shortage of resources contributes to a reduction in the quality of patient care in facilities. Decreased activity programming and staffing levels were also identified as reasons that patients did not receive timely and necessary treatment. Participants suggest that more staff and better training would ensure that patients receive a higher quality of care in mental health facilities.

Access to Mental Health Facilities

Participants believe that mental health facilities should be geographically spread out over the province to allow rural residents to have greater access to mental health support. The Sunshine Coast, the Upper Fraser Valley, Hazelton, and Kelowna are mentioned as areas in particular need of mental health supports. Many submissions also indicate that Riverview should be re-opened.
Participants suggest that an increase in facilities and services would reduce hospitalizations by providing a place for people who live without support. Many also believe that increasing facilities throughout British Columbia would decrease pressure on the court and policing systems.

Out-Patient Services and Community Supports

Many of those involved in the Conversation suggest that there is a gap in service between a patient being treated in a facility and someone who is living in the community. Numerous participants say that people with mental health concerns are discharged too early from facilities and do not have an appropriate follow-up treatment plan in place.

_Some patients in mental health are discharged before they’re ready to go and end up back in our hospitals for another stay, which ends up costing the taxpayer more. This is due to pressure placed on psychiatrists and nurses to discharge them to make room for new admissions from emergency departments._

– Web Dialogue, Vancouver

Comments received indicate that facilities should make more comprehensive care available. A post-discharge plan for patients to continue with treatment and follow-up outreach services for people who need support to stay in the community are both recommendations related to making mental health services more effective. Developing a system of graduated care for mental health similar to what is available to seniors is also suggested.

Increasing community supports are identified as a way to assist people once they had been discharged from a facility. Many people indicate the need for services like supportive housing, public drop-in centres, peer mentoring, and community care facilities, which would include communal kitchens, medication monitoring from nursing staff, and personal counselling services.

_Let’s reduce stigma, increase investment in housing, recovery supports in our communities and adopt an integrated approach._

- Regional Forum, Campbell River
Conclusion

Participants in the Conversation believe that there should be more mental health facilities and services available in the province, and that patients should receive more comprehensive care. Some believe mental health patients require more medical interventions, both while staying in facilities and after discharge. Others add that medical services should be combined with community resources to assist patients to live in and be productive members of society. There was general agreement that people with mental health concerns require greater access to integrated, co-ordinated and multi-disciplinary supports.
Mental Health Facilities and De-Institutionalization

This chapter includes the following topics:

- **Patient Care**
- **Accessibility of Mental Health Facilities**
- **Administration of Mental Health Facilities**
- **Out-Patient Services and Community Supports**

**Related Chapters**

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Addictions; Social Determinants of Health; Patient Safety; Community Care and Access.

**Patient Care**

**Comments and Concerns**

**Positive Comments about Treatment in Mental Health Facilities**

**De-Institutionalization**

**Concerns about Treatment in Mental Health Facilities**

- Positive comments about treatment in mental health facilities:
  - Magnolia House is a good facility for housing mentally ill.
  - The Early Psychosis Intervention Program prevents hospitalization and helps people keep a job.
  - Ravensong Centre, which includes doctors, nurses and addiction counselling, is a good facility.
  - Can the precedent at the Murrayville Manor Boarding Home be extended to the homeless mentally ill in general?

- Comments on De-Institutionalization:
  - Closing Riverview was a bad idea it had many good programs for training mentally ill patients.
• Closing facilities has put pressure on emergency rooms since many mental health patients now have no supports.
• Closing Riverview without replacing the mental health beds has resulted in an increase in drug abuse.
• The results of closing facilities are homelessness and increased policing costs to monitor people with mental health issues.
• Closures in mental health download problems to municipalities.
• Citizens are now wondering why there are so many street people. Why are so many people homeless and addicted and in pain and hungry? Because we not only stopped looking after them, but we closed the facilities, did not build new ones and have removed the laws that allowed us to protect and, hopefully, treat and help them to adjust to living on their own.
• By shutting down mental hospitals and integrating mentally ill patients back into society we are doing them an injustice. People are living on the streets, doing drugs and so on because they have no where else to go and do not know how to use their resources.

• Comments on treatment received in mental health facilities:
  • The Eric Martin Institution is a terrible place and only makes conditions worse.
  • Cuts to activity and staff at psychiatric facilities result in lower quality of care for patients.
  • Medical care services sometimes do not pay attention when a person says they need help.
  • Some patients have been abused by staff at mental health facilities.
  • Putting homeless people in psychiatric facilities is not the answer to homelessness.
  • The reduction in the number of clients for mental health centres has resulted in harassment of existing clients as a result of there being too many staff available.
  • The increase in nurses per patient in general hospitals was three times greater than for patients in mental hospitals.
Ideas and Suggestions

- People on the streets with mental health issues should be in long-term care facilities.
- Facilities reduce resources spent on patients who are repeatedly admitted to hospitals, commit crimes and are not compliant with treatment.
- Restore and try to expand the past mental health services to take the pressure off the police and court systems.
- Continuing care and other health care professionals should be provided with Mental Illness First Aid training.
- Increase staff in mental health facilities and give them appropriate training.
- There should be video surveillance in all areas of psychiatric hospitals and wards. This would assist a patient to back up claims of mistreatment.
- The system needs a thorough oversight organization to prevent abuse in mental health facilities.
- Use physical restraints on patients.

Outstanding Questions

- Does your government have a Charter Section 36 commitment to provide healthy sleeping quarters for the homeless mentally ill?

Accessibility of Mental Health Facilities

Comments and Concerns

- British Columbians have mentioned a lack of mental health facilities and services in the following areas:
  - Regions: the Sunshine Coast; the Upper Fraser Valley; Hazelton; and Kelowna; and
  - Facilities: Eric Martin Pavilion; Riverview; Tranquille and Woodlands.
- Getting a psychiatrist on the phone for an emergency case is difficult; it is rare to get a transfer to a psychiatry inpatient unit.
- Cutbacks to day programming are not good.
- The limited services available for people with mental health concerns make the system work like a revolving door.
• Institutional accommodation is not a good idea.

• British Columbia has made good progress in providing regional mental health facilities.

Ideas and Suggestions

• British Columbians mentioned a need for enhanced mental health recovery services in the following areas:
  
  • Regions: Cities and the surrounding areas on Vancouver Island;
  
  • Facilities: Riverview; and the mental health facility on Grant Avenue; and,
  
  • Services: 24 hour emergency community services; group therapy; emotional support counsellors; group homes for young people; alternative therapies; lock-up residential care and supervised group homes for some psychiatric cases; treatment centres for eating disorders and gay, bi-sexual and trans-gendered people; and psychiatric beds.

• There should be different facilities for different kinds of illness.

• Decentralize mental health resources so people do not have to travel to urban centres for help.

Administration of Mental Health Facilities

Comments and Concerns

• The administration of mental health care does not seem to be very organized.

• The current mental health management system provides no assistance to people who support family members with mental health issues.

• Care for the great majority of those with psychiatric illnesses was left entirely to the provincial governments, with none of the federal support for the upgrading of facilities or services provided for other medical conditions. This made investing dollars in the other, non-psychiatric areas of health care much more attractive for provinces since such investments would be matched by the federal government.

• Some patients are discharged too early and end up back in hospitals for another stay.

• Some people are inappropriately admitted to facilities.
• Access to government programs for people with mental health issues is limited, which results in people not getting the necessary supports and ending up in hospital.

• Reducing the number of patients who miss psychiatrist appointments would result in a more efficient use of resources.

• Some patients are released from hospital before suitable housing is in place. These patients then go to a homeless shelter.

• Some facilities do not have the necessary resources to treat patients with mental illness; this represents a risk to other patients.

• Too many family members are employed in the same facilities.

• Addicts in the emergency room are often put at the bottom of the list for treatment.

• Treatment delays can mean that patients are unable to be rehabilitated.

• When patients go to a mental health facility, their records go with them; good communication between facilities is maintained.

• Mental health staff treat each other like family.

• Psychiatric hospitals and psychiatric group-houses cost the provincial government a fortune to operate every year.

• Mental Health services should have health professionals available to proactively identify persons with mental illness and admit them to hospital.

**Ideas and Suggestions**

• Facilities should ensure successful community treatment options are in place before discharging a patient.

• The money saved from closing Riverview should be transferred to the Northern Health Authority.

• Separate treatment for mental health and addictions.

• Separate the intake for emergency psychiatric patients from general emergency intake.

• Caring for people with mental disorders in separate facilities will increase housing options for everyone.

• Facilities need a triage process to ensure mental health patients receive appropriate care from the appropriate place.

• All mental health services should be available at a one-stop location.
• Public drop-in centres need to be available for people who are in the most need for mental health services.

• The health care system should use community public and private psychotherapists rather than the medical intervention of psychiatrists.

• Ontario used a group therapy method to treat psychiatric patients, which helped the recovery process and decreased the amount of time patients were in the hospitals.

• There should be no wait list for those who need help with their mental well-being or addictions.

• Health care needs a new model of care where a person’s level of need is clearly defined and reassessed at regular intervals.

• A system should be implemented to serve the families who provide the daily care for mental health patients.

• There should be more support provided to the families, letting them know what services exist, what is provided and how to access these services.

• The well-being of the individual and the safety of the public must be a prime focus in determining who should stay in a mental health facility.

• The resources should follow people with mental illness and be used to humanely treat them and rehabilitate them.

**Outstanding Questions**

• How can someone be sent to a mental health facility when an involuntary certificate was signed and no doctor had performed an assessment?

**Out-Patient Services and Community Supports**

**Comments and Concerns**

**Out-Patient Services**

**Community Supports**

• Comments about outpatient services:
  - There is a lack of on-going planning for patients who require acute care.
Facilities do not follow up with patients after they have been discharged from a mental health facility.

There is no local facility that supports and/or houses patients before they transition back to community after acute care.

The North Shore Centre, an out-patient facility, provides excellent individual and group therapy; however, day time groups need evening sessions so people can both work and attend the sessions.

Comments about community supports:

Institutional downsizing was not matched with equal investments in community care, whether in general hospitals, community mental health agencies or clinics, or other supportive services. This situation was disastrous for the mentally ill.

British Columbia showed a loss of almost 40 per cent of its rated bed capacity for patients with psychiatric illnesses during the period 1990 to 2002. These changes in institutional care were not accompanied by alternative programs to address the needs of the sufferers, nor the requirements for a whole system.

Sending people into the community without adequate supports leads to homelessness.

British Columbia lacks supportive housing for people with mental health issues.

Without supports, people with mental health issues do not budget wisely and can forget to take their medications.

Communities lack the capacity to assist mental health patients.

There is only one mental health organization in the province that services Aboriginal communities in British Columbia.

Finding the appropriate access point to mental health services is very difficult.

De-institutionalization did not work because it was not followed by serious investment in community support systems.

Health care needs to differentiate between people who do better on the street and people who need more support.

Community health professionals seem unprofessional and inadequately trained.
Ideas and Suggestions

Outpatient Services

Community Supports

• Ideas about outpatient services:
  • Government ministries should collaborate to provide appropriate supports to people with mental disorders to ensure that they do not go back to the hospital.
  • Each patient should have a follow-up plan for continued treatment before being discharged from a mental health facility.
  • British Columbia needs halfway-houses for mental health patients who have been discharged from hospital.
  • There should be follow-up outreach that helps support those who are struggling to stay in their homes.

• Ideas about community supports:
  • Provide emergency shelters, assistance from private charities and support to find work, and individual homes for homeless people.
  • Provide supportive housing for people with mental illness.
  • Community care facilities for the mentally ill should include:
    a. Small personal rooms;
    b. Communal kitchens offering full meal service;
    c. Medication monitoring by on-site nursing staff; and
    d. Personal counselling.
  • Provide more long-term residential resources for Aboriginal children with mental illness.
  • There should be transitional levels of care for mental health patients similar to levels of care in place for the elderly (acute care, extended care, assisted living, independent living and supported community living).
  • Peer support and mentoring should be available to people with mental health concerns.
  • Services available to mental health patients should include financial planning and family counselling.
  • Reduce the stigma for those on welfare.
• Provide more in-home support for First Nations families when people return from receiving treatment in facilities.

**Outstanding Questions**

• With Riverview Hospital closing, what support systems are in place in the communities?

• When will supports be provided in communities to assist people with mental health issues?
Addictions

Addictions were among the issues raised by many participants during the Conversation on Health. Access to and delivery of addictions services, public perceptions, education and awareness, legal implications, and harm reduction were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of addictions.

Access to Addictions Services

Many of those involved in the Conversation on Health think that addictions services should be more available throughout the province. Northwest British Columbia, the Sunshine Coast, the West Kootenays, the Okanagan, the Peace district, Victoria and Prince George were mentioned as areas in particular need of increased services and facilities. Some people identify travel as a barrier to people in rural areas who want to receive treatment. Submissions about access to addictions services also extend to issues of staffing and cost. Several people indicated that too few trained professionals work for rehabilitation services; others noted that these services are too expensive. These factors are identified as additional reasons that people are unable to access treatment.

Some participants feel that the lack of accessible addictions services result in people with substance abuse issues seeking treatment from hospitals. They comment that an increase in appropriate substance abuse services will reduce wait times for other patients in emergency rooms.

Delivery of Addictions Services

Many participants indicate that the delivery of addictions services is not designed to maximize treatment success, and that there are too many rules for entering rehabilitation. Others emphasize that waiting lists are too long and that there is a lack of ongoing care for people who had been discharged into the community. Most participants feel that services are not comprehensive enough, and not designed for the particular needs of people with addictions issues.

Make the system easier. Ease of connecting with needed help [and] support is imperative.
–Regional Forum Written Submission, Castlegar
Several ideas are proposed to improve service delivery. Many people indicate that an advocate can assist people seeking treatment to navigate their way through the system. Others note that creating services with fewer entrance criteria will encourage more successful recovery. Mobile nurses and community support workers are also identified as a particular method of ensuring better patient outcomes, particularly in rural areas.

Public Perception, Education and Awareness

There is general consensus that awareness of the issues and services around substance abuse is low. Most participants agree that the public does not know how and where to access help for addictions and that greater promotion of available supports is needed. The stigma surrounding people with addictions is one of the reasons cited for this lack of public awareness.

Many contributors indicate that three specific groups, First Nations, youth, and those who suffer from Foetal Alcohol Spectrum Disorder (FASD), require better education and support related to addictions. Not only do several submissions indicate that these groups need more actual addictions services, but they also suggest that youth, First Nations and Foetal Alcohol Spectrum Disorder patients require more discussion groups, recreational activities, positive advertisements and support from parents and elders.

I would like to see some aggressive advertising on the dangers of excessive alcohol consumption - something aimed at children and youth to counter the sexy, cool, even athletic image of beer drinkers portrayed in commercials.
– Web Dialogue, Duncan

Legal Implications

Many submissions address the debate about prohibition and legalization of alcohol, tobacco, and other addictive substances. Some participants note that banning substances is not effective and does not necessarily prevent addictions; however, others indicate that addictive substances are easily accessible and poorly regulated.

Get tobacco products out of health care provider facilities such as pharmacies as a minimum standard. Ideally, restrict tobacco sales to specially-licensed, adult-only venues.
– Web Dialogue, North Vancouver
Enforcement is an important issue to many. Some people want stricter penalties for drunk drivers and people who sell illegal drugs; some think more control over the production and distribution of addictive substances is a better approach. Other submissions also identify de-criminalizing drugs as an important step in assisting people to recover from their addictions issues.

Harm Reduction

The use of harm reduction strategies was heavily debated by participants in the Conversation on Health. Some believe that needle exchanges should be more controlled or completely not available, while other respondents think needle exchanges should be expanded and given permanent status.

Of the people who believe that harm reduction is important to treating addictions, many propose that needle exchange sites develop new services. Some of the suggestions include starting drug purity testing and point-of-care HIV screening.

So it's an injection site where drug users are going several times a day every single day for one reason, but if you do point of care instant test HIV screening there, and then a quick diagnosis and access to care, suddenly it's more than that.

–Focused Workshop on Primary Health Care, Vancouver

Conclusion

Addictions were a source of great debate for contributors to the Conversation on Health. Overall, participants believe that addictions require more attention from the government, from communities and from individuals. Improved education and awareness is needed to combat substance abuse. Though several people believe people with addictions require easier-to-access and more comprehensive care, others think that addictive substances should be more tightly controlled, and the people who use them more severely penalized. Beyond that, the concerns and ideas about addictions are many and various. Participants in the Conversation on Health sought more information and more opportunities for discussion around this complex issue.
Addictions

This chapter contains the following topics:

- Mental Health and Addictions
- Access to Addiction Services
- Delivery of Addiction Services
- Funding/Models of Government Programs
- Youth and Addiction
- Foetal Alcohol Spectrum Disorder
- First Nations and Addictions
- Legal Implications
- Awareness and Public Perceptions of Addiction
- Socio-Economic Factors
- Harm Reduction

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

- Regulation of Psychoactive Substances
  Submitted by Health Officer’s Council of British Columbia
- Aboriginal Conversation on Health
  Submitted by Vancouver Coastal Health Authority
- Research on Child Health - Final Report (Quantitative Research)
  Submitted by BC Children’s Hospital Foundation
- Submission to the Conversation in Health
  Submitted by the Representative for Children and Youth

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Mental Health Facilities and Deinstitutionalization; Mental Health; Social Determinants of Health; Access to Hospitals in Rural Areas; Health Human Resources; Training; First Nations; Public Safety; Patient Safety and Collaboration in the System.
Mental Health and Addictions

Comments and Concerns

- People with mental illness sometimes self-medicate with drugs.
- Addictions are a symptom of a society in pain.
- Substance abuse may activate mental health issues.
- Drug and alcohol use should not be lumped into mental health.
- Stealing and vandalism is a problem associated with people who have concurrent mental disorders and addictions.
- The province has recognised that there is a correlation between mental health, substance abuse, crime and social problems.
- There is a need to acknowledge other types of addictions: gambling, credit card spending, for example.

Ideas and Suggestions

- Mental health and addictions services should be linked.
- There is a need for coordination between youth mental health and substance abuse.
- Separate out mental health from addictions/substance abuse.
- We need separate recovery for addicts and the mentally ill; the challenges they face are completely different.

Outstanding Questions

- How do we treat mental health issues resulting from use of illegal drugs?

Access to Addiction Services

Comments and Concerns

- A lack of addictions services was mentioned in the following areas:
  - Regions: the northwest of the province; Sunshine Coast; the West Kootenays; the Peace District; the Okanagan, past Nelson to Nakusp; Fort St. John; Victoria; and Prince George; and
Services: treatment centres; an addiction centre for youth; post-rehab care; services for prison inmates; needle exchange and drug education programs; an addictions helpline; HIV testing and programs; and drug counsellors.

There is an urgent need for increased addiction services, such as hospital treatment, day programs and extensive counselling services.

There are too few people doing too much work; addictions services do not have enough well-trained people.

The rehabilitation services needed to overcome substance abuse are too expensive.

Substance abuse patients take up a lot of bed space in hospitals and delay treatment for other patients.

Crystal meth is a big problem in British Columbia.

The government continues to enable the use of more liquor and more gambling.

Northern weather conditions prevent substance abuse patients from travelling to access services.

Addiction should not affect access to health care services.

Treatment centers are available.

Substance abuse is as a bigger health concern on Vancouver Island than in the Lower Mainland.

Ideas and Suggestions

British Columbians mentioned a need for more of the following addiction services:

- Regions: northwest British Columbia; Terrace; Fort St. John with access for Fort Nelson, Chetwynd, Dawson Creek, and Hudson Hope; and North Vancouver.

- Services: mobile services for rural communities; crack, cocaine, and crystal meth treatment centres; treatment centres for women; out-patient addiction services; a 24 hour addiction help line, a family helpline, and a pregnancy helpline; smoking cessation programs; street level primary health care; social rehabilitation and a full-time work skills program; and addiction advocates.

- Substance abuse treatment centres would reduce emergency room admissions and free up acute care beds.

- I think we should build a facility in the Northwest Territories for addicts. A certified health professional should ride along with a policeman and when they come across a drug addict the health professional should have the power to say they can be
arrested. From there we put them on an airplane that makes daily trips up to the facility. The facility would have an entry level detox station followed by rehabilitation. After that, patients would have to learn about money and finances, nutrition and cooking and shopping. Perhaps there could be a huge greenhouse so they could learn to grow their own food. There should also be creative outlets, photography, animation at the centre.

**Delivery of Addiction Services**

**Comments and Concerns**

- There is no coordination to develop a strategic approach for dealing with the issues of addictions and mental health.
- Treatment facilities have too many rules, which may prevent a patient from receiving timely service.
- Services are not necessarily aligned with the individual needs of people.
- Drug addiction prescriptions are not available for long enough periods of time to be effective.
- There are several barriers to treating addiction: lack of treatment options; wait lists; insufficient length of stay; and the requirement for sobriety to commence treatment.
- Health professionals are not referring substance abusers to support groups and/or services.
- If people with substance abuse issues do not want help, there is no way to help them.
- There is no ongoing care for substance abuse even though alcohol and drug addiction has been touted as a chronic illness: clients leave treatment without supports.
- Communities often resist the construction of mental health or addiction facilities.
Ideas and Suggestions

- Concurrent disorders need to be treated at the same time; full spectrum treatment is required.

- Substance abuse rehabilitation programs should be much longer in duration, perhaps as long as 6-12 months.

- The system is not easy to navigate for people with addictions issues; they need an advocate.

- The system needs low-barrier services (that is, no entrance hurdles or eligibility criteria).

- Shorten waitlists for drug and alcohol counselling.

- Shorten wait times between referral and consultation.

- Place an alcohol and drug counsellor in Income Assistance offices across the province. People may not go for their medical appointment, but they will pick up their cheque.

- Provide better follow-up in communities: more mobile nurses, community support workers, and criminal support workers.

- Make the system easier to access; connecting with necessary substance abuse support should be easier.

- Keep substance abuse/abusive patients in a separate area away from the general public.

- Rural areas have specific issues and needs.

- Detoxification and rehabilitation should not be separate.

- Set up a "Buddy system" for addiction reduction.

- Do not provide medical services to drug addicts.

- Implement a payback treatment program for drug abusers. If they do not have a job, they should work for the program’s counsellors; if they have a job, they should have to contribute financially to the program.

- Test for addictive personality types early in life.

- Addicts should be given job training. They can then become productive members of society.

- Create community health care clinics and provide multi-disciplinary services.
Outstanding Questions

- Where will addicts be treated, given the shortage of physicians and the lack of treatment, health facilities and basic infrastructure to support their healing?
- Why are addiction services cancelled before they are properly assessed and replaced?

Funding/Models of Government Programs

Comments and Concerns

- The lack of a central office that oversees continuity and quality of care has led to poor, disjointed and disorganized addiction services in British Columbia.
- Communities cannot afford treatment programs on their own.
- The responsibility for addictions continues to be moved between ministries.
- Funding is only targeted at the end of the spectrum, or once people have become addicted. There is no funding for prevention.
- Legislative and policy frameworks for psychoactive substances have not kept pace with established best practices.
- Millions are going into housing and medically attending to people who basically do not want to be housed or made fit.
- Addiction is considered a medical issue, and yet residential addictions treatment is almost exclusively offered on a user-pay basis at a cost of thousands of dollars.
- There is high professional turnover in communities resulting in a lack of continuity of service provision.
- We have invested literally tens of millions of dollars in the expansion of facilities and services across the province for people with mental illness.

Ideas and Suggestions

- Develop a collaborative, cross-ministry, approach to health and substance abuse services.
- Create a steering committee with broad community representation to propose policy and regulatory improvements for tobacco, alcohol, cannabis, opiates, stimulants, hallucinogens, and sedative/hypnotics.
- Recovered addicts could help a lot in the system.
• Leaders should act as role models: test government officials and band council members for substance abuse.

• Service providers need to be more included in medical decisions.

• More of the money that goes into the government coffers from taxes on cigarettes, alcohol and gambling needs to be used to treat people with addictions.

• Public health should fund non-traditional interventions for people with substance abuse issues.

• Funding treatment centres would be a big initial cost, but would result in long-term cost savings due to reduced hospitalisation and emergency room visits.

• Follow the Calgary Dream Centre model for addiction services.

• Explore the Italian model for addiction recovery.

• Treatment programs need to be tailored to specific categories of psychoactive substances.

• Invest more in the treatment of seniors who are abusing alcohol.

• Use old hospitals and abandoned schools as sites for new treatment centres. These facilities could also house ambulance stations, community clinics and community police stations, creating one-stop service centres in our communities.

• Although the focus is on the harm reduction model, there needs to be more funding for abstinence programs.

• Drug companies should pay for their research.

**Outstanding Questions**

• How much does the Vancouver Island Health Authority spend treating addictions?

• How do we go about breaking the cycle of passing alcohol addiction from one generation to the next?
Youth and Addiction

Comments and Concerns

- Youth view substance abuse as a much greater concern for children's health than smoking.
- Substance abuse and lack of exercise are considered to be very important issues; one-in-five children enlist both items as top concerns.
- Getting youth back, once they are addicted to alcohol and drugs is difficult.
- There is fear of putting children in care because it can be hard to get them back.
- Children are experimenting at younger ages (smoking and drinking alcohol).
- Drugs and alcohol are disruptive and result in children being expelled from school.
- Counsellors are being asked to play a parenting role in the absence of parents.
- Talking to students is not working. The reality is the average parent will tell their children that drugs are bad, but alcohol is tolerated.
- The school system has minimal repercussions for drinking.
- There is currently no treatment available for children who absorb heavy metals from mothers with addictions.
- Substance abuse is often a learned behaviour.
- Many youth are getting hooked on drugs and alcohol. This leads to many suicides or attempted suicides in the North.
- The government agencies interfere with First Nations parents who try to get their children away from alcohol. The system dominates; ever since residential school, decision-making has been removed from parents.
- Many foster children have severe Fetal Alcohol Effects (FAE)
- Youth turn to alcohol to hide from previous abuse.
- Pregnant women on drugs produce sick babies who often grow up in foster care.
- Identify high risk kids and keep them incorporated in day care.
- The Drug Abuse Resistance Education (DARE) program has been successful.
- The number of children being born with substance abuse issues, such as Crystal Methamphetamine addictions, is reaching proportions that render the current care systems inadequate.
Ideas and Suggestions

- Provide emergency housing for adolescent addiction.
- Promote education about managing the risks of alcohol and drug use for youth in care.
- Kids do not deserve to live with drug addicts. Fine the addicts, the same as we fine drunk drivers.
- There should be more informal meetings to talk about addiction with youth; use positive reinforcement and do not overwhelm them.
- Parents should be allowed to physically discipline children.
- Early, pre-teen intervention may reduce health care costs as well as the severity of addiction problems.
- There should be incentives for parents to prevent their kids from drinking.
- Children need a youth or recreation centre to provide healthy activities, such as basketball.
- Establish activities in school rather than using suspension or expulsion to discipline students.
- Control situations where drinking occurs (bush parties, school graduations).
- Provide day care for people with addiction issues.
- Put nurses in schools.
- Drug safety houses are useless and give young people the idea that drug are acceptable.
- Show children what a drug addict’s or an alcoholic’s life looks like.
- Parents need to let their children take responsibility for their actions.
- Support positive parenting and parenting skills development at the community level.
- Provide a better program to help police deal with those they find abusing drugs or alcohol.
**Foetal Alcohol Spectrum Disorder (FASD)**

**Comments and Concerns**

- The 2003 provincial Foetal Alcohol Spectrum Disorder Strategic Plan for British Columbia indicates that each child affected by Foetal Alcohol Spectrum Disorder may require an estimated $1 million to $2 million over the course of their lifetime to support remedial medical, educational and social costs.

- Many individuals do not know what Foetal Alcohol Spectrum Disorder is, how it is caused, what limitations it can create or how to prevent it.

- It is very difficult to get a diagnosis for Foetal Alcohol Spectrum Disorder. There are lengthy wait lists and high costs associated with getting a diagnosis.

- It costs approximately 1.3 million dollars to sustain an individual with Foetal Alcohol Spectrum Disorder over a lifetime.

- There is very little support for individuals with Foetal Alcohol Spectrum Disorder after the age of 18.

- There is stigma attached to Foetal Alcohol Spectrum Disorder (especially towards the birth parent) because it is preventable.

- There is inadequate support for Foetal Alcohol Spectrum Disorder in Burns Lake.

**Ideas and Suggestions**

- Foetal Alcohol Spectrum Disorder patients need life skills, financial, and educational support, and counselling to deal with the limitations they will face for their life time.

- People with Foetal Alcohol Syndrome need early intervention.

- Foetal Alcohol Spectrum Disorder is not recognized as a disease and, therefore, there is very inadequate funding for services targeted to those with Foetal Alcohol Effects (FAE).

- There is a need for prenatal programs for marginalized women to decrease the number of foetal alcohol disorder and drug affected infants.

- Increase coordination between Foetal Alcohol Spectrum Disorder services and other community services.

- We encourage the development of a provincial Foetal Alcohol Spectrum Disorder prevention strategy, including community development, health promotion and targeted strategies to raise awareness of the disability and risks associated with alcohol and substance use during pregnancy.
• Alcohol consumption during pregnancy is probably the most common preventable cause of congenitally acquired mental and behavioural disabilities in children in British Columbia.

• Mothers of Foetal Alcohol Spectrum Disorder patients should be criminally charged.

• Provide a helpline for women who are both alcohol dependant and pregnant.

• We welcome the provincial government's recent ActNow initiative, which aims to increase access to services for women at risk of using alcohol during pregnancy.

First Nations and Addictions

Comments and Concerns

• One of the biggest problems that First Nations and Aboriginal communities face is the scourge of drugs, drug trafficking and all of the associated illnesses that come with it. Intravenous drug use has contributed to an increase in HIV/AIDS and Hepatitis C.

• When a person has completed addiction treatment, they come home and back into the war zone.

• Issues related to drug-use and alcohol consumption in First Nations communities must be confronted.

• I am concerned about the ratio of liquor outlets and gambling establishments to recovery and treatment centres.

• There is a lack of on-reserve addiction services; on-reserve and off-reserve patients do not have equal access.

• There are not enough properly trained counsellors to deal with the current volume of problems.

• Residential schools are a major source of addiction in native communities.

• There are so many young getting involved in the chemical drugs and the time frame is five to eight years for the drugs to kill them. However, we do not have time to wait until they are adults and I do not see enough treatment centres in place.

• Drug users who ask for help do not receive it.

• Kermode Friendship Society is trying to get back its Aboriginal addictions counsellor. Funding for the counsellor was pulled without any community consultation.
• First Nations people need a place to have informal discussion with no Chief present. Children also need a place to discuss issues with no influence from an authority figure.

• Agencies are starting to pull in Elders to speak in schools and in agencies themselves to provide a better idea of the unique culture in Aboriginal communities and what goes along with it.

**Ideas and Suggestions**

• A systemic approach to drug and alcohol issues and treatment programs is required; treat the whole, not just the symptom.

• Meet the client where they live with the intent to empower them to make a positive decision.

• There is a need for post-treatment facilities in First Nations communities, where people have a better environment to continue on with their success and recovery.

• Relapse is part of drug and alcohol recovery; people need to acknowledge and prepare for it.

• There should be more treatment centres and they must be operated by community members.

• Provide more education in the community on how to recognize the symptoms of addictions versus those of mental health issues.

• There should be forums to develop strategies to seek solutions to addictions issues between bands that are sustainable. Health Canada could fund these forums.

• Provide detoxification training on reserves to deal with emergent cases.

• Create youth healing programs, including incentives for detoxification, in First Nations communities.

• Involve more parents in prevention and provide more education. Close the gap between Elders and youth to give them cultural identity.

• There is a need for First Nations communities to have access to training for parents who have youth facing issues like suicide and drugs.

• More treatment centers for families should be opened on reserves. There are not very many, a lot of times they are full, and sometimes access is way beyond some people’s means.

• Ban or evict drug dealers from reserves.
• There should be support for women addicted to prescriptions in First Nations communities. They should have access to a psychiatrist.

• Provide a youth healing centre for those in First Nations communities.

• Foster trust so that people will seek assistance.

• There are plans to build an Aboriginal Healing and Wellness Centre at Centre Creek which will be available to all nations and address all levels of treatment.

• Abolish cigarettes and alcohol from First Nations communities.

Legal Implications

Comments and Concerns

Legalization

Enforcement and the Justice System

• Comments on legalization:
  • Criminalization does not reduce addiction.
  • Theft and prostitution are used as a means to finance addiction.
  • Cigarettes and alcohol are too available; there are no regulations on the chemicals that make people addicted.
  • Prohibition is ineffective in reducing the use of illegal drugs.
  • Smoking and automobiles both contribute to air pollution. If smoking is banned, why not also ban the automobile?
  • The Royal Canadian Mounted Police is often in the position of dealing with addicts and detoxification treatment.

• Comments on enforcement and the justice system
  • The justice system is too lax on drug dealers.
  • There is a lack of judicial resources for law enforcement to prevent drug trafficking.
  • There has been great progress on eliminating smoking.
  • While the law is a powerful tool for protecting and improving health, failure to use the law appropriately for psychoactive substances has contributed to many problems.
Tobacco abuse, active and passive, is the leading cause of preventable disease and disability. Our province, once a leader in tobacco regulation, is now almost last in Canada.

**Ideas and Suggestions**

**Legalization**

**Enforcement and the Justice System**

- Ideas about legalization:
  - Legalize drugs.
  - I would like to see marijuana legalized.
  - Use resources from legalising drugs for addictions treatment.
  - Decriminalize the sex trade.
  - Do not legalize any drugs.
  - The government should be more stringent regarding illegal drug distribution and manufacturing.
  - Ban the drugs and substances used in crystal meth production.

- Ideas about enforcement and the justice system:
  - When a person is caught using drugs they should be taken to a large treatment centre where there is no way out until they are clean.
  - When a youth is caught using drugs, their sentence could be to work in a place like the Vancouver injection site for a year.
  - People who habitually cause accidents or hurt people need to be put into rehab programs, which includes clean-up and support programs.
  - Pass laws to prevent pregnant women from entering pubs and liquor stores.
  - Drinking establishments should bear some responsibility for alcoholism.
  - Expand the definition of addictions to include gambling and prescriptions, not just drugs.
  - Set a policy for family justice, social workers and health workers to take mandatory drug testing; also test young drivers.
  - Institute the death sentence for convicted drug pushers.
When we consider billing people whose behaviour puts them at risk, we need to keep in mind that the government is in the business of selling liquor to addicts and providing slot machines to addicted gamblers.

- Get tobacco products out of health care facilities, such as pharmacies; restrict tobacco sales to specially-licensed, adult-only venues.
- Increase the age to purchase tobacco products.
- Eliminate designated smoking rooms and create outdoor buffer zones around workplaces and public spaces.
- People should have to pay for their medical expenses if they cause a car accident if driving while impaired.
- Drug paraphernalia should not be available to purchase in novelty stores in plain sight with no age restrictions.

Outstanding Questions

- Why can the government not at least stop cigarette manufactures from adding all those extra carcinogens and nicotine delivery systems to the tobacco?

Awareness and Public Perceptions of Addiction

Comments and Concerns

- The public lacks information on who is providing which service, where and when.
- There is too much money spent on treatment rather than prevention.
- Substance abuse is not a priority due to bad public perception the fringe status of addicts.
- Addictions are criminalized and stigmatized.
- The village government brings in excellent programs but nobody will walk through the doors to get help.
- The failure rate of interventions is very high.
- The number of high-risk clients is dropping.
Ideas and Suggestions

- Treat addicts with respect and give them support.
- Reduce the stigma of drug addiction.
- Provide more public education such as school program on drugs and alcohol prevention.
- Bring in people who have first-hand experience with drug and alcohol abuse to lead prevention programs.
- Better promotion is needed for the services offered by: Alcoholics Anonymous, Alanon, Narcanon, and depression support groups.
- I would like to see some aggressive advertising on the dangers of excessive alcohol consumption.
- Educate police officers on handling mental health issues, addicts, and sex trade workers.
- Families should have automatic referrals to information and community support once a diagnosis has been made.

Socio-Economic Factors

Comments and Concerns

- The age expectancy among persons suffering from addiction is now lower.
- Literacy barriers can stop people from accessing programs.
- Mental health issues are affected by poverty and addictions.

Ideas and Solutions

- The Downtown Eastside in Vancouver requires more support to improve living conditions, enhance nutrition, deal with mental health issues and provide addiction services.
- Addiction and mental health issues are not only Downtown Eastside issues; they are more prevalent but less visible in many other areas.
- People with addictions are most likely to develop chronic health issues: Hepatitis C and B, and HIV, as well as a range of other health issues that result from living on the street in poverty.
Harm Reduction

Comments and Concerns

- Insite lacks permanent status.
- The government is funding criminal activity under the health system (for example, the needle exchanges).
- Long-term methadone programs are just a source of free drugs for abuse.
- Needle exchange programs are expanding. The Insite facility in the Downtown Eastside is reducing mortality and health crises associated with drug use.
- We are very proud of the Insite Centre in downtown Vancouver, which serves a growing population of drug users who otherwise have little access to health care through traditional resources.

Ideas and Suggestions

- British Columbia should not have drug injections sites.
- Needle exchange sites should be established throughout the province and have long term funding.
- Move injection sites out of the downtown core.
- Methadone use should be limited.
- Methadone should be available at the pharmacy.
- Safe injection sites must also provide a compulsory rehabilitation program.
- Provide additional harm reduction programs (such as drug purity testing).
- Institute point-of-care HIV screening at needle exchange sites.
- Drug addicts should be offered free treatment for their addiction rather than a free shot of narcotics at a public expense.
- Funding for the needle exchange and methadone program is perpetuating a drain on the medical system.
- Methadone programs should be reserved for in-patient drug abuse treatment programs.
**Outstanding Questions**

- Has the safe injection site reduced the spread of HIV/AIDS and Hepatitis C?
- Has public order been improved in the downtown East Side as a result of the safe injection site?
Part III: Envisioning a Revitalized Health Care Workforce

Both public and health professional participants want to see a strong and vital health care workforce. They understand that demographic challenges and increasing competition across the globe for health care practitioners means that we need to face up to our challenges around attracting, training and retaining health care professionals in British Columbia. In this section you will read some of the ideas and concerns of participants around their vision of a revitalized health care workforce, which includes:

- Attracting and retaining health care workers and attracting workers to rural areas;
- Improving administration and scheduling for health care workers;
- Focusing on training health care workers;
- Supporting all workers to operate to their optimal scope of practice;
- Integrating complementary and alternative health care practitioners;
- Encouraging and supporting an environment of teamwork and inter-professional collaboration;
- Expediting foreign trained professionals’ integration into the workforce; and,
- Improving the work environment of health care workers and their remuneration to produce better health outcomes.

In this section:

- Health Human Resources
- Training
- Scope of Practice
- Complementary and Alternative Medicines
- Foreign Trained Professionals
- Morale
- Health Professional Compensation
- Services Received
Health Human Resources

British Columbia’s health care workforce was a common discussion topic among participants in the Conversation on Health. Demands on health human resources included comments on scopes of practice, rural demands, the demands between the private and public sectors, remuneration of professionals, and the management and leadership structure of health care. Labour relation discussions centered on essential services, collective bargaining, and the roles of unions and professional associations in the bargaining process. Here is a sampling of what British Columbians had to say about health human resources.

Health Human Resource Demands

British Columbia’s baby-boomers are retiring in large numbers and subsequently, the health care sector is set to lose many knowledgeable and skilled health professionals. Participants are concerned that the number of new medical professionals entering the system will be insufficient to meet current or projected demands for health human resources. Participants also express concern about the accessibility of general practitioners, citing difficulty in finding a family doctor who is accepting new patients. Many agree that filling more full-time positions with practitioners from on-call and part-time pools may alleviate some demands and workloads. Further, some suggest employing health professionals past retirement age to mentor and train new staff.

In an effort to recruit more people into a career in health care, participants suggest hosting job fairs and offering aptitude testing to encourage those best suited to the health profession. Volunteer services such as candy stripers, they argue, should also be utilized and the program expanded to offer more exposure to careers within the health sector for youth. Some participants argue that the staffing shortage could be resolved by subsidizing student’s tuition and increasing available training spaces at colleges and universities. Additional recommendations include ideas around catering to the values of younger generations, by offering a more flexible working environment and schedule, and creating a healthier workplace with gym facilities, and more child care options.
Some participants also suggest that increasing the number of Aboriginal practitioners on all levels would aid in the delivery of culturally appropriate care to those who need it, while increasing awareness of these cultural sensitivities to the rest of the practicing field.

“We need to anticipate and recognize the current and future shortage of health care professionals by investing in training, retention, recruitment, and support strategies… and maximizing the scope of practice of clinical and support personnel.”

-Health Professionals meeting, Burnaby

Scope of Practice

Participants view changing scope of practice as a tool to fill service gaps and to allocate health human resources more effectively. Some strongly believe that British Columbia’s nurses are capable of assuming a greater role within the health care system. They also think that nurse practitioners could both take on a greater, possibly managerial responsibility within clinics, and triage patients as they enter emergency departments. Participants also suggest increasing the role and availability of community health nurses to enhance rural accessibility to health services.

Many participants want access to new and under-utilized services in order to improve the health human resources picture in British Columbia. They believe that general practitioners should not be the sole gate-keepers to health care and pointed to complementary therapies as alternate points of treatment. Others regard midwifery as another beneficial service, which should have expanded duties and hospital privileges. Participants also discussed creating a patient ombudsman or patient case manager, who would direct patient care in a more organized manner. This, they argue, would reduce duplicate and unnecessary testing or treatment. Other participants think volunteer services should be relied upon to provide basic services and free up medical professionals who are currently responsible for these duties.

Rural and Remote demands on Health Human Resources

Many participants voice concerns around the current process for the recruitment and retention of health professionals in rural and remote areas of British Columbia. Offering incentives such as subsidizing housing for practitioners and their families, and financial incentives to practice in rural areas would bolster human resources to satisfactory levels. Newly-graduated and foreign trained professionals could be required to practice in northern and rural British Columbia for a number of years to
help alleviate the chronic staff shortages these areas experience. Some think that
ambulance services in rural and remote areas need to be upgraded by increased
funding and staffing, as many participants raised concern over the extremely long
waits for ambulance services.

Public versus Private Demands on Health Human Resources
The issue of public versus private practice created significant debate around health
human resources. A number of participants believe that a private system would drain
the public stream of its practitioners by offering higher rates of pay and more flexible
working conditions. Others believe that a private health care system would be a relief
to the overcrowded public system, while some were proponents of a dual delivery
system that regulated the amount of time a practitioner spent in each area. Some
participants raise concerns about the efficacy of privatized cleaning, food, and laundry
services. There is a perception that hospital cleanliness and patient safety have been
compromised as a result of privatization and that, due to a low number of sanitation
staff, nurses must take on cleaning duties that only compound their workloads.

There is the difficulty [in] trying to keep physicians working in the public system if they can
make more money in the private system.
- Web dialogue, Kamloops

Remuneration of Health Professionals
Participants voice concerns that the current fee-for-service remuneration model for
physicians is not conducive to the provision of quality health care. They feel that the
limit in the range of the Medical Services Plan (MSP) insured services make some
treatments unavailable. Many participants also express concern that the 10-minute
visit fee is inadequate or insufficient to fully diagnosis a medical problem. Some
suggest offering a salary to practitioners as a way to address the issue of appointment
times. Participants also suggest upgrading the salary models of ambulance crews to
create more full-time positions in rural and remote areas of British Columbia.

Administration, Management and Leadership
The Conversation on Health touched on the professional management and leadership
structures within the health care system. Participants view good leadership as critical
to the efficient operation of the health system and to maintaining the morale of front-
line workers. Some participants expressed concerns over what they believe are
unnecessary and expensive executive contracts and large severance payouts. Many participants would like to see a reduction in the level of bureaucratic and administrative staff and the devolution of responsibility to those working on or nearer the front-lines of care. Such a move, they believe, would require leadership and management training for primary care practitioners willing to take on such a role. Establishing head nurse and team leader positions would provide a good foundation for promoting discipline and efficiency in the various departments.

*There seems to have been a rapid increase in the number of middle management positions in the health care system that often overlap and have no tangible or measurable impact on the way health care is delivered.*

-Dialogue, Langley

**Collective Bargaining**

There is some concern that long-term contracts only last one year with insufficient time for re-negotiation. Participants believe that all the medical professions should be brought to one table at once to facilitate coordinated bargaining. Many believe that this single representation would result in a more focused approach and result in a more cohesive health care system.

Some participants suggest that contracts should be performance-based, with a process implemented for requesting a review when something fundamental has changed. Others argue that too much health policy is negotiated in the context of a collective agreement.

Many participants suggest that collective agreements be revamped to offer more flexibility to health professionals. Collective agreements may have placed too many restrictions on employees resulting in some jobs being done incorrectly or not at all. Participants cite the cleaning of hospitals as a common example.

*If we’re going to a change management process effectively, then we’re probably going to have to have some short-term expert to help deal with some of the labour relationships issues that are going to emerge from this, and that’s where some of the…extra money would need to be invested.*

-Primary Health Care Focussed Workshop, Vancouver
Unions and Professional Associations

Many participants state that there should be a mutual understanding between management and unions that client services remain the most important issue. Currently, they believe, there is an environment of conflict between governments, employers and unions. Some argue for more collaboration among all unions and the government on necessary health care changes. For some participants, this means strengthening the Government’s role in dealing with health professionals and ensuring interest groups are not responsible for making decisions.

Essential Services

Many participants consider health care an essential service. Mediation and meaningful negotiation is considered important, but many participants believe that labour strikes should not be allowed: the focus should be on delivering satisfactory health care to patients. Some participants state that, if a strike lasts longer than a week, those workers be replaced. Others express concern about the importance of providing health services around the clock and the practicality of health professionals taking extended vacation.

Conclusion

British Columbia’s health care professionals are retiring in record numbers. A province-wide effort to increase recruitment and retain professionals is necessary. Options such as expanding practitioners’ scopes of practice and creating new types of practitioners could address shortages more quickly. Participants suggest the province take affirmative steps to increase the number of health care providers in northern and rural communities, guaranteeing all British Columbians timely access to care. Health services could be delivered by a professional in either the public or the private system, or from both systems. A number of people would like to see more discussion and collaboration among unions and government to ensure needed changes in the health care system will be implemented and supported. Having more time to discuss issues with one’s general practitioner may require a reform in the way health professionals are paid, such as moving away from a fee-for-service model to a salary model. Finally, many participants call for a sizeable reduction of administrative and executive staff, and a shift towards granting more authority to the front-lines of health care.
Health Human Resources

This chapter contains the following topics:

Health Human Resource Planning
Recruitment and Retention
Leadership, Administration and Management
Labour Relations

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

Primary Health Care
Submitted by the BC College of Family Physicians

Health Human Resource Comments
Submitted by the British Columbia College of Family Physician

Presentation to the Conversation on Health
Submitted by the Massage Therapists Association of British Columbia

Family Practice Recommendation for British Columbia’s Health Care System
Submitted by the Society of General Practitioners of British Columbia

Submission to the BC Conversation on Health
Submitted by the Society of Specialist Physicians and Surgeons

From the Beginning to the End
Submitted by the Bella Coola Discussions on Health

Aboriginal Conversation on Health
Submitted by Vancouver Coastal Health

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

Submission to the Conversation on Health
Submitted by the British Columbia Government and Service Employee’s Union

Submission to the Conversation on Health
Submitted by the BC Cancer Agency

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

2020 The Future Without Breast Cancer
Submitted by the Canadian Breast Cancer Foundation
Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Training; Morale; Access and Public Private Debate.

Health Human Resource Planning

Concerns and Comments

Health Human Resource Planning
Public versus Private Demand

- Comments on health human resource planning:

- Funding is available for new and innovative health initiatives; however these initiatives require human resources that are simply not available.

- British Columbia’s health care system seems to be operating at 130 percent of its capacity without additional staff.

- There has been very little effort to increase the utilization of allied health professionals to try and address human resource shortages.

- The majority of health human resource planning has been provider-based analysis as opposed to a needs-based analysis.

- There has been a shortage of nurses and doctors ever since adoption of the recommendations contained in the Baring report fifteen years ago; suggesting limitations in the number of entrants to medical and nursing schools.

- Doctors dictate their locations of practice and their billing system, effectively ignoring Provincial and public requests for practice in under-served areas.

- The Canadian Medical Association is lobbying against generalists and not allowing their full integration into the system.

- There are physical limits as to how much volunteers really can do to help.

- A greater use of volunteer services will result in a net loss in health care positions.

- There is a general lack of respect for volunteers and their services.

- There are physical limits as to how much volunteers really can do to help.

- A greater use of volunteer services will result in a net loss in health care positions.

- There is a general lack of respect for volunteers and their services.
• When a phase-one clinical trial volunteer re-locates to Vancouver, the only medical resources available to them are the phase-one clinical trial team, whose interests are contrary to those of the patient. The government pays nothing towards the care of these terminally-ill patients.

• There are many professionals available but no full time permanent jobs.

• New medical graduates have a lot expected of them. They will be expected to do far more, or be criticized that they are not as good or efficient as those who are retiring. A person with 30 years experience can multi-task, even though the young person is trained in multi-tasking, they just do not have the work experience. In addition to a loss in numbers, the province is also looking at a loss of experience which cannot be replaced one-for-one. This will have a large impact on how productive the health care system is going to be.

• Despite the present and projected nursing shortages in British Columbia, many nurses seeking work in communities that actually need nurses cannot get full-time jobs. Instead, they must suffer the inconvenience and insecurity of the casual list system. This often persists for two or three years until a nurse achieves enough seniority to win one of the scarce and coveted full-time positions.

• The Provincial Government has yet to roll out a long term strategy for recruiting and retaining health professionals specializing in care for seniors.

• Midwifery is not attracting new practitioners due to low pay and little in the way of incentive.

• The Trade Labour and Investment Mobility Act (TILMA) is aiding in the destruction of communities.

• Human resource hiring systems do not always support the hiring of Aboriginal practitioners.

• Simply increasing class sizes may not be a viable option as doing so will significantly increases costs to universities.

• Universities are not providing enough training seats to address the health human resource crisis.

• Health professionals are retiring at a much faster rate than they are being replaced.

• The health human resource system creates a division between physical and mental health; the mental health side is marginalized not only in training but also in practice.

• British Columbia does not suffer from a shortage of available labour, there is simply a lack of willingness to utilize many practitioners to their full potential.
• Hospital capacity issues are not the result of a lack of doctors but often result from a lack of post-operative care and a lack of basic cleaning staff to cycle facilities for the next patient.

• The human resource issue is viewed almost entirely a numerical problem, but there is also enormous and persistent evidence that it is a distribution problem. There are not enough physicians and specialists working in rural areas when there is a virtual saturation of urban areas with all types of personnel, and yet people still report that they are unable to receive care from a family physician. The ratio of family physicians to citizens seems to have no effect on this phenomenon.

• The Health Human Resources Advisory Committee was not solution driven.

• There is little evidence-based planning when allocating health human resources.

• Many participants viewed staff sitting idle within hospitals.

• There is a lack of residency positions for International Medical Graduates (IMG)s.

• The current health human resource scenario represents a seller’s market for labour. Management has to implement a cost-benefit analysis every time new labour is needed therefore a simple mathematical tool to assist in hiring is would speed up the process.

• Too many locums prevent a continuity of service to patients.

• Human resource figures and statistics are irrelevant. The ratios reveal almost nothing because health human resources comprise a mix of professions. It is the entire package of personnel and what they do that matters.

• There is a need to recognize that health care workers cannot do at 60 what they once could at the age of 30. Asking them to extend their working terms past retirement may be impossible.

• British Columbia must rely on recruiting International Medical Graduates (IMGs). International Medical Graduates make significant contributions in medical services, however to make our health system sustainable, British Columbia 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 British Columbia’s physicians are aging.

• Although there is talk about a shortage of workers, nothing constructive is being carried out to address the issue.

• Provincial re-certification is limiting the movement of professionals to higher demand areas in other provinces.
• Students are still waiting many years to enter into medical school or nursing programs; this shows extremely poor human resource planning when taking into account British Columbia’s critical human resource shortages.

• Multiple unions, multiple employers, and multiple professional bodies increase the vastness and the complexity of the health care system.

• The health care system has been characterized from its inception by an absence of anybody responsible for long-term human resource planning.

• There is a need to ensure that any mathematically based health human resource planning models are realistic. Currently, while implementing a health professional, one assumes that that professional will be operating at 100 percent of their capabilities, however this 100 percent efficiency is not always the case as some professionals will work harder than others.

• Local businesses suffer when health sector positions are eliminated within their regions.

• Comments on public and private demand for resources:
• The Province must stop health professionals from double dipping, or working in both the public and private sector.

• The use of doctors in walk-in clinics is a waste of the taxpayer’s money as these physicians may not be working full time. In the face of such a labour crisis, they should be required to do so.

• Doctors are working in the private sector simply because they will earn more.

• Health care services in Provincial prisons have been privatized. Registered Nurses were provided with the option of severance package or being hired on with the new owners and consequently, nursing services have been reduced. A Vancouver jail has had two Registered Nurses per shift 24 hours a day since the 1960s. Now the jail has had its health care centre closed several nights in a row, including some weekends. Licensed Practical Nurses have been introduced to the Vancouver jail but cannot work without the presence of a Registered Nurse. Prison nursing is a specialty that rarely incurred vacancies yet many nurses now refuse to work for an inferior collective agreement, leaving the jail without service. This is a great cost to lower mainland resources as inmates are transferred to our emergency rooms for care that a Registered Nurse could have provided. Two police officers must escort inmates with emergency health services staff, allowing profit to flood out of the of prison health services budget.
• A private clinic siphoning talent from the public system should be accepted as a non-issue; British Columbia is already losing talent to private systems around the world.

• I think that in a mixed delivery system, we will see a real problem with attracting and maintaining critical services in the public hospitals. Nurses and doctors will be siphoned from the public system into the private where there is more money.

• British Columbia’s health human resource pool will not sustain two separate systems.

• Why is it that in the time of so called budget restraints we are continuing to contract out so many of the services that could be done in-house at far less cost.

• The brain drain or loss of trained professionals is working against the Canadian public services and into the hands of private American organizations.

• In a healthcare system offering both public and private care options, higher quality doctors would leave to find employment in the private sector. Private sector care would be out of reach of the poor, and the public sector would continue into their human resource crisis.

• Private sector care has their own recruitment and retention problems because working conditions in private settings are so poor that nurses will not stay within them.

• No contractors of any kind should be allowed in hospitals.

• The privatization of house keeping and food services has compromised two of the most important patient services within the hospital.

• The retention of quality workers is becoming harder for the privatized companies and it is the public that suffers.

Ideas and Suggestions

Health Human Resource Planning
Public versus Private Practice Demands
Education and Training

• Ideas about health human resource planning:

• The made-in-British Columbia solution to addressing health human resources must be part of a more integrated made-in-Canada solution and the two must go hand-in-hand. It is wrong to think that British Columbia can single handedly solve its
health human resource problem; all we are doing is merely export that problem to other parts of the country.

- British Columbia requires only a temporary infrastructure of doctors and health workers to care for the oncoming baby boomers. If the province commits to permanent infrastructure and labour, there will be a resounding surplus once this crisis has passed.

- Encourage greater mobility for doctors within Canada. Break down any barrier that would stop professionals from crossing provincial borders. Create a national professional jurisdiction to facilitate movement of professionals from one province to another.

- Administrators should be able to foresee shortfalls in staffing and plan to avoid these problems.

- The current global population is not able to provide for the upcoming demand for labour. Encourage people to have more children.

- Public input must be incorporated into deciding appropriate staffing levels for acute and chronic care. This would include not just nurses, but also Physiotherapists, Occupational Therapists, dietary, laboratory, and all other support services.

- All British Columbian medical school graduates should be required to work within the province for a span of five years. They would be repaying the taxpayers for their subsidized educations.

- Eliminate the Trade, Investment, and Labour Mobility Act (TILMA) or at least modify it to exclude health care.

- Open up and address the human resource issues brought on by the North American Free Trade Agreement (NAFTA).

- Creation and sharing of casual job pools between facilities.

- Triple the amount of community support workers being trained and employed.

- It is about time we got rid of some of the non-productive employees, not hire more. It is no wonder that Canada's productivity is at an all time low.

- Invest in workforce planning and require individual units or departments to conduct annual performance evaluations for all staff.

- British Columbia must confront the issue of inter-provincial competition for health human resources in a serious manner.

- Health human resource planning must be backed by the Premier's Office.
• Implement mathematically-based health human resource planning models that reflect today’s reality.

• Amend legislation to make regulatory bodies accountable for supporting government health human resource planning.

• Create a pathway to keep health professionals engaged in health care in some way; for example, emergency medical personnel or ambulance attendants could be exposed to modularized training allowing them to branch into hospital operations.

• Leading edge health care research also helps British Columbia to attract and retain leading clinicians in our province.

• Focus on delivering a more integrated approach to health human resource planning; currently it is delivered in individual, professional silos.

• Create a set of indicators to mark successes in human resource planning.

• Evaluation should be integrated into policy decisions surrounding the vast complexity that is health human resources.

• Smaller, rural communities should have some level of authority when hiring health professionals.

• A prerequisite to any sort of human resource planning would be comprehensive method information gathering. Setting up stakeholder participation should include those who would be implementing the plan, having the research around the punitive need assessed and coming up with a legitimate needs assessment.

• Widen healthcare practitioner’s scopes of practice to better disperse their workloads.

• Health human resource planning should be performed in the context of operating teams and their individual roles within those teams.

• There is a need for a needs-based mechanism of distribution of healthcare personnel, which applies codes to regions in demand. Stop allowing practitioners to set up practice anywhere they see fit.

• Health human resource planning must take into account training, training spaces, promotion, and career laddering. There must be less focus on poaching from other jurisdictions, and more on the retention of the diagnostic, the clinical, and the rehabilitation personnel who already deliver services in the health care system. Laboratory technologists, x-ray technologists, dieters, pharmacists, social workers, physiotherapists, occupational therapists, and speech therapists have not been excluded from the planning.
• The shortage of health care professionals provides an opportunity to change the approach to care. The current model consists of one-on-one treatment, a doctor and a patient. However the current crisis should be used to usher in a team-based approach, with several different types of specialist attending to a patient’s needs.

• Utilize a health liaison as the initial point of entry into the healthcare system.

• If demographics prove that a large amount of patients are going to end up in institutional care, than a re-assessment of professional requirements should be in order. Highly trained professionals are not needed in these environments.

• The physician to patient ratio in mental health services should be no more than one to every thirteen patients. It may be expensive, but in the long run less expensive than repeated inpatient care. It would also reduce crowding in emergency rooms and free up specialists to see other patients.

• New graduates who are completing their required time in the public system should be required to staff twenty-four hour clinics.

• Registered massage therapists are a fairly young workforce, with an average age of around 30. Registered massage therapists can provide a long term commitment to the public health care system.

• When one talks of health human resources, one is talking about to some degree of expanding the labour pool and making it more flexible. The response to labour shortages in the private sector is to use less labour. We may be seeing self-serve coffee houses in the future if they cannot hire staff. A self-service oriented health care system may be the answer to the looming staff shortages.

• It is vital that the Provincial 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.

• Allow those at the front-line of the health care system to organize and implement health human resource planning. Those in managerial roles simply cannot get the right picture of what is needed.

• Directional planning and vision is needed when developing a health human resource plan. This structure would include:
  - Outcome assessments;
  - Information gathering;
  - Patient and population needs assessments;
  - A representative forum;
  - Implementation by stakeholders;
- Rollout; and,
- An Arms-length health research evaluation panel with a flexible timeline.

- Create a federal agency to investigate long-term demographic trends in health care.
- Develop a labour plan for British Columbia focusing on the continuum of labour potential from volunteers though various part-time work, to full time. This plan might include:
  - Incentives to volunteer, particularly covering costs of volunteering;
  - Lump-sum stipends for showing up to meetings or work;
  - Increase accessibility of training for the general public in medical matters, perhaps offering courses on things like first aid free of charge;
  - Offer free public seminars or workshops on health care aimed at increasing public knowledge of care and prevention of various conditions. Topics such as osteoporosis, cardiovascular care, asthma, and diabetes could be discussed;
  - Once a person is diagnosed with a problem, ensure health system has support groups to which doctors can refer patients for further information; and,
  - Train retired professionals to build supporting networks that provide information on where to get help, assist with follow-up to treatment programs to increase compliance.

- Align the Ministries of Advanced Education and Health on goals to address the human resource issues in British Columbia.
- Canada seems uniquely fixated on trying to produce just the right number of everything. Producing just the right number of health professionals is impossible, and any planning effort is therefore doomed to failure because circumstances change. The best strategy on the numbers side is to produce a modest surplus and see how that works out.
- There is a need for data at the unit level that could be used to dictate better allocation of health human resources.
- Follow the United Kingdom and Western Europe’s models on staffing ratios.
- Matching supply with demand of health professionals requires a greater collaboration between Treasury Board officials and the Health and Education Ministries. Funding, education, and health systems need to be collaborative as well as the professions
- Send more general practitioners to work in Northern British Columbia.
• Monies saved from streamlining hospital processes should be spent on hiring more trained staff.
• Reward those practitioners who do choose to work in rural and remote settings.
• Request high School students with musical talents to come in to long-term facilities once a week to play for residents.
• British Columbia should open its doors to newly immigrated and trained health professionals.
• Financial support should be made readily available to prospective and current midwives.
• Decrease segregation of students into trades streams early in high school and create awareness around their academic options in elementary school.
• Affirmative action is necessary to address the current staff demographics. The system is imperfect and favours certain people.
• Accommodate workers with a more flexible and manageable schedule.
• Aggressively expand recruitment and retention strategies to bridge the gap between training programs and service vacancies.
• Offer incentives for existing health care professionals to stay in their field, especially to those professionals approaching retirement age.
• The Provincial Government must offer child care and housing assistance for health professionals working in the north.
• Create an expanded role for the patient advocate.
• Maintain a positive image of the health professions through the airing of televised commercials.
• Create safer workplaces that are free from harassment and violence.
• Implement a reasonable graduated retirement plan that includes provisions for mentoring, part time work, community primary care, role changes, and locums.
• Offer signing bonuses to new professionals.
• Consult with the information technology industry for ideas on how to accommodate and motivate younger workers.
• The younger generation is looking more at sustaining their lifestyles outside of the work environment.
• Create an inter-provincial, multi-disciplinary group to tackle barriers to foreign/inter provincial recruitment.
• More focus on the recruitment of community health workers.

• Employ a better proportion of nurses, doctors and technicians to ensure an efficient response to treatments.

• Recruitment and retention teams set up by Government should be going out to high school students to attract youth to health professionals.

• Attract disaffected employees to return to work. If health care were better place to work, there may be a return of allied employees who quit due to their disagreement or dissatisfaction with the healthcare system.

• Subsidizing new students and forgiving student loans upon graduation and employment in the medical field will more than fill the void left by professionals leaving to the private sector.

• Training and honouring our health care practitioners should be much more important in our society than it currently is.

• Implement shorter shifts and lighter workloads to aide in retention of older nurses.

• Subsidize housing for all new practitioners.

• The children's hospital acute care facility is antiquated and the urgently needs rebuilding. It is imperative that we provide up to date facilities and competitive research opportunities in order to recruit these highly specialized professionals who come to us from around the world.

• Incentives such as scholarships and forgivable loans should be offered in return for five years practice in a remote location.

• Every region in British Columbia will need to develop its own recruitment strategy.

• Offer rural or isolation allowances to entice professionals to practice in remote locations.

• Increase the amount of General practitioners in British Columbia.

• Offer full-time pension contributions for those 55 years of age and who are working part-time.

• Increase the amount of permanent positions.

• Increase number of clinicians and life skill workers.

• British Columbia needs to stimulate new thinking to include males in nursing positions. Bring back job fairs at nursing schools for guaranteed job placement.

• Introduce candy stripers to provide small needs to patients as well as helping with feeding.
• Permanent nursing float pools in acute and residential care should be established in all health authorities. This would help the health regions to keep employees without losing them to the United States.

• Train and hire more homecare workers and pay them a decent wage for the tough job they are committing themselves to.

• Expand use of existing volunteer networks and offer financial support for these agencies.

• Develop recruitment tools aimed at ethno-cultural populations in rural areas so that they may serve the needs of those in their communities with a better understanding of those needs.

• Rurally trained professionals are more likely to practice within in their region of training. These professionals are also more likely to practice family medicine.

• Legislate all health professionals under terms of the Health Professionals Act.

• British Columbia is experiencing a shortage of doctors and nurses. Emergency ambulance crews are highly-trained and should expect some kind of security in their jobs.

• Implement a personal health navigator to ensure patients are receiving coordinated care at integrated health centers, looking at physical, emotional and psychological health.

• Have more than just researchers and lab technicians involved in caring for Phase-One clinical trial patients. Terminally ill patients are usually connected to community nurse and palliative care services in their home community. If their client opts to participate in a Phase-One clinical trial, those community services should connect their client with the equivalent services in Vancouver.

• There should be two main types of therapists; Clinical Psychologists and more narrowly-trained stream of therapists.

• With the exception of one central office, dieticians should be phased out. The remaining office would then be responsible for creating a dietician's electronic database that would be available Province-wide.

• There is a need for a full time volunteer coordinator.

• Create a registry of community services in order to identify and fill and gaps in necessary human resources.
• Midwifery should be better supported across British Columbia. Midwives practicing in northern British Columbia have the ability to admit women into hospitals. Women enjoy having the bond between a midwife and themselves in the pre and post-natal periods.

• Create a registry of community services in order to identify and fill gaps in necessary human resources.

• With the exception of one central office, dieticians should be phased out. The remaining office would then be responsible for creating a dietician’s electronic-database that would be available province-wide.

• Ideas about public versus private demand:
  • As long as doctors are working full-time treating patients, it should not matter whether they are in the public, private, or both systems.
  • I do not believe that doctors will flock from hospitals to the private facilities. I think they will work wherever there are interesting cases, as long as there is no huge disparity in the income. A heart surgeon or hip replacement specialist will stay within the public system if that is where those surgeries are.
  • A parallel private health system will at least keep health professionals in Canada.
  • Re-instate food and cleaning services to public sector positions.
  • By creating a public-private system that complements the needs of one-another, we can attract medical professionals to Canada and retain many of our own who would otherwise be heading to the United States.
  • Professionals should be allowed to work in either the public or private facilities. In the event of a conflict of interest, the public facilities will take precedence for service.
  • The Provincial Government controls the supply of professionals through its financing. When the budget is insufficient, nurses are laid-off or put on part-time hours and specialists are allowed only a limited number of operations. For example, an Orthopedic Surgeon finished his annual quota of operations earlier than expected; there is still an abundance of clients but he can practice no more until the next fiscal year. He should certainly be available to a private clinic for several months without affecting the public service.
  • Doctors have a moral obligation to provide universal health care.
  • The companies continue to make their profit and there is no other solution other than to bring the activities of these groups back into the public fold by paying appropriate wages and benefits.
• Private sector vacation time is dispersed throughout the year so as not to disrupt business. The Provincial Government should look at this model as one of the successes of the private sector.

• Any practitioner working in both the private and public sectors must provide at least fifty percent of their time to the public system.

• Address the current health human resource issues in some way that does not include privatization.

• Prohibit working in both public and private systems.

• Contract out all healthcare positions that do not involve direct patient care.

• Allow doctors the flexibility to operate within the public and private system. A practitioner could work two days a week in the public system, and three days in a private facility.

• Initially some health human resources will leave the public system to staff private clinics, but this will only occur in the early stages of the transitioning.

• Ideas about education and training:

• Increase the amount of seats, instructors and practicum spots available to medical students.

• Continue to expand British Columbia’s training capacity so that the Province can meet its current and projected human resource needs with the goal of being self-sufficient.

• Health professionals should be educated right from the start that they will likely have five careers, all in healthcare, all.

• Increase the number of residency training positions for Canadian medical graduates to a ratio of 1.2 positions per graduate.

• Fast-track the development of training programs for Physician’s Assistants in British Columbia.

• Place Nutritionists in public schools to address public health issues. Include speakers with emphysema to speak with students.

• Increase perks and incentive instead of lowering the standards of education to bolster recruitment.

• Increase 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.
• It is proven that professionals will usually stay within the region that they complete their practicum in. For example, Alberta will only allow Licensed Practical Nurses to complete their practicum within the province.

• Pair newly-graduated nurses with more experienced nurses to offer support and increase the amount of hands on, practical training.

• Create a system to train volunteers to assist medical staff with duties like feeding and running errands for the patients.

• The large amount of public money spent on overtime payouts would be better spent training and hiring new professionals.

• Utilize older and more senior staff to mentor new medical students within the hospitals.

• Increase training opportunities and funding for health science professionals.

• Apprenticeships help eliminate the shortage of trained personal.

• Create a mandate requiring newly trained professionals to practice within British Columbia for a pre-determined number of years, based on the subsidy level of their education.

• The Province must request its educational facilities to produce twice the number of professionals that are currently retiring per year.

• The only feasible way to counter the vacancies brought on by large numbers of retiring professionals will lay in the hiring of foreign trained professionals.

• Hospital training should offer a larger workload to interns. This would have the dual effect of increased hands on training for the student and less work for hospital staff.

• Nursing schools should return to hospitals. There, students would receive valuable hands-on training and address personnel shortages at the same time.

• Increase number of seats in post-secondary institutions.

• Grade 11 and 12 students should start in assisting in hospitals.

• Create a registry of long-term healthcare workers that have been convicted of abuse.

• There is a need for professionals with common sense, not just university degrees.

• Make midwifery an illegal practice.

• Address policies that block the hiring of more full-time personnel.

• List more alternative health care providers.
• Create a patient survey to determine what makes a good doctor. Create a list of best practices from this list and distribute openly to physicians.

• There is a need for more multi-cultural health care providers.

• There was a period in which midwifery was widely accepted. This period enjoyed shorter post-delivery hospital stays and a reduced demand on health practitioners during birth.

Recruitment and Retention

Concerns and Comments

Recruitment and Retention of Physicians
Recruitment and Retention of Nurses
Aboriginal Representation within Healthcare Practices
Region and Department Specific Demands
General Comments on Recruitment and Retention

• Concerns and comments on the recruitment and retention of physicians:

• British Columbia does have more general practitioners than the Canadian average but still fewer than almost every other developed country. Nevertheless, in 2004 89 percent of patients in British Columbia had a family doctor, the same percentage as in 1994, and higher than the Canadian average of 86 percent. However, there are concerns about the future supply of these physicians because an increasing number of newly graduated general practitioners 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.

• The shortage of General practitioners makes it extremely difficult for patients trying to find a family doctor that will accept them. Canada has fewer physicians per thousand citizens than most other developed countries, according to the Organization for Economic Co-operation and Development (OECD).

• We do have a shortage of doctors in Canada, but one must bear in mind that a large percentage of doctors, half of all Orthopedic Surgeons, leave practice within five years of graduation because they cannot find placement within their field.

• The aging of British Columbia’s practicing 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. Subsequently, an aggressive recruitment and retention campaign will be needed to bridge the gap between training programs and service vacancies.

- Any conversation on health is worthless until there are enough physicians within the province allowing everyone equal care and access to a family doctor.

- Of the 30 highly-developed nations in the world, Canada ranks 26th for the number of physicians per capita. More than 3.6 million Canadians and 150,000 British Columbians do not have a family doctor. Some 20 percent of British Columbian General practitioners plan to retire or move within the next five years, and 80 percent are over the age of 40.

- It is almost impossible for a newcomer to this province to find a general practitioner that is accepting new patients. These individuals and families then rely on walk-in clinics or the emergency departments making the system more inefficient, both at the hospital level and at the clinic level, where it is unlikely that a patient will see the same doctor twice in a row.

- A patient is not always guaranteed access to a General practitioner, even through a walk-in clinic.

- There is a potential danger in drastically increasing the number of physicians in the country. In the late nineties both Germany and Italy had such an oversupply of physicians that Germany had thousands of doctors drawing unemployment insurance, and Italy had many surgeons who were performing one surgery every two weeks. A large increase in the number of physicians in BC will increase healthcare costs and make it more difficult to bring in reforms which may require fewer physicians.

- People are unable to obtain a regular family doctor because there is a shortage of family practitioners. However, the number of doctors required in the system does not just depend on numbers in relation to population. Other factors, including the practicing patterns of the doctors in the system, the way that they are utilized and organized and where they are located, matter as much as the numbers. In the Canadian health care system, individual physicians guide these factors to a large degree. For many years, thanks to the dedication of physicians who worked long hours, and who were willing to live, and practice traditional medicine in small towns as well as in urban and metropolitan areas, these individual choices did not greatly effect the effectiveness of the health care system. However, times have changed, the medical system has undergone some major changes in the past 16 years, and the individual choices of a number of physicians has led to thousands of Canadians being unable to find a regular family physician.
• Before a General practitioner attends to a single patient, he or she must pay a full licensing fee and full Canadian Medical Protective Association fee. If he or she decides to slow down practice for a progressive retirement, their proportion of income will drop but their fixed costs increase.

• British Columbia requires approximately 400 new physicians each year to replace those who are moving or retiring. Projections show a continued decline in the number of physicians per citizen as British Columbia’s population grows and ages. Even with expanded training levels, British Columbia is not keeping pace. Sixty percent of family physicians in British Columbia now either limit the number of new patients they see or do not take new patients at all.

• Patients withhold information at walk-in clinics because they feel intimidated by their assessing physician. It is becoming increasingly difficult to find a family physician, and when one is found, they have so many patients that appointments cannot be made for one or two weeks. Patients go to walk in clinics or emergency rooms because they cannot wait a two week span to have their needs addressed.

• The availability of general practitioners who have or request their hospital privileges has significantly decreased.

• Around one third of Canada's obstetricians will retire in the next five years.

• The health care system is now seeing more women interested in being doctors and they are interested in a more balanced lifestyle. It is not hard to imagine why British Columbia is having trouble attracting general practitioners because they have the banker’s hours of Monday to Friday, eight am to five pm.

• The gender distribution of practicing physicians has changed dramatically over the years. Currently, more then 50% of medical graduates are females who may elect at some point in their career to limit their practice to start and/or raise their families. There have also been changes in the personal priorities of physicians generally, recognizing the need to balance work and family life.

• Concerns and comments on the recruitment and retention of nurses:

  • One third of British Columbia’s pediatric nurses are poised for retirement.
  
  • One third of nurses leave their profession in the first five years due to their high levels of stress.
  
  • There is no problem getting people into undergraduate nursing programs, the challenge lay in retaining them for five years after they have graduated, after they realize that the field of nursing will not live up to their expectations.
  
  • Emergency room nurse retention levels are a concern.
• There are no positive images of nurses in our society. Male students with a good grade point average would never be encouraged to be a nurse yet it is an exciting, challenging, adequate paying, flexible and global career.

• The closing of hospital beds disrupted many nursing careers. Many now rush around between several part-time positions in order to receive full-time pay, resulting in more stress on practitioners and poorer service given patients.

• Nurse Practitioners will be in very high demand as the need for health care professionals exceeds current graduation levels.

• Removing charge nurses from the system may have created a short-term financial gain, the rest of the nursing staff are now burdened with a heavier workload.

• British Columbia has lost many nurses by putting them on call, excluding employers from paying benefits. These nurses took up other professions that better appreciated their skills; the Province is now suffering the consequences.

• The Organization for Economic Cooperation and Development (OECD) predicts that by 2016, Canada will have the most severe of all OECD nations, with a shortfall of up to 31 percent compared with demand.

• A goal of the Health Authorities has been to significantly build up the number of residential care beds. However a nurse is required to service that bed and with two-thousand present nurse vacancies, this initiative poses a serious problem.

• Nurses trained with a geriatric focus or certifications are short in numbers.

• The recent pay raises granted Members of the Legislative Assembly would have been better utilized by hiring more nurses.

• Concerns and comments on Aboriginal representation within healthcare practitioners:

  • Aboriginal peoples constitute only 0.6 per cent of the nursing workforce, 0.1 per cent of the dental workforce, 0.2 per cent of medical practitioners, and 1.1 per cent of health services managers.

  • Most of the doctors working within Aboriginal communities are not from Aboriginal ancestry or background.

• Comments on region and department-specific demands:

  • Emergency rooms lack emergency specialists.

  • While the budget for British Columbia Ambulance Service has increased, the resources on the street have not kept up to the increase in demand for services.
• Summer long-weekends prove to be a very dangerous time to be admitted into a hospital as consultative and specialist staff are often unavailable or on holiday.

• New graduate nurses at the Royal Inland Hospital are lucky to get a long enough orientation let alone a signing bonus.

• The Interior Health Authority eliminated many of their Registered Nurses and is now probably paying more out in overtime and to travel nurses to fill the facilities with casual employees.

• Victoria is in great need for general practitioners.

• Okanagan medical service staff are leaving their practices in large numbers for employment elsewhere.

• Providing staff coverage for Vancouver Island intensive care units in the summer is challenging due to funding changes instituted by the Vancouver Island Health Authority.

• There are no local health care nurses in the Tofino area. There is also little in the way of housing or support for these health professionals as rent prices are very high.

• The town of Lytton cannot fully staff their health care centre.

• There is little incentive drawing practitioners to the Sunshine Coast.

• A local hospital has been forced to close their Intensive Care Unit numerous times because of no staff.

• The recruiting center for Northern British Columbia is currently located in Prince George where they hire health professionals for all the major centers and leave nothing for the remote rural communities.

• Increase the use of traveling specialists; only five visit Smithers on a frequent basis.

• There is a shortage of Registered Nurses in Northern British Columbia.

• Many health professionals tend to gravitate to the larger urban centers to be on the cutting edge of medicine.

• The city of Chase lacks physicians.

• The Royal Jubilee hospital in Victoria often lacks the necessary staff to perform renal dialysis procedures.

• Gabriola Island has a population of 4500 and three physicians with which to serve them. There is no after hours service other than an ambulance which simply transports people to hospital rather than treating problems in the community.

• One of the challenges that face the more remote communities is retention of health professionals. There seems to be little issue with attraction however physicians want
the opportunity to hone their skills. With small populations to practice on, they are not feeling they get to practice as much as they would ultimately desire.

- The Province, particularly Vancouver Island, is dramatically short of cardiologists.
- There are six over-worked pathologists in all of Vancouver that provide autopsies for Vancouver, the Yukon, and the Islands.
- Many First Nations communities and reserves critically lack doctors and nurses.
- Other provincial authorities are sending letters offering money training, and job placement for spouses to nursing graduates at Thomson Rivers University.
- Forensic psychiatry is offered by only one clinic in rural British Columbia. This clinic is responsible for serving the entire region between Hope and Clinton.
- It is clear that after six years of unsuccessful searching in Kamloops, Penticton, Kelowna and Surrey for a doctor accepting new patients that medical services are not being made available to all, but rather to those who can afford to go elsewhere for them.
- When I go to the Mary Pack centre for treatments, it is clear that the warm pool and physiotherapy tables are being underutilized due to lack of staff.
- The severe nursing shortage has forced the closure of an operating room in Vernon. This put an immense amount of pressure on the remaining nursing staff and left a newly recruited anesthesiologist out of work. The solution was to put more pressure on the nurse manager of the operating room staff, who is already under immense pressure to reopen the closed operating room.
- Ever since the Northern Health Authority laid-off many of their experienced maintenance personnel, the quality of and quantity of maintenance duties has suffered.
- Intensive care units are extremely understaffed, requiring nurses to call for outside assistance.
- There is a need to examine sick time and staffing levels across the province.
- Keremeos is suffering from a shortage of physicians.
- Doctors have a monopoly on providing services in emergency.
- What is the reasoning behind the staffing of emergency rooms mainly during the day? Clinics and General practitioners are openly available so why short-staff an emergency room at night?
- I am very concerned with the staffing ratios in Residential Care Facilities. More staff is needed in order to provide dignified care for the elderly. By more staff I am
referring to care aides. I know a certain amount of time is dedicated to each resident but different amounts of time are needed for each individual. Unless you have actually practiced this type of care, the math only works on paper and not in the real world. As it stands now, each care aide has between 10 to 11 residents to care for on a day shift, between 13 to 15 on an evening shift and 29 to 30 on a night shift. The bottom line is more care aides are needed not more management.

- There are secretaries working for secretaries with one job function for an entire day when there are only three part time cleaners for an entire hospital, and only two are available on the weekend.
- Specialty areas like Computerized Axial Tomography (CAT) have very few staff but are critical to timely and adequate care.
- There is no ward doctor or Nurse Practitioner assigned to post surgical units who can prescribe changes to medication regimes.

General comments on recruitment and retention:
- British Columbians expressed concern over a shortage of professionals in virtually all fields of practice.
- The College of Physicians and Surgeons is not responsible for the recruitment of physician human resources and cannot provide appropriately licensed physicians upon request.
- The regional health authorities are unable to recruit and retain financial and administrative staff.
- From 2001 to 2005, the total number of physicians in British Columbia increased by five percent; however, the ratio of physicians per population increased only by half a percent. Even with expanded training, physician supply in British Columbia is not keeping pace with population growth and aging. Between 1994 and 2001, the number of Registered Nurses per 10,000 residents declined from 74 to 68. This is the lowest nurse-to-population ratio in Canada. In 2005, the average age of a nurse in British Columbia was 46.4 years, 1.7 years older than the national average. In British Columbia, Registered Nurses aged 50 and older represented almost 40 percent of the 2003 workforce. In 2005, 47 percent of British Columbian physicians were 50 years or older, with 17 percent of them over age 60. 52 percent of British Columbian specialists were aged 50 years or older, while 43 percent of family physicians were aged 50 years or older. The number of General practitioners in British Columbia who are accepting new patients declined by almost 70 percent between 1999 and 2006 while the province’s population grew by 7.5 percent.
• Early intervention programs lack trained specialists like Occupational Therapists and Physiotherapists and premature babies are not getting the intervention treatment they require.

• Young people coming on stream now have much different mind-sets and values than those who are designing the system. If there is no effort to connect with the values of the younger generation than any recruiting effort will be a waste of time.

• There are not enough doctors and support workers to provide early intervention services for seniors.

• There is a lack in general access to Physiotherapy, Occupational Therapy, and recreation therapy.

• One-half of part-time and one-third of full time Pediatric physiotherapists will retire in the next five years.

• There is a shortage of child psychiatrists, which is resulting in many children and adolescents being unable to access specialty care.

• There are retention issues in the finance department of health.

• Grade schools lack recruitment and information regarding various health fields.

• The United Kingdom, along with many other countries and provinces, are actively recruiting Canadian Registered Nurses.

• The current system lacks incentives like signing bonuses when hiring new professionals.

• The availability of quality childcare is a critical recruitment and retention issue. Young people are dramatically impacted by the diminishing number of quality childcare spaces and unless health care comes to grips with that, there are going to be tremendous difficulties on the recruitment and retention front, regardless of how successfully we deal with other issues.

• Recruitment of health care professionals in British Columbia will continue to be a challenge as long as the model focuses on illness and disease instead of wellness and health.

• There are physical limits as to how much volunteers really can do to help.

• A greater use of volunteer services will result in a net loss in health care positions.

• There is a general lack of respect for volunteers and their services.

**Ideas and Suggestions**

**Recruitment and Retention of Physicians**
Recruitment and Retention of Nurses
Aboriginal Representation in the Healthcare Sector
Region and Department Specific Demands
General Ideas about Recruitment and Retention

• Ideas about the recruitment and retention of physicians:
  • Create and circulate a list of physicians practicing within British Columbia.
  • Hospital physicians should be on staff 24 hours a day, seven days a week in order to discharge patients during evenings and on weekends.
  • Regular access to a family physician would expedite the diagnosis of chronic diseases and allow health professionals to address them earlier.
  • The Health Authorities along with advisory input from the College of Physicians and Surgeons should hire doctors and the Provincial or Territorial Governments should be the ones to grant licenses.
  • Doctors should be under the direct supervision of an employer and must be working full-time equivalency in order to serve the public, whose tax dollars helped in the subsidy of their educations.
  • Allow physicians to operate in a more mobile function between facilities in major urban centres.
  • Introduce the role of the physician’s assistant to ease the burden on the doctor.
  • Have Homeopathic and Naturopathic Doctors included as point of access equal to that of a general practitioner.
  • Find ways of getting family doctors to spend more time with their patients.
  • The Ministry of Health should assign a personal physician to a Phase-One clinical trial patient upon their arrival in Vancouver. The Province could add that cost to the contract negotiated with the pharmaceutical company leading the clinical trial.
  • Pediatric specialists such as neurology, orthopedics, and psychiatry are required on an outreach basis.
  • If physicians were bound to the duties they were trained for, there would be more available doctors and fewer patients lacking a family physician.
  • Each and every British Columbian should have a Family Physician.
  • Consider implementing three practicing levels of doctor; specialists, general practitioners and junior doctors; responsible for treating simple medical illnesses. The junior doctor would complete two years of training on top of what is required for senior nurses. The pay scale would be higher than that of a Registered Nurse and lower than that of a Medical Doctor.
• Ideas about the recruitment and retention of nurses:
  
• Hire nurses back into Northern British Columbia with incentive programs.

• We need to show images of what nursing is really like, how rewarding it is and how diverse it is. We need to encourage young people to consider it as an excellent career opportunity in that you can set your own hours and travel the world. Nurses change people's lives and save lives too.

• Re-instate the head nurse within hospital wards.

• There is a need for home care nurses who have the skills and training to assist the elderly.

• The long delays caused by the College of Nurses when hiring a foreign trained Registered Nurse should not be a problem as operating room scrub technicians belong to a different governing body. This would consist of a cost savings and enable British Columbia to provide added services to the community, thus shortening wait lists.

• Hire and train more Licensed Practical Nurses and decrease the reliance on Registered Nurses as they are cheaper and faster to produce.

• Place Nurse Practitioners in community run walk-in-clinics, such as the Centre Local de Services Communautaires in Quebec.

• Hospitals must implement an aggressive recruitment program aimed at getting nursing numbers up to more acceptable levels.

• Place more Nurse Practitioners in emergency rooms to relieve the pressure on doctors and ambulance crew.

• Nurses should work full time positions instead of the majority of them working three part time jobs.

• California and Australia implemented set ratios of nurses to patients. This led to a dramatic increase in the number of Registered Nurses available for work because many who had left the profession came back, attracted by the prospect of manageable patient loads. While government and health care employers may fear that implementing nurse-to-patient ratios could force the closure of services during a nursing shortage, real-world application has proven otherwise. These ratios should be set by the Registered Nurses themselves in order to properly control their workloads.

• Hire social workers instead of nurses for jobs requiring an experienced social worker; for example geriatric emergency nurses at some Vancouver hospitals could easily be replaced by social workers, helping deal with the nursing shortages.
• Registered Nurses are highly skilled in administering shots and performing certain treatments, therefore they should be staffing clinics in support of physicians.

• Increase the amount of practicing street nurses in small urban and rural communities.

• There is no need for head nurses in long-term care facilities.

• Provide the patient more access to Nurse Practitioners for minor problems.

• Cleaning is not within the nurse’s scope of practice. There should be more effort to hire the proper support staff to take this burden of nurses.

• Gerontologists and nurse clinicians are needed in emergency, long term care, and in primary care clinics.

• Implement a nurse responsible for palliative care service co-ordination.

• Legislate the position of a triage nurse in emergency rooms. They would have the authority to send cases away to clinics if necessary.

• Some staff hold positions that they are not qualified for; clerks are overseeing Registered Nurses and making decisions without full knowledge and consultation on situations.

• Use operating room technicians to assist in operating rooms to alleviate the pressure on surgical Registered Nurses.

• Utilize Licensed Practical Nurses and Registered Care Aides to their full scopes of practice to help alleviate Registered Nurses workloads.

• Allow Nurse Practitioners to take over some of the more complex patients from doctors.

• There is a need for nurse clinicians in doctors’ offices to screen charts to ensure test results prior to seeing doctor.

• Expand the role, raise the pay, and offer new dress to Nurse Practitioners. These new Nurse Practitioners would staff walk-in clinics and compete to take some of the pressure off of doctors.

• Hire more Registered Nurses to monitor hallway patients.

• Increase the roles of the public health nurse to include preventative services.

• Promote the utilization of Licensed Practical Nurses in every British Columbian community as such a move would decrease the pressures placed on doctors.

• Nurses should triage emergency rooms and Nurse Practitioners should be the first line of care.
• Offer nurses incentive to remain in a full-time position in a specific ward with cash bonuses after every six months, extra time off with pay, registered retirement savings plan lump sum deposits and more access to educational opportunities. Show them they are an important part of the health care system and ensure that administration hears their voices by improving access to collaborative brainstorming and support sessions.

• Ideas about Aboriginal representation in the healthcare sector:
  • Recognize Aboriginal health team members and their contributions to bridge the gaps in health human resource planning.
  • Expand the role and implementation of the First Nations health liaison officer.
  • Increasing the number of Aboriginal health care practitioners is a priority and this should include:
    o Adequate resourcing;
    o Setting targets for training;
    o Developing programs to attract Aboriginal health care practitioners to remote areas;
    o Linking secondary and post secondary education avenues; and,
    o Expanding e-health and tele-health initiatives.
  • Aboriginal expertise must be consulted with when hiring, training, and making decisions such as traditional health accreditation.
  • Aboriginal nurses must be included and retained within the partitioning health field.
  • Implement First Nation liaisons in hospitals to increase communication for discharge planning and home care
  • The Saskatchewan Association of Health Organizations considers the First Nations population as possessing a large number of young, potential health professionals. British Columbia should be investigating the same possibilities.
  • The federal government must support first nations nursing.
  • Offer First Nations graduates bonuses to return and practice within their communities.
  • First Nations youth must be encouraged to enter into occupations in the healthcare field.

• Ideas about regional and department-specific demands:
  • The British Columbia Cancer Agency requires a Pediatric Anesthesiologist on their staff.
• British Columbia does have many new medical graduates and is often finding placement for these new professionals in Northern British Columbia.

• A requirement for Physicians completing their practicum should be a certain amount of practice outside of Victoria or the lower mainland.

• Place doctors and specialists from outlying rural communities back in the local hospital.

• Attract more emergency room physicians, general practitioners, and other allied health professionals to the coast by improving diagnostic and treatment equipment and supporting affordable housing for professionals.

• The Provincial Government should look at forgiving student loans to those who commit to practice in a rural setting for a period of time.

• Increase access to mental health and addictions services in Northern British Columbia.

• Create a team of traveling specialists who can be flown to anywhere in the province on a moments notice.

• Place a security guard at the entrances to emergency rooms.

• Adequately staff health care teams practicing on British Columbia’s populated islands.

• Northern hospitals require more volunteers and staff to be able to assist patients with mobility issues.

• Northern health service providers should be able to rely on technologies such as tele-communication and a greater use of e-tools such as power chart, electronic medical records, and video conferencing.

• Utilize ambulance crews in a more efficient manner; they should be picking up patients and saving lives rather than sitting in emergency departments awaiting the admission of their patients.

• Create or increase Northern allowances to attract professionals trained in mental health and addiction counselling services.

• British Columbia’s metropolitan citizens have access to world-class health care.

• Ensure optical surgeons are available to regions of British Columbia.

• Northern British Columbia requires an outreach Pediatric Psychiatrist.

• Clinics that cater solely to long-term chronic disease are in need of trained specialist staff.
• Place an enterostomal therapy nurse in an Okanagan hospital, which can help deal with ostomy issues.

• Although Dawson Creek requires a the services of a radiologist, however these services can be delivered by a practitioner in the lower mainland using e-communication tools.

• The Matsqui-Sumas-Abbotsford general hospital must increase their capacity to offer psychiatric services to their patients.

• Rotate staff through urgent care and emergency rooms to decrease burnout.

• Increase staff at known times of increased utilization such as long weekends and during the summer months.

• Mandate better use of Physiotherapists and Occupational Therapists in residential care units.

• Long-term care facilities require more staff to address the needs of their residents in a more efficient manner.

• Have Naturopathic Doctors on staff at hospitals.

• Emergency departments require and increased in the number of staff on hand over weekends and holidays.

• The British Columbia Cancer Agency needs a child Anesthesiologist on staff.

• By properly allocating human resources, the Province could staff extra beds. One Nurse Practitioner could run an entire ward filled with geriatric overflow if Licensed Practical Nurses and Registered Care Aides were hired to work under his or her guidance.

• Open operating rooms 24 hours a day, seven days a week so they may be better utilized to address the wait lists.

• The hospitals themselves must hire cleaning and kitchen staff in order to ensure fair pay.

• There should be more social workers or advocates trained to listen and try to settle people down when they arrive at emergency confused and scared; thus freeing nurses from dealing with this mundane task.

• Eliminate the positions held by Hospitalists and employ dedicated staff doctors.

• Cancer centres would benefit from a patient and family counseling department.

• Hospitals must increase the number of physiotherapists available to all departments.
• More long-term staff are required to reduce the time to respond to the needs of long-term care residents.

• There is an acute need for trained mental health workers in all aspects of health care.

• General ideas about recruitment and retention:

  • Money may not be the only factor in attracting a good working force to any organization. Other important factors in recruitment and retention of health professionals are:
    o Stability of work;
    o Congenial working environment;
    o Adequate holidays well covered by available locum;
    o Continuing education & research opportunities;
    o Recognition of excellence; and,
    o The chance for promotion.

• There is a need for a full time volunteer coordinator.

• Hire enough staff to properly clean and sanitize hospitals.

• Staff do not need to receive bonuses at year end but free parking or flexible start times, or even an earned day off could be used as incentive to stay at a job.

• By allowing younger persons to volunteer in hospitals, we may be stimulating an early interest in an occupation in the health care field.

• Rotate doctors from cities and rural areas. Both can learn from the experience and both can realize what the other is up against.

• Allow professionals more recognition, flexibility, the opportunity to train and mentor new staff, and the opportunity to learn new skills. Apart from being burnt-out and demoralized, hospital staff prefers to stay in the sector. Ask them what it would take to keep them within the system.

• To improve the work environment, an effort must be made to initiate more flexible work models for health care providers at different ages and stages of their lives.

• Reserve housing neighboring hospitals for health professionals and their families. This would be especially beneficial for the recruitment and retention of staff in rural areas.

• First and foremost we must recruit and retain family doctors with long term lucrative contracts for both the doctor & the health authority, maybe by using peer to peer recruiting.
• The health care system must attract, train, and compensate care aides to enable seniors to age in their homes.

• British Columbia has many isolated, yet populated islands requiring the service of Nurse Practitioners, Physiotherapists and Occupational Therapists.

• The education system must respond to the health human resource shortages by providing a greater emphasis on completion of high school, a focus on science-based education, an orientation to university education, and the capabilities of local students to achieve professional levels of education. A component of this could be greater mentoring from local professionals and visitations from former residents of rural communities who have achieved such educational and professional goals.

• Increase the amount of practicing midwives in British Columbia.

• Job redundancy is becoming more common, thus an effort to cap the amount of practitioners in these jobs is needed.

Leadership, Administration and Management

Concerns and Comments

Staff Scheduling
Remuneration
Healthcare Administration

• Comments on staff scheduling:
  
  • What kind of service can you expect from a medical team that has been at work for almost twelve hours? It is silly to believe that the average doctor or nurse is delivering good patient care after eight hours on-duty. What is efficient about a system that encourages long hours of unproductive work?

  • Surgeons and anesthetists are not available around the clock.

  • Staff shortages should not be attributed to a lack of workers, rather they are due to wasteful allocation of employee hours and triple over-time.

  • Nurses with families are finding it difficult to maintain their credentials due to the inflexibility of their scheduling.

  • Primary care physicians are working short weeks in order to maintain a decent work-life balance. Unfortunately this means that patients cannot access their doctors in a timely manner.
• Doctors may not want to work the hours that they have in the past such as one week on followed by one week off.

• A nurse working a shift on a long statutory weekend can earn approximately the equivalent of one full week of day shifts. This is possible due to lucrative stat holiday pay, shift differential and weekend pay. If the nurse should not finish work on time and requires overtime, the hourly rate increases phenomenally yet again.

• Within home support staff, there is a growing trend to utilize casual hours or split shifts, which means community health workers must be available within a ten hour window, but often end up working and getting paid for a few hours in the morning and a few in the afternoon with nothing in between.

• Emergency room nurses are overworked, putting in extremely long hours with no choice.

• Comments on the remuneration of health professionals:
  
  • The problem is not a shortage of human resources but poor allocation of money with which to pay them.
  
  • Publicly employed and unionized cleaning and cooking staff were compensated much more generously than private sector staff.
  
  • Why would a paramedic in their right mind want to receive twenty dollars of pay for a ten hour shift when they could have made many times that working another job.
  
  • The Health Employers Association of British Columbia has created a huge gap in wages between Registered Nurses and other specialized health professions such as Respiratory Therapists. This discrepancy will increase to seven dollars and hour by the end of the current contract. How does the Provincial Government plan to attract new students into respiratory therapy when they are treated as second class professionals?
  
  • A Specialist will earn up to forty per cent than a family physician per annum.
  
  • Simple economics dictate the shortage of doctors in Canada. Those within the system benefit from a shortage of doctors. The less available doctors are, the more visits are required per doctor, equaling a better income for these doctors.
  
  • There is little doubt that the new generation of health care employees will demand and receive higher wages and better benefits. Those costs will be higher if we do not begin to train larger groups of professionals.
  
  • A physician willing to enter geriatric medicine will encounter too many financial disincentives to even begin practice.
In the past, addressing rural health human resource planning came down to just paying more to those who choose to practice in the communities. What we continually hear from people now is that it is about the money anymore. Most healthcare professionals are practicing their high level of skill, they are reasonably well paid and they possess good technical jobs. An extra five percent over two years is not going to make them happy people. These rurally operating practicing professionals are just incredibly unhappy on the frontlines.

- Doctors are only allowed to bill one visit per patient per day
- The current physician remuneration structure is not conducive to employing duty doctors.
- The fee-for-service model limits the amount of time a physician can spend with their patients.
- The generous pay-outs and severance packages to management staff are an unacceptable waste of taxpayer monies.

Comments on healthcare administration:

- The current health care system is burdened by an excessive amount of administration.
- How can the current administration say that healthcare is working well and at the same time implement layoffs of highly skilled practitioners?
- There seems to have been a rapid increase in the number of middle management positions that often overlap and have no tangible or measurable impact on the delivery of health services. These positions have also led to the removal of many talented nurses and technicians from the front-lines.
- Some staff are being promoted rapidly into high-level leadership roles, yet they possess no proper skills.
- Healthcare lacks the training regimes required for employees transitioning into managerial roles.
- We do not need more managers and administrators as those that we have need to do more than socialize. They need to manage and make decisions.
- Health administration responsibilities have moved to business representatives with good resumes.
Ideas and suggestions

Staff hours and Scheduling
Remuneration
Healthcare Administration

• Ideas about staff hours and scheduling:
  • Occupational Therapists and Physiotherapists must work more than Monday to Friday, 8:00am - 4:00pm.
  • The system does not work well without part time staff. Part time staff afford a degree of flexibility to accommodate seasonal and other variables in workload requirements. Full time positions do not allow for reduction in working hours.
  • Regular and predictable hours are required to recruit and retain qualified community health workers.
  • Allow employees to set their own schedules as self scheduling allows flexibility and more room to schedule work around other commitments.
  • Hospitals should require staff to work no more than eight hours at a time.
  • If the agreed Government employee work week is 35 or 37.5 hours, overtime should not be paid until this weekly allotment of hours has been achieved.
  • An effort must be made to end the excessive overtime hours required of British Columbia’s health professionals.
  • Both management and the unions need to offer more flexibility in scheduling such as increasing the use of split shifts.
  • The Provincial Government must work collaboratively with other public institutions to create permanent, full-time positions for health care personnel.
  • Doctors, especially emergency room physicians and interns should work no more then 12 consecutive hours and have a rest period that matches their working hours; for example if a physician works ten hours, they must then rest for ten hours before they can practice again.
  • I am quite shocked that nurses are required to extremely long shifts. Arrange their shifts so that they are more sensitive to the sleep patterns and the needs of a person's body.
  • Hire more staff and utilize them on a 24-hour schedule not 12 hour schedule.
  • Scheduling for premium shifts such as statutory weekends and holidays should not be available to those working only for their own personal gain.
• Staff may be taking two hour lunch breaks and one hour coffee breaks due to the nature of extremely long shift scheduling.

• The nurses should only work nine hour shifts with a one hour overlap to relay information to the new shift.

• Increase the amount of full-time or permanent part-time positions; doing so will rebuild health care teams, stable workplaces, and decrease the fragmented care given by tired part-time workers working in between facilities for full time equivalency.

• Some staff are required to put in extremely long hours, while others cannot seem to get enough hours. A formal appeal process is necessary for these types of incurrence’s along with a high-level supervisor to delegate hours fairly.

• Ensure that family caregivers are given time off that is paid for by the Government.

• Health authority management should have their holidays cancelled and be required to assist care facilities that are under-staffed during traditional holidays.

• Ideas about remuneration:
  • Compensate general practitioners for specialized health care instead of forcing them to refer many patients to specialists.
  • Raise nurses’ salaries to create more interest in the profession.
  • Pay doctors and nurses better for their excellent service.
  • In return for subsidized training, British Columbian physicians should be required to practice for at least five years at a substantially lower rate of pay.
  • New doctors need a salaried employment, effectively bringing an end to the doctoral monopoly and more focus towards a multi-disciplinary clinic-environment.
  • European countries have historically produced more medical doctors per capita than we have, and they pay them less.
  • Physician billing based on a fee-for-service basis, has changed how a physician attends to a patient. Salaried physicians would decrease the amount of extra money billed for on explorative procedures.
  • All doctors should be employed directly by the Health Authorities.
  • Address the pay inequities for personal care aides working as home support workers.
• There are too many specialists and not enough family physicians. Family Practice could be encouraged through higher salaried remuneration.

• Support staff must receive adequate pay and benefits to insure proper staffing for home support and assisted living.

• Caregivers require adequate financial coverage for the cost of their supplies.

• It would be advantageous if fee guidelines provided incentive to Family Physicians for early recognition or early diagnosis and provision of care to people affected by dementia.

• Create a system that grants pay raises to all practicing health care professionals instead of individual practitioners. Under that same system, cutting pay would require universal cuts in salary, so that no one practice or practitioner is singled out.

• Ideas about healthcare administration:
  • Internal promotion of administrative staff is much better than tendering expensive contacts to private sector individuals.
  • Implement an independent audit to determine the number of peripheral administration staff compared to front-line workers.
  • The Provincial Government must reduce the amount of administrative personnel in the health authorities and turn the savings over to the front lines by offering more permanent positions. An increase in .5, .7 and .8 positions to Registered Nurses and Licensed Practical Nurses, with greater flexibility in their shift rotations.
  • Ensuring that administration is granted flexible scheduling will help in addressing the shortages and poor retention.
  • Hire people who have proven themselves in the business world to run British Columbia’s hospitals as most academics tend to be idealistic and impractical.
  • Professional administrators are required in hospitals to ensure that everyone is doing their job to the best of their ability and in an organized manner.
  • Do away with the upper-level lawyers and bureaucrats in the system today. Offer more authority and control to the front-line employees. This would both reduce staffing costs and increase the operational efficacy of the health care system.
  • Lay off around fifty percent of the administration of health care.
  • There is a need for strong front line leadership and reasonable span of authority to ensure success at operational level.
• Medically trained personnel want their superiors to possess medical training of some sort.

• Have hospital administrators and executives work at least one day and one night shift a month in the areas they are responsible for. Have them buddy with any of the health care workers they should be answerable to.

• Increase the amount of front-line supervision to discipline and support front-line workers. Have designated duties at designated times. Have a floor supervisor who supervises all aspects of care from janitor to nurse.

• Invest time and money in leadership development which helps retain staff and improve morale.

• Offer site managers orientations for consistency.

• Get rid of the dead weight on top and use that money to put into the people who actually do the physical work with the residents you could make a big impact in the health care system.

• At the unit level you need someone who brings leadership and management, because leadership is about having vision, and if you are looking at how practice should unfold, there needs to be somebody there who's got the capacity to articulate that vision and inspire the staff on the unit to achieve that vision, but you also have to have some of those management skills.

**Labour Relations**

**Concerns and Comments**

**Collective Bargaining**

**Unions and Professional Associations**

**Essential Services**

• Comments on collective bargaining:
  
  • Labour codes are affecting private contract work.
  
  • Too much health policy is negotiated into the context of a collective agreement.
  
  • Collective agreements place restrictions on some practitioners’ ability to do their jobs.
  
  • The Provincial Collective Agreement of April 2006 was forced upon nurses.
  
  • Governments, employers and unions are always in a state of conflict. Governments and employers want to cut the number of union members who are
delivering services and it all comes down to saving money and lowering the quality of care.

- There is little time for re-negotiations.
- Our worth has not been acknowledged through collective bargaining and we have been walled in.
- Long-term contracts are only valid for one year.
- Collective agreements are forcing nurses to work overtime.
- Interior Health Authority employees may not speak publicly about their work environment unless approved, and subsequently fear losing their jobs if they speak out. Physicians can speak publicly because they are not Interior Health Authority employees. As a result, the public believe that nurses have no complaints.
- Those working in healthcare have no motivation to change the system due to a conflict of interest. Process improvements and efficiencies might mean a loss of jobs.
- High wages, high benefit packages and strict guidelines on job descriptions create cutbacks in other services.
- A successful business would never treat its employees the way that the healthcare system treats its workers. There is a disregard for contracts, unsafe, unhealthy, and unproductive work hours, planned avoidance of benefits and generally adversarial treatment of health care workers in all sectors.
- Labour agreements offer relative stability and some opportunity for planning.
- Most people believe in the fairness of collective bargaining and the right to earn a wage that can support a family.
- The nature of contracts between doctors and the Medical Services Plan needs to be reassessed.
- Introducing competition requires public-sector employees to be more accountable for costs and quality of the work they perform.
- Being held accountable does not always inspire cooperation in the public sector; more often, it stirs up hostilities.
- A large portion of hospital costs are associated with compensation packages.
- In a system where people are covered by a labour agreement and only have to sign in as to when they start and end work, there is potential for abuse.
• Comments on unions and professional associations:
  
  • We have a heavily unionized workforce with too many processes and paper work.
  
  • The gatekeepers of healthcare are self-employed and have vested interests.
  
  • The British Columbia Medical Association is a very strong union and lobby group. They serve their members and control the health care system.
  
  • Shift work and long shifts are affecting quality of patient care and are not cost effective. Nursing unions fought for the twelve hour shift, but perhaps this position needs to be re-visited.
  
  • Restrictive work practices protect union jobs but ruin productivity.
  
  • Unionized employees in hospitals have very light workloads.
  
  • Unionized employees are safe even if they are not doing a satisfactory job or treating patients poorly.
  
  • Unions are cutting off volunteers such as candy stripers and outpatient aides.
  
  • Unions are afraid of losing membership and control over the delivery of health care in British Columbia.
  
  • Unions use fear tactics and smear campaigns to lobby British Columbians into believing that private care is a vice of greed, as opposed to a model of efficiency.
  
  • Unions control the debate on health care spending and reform.
  
  • British Columbia is heading in the direction of a health care crisis, with an aging population and powerful unions that are reticent to change.
  
  • There is a climate of confrontation within trade unions.
  
  • Contracting out is an attack on unions.
  
  • The British Columbia Nurses’ Union will not let nurses work part time; they insist that they be paid full-time benefits. Even teachers do not have this right.
  
  • Nobody has the courage to take on the unions.
  
  • Employees who do outstanding work are not being properly encouraged or recognized.
  
  • The only people who do not want more private involvement in the delivery of healthcare are the unions.
  
  • Public sector unions have a major influence on the system, raising loud protests whenever any improvements are proposed.
• The unions are too strong in British Columbia. Managers are unable to manage because they are afraid of the unions. There is no accountability for most health care workers.

• Government unions that strike are in the wrong. They are paid very well and have benefits and pensions. They are being paid more than they are worth.

• There is a problem with unions concerning seniority and work schedules. There are nurses who are willing to work, but not the schedule they have been offered.

• The British Columbia Medical Association is acting more like a union than an advocate for system improvements.

• Unions will cooperate if things are restructured and there is authentic participation where people relinquish some control.

• The number one problem in health care in British Columbia is the Health Employees Union, the British Columbia Nurses’ Union and the BC Medical Association. These special interest groups control and manipulate the health care agenda in British Columbia.

• Unions control the medical system. In a professional area such as health care, it should be an option to join the union.

• The unions are dictating public policy and how health care is delivered.

• When there is a union, prices cannot be controlled.

• Unions have too much power; nurses are not disciplined when they are not fulfilling their job description.

• Too much money is wasted while the public is being manipulated by the unions.

• The unions do not want a change and that is why the system is inefficient.

• There are empty beds in hospitals that are waiting for someone in the proper union to clean them.

• Unionized workers who work beyond their requirements are reprimanded by the unions.

• Unions are holding the health care system hostage, and necessary changes cannot be made as a result.

• The high price of labour unions is one of the most costly parts of our health care system.

• Private clinics are able to provide efficient and accountable health care. Workers are proud to work there and deliver quality care. This is because there is no union.

• Some of the union-related issues are not as complicated as we might think.
• Fee-for-service rewards quantity over quality, and is unfair to the patient and the health care provider.

• The British Columbia Medical Association has too much power. It has placed too many limits on cost-efficient options like midwifery, pharmacists being able to distribute prescriptions and expanding the responsibilities for Nurse Practitioners and paramedics.

• The proposed governance structure for the College of Dental Surgeons does not allow for Certified Dental Assistants to have a voice in the future of their profession. Certified Dental Assistants are appointed by the College of Dental Surgeons of British Columbia, and not elected by the constituency that they represent.

• The British Columbia Medical Association (BCMA) has a vested interest in not improving the system and maintaining the inefficient status quo.

• The basic problem with the health care system is that it does not focus on health. The College of Physicians and Surgeons have a monopoly on public health care dollars. They have joined forces with the pharmaceutical companies and the focus is on making money.

• There is no professional link between Licensed Practical Nurses and Registered Nurses, which is a major problem. Their interests are in conflict.

• The Canadian Medical Protective Association is putting physicians in a place where they do not feel they can engage other professionals regarding insurance liability because of the risks they are assuming.

• The Canadian Medical Protective Association is an amoral organization that suppresses the injustices committed by their members, and is protected from legal action taken against them.

• It is organized labour that protests private health care. This may be due to private facilities not being unionized, and organized labour losing membership as a result.

• Unions lobby for their own interests and not for those of the general public. Their arguments are based on employee rights rather than patient needs.

• Physicians go to school for many years to learn how to diagnose and treat patients. It is unfortunate to see their governing body place unnecessary restrictions on their practice.

• Health care unions are concentrating on protecting their interests as opposed to doing what is best for patients and taxpayers.
• Government financed services do not have to be provided by government employees. Union rules just add unnecessary costs to health care delivery.

• The public system is driven by seniority and not performance, which breeds complacency.

• Legislate all health professionals under terms of the Health Professionals Act.

• Public sector monopolies increase the cost of healthcare, maximize the labour required to perform work and reduce the money available for patients and the medical care they need.

• Without any competition from the private sector the unions have extracted unsustainable employment situations.

• Public sector unions are politically motivated organizations. It is questionable whether the priorities of union leaders are focused on patient care.

• Those who are in a position to profit from healthcare are the public sector unions, doctors and others who benefit directly by the elimination of forces of competition.

• Comments on essential services:

  • Hospitals are not being run as efficiently as they could be due to notions revolving around time off work. Health care professionals do not see the importance of providing service twenty-four hours a day, three-hundred and sixty-five days a year. Unions are also to blame for perpetuating these types of demands in their contracts. Nurses, for example, wish to be home with their children on weekends during the school year. This is not practical.

  • Non-essential health care union employees are draining the system. Unskilled employees have wages that are too high and they have too many benefits.

Ideas and Suggestions

Collective Bargaining
Unions and Professional Associations
Essential Services

• Ideas about collective bargaining:

  • Contracts and budgets should provide core services for regions based on present and perceived future demands. It should be reviewed regularly with a small flexibility within these budgets to deal with unforeseen circumstances. The services would then become less politicised and allow for yearly planning.
・ We need good Samaritan laws to protect health care providers from lawsuits.
・ There needs to be a process for requesting a review when something fundamental has changed.
・ We need to write performance-based contracts.
・ Do not negotiate contracts with large severance payments if the employee proves to be unsuitable.
・ Revamp the collective agreements to have fluidity, to enable health professionals to move between working in a physician’s office one day, in a home care clinic the next, and in an office the next day. The ability to move around to certain locations should exist without losing seniority.
・ Bring all medical professions to one table to be involved in the change process, and to facilitate an integrated bargaining approach. Single representation will result in a focused approach.
・ We need to retain health professionals by honouring collective agreements and providing the tools and environment they need to do their best work.
・ There should be flexibility in collective agreements to address emergency room requirements.
・ Contracts for health professionals should include mandatory time spent working in a rural area.
・ When hospital employment contracts are signed, salaries and benefit packages should be published. If it was known what those costs were, there would be fewer walk-out threats or strikes, and labour costs would be more reasonable.
・ There should be less sick time for health care workers. The first sick day of a stretch of illness should be unpaid. This would stop workers from phoning in sick simply because they want a day off.
・ Have a health care negotiation system that removes the threat of withdrawal of services by professional associations and organized labour during contract negotiations.
・ Health care, public service contracts should be objectively reviewed. Anti-productive clauses should be modernized to focus on patient care versus union benefits.
・ Whatever nurses want they should get, within reason. Other hospital employees should get whatever they want as well. The cleaners have a very difficult job and should be rewarded.
・ We need to create career positions rather than casual and part-time positions.
• We need to have more flexible hours especially for employees who have worked over a certain number of years.

• We need a team approach to management where everyone has ownership in the jobs and can see their part of the big picture.

• Allow nurses to speak publicly without consequences, and be able to share what their work-life is really like.

• There needs to be whistle blower protection when someone reports financial abuse in the system.

• All nursing disciplines should be under one collective agreement, like the Nurses Bargaining Association.

• There needs to be more representatives on the bargaining committee, including Northern Health Authority representatives, who are health care providers and not from human resources.

• Maintain social contracts. There is an expectation that the public system will be there when it is needed.

• There should be better relations and more collaboration between labourers and management.

• Honour the collective agreements.

• There needs to be open dialogue between professions, and bargaining units.

• The government should better understand the needs of health care workers and come to the bargaining table in good faith.

• Collective agreements present barriers to team practice. They need to be altered to take collaborative practice and teams into account.

• Ideas about unions and professional associations:

  • The standards and ethical practices of doctors needs to be monitored by an independent body, and not the British Columbia College of Physicians and Surgeons, who are biased and too lenient on doctors who receive serious complaints.

  • We should increase cooperation between the health authorities and the Hospital Employees Union. The liaison between hospital administration and those doing the practical work needs improvement. There is too much wasted labour and funding.
We need to work on developing a positive relationship between the Ministry of Health and the board of examiners in optometry. There is room for improvement in the development of bylaws and changes in regulations.

Unions and associations should review their current language, policies and regulations to open up employment opportunities.

Unions need to be reminded that their work is health care.

The government needs to stand up to the unions. Unions are controlling the health care system and protecting those who are not doing their job.

Be firm and resistant to special interest groups and unions.

Improve health care by eliminating the unions. Overstaffing and sick leave abuse are robbing the health care system of millions of dollars.

Only fully unionized workers should be employed in health care.

We have to remind the unionized employees that the system is a public one and not there solely for their benefit.

We must retrieve our health system from the hands of the government unions. This is the first priority.

Health care needs to be streamlined. Services that can be provided for less money like the laundry services, or food services should be privatized and non-unionized. These are low-level positions that anyone can perform adequately.

Shift the power to management and decrease the focus on unions.

We need to find ways of moving past the union-management adversarial model.

There needs to be more understanding between management and the unions so that client service remains the most important issue.

Doctors should be eliminated from professional unions.

Building a collaborative practice requires meeting with different unions and working through the issues.

We should stop trying to break the union and, instead, cut wages for upper management.

The health care system is so massive that it generates its own momentum and its own economy. We have to find a way for the system and the unions to shift their emphasis. Job security and job rigidity need to be separated. Job security is a good thing, but job rigidity is not.

Unions need to take ownership and contracts need more flexibility.
There needs to be consistent and fair rules regarding employing nurses from other countries. Unions often complicate this situation.

A better use of volunteers could save the health care system money.

Nurses belong to a strong union and this is part of the problem. The government should have more control, and be doing more than just paying wages.

There needs to be more collaboration among all unions and the government on needed changes in health care.

We need to work with unions to make the system more flexible.

When the government provides more health care dollars, it is benefiting the unions. Current contracts should be cancelled and all health care employees should have to reapply and re-qualify for the same positions.

The current mandate of the Canadian Medical Protective Association needs to be changed.

The government needs to strengthen its role in dealing with health professionals to ensure interest groups are not responsible for making decisions.

Legislation needs to be changed to reduce the influence and power of the British Columbia Medical Association.

Licensed Practical Nurse training should be recognized by the Registered Nurses Association of British Columbia.

We should attempt to get all health professionals under the Health Professions Act.

Reduce the lobbying power of associations and unions who restrict practice.

There needs to be positive relationships between unions and management.

We need to increase accountability for health care at the provincial level. Each British Columbian should receive an annual statement of health care system usage.

WorkSafe British Columbia should track claims to find those who abuse the system.

Ideas about essential services:

If strikes go on for longer than a week, it should be law that all of the striking workers can be replaced.

The focus should be on delivering health care to patients. All non-essential jobs should be privatized.
• Health care is an essential service. It should not be subject to union whims and disruptions. Mediation and meaningful negotiation is important but striking should not be allowed. There should be no right to strike in any government service.

• The right to strike should be eliminated.

• The cost of union contracts has been enormous. Has data been collected to assess the effect?

• What is the purpose of the British Columbia Nurses Union, the Hospital Employees Union and the Health Sciences Association of British Columbia? What are their mandates? They need to be held accountable for their roles in perpetuating problems within the health care system.

• How do doctors manage their patient loads and still make time to stay current on new drugs and treatments?
Training

The Conversation on Health frequently focused on the education of British Columbia’s current and future workforce. Tuition costs, space and demand for educational seats, and models of education were commonly discussed. Participants addressed Multi-disciplinary training and the continuing education of health professionals. Here is a selection of what British Columbians had to say on the subject of the training of health professionals.

Tuition Costs and Training Fees

The Conversation on Health received a considerable amount of feedback about the cost of medical education in British Columbia. Some are concerned about large student debt-loads driving health professionals out of the province in search of higher pay. Others believe that high tuition fees are deterring lower-income students from entering medical studies. Several discussions suggest fully subsidizing health professionals’ education in return for spending a number of mandatory years practicing within the Province, similar to the education pay-back model that exists in the military. Some participants extend the requirement for service specifically to rural and remote locations, while others suggest compulsory practice solely in the public sector. Participants believe that critically understaffed health care disciplines could be filled by targeting subsidies to those training programs.

Space and Demand within Educational Institutions

Numerous participants describe the number of medical students currently being accepted into universities and colleges as insufficient. They think that this number would not meet the current or projected demand for trained staff and call for an expansion in the available post-secondary medical, technical, and health science seats.

Much of the discussion also focuses on access to the seats currently available in post-secondary institutions. Some participants believe that professional colleges and associations are overly-protective of the spaces for medical education, which, they argue, prevents many qualified students from beginning study for several years and possibly discourages them from entering a medical profession. Many also voice concerns about the accessibility of educational institutions for residents in northern and rural areas of the province. Some participants recommend the expansion of
private education to create more available space for prospective medical students in British Columbia.

_We have an increasing tendency to ramp up entry-to-practice credentials…it is denying working class kids an entry into many professions, and it's exacerbating the shortages._

- Focused Workshop on Health Delivery, Vancouver

Models of Education and Training

Many agree that British Columbia’s health practitioner training models require changes to produce the graduates needed to meet current workforce demands. Participants cite restructuring mental health training to increase its accessibility to all professionals and expanding clinical training opportunities to address a deficit in practical, hands-on training as examples of necessary change. Many participants also call for an increase in the number of internships and mentoring positions for students. Others recommend that senior professionals should be retained past the retirement age to mentor the new students.

Some participants emphasize that, although these reforms are necessary, they will place more stress on the already thinly-stretched health human resource pool. To overcome this difficulty, they suggest laddering or bridging programs, which would allow Licensed Practical Nurses or care aides to practice while upgrading their educations. Other suggestions include: reducing the four year registered nursing degree to a three year to expedite registered nurses into the workforce; and, in First Nations communities, integrating traditional healing and cultural sensitivity into current training regimes.

Multi-disciplinary Education

Many participants suggest that various levels of the education system must reform in order to implement a multi-disciplinary approach to health care. Opening up lines of communication between the colleges, they argue, is necessary to allow for the sharing of practices and information, and reduce uncoordinated training and education. Others recommend more frequent co-ordination between educational institutions and the practicing workforce. Some suggest integrating a range of medical studies into common classes, which would create more respect across professions. Many participants believe that some level of alternative and complementary education should be taught to all students in the medical profession to encourage its integration into mainstream medicine.
Continuing Education for Health Professionals

The majority of participants understand that health professionals require increased support for continuing education. Many participants viewed additional training in alternative and complementary medicine as key to creating a more holistic practitioner. Training to better educate all practitioners on caring for those with mental health issues is also a priority. Others recommend leadership and management training for administrative and front-line personnel to create a more efficient and personable working environment.

Further education that allows health practitioners to broaden their education and enhance their skills can be critical in retaining professional staff, particularly in a world where the competition for skilled talent is increasing.

-The University Presidents’ Council of British Columbia, mail

Conclusion

Participants in the Conversation on Health believe that the education system has an opportunity to help address British Columbia’s health human resources shortage. Fully subsidizing tuition fees and costs relating to ongoing education in return for mandatory practice within the province, they argue, would bolster recruitment and retention. To create more training opportunities, some participants believe the professional colleges and universities must increase the amount of post-secondary seats currently available to medical students. Participants also suggested that, while in training, students should be taught the values of multi-disciplinary care to stimulate a better understanding and higher level of cooperation between professions. The scope of education for medical students should be more concise to increase the number of trained professionals while also removing any unnecessary credentialing and extending practical training to within the hospital. Participants see education as an ever-changing and ongoing process that must be encouraged and supported throughout a health professional’s career.

I would like our health care to be the best in the world and would like the top students to want to go into medicine.

- Email, Coquitlam
Training

This chapter includes the following topics:

**Education and Health Human Resources**
**Multi-Disciplinary Education**
**Education and Training Models**
**Ongoing Education**
**Tuition Costs and Training Fees**
**Credentials and Licensing**

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Submission to the Conversation on Health
Submitted by the British Columbia Nurse’s Union
2020, The Future Without Breast Cancer
Submitted by the Canadian Breast Cancer Foundation

Related Chapters
Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Health Human Resources; Scope of Practice; Morale and Collaboration in the System.

Education and Health Human Resources

Comments and Concerns

Health Professional Recruitment
Access to Education
Post-Secondary Funding and Staffing

• Comments on health professional recruitment:
  • British Columbia may possess an insufficient number of citizens interested in an occupation in the health care field.
  • Negative imagery and poor public perception of the health care field is driving away prospective students at the high school level.
  • The current education system is turning out only half the amount of trained professionals needed to properly address the Province’s health human resource issues.
  • The student limits that the professional colleges enforce do not help in addressing the health labour shortage issues in British Columbia today.
  • There are long wait lists for First Nations band-subsidized education.
  • Physiotherapy education consists of only 60 seats in British Columbia – too little to affect the labour shortage issue in the province.
• The wait to enter into a nursing program is too long.
• A re-assessment of medical school recruiting criteria is long overdue.
• The colleges and universities of British Columbia require an investigation of their admittance practices.
• Health service volunteers are becoming a rarity; the increased amount of training required to work with patients is becoming overwhelming and is driving people away.

• Comments on access to education:
  • Paediatric therapist training programs are only available in the lower mainland.
  • All teaching institutions are in the coastal, lower-mainland region; the northern and interior regions are left with little choice for their education.
  • Mental health training is lacking in northern British Columbia.
  • Residents in Fort St. John and Dawson Creek have limited access to the University of Northern British Columbia’s Bachelor of Nursing program.
  • Athabasca University is the only distance education option in western Canada due to restrictive legislation.
  • The Thompson Rivers University does not have a Licensed Practical Nursing program.
  • Those who apply on-line to various universities and colleges do not receive an immediate response regarding the status of their application.

• Comments on post-secondary funding and staffing:
  • Colleges and universities lack the funding necessary for an increase in dietician training.
  • Funding for first responder training is extremely poor.
  • Care aides and Registered Care Aides lack the funding necessary to any increase in training and certification.
  • There is a concern that the British Columbia Institute of Technology (BCIT) is losing many teachers, professors and instructors.
  • The Vancouver General Hospital may lack staff trained in the role of teaching technician.
  • Schools have lost the ability to network and set up clinical placements for their graduating students.
Ideas and Suggestions

Health Professional Recruitment
Access to Education
Post-Secondary Funding and Staffing

- Ideas about health professional recruitment:
  - Allow for more medical education seats at the University of British Columbia and the University of Northern British Columbia.
  - The provincial government must double the number of students and interns to address the shortage of trained doctors and nurses.
  - Expand the number of residency spaces available to doctors in training.
  - The protectionist tendencies harboured by the professional colleges must be addressed; the Province lacks trained health professionals and the low-supply, high demand rationale practiced by these colleges must end.
  - More universities, colleges and institutes are needed in Canada to address current labour shortages.
  - Provide paid work experience for professionals still in training.
  - Attract more professors and teachers to medical schools by increasing salaries.
  - Create incentives such as flexible scheduling and lower admission fees to encourage enrolment in the Licensed Care Attendant and Licensed Practical Nursing programs.
  - Reinstate nurse’s aides during the summer, to recruit new people into the health field.
  - The proposed expansion of the University of British Columbia’s School of Pharmacy would provide the province with a greater number of pharmacists; they would also understand their role in a sustainable health care system by working with patients, physicians, and nurses to ensure effective and appropriate drug use.
  - Add incentives to increase enrolment in family physician training.
  - Outsource education to accredited foreign educational systems such as the United States of America.
  - Offer incentives for Canadian citizens to train outside Canada and return to a local practice upon graduation.
  - Establish a government-mandated standard for entrance into medical schools.
• Conduct interviews prior to acceptance into medical colleges to identify those interested in long term dedication to the health care field.

• Expand and privatize medical education institutions.

• Increase interest in an occupation in health career at the high school level.

• An effort must be made to encourage Aboriginal youth into occupations in the healthcare field.

• Eliminate restrictive legislation on open learning.

• Establish career and aptitude testing in high schools to discover and recruit those ideal for the health professions.

• Those with computer and math skills can be recruited for occupations in human resource management or general administration sector.

• Eight hundred students will be accommodated in the new Faculty of Health Sciences at Simon Fraser University.

• Ideas about access to education:
  • Create new schools in the smaller rural centres.
  • Expand undergraduate programs.
  • Increasing the human resource pool can be achieved by increasing the capacity of training programs such as:
    a. Midwifery;
    b. Para-medicine;
    c. Registered nursing;
    d. Licensed practical nursing;
    e. Physiotherapy;
    f. Recreation aides;
    g. Diagnostic services;
    h. Rehabilitation services;
    i. Clerical and administrative services;
    j. A wide array of health sciences;
    k. General Practice;
    l. Audiology; and,
    m. Speech therapy.

• Encourage more First Nations representation in the health professions by increasing the amount of northern training programs.
• Create college programs in northern British Columbia that offer the first two years of an undergraduate degree.

• Educating professionals in the community will likely result in their practice within that community. Create more community education programs to facilitate this.

• Create internet-based courses for care aides and support staff.

• Create elderly peer leadership training at local colleges.

• Establish more training for Physiotherapists at the University of Northern British Columbia to address staff shortages in the north.

• Universities have brought $77 million to British Columbia from the Canadian Institutes for Health Research to support health-related research activities.

• There is a need for counsellors trained in family dynamics.

• Offer training within First Nations’ communities.

• Ideas about post-secondary funding and staffing:
  • Increase the number of health care instructors by hiring retired professionals.
  • Address shortages of instructors while maintaining the qualifications they require.
  • Northern British Columbia’s educational institutions require the resources to train and produce a wider array of health professionals.
  • Create a mobile teaching unit that provides basic education services directly to rural communities and reserves.
  • Although the recent expansion of the number of training positions in the UBC Medical School is a positive step, but the time involved in training physicians means the effect will not be felt for some time.
  • Target provincial training monies to increase the number of Aboriginal Registered Nurses and Medical Doctors.
  • The provincial government needs to allocate additional funds to train more midwives.
  • Provide more capital investment in Fort St. John to create new labs and more space for medical programs.
  • Programs aimed at upgrading and credentialing foreign-educated professionals require an increase in their capacity and thus an increase in the resources allocated to them.
  • Initiate greater collaboration between home and community care managers regarding the allocation of education monies and resources.
Multi-disciplinary Education

Comments and Concerns

Collaboration between Colleges and Universities
Training Health Professionals

- Comments on collaboration between colleges and universities:
  - The academic system is extremely slow in adopting new processes which challenge established orthodoxy.
  - There is no impetus in the education system to work collaboratively for the benefit of patients.
  - Educational institutions train in silos, thinking and planning only for the individual profession.
  - The colleges and associations do not communicate among themselves.
  - The individual colleges do not have any interest in sharing or opening their curricula to a more collaborative approach.
  - Various colleges and associations have a different scope of practice for the same position.
  - Health Canada has offered twenty million dollars, or only two years worth of funding to initiate grass-roots collaborative efforts across the country.
  - High level legislation aimed at increasing teamwork and collaboration could prove harmful if not done after consultation with a number of differing parties.
  - There is a split between the operating Medical Association and physicians as a whole because the association tends to be run by older people. New physicians need to take the place of the executive in the medical associations because they have had more exposure to these cooperative models.

- Comments on training health professionals:
  - Healthcare professionals lack transferable skills and knowledge.
  - Doctors are so specialized that they cannot practice in other fields.
  - Physicians have ingrained patterns of autonomous behaviour which is an education factor.
  - New doctors may be interested in multidisciplinary teams but do not know much about them.
• There is no effective training on teamwork in pre-licensure education.

• Alberta and British Columbia are behind other provinces with regard to successorship and mentoring.

• Some educators with only one year of out-of-school experience are teaching the next generation of professionals.

• Apprenticeship programs are non-existent.

• There is concern over the scaling back of mentorship programs.

• The remuneration offered mentors is inadequate.

• There is too much pressure being put on student mentors.

• Drug companies should not be the ones providing pharmaceutical education for physicians.

**Ideas and Suggestions**

**Collaboration between Colleges and Universities**

**Training Health Professionals**

• Ideas about collaboration between colleges and universities:

  • Building a multi-disciplinary approach within the educational system will allow for a new generation of health care providers who are able to communicate effectively and work with each other.

  • Increasing inter-disciplinary training would improve efficiency in the educational system.

  • I think there needs to be more done about working collaboratively during their medical and nursing and physical education.

  • Change the education strategies in universities, colleges, institutes, and professions to better integrate collaborative studies.

  • Increase multi-disciplinary learning by utilizing the same educator for nurses, Nurse Practitioners, medical students and the midwifery and pharmacology programs.

  • British Columbia is becoming the home to a new model for medical education. The expansion of the University of British Columbia's medical education program includes partnership with the University of Northern British Columbia and University of Victoria. The distributed model provides students with the same curriculum to all three sites, delivered through a combination of cutting edge
videoconference and internet technology, face-to-face instruction, and learning from local doctors in various health care settings.

- The medical deans of Australia and New Zealand have signed up to Canada’s national curricular framework for Indigenous health and medical education is now linked to the accreditation of medical schools in Australia.

- Comments about training health professionals:
  - Universities should offer courses that encompass all fields of medical study. This would force the practice streams into one venue, if at least for a short period of time. This would be a critical step to ending the individualist attitudes of practitioners.
  - Having common courses, such as public health, in the curriculum of nurses and doctors would aid in the communication and collaboration of these professionals.
  - Establish one year in a medical students’ education as their multi-disciplinary training year.
  - Implement collaborative training with the Ministry of Forests and Range and the Ministry for Employment and Income Assistance to gain greater knowledge about the social determinants to health.
  - Team behaviour requires team training.
  - Health teams should be trained along the same lines as airline crew. Although they operate together for a short period of time, they are efficient and understand each other’s roles.
  - Pharmacy and medical students should be taking some of the same courses together.
  - Create a unified college of professionals for those willing to learn in an environment immersed in multi-disciplinary content.
  - Create a better system for communication and collaboration between educational institutions and real world workplaces.
  - Facilitate better dialogue between the workforce and educational institutions to increase the training capacity of those fields in high demand.
  - Provide more opportunity for professionals from different cultures to understand each other and to train among themselves.
  - Have more collaboration between health professionals and school administrators and teachers to improve the education on health in our schools.
• Increase mentoring with apprenticeships for medical assistants and Nurse Practitioners.
• Employ more staff trained to take on more mentorship and preceptor roles.
• Offer incentives for mentors taking the time to train new staff.
• Decrease the amount of mentors in the healthcare system.
• Encourage mentors to scale back their practice and pass those practices on to the student.
• Allow retiring or retired professionals to continue or return to practice to mentor new professionals without impact to their pensions.
• Host career fairs for health professionals.
• Attach professional schools to hospitals.
• Create a forum for health professionals to discuss how they may compliment each other.
• Health professionals requiring long-term disability leave should be retained to train and mentor new staff.
• Pharmacological and medical students are participating together in some courses in some regions.
• The Inter-professional Rural Placement Program is a promising model.
• There is data indicating that those professionals who go out and get re-invigorated with new collaborative information come back to the team a very enthusiastic learner.
• Current mentorship programs are working well.
• The University of British Columbia program partnership with Cowichan Tribes Ts'ewulhtun Health Centre is a step in the right direction.
• Those doctors trained alongside Nurse Practitioners tend to be more open to delegation of their duties.
• Require a level of collaborative and quality improvement education in all professions.
• Community centres will require a specific type of health care team. Data containing the needs of the aging demographic would be necessary, and from that point, one could sort out timelines required to train personnel.
• British Columbia must look at inter-education, and at the notion of why a team
does or does not work. We also have to look at how we retain people in the
system.

• The Deans and Directors must meet more than twice per year.

Education and Training Models

Comments and Concerns

Administration and Management
Credentials and Program Length
Training and Curriculum Content
Practical Experience

• Comments on administration and management:
  • Advanced education has become too de-personalized.
  • Universities, colleges and institutions are at the cutting edge of orthodoxy and,
    once they are in place, it is very hard to change those established conventions and
    practices.
  • Canada has been very slow to exploit the potential of people to learn new skills
    beyond the age of 24. This would solve a lot of competency and capacity
    problems by just taking a very modular, logical approach to how people learn.
  • Content taught in university ten years ago is now taught in high school; medical
    education outdates itself extremely fast.
  • Many students are choosing to take specialized training in order to increase their
    potential earning power or obtain more flexible working hours rather than taking
    a generalized medical degree.
  • The information doctors use to treat hepatitis is outdated or obsolete.
  • The cultural discrimination in educational institutions is unacceptable.

• Comments on credentials and program length:
  • The four year program required for Registered Nurses is too long.
  • The British Columbia Nurses Union is instigating political opposition to shorter
    nursing programs.
  • After four years of training, students realize that they do not enjoy the practice of
    nursing.
Comments on training and curriculum content:

- Training around cultural sensitivity is either lacking or non-existent.
- Colleges and universities lack training in practitioner-patient communication.
- The Medical Diagnostic Services (MDS Metro) chain of laboratory employees are lacking in job-specific training.
- With the exception of injection education, there is no operating room content in a nurse’s curriculum.
- Many Canadian Diabetes Association volunteers lack adequate training.
- Medical training is focusing on the prescription of drugs and treating symptoms instead of addressing the root causes of disease.
- Family physicians do not receive adequate training to recognize that dementia is not a normal part of aging, and that early, and proper diagnosis is critical to ensure positive health care outcomes.
- The four year physician program focuses primarily on acute care, yet most do not need this level of training.
- Current curricular scope does not meet today’s work force scope and lacks in:
  a. Prevention;
  b. Management of aggressive behaviour;
  c. Medical training;
  d. Safe client handling, and;
  e. Gerontology.
- The current training model for students surrounding mental health issues is extremely poor.

Comments on practical experience:

- Nurses in British Columbia are entering their fields after graduation with little to no practical experience.
- At present graduating nurses are not sufficiently trained to start working without some degree of supervision and on-the-job training due to high acuity and an over-generalized education.
- Recent nursing graduates may be showing hesitation when administering morphine due to poor training.
• Practicum students are seen as a liability and too risky to take into practice by hospital staff.

• The heavy workloads borne by hospital staff are not conducive to the addition of training a practicum student.

Ideas and Suggestions

Administration and Management
Education Delivery Models
Credentials and Program Length
Training and Curriculum Content
Practical Experience

• Ideas about administration and management:
  
  • Regularly test education models to ensure the efficacy of practitioner training.
  
  • Hold educators accountable for their role in the effective training of British Columbia’s health professionals.
  
  • Accompanying any change in the education culture must be change in the culture of professionals. The two must co-relate any goals in order for them to be effective.
  
  • Create a flexible education system that dictates how personnel can be better utilized across a wider scope of practice, instead of a narrow and orthodox training regime.
  
  • Incorporate observations from medical best practices into the education system.
  
  • Make tapping into the Vancouver Island Health Authority’s training programs easier for First Nations peoples.
  
  • Create a network of social accountability for medical schools.
  
  • British Columbia possesses a great college infrastructure.
  
  • The control over learning competencies by professional colleges is positive.
  
  • Direct the development of education programs based on population needs. For example, a marked population increase in chronic disease or issues surrounding aging should be followed by corresponding curricular changes to include more education on chronic disease management and gerontology.
• Ideas about education delivery models:
  
  • Allow for more on-line and part-time training of professionals.
  
  • Pair on-line training with companion aide duty in order to gain bedside experience.
  
  • More in-home training for midwifery students.
  
  • Reduce the number of universities, colleges and other teaching institutions to enable a unified focus on the training needed for real-world practice.
  
  • Modify the nursing program to fit into smaller week-long or month-long modules to accommodate those living in remote communities.
  
  • Nurses should spend two years training in the classroom, followed by two or three years working in an applied hospital setting.
  
  • Run medical schools for-profit and without taxation support or provincial government subsidy.
  
  • There is a need for more privately operated medical schools.
  
  • Students possessing an undergraduate degree could work within a practice in a restricted manner while finishing their medical studies at night.
  
  • Accredit alternative and complementary medical approaches.
  
  • Create educational sessions for police, primary care givers and emergency workers surrounding proper care for those with mental health issues.
  
  • First Nations peoples must become engaged in the educational-policy making process.
  
  • The University of Northern British Columbia’s Medical Doctors’ program is a model program.
  
  • Other institutions could follow the curricular model for Aboriginal health set by the University of British Columbia.
  
  • The Northern Rural Project is achieving success in co-ordinating health education with healthcare.
  
  • Create two streams of professional degree programs for nurses: an active nursing program and a residency program with a stipulation for required practice in rural settings before moving on to cities.
  
  • Have nursing students choose a specialty by the end of their second year or the beginning of their third year so that the fourth year or during the last half of the fourth year, they could focus on the specialty training of their choice.
Include a rural year of practice in a medical student’s training.

Ideas about credentials and program length:

- Introduce a laddering of education strategy that includes cross training and mentoring and allows students to work earlier such as:
  
  a. Six months training for a Registered Care Aide;
  
  b. One and half years training for a Licensed Practical Nurse;
  
  c. Two and a half to three years for a Registered Nurse;
  
  d. Four years for a bachelor of science in nursing; and,
  
  e. Five to six years to achieve a Nurse Practitioner’s level.

- Introduce a three year hospital training program for Registered Nurses.

- Restore the 28 month Registered Nurses diploma program.

- Establish a Licensed Practical Nursing program that can be completed in two years.

- Canada should emulate Britain’s model of a five year medical degree.

- Do not sacrifice the quality of one’s education for faster degree programs.

- Implement national standardized exams for graduating practitioners.

Ideas about training and curriculum content:

- Better training creates better staff, which takes the pressure off hospitals.

- Ensure that general practitioners, especially those who practice in isolated rural communities, are trained in all birthing methods.

- Implement flexible education policies to support culturally specific educational requirements within Aboriginal communities.

- Simon Fraser University has a new undergraduate programme and graduate programmes training specialists in public and population health, global health and infectious disease control, and mental health.

- Nursing schools must go back to training generalist nurses competent in surgery and obstetrics.

- Western medicine requires the integration of traditional Aboriginal healing ceremonies.

- General practitioners require more education around cancer treatment.

- Implement more mental health education programs surrounding topics such as diagnosis, support and treatment options.
• Train family physicians in the more complex and specialized treatment methods required for senior care.

• Students need more content delivery in their training; for example, there is a lot of information taught to students on treating asthma, though very little on how to effectively communicate with the patient the reason for their treatment methods.

• Expand education on herbal medicines in allopathic training institutions.

• Home care support workers require a more comprehensive training curriculum.

• Provide specialized training for 24 hour, seven day a week triage and clinician roles.

• Establish a more appropriate training regime for palliative care workers.

• Allow for more preventative training for soon-to-be primary care physicians.

• Increase the amount of education on the role of health technology in modern care techniques.

• Create additional education for care aides, nurses and doctors around end-of-life care.

• Create a course on operating room practice similar to that which exists in Alberta.

• Include non-violent, crisis intervention training in the educational curriculum of medical students.

• A Medical Doctor’s training must include education surrounding proper nutrition and the benefit of organic foods.

• It is critical that the medical school curriculum include sufficient attention to health issues affecting the frail elderly.

• Skills such as critical thinking, problem solving, and ethics are important to producing a well-rounded, practical health professional.

• Mandate comprehensive education surrounding addiction and mental health.

• Universities must create more content focused on the social determinants of health in school curriculum.

• Primary health care providers require specific training in women’s physiology and its unique response to illness.

• Implement basic medical training classes within high schools.

• Standards for Registered Nurses and Care Aides working in geriatric and palliative nursing must be raised by including training around dementia.

• Triage nurses practicing in emergency rooms are well educated.
Health care providers educated in Canada possess a high quality of medical training.

Highly trained generalists are doing a great job in British Columbia.

Integrate conflict resolution skills into the medical student’s curriculum.

Allow for more compassionate care education when training palliative care workers.

Train those planning on permanent practice in northern and rural British Columbia with multiple fields of practice.

Medical students require an increased exposure to detoxification programs to better their knowledge about addiction and rehabilitation.

Universities or medical schools should be offering content surrounding the health authority’s management structure.

Make bedside experience part of a professional’s training.

There is no single form of culturally appropriate care; therefore, physicians must be taught to adapt to the diverse needs of their patients.

Professionals need generalist training to cope with an ever changing variety of health care demands.

Include units similar to a Registered Nurse’s training on staff supervision in a Licensed Practical Nurse’s training.

Include comprehensive emergency room training in the medical student’s education.

Resources such as libraries are available to some health professionals.

Ideas about practical experience:

There are teaching hospitals in British Columbia that are performing at an excellent level.

Medical professionals in training should spend a number of years working within a busy urban hospital.

Develop an apprenticeship system that rewards education and experience.

The unique strengths of University of Northern British Columbia and University of Victoria, and their related communities, enhance the learning experiences of the students. Students in both the Island Medical Program and the Northern Medical Program have the opportunity to spend time in small, rural and coastal communities such as Ladysmith, Port McNeill, Hazelton and Dawson Creek. These
hands-on experiences in rural practice will help to build the pool of physicians needed to deliver health care in all parts of British Columbia.

- Offer university or college credit to those who engage in community training programs.
- Increase the use of internships in British Columbia.
- To some extent, every hospital should be a teaching hospital.
- Re-invigorate the staff working in teaching hospitals.
- Qualify on-the-job training as university credit.
- Use primary care centres as platforms to educate a new generation of professionals.
- Create more opportunity for students to learn and train within the hospitals rather than within the classroom.
- Medical students should be required to volunteer their services in community care facilities.

**Continuing Education**

**Comments and Concerns**

- There is a lack of human resource development funding at both the federal and provincial level.
- The healthcare sector provides little training in administrative change management.
- Health professionals do not have the time to engage in ongoing education.
- A large number of nurses are required to seek out specialized education after graduation in order to continue practice.
- Some nurses who wish to upgrade their education are excluded from accessing public funds due to family income regulations.

**Ideas and Suggestions**

- Incorporate a culture of change that requires practitioners to undertake ongoing education which could also include an ongoing review of their capabilities.
- Encourage current nurses to upgrade to Nurse Practitioners and allow their existing practical experience be applied toward their degree.
• University courses for existing professionals should include education on more holistic treatment.
• Subsidize the expenses incurred by those who must travel to receive their education.
• Support ongoing education for caregivers, professionals and volunteers.
• Offer seniors’ care courses to all health professionals.
• Increase First Nations cultural awareness training, developed in conjunction with Elder and Youth councils, for health professionals.
• Develop consistent training programs for nurses that focus on mental health issues.
• Make leadership training available to any front-line health professionals.
• Further education that allows health practitioners to broaden their education and enhance their skills can be critical in retaining professional staff, particularly in a world where the competition for skilled talent is increasing.
• Ensure management is continually trained and up to date on health information and techniques.
• Continue to educate healthcare providers concerning healthy living initiatives, social determinants of health and preventative health strategies.
• Nurses need to engage in sensitivity training before treating patients diagnosed with chronic diseases.
• All practicing professionals need access to advanced, chronic disease education.
• Continuous education should be compulsory with strong incentives to study new methods of treatment.
• Offer cultural education delivered by First Nations teachers.
• Provide the opportunity for practicing health professionals to change fields.
• Ensure that mental health workers employed within First Nations communities are trained in traditional and spiritual methodology.
• Addictions counsellors need ongoing, updated training.
• Award bursaries or grants to paramedics wishing to further their education.
• Health professionals should adhere to a four day work week with one day reserved for training and education.
• To increase the overall efficiency of the system, health professionals should receive the necessary training to become experts within their scope of practice.
• Surgeons need enough guaranteed operating time to maintain and further develop their skills.
• Offer Licensed Practical Nurses a specialty course on operating room practices.
• Provide training opportunities for clinical office staff on new procedures and techniques.
• Our best health care research must be available to decision makers and front-line practitioners who deliver patient care.
• The most efficient practice conditions prevail when nurses are in the workplace providing care for 80 percent of their working hours, while spending the other 20 percent on professional development and mentoring.

Tuition Costs and Training Fees

Comments and Concerns
• The high cost of university tuition is eliminating many working class students from a prospective career in health care.
• Students are being driven into poverty by increasing educational costs.
• The high cost of education and the resulting debt cause many graduating students to leave the healthcare field entirely.
• In order to attend training to become a paramedic or ambulance attendant, people must take unpaid leave from work, placing them in a financially compromising situation, sometimes deterring them altogether from entering into study.
• Too many subsidized and publicly trained professionals are leaving to find employment in other provinces and countries.
• The provincial government must investigate the discrepancies in training costs across British Columbia.
• The British Columbia loan forgiveness program should include students in specialty areas and facilities rather than to just those who work in geographic locations that qualify as under-served. A recent graduate may have $21,000 in student loan debt and the operating room in their town seriously may be understaffed, but since that area is not classified as under-served no forgiveness of the student’s loan will occur.
• The high cost of education is forcing some health professionals to become very financially driven and aggressive regarding remuneration for their services.
I**deas and Suggestions**

- Fully subsidize a medical student’s education.
- Those professionals who choose to leave British Columbia upon graduation should repay the subsidized portion of their education.
- Increase medical study tuition.
- Other countries fund post-secondary education based on the belief that graduates go on to become positive, supportive and contributing members of society.
- Reduce tuition and training fees for those enrolled in medical studies.
- The health authorities should be directly responsible for providing financial and other assistance for students.
- The high public cost of educating health professionals demands that British Columbia develop better strategies for keeping those professionals within the health care system.
- Forgive the student loans of those students who finish their medical school residency.
- Doctors who have received subsidized training should have to work a term of between one and fifteen years in the public system or face repayment of all subsidized monies.
- The provincial government should subsidize seats in private colleges for students.
- Create a student loan forgiveness program that is reliant upon graduates spending a number of years working in rural communities.
- Their must be more financial assistance available to Aboriginal medical students.
- Guarantee funding for new graduate Registered Nurses and undergraduate nursing programs.
- Student loan forgiveness should be offered to those in specific fields and practices that are in need of additional human resources.
- Offer a reduced salary to practitioners if they choose to receive fully subsidized education.
- The cost to train more nurses would pay for itself in the long-term.
- Offer subsidy or bursaries to those interested in gerontology training.
- The on-line application process for medical studies should include a receipt of application along with follow-up by recruitment personnel.
Credentials and Licensing

Comments and Concerns

- The over-credentialing of health professionals is becoming more prevalent, forcing health professionals into lengthy but unnecessary graduate studies.
- Ramping up the credential requirements for practice in British Columbia will not address health human resource issues; rather they will only continue to exacerbate them.
- There is a lack of inter-provincial recognition and standardization of professional licensing requirements.
- Health care practitioners are over-educated and under-skilled; for example, nurse managers require a master’s degree, but this does not guarantee they have good leadership skills.
- The British Columbia Medical Association is restricting the level of education that physicians may receive.
- There is no requirement for re-assessment once a practitioner has left university.
- A two year and a four year program for Licensed Practical Nursing both contain the same content; however, one requires a greater amount of dedicated time and money.
- The training required for home care workers is of low quality.
- The Registered Nurses Association of British Columbia needs to change its requirement regarding the Bachelor of Science in Nursing for registered nurses.
- Make it mandatory for nursing program instructors to have a Master of Science in nursing degree.
- Physiotherapists require a master’s degree to practice.
- Registered Care Aides lack a dedicated regulatory body, which is leading to an inadequate level of training.
- Fewer physicians are emerging from residency programs following the Federation of Medical Licensing College’s decision to extend physician training and abolish rotating internships. This decision will force many students into sub-specialty areas rather than assuming a wider scope of training.
- The British Columbia College of Family Physicians should not hold the authority to audit their members; an independent body free from internal interests should accomplish this.
The College of Registered Nurses and the British Columbia Medical Association are holding up nurse’s licensing.

Idea and Suggestions

- Increase professional education across all fields and broaden credentials.
- Nationally standardize the credentials necessary for a medical doctorate; health could use the Red Seal program that governs trades-people as a national model.
- Implement an international accreditation standard for health licensing.
- Review the College of Nurse’s guidelines and professional standards.
- Implement realistic degree and certification requirements.
- Look to other jurisdictions for ways to improve the licensing process.
- The College of Physicians and Surgeons of British Columbia should not be responsible for the accreditation of doctors.
- Each province needs an impartial Board, made up of representatives from all professions, which adjudicates the credentials of all professionals.
- Merge the three colleges of nursing into one single, self-regulating, professional body.
- Create a provincial government office that would be responsible for evaluating the qualifications of practicing family physicians. This body would also be responsible for providing malpractice insurance to practitioners.
- Eliminate the need for credential and allow those who successfully complete their education to practice freely within their field.
- Accredit proficient foreign educational institutions instead of having to accredit individual persons upon arrival in Canada.
- Mandate a pilot project that regularly assesses the capabilities of health care practitioners; it would operate independent of the various regulatory bodies of colleges.
- Implement regular evaluation methods for doctors, dentists and nurses sent to remote communities for practice.
- Health care administrators need more health oriented training.
- Investigate the waiving of certain credentials or certificates for some professions.
- Offer community health representatives credit in the Prior Learning and Assessment Recognition Plan (PLAR) for their time spent working in the field.
- Offer restricted licenses to practice in some fields, such as family practice, where obstetrics certification and certain other qualifications may not be required.
- Care aides and support workers in rural areas can easily upgrade to Licensed Practical Nurses.
- The provincial government should subsidize nurses’ licensing fees.
- Should a candidate fail the initial adjudication process, he or she should be informed of their deficits and sent to a competent counsellor who would assist in addressing these deficits for success with future testing.
Scope of Practice

Participants in the Conversation on Health discussed scope of practice at great length. They touched on topics such as the requirements for multi-disciplinary care and the re-defining of practitioner scopes of practice. Discussion centered on the roles of nurses, doctors, dental and pharmacological care specialists. Here is a sampling of what British Columbians had to say about scope of practice.

Re-defining Scope of Practice

Many participants request that scopes of practice be re-evaluated as many of British Columbia’s health care practitioners are currently over-worked and under-utilized. They argue that devolving responsibilities or expanding the range of duties practiced by professionals, such as dental assistants, may aid in filling service gaps brought about by current labour shortages. Participants also suggest altering practice regulations to reassign duties as practitioners see fit, while others believe legislation is necessary to establish scopes of practice. The younger generation of practitioners are a resource for new and innovative ideas that could be promoted through open forums with decision-makers. Participants also argue that professional colleges should assist the transition from an uncoordinated training approach in universities and colleges to a more open network of communication and cooperation.

*Empower all health professionals to reach their full scope of practice through regulatory changes that reflect their training and education.*

-Health Professional meeting, Vancouver

Multi-disciplinary Care

Encouraging a team model of health care delivery may require a shift in scopes of practice. Many participants agree that complementary and alternative, not just traditional health professionals should be able to refer, assess, and possibly prescribe medication to patients. Further, they state that alternative and complementary care practitioners should be included as integral parts of multi-disciplinary teams. Many participants believe that the midwife is an underutilized and at times, persecuted member of the health care system. Increasing their numbers, roles, and privileges within the hospital setting would free up many doctors and nurses and provide women with a safe and comfortable method of birthing.
Removing barriers to Multi-disciplinary Care (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.

-British Columbia Medical Association, Electronic Written Submission

Nurses

Nurses’ scopes of practice were widely discussed, and many participants believe that nurses are capable of taking on greater responsibility and authority within the health care system. In particular, participants suggest that the nurse practitioner’s role be significantly expanded to assume a role similar to that of a general practitioner’s. In order to for this to happen, Licensed Practical Nurses and care aides must assume a broader set of responsibilities in their fields of practice. Delegating tasks to Licensed Practical Nurses and care aides may also result in reducing overtime hours nurse practitioners currently work. To ensure these new scopes of practice are adhered to, some suggested delegating a supervisor in the form of a head nurse to each floor of the hospital or care facility.

Physicians

The Conversation on Health discussion provides many ideas about changing physicians’ scopes of practice. Some participants contend that doctors must be open to the delegation or devolution of their duties; something they may currently be hesitant to do. Some argue that general practitioners should share their role as gate-keeper to health services; doing so would result in a decrease in the number of visits to the doctor’s office for only referrals. Patients awaiting results or basic advice should be able to consult with their physicians over the phone, further shortening the need for visits to the office. Some propose the implementation of a physician’s assistant, who would be responsible for the elementary procedures a physician would normally carry out.

Many participants emphasize that physicians must be involved in the decision-making process when reform is necessary in the health care system.
Pharmacists and Pharmacology

Many participants question the role pharmaceutical companies play in the delivery of health services. The education a physician receives on a particular drug should not, they believe, come from a company representative, nor should they receive any type of bonus or reward from the company when prescribing their product.

Many participants also recommend changing prescription practices and scopes of practice. They suggest that doctors could approve longer prescription lengths by allowing for multiple refills of a single prescription. To address patient backlog at physicians’ offices, some suggest tasking long-term prescription renewal to nurse practitioners and pharmacists. Along with prescription renewal privileges, pharmacists could play a larger role in the care and management of long-term and chronic illnesses if granted access to a patient’s full medical records. Many participants consider the pharmacists an underutilized asset to the healthcare system.

In the current system, pharmacists expend most of their energy in dispensing medications from the bulk stock to individual packages. This is a waste of their talent. A large part of this exercise can be deputized to dispensers with special training but paid less expensive salaries.

-Email, Victoria

Conclusion

Many participants believe that the current roles and responsibilities practiced by health care professionals require change. Practitioners are being educated to meet an increasingly high set of standards, yet remain underutilized in their day-to-day practice. Re-defining and expanding our health professionals’ scopes of practice will allow them to provide a level of care more reflective of their qualifications, while increasing the efficiency and accessibility of British Columbia’s health care network.
## Scope of Practice

This chapter includes the following topics:

- **Scopes of Practice**
- **Re-defining Scopes of Practices**
- **Multi-Disciplinary Care**
- **Physicians and Surgeons**
- **Nurses**
- **Pharmacists and Pharmacology**
- **Dental Care**
- **Eye Care Specialists**

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Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Primary Health Care; Health Care Models; PharmaCare; Public Private Debate and Medical Services Plan.

Scope of Practice

Comments and Concerns

Leadership and Governance

• Comments on leadership and governance:
  
  • The current management lacks positive behavioural tendencies of good leadership.

  • Behind-the-scenes administrations manage the current system from closed doors. They make decisions that affect the day to day work of professionals without any prior consultations or considerations of the repercussions of their decisions.

  • Staff workloads are so strenuous that there is no time for practitioners to take on a leader’s role.

  • The excessive workloads borne by practitioners are limiting their engagement in mentorship or preceptorships.

• Filling the service gaps in health care is requiring health professionals to practice in areas that they may not be fully qualified for, which creates a lack of professional care.

• Poorly defined objectives, duties, and time frames in hospitals lead to overworked employees.

• Out-patient cancer care requires centralized physiotherapy services.

• Initiate an independent audit on best practices and share the results with all health care practitioners.

• Burn-out among health professionals can be attributed to a high occurrence of administrative work.

• University graduates are in demand for positions that Care Aides and Licensed Practical Nurses could carry out.

• Emergency rooms lack support services such as Physiotherapy.
• Residential Care aides may be lacking the appropriate education and necessary competencies to effectively carry out their duties within long-term care facilities.

• Emergency room staff lack the necessary skills and training to work effectively with the mentally ill and elderly patients.

• Encourage the sharing of Aboriginal health best-practices and research between communities.

• Many professionals’ collective agreements unduly limit their operational capacity.

• Health professionals are overworked yet are under-utilizing their training, thus lowering practitioner morale.

• Highly trained professionals are not being utilized to the very limits of their training. The following are prime examples of poorly-utilized practitioners:
  a. Certified Dental Assistants;
  b. Dieticians;
  c. Pharmacists;
  d. Nurses;
  e. Midwives;
  f. Physiotherapists;
  g. Social workers; and,
  h. Speech Pathologists.

• Current legislation does not allow Registered Massage Therapists to practice to the full extent of their training. Broadening their scopes of practice in to match their training would assist patients, and fill a growing need for health care professionals in the province.

• The various fields of health care lack effective communication tools.

• Community-care workers do not have any connection to mainstream health practitioners.

• Nurse Practitioners, naturopaths and pharmacists should have the ability to refer patients to specialists.

• Health care providers are not delivering culturally appropriate care.

• Doctor’s practices and ethics are lacking supervision.

• Practitioners are making mistakes and have no way to communicate these mistakes to each other.

• Unregulated employees are operating in service delivery areas that only regulated employees should be responsible for.
• There should be no professional monopoly on work unless it is professionally justified that any other treatment method would qualify as dangerous to the patient.

• Midwives in private practice are on call 24 hours a day and seven days a week; this, combined with a lack of additional hospital privileges means they cannot easily network with other midwives to either give themselves coverage or allow them to take on more patients and grow their practices.

Ideas and Suggestions

Leadership and governance
Practice in the public and private sectors
Standards of care
The patient’s Role in Healthcare
Midwives

• Ideas about leadership and governance roles:
  • Engage regional Health Authority managers in the planning processes.
  • Managers must re-design workflow plans to address labour shortages.
  • Front-line workers must be included in the decision making process by administration.
  • Build capacity for more front-line leadership and increase the depth of organization including innovative planning from the front-line and just-in-time issues management.
  • Create more front-line supervision to discipline and support employees.
  • Implement the role of a floor supervisor who would be responsible for managing the duties of the nurse to the janitor.
  • Remunerate Health Chief Executive Officers (CEO)s in accordance with their Health Authority’s performance records.
  • Those currently in management positions should involve their staff in a discussion on how to effectively bridge the service gaps in health care.
  • There is a need to address the protectionist culture that exists between some professional colleges and their respective fields.
  • Assess what attracts and sustains senior leaders within the health care field.
  • Scopes of practice will expand with good leadership and management within the Health Authorities and educational institutions.
• Health Authority board members should be the champions of the health professions
• Health Authority staff members should be required to have served some length of time in primary health delivery.
• Those who are allocating Health Authority budgets must possess the necessary business and financial qualifications.
• Elect Health Authority board members instead of appointing them.
• Establish a centralized, third party regulatory body for all health professionals including those that are self-governed.
• Encourage front-line practitioners to become more involved with the Health Authority bureaucracy, even sit on the regional boards.
• Administrative staff in the Interior Health Authority need to understand their own structure, policies, procedures, and how treatments interact.

• Ideas about the private and public sectors:
  • Regulate the amount of time professionals spend working in the public and private systems in order to maintain a balanced human resource pool.
  • Implement a rule that does not allow for employment in both the private and public sector, thus eliminating double billing by practitioners.
  • Allow employment of practitioners by any number of facilities and allow them to operate between those facilities, directed by demand.

• Ideas about standards of care:
  • Make the operating physician take responsibility for mistakes made during surgery. Offer other recourse to the patient other than writing to the College of Physicians and Surgeons.
  • Health professionals need a safe and secure environment to air their concern or report of mistakes made during practice. This forum could also hear reports of abuse or fraudulent use of the medical service plan billing system by professionals.
  • Implement the role of a health services ombudsman who would hear from patients, their concern or complaint regarding mistreatment or malpractice.
  • The Ministry of Health must maintain a public list of health service personnel who have committed medical infractions.
• Ideas about the patient’s role in healthcare:
  
  • Patients should be encouraged to ask more questions of their doctor regarding their treatment. This may doctors to undertake communications education.
  
  • Patients should have more control over their treatment.
  
  • Assist patients in their search for efficient care by providing them with a patient care representative or case manager. Efficient treatment options can be tailored to a particular patient’s needs and would eliminate any duplication in testing.
  
  • Patient outcomes should govern the salaries of health professionals.
  
  • Proper continuiy of care allows for deeper relationships between the client, family and peripheral care aides.
  
  • Focus on allowing patients to be the experts in their care; the health professional’s role would be only that of a supervisor.
  
  • Strengthen and build new community-based patient education programs that promote wellness, prevention, and chronic disease self-management. Ensure that community family doctors are involved in the planning and management of these programs.
  
• Ideas about midwives’ scope of practice:
  
  • Initiate a publicity awareness campaign addressing the benefits of using a midwife.
  
  • Midwives require an expansion in their hospital privileges.
  
• Implement an emergency room triage individual responsible for directing lesser health issues towards a clinic while allowing emergency room admittance to those with genuine medical emergencies.
  
• Registered Massage Therapists have extensive training specific to musculoskeletal conditions. This training should be better utilized by creating a primary care role for massage therapists.
  
• Increase the authority of Naturopathic doctors to allow for prescriptive rights and the ability to admit patients to the hospital.
  
• Increase the resources dedicated to training care aides to better their education and allow for a broader operational capacity.
  
• Para-medics require the authority to triage their patients and decide upon their destination if they require further assistance.
• All medical staff should abide by the guidelines of care outlined by the Canadian Diabetes Association when treating diabetic patients.

• Occupational and Physical Therapists need to be available more than Monday to Friday, 8:30am to 5:30pm.

• Re-instate the Orderly back into hospitals.

• The Ministry of Health should require that health professionals carry the credentials necessary for work in palliative care facilities.

• Create a Care Aide specializing in the support of those suffering from mental illness and developmentally challenged children in public schools.

• Primary care workers must be trained to operate in a more collaborative and cohesive manner.

• Change the scopes of health care professionals to better suit the recruitment of new professionals.

• There must be an increase in the amount of intermediate health care professionals practicing in British Columbia.

• Social workers working within mobile street clinics should be well versed in both mental health and criminal justice care.

• Incorporate front-line staff in finding holistic solutions to issues in their field.

• Thoroughly integrate alternative care into a patient’s treatment instead of using it as a last resort.

• The gate-keepers to healthcare services should be those practicing para-medicine.

• Eliminate all unnecessary bureaucratic paperwork.

• Peer support groups help those with potentially terminal and chronic care diseases on an emotional level; a highly educated and trained professional cannot always offer such an exemplary level of compassion to their patients.

• Utilize nutritionists much more effectively to educate patients on proper nutrition.

**Re-defining Scopes of Practice**

**Comments and Concerns**

• Implementing change in scopes of practice will be challenging. Management will be advising new professionals that the current practitioner’s operational limits are
not what they want to be emulating, yet these students will be placed into clinical settings where there is no evident change.

- The professional colleges hold different ideas concerning scopes of practice than those actually working in the field.

- Canadian researchers have looked long and hard for evidence to suggest that devolving a task, whether it is endoscopy to nurses or some long-term care to Licensed Practical Nurses or primary care from physicians to Nurse Practitioners, has caused harm to the patient. They have found none. The scope of practice regime in Canada is inaccessibly rigid. There is too much turf protection. The ability of professionals to acquire new competencies and use them to good effect for the public and patients is severely constrained by limits placed by colleges and associations.

- The challenges lay in pushing authority downwards and at the same time providing recognition to those front-line workers.

- It is very difficult for personnel to acquire new competencies in a modular format as has been recommended time and time again.

### Ideas and Suggestions

- Re-design the health professionals’ scope of practice around their necessary competencies and population needs. Analyze what certain professions have to offer and how to balance and reduce duplication in the system.

- Implement a new model of care that is able to cope with a growing market for care and a shrinking human resource pool. This could be assisted by a detailed analysis of what allied health care providers can do for the system.

- Increase the effective and available entry points into the health care system. This would include assessing and delegating who can order tests, who can monitor the follow-up, what is the best use of a professional’s training and expertise and would include alternative methods.

- Doctors should not be the sole gate-keeper to health care. This position would benefit from delegation to a variety of well-qualified practitioners.

- Elimination of the educational and management silos within health care would allow practitioners a much wider scope of practice.

- The education system must take more responsibility in the expansion of health professional’s scopes of practice.

- Create more flexibility within the roles of health professionals.
• Conduct a critical path analysis on the widening scopes of practice and address the issues that are blocking the path of this expansion.

• Ensure the intimate involvement of the Ministry of Advanced Education when adopting new scope of practice policy.

• Changes in practitioner scopes of practice will require legislative change.

• Empower all health professionals to reach their full scope of practice through regulatory changes that reflect their training and education along with the provision for funding and appropriate resource allocation.

• Government should review and test restrictions placed on professions by their professional associations.

• The Province should rely more on pilot projects when changing scopes of practice.

• Create an international body to mandate and regulate professional operating standards.

• Initiate a set of general practice standards and evaluate health professionals based on those standards.

• The regulated professions should possess a wider scope of practice; those unregulated professions should continue in their narrower practice.

• There are protocols such as the Transfer of Function, whereby a professional can delegate duties to another professional by implementing training and supervision.

• There is an effort in northern British Columbia to train x-ray technicians to perform basic laboratory work in order to create a full-time workload for one professional, which is a good example of widening scopes of practice.

• Relax scope of practice legislation that lacks objective evidence.

• Health professionals need a better understanding of what each individual profession is responsible for in order to maintain an effective work environment.

• Invest in a thorough analysis of what health professionals are doing day-to-day and request options to optimize their performance.

• More workload planning is necessary in order to safely expedite the entry and exit of patients into and out of hospitals.

• Listen to the innovative ideas offered by front-line workers when evaluating scope of practice changes.
Multi-Disciplinary Care

Comments and Concerns

- Doctors may be resistant to changing their roles as the gate-keepers of the healthcare system.
- The Canadian Medical Protective Association is putting physicians in a scenario where they feel they cannot engage others as employees because of the liability risks they are assuming.
- Physicians work primarily as independent practitioners rather than co-operatively with Nurse Practitioners, Physiotherapists and Pharmacists, which would be more effective and less costly.
- It will be a challenge to change into a more multi-disciplinary system when some doctors are operating within a small-business model of healthcare delivery.
- The sharing of information between professionals is ineffectual or non-existent.

Ideas and Suggestions

- Support the integration of health care professionals.
- Inter-disciplinary health care models would improve the quality of a patient’s initial interaction with the health care system.
- House many different practitioners under one roof and establish a formal and informal network of communication between professionals. The informal network would consist of a willingness to flatten out the hierarchy within the system.
- Increase the collaboration between traditional and non-traditional medicines.
- A basic model for a primary care team consists of three Registered Nurses working under a doctor’s supervision.
- Multi-disciplinary teams including; academics, physicians, health authority representatives, aboriginal liaison, staff, union and the volunteer sector would keep the focus on holistic treatment.
- Each one of these health care teams must analyze the needs of those they are serving and assign work to those best qualified to maximize efficiency.
- Physicians may need to hold the legal liability for these teams.
- A qualified medical practitioner and a traditional healer should assist in First Nations mental health assessments.
• Blend the rigid hierarchy of specialist, doctor, Registered Nurse, Licensed Practical Nurse, and Registered Care Aide.

• Removing barriers to multi-disciplinary care 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.

• The College of Physicians and Surgeons requires education regarding the implementation of integrated care methodology.

• The government must support the redesign of health professionals’ fee structure in order to facilitate a more collaborative model of care.

• Create a web-log and allow fellow practitioners to come together in conversation without having to travel.

• Practitioners in the health care field must have an equal stake in the system to allow for better communication and integration of services.

• Provide incentives to practitioners for the set up of multi-disciplinary care networks.

• Involve pharmacists with physicians to check for potential drug interactions upon a patient’s discharge.

• Develop a common language for use by practitioners across all health sectors.

• Call on volunteers and retired nurses instead of doctors to perform blood pressure and blood sugar testing in long-term senior-care facilities.

Physicians and Surgeons

Comments and Concerns

• The gate-keeping of British Columbia’s health care by physicians must change.

• Doctors may be blocking their professional allies from practicing to their full potential.

• Physicians are not taking full advantage of allied health services.

• Health care may be unduly centred on the methodology of the physician.

• Physicians may be discontinuing care to patients who choose a Registered Midwife for their services during childbirth.

• Physicians may be withholding referral of their patients to certain fields of practice due to a lack of personal respect for their methods.
• Doctors may be hesitant in relinquishing some of their practicing responsibilities to Registered Nurses.
• Physicians may not be conducting referrals over the phone to a lack of remuneration for this service.
• Many family doctors are opting out of birthing as part of their practice.
• A doctor should be the only practitioner to write prescriptions.
• There is an abundance of specialist practitioners yet far too few general practitioners in British Columbia.
• The health care system is pushing the family doctor out of the continuum of care.
• An overwhelming demand for cosmetic surgery is consuming surgeons.
• Only 20 per cent of general practitioners provide child delivery services in British Columbia.
• Some doctors may not be recognizing and utilizing alternative medical treatments.
• There are fewer doctors accepting new patients.
• The rushed environment of the doctor’s office is leading to over-prescription and less actual counselling and advice by physicians to their patients.
• The physician’s toolkit of pharmaceuticals, surgery, nuclear medicines and wait-and-see is extremely concerning to some.
• Physicians are responsible for admitting and discharging patients to and from acute care hospitals and ordering diagnostics. Many of these diagnostic tests are unnecessary and do not advance the health of the individuals receiving them.
• Doctors are restricted to one visit per patient, per day.
• The rule employed by some physicians of one-issue-per-visit does not address those with an interrelated series of medical issues or concerns.
• Surgeons are not limited in their practice by a lack of resources, but by a budget of operational time that quickly expended.
• With general practitioners no longer practicing in emergency rooms, health care now employs emergency room physicians but at a premium cost. The general practitioner’s role in hospital has been broken down into many, more expensive specialty fields.
• The shortage of available family doctors is putting a large strain on emergency room staff.
• Encourage general practitioners to use all their expertise for the benefit of their patients by ensuring the availability of support staff, equipment, and facilities for their use. This would include:
  
  • Increasing access to acute, rehabilitation, psychiatric and long-term care beds;
  • Increasing operating room capacity in community hospitals to reduce surgical wait-times and to provide emergency obstetrical support; and,
  • Increasing diagnostic imaging capacity such as ultrasound, Computerized Tomography (CT) and Magnetic Resonance Imaging (MRI) in every region. Remove barriers to general practitioners ordering these tests and where possible use mobile and remote technology to reduce travel for rural residents.

• There is a severe shortage of available operating room time offered to surgeons.

• Physicians are physically exhausted due to excessive workloads.

• The amount of time a doctor is allotted to a patient is not enough to properly assess their needs and issues.

• Physicians are operating outside of the medical system’s methodology.

• The ability for a physician to pick and choose their patient lists represents an unethical use of their authority.

• The act of running a physician’s office, and practicing within that office constitutes a conflict of interest.

• Re-assess the list of reserved acts for certain health professionals.

• Physicians see themselves primarily in a treatment role rather than that of a practitioner who can help prevent illness and disease before it occurs.

Ideas and Suggestions

• The provincial government must realize and appreciate the importance of family medicine. Family doctors provide most of the care in this province and are involved in cradle-to-grave care, promotion of health prevention, well being, mental health, acute care and much more.

• Address the current labour shortages by increasing the number of general practitioners and allow them an increased field of operational duties.

• Involve doctors in the decision making process when allocating health care funding.

• Re-engaging doctors in the system will allow doctors to take ownership in their system and to align their incentives with those of the public system. They would
drive health care systems towards efficiencies based on effective ways of providing care.

- Implement a system of rewards to physicians for taking on difficult cases, for going above the call of duty, and for referring non-urgent cases to a medical clinic rather than letting them populate emergency waiting rooms.
- General practitioners should be offered incentive for taking on patients in a family practice.
- If physicians were able to practice to their full potential patients would not continually be coming to see them.
- Doctors should be able to teach their patients strategies in health prevention.
- Preventative health is delivered by a paediatrician up until the mid-teenage years in Argentina; a general practitioner could provide these services in Canada.
- Increase the physician’s role in smoking cessation.
- Stop the provincial government from restricting the physician’s choice in treatment options to those that are relatively inexpensive.
- Physicians require the education and knowledge to be able to focus on the more obscure types of cancer.
- Physicians should have the ability to refer patients to peer support groups.
- Physicians attending to cancer patients must be more compassionate in their methods of communication. These patients should have a choice in how they hear results and opinions.
- Grant oral surgeons hospital admitting privileges under the hospital act; they currently require a physician to co-admit their patients which creates redundant costs within the system and puts the patient’s safety at risk.
- Pay physicians to review tests or x-rays and allow them to consult the patient via e-mail or over the phone.
- Expand the amount of daily hours a physician may work.
- Remove the limits on the number of patients a physician can treat or assess per day.
- Doctors should have the authority to charge more for extended visits in their practices in order to fully assess their patients.
- Hire clerical staff to take over the typing duties of doctors and relieve the expensive training time doctors require on these typing systems.
- Doctors must perform their own typing.
• The family physician should remain as the coordinator of care.
• Whilst still in training, educate doctors of the roles and content of other professions to provide more knowledge when referral is necessary.
• Doctors should be encouraged to work in groups and take some of the overtime stress off nurses.
• Encourage specialists to carry out common treatments and procedures and relegate the more complex cases to exceptional general practitioners.
• Scale back the role that major pharmaceutical companies have in drug education.
• A practitioner other than a physician should be responsible for the renewal of long term prescriptions.
• Allow for more home-visits by doctors.
• Doctors must have contingency plans for all of their patients when they choose to relocate their practice.
• Emergency rooms require the presence of more doctors or specialists.
• Hospitals require stand-by practitioners at peak hours of operation.
• The time a surgeon or physician receives in the operating room should be proportional to the time they practice in their clinics or hospitals.
• Create a network of patient co-management through the use of accessible electronic health records.
• Replace doctors with computers and make nurses liaise between the patient and the computer.
• Patients should possess the ability to correspond via e-mail with their doctors.
• Reimburse specialists for consulting with family doctors over the phone.
• Patients should have the option to relay diabetes self-test results over the phone to their general practitioner.
• Physicians in Canada have more autonomy when it comes to wait-list management than in any other jurisdiction.
• Doctors possessing the appropriate training to treat those patients with mental illnesses are in high demand.
• Doctors may not possess the financial training required for budgeting tasks so make them accountable to a board or panel comprised of experienced business professionals.
• Doctor should be responsible for a proportionate cross-section of their community instead of hand-picking patient lists.

• A Physician’s Assistant is medically trained for surgery and general practice while under the auspices of a general practitioner. They operate with certain autonomy and free up the general practitioner to attend to more acute or complex cases. British Columbia would benefit from their implementation alongside physicians.

• Minor procedures such as mole-removal being relocated to within the doctor’s office would prove to be a significant savings.

• The expectations that doctors keep to their scheduled appointments should be raised. Doctors should be rewarded for their own efficiency and doctors who think it is alright to come in late should be penalized.

**Nurses**

**Comments and Concerns**

• Nurse Practitioners are not doctors and do not have the expertise or education to deal with all specialties and illnesses.

• Be careful with Nurse Practitioners. Although an experienced Nurse Practitioner, willing to make tough decisions would do a good job at less cost than a physician, there may be downfalls to allowing them the authority. First, the Nurse Practitioner will see the patient and then simply send them on to the doctor. Second, the Nurse Practitioner will spend an hour seeing a patient with a simple sore throat. Both factors result in increased costs rather than savings.

• There is little public knowledge of the different roles and practices that nurses carry out in British Columbia.

• Nurses, who are staffing hospitals twenty four hours seven days a week, take on the Physiotherapist’s role, the Occupational Therapist’s role, and the Registered Massage Therapist’s role when they are not present.

• Nurses have to carry out the duties of a porter due to a lack of support resources.

• High wage earning nurses are emptying laundry baskets.

• Nurses and nurse’s assistants are over-worked and tired.

• Nurses working long overtime hours are sustaining the current health care system.
The twelve hour shifts that nurses are working are not effective both in cost and patient outcome; nurses are less productive after ten hours of work due to exhaustion.

Nurses are spending too much time caring for elderly patients awaiting placement when they should be dealing with other issues.

The Registered Nurses’ union lobbied aggressively against Licensed Practical Nurses, yet a few years later, Registered Nurses went on strike when their workload dramatically increased.

It is difficult to reactivate a Registered Nursing license and the Registered Nurses Association of British Columbia is not actively assisting nurses who are in this situation.

There is no colour coding in the dress of nurses and licensed nurses and many employees will wear their identification badges inside their pocket for their convenience. This may lead to a family member searching for hours to find the nurse in charge of care for their family member.

Due to shortages in staff, nurses are offered promotion far too quickly. They become overwhelmed with their responsibilities and leave practice after a very short period of time.

There may be no work for an expanded nurse’s role within the health care system.

Nurses lack a clear and defined leader within the workplace.

It is challenging to find nurses willing to take on leadership positions due to a recent drop in wages.

The professional bodies that govern Licensed Practical Nursing and Registered Nursing retain sole control of curriculum, licensing and field of practice regulations.

The contracting-out of cleaning and sanitation services has unduly shifted these responsibilities to nurses.

Nurses and doctors dominate the current culture of healthcare; this culture lacks critical reflection about its influence and power within the healthcare community.

Some aid station personnel are probably forced to operate beyond their scope of practice.

Nurses do not spend enough time providing support and education to patients and their families. Post-operative monitoring is also inadequate.
Ideas and Suggestions

Nurse Practitioners
Licensed Practical Nurses

- Ideas about Nurse Practitioners:
  - A greater reliance on Nurse Practitioners, alternative and complimentary therapies can save the system money.
  - A Nurse Practitioner can provide all the services that a general practitioner is responsible for.
  - The health authorities and the provincial government should set up clinics throughout British Columbia staffed by Nurse Practitioners to deal with routine examinations such as blood pressure, wound dressings, ear, nose, throat, and other minor problems.
  - Within isolated communities, Nurse Practitioners could provide a wide range of medical services in lieu of a doctor, including medication prescriptions and attending to emergencies.
  - Include Nurse Practitioners in gaining information on patient needs which may aide in diagnosis.
  - The list of Reserved Actions should put clear limits on what a Licensed Practical Nurse can do and shrink their scope of practice.
  - Many elderly patients will benefit from the more holistic method of care adopted by Nurse Practitioners.
  - Challenge the current culture of only allowing Nurse Practitioners employment in safe, low-risk scenarios.
  - The Nurse Practitioner is able to take the time to give patients the attention they require.
  - Nurse Practitioners should not be doing administrative tasks such as answering telephones and the filing or filling out of paperwork.
  - Nurse Practitioners should make house calls.
  - Nurse Practitioners have been extremely successful in the operating room. They are responsible for the pre-operation and post-operation work, which frees up the doctor to perform other operative services.
  - Allowing Nurse Practitioners to practice medicine independently will only result in more referrals and longer wait-lists resulting in a higher overall cost to the system.
• Allow the Nurse Practitioner to become the primary point-of-entry into the health care system.

• Ideas about Licensed Practical Nurses:
  • Do not replace Nurse Practitioners with full-scope Licensed Practical Nurses since this would constitute a danger to the public.
  • Licensed Practical Nurses can provide patient education, intervention, and assessments in lieu of a doctor’s presence with that patient.
  • Chronic disease management should be governed by Licensed Practical Nurses who have the time and opportunity to engage in discussions of non-critical matters with the patient.

• In some cases, nurses have gained some autonomy; for instance, a nurse will demand an x-ray to ensure that there is an issue before bringing in a doctor.

• Create specially trained nurses to deliver a wider array of services.

• Replace the doctor’s role in the health care system with a Registered Nurse, and replace Registered Nurses with Licensed Practical Nurses.

• The enhancement of Care Aides would allow Registered Nurses to perform more in accordance with their training.

• Nurse’s aides and Licensed Practical Nurses should bear more of the nurse practitioner’s workload in order to cut back on their expensive need for overtime.

• Increase the availability and role of the prevention nurse within small communities.

• A health services navigational nurse would guide a patient through treatment options and avoid duplication of testing; providing a significant cost savings to the health care system.

• Nurses practicing in emergency rooms require more authority and autonomy.

• Introduce or expand existing school nurse programs in public grade schools.

• Administrative support services are required to assist nurses in their administrative duties.

• Establish a floor supervisor responsible for operation of a certain floor within a hospital.

• Train some nurses to be responsible for the treatment of a single type of cancer; for example, one nurse would be solely responsible for breast cancer patients, while another nurse would be responsible for treating those with lymphoma.

• Nurses should not be restricted from working under private contract.
• Nurses do not require, nor should they be authorized for any further authority within the medical system.

• Those with chronic diseases benefit from increased exercise and proper nutrition; the appropriate service provider should replace the doctor in these roles.

• Transform the role of the older, experienced nurses into that of an educator. They would educate patients and their families concerning available resources and where to find them in the health care system.

• Allow nurses the authority to set broken bones and suture wounds.

• Promote the Nurse Hotline more; they may be able to resolve a lot of issues over the phone before.

• Raise the authority level of Southern British Columbian nurses to equal that of those in the North.

• Develop a system of care that utilizes an Advanced Practice Nurse, trained in the principles of primary health care.

• If the prevention nurses were the sole administrators of vaccines, there would be a decrease of general practice visits and, therefore, a cost savings.

• Determine and implement a benchmark nurse-to-patient ratio.

• There is a need for more privately owned supervision and control of cleaning services within hospitals; it is not the nurse’s responsibility to check on the cleaners’ thoroughness.

Pharmacists and Pharmacology

Comments and Concerns

• The relationship between physicians and the pharmaceutical companies has been deemed inappropriate:
  • Physicians are receiving gifts and free trips for prescribing based on brand and quantity;
  • Doctors may feel obliged to favour one drug over another due to an influence by pharmaceutical representatives; and,
  • The education a physician receives regarding certain drugs is almost entirely provided by a pharmaceutical brand representative.
• Doctors should not prescribe vitamins because they do not have the time available to do an in-depth assessment for vitamin requirements and doctors would need to retrain education on vitamins.

• Most doctors are still in the habit of hand-scribbling prescriptions; this may have something to do with tradition but does nothing for the quality of patient care. On two occasions over the past two years, a particular pharmacist had to phone the prescribing doctor to clarify his writing. There is no downside to electronic preparation and transmission of prescriptions.

• Prescriptions are increasing at an alarming rate; focusing on more preventative methodology will decrease the public’s need for pharmaceuticals.

• Non-clinical issues are overwhelming community pharmacists.

Ideas and Suggestions

Pharmacists

• Ideas about pharmacists:
  • Pharmacists should be solely responsible for writing and handling prescriptions.
  • Pharmacies do a good job in educating the patient on the proper use of their prescription.
  • Pharmacists are well versed in the proper utilization of medication; they are concerned when drugs are unnecessarily prescribed to people and with no explanation of their side effects.
  • Pharmacists should be able to refill prescriptions and/or prescribe medication for chronic illnesses. One pharmacist comments that he has made drug therapy the focus of all of his education yet he cannot prescribe. On the other hand, a family physician, trained in diagnosis, has minimal knowledge of the medications they are able to prescribe.
  • Pharmacists should not be able to prescribe medication or refill prescriptions for the following reasons:
    a. Family physicians need to be able to recall a patient to monitor their health and the medication that they are taking;
    b. It hinders a family physician’s ability to keep track of all the medications that a patient is taking, even with the communication that has been established over the years between specialists and family physicians; and
c. If you introduce another person who can also prescribe medication, it will be even more confusing and more difficult than it is now and that it is a real problem in family practice.

- In Europe, pharmacists are able to make routine prescriptions that save on doctor visits.
- Authorize licensed pharmacists to re-issue prescriptions. They could renew prescriptions and notify the doctor for inclusion in a patient file using electronic prescribing assisted by decision support software.
- Pharmacists should be responsible for educating doctors about pharmaceuticals and their side effects.
- A consultation by a pharmacist could help prevent hospitalization.
- Pharmacists should be able to renew prescriptions for up to one year before a patient needs to see their doctor again or the patient’s circumstances change.
- Pharmacists should review a person’s dispensing history and follow-up with those to make sure they are finishing their drug therapy.
- Allow pharmacists access to patients records to better monitor their conditions.
- People should rely more on their pharmacists for health information because they possess a vast wealth of knowledge.
- Pharmacies should be able to assess and help treat conditions as a primary care facility.
- Patients should not have to visit a doctor in order to have prescriptions refilled. Pharmacists should be able to refill prescriptions and have access to patient records to guide them.
- A nurse should be responsible for carrying out simple blood pressure tests prior to renewing a prescription.
- The public should be able to renew a prescription over the phone
- Pharmacists and Nurse Practitioners should be able to prescribe medication.
- The process of writing repeat prescriptions for those with chronic diseases should be transferred to the authority of a suitably trained nurse.
- Reward doctors who keep their patients healthy and free of pharmaceuticals.
- A nurse should be able to fill prescriptions over the phone after a mandatory check up. In this case, the physician would get a discounted rate of pay.
Dental Care

Comments and Concerns

Certified Dental Assistants

- Comments on Certified Dental Assistants:
  
  - Certified Dental Assistants are well suited to the provision of safe and effective public oral health services. However, the draft dentists’ bylaws and the requirements for supervision prevent Certified Dental Assistants from practicing their profession to the full extent of their capabilities, which limits access to care.
  
  - Certain concerns were raised over Certified Dental Assistants who may have failed the national exam, have not met national standards and have not finished their training yet are being allowed to practice.
  
  - One profession (Certified Dental Assistants) being regulated by another profession (the College of Dental Surgeons of British Columbia) has far too many inherent conflicts of interest.
  
  - The proposed by-laws for the College of Dental Surgeons of British Columbia on classes of Certified Dental Assistants may prove to be very confusing. A clinic could potentially have four different classes of dental assistants:
    
    a. Practicing certified;
    b. Temporary certified;
    c. Limited certified; and,
    d. Dental assistants.
  
  - Certified Dental Assistants receive education relating to preventive health. However, the circumstances in which a Certified Dental Assistant may legally provide oral health promotion and preventive services are limited to the public outside of the private dental office.
  
  - The draft dentists’ bylaw perpetuates a situation wherein dentists may delegate a critical task such as infection control for the entire dental office to someone who is potentially untrained and has not demonstrated a recognized standard of performance or competency in this task.
  
  - Dental assistants have been recognized as an independent and self-regulating profession in a number of other provinces. However, British Columbia reinforces outdated regulations that place dental assistants in a position where their employer may also regulate their profession.
• Current legislation prevents Dental Hygienists from operating to their full capacity. There is a need for independent Dental Hygiene practices but the current legislative restrictions create road blocks in the profession’s ability to provide a viable program. Dental Hygiene is a separate entity from Dentistry.

• The by-laws proposed by the College of Dental Surgeons of British Columbia are confusing, hard to read and thus not meeting the requirement of public transparency.

• The proposed by-laws by the College of Dental Surgeons of British Columbia place intra-oral skills in the so-called public domain. These skills are consistently taught in dental assistant programs across Canada and are authorized acts for licensed dental assistants in the rest of Canada. The placing of these skills within the public domain does not occur in any other jurisdiction in Canada.

• Dental Hygienists cannot bill directly to a patient's dental plan which again hinders access to care because it adds another complication to preventive care.

• The bylaws for Registered Dental Hygienists limitations on practice require a client be examined by a dentist during the initial visit or prior, up to 365 days, to clinical services being provided. This by-law is restrictive to home-bound and handicapped clients who cannot access a regular dental office. Many registered dental hygienists are willing to provide care to clients in their homes or at alternatives to a regular dental office, but are limited by the requirement for a dentist to provide an exam.

• Concern was aired regarding the possibility that dental offices may be discouraging clientele on income assistance from seeking dental services. General dental practices may not be accepting dental insurance assignments from individuals who are receiving Income Assistance.

Ideas and Suggestions

Certified Dental Assistants

• Ideas about Certified Dental Assistants:
  • It is the Certified Dental Assistants of British Columbia’s assertion that regulation of Certified Dental Assistants be removed from the authority of the College of Dental Surgeons of British Columbia.
  • A Certified Dental Assistant can efficiently, effectively and safely maintain a clinical practice.
The Certified Dental Assistant provincial curriculum instructs the student in current standards of dental practice. This education leads to the practical application of knowledge demanded by this profession.

Certified Dental Assistants possess formal training in cardiopulmonary resuscitation (CPR) and first aid.

Review the draft dentists’ bylaws about Certified Dental Assistants’ practice in public health. Create standards for enhanced education and training for expanded dental assistants.

Develop vision for certified dental assisting practice in public health.

Create bylaws reflecting the importance of access to care and sustainability that allow certified dental assistants to practice most effectively in the wider public domain in the area of oral health promotion and delivery of preventive services.

Produce a recognized College of Certified Dental Assistants under the Health Professions Act.

All dental assistants should be Certified Dental Assistants.

Ensuring appropriate autonomy of Certified Dental Assisting regulation requires:

a. Embracing a definition of public interest that not only guarantees lack of bias or apprehension of bias but also guarantees a demonstration of professionalism through rigorously established standards.

b. Entering into a discussion about and agreeing upon valid determinants for decision making about appropriate autonomy in regulation for certified dental assisting. These determinants must include placing as much weight on aspects of public interest mentioned in number 1 as are placed on the risk of harm.

c. Place the profession of certified dental assisting in the best position to articulate statements about its regulation in the public interest because it knows itself best.

d. Removing certified dental assisting regulation from the authority of the Certified Dental Assistants and support the creation of a college of certified dental assistants under the Health Professions Act (HPA).

e. Engaging with the Certified Dental Assistants to determine a new approach for the regulation of certified dental assisting in order to find new ways to guarantee access to safe, sustainable care for all British Columbians.

Recognize only one standard of dental assisting in regulation which is that of an educated and qualified dental assistant certified by the regulator. Modify references
to dental assistants in the dentists' draft bylaws with this single standard as the benchmark.

- Dental Hygienists should be considered the primary care gateway to dental health.
- Halt the approval of the proposed by-laws by the College of Dental Surgeons of British Columbia until the Conversation on Health has concluded.
- Access to preventive dental hygiene by registered dental hygienists is an integral part of overall health.
- The system whereby a dental hygienist refers a patient for examination not only improves oral health, but increases the likelihood that those disadvantaged patients will access dental care at some point.
- Remove the requirement for a patient to have seen a dentist within 365 days in order to receive treatment by a dental hygienist.
- Dental assistants in Saskatchewan have been regulated since 1969 and self regulated since 1998. This has contributed to all practitioners operating to their full scopes of practice while working as part of a multi-disciplinary team.
- Include public health programs, their evaluation and monitoring, and the evaluation of personnel.
- Through collaborative research, create standards for enhanced education and training for expanded dental practice in long-term care, seniors' residential care and home care environments.
- Provide an update on existing research in the areas of children's dentistry and the enhancement of dental health for First Nations, tobacco users, and the working poor.

**Eye Care specialists**

**Concerns and Comments**

- Optometrists in all but two jurisdictions in North America can prescribe medications. British Columbia comprises one of the two provinces that disallow this practice.
- New regulations regarding sight testing place Opticians under the control of Optometrists, their market competitors. This may force the closure of many Opticians’ doors.
• British Columbian optometrists are restricted from practicing to the full extent of their training by not being able to prescribe therapeutic pharmaceuticals. This leads to the over-utilization of physicians and emergency resources.

• An Optician is not allowed to check their client’s visual acuity and dispense new corrective lenses, even with only a slight modification. This means the client who wanted to be assured of their visual acuity is now required to return to the Ophthalmologist or Optometrist for a sight exam, but would also in receive and unnecessary eye health exam.

• Our aging population brings with them an increased incidence of chronic eye disease. This demographic will require a greater need for ophthalmologists’ services; the subsequent waiting lists for procedures such as cataract surgery will only lengthen.

• There is a growing awareness that the ratio of ophthalmologists to patients is falling and is particularly acute in the non-urban and rural settings of British Columbia.

Ideas and Suggestions

• Optimizing vision care requires permitting optometrists to practice to the limits of their training and abilities. They must be able to prescribe therapeutic drugs to aid in the treatment of chronic eye disease.

• Clearly defining the general practitioner’s, optometrist’s, and ophthalmologist’s scopes of practice may enhance the efficiency of vision care provision. These designations may also free up ophthalmologists to perform services that only they are trained to provide, thereby helping to maintain waiting lists at more acceptable levels.

• A working group in Nova Scotia focusing on eye care has developed an integrated vision care initiative for the management and treatment of patients with red eye and diabetes based on explicit delineation of scope of practice for general practitioners, Optometrists, and Ophthalmologists.

• Permitting Doctors of Optometry to practice to the full extent of their training and adopting a policy of service-based rather than provider-based coverage will increase the efficiency of health care systems by reducing redundant billing.

• Many agree that an automated sight test, also called auto-refraction, has been scientifically proven to be a safe, reliable and reproducible test. It uses equipment and a sophisticated computer program to test and measure visual acuity. It also calculates whether clients would see more clearly with the help of corrective lenses and determines the strength of lenses needed.
• The College of Opticians of British Columbia believe the amendment to the Opticians Regulation will provide a safe and effective service, will better inform the public about issues of eye health and will increase the identification and appropriate referral to other eye specialists of potential vision problems in citizens that might otherwise go unidentified.

• The College of Opticians of British Columbia has designed multi-level screening program to exclude from automated sight testing those individuals at higher risk for eye health problems, who instead need to have complete eye health exams. Clients will also be screened on the basis of the results of the sight tests and those persons identified who require a complete eye health examination will be referred for further investigation.
Complementary and Alternative Medicines

Complementary and alternative medicine was among the issues raised by many participants during the Conversation on Health. Health professionals, education and awareness, complementary and alternative practitioners, administration and Medical Services Plan coverage were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of complementary and alternative medicine.

Health Professionals

In general, participants feel that health professionals do not accept alternative medicine or support patients’ right to chose. They believe that doctors do not have adequate knowledge and training of alternative therapies or enough incentive to recommend them. They also think that doctors have a duty to increase their own understanding of these therapies. Without it, they argue, patients will not receive the collaborative expertise of all health professionals providing the best possible care.

Suggestions focus on cooperation between doctors and alternative practitioners as the key to receiving high quality treatment. Doctors should have to learn about alternative therapies and different cultures and practices, including First Nations traditional healing, and blend this knowledge into their own practices. Participants feel that this will lead to medical care that puts the best interests of the patient first.

Blend traditional First Nations medicines with conventional western medicine. Educate health professionals about different cultures and practices.
– Health Professionals’ Forum, Prince George

Education and Awareness

Submissions identify poor education about complementary and alternative medicine as a factor in its limited use by the medical community and the public. Though some indicate that awareness has increased over the past few decades, many argue that a lack of information about alternative therapies has led to the unnecessary progression of treatable chronic conditions. Others also note that alternative medicine may completely prevent certain illnesses and reduce the need for expensive curative treatment.
Many participants suggest that alternative practitioners could inform the public about lifestyle patterns such as eating and sleeping habits, which may enable individuals to notice and correct signs of ill-health on their own. Increased awareness may also allow chronic disease sufferers to better manage their symptoms and avoid the need for acute health care. Participants think that more education would lead to greater patient empowerment.

Complementary and Alternative Practitioners

Participants’ opinions about complementary and alternative practitioners were split. Some think that these practitioners are not as well-trained and cannot offer the same level of care as Medical Doctors; others were impressed by their skill. Many voiced concern that alternative practitioners, particularly Naturopathic Doctors, lacked the ability to access laboratory results, refer patients to specialists and visit patients in hospital. Quality of treatment causes disagreement as well: though some patients receive excellent care, others saw no benefit from the treatment they receive from alternative practitioners.

Administration

Accreditation of alternative disciplines is a source of varied opinion in the Conversation on Health. Some argue that practitioners such as naturopaths based their therapies on sound scientific practices. Others disagree and counter that the health care system needs an accreditation and regulatory approval body that would identify the appropriate scope of practice for groups of practitioners based on evidence. Still others take the middle road, willing to see alternative therapies funded if further research proved their benefit.

_"I think great care should be exercised in incorporating alternative medicine in to the publicly funded system. It should be defined just what procedures will be used, and are they researched and regulated by a Board of Oversight. The costs should be closely audited and regulated._

– Web Dialogue, Surrey
Medical Services Plan Coverage

Much of the comment about coverage for complementary and alternative therapies under the Medical Services Plan focuses on the effect of cost to individuals. Some feel that the lack of coverage is a barrier for the public, particularly low-income families, to accessing treatment from alternative practitioners. Having to pay out-of-pocket for these treatments leads others to feel financially over-burdened: they pay both to support the health care system and to choose alternative health care.

*Alternative medicine should be integrated and encouraged as part of the health care package. Currently, it is too expensive for many of those with chronic diseases.*

– Regional Public Forum, Castlegar

There is no clear-cut agreement about whether or not complementary and alternative therapies should be covered. While some think patients choosing these therapies should pay their own way, others say the treatments should be covered, describing them as effective alternatives to costly and more conventional care. They cite increased affordability of and accessibility to services as the main benefits to coverage under the Medical Services Plan.

Conclusion

The discussion about complementary and alternative medicine centres on choice in the system and collaboration between all health professionals. Though participants cannot agree on whether complementary or alternative treatments should be covered by the public health care system, the majority believes that more treatment choice would benefit many British Columbians, and particularly those suffering from chronic illness. Many participants advocate a cooperative treatment atmosphere, involving many health practitioners in treatment rather than one point-of-entry to the medical system. They argue that this approach will provide higher quality, more holistic care for patients in the province.

*Sure, complementary and alternative medicines, just to let people have options. Even at these centres if people want to find out what options do exist for them, they can ask, you know, this is my problem; is my only option to just go to the medical doctor, or can I see a physiotherapist without a referral? Or can I see a naturopathic doctor without a referral? What kind of services exist in this community?*

– Focus Workshop on Complementary and Alternative Medicine, Vancouver
Complementary and Alternative Medicines

This chapter includes the following topics:

**Health Professionals**
**Socio-Economic Issues**
**Chronic Disease Management**
**Education and Awareness**
**Complementary and Alternative Practitioners**
**Administration**
**Medical Services Plan Coverage**
**Alternative Care Providers Role in the Team-Based Model**

**Related Electronic Written Submissions**
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

- Presentation to Conversation on Health
  Massage Therapists Association of BC

- Submission to the Conversation on Health
  Health Action Network Society (HANS)

- BC Conversation on Health A Partnership...for Health Care or Wealth Care
  British Columbia Chiropractic Association

- Brief for The BC Government’s Conversation on Health
  College of Massage Therapists of BC

- Report to the Conversation on Health
  BC Cancer Agency

- Submission to the Conversation on Health
  Life Sciences British Columbia

**Related Chapters**

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including:
Chronic Disease management, Medical Services Plan, Primary Health Care, Health Care Models and Collaboration in the System.
Health Professionals

Comments and Concerns

- Doctors and the British Columbia Medical Association do not support patients’ right to choose alternative services.
- Doctors have become the gate keepers of medicine. They feel they have ownership of the medical system and a paradigm shift will be very difficult.
- The medical model is too focused on the physical aspects of health. Patients are people, not parts.
- Doctors do not have adequate training in alternate therapies and do not support their use.
- The public already frequents alternative practitioners and uses herbs and natural medicines; doctors should not be ignorant of these treatments.
- Doctors are threatened by alternate care and use of supplements, which results in a tendency to over-treat patients with conventional medicine.
- Patients accessing both allopathic and alternative practitioners are often pressured by their general practitioners not to waste their time and money on alternative therapies.
- There are no incentives to physicians to suggest alternative therapies; incentives come from billable hours and prescriptions.
- Practitioners not working in co-operation with each other in the best interests of the patient are fearful of jeopardizing patient welfare through the introduction of prescriptions that, combined with other therapies, may have negative patient interactions.
- Some medical researchers are closed-minded and less receptive towards understanding the holistic medicine approach.
- I think doctors inadequately know their patients. Rarely do you find one who asks about your nutrition, your stress levels, your digestive tract, your relationships, your sleep habits. All these things that affect one’s level of well-being.
- There is far too much reliance in traditional, allopathic medicine on drug treatment, rather than the root of the problem.
- Many of the medicines prescribed by traditional doctors either mask the pain or cause bad side effects.
- Allopathic practitioners often play with people’s health in trying different treatments, which they have no idea will be effective or not.
• Any medical doctor who is a member of the Canadian Medical Association can also practise alternative, complimentary methods.

• I am all for alternative medicine provided its benefits are proven and prescribed or recommended by a doctor.

• I think attitudes among conventional medical practitioners are changing.

• My general practitioner and my naturopathic doctor work together keep me as healthy as possible and therefore save the health care system from future costs associated with diseases that are now preventable or manageable.

**Ideas and Suggestions**

• Given patient first principles. It should be the expectation of the system that various experts collaborate, without prejudice, in the best interest of the patient.

• Change the disdain individual medical practitioners have for regulated complementary practitioners; the tradition starts in medical school.

• Preventative and symptomatic medicine can and must co-exist working together to bring human health to the greatest optimum level of living on this planet.

• Train all doctors to know a little about everything, including alternative therapies (for example, chiropractors or naturopathy). Blend traditional First Nations medicines with conventional Western medicines. Educate health professionals about different cultures and practices.

• Diminish reliance on drugs as cures; use other methods such as homeopathic.

• Doctors should be able to prescribe alternative drugs.

• Different professions have built research and need to share this information across medical disciplines.

• Introduce nutritional treatments in hospitals and allow our doctors to prescribe them.

• Free up medical doctors to use whatever products or devices they see fit for whatever condition they run across.

• The public needs to do more to remind people that there are services they can access before going to the doctor.

• The doctors of British Columbia need to visit European countries where allopathic and naturopathic traditions work side by side.
- Introduce mandatory education for health professionals on exercise and nutrition, and a sliding scale billing system to reinforce the shift in attitude along the lines of: highest payment for wellness checkups where holistic advice is given; next highest for illness checkups where holistic advice is given without the need for a prescription; and basic payment where prescriptions are provided.

- Doctors should be audited for properly prescribing drugs to ensure that they are not working for the problem.

**Socio-Economic Issues**

**Comments and Concerns**

- Low income people are seldom able to access alternative health care practices due to cost.

- Costs of alternative treatments are being borne by the patient regardless of their income level or ability to pay.

- There is reduced availability of complementary health care services, especially for lower income families.

- Some Registered Massage Therapists offer a sliding fee scale, which enables people with disabilities, seniors on limited incomes, residents of group homes and the working poor to receive needed massage therapy treatment.

- Unfortunately, the only people who are benefiting from naturopathy are those with enough money to pay for it privately.

- Some people need the financial support to access alternative therapies.

- Beneficial treatments by alternative practitioners are out of reach of some, especially pensioners.

**Ideas and Suggestions**

- Patients of medical doctors often cost the medical system over and over again because of increasing resistance to pharmaceuticals, adverse drug reactions, and continuing poor overall health. Our family, on the other hand, costs the medical system very little, but we pay a lot, even though we have a low income.
Chronic Disease Management

Comments and Concerns

- People are unaware that Traditional Chinese Medicine can cure or alleviate some chronic diseases.
- Restrictions to Medical Services Plan payments for alternative therapies have prevented many people from maintaining their health and alleviating chronic and sometime acute ailments.
- Naturopathic physicians have proven to be extremely useful in the treatment of chronic disease.
- Alternative medicine should be integrated into the health care system; currently, it is too expensive for many of those with chronic diseases.

Ideas and Suggestions

- British Columbians mentioned receiving benefits from the following supplements and treatments for their chronic illnesses:
  - Magnesium, Co-enzyme Q10 and fish oil supplements for cardiovascular illnesses;
  - ozone therapy;
  - St. John’s Wort for Depression;
  - valerian for sleep disorders;
  - Chinese kudzu for alcoholism;
  - flaxseed oil, omega-3, and Vitamin D for cancer treatment;
  - Prolotherapy instead of joint replacement;
  - Oblonga and saptrangi to treat diabetes;
  - Folic acid to treat stroke;
  - Chelation Therapy; and
  - Massage therapy for treating low back and neck pain, osteoarthritis, depression, and headaches.
- Macrobiotic diet does not only preserve good health; it can, in many cases, reverse the course of the sicknesses like cancer, heart diseases, and diabetes.
- Educate the public and health professionals that Traditional Chinese Medicine can cure or alleviate many chronic conditions.
• Western medicine is best for acute emergency situations, where Eastern medicine is better for treating chronic illnesses.

• I believe there are alternative therapies and medicines that can reduce risk factors in certain diseases so that there are less people who will require more expensive, conventional therapies.

• Podiatry services for seniors with reduced hand function or mobility can prevent infections and other problems related to inappropriate nail care.

• Massage therapy, physiotherapy and acupuncture are among these alternative therapies which have proved valuable to those suffering from chronic problems, such as osteoarthritis, soft tissue damage related to auto collisions, and workplace injuries. Naturopaths are successful and effective in treatment of allergy, lifestyle diseases and dietary problems.

• Establish learning forums for people with different medical conditions.

• Some ethnic groups, because of diet or other habits, experience some diseases with less frequency.

Education and Awareness

Comments and Concerns

• Education about alternative medicine is greatly lacking in our school system.

• Providing better information to the public about alternative medicines would help to level the playing field. We need to remove the barriers to accurate and complete information.

• There is limited access to and knowledge about First Nations traditional medicines.

• Provide information on First Nations traditional healing on website.

• Although ample information on allopathic therapies and practitioners is available through the British Columbia Health Guide and the British Columbia Nurse Line, virtually no information is included regarding alternative therapies.

• Over the past few decades, there has been a swing in public consciousness towards preventive and alternative practices that are still not fully recognized, acknowledged or supported by our government.
Patients who use alternative medicine seem to become much more aware of the inner workings and connections of their body, mind and spirit. They cease being just a patient and become much more active and knowledgeable in their health care plan.

**Ideas and Suggestions**

- Create a help information line for people who want to use vitamins and herbs
- Naturopathic physicians can play a big role in our health care dilemma in helping to educate on lifestyle and noticing patterns that can lead to potential disease.
- Alternative practitioners could offer free 15 minute consults, just so somebody can get information without having to make any type of commitment.
- Provide education for children in schools and media exposure for alternatives; promote through television, on milk cartons, and other spots for general public awareness.
- A widespread program of government sponsored public education would encourage patients with soft tissue complaints to first seek massage therapy treatments from Registered Massage Therapists.
- Put more non-drug treatment options into British Columbia Health Guide.
- Information about alternative therapies should be available in the Health Guide and through the Nurse Line. Make it easier to access information about the range of health services available to the public.
- People need to be educated about using alternative therapy when antibiotics cannot treat the disease.
- Hip and knee replacements, and so on are valuable but it would be better to teach people how to move so they do not end up needing these kinds of operations.
- Promote and support breast feeding.
- Allow alternative health care providers to advertise their services and products through the media.
Complementary and Alternative Practitioners

Comments and Concerns

Training
Scope of Practice
Treatment

• Comments about training:
  • Alternative practitioners, such as chiropractors and naturopaths, do not have the same scientific training as Medical Doctors (MDs); they are not trained in universities.
  • I am concerned that the Ministry of Health is making a huge mistake by trying to do away with the designation of Registered Aromatherapist. Registered Aromatherapists take specialized training in the essential oil blending, massage techniques, anatomy, physiology, and other courses that will give them the education to work with clients in a professional manner. Without this designation and training, any one could say they are an Aromatherapist.
  • I do not think that we can substitute someone with lesser training and expect them to deliver the same quality of health care.
  • I have used chiropractic, nutrition and physiotherapy and am completely impressed by the levels of knowledge and skill of the practitioners in these areas.
  • Naturopathic doctors save our current medical system tremendous amounts of money because they focus on prevention, education and curing diseases.

• Comments about scope of practice:
  • Naturopathic physicians lack access to certain services in the health care system (for example, x-rays, lab tests, visiting hospital in-patients).
  • The ability of our naturopathic physician to provide the care is compromised by outdated regulations. Any laboratory work that our naturopathic doctor determines is needed must be referred to our family doctor; naturopathic doctors also cannot refer patients to a specialist.
  • I am a practicing naturopathic doctor, and find it very frustrating not to be able to use a British Columbia provincial lab.
  • The idea that naturopaths might be able to refer people to specialists concerns me.
• I see the waste of provincial funding by the medical profession’s general lack of knowledge in soft-tissue injury and their effects. Alternative therapies can make the health care system work more efficiently by way of patient education, and direct treatment and rehabilitation of soft tissue injuries.

• I choose to go to a naturopathic doctor but I still need to go to a medical doctor for blood work and tests because that is what is covered. In the end, I spend more money and the services are duplicated because I have to see two doctors.

• Hip and knee replacements have become pandemic. There are other treatment options to explore before surgery is employed.

• Current research indicates that patients should try a course of conservative care (such as chiropractic or physiotherapy) for six months before many back surgeries should be considered.

• Arizona permits naturopathic doctors a very broad scope of practice: prescribing rights, referrals, access to labs.

• Comments about treatment:
  • I believe there is a strong corps of naturopathic doctors who do indeed offer valuable options which many of us desperately need, when standard therapies have not helped.
  • Alternative practitioners can take the time to educate patients about prevention and empowerment and, thereby, save money through early detection and treatment of many chronic diseases.
  • Chiropractors and naturopaths promote and build health with non-invasive procedures, vitamins, minerals, herbal supplements and healthy diet.
  • Alternative medicine looks at the whole person; treatment is often less expensive. I have seen too many traditional doctors prescribe a cornucopia of drugs that cause further problems for the patient.
  • Alternative therapies, such as Traditional Chinese Medicine, focus on the whole health of the person. They care about the fact that the person is out of balance. They recognize that the body wants to come back to health, and that it simply needs the support, through herbs, acupuncture and a relationship of trust and sharing with their health professional.
  • I refuse to go through with the doctor’s advice, which is to live on morphine to take away my pain. Instead, I am seeking alternative therapies to get rid of the pain altogether.
I have a chronic digestion problem and I visit my family doctor. I tried his prescription and came back several times; the improvement was minimal. Eventually, I tried alternative therapy. My problem was gone after three days.

Why is the chiropractic profession still being allowed to practice? This profession has injured many people, causing a huge expense to health care.

British Columbians noted that massage therapy has contributed greatly to treating many conditions, such as: chronic depression; Attention Deficit Disorder; Autism; developmental delays; eating disorders; and juvenile rheumatoid arthritis.

As a result of Celiac Disease and Irritable Bowel Syndrome, I sought alternative medical advice and have had great success through naturopathic medicine.

In 2006, I had surgery for colon cancer. At my own expense, I started a course of Traditional Chinese Herbal therapy and in July 2007 was discharged from Royal Jubilee Hospital Cancer Center with a test showing that I was cancer free.

**Ideas and Suggestions**

**Training**

**Scope of Practice**

- Ideas about training:
  - Naturopathic doctors’ education is just as detailed and scientific as medical doctors and our health care system could benefit financially by including them as a respected health care provider.

- Ideas about scope of practice:
  - Physiotherapists and chiropractors should be utilised sometimes before or without general practitioners visit. Physiotherapists and chiropractors should be visited first for musculoskeletal problems.
  - Traditional Chinese Medicine professionals should be able to treat their patients in the hospital; patients should be able to access dieticians without referral from doctor.
  - Naturopathic physicians who are trained in diagnosing, prescribing, and referring to specialists must be allowed to treat their patients in our public hospitals, and must be allowed access to laboratory testing, as other physicians are.
  - Alternative health care should be able to conduct initial assessments before patients go to a medical doctor.
• Herbs should be classified as drugs and be prescribed by qualified Traditional Chinese Medicine practitioners.

• Christian Science Practitioners and nurses want to be officially recognised and have the rights of patients who prefer to rely on healing prayer alone for there health care and recognise the valid needs of these patients equally.

**Administration**

**Comments and Concerns**

**Accreditation**

**Funding and Service Delivery**

• Comments about accreditation:
  
  • Naturopathic doctors follow scientifically sound practices as the recognized experts in natural therapeutics.
  
  • Naturopathic medicine is science-based primary health care that focuses on disease prevention and wellness.
  
  • Most alternative medicine is based on bad or no science.
  
  • Alternative practitioner cannot provide evidence to support their claims because they do not have access to health data.
  
  • The only thing I am opposed to are types of care that have no proven benefit. Prescribing marijuana to people without requiring that it be exposed to the same testing that other prescription drugs have to go through is ridiculous.
  
  • Health care resources should only be applied to treatments with proven health benefits; do not allocate funding resources to ineffective or unproven treatments.
  
  • Alternative and complementary medicine is far too loosely regulated, and definitely unproven. Mostly pharmaceuticals are prescribed, questionable blood testing done and in some cases downright dangerous practices are used.
  
  • Evidence-Based medicine has become the new buzz word in health care. The standard argument is that non-mainstream medicine is unscientific, unproven and therefore not worthy of inclusion in our publicly-funded health system.
  
  • There is a massive amount of clinical evidence proving that herbs, vitamins, essentials fatty acids, and so on have proven benefits. For a government to refuse to look at these proven benefits is not good.
• Acupuncture, massage, herbal, and other alternative therapies are based on medical practices that have been in existence for thousands of years.

• The recent designation of Traditional Chinese Medicine practitioners as doctors and primary care providers has established a positive precedent for other alternative therapy policy developments.

• Comments about funding and service delivery:

  • There are many health care services that provide support for health and well-being, even though they are completely disjointed; how do you integrate these services for the benefit of patients?

  • Incentives for doctors to practice in rural areas are more than double the total amount spent on supplemental services such as physiotherapy and massage therapy. This demonstrates the poor allocation of health care funds.

  • Cuts to the Medical Services Plan for alternative therapies have resulted in alternative practitioners moving to other occupations or geographic areas, thus creating a shortage of qualified resources for consumers.

  • I want the government to better monitor health professionals to protect the general public. There are people out there pretending to be doctors who are not.

  • I think great care should be exercised in incorporating alternative medicine into the publicly-funded system. It should be defined just what procedures will be used, and the costs should be closely audited and regulated.

  • The requirement to have drug information numbers for herbal remedies forced many small producers out of the marketplace.

**Ideas and Suggestions**

Accreditation  
Funding and Service Delivery  
Health Care Models

• Ideas about accreditation:

  • Practitioners of alternative medicines should be certified.

  • While alternative medicine is not regulated, there are lots of proven alternative treatments to drugs and surgery that are provided by regulated health professionals. Naturopathic doctors, physiotherapists, chiropractors, massage
therapists and doctors of Traditional Chinese Medicine are all licensed and regulated by the Ministry of Health.

- Make any group that wished to be funded become a professional body and provide formalized proof of training and the efficacy of therapies to be funded.
- The provincial government should regulate and set standards for alternative medicine and medical treatments, including standardised scientific licensing exams.
- Remove the title of doctor from Traditional Chinese Medicine practitioners. The government should not include Traditional Chinese Medicine as part of Canada Health Act.

- Ideas about funding and service delivery:
  - Our health care system could be improved if wasted money, spent on natural remedies was not an option that led into the mainstream health system.
  - Do not waste money on alternative medicine. It is the modern equivalent of the patent medicine salesman visiting rural communities in his wagon and selling snake oil to the country folk.
  - Spoon feeding pills and expensive diagnostic tests and operations only encourages dependency and increased disease care costs throughout the rest of the patient's lifetime.
  - Until we can be sure that alternative medicine helps and does not hurt, it should not be funded.
  - Complementary therapies should not be included under the pharmaceutical industry because the costs would escalate dramatically.
  - Re-commit funding to patient choice for treatment modality.
  - The Ministry of Health should consult alternative health care providers.
  - The federal government should be asked to fund a university evaluation of existing studies on various herbal treatments.
  - Funding the alternative system will also alleviate the shortage of doctors and specialist doctors.
  - Build incentives for preventing disease into the health care system; make alternative supplements and vitamins, Traditional Chinese Medicine, naturopaths, and homeopaths tax deductible.
  - Provide midwifery in the home.
• Recognize the science behind complementary therapies; provide more research funding and support objective studies of complementary medicine.

• There needs to be a return to a more traditional following of health care practices. Religion should be more at the forefront.

• The long-term costs to the health system from a lack of formal follow-up for joint replacement surgeries make any short-term recovery trivial.

• Is it not time to pass legislation forbidding the College of Physicians and Surgeons of British Columbia from taking action against such doctors unless a serious complaint has been made to the College by a patient?

• The government needs to honour the spirit of the Canada Health Act. Honour a patient’s right to choose alternative treatment.

• When you look at the approach to such issues as natural health products and the way of aligning traditional medicines with Traditional Chinese Medicine, again, British Columbia has lead the way.

• The Government of British Columbia has helped create a massage therapy profession that contributes to the health of patients from the birth to end-of-life.

• The Government of British Columbia must be commended for its stated commitment to modernizing the health care system. In The Picture of Health, the patients first principles focus on such factors as access, effectiveness, efficiency, safety, equity, and appropriateness.

• Ideas about health care models:

  • One aspect of the American system that should be looked at is the use of non-standard medical personnel such as naturopaths.

  • A recent trip to Australia highlighted these issues as naturopathic doctors are utilised by the general community for medical advice at least fifty percent of the time.

  • Many doctors in Australia also refer patients to alternative medicine practitioners and often work in conjunction with them to supplement each other’s advice.

  • In China, most hospitals have both Traditional Chinese Medicine and Western practitioners working together.

  • The best option for improved health for all is to promote and subsidize the production of raw goat milk such as Quebec is doing.
In order for health care to be sustainable, we must acknowledge alternate forms of medicine including chiropractic, homeopathic, physiotherapy, massage and herbal medicine along with nutrition and exercise.

**Outstanding Questions**

- How much provincial funding is being spent on seeking natural cures?

**Medical Services Plan Coverage**

**Comments and Concerns**

**Cost of Alternative Therapies**

**Choice in the System**

- Comments about the cost of alternative therapies:
  - It can often be more expensive to visit an alternative health practitioner, which can steer people away from excellent treatment options.
  - Alternative medicine has been helpful to a lot of people but it is too expensive to continue it for any length of time.
  - Chiropractic, acupuncturist and naturopathic services provide less costly, more effective results.
  - Complementary and alternative medicine is care for those that can afford it; British Columbia has a two-tier medical system.
  - It was the horrendous cost of the supplements and complementary treatments that finally turned me off. I do not think our public system can fund these treatments any more than it can fund the cost of all prescriptions meds.
  - Why are fees for chiropractors, naturopathic doctors, physiotherapists not covered by the Medical Services Plan? It is very disheartening to know that help is available but unaffordable for most.
  - If British Columbia takes a look at some European countries where they have integrated naturopathic doctors into the system, they are able to cut down on some of the costs; not everybody goes rushing into the medical doctor's office for this, that or the other thing.
  - It is good that complementary health care therapies are independent of our government funded health care system.
• Comments about choice in the system:
  • Previous cuts to payments for massage, chiropractic, naturopathic and other treatments demonstrate government’s failure to provide treatment options for its citizens.
  • The system does not support people who use alternative medicine: they pay tax toward medical services they do not use, and then pay out of pocket for alternative therapies.
  • For me and many of my family members, we are already paying out of pocket for our medical expenses. We resent having to support a medical system that doesn’t support our needs.
  • I believe the patient has the right to choose how they would like to be treated. This involves making all options viable and equally affordable. As it stands, patients have very little choice: they can go to a medical doctor.
  • I do not see why my choice of a doctor should cost me more money! Naturopathic physicians have the same amount of education, but possess potentially better knowledge for improving the health and well being of citizens.
  • It is ridiculous to expect people to take more responsibility for their own health if they are punished financially for making the effort. There are supplements that are extremely beneficial to an array of diseases or issues; however, they may be extremely expensive.
  • The public spends a lot of money on alternative medicine, which is not necessarily a savings to the health care system. It is still a cost to the economy and diverts funds from more effective measures.
  • I was dismayed when they were almost excluded from the medical health services. I had thought that British Columbia was extremely progressive in recognising the potential benefit that these modalities can have.
  • There are not a lot of options through the conventional system for treating conditions such as Irritable Bowel Syndrome. However, nutrition and dietary counselling are tremendously helpful.
  • There are now more options: acupuncture is more accepted; there is more information about alternative therapies; and more products are available in drug stores.
  • I also have to compliment you on your inclusion of midwives into the medical system. This is an awesome service that deserves to be promoted more.
Ideas and Suggestions

Cost of Alternative Therapies

Choice in the System

- Ideas about the cost of alternative therapies:
  - Fund alternative health care services under the Medical Services Plan, such as: naturopaths, aroma therapists, clinical counselling, herbologists, dental care, optometrist hearing aids, massage therapy and acupuncture.
  - Provide art therapy, music therapy, physiotherapy and horticultural therapy to long-term care residents.
  - Chiropractors are very accessible to treat acute and chronic conditions but are not being used or people cannot afford to go to them. Allow patients to choose chiropractors as a primary portal of entry to doctors, and make it affordable.
  - For using good preventative health and being less of a burden on the economy, why do I feel I am being punished financially? People need to be motivated to use the skills of natural health professionals to ease the burden on our system.
  - Patients of naturopathic doctors should be rewarded in some way by lower Medical Services Plan premiums.
  - I hope the Government of British Columbia incorporates alternative medical treatment in to the Medical Services Plan. By ignoring non-allopathic medical treatment the government is forcing a larger and larger segment of the population to pay high prices for their own medical care.
  - Legalized marijuana as a medical alternative therapy.
  - People should be allowed to make a certain number of visits per year to the alternative professional of their choice.
  - People who are unable to use mainstream medication should be offered assistance in attaining medication from naturopaths. If you have allergies alternative therapists, for example naturopaths, are very important and can save the system big bucks.

- Ideas about choice in the system:
  - Preventative medicines, traditional medicines and ceremonies need to be recognized.
  - I think that everyone should have a choice as to who we see and part of the fee should always be covered by the government.
There are areas of the health care system that can be improved through better integration of services provided by all health care providers, including naturopathic physicians, in a continuum of care that better reflects patient choice.

Allowing patients to choose what type of treatment they want would save the province a lot of money.

There should be more government funded research for non-lucrative processes and medications.

Let the people decide what kind of medical help they need rather than limiting it to only one type of medicine. In so doing, health care money will be better spent in utilizing much cheaper and often more effective remedies.

I can learn from visiting my holistic health practitioner and begin to care for myself and my family through this relationship. It is enabling me as opposed to making me rely on someone else, or another system.

I believe that anyone who uses naturopathic or holistic services should do so at their own risk.

Outstanding Questions

• How will British Columbia bring alternative health care into the provincial system?

Alternative Care Providers in the Team Based Model

Comments and Concerns

• Practitioners such as Chiropractic and naturopathic care are excluded from health care and this limits the general public’s understanding of what they do.

• Naturopathic doctors have restricted laboratory and referral privileges.

• Many doctors still shun alternative medical practitioners.

• Allopathic physicians do not currently accept that other practitioners have a place in the medical system.

• There is a division in primary care between naturopathic and general practitioners.

• The general practitioners have so much power and will not be willing to open up to other types of non-mainstream alternatives.

• Some doctors will not see a patient if she is using a midwife.
Doctors will not send test results to alternative practitioners.

Lack of collaboration and acceptance between alternative providers and medical providers.

Alternative and traditional practitioners often too reactive to each approach.

Concerns was raised that some patients suffer verbal abuse from their practitioners when they confide that they are seeking alternative care methods.

Medical doctors do not recognize the benefits of natural methods and their attitude prevails amongst themselves. There is a bias of medical people towards those whose choose not to use pharmaceutical drugs or conform to the health system.

There is a great reluctance on the part of doctors to refer patients to other types of health care which in many cases be of assistance. This due to a lack of knowledge, familiarity with, or competitive concern.

The Doctors and Surgeons Association will not allow a doctor to refer to alternative methods.

There is no hospital chaplain. People need for spiritual support.

**Ideas and Suggestions**

- Registered massage therapists, opticians, chiropractors, acupuncturists, naturopaths, nurse practitioners, pharmacists, homeopaths, and therapists are a cheap and effective first source of care rather than seeking out a Medical Doctor.

- There should be one wing in hospitals with a free Naturopathic Doctor, herbalist, acupuncturist, osteopath, massage therapist, Chiropractor etc and a free fully equipped fitness center open 24 hours a day, seven days a week.

- My neurologist monitors my Multiple Sclerosis. My family doctor takes care of my annual checkup. My naturopath, however, did more testing and had longer conversations with me about my health history, environmental factors, stress and diet than any other health care professional before him.

- I think a collaborative effort between mainstream and alternative medicine could do a lot to get patients back to living productive lives. With the availability to tests and equipment by mainstream doctors, there could be a closer monitoring of a patient’s progress while undergoing alternative treatment.
Practitioners of alternative medicine should be encouraged and compensated. Both standard and alternative health care should be encouraged to participate within the spectrum of collaborative practice.

Educate alternative medicine practitioners on how to read charts. Create a common language for all professionals.
Participants in the Conversation on Health debated the role of foreign trained professionals in the Province’s health care strategy. Their discussions centered on the role that the governing colleges play in accreditation and the requirements that may be necessary for practice within the province. Here is a sampling of what British Columbians had to say about foreign trained professionals.

The Accreditation of Foreign Trained Health Professionals

With practitioner shortages in many fields, looking abroad to recruit already-trained professionals is a common idea. Some believe that the current practice of accrediting only a small number of foreign professionals each year, which is the responsibility of various professional colleges, is an inadequate response to the human resource shortage in British Columbia. Some participants feel the professional colleges harbour protectionist tendencies in their requirements for excessive testing and re-training of those educated out-of-province.

The opinions about changing accreditation practices are varied. Those in favour of increasing the number of foreign professionals suggest legislatively granting more accreditation spaces to them. Others suggest removing the colleges’ authority to set limitations by creating an independent credentialing body. However, some believe that the low annual number and strict entry requirements are necessary to protect British Columbia’s high quality of care. They also feel that increasing the number of seats reserved for foreign professionals may only make it harder on local students to access medical training. Others feel that British Columbia is a wealthy province and should not have to rely on foreign labour to address its labour shortages. Some question the ethics of recruiting health professionals out of countries that may be desperate for the services those practitioners provide.

*We need to break down barriers from health professional associations and immigration to recruit and retain health professionals from other countries and get them working in their profession sooner.*

-Health Authority Board meeting, Vancouver
Requirements for Practice within British Columbia

Participants in the Conversation on Health have many suggestions about the requirements for foreign trained professionals to practice in the province. Notably, many suggest that all foreign trained professionals should be proficient in the English language. Some suggest offering night classes or attaching a personal tutor to job-shadow foreign trained professionals to address language deficiencies. Some request that foreign professionals have the option of challenging the accreditation exams without any additional training or course-work. Other suggestions include: offering a limited practice credential to foreign trained professionals until they gain full accreditation; and offering a subsidy for education or credentialing fees in exchange for a requirement for service in northern or rural British Columbia.

*I think in many ways it is unseemly the way health regions across this country troll in [third] world countries for health professionals...The relative value of a physician in Bangladesh, has got to be 100 times the value that it is in Canada given the lack of them and the cost to their whole society of producing one.*

-Provincial Congress, Vancouver

Conclusion

Participants view the recruitment and training of foreign trained professionals from many different standpoints. Some believe the accreditation of these professionals is crucial in meeting over-arching and region-specific health human resource goals and that the limitations placed on their ability to practice must be removed. They feel support should be offered in various forms to facilitate their integration into the Provincial health care system. These views, however, are not universally accepted. Some participants believe that an influx of foreign trained professionals will make it all the more challenging to local students to enter into medical practice and that recruiting foreign professionals may have a detrimental effect on other countries that are equally desperate for health services.
Foreign Trained Professionals

This chapter includes the following topics:

Accreditation
International Education
Requirements for Practice within British Columbia

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

Health Human Resource Responses
Submitted by the BC College

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

Submission to the Conversation on Health
Submitted by the British Columbia Government Employees Union

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Health Human Resources and Training.

Accreditation

Comments and Concerns

• The various professional colleges and associations may harbour protectionist tendencies.

• The British Columbia Medical Association is territorial in their selection of foreign trained professionals.

• The artificial reduction in supply maintains the expensive status quo for the vested interest of certain professionals, but not for the public interest.
• Discuss the challenges associated with the rules and policies of medical associations. Too many potential international professionals are practicing elsewhere because British Columbia will not transfer accreditation.

• The College of Physicians and Surgeon’s rules for temporary registration of general practitioners are not helpful in attracting doctors to work in British Columbia.

• Foreign trained professionals are not receiving credentials from the College of Registered Nurses of British Columbia.

• Bureaucracy and certain professions are barriers to allowing certified foreign professionals to work in British Columbia.

• Successful acceptance in the Canadian Registry does not guarantee employment.

• Doctors hold a monopoly on the health care system, making it extremely hard for foreign physicians to enter their fields of practice.

• Accepting international medical degrees and post graduate training of international medical graduates at face value is impossible and not in the public interest.

• Most post graduate medical training programs in other countries have not been evaluated, nor is it likely that they will be as the funding, and expertise requires for such an undertaking is simply not available.

• There is also significant variation in non Canadian post graduate programs. Some are accredited, others are not scrutinized at all, making the basis for accreditation difficult to evaluate. The quality of these programs cannot be determined.

• There is significant differences world wide in the quality, scope and length of undergraduate medical education leading to a medical degree. Some countries require seven or eight years, other only four. Some training regimes offer exposure to many medical disciplines and offer significant patient contact, while others are entirely book and lecture based. There is also significant variation in entry requirements. All medical degrees are not the same.

• British Columbia certifies only 16 foreign trained personnel per year.

**Ideas and Suggestions**

• Remove the authority to license from the College of Physicians and Surgeons and the British Columbia College of Nurses and give this authority to an independent credentialing committee.
• The College of Physicians and Surgeons should evaluate different education standards and accredit professionals from jurisdictions that have similar standards to Canada.

• High medical standards and a requirement for proficient language skills are successfully being upheld by the colleges and associations.

• Expedite the licensing qualifications for foreign professionals.

• Recognition of International medical graduates from English speaking countries with history, traditions and culture in common with Canada is easier as these education systems are more comparable.

• The College of Physicians and Surgeons should be responsible for educating foreign trained professionals.

• Medical regulatory bodies are not educational institutions and their mandate does not include the provision of educational opportunities for international medical graduates.

• Advise the colleges to conduct exams in China to establish competencies for immigrating practitioners.

• The College of Physicians and Surgeons has advocated for the establishment of a properly funded assessment and evaluation program for international medical graduates. Rather then assessing the source of education, evaluate the international medical graduates current knowledge and practices in a supervised, standardized accreditation program.

• The Provincial Government needs to be firm with the professional regulatory organizations and put in place hard targets that they must meet in order to accelerate the accreditation process.

• If language is a barrier, then the Canadian Medical Association and the British Columbia College of Nurses needs to create in-house crash-courses in English as a Second Language. It is an insult to assume that bright doctors and nurses, who have completed years of advanced education in their home countries, are unable or unwilling to learn English.

• Universities are willing to increase our current efforts to develop and deliver programs designed to adapt to foreign credentials. However, universities cannot act alone in this area and require the approval and collaboration of professional associations.
International Education

Comments and Concerns

- Making foreign trained professionals to take extra English classes and pass tests in order to practice in Canada is an insult to them.
- Foreign trained professionals are shunned upon arrival in Canada.
- Cuban national health professionals are being blocked from practice in Canada.
- Stealing professionals from third world countries where the need is greater than that in Canada is offensive and immoral.
- People coming from other non-English speaking countries claim to have similar qualifications as those required in Canada. This is often not the case and it leads the general public to falsely believe that qualified doctors are driving taxies.
- British Columbia should work to attract medical professionals from countries like India, Pacific-Asian countries and the United States.
- I consider it unethical for rich provinces like British Columbia to rely on the precious nursing resources of third world countries to provide skilled nurses, while the third world country goes begging.
- The demographic issues that are being experienced in Canada are not unique to other jurisdictions.
- The United Kingdom has laid-off thousands of nurses to expedite the movement of foreign professionals back to their country of origin.
- The hiring of foreign trained professionals takes potential health care jobs away from British Columbia’s youth.
- The amount of South African practitioners being allowed to immigrate and work within Canada is completely unethical.
- There is an outcry for health human resources, however, when foreign trained professionals travel from abroad to work in British Columbia, they are not wanted.
- When discussion arises about recruiting foreign physicians, one must look at Sub-Saharan Africa as an example. Recruitment from health care systems that are incredibly fragile and are being ravaged by the HIV virus and aids constitutes a serious ethical dilemma.
There is at least anecdotal evidence to suggest that the Philippines is deliberately over-producing nurses with the expectation that they will emigrate and send remittance payments back to their families. These remittance payments are in fact, growing in importance in sources of hard currency, and in the sources of wealth for families in those developing countries.

**Ideas and Suggestions**

- Allow professionals who are trained in the European Economic Community and the United States to work in Canada without additional training.
- Actively recruit physicians and nurses from other Commonwealth countries.
- Do not look to other countries to fill the health care gaps in British Columbia.
- Allow the immigration of under-utilized health professionals from the United Kingdom.
- Do not allow foreign trained professionals to practice in British Columbia.
- Initiate better collaboration between Immigration Canada and the Canadian Medical Association to ensure that immigrating professionals possess the appropriate knowledge of the credentialing system.

**Requirements for Practice within British Columbia**

**Comments and Concerns**

- There was concern that private sector clinics may be opened by foreign trained professionals who may not possess the proper qualifications.
- Foreign medical doctors are not accepted in Canada.
- The current requirement on foreign trained professionals to repeat classes and education is discriminatory.
- Doctors from other countries are under-employed in Canada because of an uncertainty of their medical and language skills, which leads to a high perceived risk of malpractice.
- Foreign trained health professionals are being driven into other professions, which decreases the chance that they will return to their practice should they eventually be given the chance.
• Some foreign trained doctors cannot immediately attain the credentials to practice in British Columbia; however, Ontario accepts them with open arms.

• There is a need for greater representation of the diversity of British Columbia in health care.

• The public is somewhat nervous about going to see someone who is trained in an unconventional way. This public image must be addressed.

• I feel it is criminal to deny a capable person the right to practice if they have come here intending to do so.

• We train visa-medical personnel from other countries, yet cannot provide accreditation for immigrant physicians arriving in Canada.

• Foreign trained professionals become bogged down in the costs of upgrading their education.

• There are cases of certified nurses emigrating from the Philippines to Canada, only to be relegated to nanny duty.

• Foreign trained health professionals are moving from Canada to the United States due to a more accepting certification process.

• Allocating funding to recruitment and training of foreign trained professionals still constitutes a significant financial burden.

• While there is an extreme doctor shortage in parts of British Columbia, we have trained cardiac surgeons and psychiatrists driving taxis and washing laundry for a living.

• Although there are certain courses that one must take to certify for Canadian practice, these course are not openly available.

• Because health authorities take so long to offer positions to certified foreign health professionals, these professionals often return to their country of origin.

• The Medical Council of Canada requires that foreign trained professionals have experience practicing in Canada before they give a license. But how is it possible to get this experience without a license? Also, how is it possible given the lack of funding for fellowships or residencies in Canada?

• There are over 300 Canadian medical students studying in Britain, the Caribbean, Australia and other countries. They are getting great educations, are welcome with open arms and in the United States are offered great residencies. However, Canada finds ways to bar these doctors from coming home. With our current doctor shortage when is Canada going to wake up and help our international medical graduates come back to practice in Canada?
• I find it hard to believe that doctors from the European Union are not as qualified as doctors trained in Canada or the United Kingdom.

• Deciding who is going to fund the education of foreign trained professionals will be challenging. If the Provincial Government were to fund training, the professional may move to another province two years later, and then who would set up reparation payments? Funding would logically have to come from the Federal Government level.

• The World Medical Association has guidelines on ethical recruitment such as the Commonwealth Code of Practice of 2002. Canada says that it supports this code of practice, but will not sign it because it cannot enforce it. The Government of Canada does not actually employ very many health professionals and it is not going to sign a Code of Conduct that the provinces would have to enforce.

• We have Russian doctors driving taxis and Filipino nurses working at Subway, as access to upgrading their education is too limited.

• Why bother attracting people from foreign countries to take lesser paid jobs that is not in their field of experience?

• A Korean gynaecologist/obstetrician in Cranbrook chose not to pursue his field due to the onerous conditions necessary to qualify.

• Foreign trained doctors working in Canada need to acknowledge and use those customs and practices that Canadians have. For example, one South African doctor said that he would not refer a patient to a massage therapist because he did not believe in this type of treatment.

• Foreign trained professionals immigrating to Canada are lacking language skills, sensitivity and a willingness to get involved in the Canadian culture.

• We need to realize that we are creating a two-tiered staffing scenario whereby foreign trained doctors make up the majority of the medical providers in rural areas.

• There is no active communication with other countries regarding Canada’s educational criteria.

• Locally trained doctors have proven to be no better trained than foreign education professionals.

• Some non-government organizations will argue that the very structure of the Canadian immigration system is in fact a form of active recruitment. We privilege the highly educated and high skilled immigrants.
Ideas and Suggestions

- Initiate a Bill at both the federal and provincial levels that would integrate foreign graduates through their respective colleges faster.

- Implement a requirement that foreign professionals must work for two years in a general practitioner’s role in order to increase the access to family doctors.

- British Colombia needs an environment that encourages foreign trained professionals to join the health care field.

- Certify foreign trained professionals by requiring them to take training courses and to spend time working with a certified practicing doctor.

- Foreign trained doctors with references from their country of origin's medical board and employer(s) should be required to work in three year paid internship programs in British Columbia’s remote hospitals.

- Foreign professionals must be required to return to their country of origin for four months per year in order to maintain an international balance of health human resources.

- Explore the creation of a Master Professional Appeal Board that is made up of doctors, nurses, lawyers, accountants and engineering professionals, to review appeals from professional associations.

- Outsource Canadian health education in a cost effective manner to other countries such as India or the Philippines.

- Create legislation that requires foreign professionals to initially train and work in rural areas of British Columbia.

- Foreign trained professionals should be able to work in Canada, but they all should be fully fluent in the English language.

- Allow foreign professionals to challenge licensing exams.

- Standardize training for foreign trained professionals and implement a quick evaluation. Mentoring by Canadian trained staff would begin to ease off after a six month period.

- Foreign trained professionals should only have to test for accreditation, rather than having to repeat their training.

- Foreign trained professionals should be fluent in English and in medical terminology such as names of instruments.

- If foreign trained professionals require English language education, then have a tutor shadow them on the job to reinforce their vocabulary.
• More residency positions are needed for international medical graduates based on the size of a country’s population and the number of immigrating international medical graduates from it.

• Cut down on the number of training visa-doctors, which are a misallocation of training resources, and allocate more positions to international medical graduates British Columbia residents.

• Follow Alberta’s Bridge program for credentialing foreign trained professionals.

• Recruit foreign professionals using the internet.

• Allow professionals to practice under assistant internships, temporary licenses and careful supervision for a few months.

• Restrict the practice of foreign trained professionals working in Canada to only Registered Nurses.

• The Federal Government and the Provincial Government must work together to address immigration issues for foreign professionals.

• Increase the amount of training seats in colleges and universities for foreign trained professionals.

• Review a foreign trained professional’s experience and skills when they are in their country of origin before allowing them to work in British Columbia.

• International Medical Graduates (IMGs) should be allowed to practice under temporary licenses.

• Create a national standard for credentialing foreign trained professionals.

• Do not look to other countries to fill the human resources gap; fill it with home-grown professionals.

• Allow foreign trained professionals to work in Canada on a trial basis at a suitable wage until they have established a proven ability to perform their duties.

• Developing third world countries make up the majority of foreign trained professionals.

• Place foreign professionals in government-run clinics for their first few years of practice.

• An appendectomy is the same in China as it is in Canada, is it not?

• If foreign doctors have English language deficiencies, then restrict them to service within their own ethnic communities.

• Encourage more nurses and paramedics to immigrate to British Columbia.
• Open a hospital that would allow foreign doctors, nurses and other allied health staff to practice under certain conditions. These professionals would not be allowed to practice outside of the hospital.

• Create new classifications of professionals such as para-medicals or para-surgeons for foreign trained professionals to fill.

• Allocate any available health funding to the recruitment of foreign trained health professionals.

• Foreign doctors and nurses should be given a test to see if there is a discrepancy between their abilities and understanding of Canadian practices. If there is a discrepancy, then education to upgrade should be free.

• Doctors with training and experience in other countries are just as well prepared to do their jobs as are Canadian ones.

• Take extreme caution and be as strict as possible when certifying foreign trained professionals.

• We have a shortage of doctors largely due to retirement so give qualified foreign trained professionals residency.

• British Columbia has a number of centres with aging, multi-ethnic populations. Increase the training and hiring of professionals who can provide cultural and linguistically appropriate care for seniors.

• The Provincial Government needs to focus on integrating more International Medical Graduates (IMGs) and that includes paid clinical assistants as well as an expansion of residencies.

• International Medical Graduates (IMGs) should be allowed access to all practicing aspects of their fields.

• Stop the training of visa-doctors who simply attain their training and return to their country of origin.

• Suspend the visa training of foreign doctors until British Columbia has addressed its own human resource issues.

• The geographic location of training is irrelevant. For example, India is fast becoming a center for certain medical procedures that are available to those willing to pay for them.

• Facilitate the training of health professionals in the third world.

• The Canadian Medical Association should not be the only evaluating body of foreign credentials.
• Recognize reciprocal training agreements with other countries.
• Widen the scope of practice for foreign trained professionals.
• Develop a one to two year training program with a gap analysis of what is missing from foreign models.
• Foreign trained professionals could spend one year in a Canadian teaching hospital to be certified for practice.
• The Medical Council of Canada should help foreign trained doctors learn the system in Canada, as is done in Norway.
• The Provincial Government should be stepping in before we lose more trained Romanian health professionals, as other countries are opening their doors to them.
• Make it easier for foreign professionals to integrate into the current system and do not send them to rural areas upon entering the system.
• Waive examination fees if they prove to be a barrier to foreign trained professionals.
• As with Canadian undergraduate and post-graduate programs, International Medical Graduates (IMGs) should learn in teaching practices, under supervision appropriate to their level of expertise. This is time-intensive work and the preceptors need to be remunerated as professional educators.
• Restore post-graduate residential positions to enable foreign medical graduates to show what they can do under supervision of experienced physicians.
Morale

Morale within the health professions was a topic for discussion in the Conversation on Health. The importance of addressing issues related to morale, staff shortages and workload, appreciation and recognition, workplace conditions and culture among health professionals were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of morale.

Staff Shortages and Workload

Many participants agree that health care professionals are frustrated, discouraged and over-worked. They feel that the workload is so large that burnout seems inevitable, resulting in compromised patient care. Some health practitioners have left the profession because the strain of work prevents them from taking pride in the quality of care they provided. Participants feel that, due to shortages, finding a general practitioner who currently accepts new patients is difficult. Others think there is little incentive for doctors to provide good service because there is no competition for patients.

Appreciation and Recognition

Appreciation and recognition sparked significant debate in the Conversation on Health. Some participants express concerns that health professionals do not feel valued. They feel that medical professionals have little control over their work environment and are sometimes disheartened that patient numbers remain continuous regardless of their efforts. Other participants note that medical professionals may be discouraged that their input about improvements to the system may not be acted upon. However, some opinions indicate that some health professionals do consider their jobs rewarding and have long, diverse careers.

*If staff feel recognized they will work with us to solve issues and increase productivity.*

–Workshops Flip Chart Health Human Resources, Vancouver

Workplace Conditions

Most British Columbians who participated in the Conversation on Health feel hospital standards have deteriorated and the level of professionalism has lessened. This, they argue, has reduced the sense of pride medical professionals feel in the workplace.
There are not enough staff, not enough operating time and a high occurrence of infection within medical facilities. Too many beds have been closed, which has increased the stress on medical professionals. Participants state that hospital administration has not been proactive in improving working conditions, resulting in more staff resignations and illness. Many believe the health authorities do not support or encourage healthy lifestyles for their employees, and people have been poorly supervised leading to a drop in morale. Overall, the quality of life at work for medical professionals was considered to be low.

*Promote healthier staff. Provide stress-free areas for breaks, healthier food onsite, physical activity opportunities, showers for cycling to work, jogging at lunch, and subsidize gym/recreation centre memberships.*

- Health Professional Forum Focus Group, Castlegar

**Culture among Health Professionals**

There has been a loss of team atmosphere in hospitals, which has resulted in inadequate communication between health professionals, according to some participants. Some suggest that the urgent nature of the work prevents health professionals from forming relationships with colleagues. Others suggest territorialism among professionals drains resources, energy and the focus required for solution building. Many participants agree that unclear lines of communication and a failure to work together can lead to medical mistakes, resulting in serious health issues for patients.

*What would improve health care delivery is what would improve any product: being treated consistently, honestly and fairly by the employer, which instills pride into the work life of the employee.*

- Mail

**Conclusion**

Many participants agree that medical professionals are over-worked and under a great deal of stress. This, combined with the loss of camaraderie within the health care system, has undermined morale. More attention needs to be paid to encouraging healthy lifestyles for health professionals and the work environment should be changed to facilitate and strengthen communication between professionals.
Morale

This chapter includes the following topics:

**Staff Shortages and Workloads**
**Appreciation and Recognition**
**Workplace Conditions**
**Culture among Health Professionals**

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**Related Chapters**

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Information Technology; E-Health and Electronic Health Records; Primary Health Care; Health Care Models and Collaboration in the System.
Staff Shortages and Workloads

Comments and Concerns

Staff Shortages
Shortage of Nurses
Workloads

- Comments on the outcomes of staff shortages:
  - It is difficult in British Columbia to find a general practitioner who is accepting new patients.
  - Patient care is compromised and stress levels are high due to staff shortages.
  - Medical professionals must perform additional tasks outside of their job description because of staff shortages.
  - Fatigue and shortages sometimes results in staff performing tasks they are not qualified for.
  - Hospital staff are cynical and exhausted. The workloads are so enormous that burnout is inevitable.
  - There is not enough staff or operating time and a high occurrence of infection in health care facilities.
  - Health care professionals cannot meet patient service expectations because they are already working beyond capacity.
  - Shortages put pressure on staff to work overtime, which lowers morale.
  - Shortages make it is difficult for staff to get time off work.
  - Medical institutions are turning employees into patients. They are overworked and understaffed, causing employees to become sick or injured, or take stress leave due to burn out.
  - Some health professionals choose to work part-time to avoid the burnout and bureaucracy within the hospitals.
  - There are many health care professionals who could contribute much more than they are currently willing to.
  - There is little continuity in care because some medical professionals work two to three part-time jobs.
  - Nobody is more frustrated than health care providers when our most valued and costly resources are not being used efficiently.
- Comments on the shortage of nurses:
  - The media portray nurses in a disrespectful and inappropriate light. This makes it difficult to attract young people to a career in nursing.
  - Nurses are working more overtime than any other profession. They work such long hours that they cannot do their jobs properly.
  - Nurses are often too stressed and busy to be caring.
  - Nursing is now considered to be the most stressful occupation in Canada, based on sick time and Workers Compensation Board claims.
  - Nurses seem accustomed to apologizing for the deteriorated state of the hospitals and resigned to the idea that the system does not work and there is nothing they can do about it.
  - Nurses should be offered incentives to remain full-time on a specific ward. They should be shown that they are an important part of the health care system and ensured their voices are heard.
  - Nurses have little opportunity to take breaks from the stress and intensity of caring for high need patients and even less opportunity to provide patient education.

- Comments on the outcomes of heavy workloads:
  - There is little job satisfaction in medical professions due to heavy workloads.
  - Some health professionals leave the profession because they are burnt out and can no longer take pride in the quality of care they provide due to the strain they are under.
  - The workload in British Columbia is so high that many health professionals leave for other provinces.
  - Doctors have a poor quality of life due to heavy workloads and little leisure time.
  - The extreme stress on staff in emergency rooms is due to lack of support.
  - The short time practitioners spend with each patient limits their effectiveness and compromises patient care.
  - The critical work is demanding and emotionally and physically draining. There are times when the patient needs can drain the staff.
Ideas and Solutions

- We must ensure that nurses are not over-worked or have too many patients at one time.
- The stress load on physicians and nurses needs to be eased somehow.
- The safety issues for those working alone in community health centres need to be addressed.
- We require a system that directs our health care providers to areas of need.

Outstanding Questions

What are the dollar costs of excessive overtime and burnout to the system? Are these costs greater than those of providing benefits to extra nurses now working casual and on call, who would be happy to job-share?

Appreciation and Recognition

Comments and Concerns

- There is a lot of anger and frustration aimed towards medical professionals and British Columbia could lose valuable long-term employees if this persists.
- Nurses are not paid well and have to work long shifts; it is a thankless job.
- Health professionals are not feeling valued. They have no control over their work environment and their input is not heard or acted on.
- No one is rewarded for a job well done. There is little respect or recognition for staff from management or the government.
- Working in the medical field can be disheartening because the amount of people needing care seems endless.
- Depression rates among nurses and physicians are high.
- Medical professionals are abused by the public.
- With little time to complete tasks properly, lawsuits against medical professionals and hospitals have increased.
- Some nurses find their jobs to be rewarding and have long, diverse careers.
**Outstanding Questions**

- How can we engage and motivate medical professionals and make their work more interesting and rewarding?

**Workplace Conditions**

**Comments and Concerns**

- Hospital standards have deteriorated, and the level of professionalism has lessened. This has reduced the sense of pride medical professionals feel in the workplace.
- Some medical centers appear to be well run and happy places to work.
- Hospital administration has not been proactive in improving working conditions resulting in staff resignations and illness.
- People have been poorly managed which has undermined morale.
- The health authorities do not support or encourage healthy lifestyles for their employees.
- Nurses do not have enough job security or stability, and this is why there are few new nurses entering the system.
- The crowded hospital conditions are stressing staff and lowering job satisfaction.
- Too many beds have been closed, which has increased stress on doctors and nurses.
- Doctors are frustrated and being held back from fully treating their patients due to a lack of access to technology and facilities.
- Doctors and hospital staff are fed up and disheartened with emergency care.
- It is much more glamorous to work in the private sector where the pay is higher and clients are wealthier.

**Ideas and Suggestions**

- A new management plan should be implemented with an independent review. The people who work in the hospitals deserve this.
- More attention needs to be paid to encouraging healthy lifestyles for health professionals.
- There needs to be more childcare provided for those doing shift work.
Outstanding Questions

- What is needed to support the development and functioning of medical professionals and their workplace?

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Culture Among Health Professionals

Comments and concerns

Communication
Collaboration between Health Professionals
Territorialism

- Comments on communication:
  - There is poor communication within Elder care facilities.
  - Poor communication may lead to duplicate testing.
  - Unclear lines of communication can lead to serious health issues with incidents like a doctor giving unclear pre-operational instructions.
  - General practitioners often send inadequate or insufficient patient information to the specialist. The specialist may not review the information thoroughly which can result in inadequate care.
  - There is an inconsistency between doctors that comes from miscommunication.
  - Practitioners are always in urgent mode which leads to poor relationships with their colleagues.
  - Pharmacists are starting to connect more with physicians and nurses.

- Comments on collaboration between health professionals:
  - There is little cooperation and coordination between hospital-based and clinic-based physicians.
  - The British Columbia Nurseline and emergency rooms lack collaboration.
  - Concern was raised over the amount of collaboration between physicians and the major pharmaceutical companies.
  - Health care professionals should not be ignorant of each others abilities. Doctors should admit when they are not knowledgeable in an area and offer to refer the patient to an alternative health practitioner if that would help.
• Some doctors have been consulting with midwives to research ways to assist women to better prepare for birth.
• Some doctors do not fully utilize allied health professionals services especially physiotherapy.
• Patients are being required to speak with four, sometimes five different professionals.
• Community health workers are not integrated by any means to other health care professionals.
• There has been a loss of team atmosphere in hospitals.
• Health professionals do not seem to realize they are all working for one organization and for the betterment of their patients.

• Comments on territorialism:
  • Territorialism prevents multi-disciplinary interaction. Currently the system looks as follows:
    a. Administration versus the health care employees;
    b. Unions versus unions; and,
    c. Registered Nurses versus Licensed Practical Nurses.
  • Competing disciplines may not want to work together.
  • Doctors may not want to give up any authority to Nurse Practitioners.
  • The current health culture consists of blame and a general lack of trust.
  • Research may not be openly shared between professionals even though it would benefit the patients.
  • There is no use of technology to transmit medical images between remote sites. Tests are being conducted in a redundant manner, because sharing data is not encouraged.
  • Inter-fighting drains the resources, energy and focus required for solution building.
  • Physicians do not want to step on their colleague’s toes and will concur with the first doctor’s diagnosis without doing their own tests.
  • The medical culture is burdened with rigid contracts.
Ideas and Suggestions

Communication
Collaboration between Health Professionals
Territorialism

• Ideas about communication:
  • There needs to be more communication and collaboration between:
    a. Physicians and specialists;
    b. Physicians and nurses;
    c. Physicians and patients;
    d. Physicians and pharmacists;
    e. Licensed Practical Nurses and Nurse Practitioners;
    f. Management and hospital employees; and,
    g. Physicians and emergency staff.
  • The work environment itself must be changed to facilitate better and easier communication between professionals.
  • Facilitate communication between associations and colleges to reduce future confrontation and territorialism.
  • Create opportunities for fellow practitioners to come together in dialogue without having to travel.
  • Facilitate communication by using teleconference technology as the cost of face to face consultation is very high.
  • Use hand-held communication devices to facilitate communication between team members.
  • Develop a common language between health professionals.

• Ideas about collaboration between health professionals
  • Teamwork should be a priority for every health care provider.
  • Physicians need to become part of the team, to work with other professions and with patients, so that they are not seen as these inapproachable experts, but rather as peers and colleagues and collaborators.
  • Together, chiropractors and physicians should provide comprehensive treatment options for their patients.
• The privacy act should be amended to make the transfer of patient information easier.

• Ideas about territorialism
  • End the turf wars between health professionals.
  • The general public, patients, physicians, medical support personnel, administrators, politicians, and the private sector must work together to eliminate the protectionism of health professionals. Cooperation and sustainability are an integral part of any working health care system.
Health Professional Compensation

Health professional salaries was a topic of discussion in the Conversation on Health. The model used to compensate physicians and the salaries of health professionals were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of Health Professional Salaries.

Models of Physician Remuneration

Many participants in the Conversation on Health feel that fee for service is not the most cost effective way to compensate physicians, since it does not create accountability for health outcomes. Many feel that fee for service acts as an incentive to over-service urban areas and patients with minor ailments while under-servicing rural areas and patients with complicated chronic conditions. Some suggest creating salaried positions as a means to address these issues. Offering salaried positions to physicians, they argue, would also facilitate creating integrated teams of health professionals while allowing doctors to find a more amenable work/life balance. Participants also examined blended compensation models including components of fee for service, salary and capitation, with the goal of achieving more holistic care and better alignment of remuneration with accountability for health outcomes.

Some participants suggest addressing accountability concerns through pay for performance models. Many international jurisdictions use performance incentives linked to health outcomes as one part of physician compensation. Others are cautious about pay for performance, suggesting that the model would have to be very well thought-out to limit unintended consequences and that the monitoring required would only be possible with a fully implemented electronic health record system.

Fee for services is like the nail in the foot. It's holding us down. It's not in itself a problem except that it's preventing anything else from happening…

- International Symposium, Vancouver
Health Professional Salaries

There is little agreement about the range of health professional compensation: participants see the amount health professionals are paid as both too high and too low. Many participants feel that general practitioners should be paid more in order to attract more medical students into family practice instead of specialty fields. They also suggest increasing pay incentives to draw more health professionals to rural areas of the province. Some participants think the disparity of pay between health professionals is too great, with doctors making too much compared to Registered Nurses, for example. Others are troubled that too many health professionals are being asked to work as casuals while their peers are working excessive over-time, which creates retention issues and staff burnout.

Many participants express concern about the wages for community care workers, long-term care aides and hospital support staff. They feel that their wages are no longer competitive enough to attract and retain staff and that the continuity and quality of care have suffered as a result.

Conclusion

British Columbians are looking for a model that compensates health professionals fairly for the difficult job they perform, ensures services are accessible around the province and provides more holistic care for patients. Most feel that the current fee for service model cannot achieve these goals and that the model of physician remuneration will have to change if the health care system is going to adequately address the needs of British Columbians. British Columbians’ opinions are divergent on the rate of pay for physicians and other health professionals, except in the need to increase incentives for family doctors and for health care professionals who work outside of urban centres.

If you do not bring the… physician into this picture with clear incentives for appropriate care and disincentives for suboptimal care, we will not measurably alter the system.

– Online Dialogue, Pender Island
Health Professional Compensation

This chapter contains the following topics:

Models of Health Professional Remuneration
Health Professional Salaries

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

Health Human Resource Responses
Submitted by the BC College of Family Physicians

Family Practice Recommendation for British Columbia’s Health Care System
Submitted by the Society of General Practitioners of British Columbia

Submission to the BC Conversation on Health
Submitted by the Society of Specialist Physicians and Surgeons

A Summary of the Public Forum on Health Care, Organized by the Kamloops Citizens Concerned about Public Health Care
Submitted by the Kamloops Citizens

Submission to the Conversation on Health
Submitted by the British Columbia Cancer Agency

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Morale and Health Human Resources.

Models of Health Professional Remuneration

Comments and Concerns

Fee for Service
Doctors Working on a Salary

- Comments on the fee for service structure:
  - Fee for service is the wrong approach. A different kind of agreement where capitation and fee for service or some combination of the two methods has to be
shaped. The fee for service system mitigates against innovation in service delivery because the only way you can deliver a service is face to face with a doctor. That is really the biggest barrier.

- Fee for service billing is a disincentive for doctors to practice outside of the heavily populated urban centres.

- The current method of payment for physicians has a built in conflict of interest. The physicians are rewarded with fees per patient seen. The more often patients are seen, the easier the clinical condition; the higher volume of patients will be seen per day and the higher the physician income. Physician reimbursement should be modified with provisions for rewarding experience of the caregiver, excellence of care, better patient management process and outcome.

- Physicians are operating like lawyers; their only concern is to bill for as many hours as possible.

- The fee for service system prevents integration with professionals who are not on fee for service.

- It has been said that physicians could not be expected to be dedicated to their profession if they did not receive a fee for service. What about the Hippocratic Oath?

- I wonder if the most cost effective way to remunerate doctors is fee for service. I believe fee for service encourages doctors to take on too large a case load and results in overpayment for specialists who frequently have too low a case load.

- A fault of the system is that it provides free equipment, supplies and facilities to doctors who insist that they are self-employed. What other self-employed person enjoys this benefit?

- As a doctor who is paid on a fee for service basis, I would instead opt for sessional work. At least that way I am getting paid for my time rather than per patient. Having been in a medical clinic where volume was the key to financial success, and now in a clinic where the majority of my patients take a lot more time, I am ready to throw in the towel and go back to seeing colds and flues. I could make a lot more money than I do seeing 25-30 patients daily in six hours and making peanuts because I take time to explain things. It is frustrating to be making multiple calls, filling out forms and spending time because it makes people feel better while I am getting paid nothing for it.

- Fee for services is the nail in the foot. It is holding us down. It is not in itself a problem, except that it is preventing anything else from happening.
There is no accountability in a fee for service system. It is simply a rolling account that you can draw from indefinitely. No one has to justify their actions and decisions. It is the most bare bones form of accountability possible.

The fee for service structure does not lead to a holistic approach to patient care.

The fee for service payment is a protected envelope for physicians. There is nothing to stop them from over-doctoring. It is a perverse incentive.

The trouble is that fee for service is not satisfactory for physicians anymore because it only rewards low acuity behaviour and high volume care. The physicians were okay with that at first because they could still make money, but now they have cornered themselves. The acuity has gone up, and the pay by fee for service has not kept up with their workload. There was a readjustment at some point back to what the market would be for the service and not the visit anymore, but we are not funding a visit anymore. We are trying to fund a service, but the cost of the service is now bigger than what the visits were paying. We have to add in the accountability piece that was not there. It may actually cost us more money to move to this model, but if we can get better accountability and the outcomes that we were expecting in the service levels, it would be worth the cost.

It is a problem that doctors get paid the same amount for seeing a sixty five year old with complications from diabetes and chest pains as they do to see a five year old with the ear infection.

Doctors are working like they are on commission, pushing people through the system rather than providing quality care.

The fee for service remuneration model for doctors works against the needs of seniors.

Due to a daily patient cap on family practice, the only way for general practitioners to make a profit is to work overtime, or to avoid the overhead costs of family practice by working in a walk-in clinic.

There is no doctor educated in this province that has not had the subsidy of every tax paying British Columbian behind them. Yet, every physician that I have ever known has explicitly declared their right to fee for service, because of the privileged position they have now as a physician.

Faster diagnosis and treatment might result from doctors being paid for each patient they treat, and not by each patient's visit. This may also encourage doctors to take more of an interest in the patient’s lifestyle so that fewer visits to his office would be needed.

There is no alignment between current remuneration methods and outcomes.
- The pay structure can influence a doctor’s treatment approach.
- Family doctors are becoming a thing of the past because we have allowed the fee schedule to be managed by the British Columbia Medical Association (BCMA) and the walk-in clinic doctors have a stronger voice in that organization than the family doctors.

- Comments on salaried physicians:
  - In Vancouver Coastal Health Authority we have hospitals that are staffed by salaried doctors and it is not the solution. The salaried doctors have the mentality that they are only there for eight hours and we should not expect them to be there beyond that. That is one of the reasons salary is not always the answer.
  - If doctors were salaried, they would not be able to hire the other staff needed to run a clinic. Whatever the model of funding, it has to account for everybody on the health care team.
  - Surgeons’ being paid based on a fee for service model is problematic. The more surgeries they do, the more money they make. We could get away from the issue of excessive and unneeded surgeries by placing surgeons at the acute care level on salaries.
  - It is difficult to staff remote areas like the Sunshine Coast on a fee for service basis. Salaried positions are one way to address this issue.

**Ideas and Suggestions**

**Performance Incentives**

**Ideas about Salaried Physicians**

- Ideas about performance incentives:
  - My concern about providing performance incentives is that you can create skewed deliveries. You end up with a percentage of the population who get bounced from pillar to post because they are too expensive to treat. However, it does depend on how it is structured. Unintended results are a well-known side effect of any kind of pay for performance scheme, which is not to say that you should stay away from paying for performance. You need to balance the side effects with the positive elements.
  - Physician salaries must be linked to appropriate patient outcomes.
There are all kinds of professions where performance is not related to pay. What are doctors going to say when you hit them with this demand? Why are doctors being singled out?

- We should avoid pay for performance as it increases competition.
- Doctors should receive incentives for providing holistic care.
- Physician pay should be based on performance measured in patient outcomes. You must clearly define the targets and measure the results.
- When we are comparing the health business to any other type of business, ask yourself when do we reward shareholders or employees for poor performance? Do we continue to increase salaries? No. So why should we do so in the business of health? There is not an endless pot of money in the system to reward people and institutions for poor outcomes.
- The contract between family practitioners and the National Health Service (NHS) in the United Kingdom was changed two years ago so that a significant element of their pay is now related to doing surveillance of their patients. For the first time, money was to be properly spent on quality, prevention and early health rather than late disease.
- Instituting a pay for performance system requires costing procedures in greater detail than is required in a fee for service setting. That process will create some anomalies and introduce more paperwork. There is quite a lot of refinement required, especially in establishing how to pay for the whole service rather than for a procedure.
- Other countries are experimenting with pay-for-performance approaches to motivate improvement and hold physicians accountable for care. The Dutch and German systems blend capitation, fees for consultations, and payments for performance with an integrated, electronic disease management system.
- I am all in favour of people getting paid more money for doing better. That strikes me as an inherently good principle.
- If you had a fully implemented electronic health record, you would not need the capitation model because you could base fee schedule payments upon deviations from established standards. Health promotion and prevention would be paramount if you had that electronic records and knew exactly what was going on with your patient the minute you turn on your computer.

- Ideas about salaried physicians:
  - Salaried doctors are ideal in smaller communities as they treat patients in a more holistic fashion.
• We should put doctors on salary so they are not competing for budget dollars. We could include office expenses in the salary.

• Fee for service is the best model for paying doctors.

• If all physicians were paid salaries, we would have a much more accurate picture of the true cost of providing care to the population and physicians would not spend any of their time with patients who could be better attended to by a less costly provider.

• Salaried family practice clinics such as the University of British Columbia’s Family Practice work very well.

• There is a whole cadre of young doctors who really hate fee for service. We are on the cusp of an opportunity to change how we pay physicians in a fundamental way. These young doctors are not prepared to work 85-hour workweeks. We have to take advantage of this opportunity.

• We need a remuneration system between fee-for-service and salary.

• Fee for service providers are more efficient than those on a salary.

• New Zealand, in a decade, has managed to get almost all of their doctors off of fee for service and they did it in an ingenious way. The money to pay doctors was given to the regional health authorities and they organized multi-professional primary healthcare clinics. The government then subsidized the user fee for any patient that went to one of these new clinics which made them very cost effective for patients.

• Doctors should be federal public servants and paid a salary.

• We should not put doctors on salary, except in unusual circumstances. Some will say that doctors on salary are less rushed and therefore provide better patient care. I challenge them to provide hard data that shows better objective health outcomes when doctors are on salary. Patients may feel as though they are getting better care, but I am not sure that is worth the added costs.

• A World Health Organization (WHO) study revealed that Canada has only 2.1 physicians per 1,000 patients, while Italy, which uses a salaried system, has 5.8 doctors per 1,000.

• In a salaried environment, family practice doctors could negotiate working conditions, giving them a life outside medicine. The current environment discourages potential family practice doctors.
• Ideas about Capitation Systems:
  
  • I would like to see a system where family doctors are paid by how many healthy patients they have on their lists, and less on how many sick people they treat.
  
  • We should explore the option of giving physicians the mandate to manage the care of a certain number of people for a fixed price instead of fee for service compensation. This may encourage earlier prevention and promotion of healthy lives instead of waiting to deliver episodic care when it is too late and much more expensive.
  
  • The doctors should be compensated like they are in China, where they are only paid when they keep the patient free from the disease.
  
  • In the clinics, where there is a blended pay structure, doctors are assigned a certain number of patients and they are measured against those patients’ outcomes. It works beautifully, but the problem is that it only works when the patients are in the community. Once they are transferred to the hospital, the doctor in the community clinic does not go to the hospital to look after them and there is a breakdown in continuity.
  
  • It is very important to have payment and incentive systems that align physician and system goals
  
  • We should change the pay structure for providers to encourage integrated care centres as a 24 hour alternative to emergency rooms.
  
  • A valued employee is a happy and more efficient employee, which ensures quality patient care.
  
  • Doctors should be paid by the time spent with each patient, not by the number of appointments.
  
  • It should not matter if it is a general practitioner or a specialist that provides a service: they should be paid the same rate for the same service.
  
  • Physicians should be paid sessionally or by a mix of sessional and fee for service.
  
  • Changing the way physicians work requires changing the physician pay structure.
  
  • In the Interior Health Authority, there are fee for service social workers, nutritionists and physicians, working on the same team and under the same model. It allowed for each service to be compensated appropriately and facilitated innovations like group appointments. However, the feeling seems to be that we do not want to create more fee for service professions, but if we were to use a blended system it would achieve the same results.
• The practice program is making a case for family doctors moving to giving their patients same-day access to their clinics. The short, simply treated patients would return to their family doctors instead of going to walk-in clinics, which means that doctors could earn 10 to 25 per cent more money.

• Funding the practice instead of the physician individually is a good way to bring more people into the primary care system.

• We should have options available so physicians can either work in a fee for service private practice or in a community health centre on salary.

• If we could pay family physicians differently in primary health care clinics, we would have more primary health care and more integration, with many types of professionals all working together.

• We have to change the billing situation so that doctors are no longer rewarded for the quick fix prescription.

• Doctors would be less inclined to bring back patients for unnecessary visits if they were paid according to how many patients they are treating rather than per visit.

• The South Community Birth Program got federal grant money to start up a multicultural, multidisciplinary program for prenatal care. They took the midwives’ and the physicians’ billing rates and put it all in a pot with an agreement about how they would pay everybody on the team. So, even though the funding mechanism looked at midwives and physicians quite differently and individuals who performed a service billed based on their own billing rate, there was a more rational system that pays them.

**Outstanding Questions**

• Are physicians accountable for the money they receive?
Health Professional Salaries

Comments and Concerns

Doctors
Nurses
Support Staff and Community Care Workers

- Comments on doctors salaries:
  - Doctors are not paid adequately for the services they provide.
  - I am appalled by the level of compensation that doctors have extorted from our politicians.
  - The health care system is in trouble because doctors and dentists charge too much for the services that they provide.
  - The difference in the roles between health professionals, such as doctors and nurses, does not justify the huge differences in the incomes.
  - The salary for general practitioners is not sufficient.
  - Family medicine is not chosen as a postgraduate program due to the significantly reduced lifetime income of family physicians in comparison to most specialty disciplines.
  - It is absurd that the compensation package for family doctors is so low that it forces them to schedule 15 minute interviews with patients.
  - A high salary for doctors just attracts those people looking to make as much money as possible. Greed should not be the driving principle in selecting who should become a doctor. The status of doctors in Canada is out of whack; they are not paid this way in much of the world. You would still have good people wanting to do this work at a much lower rate of pay.
  - The unintended consequence of paying doctors well is that they may choose not to maximize their income; they may choose to maximize their lifestyle instead.
  - The greatest cost to the health care system is the cost of our highly trained physicians. A general practitioner can bill in excess of $300,000 a year, and a cardiologist can bill in excess of $1,200,000 per year. How can they demand these figures? It is because the barrier to become a physician in North America is extremely high, which leads to fewer physicians, who are overworked and have very high salary expectations.
Family Practice is doomed to fail in this province due to doctors having to finance the facilities and costs of salaries out of the returns meted out by the government. Any normal business increases prices when costs increase.

Walk-in clinic doctors work nine to five, make three times the money other family doctors do and they never have to set foot in a hospital, have no hospital privileges, no emergency room experience and do not work on-call.

Doctors in Canada make an average of $202,000 a year. Alberta has the highest average salary of around $230,000.00 while Quebec has the lowest average annual salary of $165,000.00. This discrepancy creates interprovincial competition and pressure to increase these already high rates of pay.

Wages for physicians in British Columbia need to be competitive with Alberta which pays about 30 per cent more for the same services. As time goes on, it will be more and more difficult to compete.

Most doctors only remain in rural areas long enough to receive the incentives.

Current Medical Service Plan billing regulations dictate that physicians’ fees are reduced by 50 per cent if they see more than 50 patients a day, and are reduced to zero if that physician sees more than 65 physicians daily.

I would bet there are some feelings of inequity around pay between physicians and nurse practitioners. I think there are a lot of general practitioners who do not earn $85,000 a year and have to work a lot harder for what they do earn. The physician is paid for fee for service while the nurse is on a salary and if the nurse takes patients away from the physician, then there is a problem for the physician.

It is not right that physicians do not get paid for emergency room service.

Clinics do not stay open 24 hour a day because they are not paid to do so. Doctors are only paid by the number of patients they see and not enough patients come into clinics at two AM to make it worthwhile for the clinics to stay open.

Medical professionals working in a medical research role are paid much less than practicing doctors. However, researchers add much more than the practicing doctors.

Pediatrics is the lowest paying specialty. Children are not getting their share of the pot.

There is an inconsistent fee structure for surgeons. They get the same flat fee per procedure despite improvements in technology and surgical procedures, which have decreased pre- and post-operation care requirements.
More consideration needs to be given to alternate payment plans for physicians. As a physician, I see many inequities in the payment systems. A glaring example is the fee for cataract surgery. This used to be a difficult, time consuming operation. Now, thanks to improved technology, eye surgeons can do upwards of 10 to 14 procedures per day. This means a surgeon can earn upwards of $7400 per day, in addition to a mark-up the surgeon may charge on a foldable lens, which is not supplied by the hospital. This practice may create an inducement to schedule patients for this surgery. I think this is a great example of the benefit of paying physicians and surgeons on a time, rather than piecemeal basis.

The majority of doctors are paid 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. British Columbia is challenged by Alberta, where higher payments, particularly for specialist services, attract specialists who might otherwise have chosen to work in British Columbia. The resulting shortage of specialists affects service delivery here. 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, the Society of Specialist Physicians and Surgeons expect that the provincial competition for specialist services will intensify.

Naturopaths can be registered through the government, but they only get about $15 per patient. Every Naturopath I have seen has spent about an hour with me because their process involves the whole body, not just one part of it. What doctor can make a living being paid $15 an hour?

- Comments on nurses salaries:
  - The wage gap between Licensed Practical Nurses (LPN) and Registered Nurses (RN) is too large.
  - How do you think I feel working beside a Registered Nurse (RN) who is getting twice the pay while doing the same job? I am dealing with patients’ lives. If I give the wrong dose or miss a medication a patient could suffer or even die. Tell me, is all that responsibility worth $22.00 an hour? I do not think so.
  - New nurses are not offered full-time jobs and are mostly working in casual positions.
  - We have thousands of nurses working incredible amounts of overtime at a huge cost to the system when additional full-time or part-time nursing positions could be added at regular pay rates. This would save money and reduce employee
burnout. However, current managers seem unwilling to add positions to their departments because it will affect their budget.

- Many nurses are still bitter about the wage rollback.
- I appreciate that nurses do a difficult job, but they are overpaid for what they do in comparison to the real world.
- A nurse working shift on a long statutory week end, can earn approximately the equivalent of working a full week of day shift at regular pay because of lucrative stat holiday pay, shift differential and weekend pay. If he/she should not finish work on time and puts in for overtime, the hourly rate increases phenomenally yet again.
- Nurses are often left to do the cleaning since hospitals started contracting out. The cleaners are not trained to infection control, and ten dollars an hour is not incentive to do a thorough job.
- A nurse receiving WorkSafe BC compensation can match or better her regular salary, as compensation has not been subject to income tax. I have seen this arrangement go on for months and months. It is an embarrassing scam that has not been addressed. Most nurses who have not been recipients of WCB do not realize this and those who discover the benefit are apparently not talking.
- We cannot encourage enough nurses to take leadership positions because of drop in wages they would experience.
- I am not happy about nursing students having to work for no pay during their training. Would you come to work for no pay? This practice really discourages potential nursing students from signing up. We should pay at least the minimum wage for the training hours.

- Comments on support staff and community care workers salaries:
  - Some facilities do not pay enough for health care workers to live comfortably.
  - Casual workers are not staying around as there are not enough hours available for them to earn a decent wage.
  - Staffing hospitals with casual labour is cheaper, but it causes retention issues. In many parts of the province, living on part-time hours with no guarantee of work is impossible.
  - There is too great a discrepancy in pay between managers and health care workers.
  - A friend of our grandson is earning $27 per hour for laundry work. At those wages, laundry work should be contracted out.
The Health Employees Union (HEU) took a pay cut of 15 per cent, and then had their jobs privatized. The pay cut has forced many workers to hold down two jobs and work lots of overtime to make up the difference. Many HEU workers cannot make ends meet on the reduced wages.

The Hospital Employees Union holiday pay is three to five times greater than basic pay.

Hospital management receives bonuses while health care employees continue to receive poor wages.

How do you hope to retain support staff when they are improperly classified and inappropriately paid? I am appalled that government would give themselves a 29 per cent pay increase when I still have not come back to my previous pay level since our mandated decrease a few years ago.

The wage rates for maintenance staff are too low. Low wages result in higher turnover and more costs.

The pay cuts to care aides who work with seniors was like a slap in the face.

The wages paid to hospital cleaning staff, which at one time were higher than those paid for similar jobs in hospitality industry, are now worse than similar jobs outside of hospitals.

Health care workers are one of the most likely professions to be exposed to violence and are protected by inexperienced contract security guards who are paid eight dollars an hour.

Home care workers are trained as long-term care aides. They drive their own vehicles to remote homes, bathe, cook and care for frail elderly in the worst weather, and are paid less than their counterparts working in facilities with modern conveniences and co-workers on hand to assist if needed.

There should be a relationship between the minimum wage and health administrators’ salaries.

Public sector employees lead the country in wages, benefits and quality of working conditions.

The rate of pharmacist remuneration in British Columbia is one of lowest in Canada.

Pharmacists should be compensated for their medication management role within the primary health care model. Compensation should not be restricted to the professional pharmacy services associated with product distribution.

Paramedics deserve a wage increase.

I would like to see a significant increase in funding directed to midwifery.
Salaries alone make up over 50 per cent of the health care budget, but increased salaries and staffing rates have not resulted in better health care.

Retired medical professionals are paid too much money. They have taken a large payout, have a large pension and are paid well to come back to work. Essentially, they have three wages.

**Ideas and Suggestions**

**Physician Services**

**Pay Incentives for Family Physicians and Rural Health Care Workers**

**Support Staff and Community Care Workers**

**Doctors**

**Nurses**

- **Ideas about physician services:**
  - I think if a patient is willing to go to the trouble of getting a certificate of authenticity, and is willing to use secure e-mail, then doctors should consult via e-mail and should be able to bill for that service.
  - We should allow family physicians to bill at least one hour per year for a comprehensive general physical examination for each patient. Not only would that help attract doctors into family practice, but it would help develop a proper doctor-patient relationship and reduce unnecessary appointments and inaccurate diagnoses.
  - Health care providers should be motivated to encourage healthy lifestyle choices over use of drug treatments.
  - Doctors need to be financially motivated to have a healthier patient list that requires less acute care.
  - I would like to be paid for all the phone consultations I do directly with my sick, elderly patients. Phone guidance is very helpful when managing chronic disease, and patients appreciate not having to make a trip to the office.
  - Pay doctors fairly for visiting long-term care facilities.
  - Doctors should deal with all presenting health issues in one appointment.
  - We should change the billing rules to allow physicians and specialists to bill for longer appointments for people with multiple needs.
  - There should be more remuneration for doctors practicing prevention and health promotion. Patients will get more time, which they want, fewer referrals,
prescriptions and procedures, which they do not want, the wait times will decrease and doctors will be happier.

- Physicians should receive higher rates of pay for office visits that occur after 5pm.
- I have had glaucoma for 18 years. I visit my ophthalmologist every four months for a check-up. My doctor has scheduled me for a field vision test, photos of my optic nerve and then an appointment to discuss these with him. I have been told I cannot do this all on one day as he will not get paid. I have to make two appointments for the same thing and then he will get paid. I have to travel a considerable distance to see my doctor and this puts the added pressure of more expense to me. Where is the logic in this? Who is the brain surgeon that came up with this nonsense? This needs to be changed.
- Pay physicians a fair fee to spend time counseling patients on weight loss, smoking cessation, alcohol abuse, etc.

- Ideas about pay incentives for Family Physicians and rural health care workers:
  - Full service family physicians should be paid more than those who work in walk-in clinics.
  - The fee for service schedule should be subsidized to encourage more doctors to work in smaller rural hospitals.
  - Retaining doctors in rural area requires more salary incentives.
  - The provincial government needs to provide increased isolation pay and remote allowances for health professionals.
  - We could attract more family physicians into practice by assisting them with the start-up costs of a new family practice.
  - Wages should be supplemented for health care workers wanting to upgrade their credentials and pursue one of the careers experiencing a shortage.
  - Attract more medical students to general practice by paying general practitioners at a rate competitive with specialists. Retain general practitioners already in practice with a substantial increase in compensation and annual increases thereafter for the rising costs of running a medical practice.
  - We should treat family doctors as a specialty and pay them accordingly.
  - Specialists should not be paid more then general practitioners.
  - We have to match other provinces’ wages and recruitment incentives.
• The Ministry of Health's 2006 agreement with the British Columbian Medical Association (BCMA) to increase the remuneration of family doctors is positive and welcome.

• Ideas about wages for support staff and community care workers:
  • Community health care workers should be paid to work for eight straight hours, but their work days are broken up and they end up being paid for a fraction of the time they dedicate to their job. They should also be subsidized for the money they spend on gas.
  • The government should not target health care workers' wages to reduce expenses.
  • Restore the cleaning and food services positions to the public health care system using fairly paid, well-trained unionized staff.
  • The government should give back the 15 per cent that was taken away from health care workers.
  • Working in a care home is a very important job and the workers pay should reflect that importance.
  • Home care workers need better pay and the ability to perform a wider range of duties.
  • There must be more equity in remuneration for all health professionals engaged in primary health care and prevention.
  • We have to set wage rates that are competitive with the private sector or market-based wage rates.
  • Competitive wage rates are needed to retain trades people in this competitive economy.

• Ideas about doctors salaries:
  • We should set doctors’ pay at a multiple of the average provincial wage. Two times the average would be appropriate and fair.
  • Institute a pay structure that rewards productivity.
  • Many medical students, nurses and doctors go to the United States because they have the opportunity to make more money there. They should be paid what they are worth, so they will stay in Canada.
  • Opening a large number of new training seats and flooding the market with doctors would allow us to reduce doctors’ pay.
- We should limit doctors’ salaries to no more than what the Premier of the province gets per year.

- We should create differential wage scales based on types of practice. For example, there should be premium pay for specialists and less pay for less demanding, long-term care facility positions.

- All doctors should be made employees of the government.

- **Ideas about Nurses Salaries:**
  - The salaries of nurse practitioners should be above those of other nurses, but well below those of doctors. For most of patients, a visit to the nurse practitioner would suffice and could reduce the cost of health care.
  
  - Nurse practitioners who want to partly or wholly replace general practitioners should be placed on fee for service and not paid a salary.
  
  - The casual part-time mentality for nurses needs to stop in order to cut back on paying for benefits.
  
  - Open up the fee for service envelope to pay for nurse practitioners and other providers. This is the only way that the nurse practitioners’ role will flourish.
  
  - There needs to be incentives for students to go into nursing and to stay in British Columbia once educated. There should also be incentives to return to nursing for those who have left.
  
  - We need to appeal to health care professionals to limit their incomes. The salary of professionals is disproportionate to the wages of service workers. Reducing the wages of the lowest paid workers is not a sustainable way of saving health care dollars.
  
  - Unions have to be more flexible in offering competitive incentives and salary ranges.
  
  - There should not be any more market adjustments for health care workers’ wages.
  
  - Employees need to have a break from work and to be able to refresh and refuel. They should have more breaks over the half hour and more paid vacation that increases with seniority.
  
  - I think it is about high time the Paramedics were given a wage increase and a signed contract.
  
  - If there is a totally open and free market private system, then doctors and nurses will obviously choose to work in private care. There must be some harmony in pay rates between both systems to avoid draining the public system of all its staff.
- The government should not pay pensions. Employees should pay their portions out of their salary, and no benefits, such as extended medical, should be paid after the employee retires.
- A higher wage means better job satisfaction, which means higher productivity.
- All personnel in the health care system should have full-time positions with benefits.
- Health professionals’ salaries should be indexed quarterly according to the rate of inflation.
- We should cap all salaries so we would have more money to hire more health professionals.

**Outstanding Questions**

- How do we create incentives for health care professionals to be more effective and efficient in providing services?
- Why is it not possible for patients to book a double appointment with their physician to discuss multiple health issues?
Services Received

Throughout the Conversation on Health, participants commented on their personal experiences and the experiences of their loved ones within the health care system. They talked about emergency room and hospital stays, and expressed appreciation for health professionals, as well as concerns about efficiency, quality of care and staff shortages. Participants talked about specific health professionals, and concerns about the inability to find a physician. Participants were frustrated with the level of care provided to seniors in care facilities.

Comments regarding experiences with wait lists included concerns about the consequences of long wait times and options to avoid the queues. Participants concerned with equity of care focused on the fair treatment of patients by health care professionals. They commented on alternative care and medicine, which many participants recommended be incorporated into the health care system. Other participants raised mental health as an issue, and comments included ideas about using fewer drugs and offering better treatment options. Participants also commented on investments in disease prevention and health promotion.

I want to acknowledge the health care professionals on the front lines who deserve much of the credit for British Columbia’s leadership.

- Provincial Congress, Vancouver
Services Received

This chapter includes the following topics:

- Emergency Rooms
- Hospital Stay Experiences
- Health Care System
- Health Professionals
- Experiences with Wait-Lists
- Equity of Care
- Quality of Care
- Alternative Care and Medicine
- Mental Health
- Seniors Care

Related Electronic Written Submissions
(www.bcconversationonhealth.ca/EN/electronic_written_submissions)

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Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including:

Emergency Rooms

Comments and Concerns

- There is less chaos in the middle of a fire than there is in the emergency at Royal Inland in Kamloops.

- The emergency rooms in the Interior are absolutely horrible, and nothing is working there.
I had a massive stroke and the health care system was terrible. I spent six months in hospital, and now I would rather die at home than go to the emergency room.

I had an ingrown toenail with a very bad infection. It took me three separate visits to emergency before a doctor would finally remove it. Doctors are not doing their job.

My husband was taken to the emergency room by ambulance and was left unattended because no nurses were available. The staff did not phone me, and he bled to death while in hospital. No person was reprimanded for the incident.

The ambulance service and the Duncan Hospital are fantastic and put the patient first.

While my husband and I were waiting at the hospital emergency, a young man came in with his foot wrapped in a cloth. As he stood there, a pool of blood formed around his foot. I told the triage nurse and she ignored me. Fortunately a paramedic saw the injured man, put him in a wheelchair, took him to have the wound cleaned and dressed.

In August of last year my husband had a ruptured hernia. I took him by ambulance to the Royal Columbian Hospital. He was assessed there and needed surgery. He and eight others were kept in the hall by the emergency room exit from 6:30 p.m. to 1:30 a.m. No one was allowed in the emergency room. I took a walk and looked in on some rooms, and all the beds were empty. He was so cold they put six blankets on him.

Immediate attention is given when you arrive by ambulance.

The emergency room staff members, at Dawson Creek, were not helpful with assisting me to find the cafeteria.

The emergency room staff were excellent and the care was good once I got a bed.

The emergency room staff are often rude, slow and show a lack of empathy. They make clients wait unnecessarily.

While waiting for two hours in the emergency waiting room, I observed staff standing around and conversing, with little sense of urgency.

The treatment in the emergency department at the Prince George Hospital was terrific. While waiting for admittance the nurse on duty brought us supper.

My experience at the Royal Jubilee Hospital emergency was excellent. The staff triage was exceptional, and while I waited for treatment, those who needed immediate attention seemed to receive it. I waited seven hours to see a doctor, and surgery was performed shortly thereafter. I was discharged twelve hours after me surgery, which I feel is very efficient.
• I was impressed with the emergency room staff and facility at the Royal Jubilee Hospital.

• While waiting in the emergency room, I was treated with abuse and indifference.

• I was taken into emergency and the efficiency and dedication of the nurses was nothing but excellent. Things have improved since my last emergency visit many years ago.

• After two days of sitting in an emergency room and taking very strong pain medication, I was asked to define the level of pain I was experiencing. This was an inappropriate question to ask someone obviously lacking clarity of thought.

• I checked in to the Surrey Memorial Hospital with severe abdominal pain, and waited for over six hours. I was treated poorly by the attending staff as was an elderly couple in the waiting room. The chairs in the waiting room have high arm rests which do not allow anyone to lie down.

• I had a serious stroke and was transferred from the Nanaimo Hospital to the Vancouver General Hospital. I arrived there after five hours, which was too late to stop the damage from the stroke. I had a migraine and strong hiccups which kept me from sleeping. I remained in the emergency room for three days before I got a bed and a room.

• The emergency room doctor identified our unique situation, recommended surgery and referred my wife to a neurosurgeon within forty-eight hours, which we really appreciated. The emergency at Eagle Ridge in Coquitlam was fantastic.

• The emergency room staff do an excellent job and treat the serious cases immediately.

• I received good care during two brief emergency visits to Saint Mary's Hospital. The nurses, administration and doctors were great.

**Ideas and Suggestions**

• There needs to be more training for emergency room staff.

• There should be more than one person doing admissions in emergency rooms.
Hospital Stay Experiences

Comments and Concerns

• Hospital staff is generally courteous and patient despite intense pressures.

• The Burnaby Hospital has outstanding personable care and wonderful staff.

• I had my baby nearly two years ago at Langley Memorial Hospital and apart from being woken up in the middle of the night to have the baby weighed, everything was absolutely wonderful and I would not change a thing.

• I have a chronic disease and am usually treated at Saint Paul’s Hospital in Vancouver where I receive exceptional care.

• I was passed around like a party favour between the doctors and the specialists.

• Patients in pain are often treated like drug addicts.

• The social and emotional aspects, which are intrinsic to healing, have been disregarded.

• During an eleven day period when I was admitted to Vancouver General Hospital, I was treated with outstanding care and vigilance.

• The service at Vancouver General Hospital was excellent and the hospital was clean.

• In Victoria, I found a good doctor at a walk-in clinic.

• My stay at the hospital was hell on wheels.

• My experience with the Vancouver Multiple Sclerosis clinic was not positive.

• There is a lack of compassion by administration staff.

• Going through surgery is like going through a meat market. They want to get you in, cut you open, sew you up and then send you home to make room for the next person who is going to be operated on.

• I was a candy striper at Royal Jubilee Hospital and learned so much there.

• I had hand surgery and I was impressed both by the care of my surgeon and the day clinic where the surgery was done. I did not have to wait long to see a specialist or for the surgery.

• Saint Paul’s Hospital has the best heart specialists in British Columbia. They saved my father’s life when he had a severe artery blockage.

• The staff and support in the maternity ward at Lion’s Gate Hospital are wonderful.

• Hospital staff do their very best to deliver quality care.
• The care I received at the Campbell River Hospital was exemplary.

• I had good service and treatment at the cancer clinic in Prince George.

• I had horrible experiences during an eleven day hospital stay at the Dawson Creek Hospital.

• Many people in Surrey are afraid to go to the hospitals because so many people leave the hospital in worse shape than when they arrived.

• The staff at Penticton Oncology work very hard but I was not treated as a human being. I was regarded as a “lymphoma case”. No one asked how I was feeling or coping or how my family was coping.

• The hospital staff were very rude to my children when they were trying to find out which hospital I was in.

• The worst care given by health professionals is at Surrey Memorial Hospital. This is due to tremendous pressures, being understaffed, lack of funding and the high population of the area.

• When I went to the hospital in Cuba, the doctors were caring and efficient. Why does a developing country have a better health care system then Canada?

• I was transferred from the Stollery Children's Health Centre in Edmonton, to the Victoria General Hospital and felt I had stepped back in time about twenty years.

• Hospital staff expressed apathy during the passing of a loved one.

• At the Kelowna General Hospital there are patients sitting in the hallways and on chairs, robbing them of their privacy and their dignity.

• I had a negative experience at the Dawson Creek District Hospital from the ultrasound technician. I was forced to wait with a full bladder for ninety minutes, my daughter and husband were not allowed in the room, and I was not allowed to know the sex of the baby. I was told that it was because Asian families sometimes abort female foetuses.

• I have had bad experiences with admissions and administration staff in hospitals. The staff tends to be rude, unprofessional, discourteous and outright cranky.

• After a lengthy investigation my diagnosis was still inconclusive. The doctor prescribed some medication and told me to come back if it got worse. Following that, I had to wait in the emergency room hallway for four more hours before the doctor came to sign off my discharge.

• While I was being treated in a hospital, there seemed to be confusion as to the amount of anaesthetic I should receive.
• My experience with medical clinics is negative.

• My husband was in the hospital, and could not be located. I had been certain my husband had died. He was in another patient's bed receiving their treatment.

• I was in hospital and the clean sheets smelt of feces. The nurse told me that they were having problems with where the laundry was being sent.

• My surgeon was very thorough and answered all my questions, and all of the staff were wonderful.

• My plastic surgeon gave me back my self-esteem and hope for the future. He was compassionate and I feel lucky to have found him.

• My treatment at the hospital in Comox was great.

• I have had several treatments in hospitals and I am amazed at the competency and dedication of the physicians, surgeons and nurses.

• Doctors in hospitals have no private practice and run around from patient to patient, floor to floor and never return calls from family members. This lack of communication is unacceptable.

• I was in the hospital for surgery and was shocked to be put in a ward with two men. After gaining some strength and going for a walk down the hall, I discovered empty rooms.

• When someone requires assistance there is no staff around.

• My husband was subjected to appalling conditions at the Vancouver General Hospital. I could hardly get through the crowds of patients to see him only to find he had been left in half of a cubicle. He was near death and had not been offered water. There was an open urine container in the cubicle and it stunk. My husband had not had the blood cleaned off him and I could not find a cloth to wash him myself.

• The care I received at a Vancouver hospital was very good.

• My surgery was on time with minimal waiting and my surgical care was excellent. Those involved were great. I lacked for nothing in comfort, care or information on expectations.

• The level of care at Vancouver General Hospital, where my twins were born, was exceptional.

• I had great care and attention for three weeks at Lion's Gate Hospital.

• Once I was diagnosed, the treatment I received was fabulous.

• The people at the Fraser Valley Cancer Clinic are amazing.
• My stay at the Fort Saint John Hospital was like a five star resort compared to the treatment I received in Dawson Creek. The staff are angels. Everyone is treated with respect and dignity and given wonderful care and attention.

• I found the doctors and nurses at Lion’s Gate Hospital to be dedicated, professional and hard working.

• The hospital in Vernon is one hundred years old and still functioning because of the people staffing it.

• I would like to take this opportunity to say thank-you to the doctors and nurses at the Victoria General Hospital and the Delta hospital who have supported me during my fight with kidney disease. My care has been excellent both before and after my transplant.

• My family has had great service from all medical facilities in Richmond.

• Golden and District General Hospital are doing a great job and I have had the best medical service there.

• My mother passed away at Burnaby General Hospital. When she was admitted, the care team recognized there was not much that could be done to improve her condition, and this was explained clearly to her. She was only to be kept comfortable in her final days.

• My family has received great and timely service at the hospital. The staff were attentive, knowledgeable and kind.

• I had a hip replacement at Saint Paul’s Hospital. It was incredibly successful and everyone was wonderful.

• The medical professionals I dealt with during my pregnancy and birth were exceptional.

• My father was admitted to Burnaby Hospital where the doctors initially misdiagnosed him and he eventually passed away. Shame on the uncaring doctors and the substandard health care system.

**Ideas and Suggestions**

• Music should be softly played every day for an hour or so. I am sure there are various organizations and individuals who would gladly help out with this.

• Patients need to spend more recovery time in hospital.

• The nursery at Langley Memorial Hospital should be brought back.
Health Care System

Comments and Concerns

- There is a lack of accountability in the health care system.
- The health care system does not consider what the patient thinks, feels or how they are doing. Emphasis is placed on what the medical profession thinks is the right thing to do.
- The current system does not allow for health care workers to act in the best interests of patient.
- The health care system needs more regulation, with set standards that health care professionals abide by. Things need to be done in the same way throughout the province.
- The health care system rolls along, making decisions that have little regard for the patient's knowledge or benefit.
- The low quality of care existing in most walk-in clinics is impersonal, rushed, and the patient is left feeling the need to seek a second opinion.
- Most physicians are against the concept of a universal-care plan. Physicians are also against having a fair and democratic system where people have to wait their turn for care, regardless of their financial status.
- I do not know why I was charged money to see a specialist if we have universal health care in British Columbia. How is it legal to charge for medical procedures? Would I receive inferior service if I did not pay?
- Patients are not processed as people any more. They are viewed as statistics and goals, used to make the politicians look good.
- In most cases, patients just want to receive treatment and get out, but there are many who visit their general practitioner weekly, demanding diagnostic tests, treatments, and medications. They put a huge burden on the resources with very little benefit to their health. There is no accountability for this.
- British Columbia, unlike other provinces, requires patients to suffer through two documented relapses of Multiple Sclerosis within two years before the patient is officially diagnosed and permitted to access expensive drug treatments through the Medical Services Plan. This is standard, despite numerous studies that indicate the earlier one is treated for Multiple Sclerosis, the better chance one has at preventing further damage from the disease.
• As a third year nursing student, I think that many primary health care providers could help cut down the costs of health care by thoroughly examining their patients. Taking a little extra time to address the issues and concerns would decrease the chances of misdiagnosis and useless referrals.

• The only persons in the province that get their issues noticed are nurses, doctors, teachers and politicians. They hold the rest of the province hostage, while we pay and pay and pay.

• The public health care system is combative and uncaring.

• My personal experiences of the health care system are mostly positive.

• The breast cancer clinics are a good example of where health care should be heading. They offer a lot of information and excellent care. We should have these types of clinics for heart disease. We could help people monitor their heart health and reduce the amount of bypasses needed.

• There are so many positive things I see about the health care system. I have visited friends and family members in hospital, and they have all been so positive and appreciative of the staff and procedures received.

• I really appreciate our health care system. Health services have helped our family tremendously.

• I feel that the care I have received in this province has been excellent.

• I would like to thank the health care system because, I had surgery, and if the surgery was not done I would have died.

• The federal and provincial health care is satisfactory.

**Ideas and Suggestions**

• We need to put care back into the system.

• We should streamline the system, and have one health authority across Canada, so that all provinces operate under the same guidelines.

• Public input should be considered when forming solutions.
Health Professionals

Comments and Concerns

• General practitioner visits feel very rushed and symptom-focussed.

• If general practitioners were better organized and had more time to spend with patients, there would be less hospital admissions.

• Doctors do not listen to their patients and have outdated information on Hepatitis C.

• Doctors have poor bedside manners and prisoners receive better health care.

• When my husband was ill, a nurse would whisper to me that a test should be performed, or some change in his medication or routine should be made. I asked that nurse if she was going to speak with the doctor or at least chart the suggestions, but she told me that she could not make a suggestion to the doctor.

• Young professionals in the medical field want to work office hours and are taking a diminished interest in their patients.

• The family doctors do not examine their patients. They write consents for tests and whatever increases revenue. They do not care about the quality of their service.

• Clinic doctors do not build a relationship with patients, nor do they have patient health histories or records.

• I asked my doctor if I could get a second opinion and he gave me a month’s notice that he no longer would have me as a patient.

• Physicians have too much power as gatekeepers, but it does not have to be that way.

• Some physicians only work part-time because they can make enough money.

• When our doctor moved out of province, we were not able to find a new doctor. A walk-in clinic was not an option because my husband has had cancer and is a diabetic.

• Physicians are dropping patients from their practices for choosing a Registered Midwife to provide pregnancy care.

• General practitioners are in too much of a hurry to be thorough or to practice preventive care.

• Doctors are reluctant to remove other doctor’s bandages.

• Doctors are motivated by greed.
• Some doctors do not respect the work done by patients to research medications via the internet, etcetera.

• Local doctors are far too complacent with their regular patients and do not promote mandatory testing, (for example, endoscopy for former cancer patients, which should be a natural thing for a doctor to suggest).

• Doctors do not listen; only the patients know how their bodies feel and whether or not it feels normal.

• There is poor communication between doctors and patients.

• Some doctors at clinics have negative attitudes.

• General practitioners do not have time to really help. They only have ten minutes to get to know the patient. They should start doing casts, tonsils, appendix removal, and deliver babies like they used to.

• It is not fair that doctors can hand pick new patients.

• The system has been abused partly due to having doctors and nurses who do not care and are incompetent.

• If doctors paid attention to what the patients say, problems could be addressed more efficiently, and there would be less strain on the system.

• Many doctors seem to be stressed trying to fit in many patients. The average doctor visit is ten minutes. What happens when the doctor gets behind? Are some visits cut to five minutes? If this is the case, how can the doctor make important assessments in that short length of time?

• The doctor who looked after my father was very rude and told me I should let my father fall and break a hip if I wanted him to get into long-term care.

• I am upset with doctors who let on that they know certain areas when they are not specialized.

• Doctors serve only their interests and those of the pharmaceutical community. There needs to be a re-evaluation of how doctors treat their patients.

• General practice is in crisis and very few general practitioners will appear in the next few years.

• When doctors do not do their jobs well or are not up to date on medical information, illnesses go undiagnosed and patients hop between doctors. This becomes costly to the health care system, and doctors should be accountable for this.
• Older doctors gave a lot of free labour to Medicare, but the younger health professionals are not willing to do this nor should they.

• Doctors often focus on the symptom and not the underlying cause of medical issues. They prescribe a pill, which merely band-aids the problem.

• Very few doctors are accepting new patients and so many people have to go to walk-in clinics. This increases the risk for misdiagnosis, as the clinic doctors do not have the patient’s medical history.

• General practitioners seem to be more interested in running a business, and are not committed to the health of their patients. This is in conflict of the oath they have sworn to the British Columbia College of Physicians and Surgeons.

• Medicine is getting over-specialized so general practitioners have reduced their skill sets in an attempt to be everything to all people.

• Many doctors and other care providers are not happy with the system and their unhappiness is evident in their negative attitudes.

• Doctors have little compassion.

• Younger doctors merely prescribe drugs, (especially for depression), and have lost touch with their patients.

• Some doctors are prescribing drugs that the patients feel are not working for them. Doctors need to listen and consider their patient’s feedback.

• General practitioners are always in a rush, and they are not interested in the people. The doctor just wants the patient in and out. They do not have time to even explain what is going on, they push you out too fast. It is like fast food, in and out.

• General practitioners only care about money, not the patients.

• Doctors have saturated their profession with technology and tests which leave most of them out of touch with patients.

• Some doctors abuse the system by double billing.

• Some doctors create conflicts of interest. My doctor also sells orthotics, and all of his patients require orthotics.

• Doctors only seem interested in fixing the problem. There is little attempt to act pre-emptively to assist a patient to prevent or defer a problem.

• Doctors are convinced of their own infallibility and this leaves no room for patient input, self responsibility or empowerment.

• Doctors must recognize that they are highly trained advisors to their patients, not their decision makers.
• Because they are fee-for-service and not salaried, some doctors end up placing more priority on making as much money as possible rather than providing the best care possible to their patients.

• Not everyone with the word doctor in front of his or her name should be one.

• My family doctor gave my daughter a prescription for an expensive anti-inflammatory drug rather than sending her for diagnostic tests.

• The quality of care varies so much from doctor to doctor.

• Family doctors have become businessmen. There does not seem to be any concern for the family aspect at all.

• There are not enough socially conscious doctors in the health care system. There is too much emphasis on financial success.

• Very few physicians are accepting new patients.

• I had surgery for prostate cancer and a triple bypass. I thank the doctors and the medical system of British Columbia.

• There are wonderful doctors, nurses and support staff at the Peace Arch Hospital and British Columbia’s Children’s Hospital.

• Practitioners are doing their best and treatment is excellent once you are in.

• The doctor was honest with us so we knew what we were dealing with and could make arrangements.

• There is an emerging class of physicians who are working to meet the needs of patients using a holistic approach.

• Doctors do an excellent job. You only hear about things when they go wrong, not the ninety-nine per cent of things that go right.

• Some doctors freely share information.

• British Columbia has attracted some world-class practitioners.

• I have been well looked after and have always had a doctor to look after me.

• We have had two family doctors since moving to the Sunshine Coast and they have both been wonderful.

• My doctor takes time to listen.

• Doctors have a minimum of twenty years of education and countless hours of practice.

• The doctors who treated my cancer have done the best that our medical system permits. They are not part of the problem.
• I would like to commend the efforts of my doctor and his team for finding and eliminating my cancer.

• The doctors and nurses at the Kelowna General Hospital are doing an amazing job under difficult working conditions. They are short staffed, overworked and in need of additional help.

• I wrote a personal letter to a doctor and it helped me become her patient.

• Health professionals do a great job and work to the best of their abilities despite the shortcomings of the system. I have an incredible doctor who has been as frustrated as I have.

• There are many wonderful physicians out there who truly do have the best interests of all their patients in mind, regardless of their ability to pay.

• I was touched and impressed with the professionalism, efficiency, kindness, warmth, and honesty of the doctors, nurses (both hospital and home care) and technologists who cared for me and who helped me and my husband understand what was happening.

• When nurses come to my home, they are very professional.

• My father, a physician, passed away from cancer. The palliative care nurses provided incredible support and information.

• The NurseLine is completely useless and life-threatening.

• Nurses are not allowed to give medical advice and can only recommend that the caller see a doctor. They are not allowed to voice their opinion and are only able to read from scripts on their computers.

• When my husband was in hospice, the nurses talked excessively on their cell phones, gave out painkillers and were not compassionate.

• The nurses shared with me that they were extremely overworked and tired.

• It is inappropriate for nurses to talk about personal and staff issues in the presence of the patients.

• When I was in hospital, the care I received from the nurses was not adequate. They forgot about patients if they were not complaining. They thought patients were fine when they were not.

• Nurses who have been inside hospitals for a long time are bored and rude to patients. They do not seem to have any desire to be in social services.

• Some nurses give cruel treatment.

• Most nurses are courteous and considerate.
• Making a fashion statement seems more important than answering a call bell.
• Some nurses seem incompetent and uncompassionate, which is a disgrace to our medical system.
• Nurses do not wear identification, which is confusing.
• Nurses need better training in people skills because they do not communicate directions to patients very well.
• My mother-in-law was treated like an animal by nurses at the Vancouver General Hospital.
• A nurse made a decision to discharge me after twenty-four hours, even though I should have stayed in the hospital for forty-eight hours.
• Doctors and nurses in general are overworked and unhealthy.
• My husband had a hip replacement in Trail Hospital and was traumatized by the experience. When he came out of the anaesthetic, he waited twenty minutes for a nurse to respond. The nurse finally responded when he tore the intravenous from his arm was thrashing around in pain. The dosage was inadequate. The nurses said there was nothing they could do. When I got in touch with the surgeon the next day, the receptionist couldn’t believe the nurse had not been proactive enough to call the doctor.
• I soiled my bed and called for help but no one came. The nurse told me to get out of bed and wait. I waited for several hours but no one came, and I finally got back into the soiled bed because I was cold.
• Nurses are overworked and run off their feet.
• Several times the nurses tried to give a medication that had already been given because it had not been documented.
• Nurses are wonderful at St. Mary’s. They are angels.
• Nurses truly are angels of mercy.
• The hospital nurses were phenomenal, but they had too much to do.
• The nurses in Telegraph Creek are a very valuable resource. Without them, people would have to travel over two hours to the health centre.
• Nursing students are very compassionate, respectful and interested in learning.
• Liaison nurses are starting to become more visible and advocating on behalf of First Nations.
• Public health nurses and their programs work.
• My father passed away and during the last few months of his life we were provided with the NurseLine number from the Fraser Health Authority. The nurses were so helpful, even in the middle of the night. The NurseLine allowed us to keep my father at home where he wished to be and not rushed to emergency every time his conditioned worsened. The service truly is a godsend.

• The community health nurse visited my home for several days in a row to help me with the breast feeding problems I was having.

• The best thing about the health system is the health professionals; especially the nurses and how they manage to give excellent patient care without the resources and funding that our health care system needs in order to operate at maximum efficiency.

• Nurses in the hospitals and clinics keep the system running but are under-valued.

• The nurse who treated me was able to spend extra time assuring various tests were done and she acknowledged that I should be informed about my health needs.

• The nurses and pharmacists at the NurseLine are so professional and helpful.

• A nurse brought her son and daughter in to play the violin and organ for the patients which made them all so happy. Apparently, this was arranged by the Palliative Care Doctor.

• A nurse brought a white rabbit for my mom to cuddle on two different occasions, which made her so happy. Other patients were able to enjoy it as well.

• It was clear that nurses and doctors were working under tremendous pressure, but kept their composure and compassion.

• I am immensely grateful for the excellent nurses and doctors that have done so much to extend my life and quality of life.

• The specialist's office had a recording indicating staff answered the telephone for extremely brief periods only on specific days of the week. After a month of waiting, the hematologist’s office had not yet responded to set an appointment. According to our doctor’s office staff, this lack of response is not unusual, and it is unwise to repeat a call because the specialist's staff resent it. My husband finally received an appointment, many weeks out. Such lack of responsiveness demonstrated how little respect the specialist has for family physicians. It also shows a callous disregard for the anxious patient who has just received a diagnosis of cancer and must wait months for information.

• General practitioners and specialists should be more respectful when speaking to patients. I was verbally abused when I spoke to my specialist about Chronic Fatigue Syndrome.
• Surgeons have God complexes.

• Communication between the specialist and the general practitioner needs to improve.

• I had a negative experience trying to find a specialist for my son. All of the doctors I attempted to contact were on vacation. Only those doctors willing to work should be hired.

• My father received excellent care at the Vancouver General Hospital Neurology Rehabilitation Centre.

• We have excellent medical staff that are highly skilled in performing transplants.

• I have been seeing a haematologist at the Vancouver General Hospital and I am very pleased with the care and attention I have received.

• Surgeons at the Vancouver General Hospital were absolutely the best.

• I had an appointment with an oncologist at a cancer centre and it was a very helpful and re-assuring visit. There was time for me to ask questions and the oncologist did a very thorough physical exam. I felt extremely fortunate to have had the chance to have this consultation.

• We have an outstanding team of world class physicians, surgeons and researchers in British Columbia. Our Child & Family Research Institute has gained international recognition for its work on genetic illnesses, diabetes and childhood cancer.

• Specialists usually take the time to educate patients about their medical situation.

• Pharmacists communicate with doctors to ensure proper medications are prescribed.

• The health care system is still here because of the excellence of the medical professionals.

• Some staff members do more then they have to, even though they are not being supervised or rewarded.

• The health care system has well-trained and dedicated professionals.

• Health professionals on the front-lines are leaders in British Columbia.

• I would like to give thanks to our health professionals who are mending our bones, sewing up wounds and keeping us on a path to wellness. You are greatly appreciated!

• The entire staff of the Royal Inland Hospital was extremely caring and helpful.

• I appreciated when the hospital staff remembered my birthday.
• Patients should not have to be adversarial to get service.
• The communication between the various professionals is limited, hierarchical and dangerous to the patients. It also wastes valuable time and resources.
• There is a diminished interest in patient welfare, namely home visits and after hours availability.
• Walk-in clinics are like assembly lines.
• I question the competencies of health professionals.
• Medical students are not choosing family medicine as their post-graduate choice.
• I have seen little evidence of the values or principles of health professionals in general.
• My questions to health professionals have been ignored or unanswered during treatment. The health professionals were acting in a condescending manner toward me.
• Health professionals are doing extremely well under the difficult and strained conditions.
• Health professionals are under intense pressure and doing the best they can.
• Health professionals are quick to refer patients.
• I received excellent care at Three Bridges Clinic. The staff provided almost unlimited time and paid attention to my needs.
• Health professionals have done an exceptional job caring for my son despite the inaction and chronic under funding by the current government.
• I have nothing but praise for the health care I received on the north island.

**Ideas and Suggestions**

• Health professionals should work four days a week and go to school one day a week to keep skills current.
• We should increase training spaces.
• Staff have to be trained to deal with end-of-life needs.
• More health professionals need to have mental health training.
• We should give tuition breaks for those in nursing and medical school.
• The qualifications to be a medical professional need to be more flexible.
• Nurses should check the patient’s birth date as well as their name when giving medications in hospital as some groups have many people who share the same name. Mistakes are being made too often.

• Doctors need to lose the God complex.

• We should have health care workers who serve as ombudsmen to assist patients who have difficulty navigating the system.

• There should be a province-wide registration of doctors that is accessible to the public.

• The caps on daily patient limits doctors are allowed to treat should be removed so that they are able to see more patients.

• There should be more focus on the outcomes of care.

• I would like to see a report card for physicians. This would help me identify which physician I would like to have care for me.

• I would also like to suggest that physicians understand that patients have more information available to them through the internet and are therefore more knowledgeable then in the past.

• We should make health care providers more accountable to their patients, and provide more information to patients so that they can make informed decisions.

• Double or triple the number of training facilities according to what is most needed.

• There should be more communication between the family and doctors concerning the patient’s care.

• The family should assist in the patient’s care when there is a nurse shortage.

• Encourage doctors to perform tests earlier rather than later. This may help catch problems sooner while they can still be treated.

• Listen to the people. Do not assume that what they express is not real for them.

• Doctors need to be trained in proper bedside manner.

• Allow for feedback regarding the treatment received.

• Doctors need to take the time to say something nice to the patient and make them comfortable.

• We need a website or phone line where we can report bad treatment from health professionals.

• People need to be able to switch doctors without reprisals.

• There needs to be more caring in the business of medicine.
• Patients should have a role in evaluating physician performance.
• There should be a code of conduct for health professionals.
• Foreign-trained doctors should be fast-tracked to practice in British Columbia. Make it mandatory for them to practice in rural parts of the province for a set amount of time.
• Doctors should spend more time with the patients.
• Doctors should give more time to people on welfare when they are sick. They need to be treated with dignity and respect.
• We need to focus attention on the health care workers in our province. Many are smokers and are overweight. It is contradictory to preach better health to the population when the people that should be leading by example are not.
• Strategies need to be implemented to open up communication between surgeons and consumers.
• Nurses should find answers to patient’s questions if they do not already know them.

**Outstanding Questions**
• What incentives should we provide to doctors to spend more time with patients?

**Experiences with Wait-Lists**

**Comments and Concerns**
• People are being told by medical professionals that they will have to wait years for a required surgery, but that in a private system the wait would be significantly less.
• A triage nurse only appears every fifteen minutes at Richmond General Hospital and there is no system in place to organize who came in first. Even those with acute problems have to wait. I saw a mother screaming while holding a child with burns in her arms and there was no assistance available.
• People without a doctor have to self-manage their own problems and concerns.
• Doctors accept extra payment from patients to move to the front of the queue.
• My husband passed away while on a wait-list. I attribute his death to his poor health, a long wait-list, and poor decision making on the part of the health professionals.
• I have experienced deteriorating health (stomach problems, swelling, abnormal blood results, etcetera), as a result of having to wait months for a required heart surgery.

• I was diagnosed with endocarditis (inflammation of the lining of the heart’s cavities). My condition worsened, and I was admitted to Royal Columbian Hospital where I found that many people were awaiting heart surgery and there were only three surgeons servicing the busy centre. Patients, including me, were bumped from their surgeries several times, usually until they became critical. When I realized how backed up everything was, I contracted services in the United States.

• Due to a spinal cord injury, I am a quadriplegic. Until early 2006, I remained in a stable, fairly high functioning condition. Over time, I started to experience pain and to lose function at a rapid pace. Surgery by a highly trained spinal surgeon may have been able to end the loss of function, but it was impossible to repair the damage. When I found this out, I believed my situation was an emergency. There was no way for me or my general practitioner to speed up the process of getting to a spinal surgeon. I estimated that I lost twenty-five per cent of my function in the four months before I saw the spinal surgeon. The surgeon was excellent, recognized the situation and was able to promptly arrange for the necessary tests. Even though the physician and surgeon responded quickly, I am now, among other things, no longer able to drive or cook.

• My son waited for a long time for surgery on a slipped disc in his back. During most of this time he was unable to work.

• I had an internal problem and my doctor called the appropriate specialist to make me an appointment, which was months away. I decided to call them to see if there was a cancellation I could have. When the nurse heard my symptoms, she gave me a much earlier appointment date. The nurse told me that my doctor should have been more descriptive of my case so they would not have put me at the end of the list.

• It is a waste of time and money to send patients back and forth between physicians and specialists. The patients suffer while waiting for referrals and treatment.

• I am on a five month wait-list for an urgent Magnetic Resonance Imaging (MRI) scan. Last year, I paid eight hundred and fifty dollars to have it done at a clinic to avoid the waitlist.

• The state of public health care in British Columbia is shameful. My wife had to wait over four hours in the Burnaby Hospital emergency waiting room before being seen by a doctor. She had a blood infection and it is not known how long she will require treatment. People are suffering and dying because they have to endure unacceptable waiting periods.
- I have had to wait three months for an appointment with a thyroid specialist. This is too long, especially for those with serious conditions.
- I am confined to a wheelchair and was scheduled for surgery, but not given enough notice so that I could arrange transportation to my pre-operative appointment. Because of this, the surgery was cancelled and I now have to wait an additional six months.
- Wait times are too long and make patients feel neglected.
- I waited for my doctor to show up for my 9:00 a.m. scheduled appointment to treat my nerve-damaged hand. The doctor showed up half an hour late, and told me that he was too busy and that I would have to come back around 4:00 p.m.
- My specialist did not have an answering machine and it took me six weeks to get through to his office.
- I waited eleven months for a hip replacement, but the surgery went very well.
- My husband needed a Magnetic Resonance Imaging (MRI) scan and was told he would have to wait six months. Instead of waiting we paid to have it done. I cannot believe the length of time it will take to get in to see a specialist and eventually have surgery. He is in severe pain, cannot sleep and is stressed at not being able to work. We have paid into the system for over thirty years and now have no help when we need it. I am concerned about the damage that may be unfixable because of the wait.

**Ideas and suggestions**
- The wait would have been shorter for my son if there was private care available to us.

**Equity of Care**

**Comments and Concerns**
- There is no tracking of cultural complaints within the system, nor are the discriminatory staffs identified.
- Specialists have preconceived ideas about their patients.
- The Campbell River and Comox Valley hospitals have had complaints with regard to their treatment of patients with withdrawal and overdose symptoms.
• My doctor insulted my German ancestry when he said I was being difficult due to my cultural background even though I was born and raised in British Columbia.

• Doctors fail to do follow-ups on seniors and mental health patients.

• First Nations patients are treated disrespectfully within the medical system.

• Some medical professionals speak disrespectfully to First Nations patients. They either do not believe them or do not treat them with equal care.

• There is overt racism in hospitals from staff and doctors towards First Nations patients. Many are afraid of complaining, and if they do they are labelled as trouble makers.

• Doctors push medication on First Nations patients.

Ideas and Suggestions

• Doctors should treat everyone equally and respect their differences.

• We should create an Aboriginal Staff Association at a community level.

• Health professionals should require cross-cultural training.

Quality of Care

Comments and Concerns

• Practitioners do not have accountability for not adhering to guidelines and standards of care.

• Physicians and nurses are not paid to have a relationship with patients. The transaction is business.

• The ten-minute model is ridiculous. A physician cannot know how help in a holistic way in ten minutes.

• A man had a feeding tube inserted four weeks after he had a stroke. During those four weeks, he lost thirty-five pounds.

• Doctors do not call their patients by name or ask how you are. They dive in and do things as though their patients are just objects.

• The British Columbia Cancer Agency does a fantastic job of making patients feel cared for.

• Informed consent is not being listened to.
• There are no incentives for doctors to maintain patients' health. They are paid for treating problems.

• My husband had abdominal surgery. He was well cared for, and it seemed to us that there was an excess of nursing staff available. At least three nurses checked that he had received pre and post operative instructions. The care was good and he was discharged appropriately.

• In hospitals, there are a many employees who are not doing their jobs.

• There is not enough support for patients when they first receive a frightening or upsetting diagnosis.

• I feel I am treated with disdain and suspicion because the doctors are unable to accurately diagnose my condition.

• There is little time to talk at length in the doctor’s office and there is not enough communication between doctor and patient.

• I do not feel cared for and my health concerns and issues have been dismissed over the years by my physician. I see no benefit in visiting my physician; it is a waste of time and money.

• My niece was not properly questioned or advised and suffered verbal abuse from her physician. She complained of severe constipation which was much later discovered to be caused by a cancerous tumour attached to her sacrum.

• Health professionals do not care about their patients anymore.

• I am having a hard time finding a physician I trust.

• The standard of care my mother received was adequate but not outstanding. Due to staff shortages, addressing her needs took much longer than it should have. She was uncomfortable most of the time.

• My husband was unable to effectively communicate his health issues with his physician because of the one problem per visit rule. They later discovered his multiple problems were symptoms of prostate cancer, that later metastasised into his bones. He passed away after a year of medications and pain.

• I was over-anaesthetized because the medical staff were mistaken about my weight.

• Poor diagnosis can have fatal consequences.

• The health care system put me and my unborn child at risk by not providing proper care.

• The doctors dealt with one contributor’s serious ailment as if it were a minor issue.

• We hide medical mistakes and do not discuss them in an open manner.
• Doctors did not follow through after fixing a patient’s broken pelvis, which led to related medical complications later.

• My husband was not properly diagnosed. The doctors believed he had Alzheimer’s for two years before discovering he actually had Parkinson’s disease.

• Doctors are too busy to see the early signs of disease and make a proper diagnosis.

• I had asked my doctor to send me for a Magnetic Imaging Resonance (MRI) scan for a back problem. The doctor sent me for x-rays instead, even though I have a history of serious back problems, including a herniated disc.

• Doctors do not go to jail for malpractice.

• I have been mistreated by doctors over and over again.

• Specialists rely on their memories of each patient to determine what treatments they have received. This leads to unsuccessful treatments being repeated, and costs the health care system more money than is necessary.

• I became very ill after being prescribed toxic quantities of a medication for migraines. My physician did not recognize my symptoms to be caused by prolonged usage and barbiturate overdose from this drug.

• I was given a prescription that caused me acute pain. Doctors need to solve what is causing the symptom, rather than just prescribing drugs.

• Covering up doctor’s surgical mistakes costs money and causes pain and suffering for the patients. Health care will not improve this way.

• Doctors prescribe medications that have serious side effects without fully informing the patient.

• While in hospital, my intravenous required refilling five or six times during the night. My blood was running back up the tube in spite of the fact that I had informed the nurses my intravenous was running out.

• An infant was brought back to a doctor to fix a botched circumcision, and it is not the first time this doctor has botched a circumcision. Parents are not educated about circumcision and are not told about the potential for loss of sexual function and sensitivity. Parents are scared into circumcision with false claims of the child catching disease if they are not circumcised.

• The repeated tests and new drugs I have had for treating my arthritis are a waste of time and abusive on the part of the doctors. I have been called on to discuss the latest test results and the doctors did not even know why I was there.

• I was referred to a surgeon in Trail and he diagnosed me with Crohn’s Disease. For three years I was on a health rollercoaster. I was prescribed the wrong type of
medication with the wrong dosage and given the wrong length of time to take the medication for. The treatment I had may result in future problems, including cancer.

- My husband went to emergency with chest pain, was diagnosed as having a stomach ailment and discharged with Maalox. He later died. If he was given more accurate and reliable testing, he may have survived.

- I was in an accident and was taken to the Richmond Hospital and later released after x-rays were taken. I still had pain and went back. More x-rays were taken but nothing was seen. On a third visit, I was examined and found to have a broken neck.

- There have been many undiagnosed cases of Lyme disease because many doctors are unfamiliar with it.

- I took my infant to the family doctor because the child had blood in his stool. The doctor dismissed me as an anxious mother, but it was later discovered the infant had Crohn’s disease.

- I am highly over-medicated and feel that I am being drugged to death.

- It seems that doctors have to nearly kill someone or sexually assault them in order for their association to do anything.

- At the hospital, I was told I could go home but was not to eat because I still might need surgery. The reception staff called my husband for me because I was feeling dizzy. I was given medication, but have no memory of being given instructions. I did not eat for two days in case I needed surgery and no one called me.

- I had surgery, but my doctor did not inform me of the risks involved. The surgery has left me crippled.

- It is quicker and easier to give a patient a prescription than it is to address their lifestyle choices that lead to the need for the prescription in the first place.

- Medical staff are so busy delivering care that they never focus on how they deliver care.

- The health care offered is simply scratching the surface. Doctors are not getting to the root of the problems.

- Follow-ups after testing are not efficient. Sometimes the patient has to phone to see if the results are in. Even if the test results are fine, a follow-up call would reassure the patient.

- After surgery, access to rehabilitation seems dependent upon the orthopaedic surgeon’s rapport with the physiotherapists.

- My husband, who has a spinal problem, has repeatedly had his surgeries cancelled. He will not die from his condition, but will lose his ability to walk.
• I have endured very poor treatment and no follow-up between my doctor and specialist.

• I have experienced physicians who upon learning of my terminal diagnosis, write me off and merely provide prescriptions.

• I changed doctors because it was taking three visits for almost every issue. I was always told that my physician did not have time to write a renewal and that I would have to make another appointment.

• I broke my ankle and it did not heal properly. My physician referred me to orthopaedic surgeon via a fax, but I have not heard whether the surgeon received the referral. I do not know the name of the surgeon I was referred to. My physician said he does not know whether or not the surgeon received the fax but will not send another one. I have been waiting two years for an appointment.

• I read an online article on stroke prevention because my husband has had a mini strokes and I was looking for information on blood thinners because he cannot take aspirin. Our physician told us nothing could be done until he had a massive stroke.

• While I was on the operating table, awaiting surgery, I discovered the surgeon was not planning to do what the oncologist had said needed to be done.

• Following surgery, I was required to have regular check-ups with my specialist. I needed to obtain approval from my physician for these check-ups with the specialist. This is a waste of time and money.

• People go to see their physician and within three minutes they walk out shaking their head, with a prescription in their hand, wondering what just happened.

• My father had a stroke and was left for hours in the hallway at the hospital before anyone attended him. He then spent four days in a bed in the hallway. He was transferred to Victoria General Hospital where he was finally given a room. This is unacceptable.

• After a fall, my mother was kept on a stretcher in a hallway with four other patients on stretchers. The nurse was unable to access the equipment she needed to care for them. The physician spoke to her briefly, and in such a way that she could not hear or understand him. After x-rays, the woman was sent home without any tests to determine why she had a dizzy spell and fell in the first place. Nothing was administered for her pain and no report was sent to her physician of the visit that lasted for five hours.

• My pregnant daughter-in-law was given x-rays instead of an ultrasound and is afraid that this has endangered the baby.

• Doctors should not treat back problems simply by prescribing anti-inflammatories.
• There needs to be a men’s health centre. I have received poor treatment as a single father at a women’s centre.

• My doctor and a cancer specialist were unwilling to listen to my concerns that my husband has a problem with his bladder. I had to wait until another doctor was covering for my regular doctor to get care for my husband.

• Only those in the medical field are qualified to know what health services people need.

• My eye sight was deteriorating, but I felt that physicians were not listening to me. I went to many specialists and had many tests performed on my eyes. Finally a diagnosis of Birdshot Retinochoroidopathy was reached, which is extremely rare.

• Celiac Disease and Irritable Bowel Syndrome are viewed by physicians as conditions where patients need to get used to it, and adjust their lives to suit.

• I have suffered for many years with a ruptured disk in my lower back. Surgery could correct this, but it must get worse before any surgeon will do it. In the meantime, I have to live on pain killers, anti-inflammatories and massage therapy.

• My son was suffering from abdominal pain and it was discovered that he had gallstones. His surgery was scheduled for two months from the time he was diagnosed. After three weeks his pain became unbearable and he was taken back to the hospital where it was discovered that he had a serious infection. We were told that he could have died had they not brought him to the hospital. There was not enough care given to my son.

• Patients have come to expect instant answers for their medical issues, and that a pill will solve the problem. In this environment, drug costs are going to continue to rise.

• My son had a painful condition called osteoid osteoma in his hip bone. After much waiting and pleading for surgery, he was given two surgeries and achieved relief from his pain.

• Retired health care professionals are often given too much responsibility in looking after family members in hospitals.

• My father had a stroke and subsequently spent eight years in and out of the hospital. My father died prematurely because he was not given attentive care.

• The health care system and health professionals are disorganized.

• Where community programs are in existence workers are doing a good job.

• The primary care facilities that do exist offer more patient-centered care, less expensively, and closer to home. They use non-doctor health care professionals more directly rather than using the doctor as a gatekeeper in all situations.
• I have benefited from the fantastic ability, competence and care of the health care professionals.

• I have had a very positive experience with cancer treatment and would like to take part in a patient survey.

• The outreach programs offered through British Columbia’s Children’s Hospital have provided excellent, close to home access to some specialty services and should be maintained.

• My overall experience with the health care system has been positive.

• I had a bad accident on my motorbike. The pain management was excellent. The medical professionals asked me to rate my pain from one to ten and really listened.

• When you have a real need for medical care it is there for you. My family has had only positive experiences with our hospitals. I am tired of the negative publicity the health care system gets.

• I have been extremely happy with the friendliness, professionalism and efficiency of the people there to help me.

• My doctor referred me to a specialist where I have been treated with great care and expertise.

• The skill and dedication of our medical community is second to none.

Ideas and Suggestions

• We need to make sure that people are given the best service in their community and are not sent away. Doctors need to give family members the whole truth.

• There needs to be an environment where the professionals are focused on patient welfare.

• We need to treat people the way we would treat ourselves.

• There are people in the public sector who work hard on the public’s behalf and there are people in the private sector who do very good work on behalf of their shareholders. There are different reasons and purposes for both sectors and we should not confuse the two.

• Medicine is not a business. It is a bit of science mixed in with a lot of humanity. Too often doctors, health authorities, government and the public lose track of the human side of health care. It is time for a moral reality check not a financial one.

• We can learn from the private sector.
• There needs to be a focus on patient-oriented care and fewer redundant interventions.
• Medical professionals should set a good example for health. Hospital staff should not be outside the hospital smoking.
• Doctors should place focus on preventative care.
• Health care professionals should not prescribe drugs unless it is absolutely necessary.
• The public needs to know that they have rights. They need to know how to respond to treatment that they feel has been abusive. They need to be assured that there are methods of reporting professionals who treat them badly and that the governing bodies will respond appropriately.
• Physicians should be held responsible when they botch a surgery.
• There are no repercussions for doctors who do their jobs poorly. Just like in any other profession, doctors should lose their jobs if they do not do them well.
• Marketplace reported that the number one reason for infections related to hospitalization is due to staff not washing their hands.

**Alternative Care and Medicine**

**Comments and Concerns**

• My naturopathic physician has successfully treated my arthritis by changing my diet and giving me injections of glucosamine. This outcome is not a placebo-effect.
• My naturopath prescribed a thyroid supplement which cost nineteen dollars. After taking only a few capsules, my thyroid corrected itself with no side effects. There is no expiry date on those capsules. I can take them again if I need to.
• My wife was treated for a health problem for years by physicians, but was completely healed in one month under a naturopath’s care. Another problem was cured in one visit to a naturopath after being under a specialist’s care for a year.
• I went to a naturopath for help with a shoulder problem, and he helped me regain total range of motion in my arm. When I told my physician about it, he told me he does not believe in naturopathic medicine.
• I had poor results when using Western medicine, and while on a waiting list to see a specialist for a bone scan, I went to a massage therapist who healed me within a week.
• I was told to put my son on Ritalin because he was hyperactive and possibly had Attention Deficit Hyperactivity Disorder. I did not want to do this, and took my son to a naturopathic doctor. He told me that my son’s body turned lactose into high energy sugar and this contributed to his asthma. We removed all lactose from our house were amazed that he could now sit still and learn. His asthma symptoms are now almost non-existent. With dietary changes, the naturopathic doctor also helped me with my stomach problems, and helped a friend with memory loss. I have stopped going to Western doctors.

• I had a sinus infection and went to my physician who put me on antibiotics. When the antibiotics were done the infection returned and I was put on stronger antibiotics. I still did not feel well and went to a naturopathic doctor, who built up my immune system and repaired the damage done by taking the antibiotics.

• I go to my naturopathic physician once or twice a year to have my wellness restored.

• It is not right that an appointment with a Western physician is covered, but visits to a naturopath are not. Many people want to use a naturopath, but cannot afford it.

• I have been having regular visits with a massage therapist, who has helped my back and shoulder pain which enabled me to continue working. The cost has recently increased, and I am worried that soon I will no longer be able to afford it.

• Naturopathic doctors are more willing to listen and offer advice, compared to Western doctors who limit patients to ten minute consultations and a maximum of two questions.

• An injury caused by a chiropractor has ruined my life.

• Western doctors have little knowledge of basic diet, vitamins and supplements, or the hundreds of complimentary treatments available in the province.

• Having a doula prevented me from having a caesarean section, which would have cost the medical system more money.

• I rarely visit conventional doctors anymore because I have had much better results from Chinese medicine, massage therapy and chiropractors.

• I have suffered from a stiff neck for the last ten years or so. A few months ago a local massage therapist was recommended to me. After a number of sessions my neck is much better and continues to improve with each visit.

• I went for massage therapy and found relief from muscle cramping. I now have an increased range of motion and improved comfort when I am sleeping.

• Massage has helped relieve the discomfort of pregnancy, stress and has lessened the pain of old athletic injuries.
• Message therapy has helped me deal with pain due to a disability and I am able to stay off pain medication. I have learned how to manage my anxiety disorder and I no longer take medications for that anymore. I cannot imagine doing without it.

• I have greatly benefited from massage therapy treatments. They enable me to walk easier, relieve my muscle spasms, improved my arthritis pain and headaches, help with shoulder bursitis and relieve stress.

• I suffer from osteoarthritis and have found regular massage has kept me pain free and able to function at my job. Progress is very slow but massage has made a huge difference in reducing the pain and maintaining mobility. I am hopeful it will eliminate the need for surgery.

• Massage therapy is a safe, drug-free, cost-effective treatment. It has decreased my muscle pain, has helped me sleep better and helped lower my stress.

• I have Multiple Sclerosis and massage therapy is very helpful with removing kinks and pain from my muscles.

• Massage therapy has helped with headaches and now I do not have to take painkillers. My doctor actually could not help me, but my massage therapist did.

• Massage therapy completely eliminated the need for me to wear orthotics and helped me to function better day to day. I used to be very headache prone which was cured by massage.

• Massage therapy has helped with my many injuries. I have never needed surgery and take minimal pain medication. I have also been able to work full-time. Whenever problems flairs up, I visit my massage therapist and soon I am mobile again.

• My daughter has congenital tendon problems with her hips and massage therapy has been the only effective treatment. Since she started with the therapist, she no longer needs pain medication and her mobility has improved tremendously.

• Thirteen years ago I, along with five of my colleagues, went to a naturopath and completed his cleansing programme. I was the only one who continued with the program. Today, at age sixty-six, I have no problems with my health. All five of my colleagues have a variety of health issues. Each one of those ailments requires expensive medication.

• A naturopath solved my skin problems when the medical system could not.

• We have used complimentary medicine in conjunction with our regular physicians with great results. I had back surgery over a year ago and used my naturopathic doctor before and after the surgery. It was a great success and many people were
stunned by my quick and remarkable recovery. I also have an excellent chiropractor to keep me limber.

- A naturopath treated me for a stomach ailment that conventional doctors could not, but I cannot afford to keep seeing him.
- My mom had leukemia but is still living strong, healthy and in remission because of naturopathic medicine.
- Midwives provide a far more comprehensive patient and family centered service than doctors.
- I had two amazing and professional midwives in attendance for the home birth of my second child.
- I want to express my enthusiastic support for British Columbia’s midwives.
- I had two children at Lions Gate Hospital with the help of an excellent midwife and my experience was outstanding! I feel extremely fortunate to have had that experience and am saddened to hear that other women who would like midwifery care are unable to access it as there are not enough midwives in practice.
- I spent one year working with a naturopath. She was caring and took charge of my health. I was impressed by her holistic view of the body, extensive knowledge of how it functions, awareness of research and her respectful attitude.
- Chiropractors have had positive outcomes for addicts.
- I am a well educated person with a stressful job. Before I consulted a naturopath, I regularly suffered from allergies, stress related problems, and upper respiratory tract infections. It has been several years now since I have had any of those problems, and I rarely get a cold or influenza. I attribute my good health and strong immune system to the advice of my naturopathic physician.
- I am a senior and I do not take any prescription drugs because I have had the fortune to be cared for by naturopaths, doctors of Chinese medicine, ayurvedic doctors, and western doctors.
- I have been cared for by a naturopathic doctor and found the experience very satisfying. They really listen to their patients.
- I had back problems and my doctor and two back specialists did not have a solution. A friend recommended I try a naturopath. The naturopath prescribed some vitamins, and after twenty-eight days I was back at work. My doctor expressed frustration when I told him about the naturopath. A lot of health care dollars could have been saved.
- My wife and I have had two children born in a rural area thanks to midwives.
• I really appreciate that my family doctor is supportive of alternative health care.

**Ideas and Suggestions**

• A recent hospital experience was disappointing for me because of exclusive use of Western medicine. I would like to suggest implementing Traditional Chinese Medicine and naturopathic medicine into hospitals to compliment current practices.

• Doctors need training in complementary medicine.

• Medical practitioners need to be aware of the alternatives.

**Mental Health**

**Concerns and Comments**

• My son’s psychiatrist tried out new anti-psychotic drugs on him. He was not doing well on these new drugs, and became violent. Now he has spent two and a half years in Riverview Hospital and the doctors will not put him back on his old medication.

• I received shockwave therapy, which helped. But after a couple treatments the clinic would not give me anymore. I feel I was treated with cruelty.

• The mental health teams are not very effective in treating mental illness. A patient is lucky if they see the team once a week. The teams are over-worked and are not able to provide the therapy that patients desperately need.

• Employees within the mental health system are abusive and aggressive at times.

• During a stay in a mental facility, I was in lock up and needed access to the washroom. After knocking on the window to gain attention and access to toilet facilities, I had to urinate on the floor. A nurse made me clean it up. The staff was focused on work and upset when I disturbed them.

• There is no penalty for mental health staff for not complying with the Mental Health Act.

• If my sister had been offered other treatment options, she would not be in the deplorable state she is in now.

• Some health professionals discriminate against mentally ill patients and treat them poorly.
• Releasing a mentally ill patient because they are difficult is a disservice to a person desperately in need of help.

• Assistance and information for people with mental illness is not readily available, and health professionals are often patronizing.

• Not enough money is designated for autistic care.

• A woman had been brought in to the hospital who had attempted suicide. I overheard doctors commenting that the woman should have been put in jail and not brought to the hospital. There is little professionalism in hospitals.

**Seniors Care**

**Comments and Concerns**

• My arthritic and very ill 84 year old mother lay on a hard bed in the emergency room hallway for nearly 12 hours a few months ago. This, after waiting to get on the bed for over four hours. It turns out she was in congestive heart failure, but there was not enough staff to take care of her. She was in extreme pain the entire time, and she could have died.

• My elderly husband had a head injury, and was treated with neglect while in hospital. The health care system needs to be completely overhauled because there is no care in health care.

• Medical professionals do not respect the elderly.

• The facility my father is in costs over five thousand dollars a month. He says the food is horrible, and he has not been able to see his wife of fifty-three years because the facility is on lock down due to a Norwalk-like virus. I feel like I have been unable to get any answers.

• Health professionals talk down to seniors.

• Pensioners receive substandard care from dentists and optometrists. They are given the cheapest care and products which look and feel awful.

• I have to fight to get my mother’s teeth brushed and face washed at the residential care home. My mother has a diagram on how her feet should be placed in bed and in her chair, and yet it is still not done properly. At the same facility, my father was given the wrong medication. Our elderly are not being taken care of properly.

• The elderly are at risk for becoming withdrawn and isolated in care homes if they are unable to get around one their own or communicate effectively.
• My elderly father was admitted to hospital due to heart failure but the drugs and injections he was given caused serious infections and suffering. He was hospitalized for two months while recovering from the infections caused by the wrong prescriptions.

• After a woman died in a small private nursing home doctors were uncooperative and it was difficult to get anyone to come out to pronounce her death.

• I have to wash my mother because the female staff cannot lift her and she is not comfortable with male assistants.

• Hospital staff took away my mother’s bell, which she considers to be her lifeline. She felt helpless.

• An elderly couple was only able to find a general practitioner after a friend pleaded with her doctor to take them on.

• I want to bring my fiancé home from Oak Bay Lodge but I was told it will take three months to get him back in.

• I had elderly neighbours who did not even take aspirin. Two years ago, a young doctor took an interest in them and sent them for tests and to specialists. The woman ended up taking at least seven different medications. The couple was impressed with the care of the doctors and the pharmacist. They are now in an extended care home. At one point they considered stopping the medication but they were too frightened.

• Seniors are sometimes given the wrong medication without there being any consequences or the families even aware of the doctor’s mistake.

• I had Christmas dinner with my mom at the Pioneer Wing of Swan Valley Lodge and

• I felt guilty because care-workers were serving the meal, administering medications, making beds, washing dishes, washing and dressing patients, using lifts and cleaning and clearing, like slaves. Neither of these two wonderful care-workers had a break since they had started their shift, yet they were, as usual, refusing to let their fifteen residents suffer from lack of sufficient help.

• The Matsqui-Sumas-Abbotsford Hospital has offered little in the way of stimulation and care for an elderly woman who spends hers days lying in bed with no hope. The longer she stays in this situation the more she withdraws from the world.
Ideas and Suggestions

- Continuing care for seniors is essential.
- Elderly residents in care homes receive compromised care because staff are not qualified to care for them. Staff need to be familiar with individual needs.