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British Columbia

PATIENTS FIRST 2002:
THE PATH TO REFORM

Select Standing Committee on Health
Report
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December 12, 2002

To the Honourable,
The Legislative Assembly of the
Province of British Columbia
Victoria, British Columbia

Honourable Members:

I have the honour to present herewith the Report of the Select Standing Committee on Health for the Third Session of the Thirty-Seventh Parliament: *Patients First 2002: The Path to Reform*.

The Report covers the work of the Committee with respect to responses to the Committee's first Report to the House on December 10, 2001 entitled *Patients First: Renewal and Reform of British Columbia's Health Care System* and those reports relating to health care and its delivery that have been published since the Committee reported to the House.

Respectfully submitted on behalf of the Committee,

Val Roddick, MLA
Chair

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Val Roddick, MLA	Chair	Delta South
Susan Brice, MLA	Deputy Chair	Saanich South
Jeff Bray, MLA		Victoria-Beacon Hill
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CLERK TO THE COMMITTEE

Kate Ryan-Lloyd, Clerk Assistant and Committee Clerk

COMMITTEE STAFF

Anne Mullens, Consultant to the Committee

Wynne MacAlpine, Committee Research Analyst

TERMS OF REFERENCE

On October 10, 2002, the Select Standing Committee on Health was empowered to examine, inquire into and make recommendations with respect to responses to the Committee's Report to the House on December 10, 2001 entitled "Patients First" and those reports relating to health care and its delivery that have been published since the Committee reported to the House.

In addition to the powers previously conferred upon the Select Standing Committee on Health this present session, the Committee shall be empowered:

(a) to appoint of their number, one or more subcommittees and to refer such subcommittees any of the matters referred to the Committee;

(b) to sit during a period in which the House is adjourned and during any sitting of the House;

(c) to adjourn from place to place as may be convenient;

(d) to retain such personnel as required to assist the Committee;

and shall report to the House by December 13, 2002; to deposit the original of its reports with the Clerk of the Legislative Assembly during a period of adjournment and upon resumption of the sittings of the House, the Chair shall present all reports to the Legislative Assembly.

EXECUTIVE SUMMARY

One year ago the Select Standing Committee on Health released its landmark report ***Patients First: Renewal and Reform of British Columbia's Health Care System***. The 100-page report was the culmination of a two-month consultation process with the people of British Columbia about ways to sustain and improve our health care system. At that time B.C.'s health care system was consuming $9.5 billion a year, or almost 40 percent of the provincial budget. We listened to concerns and health care challenges around the province and heard their suggestions for changes. In all, the Committee heard from more than 350 witnesses and received a further 300 submissions.

The resulting report, ***Patients First,*** made 88 recommendations dealing with ways to make the health care system in B.C. more equitable, more accountable, and more focused on patient needs and effective treatments. The Committee recognized then that in many ways B.C. was lucky to have the luxury of being able to focus debate on ways to improve and sustain our health care system. In relation to the rest of the world B.C. is still very well off and our health care among the best in the world – a fact that still holds true a year later.

In December of 2001 we recommended ways to restructure health delivery and consolidate services to maximize quality of patient care, retain health providers and enable a more efficient use of resources. We recommended augmenting training and equipment for the ambulance services, encouraging doctors to form primary care teams, and creating more training spots and recruitment strategies to address the shortage of doctors and nurses in B.C. and incentives to encourage them to practice in rural communities.

Improving information management abilities and using technology, such as telehealth, to improve the efficiency and coordination of the health system and over come some of the regional disparities was a recurring theme from witnesses which then became important series of recommendations of the Committee. Another recurring theme was the need to shift the major focus of the health system from acute care medicine, which rescues people in crisis, to a proactive system that prevents illness. We recommended more focus on managing chronic disease and supporting our elderly, disabled and mentally ill populations so they can live with more independence, autonomy and improved quality of life in the community for as long as to avoid institutionalization in hospitals and residential facilities.

During the last year, the provincial government has acted on many of the recommendations the Select Standing Committee made in ***Patients First.*** Part One of this report gives a detailed accounting of all the specific reforms and initiatives now underway, including:

- Streamlining regional health authorities from 52 to six, including five geographic regions and one provincial authority to coordinate specialty services across the whole province.
- Establishing performance contracts with each of the health regions that define performance targets and hold them accountable for the delivery of patient care, specific health outcomes, and for how health dollars are spent.
- Setting access standards that define how close certain services need to be like emergency and specialty care, and set standards of travel time for all types and intensities of health care.

- Increasing the B.C. Ambulance Service budget by $30 million, increasing the education and training of paramedics across province and purchasing 160 automatic defibrillators to make them standard on all ambulances.
- Consolidating specialist services with the aim to improve the quality and consistency of patient care and to improve the working conditions for specialists to help recruit and retain their services.
- Creating provincial plans under the Provincial Health Services Authority for the coordinated delivery of specialist services such as cardiac surgery, cancer care, renal dialysis, autism assessment, and thoracic surgery.
- Initiating a chronic disease management (CDM) strategy with the aim to improve the early detection, treatment and regular monitoring of patients with diabetes, congestive heart failure, asthma, depression and other chronic diseases. CDM's goal is to reduce the serious complications and increase the quality of life for the estimated 500,000 British Columbians with chronic diseases.
- Shifting focus from institutionalization of the mentally ill and elderly to supportive living in the community.
- Coordinating access to long term care beds on the basis of priority of need rather than on the basis of time spent on a wait list.
- Creating a Life Sciences Initiative to eventually increase the number of medical school seats at the University of Northern B.C. and to create small satellite medical schools at the University of Victoria, specializing in geriatrics, and the University of North B.C., specializing in rural health.
- Deploying a nursing strategy to increase the number of nurses working in B.C. focusing on training, recruitment and retention, such as assisting nurses who have left the profession to re-qualifying or creating new job opportunities for injured nurses to return to work.
- Creating a loan forgiveness program for doctors and nurses in training who chose to practice in hard to staff regions.
- Exploring ways to make the Pharmacare plan more equitable and cost effective.

From the Committee's perspective, these changes are the start of an overall strategy to create a coordinated, accountable, systematic and rational deployment of health services throughout B.C. There was a need to implement some of these changes swiftly and decisively because of the overwhelming necessity to put the breaks on health care costs that now consume $10.5 billion a year, up $1 billion in just one year.

A recurring theme in this document is that there is a need for more public information, communication and consultation to explain the rationale for many of the changes now underway, especially to help the public understand why a change is necessary, what the improvements in health services or patient care are anticipated from the change, and how we will know whether the goals have been achieved. This means that reforms and initiatives should be monitored and evaluated to ensure they are achieving their intended purpose.

Set against the backdrop of B.C.'s program of reform, a number of other important prescriptions for change emerged in the last year. In Part Two, we examine some of the important developments of the last year, particularly with commissions and committees

searching for answers to make Canada's health care system more sustainable, responsive and cost-effective in the future.

As a European Observatory study of eight health care systems in the world noted, no one country has yet found the perfect system: all are struggling with ensuring equity of access, improving health outcomes, providing sustainable financing, improving efficiency and reducing barriers to health and social care.

Over the last year three landmark reports about health care reform have been released in Canada. Alberta's Premier's Advisory Council on Health (Mazankowski Report) called for more focus on health promotion and prevention and more choice and internal market competition, including allowing regional health authorities to explore private partnerships to improve the quality and cost-efficiency of health and raise additional revenues.

The Senate Standing Committee of Social Affairs, Science and Technology, (Kirby Committee) released the sixth and final volume of its in depth examination of the Canadian health care system. The Kirby Committee declared efficiencies alone won't save the health care system: an additional $5 billion a year is needed, which they recommended should come from a designated health tax based on income. That new money should buy change including a national pharmacare program, a national home care program, the setting up of internal market incentives and alternative funding arrangements.

Most recently the Commission on the Future of Health Care in Canada, (Romanow Commission) rendered a second opinion to Kirby. Many of the recommendations were similar – a national body to oversee health care performance and accountability, seed money for an eventual national home care program, coverage of catastrophic drugs with the goal of eventually creating national pharmacare program, and more money for primary care, diagnostic technology, information technology and rural access. At first reading it was widely interpreted that Romanow closed the door on allowing an expanded role for private-for-profit care, but further clarification from him and from closer reading of the document it appears that a role for private providers may be possible if the provision of services remains under the *Canada Health Act* and paid for out of public insurance. Romanow said the $15 billion required over 4 years could be funded from government surpluses.

These three reports provide provocative and sometimes contradictory solutions to the common ailments plaguing our system, which your Committee analysed for their application in a B.C. context. The Committee strongly supports the call for more accountability at every level but is reluctant to agree with Romanow about enshrining accountability as the sixth principle in the *Canada Health Act*, until it is clear what this means and how it would be defined. Increased federal contributions to pay for B.C.'s health care program are needed, particularly since contributions have slipped from 50 percent to only 14 percent of costs. However, the Committee cannot support increased taxes or a designated tax from an already heavily taxed population.

The Committee shares Mazankowski's and Kirby's view that creative partnerships with private providers should be explored as long as they are subject to strict standards, accountability and transparency, and that the services provided are still covered by public insurance. The Committee reserves judgement on a national catastrophic drug program as it is not clear what

the proposed plans would mean for B.C. We already cover catastrophic drugs and more assistance from the federal government is welcome if it enables us to use our money for other urgent needs. Until the details of such a program are worked out, however, it is not clear whether B.C. will be helped or hindered by a federally mandated program. Likewise, until the funding details of any national home are program have been determined, the Committee is reluctant to endorse an idea in which the federal government may dictate compliance with a program our provincial coffers cannot afford.

There are areas many areas of consensus among the findings of the three reports and the Committee's view. We all agree there needs to be a greater focus on preventive health and on quickly solving the logistical and privacy challenges to better utilize electronic information technology to manage services and track patient care. In the last year, consensus has also been reached that user fees for medically necessary services are not effective – they cost more to administer than they earn in fees, they don't discourage inappropriate use of the system and can discourage the poor and elderly from seeking needed care. The Committee supports this view that user fees won't solve our problems.

In Part Three, we discuss how Canadians seem to have no difficulty pointing out the problems of our health care system and recommending various actions to improve the situation. The difficulty, instead, lies in being able to implement the necessary changes, dealing with the fear and overwhelming resistance to change and devising an effective implementation strategy that achieves the desired results. Resistance to change is such a common problem that no less than six papers about managing change were commissioned from academics by the Romanow Commission in an attempt to find ways to allow health care reforms to successfully proceed. The papers, along with lessons gleaned from the Health Transition Fund research, all conclude that change is difficult and must be effectively managed by common strategies such as leadership, shared visions, time to plan, and commitment to public consultation and communication.

The large volume of literature on change management points to the need for a well structured process with firm leadership that is seeking specific goals and that at the same time includes the public and stakeholders in a collaborative two-way communication to reduce fear and anxiety around the change and listen to their concerns. In the health care environment this commitment to clear objectives, transparency of the process, public information and consultation is time-consuming and sometimes expensive process. As such, in an atmosphere of constant need for money for patient care, the cost of communication and consultation for specific health care reforms can itself become a focus of criticism. It can become a no-win situation: damned if you don't communicate and damned for wasting precious resources if you do.

Despite the complexities of implementing change, it seems clear that if attention is not paid to the need to address the fear of change and the need for public and stakeholders to have some avenues to become informed and involved, the policy implementation may fail no matter how worthy and correct its goals. A commitment to transparency of the process as well as to routine evaluation of the success or failure of the change after implementation helps build trust in the process. The lessons from successful implementations of change may provide important guidance for B.C. in following its path to reform.

INTRODUCTION

A year ago the Select Standing Committee on Health released its landmark report ***Patients First: Renewal and Reform of British Columbia's Health Care System***. The 100-page report was the culmination of a two-month consultation process with the people of British Columbia about ways to sustain and improve our health care system.

The all-party Committee, composed of 11 members of the Legislative Assembly, was specifically directed to hear proposals and recommendations from British Columbians regarding the sustainability of the health care system and solutions to better plan and manage public health care services, improve quality, timeliness and patient outcomes, and control funding pressures to ensure its financial health well into the future.

The Committee ultimately heard from more than 700 people and organizations. Submissions included 350 witness presentations and more than 350 written submissions. At the time it was the highest volume of submissions received in the history of B.C.'s Legislative Committee hearing process.

The resulting report, ***Patients First***, highlighted the leading issues challenging the health care system and made a series of 88 recommendations for government action. For a full discussion of the rationale behind the recommendations as well as the complete list of all the recommendations, please view the original ***Patients First,*** available from the website of the Legislative Assembly of British Columbia, under Committee reports (www.legis.gov.bc.ca/cmt/37thparl/session-2/health/reports/healthtoc.htm)

A year later, on October 10, 2002, the Select Standing Committee on Health was empowered again to examine, inquire into and make recommendations with respect to responses to ***Patients First*** and those reports relating to health care and its delivery that have been published since the Committee first reported to the House. During the month of November 2002, the Committee heard testimony from three expert witnesses about developments in the last year: Dr. Penny Ballem, Deputy Minister of Health Services and Health Planning, Dr. Perry Kendall, Provincial Health Officer, and Lynda Cranston, Chief Executive Officer and President of the Provincial Health Services Authority

In Part One of this report, we review the actions in the last year taken in B.C. towards the recommendations in ***Patients First*** and discuss some of the challenges and "growing pains" in achieving some of the more difficult and controversial recommendations.

In Part Two we examine and make recommendations with respect to the major reports relating to health care that have been released in the last year, including the report of Alberta's Premier's Advisory Council on Health, the findings of the Senate Standing Committee on Social Affairs, Science and Technology and the findings of the federal Commission on the Future of Health Care in Canada.

In short, it has been a busy and eventful year for health care in British Columbia and Canada. This report brings together these developments and proposes a new set of recommendations to help British Columbia continue on the path to renewal and reform of our health care system so it can continue providing its benefits for many years to come.

PART ONE: BUILDING ON PATIENTS FIRST

WHAT WE HEARD

In the fall of 2001 we asked: "Are British Columbians getting the best health care for the enormous amount of money we spend each year? What actions could we take to help sustain our health care system, improve its efficiency and ensure the quality of care of our health care system?" We were looking to hear the concerns, experiences and suggestions from British Columbians about ways to improve policy, planning, administration and service delivery of health care in B.C.

From early October to mid November 2001 we held hearings in 10 locations around the province and heard from more than 350 witnesses comprising a wide range of British Columbians. A further 350 groups and organizations sent in written submissions. Many of the individuals and groups appearing before the Committee had a direct interest or worked in the health care industry. A unifying factor of the otherwise highly diverse submissions was the passionate belief that B.C. must work towards maintaining its viable, high quality, and effective health care system.

At the time, the B.C. government was spending $9.5 billion per year to provide health services in the province, which amounted to 40 percent of the entire provincial budget and almost $2,500 for every man, woman and child in the province, whether healthy or sick. In the last year the budget has increased to $10.5 billion, showing how quickly and relentlessly these costs are rising.

Despite the money we have been spending - $18,075 every minute during the time our consultations were held – we heard over and over again examples and stories that illustrated numerous inefficiencies, weaknesses, poor planning, disorganization and inflexibility of the system. Some the problems in our health care system found in the fall of 2001, many of which that had existed for years, included the following:

- An uncoordinated, patchwork of care that was not even a "system" but a series of responses to acute episodes of ill health, marked with too many health authorities, inefficiency and lack of coordination.
- Severe shortages of workers: nurses, doctors and allied health professionals, particularly in small towns or rural areas or northern communities, and specialist care spread too thin.
- A lack of standards, accountability and performance monitoring so that no one knew how well we were doing at improving patient care, how much it cost, or how to focus efforts to improve performance.
- Inability to flexibly deploy staff in the most logical or effective way to maximize patient care.
- An inability to harness the power of information technology to improve efficiency, coordination and management.
- Huge amounts of money going to treat the results of preventable illnesses and injuries but little effort spent on preventing health problems in the first place, or managing chronic illness to minimize complications.

- Costs being driven ever higher by a constant demand for more services, new drugs and technologies, rising wage settlements, and the needs an aging population.

STRENGTHS IN THE SYSTEM

While we heard about many problems during our consultations, we heard about our considerable strengths, too. We must not forget that in the scheme of the rest of the world, and even the rest of Canada, British Columbia is very well off. We have some of the best health statistics, a relatively well-functioning health care system and among the healthiest populations.

- We have the lowest infant mortality rate in Canada and among the best in the world.
- We have the longest life expectancy in Canada – 82.2 years for women and 76.8 for men.
- We have the lowest rate of tobacco use in Canada and the lowest rate of teenage smokers.
- We have the best cancer survival statistics in Canada for prostate and breast cancer.
- Between 1986 and 1998 hospitalization rates for children and youth in B.C. has steadily fallen.
- We have the most physically active population in Canada.
- The health of our Aboriginal people, while not as good as other British Columbians, has been steadily improving.
- Two of our communities – the North Shore of Vancouver and Victoria – were ranked first and second in the country in the Canadian Institute for Health Information's annual survey of community performance for 22 health indicators.
- We have a committed group of health professionals – doctors, nurses, allied health care providers, support staff and administrators– who work hard everyday trying to provide the highest quality care they can.
- And every day, thousands of British Columbians see their doctors, obtain a necessary prescription, have diagnostic tests, treatments or surgery and receive good quality care returning them to good health without fear of financial ruin or hardship because of their illness.

How do we implement constructive change that addresses the weaknesses of our system without reducing our strengths? How do we get from where we are to where we think we should be without undermining what is good in British Columbia's health care system or undermining public confidence? This is the considerable challenge of the path to reform. It is not an easy path to travel.

While the Committee was travelling through the province and compiling the report ***Patients First*** , the Ministry of Health and the Ministry of Health Planning were conducting core reviews of their programs, establishing services plans, and planning strategic shifts in both health delivery and planning. The recommendations of ***Patients First*** fed into this ongoing process and in many cases mirrored what the ministries were already working on. As Dr. Penny Ballem noted in consultations this fall, the work underway at the two Ministries of Health aligned with both the work of the Committee and with what was heard from the public, illustrating that many of us in the province share the same concerns about the weakness of our health care system and are reaching similar conclusions about where the solutions lie.

According to Dr. Ballem, the B.C. government has begun to take action regarding on about 75 percent of the 88 recommendations your Committee made in ***Patients First***. These recommendations addressed:

- Overarching Principles of Reform
- Regional restructuring
- Primary care reform
- Human resources
- Information management
- Chronic and continuing care
- Preventive health
- Pharmacare
- Financial strategies

In the following pages, we briefly discuss context for the original recommendations and the subsequent government action in each area.

OVERARCHING PRINCIPLES FOR REFORM

Debate about how to renew and reform our health care system can be very fractious and polarized. The Committee noted, however, that common principles all Canadians embrace could serve as the essential building blocks to any reforms.

The overarching principles established in ***Patients First*** were:

- **Equity**
- **Patient-centred Care**.
- **Evidence-Based Care**
- **Accountability**

EQUITY

No one should face excessive financial hardship because of illness, disease or disability. Access to timely and medically necessary care should be available to all, regardless of income. We noted in ***Patients First***, however that the principle of equity does not mean citizens should not have to contribute to the financial sustainability of our health care system. Instead equity means that any financial involvement or funding mechanism should be fairly distributed across those with the ability to pay.

We recommended raising MSP premiums as a way to raise more funds for our health care system if this were done in a fair and equitable manner and if lower income groups were protected from undue financial hardship.

We also discussed the fairness of a Pharmacare plan that covered all but about $250 of prescription drug costs for all people in the province 65 years and older — regardless of their income – but did not cover the same portion of prescription costs of lower income working families with a chronically ill child.

Equity also means equitable access to services. As we noted in ***Patients First***, B.C.'s geographic expanse can make equity in access a difficult principle to apply. We did not make specific recommendations about how to ensure equity of access to necessary services in our geographically diverse province, but we recognized that is a continual problem in B.C. that constantly challenges the principle of equity.

B.C. Government Action

Medical Service Plan Premiums

Prior to ***Patients First***, Medical Service Plan premiums in the province had not been increased for a number of years. Effective May 1 2002, MSP premiums were raised by about 50 percent.

Monthly MSP Premiums	Prior to 2002	Post 2002
Individual	$36	$54
Family of two	$64	$96
Family of three or more	$74	$108

MSP premiums now raise about $955.7 million each year in revenue, or about 10 percent of the money B.C. needs to fund our health care system.

Along with the premium increase, the level of net income needed to be eligible for premium assistance was increased. This change enabled an extra 230,000 British Columbians to obtain premium assistance, according to the Medical Services Plan. Now about 1.1 million British Columbians, or about a quarter of the population have some level of premium assistance.

The current adjusted net income thresholds for MSP premium assistance are:

up to $16,000- 100 percent subsidy
up to $18,000 - 80 percent subsidy
up to $20,000 - 60 percent subsidy
up to $22,000 - 40 percent subsidy
up to $24,000 - 20 percent subsidy
Over $24,000 - full rate

According to the Minister of Finance a total of 970,000 people in B.C. are on 100 percent premium assistance and therefore do not pay anything for health care coverage and more than 4 million British Columbians – almost the entire population – choose to be insured by MSP. Unlike the United States, we do not have a large number of uninsured individuals who can't or won't pay for insurance coverage. Nevertheless, there have been concerns raised by some that these increases have presented hardships to some sectors of our society.

The Committee is gratified that the range of premium assistance has been expanded. Like all British Columbians we are concerned that people in B.C. are able to afford their MSP premiums without hardship and that they are not forced to forego other true necessities to make these payments. We note, however, that the current cost for an individual amounts to

about $1.80 a day – a seemingly reasonable price for access to a full slate of high quality health care when many people choose to spend more than that on a daily coffee. It will be important, however, to continually monitor the impact of the premium increases on the people of B.C.

Recommendation #1:

Your Committee recommends that the impact of MSP premium increases be closely monitored.

Pharmacare Program

B.C.'s Pharmacare program has been under increasing financial strain. The program now costs $700 million a year and is the fastest growing portion of the B.C. health budget. While B.C.'s population has grown by just 18 percent in the last decade, our Pharmacare costs have risen 147 percent. The costs increase by $300,000 every day. B.C. pays the greatest portion of prescription medicine costs of all the provinces, covering 53 percent of drug costs, compared to Alberta's 39 percent and Prince Edward Island's 27 percent.

The Pharmacare program pays portions of the prescription drug costs for seniors, long-term care patients, chronic disease patients, and low-income families. Individuals and families not on any of the plans are insured against "catastrophic" drug bills of over $2,000 per year. Seniors in B.C. have maximum contribution limits of $200 to $275 depending on their incomes. This age-based system has lead to a number of inequalities. The Ministry of Health Services has provided these examples:

> Barbara, 36, is a single mom earning $28,000 per year. She does not qualify as low-income and has no extended medical insurance. Her daughter suffers from juvenile diabetes and asthma and needs $2,000 in drugs and supplies per year. Barbara must pay a $1,000 deductible plus $300 in co-payments - a total of $1,300 per year. Pharmacare pays $700 - or 35 percent - of her family's drug costs. **Barbara has a $28,000 income and pays $1,300.**
>
> Stan and Val, both over 65 and retired, have a pension income of $56,000 per year. Val has lung and breathing problems, and both have high blood pressure. Together, they need $2,000 for drugs per year. Stan and Val pay up to $25 per prescription to their maximum contribution of $550 per year. Pharmacare pays $1,450 - or 73 percent - of their drug costs. **Stan and Val have a $56,000 income and pay $550.**

The Committee noted this inequality in its report last year. The Pharmacare program of the Ministry of Health Services has announced a new Pharmacare program, Plan I, which will combine the seniors plan (Plan A) and the universal plan (Plan E). The goal is to spread the burden of pharmaceutical costs more fairly across income groups and to focus drug benefits on lower income British Columbians, whether they are seniors or families.

The goal of the new plan will be to use income testing (reported tax return income) to establish the level of deductibles or co-payments that an individual would pay. Plan I was to come into effect in January 2003 but now has been delayed to further work out the details of income testing. The Committee supports the delay of introduction of the program until officials are sure they have devised a fair and equitable way to help British Columbians afford

their medications and that the costs and logistics of the administration of the plan don't add more bureaucracy and expense to the system.

Plan I has generated a great deal of anticipatory concern among seniors, some of whom fear their portion of deductibles will go up past the level of affordability. However, details are not yet available about whether this concern is justified. In ***Patients First*** the Committee noted that when Quebec raised the deductible for drugs across the province, a study found that some people on social assistance and the elderly stopped taking the drugs prescribed, resulting in adverse effects and more visits to hospital emergency rooms[1]. Plan I is different as it aims to protect low income individuals while making higher income individuals pay more. However we must still be assured that Plan I will achieve its goal: improved equity and improved cost containment without harming patient health or access to needed medications. It is no saving if costs are simply shifted to other areas of health care.

It is important to note, however, that Plan I may in fact help deal with a long-standing problem of over-medication and misuse of medication among elderly British Columbians. During the 2001 hearings, the B.C. Pharmacy Association told the Committee that while the elderly make up just 13 percent of the population they consume up to 40 percent of all prescription drugs; in addition up to 50 percent of all medications used by seniors are used inappropriately. According to the Pharmacare plan, the average senior in B.C. fills 19 prescriptions a year. Some drugs used commonly by seniors, such as benzodiazepines for insomnia and anxiety, have been shown to increase mental confusion and poor coordination and lead to a higher rate of falls and hip fractures.[2] Therefore, it is not only important to evaluate Plan I for negative impacts but to examine any positive impacts, too.

Other changes to deal with the pressures from rising prescription drug costs will be discussed in more detail further in the document in the Pharmacare section.

Recommendation #2:

Your Committee recommends that the impact of Plan I be monitored for its impacts on seniors, families and low income British Columbians. The positive and negative effects of the policy should be carefully evaluated.

Access Standards

British Columbia's 950,000 square kilometre expanse – much of it rugged inaccessible mountains , interior plateau or coastal fiords – make delivering equitable, accessible health to all regions a particular challenge. Adding to the difficulty is a population density that is among the lowest in the world at only 4.3 people per square kilometre compared to Germany's 230, the United Kingdom's 242 or Singapore's 6400 per square kilometre. As one witness before the Committee last year so vividly explained, in the North one region delivers services from Terrace to Atlin, the equivalent of providing services from Vancouver to San Francisco – but on a gravel road.

In the winter of 2002, the Ministry of Health Services created the first access standards in Canada. The process defined for the first time what is reasonable access, how close certain services like emergency care need to be, and what standards of travel time should be set for all

types and intensities of health care. New Zealand is the only other jurisdiction to put access standards in place. In that country it meant 90 percent of the population must be within 1 hour travelling time of emergency care. B.C.'s standards, however, have been made more stringent than New Zealand's.

Health regions in B.C. must now meet these minimum, mandatory standards:

Emergency Care: 98 percent of the population of a region must be within 1 hour travel time (50 km) of 24-hour, seven-day-a-week basic emergency care for stabilization and minor treatment or accident, illness, stroke and heart attack. In highly remote areas, the standard is 95 percent.

Inpatient Care: 98 percent of the population must be within 2 hours travel time (100 km) of inpatient beds. In highly remote areas the standard is 95 percent.

Specialty Care: 98 percent of the population must be within four hours travel time (250 km) to core specialty services such as general surgery, anesthesia, psychiatry, internal medicine, obstetrics and gynecology and pediatrics. In highly remote areas the standard is 95 percent.

The rationale is that these access standards will help determine the systematic placement and deployment of health services around the province. They will guide the creation of a well-integrated network of services around the province. This is an important first in B.C. that the Committee applauds. In fact, it is difficult to believe that in all the years of providing health services in Canada, no one before has sat down and thought where services need to be for such a sparsely populated province or what standards should be in place to ensure a consistent and strategic location of services to improve equity of access across the province.

However, the Committee cautions that access standards must be used to truly maximize the best coverage for the greatest number of British Columbians and not used, instead, as an excuse to rationalize the limiting of services. We note that the travel times for the access standards must be sure to reflect the realities of both summer and winter in travel in B.C. And finally, the Committee notes that the while the access standards have been described in one direction – patients going to services – in some cases it may be more appropriate and lead to better, safer patient care, if in some situations the services travel to the patient.

Recommendation #3:

Your Committee recommends that the impact, effectiveness and health authority compliance with the new access standards be monitored and evaluated.

Needs-based assessment for long-term care

In the past, access to places in long-term care facilities was typically based on a first- come-first-serve basis. Elderly individuals would put their names on the waiting list for a long-term care home and when their names came up they had the option of taking the spots. While this may on the surface seem like a fair way to allow access to services, in reality it meant that people put their names on lists for fear of not having a place and when their name came up took the spot whether they needed it or not. Individuals who had a sudden decline in health or rapid onset

of dementia, who had not had the foresight to put their names on a list, might be unable to access services despite having a greater need.

The Ministry of Health Services has now introduced needs-based assessment tools – grounded in medical research – that help ensure those people who have the highest medical and care needs actually have the highest priority for access to home care and residential care and spots in the supportive living sector. The assessment tool measures functions like activities of daily living – the ability to bath, dress and feed oneself, the ability to rise unassisted from a chair or bed. The individual's mental and physical functioning, and ability to live safely at home, are all assessed by qualified individuals using scientifically validated techniques. The use of the assessment tools removes the need for people to put a name on a waiting list because spots in a facility will be automatically offered to those whose needs are greatest. The Committee applauds these actions, and notes that on Southern Vancouver Island this new policy is credited with alleviating the problem of elderly people occupying beds in acute care hospitals while waiting for other types of care [3] and that elderly people and their families were happy with the change.

However, we note that in some regions not enough has been done to effectively communicate the rationale for this change to the people it affects. Some elderly people whose names were on the old lists, and their families, do not understand this fundamental change, do not understand that it is, indeed, a superior way of managing these resources, and do not understand that it will, in fact, lead to better access to care for all elderly people. Effective communication means listening to their concerns, answering their questions, explaining the rationale behind the change, outlining how assessments are conducted, and reassuring them that their needs will be met. An effective communications strategy not only explains the rationale but listens to and responds to concerns.

Recommendation #4:

Your Committee recommends that regional health authorities and local service providers make efforts to explain the rationale and advantages of needs assessment to elderly citizens and their families and that their concerns be heard and questions answered.

Provincial Health Services Authority

In the restructuring of the regional health authorities, which will be discussed in more detail later in the document, a new entity was created, the Provincial Health Services Authority. The first of its kind in Canada, it was created as an umbrella organization to give every British Columbian access to highly specialized health services. As President and CEO Lynda Cranston told the Committee in November 2002, " These are services such as cardiac surgery and liver transplants which simply cannot be delivered in every community. It is not economically viable; it is not cost-effective; and, most importantly, it is not safe to do so."

The PHSA also has responsibility for overseeing the specialized services that can be safely delivered in the five regions. It establishes standards, coordinates, monitors and funds highly specialized services like renal dialysis, cancer therapy, bone marrow transplants, cardiac services,

HIV/AIDS, thoracic services and arthritis treatments. The PHSA, for example, is coordinating the expansion of new renal dialysis beds around the province to decrease the need for patients to travel three days a week to obtain dialysis.

The provincial health services authority now governs and operates:

- the B.C. Cancer Agency
- the Provincial Renal Agency
- the Transplant Society
- the Centre for Disease Control
- B.C. Children's Hospital and Sunny Hill Health Centre,
- B.C. Women's Hospital and the Family Health Centre
- the Forensic Psychiatric Services Commission
- Riverview Hospital.

The PHSA is mandated to ensure that accessing specialty services is done fairly and equitably, regardless of where people live. Cranston gave as an example of improved access the province's new approach to assessing children with suspected autism. Before the creation of the PHSA children who were thought to be autistic had to wait up to 14 months to get a formal diagnosis. More than 150 children had been placed on the waiting list. During this last year, however, the PHSA proposed a plan to pool together resources, review assessment processes and protocols, and create a provincial network. The plan was accepted in July and implemented soon after. Within three months, the waiting list was eliminated. "Children are now seen within four weeks of a referral, and we're now moving on to phase 2 of our plan, which is focused on developing a regional capacity for this service so that children can be seen in their home region rather than having to travel to Vancouver," Cranston said.

Fair, timely and coordinated access to a number of services – cardiac services, renal dialysis, transplantation, general anesthetic for restorative dentistry for children, thoracic surgery, diagnostic mammography, mental health and more – are all now being organized under the PHSA structure.

Your Committee applauds this new governance model and method of organizing services and its significant strides to improve patient access in less than 11 months of operation.

PATIENT-CENTRED CARE

There are many important players in the health care system- doctors, nurses, lab technicians, pharmacists, therapists, support workers and administrators. But the most important people are patients. Services must be coordinated around their need for safe, timely and effective care. As one witness told the Committee last year, over the past decade it seems that the health care system has been more concerned with the rights, benefits and entitlements of the workers and less on the needs of patient, residents and clients.

In ***Patients First*** we noted that turf protection is rampant in health care – often at the expense of patient care. As the Fyke Report of Saskatchewan noted in 2001, there is often "special interest gridlock" that prevents innovative or sensible change that would improve patient care

from taking place. A significant portion of health care dollars often go to services or wages that have little bearing on patient care or outcomes.

Administrators told us that rigid contracts prevented them from moving health care staff to where they were needed – even within the same hospital. If budget cuts had to be made and beds closed, termination agreements gave staff up to 18 months of severance. Unlike most employment contracts that give about 2 months notice of layoffs, contracts mandated six months notice. Cost savings took more than a year to be realized. Contracts for support workers – housekeeping, laundry and kitchen etc- were 40 percent higher than in neighbouring Alberta and 30 percent higher than the rest of Canada.

In ***Patients First*** we noted that government, health- related professional associations, unions and employers must all work together to embrace flexible and cooperative arrangements for the good of improved patient care.

B.C. Government Action

Health and Social Services Delivery Improvement Act

In the winter of 2002, the provincial government introduced a new piece of legislation, the *Health and Social Services Delivery Improvement Act*. The Act gave the government the ability to put aside the contracts negotiated by the previous government, which were felt to be beyond the funding capabilities of the health care budget. The agreements were seen to be well outside the norm for other workers in B.C. and diverted needed dollars from focusing on improved patient care. The Provincial Government detailed some examples of the rigid restrictions and generous termination provisions in presenting the new legislation:

> The B.C. Women's Hospital needed to reorganize some of its maternity staff and beds into three wards, rather than four, to reduce overtime and achieve greater efficiency. The change would not have reduced any nursing staff or patient beds. However, the collective agreement prevented the hospital from simply moving nurses from one ward down the hall to another. Instead, the hospital was forced to go through the lengthy and disruptive process of issuing notices of layoff and requiring the nurses to apply and compete for their relocated positions. A simple move that should have taken a few days instead took four months.
>
> St. Paul's Hospital in Vancouver experienced a temporary nursing shortage in November. Because collective agreements prohibit the transfer of nurses between hospitals, the emergency department was forced to close temporarily, resulting in patients being shunted to other facilities. Rather than staff being moved to meet the needs of patients, patients were forced to move to where other staff were available.
>
> Security guards at a number of acute care hospitals have been deemed by arbitrators to be "employees" of those hospitals, even though the guards are hired by an outside security company. This has doubled the cost of security services at Nanaimo Regional Hospital and increased security costs at Vancouver General Hospital by approximately $1 million annually, for no additional service.

> After one year of service, Hospital Employees Union workers are currently eligible for total layoff and employment security of 56.4 weeks, compared with six weeks for B.C. Government and Service Employees Union members in the provincial civil service, and 1.4 weeks for IWA members. In fact, any regular HEU worker may be eligible for 13 months' layoff and employment security pay after just one day of work.

Under the new Act, the Regional Health Authorities can now allocate staff where they are needed and can contract for non-patient care services such as food, housekeeping, security and accounting. The Act limits bumping and establishes layoff provisions that are more in line with other workers in B.C. The new legislation, for example, sets severance for employees with 10 or more years of service at one week's pay for each two years of service to a maximum of 20 weeks. The Provincial Government and the Regional Health Authorities say this new legislation gives the flexibility they need to put patients and clients first by focusing limited health care resources on core services.

The Act however has been highly controversial because it sets aside collective agreements negotiated under a previous government. Four unions – The B.C. Government and Service Employees' Union (BCGEU/NUPGE), the Health Sciences Association (HSABC), the Canadian Union of Public Employees (CUPE) and the Hospital Employees' Union (HEU) have launched a legal challenge to the legislation. They argue the legislation is unconstitutional under the Charter of Rights and Freedoms. The case is scheduled to be determined in April 2003.

This Committee makes no further recommendations while the issue is before the courts.

Population-based Funding Formula

As the Auditor General noted in its 2002 report, *Information Use by the Ministry of Health in Resource Allocation Decisions for the Regional Health Care System,* funding to the health regions pre-2002 was based on "historical funding patterns" and did not take into account the needs of the people being served. This concern was raised numerous times by health administrators who appeared before the Committee in the fall of 2001.

In the budget of 2002, the Ministry of Health Services introduced a population-base funding formula for the first time in Canada. The formula considers the unique demographic factors of each region - the number of elderly citizens, the relative socio-economic status and health status of the population, population growth, gender distribution etc. – which have been shown to influence the types and frequency of health services needed. The formula helps the provincial government allocate funds to the regions that reflects the relative weight of the population's need for health services. Other criteria are also taken into account, such as whether services have to be delivered in remote or rural areas increasing the costs. The complexity of cases at the large tertiary hospitals, which may treat the sickest patients from across the province, is also taken into account.

The formula has been praised by the health regions because for the first time reflects the needs of the people in the health region. The Ministry of health services notes that when it was applied for the first time in the February 2002 budget, both the Vancouver Island Health

Authority and the Interior Health Authority got a 10 percent increase in their budgets, reflecting their population growth and proportion of elderly citizens in both regions.

Funding Following the Patient

The population-needs based formula also recognizes that some people in a health authority may go to another health authority to receive services — for instance, people living in the Fraser Health Authority working in Vancouver and accessing health services there. This is a form of having funding "follow the patient" which was advocated by the Committee. The health authority that treated the patient will be compensated in the next year's budget, although improvements in computer and accounting systems will eventually allow immediate payments.

The ultimate goal, under the new restructuring of the regional health authorities described in more detail later in the document, is to have each region self-sufficient for almost all but the most specialized medical care, removing the need for most patients to leave their region. There will be less need for the money to follow the patient if the patient doesn't need to leave.

Patient Outcome Surveys

As part of the new performance agreements, health regions are now required to develop a plan to measure indications and outcomes for selected procedures to determine if the intervention was necessary at the time and whether patients were helped. Patients undergoing certain procedures will be surveyed before and after the operation, to assess from the patient's perspective whether the procedure actually improved their health and quality of life. As described in more detail in the section on evidence-based care, this is the first time in Canada that outcomes of procedures from patients' perspectives have become a routine part of data collection and a required measure of system performance. At long last the system will begin to acquire knowledge about whether or not patients are truly being helped by medical interventions.

EVIDENCE- BASED CARE

Services provided in health care must be shown to be effective, safe and necessary. Unfortunately, the health care system has a history of doing a number of tests, procedures or treatments that research subsequently shows do not work, are unnecessary, or perhaps are even harmful to patient health. As the Committee noted in ***Patients First,*** a research culture firmly grounded in evidence-based care is the best guarantee of effective, helpful and safe patient care.

B.C. GOVERNMENT ACTION

As noted in ***Patients First,*** B.C. has been leading Canada in the creation of clinical protocols in collaboration with the provinces' doctors. The protocols use scientific and medical research to outline the best-practices care for various symptoms, illnesses, diagnostic procedures and treatments.

At the time of writing ***Patients First,*** Committees comprised of representatives from B.C.'s Medical Services Plan and doctors from the B.C. Medical Association had produced approximately 30 clinical protocols. In the last year a further 10 protocols have become available and another 10 are in development – progress that is encouraging considering the time-consuming and highly detailed collaborative work required to produce a clinical protocol. Their work should continue to be encouraged and supported.

The use of evidence-based standards has already allowed for better management of waiting lists for long term care, as described in the section on equity, and is another example of how significant issues in health care can be addressed in this manner.

The B.C. Government is supporting a number of other programs and research bodies in the collecting and analysis of health related data, which helps focus policy and planning for the future in evidence-based research. Some of these include the work of:

- The Provincial Health Officer, who makes regular reports on the health of the population as well as on specific health issues that need attention.
- The Mental Health Evaluation and Community Consultation Unit at UBC, provides some of the best indicators for mental health performance in Canada.
- The B.C. Injury Research and Prevention Unit, which is funded through the Children's and Women's hospital, is collecting and analyzing injury trends and prevention strategies.
- The Centre for Health Services and Policy Research at UBC, funded by the Ministry holds the administrative health data sets for patient use of all aspects of the health system. This data, stripped of all names and identifiers such as personal health numbers, is made available to researchers around the province through a specific protocol to allow exploration of many questions, such as the effects of policy on patient use patterns.

Research into clinical outcomes – how the patient fared and whether his or her health and quality of life improved after medical intervention – is an essential part of the evidence- based picture. As described in the section on patient-centred care, outcome research is now a required part of each regional health authority's performance contract. This important new focus is based on the landmark outcome research of Dr. Charles Wright, director of the Centre for Clinical Epidemiology and Evaluation at Vancouver Hospital. Wright looked at the clinical indications for six common elective surgeries and surveyed the patients before and at a series of intervals after the surgery.[4] The rationale for the project, which surveyed 6,000 consecutive Vancouver-area patients, was that since elective surgery is done not to extend life, but to improve symptoms and quality of life, patient quality of life should be a routine measurement of surgical outcome.

Dr. Wright's findings were front-page news across Canada in May 2001. Surgeries such as hip replacements and lumbar disc surgery were both highly necessary – patients had significant pain and disability prior to surgery – and 98 percent of patients reported being much better off after the surgery. Other surgeries, however, were shown to be sometimes less necessary and less effective, occasionally even harmful. A portion of cataract surgeries was done when patients still had reasonable eyesight (better than 20/50 vision) and 26 percent – or more than a quarter – reported worse eyesight after the operation.

One of Wright's most important findings for the health care system, however, was that measuring outcomes from patients' perspectives could be logistically and cost-effectively accomplished. He concluded that such outcomes research should become a routine part of surgery so that the profession can continually improve what it is doing. Now, with outcome surveys being written into performance agreements with the health regions, B.C. will become the first jurisdiction to make this information an essential part of evidence-based care. Fundamentally, the health system must be able to show that what is being done is actually benefiting the patient.

It is only through a commitment to research and evaluation that we can make true progress in health care. It is important, therefore, that this evidence-based culture continue to be nurtured and supported. The Ministry of Health Planning, with its mandate to plan for the future needs of British Columbians, should coordinate the examination of evidence-based care. It will be important not to restrict the examination of evidence too narrowly to only traditional medical interventions. Where scientific evidence seems to imply that alternative methods can effectively treat common problems, such as Tai Chi classes to prevent falls among the elderly or chiropractic manipulation for low back pain, than these should be carefully examined for their application to improve the health and wellness of British Columbians.

Recommendation #5:

a) Your Committee continues to recommend that under the Ministry of Health Planning, the support and enhancement of evidence-based research and standards of care to be applied across the province.

b) Your Committee recommends that to further achieve an evidence-based culture for health services, all health care reforms go through a process of evaluation to ensure they are achieving their intended purpose.

ACCOUNTABILITY

Accountability means establishing clear objectives, determining effective strategies to meet those objectives, measuring whether the objectives were achieved and having clear consequences if they weren't.

Your Committee recommended in ***Patients First*** that accountability be an overarching principle throughout the entire health care system requiring transparency from the federal government, the provincial government in Victoria, the regional health authorities, doctors and other health professionals and even from the patients who access the care.

B.C. Government Action

Health Administration Accountability

In the spring of 2002, for the first time in Canada, performance contracts were signed with each of the regional health authorities. The eight-page contracts define performance targets that will hold them accountable for the delivery of patient care, health outcomes and how health

dollars are spent. These performance agreements between the Ministry of Health Services and health authorities define expectations, performance deliverables and service requirements in the areas of emergency care, surgical services, home and community care, and mental health services for three fiscal years. The targets are measurable and focus on key areas of importance for the current fiscal year. The performance agreements are posted on the websites of the Ministry of Health Services and of each health authority. The board chairs of the health authorities are responsible for holding their CEOs accountable and there is some suggestion that CEO compensation may be based on performance.

Although the consequences of not meeting the performance targets are not yet clearly established – an important part of the accountability loop – the Committee recognizes that the performance agreements are a considerable step forward for health care accountability in B.C.

While the process of establishing measurable targets is highly complex, as was noted in open cabinet, performance contracts are a fundamental shift in emphasis that will help take decision-making around health care services out of the political sphere and ground it in research, evidence and professional best practices.

Recommendation #6:

Your Committee recommends that realistic consequences be established for health regions that do not meet performance targets.

Physician Accountability

Accountability for doctors is also being supported. Along with the formation of the clinical protocols, discussed earlier in this report, MSP has for a number of years run its Billing Integrity Program, which monitors billing patterns and audits doctors. Under the program, each year about 75,000 letters are sent to patients to confirm they have received services that were billed to MSP. The program also produces a billing profile for each practitioner who receives fee-for-service payments under MSP and their billing patterns are compared to billing patterns for similar physicians. On-site audits will sometimes be conducted of practitioner's officers to review clinical records and business records.

No individual audits are being done on physician compliance with the established clinical protocols, but the protocols are being used as important research instruments that can reflect back to physicians as a whole how well certain diseases are being managed. For example an examination of billing claims against MSP for patients with diabetes found that counter to the protocol, 74 percent of diabetic patients did not have a test for protein in their urine, 66 percent did not have a retinal exam, and 64 percent did not have their lipids tested in the year. These sorts of results can help focus physician efforts on services that will provide more benefits to their patients.

Greater promotion of independent evaluative research through an arms-length research body, such as that done by the Institute for Clinical Evaluative Sciences (ICES) in Ontario, could further improve B.C.'s ability to assess clinical practices and provide feedback to the medical profession and health service providers. ICES, for example, creates clinical practice atlases,

which examine trends and patterns of practice in medical care, success rates, population trends, and variations between regions. Each atlas report serves as a tool for administrators, policy makers, and health care providers to identify issues of concern and implement initiatives for improvement. These atlases have been described by health professionals and policy makers as vital documents for shaping the future direction of the Ontario health care system.

B.C. has some excellent research bodies examining health issues, such as UBC's Centre for Health Services and Policy Research and the Centre for Clinical Epidemiology and Evaluation at Vancouver Hospital. The latter, however, could receive more support to produce B.C.-specific clinical practice atlases to further contribute to the accountability, effectiveness, quality and efficiency of B.C.'s health care system.

Recommendation #7:

Your Committee recommends that research that examines general compliance with clinical protocols and other forms of research that examine patterns of practice in B.C. be routinely conducted and reported.

Patient Accountability

As the Committee noted in ***Patients First***, patient accountability requires that British Columbians be knowledgeable about their own health care needs, the steps they can take to keep healthy, and the appropriate time to access the system.

Unfortunately, little advancement has been made in this area in the last year. Services like the B.C. Health Guide program, which includes a book explaining common health problems and a 24-hour NurseLine, can help patients make decisions about seeking care or treating themselves at home. This service, however, has been poorly promoted and many people in the province do not know of its existence or of the high-quality information that it contains. As well, a highly detailed computer database of health information is now available by the Ministry of Health Services through the Internet at www.bchealthguide.org. By entering a B.C. postal code, the user can access a wide range of health information about various illnesses and diseases, when to seek treatment, the diagnostic tests available and even the support groups and health agencies to access in B.C. Again, this service has not been promoted and very few British Columbians know of its existence.

Eventually, when logistical, platform and privacy issues are worked out with electronic health records, patients should be able to access their medical files – and their charges to the health care system – on line. This will greatly help patients be active partners in their own care and become more accountable for the wise use of services.

Finally, although it is a controversial and difficult topic, we should consider as a society whether to set reasonable consequences for poor lifestyle choices, as the insurance industry has done in setting higher health premiums for tobacco smokers. Another option would be to build in incentives for healthy choices, such tax deductions for smoking cessation programs, drug and alcohol rehabilitation programs or fitness club memberships.

Recommendation #8:

Your Committee recommends that more effort be made to promote the B.C. Health Guide, the 24-hour nurse line and the website.

Premiers' Council on Health Awareness

Accountability requires that accurate information be widely available. In January 2002, all the premiers of the provinces decided to jointly fund and create an independent body that would provide accurate, unbiased information about the functioning of the health care system. Located in Ottawa, the new council will provide all Canadians – the public, health providers and administrators, researchers and educators – with access to a wide range of health information such as:

- Provincial and territorial health data and links to provincial sites
- Canadian Institute for Health Information data
- Statistics Canada data
- Information on health care reforms within Canada
- Global health research
- Conference Board of Canada information
- Wide range of other health-related data.

The council's website is www.premiersforhealth.ca

The Committee believes that the Premier's Council could serve as a highly effective forum for national non-partisan debate and discussion about controversial topics of health reform such as what constitutes medical necessary services, how patients can be held more accountable for their choices and actions that impact their own health and the sustainability of the health care system.

Recommendation #9:

Your Committee recommends the existence of the Premiers' Council on Health Awareness and its website should be more widely publicized and the Council used as an effective forum for national debate on issues of health care reform.

REGIONAL RESTRUCTURING

At the time of writing ***Patients First***, B.C.'s regional health authority structure was the most complex and cumbersome in Canada. It was clear, from the presentations to the Committee, that the system was not working.

B.C. Government Action

The Committee notes that a great deal of work has been done in regional restructuring and all the recommendations have been met. Although the restructuring had been long in planning, within less than a week of the report being released, the 52 health authorities had been reduced to six.

The five geographical regional health authorities are:

- **Vancouver Coastal Health Authority** - which includes the Vancouver, Richmond and Coast/Garibaldi region; (www.vancoastalhealth.ca)
- **Fraser Health Authority** - which extends from Burnaby to Boston Bar; (www.fraserhealth.ca)
- **Vancouver Island Health Authority** - which includes all the Island plus Powell River; (www.viha.ca)
- **Interior Health Authority**– which includes the Thompson Cariboo, Okanagan, and Kootenays all the way to the Alberta border; (www.interiorhealth.ca)
- **Northern Health Authority –** which covers the whole northern region from Prince Rupert, across to Prince George and Quesnel to Dawson Creek and Fort St. John. (www.northernhealth.ca)

Each of the health authorities has signed performance contracts with the provincial government, which can be found on the authorities' websites. The websites also have a wealth of other information for patients and providers in each of the regions, such as how to find a doctor, a job with the health region or contact information for various long-term care facilities, flu shot locations and ways to help improve your health.

As discussed in the section on equity, the sixth authority is the Provincial Health Services Authority which coordinates and delivers specialized health services to the entire province. Each Health Authority has a representative on the PHSA board to ensure the regional perspective is included in all its decision-making.

Under the new governance structure, the two Ministries of Health provide overall leadership, direction, financial stewardship and set priorities and monitor performance for the health system. The regional health authorities, however, are now charged with delivering the full range of health services to the people of the province. This means the five regions now have the flexibility to make decisions about what programs and services would best meet the needs of their specific populations.

The new governance structure according to the Ministry of Health Services has many advantages:

- Administration costs have been cut by 45 percent.
- A leadership council has been formed of all the CEOs of the regional health authorities that meets regularly – at least every two weeks to discuss policy, planning, implementation and performance.
- Similarly, the six chief financial officers as well as chief information officers and other senior executives are meeting regularly to collectively work out issues in each of those sectors, creating a uniform coordinated approach to issues across the province.

The Committee feels this restructuring marks a greatly improved governance structure for the delivery of health care in B.C. It is gratifying to hear that communication between the government and regions has improved so substantially.

The Committee is concerned, however, that communication within the regions to their own communities and populations still needs improvement. The Committee feels that many of the

people in the province do not know or understand the overall vision of health care, the policy direction and the changes that are taking place in the region. As the Committee will discuss in Part Three of this document, now that two-way communication has improved among the government and health authorities, more effort needs to be made to improve communication and avenues for consultation with the public in the regions.

Three-year Block Funding

An important change in the last year is the introduction of three-year block funding to the health regions to replace the old one-year budgetary process.

The former lack of a long-term budget commitment and the inability to plan long-term, meant regions simply could not design programs that might deliver health savings two or three years down the road. They couldn't run a deficit and they had no guarantee the money would even be there to continue to support the program. They didn't have the flexibility to make savings in one area and channel the funds the next year into another area to boost services. Indeed, a common complaint by the many administrators who appeared before the Committee in 2001 is that they were in effect penalized for being cost conscious. This "use it or lose it" budgeting approach rewarded poor performance and removed incentives from regions to manage their money well and design innovative, cost-effective services.

Now for the first time, regions have been given the flexibility to balance budgets over three years rather than one, provided they run equivalent surpluses in subsequent years.

Three-year block funding means newfound flexibility and the ability for health regions to keep the money they save from one program to apply to another program.

CONSOLIDATION OF ACUTE CARE SERVICES

During the Committee's public hearings, the need to consolidate acute care services, particularly specialist services around the province, was a recurring, albeit controversial, theme. The Committee heard repeatedly that is it is not safe for patients, not economically or physically viable for providers, and not cost-effective for the health regions to maintain specialist services in small or medium-sized communities in B.C.

For patients, the issue is improved quality of care. Repeated studies have shown that small centres that do a lower volume of surgeries have higher rates of complications and poorer outcomes[5]. A vacationing or sick doctor, or sick post-op nurse can shut down all the surgery and leave little options for care. A coordinated, consolidated network of acute care guarantees adequate volumes of patients, sufficient back up, and access to quality care 24 hours a day.

Numerous specialists told the Committee solo practice or insufficient volume is not good for them, either. They risk burn-out, isolation and the inability to maintain their skills or their livelihood when they are the sole practitioner in an area. When services are spread too thin, not only does patient care suffer but the ability to retain valuable specialists is difficult if not impossible. The specialists leave for other less isolated places where the stress is less, rewards better and the call schedules more forgiving.

For example, thoracic surgeon Dr. Michael Hummer noted that under the haphazard, thinly spread services in the previous decade, 10 thoracic surgeons had ceased to practice in the province and no new thoracic surgeons had been successfully recruited to replace them. Creating a well-organized, consolidated thoracic surgery services, he convincingly argued, would improve recruitment and retention of specialists and most, importantly, greatly improve patient care.

In ***Patients First,*** we noted that consolidation of acute care services is medically the right thing to do, however, it is not an easy policy to implement. We noted that it would entail the loss of services in some locations to concentrate them in others. It was recognized that this would be difficult for some of the public to support and understand. However, the Committee stressed that in the end it was a necessary move that would lead to improved services, higher quality care and the improved recruitment and retention of specialists.

B.C. Government Action

The B.C. government is going ahead with a plan to consolidate acute care services. Establishing the access standards, as described in the section on equity, was one of the first steps. Now, each of the five health regions, in concert with the Provincial Health Services Authority, is designing a network of acute care services that honours those access standards and makes the most sense in their regions.

The model of the consolidation network, as described by the Ministry of Health Planning, is following this basic plan:

- Small hospitals, community health centres or diagnostic-and-treatment centres will house basic 24-hour on-call emergency services, simple laboratory tests, x-ray facilities. Low risk maternity and elective day surgery may also be available. Support services such as doctors' offices, physiotherapy, home care agencies and education services for chronic disease management may be clustered together offering a "one-stop-shopping" locale for all health services to the community.
- The small hospitals/centres will feed into a larger community hospital, centrally located to draw from all the surrounding smaller communities. The larger hospital will house inpatient beds and provide the most commonly needed specialty services such as high- risk obstetrics, general surgery, pediatric care. At least three doctors in each specialty will be on staff, ensuring 24 hour a day coverage. It will have the staff and resources to handle more complex health needs and do more complex diagnostic tests.
- A third level of hospital, a tertiary referral centre, will also be in each health region to handle the most complex subspecialty care, such as heart surgery, neurosurgery and complex trauma cases.

The goal is to have all the acute care hospitals in the region, from the lowest level of complexity to the highest, linked together as a network with an information connection, even teleheath abilities, to create a seamless transition of care.

Thoracic Surgery Plan Adopted

The Committee is very gratified to learn that Dr. Hummer's plan for the consolidation of thoracic surgery has been adopted almost in its entirety as presented first to the Committee. Now, under the auspices of the PHSA, Centres for Excellence in Thoracic Surgery are in the process of being consolidated in four locations around the province. Some of the highlights of this plan include:

- Relocating practitioners from four Interior communities to Kelowna by January of 2003, with the appropriate equipment, knowledgeable and trained support staff and technical support
- Consolidating all thoracic surgery teams and equipment at Vancouver General Hospital in December 2002.
- Eventually consolidating surgery to Victoria and to one of either Surrey or New Westminster
- Eliminating fee-for-service billing for the service and instead creating a contract fee, in essence creating a competitive salary for the surgeons to give them a stable income.

Lynda Cranston, President and CEO of the PHSA, told the Committee in November 2002 that the reorganization is already attracting interest from thoracic surgeons in other jurisdictions. "We will be able to recruit new thoracic surgeons to British Columbia, which we have not been able to do over the past seven to ten years," Ms. Cranston told the Committee. She noted that the literature indicates the creation of specialty centres leads to shorter hospital stays, a higher number of patients served, fewer complications and better patient outcomes. The success of the thoracic surgery consolidation will be used as a model to help coordinate other medical and surgical services in the future.

The consolidation of other specialist services has also been improving recruitment of physicians in other areas. In the East Kootenays, for example, two new specialists – an obstetrician and an internist – were hired earlier this year in part because of the new attraction of having a critical mass of patients, a designated team, a reasonable call schedule, colleagues with whom to interact and a less stressful life. Dr. Glen McIver, medical director of the East Kootenay Health Service notes that centralization has become a many selling point when they are recruiting for the region.

DIALYSIS EXPANDED

While the public is concerned about losing services in its local area, the consolidation of services can actually mean an increase in services for the whole region. A case in point is dialysis. In past, people in the north with kidney failure had to move to Prince George – there were no other centres with dialysis services. Now, under consolidation, Terrace is getting a dialysis unit, too. Plans are to expand dialysis units even further in the regional referral centres.

Sites of Excellence For High Risk - Low Volume Surgery

In 2002, the Premiers of the provinces agreed to cooperate on consolidating high-risk, low volume surgery in a few designated centres across the country. The decision came from increasing research evidence, including the coroner inquest into the deaths of 12 children in

Winnipeg's pediatric cardiac surgery program, that large population densities are needed to safely deliver rare, high-risk surgery. Pediatric cardiac surgery, rarer organ transplants, and gamma knife radiation neurosurgery are examples of the advanced techniques that require specialized equipment and a highly experienced and trained team of health care providers. They should therefore be concentrated in a few centres in Canada.

Details of the Sites of Excellence for low volume surgery are still being worked out. B.C. will likely be a centre for one or two of the specialized surgeries, such as pediatric cardiac surgery, where we have established a safe and reliable track record. Patients needing services not performed here would be sent out of province to the nearest sites of excellence location, such as Edmonton or Toronto. The Premiers all agree that this coordinated plan will build on established expertise and will result in saved lives, better patient care and a wiser, more focused use of limited resources.

Building public and professional understanding

With B.C.'s sparse population and diverse geography, the Committee believes the consolidation of acute care services following a rational well-considered plan, such as that created by the thoracic surgeons, is the only way to ensure high quality, safe and consistent patient care and the continued recruitment and retention of our valuable specialists and specialized services.

Yet the Committee understands that in the past year this has indeed been difficult medicine for some communities and regions in B.C. Citizens in towns who are seeing their doctors and services relocate to a neighbouring town only see what they are losing locally and don't see the big picture of how everyone in the region should eventually be getting safer, higher quality and more consistent service.

Consolidation of services among the Kootenay towns of Trail, Nelson, and Castlegar, for example, is stirring up anxieties and local differences. The plan is for Nelson to keep its emergency, maternity, day surgery and some elective surgery, but to relocate the majority of specialist services to Trail, because its hospital is newer and it has more equipment and more specialists are already concentrated there. There is considerable feeling among people in the region, even some of the health care staff, that because of long-standing rivalries between the two towns, a coordinated cooperative model will be difficult to achieve.

A new proposal has emerged from the region that in order to put the past behind them and create a cooperative future in health care between all the towns in the area, a new hospital should be built in a neutral, convenient location so that no one community is seen to "win" more services while the others "lose."

The Committee understands that a "fresh start" with a brand new facility in a central, mutually convenient location would be the most ideal solution for many communities in B.C. In our current economic climate, however, it would be unrealistic for government to promise new money when it is simply not available in the public coffers. Walking away from all the capital invested in our existing hospital buildings to build new buildings when our $10.4 billion budget for health care is already short of our needs is not fiscally prudent at this time.

However, there is merit in making the goal of building new, centrally located facilities in regions like the Kootenays a long-term objective for the future. In the short-term, we need to move ahead to consolidate services, despite protests and rivalries, to ensure recruitment and retention of specialists, improve quality of care and maximize the use and efficiency of our health care resources. The quickest and most cost-effective way to do that is to first locate the services in the most logical location that is best equipped to absorb the change. With new efficiencies, regional cooperation and regional efforts at fundraising, when it comes time to invest in new facilities, a new hospital can be built in a location acceptable to all communities.

The Committee feels there is a huge need to communicate the medical rationale for the consolidation of services to the public, to hear their concerns and to be flexible, within reason, regarding time frames for implementation without losing sight of the ultimate, medically-correct goal.

The Committee feels that by giving examples of success stories, such as the thoracic surgery reorganization, and by building on those models of success, the public and health care professionals will be better able to understand, support and promote similar actions. It is particularly important that doctors and health professionals who have witnessed the improved care and improved working conditions that become possible under consolidation become vocal advocates for the change.

Recommendation #10:

Your Committee recommends:

a) Consolidation of acute care services continue with flexible time frames for implementation that builds success stories with evidence-based results.

b) Fact-based information be made available to the public about the evidence for improved services and physician retention through consolidation and that a forum be created to hear and respond to concerns.

c) The process of consolidation be monitored and evaluated to ensure it is achieving its intended aims.

d) Long-term plans be established that use the access standards to eventually replace old facilities as needed with new facilities built in regionally appropriate locations.

PROVINCIAL AMBULANCE SERVICES

A fast, efficient and well-trained corps of paramedics with access to a fleet of high quality vehicles and equipment is an essential part of a well-functioning health care system. They will ensure that sick and injured British Columbians get to necessary services as quickly as possible. The difference can mean life or death.

During the Committee's 2001 hearings, numerous witnesses stressed that they felt the B.C. Ambulance Service was not adequately meeting the needs of small town and rural populations. Concerns about training, strained community relationships, turf protection and what many felt was a too-slow response from the air ambulance, were also raised. A number of witnesses said they wanted operation of the service devolved to the regional health authorities.

B.C. Government Action

In 2002, The Ministry of Health Services added $30 million to the B.C. Ambulance Service's budget, bringing it to $188 million annual budget. According to the Ministry, other improvements are:

- 162 new or replacement automatic defibrillators were purchased, making this a standard item on all ambulances.
- 24 new paramedic positions were funded, 16 of whom will be placed in 10 small or semi-rural communities in the province.
- Additional training is bringing 1,521 paramedics up to Paramedic Level 1 to enable more timely and effective emergency care, particularly in rural communities.

The Ministry responded to concerns about waits for air ambulance transport, noting that patients are prioritized through consultation between the sending and receiving physician as well as the Air Transport Advisor (specialists in the referral hospitals who provide advice to the air coordination centre.) The Ministry notes that critically ill patients who are in hospital are safer there than in the cramped confines of an airplane where interventions to prolong life are substantially more difficult. Therefore, patients will remain at their originating hospital until staff are sure they are stable enough for transport.

Witnesses and Committee members noted that sometimes local airplanes sit idle at the local airport while patients and staff wait for the Airvac airplane to fly up from Vancouver. However, the Ministry argues that ambulance aircraft are crewed by Advanced Life Support paramedics trained to function in the demanding air environment. Local crew are not trained to this level and local medical staff are frequently unable to leave the community to accompany a patient. In addition local planes and helicopters are often not pressurized, can fly in daytime only, cannot land at Vancouver General Hospital, and lack the equipment and space to provide appropriate care to critically ill patients.

The Ministry notes that need for air ambulance dispatch to and from Vancouver is expected to diminish, however, as more of the patients' acute care needs will be met in their own region.

A core review process of the BCAS services has been underway and decisions about any possible reorganizations as well as recommendations to increase response times, improve the

efficiency of dispatch, ensure staff training and increase cost-effectiveness of the services will be released in 2003.

In addition, although fire fighters in B.C. are municipal responsibilities, a new change of rules allows them to attend training to attain Paramedic 1 level if supported by their municipality. This change will ultimately lead to more first responders in B.C. having training to more effectively deal medical emergencies.

Recommendation #11:

a) Your Committee recommends that it be given the opportunity to review the report of the core review of the B.C. Ambulance Service.

b) Your Committee recommends that training opportunities continue to be supported in order to eventually achieve the goal that all paramedics in B.C. achieve the Paramedic 1 status.

INFORMATION TECHNOLOGY

Over the last 10 years the information revolution made possible by computer technology has permeated almost every aspect of society in a dramatic way – except health care.

As the Committee heard repeatedly in 2001, there is an extreme and urgent need to address the problem of non-existent, inadequate or incompatible information systems. Information must be shared across traditional organizational and professional boundaries without undermining patient confidentiality. Promoting the wide-spread adoption of electronic health records for patients is part of the ultimate goal and will improve efficiency, access and management of patient care.

The use of telehealth – computer, videoconferencing, emailing of files or diagnostic images – also has tremendous potential in B.C. particularly in linking remote sites to specialist services.

B.C. Government Action

Information management

The Ministry of Health Services and the Ministry of Health Planning are developing an information management strategy with the chief information officers of the health regions to ensure all RHAs work together to find uniform solutions to Information Technology issues.

Canada Health Infoway

B.C. is actively involved as a partner in Canada Health Infoway, an independent not-for profit national corporation created by the federal, provincial and territorial governments following a First Ministers meeting in September 2000. Infoway's mission is to foster and accelerate the development of Canada-wide interoperable electronic health information systems, with a goal of having the main components in place in the next five to seven years. Infoway has received $500 million in federal money to create national standards for electronic health information. It

is still in the process of finalizing its business plan, investment strategy and the prerequisites to national EHRs. It is compiling a registry of all electronic health records initiatives in Canada and working with the Canadian Institute for Health Information (CIHI) to develop national standards for e-claims.

The Kirby Commission, in its recent final report recommended that the federal government stabilize Infoway's funding at $400 million a year for the next five years to ensure the development of interoperable electronic health records.

As well, the Canadian Medical Association in June 2002 released a discussion paper to set out principles that it feels should govern the evolution of EHR. Some of the principles include:

- Electronic health records must never be used to single out patients or groups of patients, or individual health providers or groups of providers, for punitive action, unless under the current auspices of regulatory review or legal investigation.
- The patient owns the data and the physician is the custodian of the data, not the government.
- Adoption of EHRs by physicians must be voluntary and that physicians are not forced to bear the entire financial burden of adopting EHRs in their practices.
- Security and privacy must be ensured; monitoring and penalties for anyone who may gain improper access, such as hackers, must be explicit and consistently applied.

The Committee believes that the continued focus on the development of coordinated, compatible, secure and cost-effective electronic health records is essential to improve the quality, patient management, efficiency and timeliness of health care system.

Recommendation #12:

a) Your Committee recommends that support continue for initiatives to create standardized, compatible information systems between B.C.'s health regions to improve the quality and efficiency of health care services and management.

b) Your Committee recommends the Provincial Government lobby for continued federal support and stable financing for Canada Health Infoways.

Telehealth

The B.C. Teleheath program, adopted in February 2002, is exploring innovative ways to use computers and telecommunications to improve patient services and medical support around the province, particularly in rural areas.

Telehealth projects currently operating in B.C. include:

- An emergency/trauma program links Terrace and Cranbrook emergency rooms with trauma specialists in Vancouver.
- Tele-psychiatry for mental health patients and distance education for mental health providers is being provided by the University of B.C.'s Mental Health Evaluation & Community Consultation Unit (Mheccu) to Fort St. John, Dawson Creek, Fort

Nelson, Powell River, Squamish and Sechelt as well as to the Yukon and Sal'i'shan Institute, a First Nations centre of excellence in learning.

- Teleradiology – in which radiologists read x-rays and diagnostic scans sent in from remote locations – is the first application of a Telehealth initiative underway in the Interior, with Kamloops radiologist reading radiological images sent digitally from Williams Lake, 100 Mile House, Lillooet, Merritt, Clearwater and Chase.
- B.C. Bedline is a web-based registry and call centre which doctors can access to find a bed for their patients.

Premier's Council on Technology

In September 2002, the Premier's Council on Health Technology released its third report exploring how e-health services could be expanded to improve medical care and recommending ways to advance how government acquires information technology. It also pointed out the financial and health benefits of wider adoption of telehealth applications.

PRIMARY CARE REFORM

An essential factor of primary care reform, advocated in Canada since 1971, is the need to move away from solo doctors operating under a fee-for-service arrangement to doctors working with a team of providers such as nurses, dieticians, therapists, and others to ensure the patient gets the services they need 24/7.

Patients First, too, promoted primary care reform because it seems to be a model of care that provides more consistent, integrated, and coordinated care for patients, a more collegial, rewarding and less stressful life for doctors and nurses; and better human resource deployment and cost-efficiencies for government. Under this arrangement, doctors would work on some form of capitated payment or adjusted salary, often with a team of other health professionals. We recommended continued opportunities and incentives for B.C. physicians to join such networks, a variety of payment models that reward quality not quantity of service, and rigorous scientific evaluation.

The Committee views the promotion of primary networks as a way to provide to British Columbians more access to weekend and after hours health care that have made walk-in clinics so popular in recent years. In addition, like walk-in clinics, they take pressure off emergency wards because many patient concerns can be addressed by a family physician without the need to go to the hospital. Unlike walk-in clinics, however, primary care clinics offer continuity of care in which the doctors and primary care team know the patient, have access to their files and can offer proactive care and chronic disease management. In ***Patients First*** it was this lack of continuity of care coupled with the shear convenience factor of walk in clinics that lead us to suggest, that if user fees were to be applied, walk in clinics would be the only place it might be acceptable. The Committee now feels that user fees at walk in clinics might discourage appropriate use or cause some patients to go to emergency rooms instead. We no longer recommend user fees be applied. Instead, the focus should be on the promotion of true primary care networks to provide the 24/7 access to high quality, appropriate care with health providers who know the patient and have access to his or her long-term medical records.

B.C. Government Action

Health authorities in B.C. are being encouraged to apply to the new federal Primary Care Transition fund to access $74 million allotted to B.C. out of the $800 million program designed to promote primary care programs across the country. The Ministry of Health Services is not dictating what model or type of program the regions should adopt. Rather it has designed three broad primary care strategies. Initiatives in the regions can:

- **Support a Range of Practice Models**: including
  - **primary care network**s, in which primary care practices not located at the same site link up to share functions such as on call services, drop-in care, urgent care or chronic disease management;
  - **shared care relationships,** in which family doctors and specialists team up to share complex cases;
  - **augmented roles for nurses,** such as having nurses be the first point of contact in the system or responsible for simple treatment;
  - **full service, primary health care organizations,** in which multi-disciplinary teams of a wide range of health professionals are all at one site, sharing electronic health records, coordinating care, offering extended hours, education programs and self-care training, calling patients in for preventive tests and monitoring performance.
- **Improve health outcomes:** Health authorities can plan initiatives that aim to focus on improving the outcomes of disease and illnesses, such as:
  - **chronic disease registries** in which the aim would be to identify and register all people with certain illnesses in a region to tailor programs and preventive services to their need;
  - **integration of clinical practice guidelines** aimed a practising physicians to standardize their treatment of certain diseases;
  - **targeted disease or population strategies,** such as developing a initiative to improve the diagnosis, treatment or prevention of a specific disease or targeting activities to a certain high risk population.
- **Research and evaluate primary care projects:** health authorities can also apply for funding to design research programs to study the results of primary care initiatives so others can learn from the success or failure of programs like shared care arrangements or the development of electronic health records.

The goal is to get general practitioners and their regional health authorities to work together to build a collaborative, local effort that addresses a patient or population need in their area. Payment models are also flexible.

In addition to the B.C. Government response, the B.C. Medical Association released a policy paper in September 2002 setting out 19 recommendations for primary care renewal.[6] The document stated that the first priority must be that participation in a primary care model must be voluntary for both patient and physician, not imposed. It also noted that physicians must be actively involved in the design and implementation of the changes, noting that physician led primary care reform is more likely to succeed than bureaucratically imposed frameworks.

The long-term success of primary care clinics and networks will also rely on careful attention to the funding formulas to ensure they appropriately compensate all health care providers on the team for the work they do and the type of patients they see. Some physicians working in primary care networks, for example, have been upset that the April 2002 agreement with the province's doctors that saw $392 million go toward fee increases and on call compensation, did not include any increase for them. Physicians will be unlikely to join primary care teams if they feel they will be financially penalized for choosing to practice medicine through these new models.

Recommendation #13:

Your Committee recommends that the Ministry of Health Services and the Regional Health Authorities move quickly to promote a flexible range of primary care models that promote integrated and coordinated care. Evaluation of the models must be a fundamental aspect of their implementation.

PREVENTIVE HEALTH

As Dr. Andrew Larder, medical health officer for the East Kootenay Region, so passionately told the Committee in 2001, the majority of cancers, heart disease, strokes, diabetes and chronic lung disease – in short the majority of the diseases "that are filling up our hospitals, our doctors' offices and our graveyards" – are preventable with an adoption of good lifestyle habits. Larder lamented that the entire focus of the public and the health care system was akin to "pulling drowning people out of the river. I implore you to ensure we devote adequate time resources to making sure people don't fall into the river in the first place."

Obesity, lack of exercise, poor diet, cigarette smoking and excessive alcohol consumption have all been known, for years, to be major contributors to ill health and increased death rates. As Isobell MacKenzie succinctly told the Committee in 2001: "People need to be educated that the single greatest determinant of their individual health is not found in a pill, a scalpel or a CT scan. It is in their everyday life—how much they eat, how much they exercise, how much they drink and whether or not they smoke. If we as individuals focus on what we can do for ourselves… that, I think is our greatest guarantee of a sustainable and cost effective health care system."

Preventable injuries are another major contributor to disability and death, and cost millions of dollars to our health care system each year. In fact, falls, particularly falls among the elderly, cause more disability, death and health spending than motor vehicle crashes in the province. Falls are seniors' greatest health risk and in 1998 alone were estimated to cost British Columbia $728 million in indirect costs and $180 million in direct health costs.[7]

B.C. Government Action

The Ministry of Health Planning and the Health Authorities are in the process of developing a Chronic Disease and Injury Prevention strategy (CDIP). The strategy - which the Ministry expects to be in place March 2003 - will focus on physical inactivity, tobacco use, poor eating

habits, alcohol and drug misuse, and injuries, especially falls among seniors. It will closely link to other related strategies such as Chronic Disease Management and Primary Care Renewal.

The B.C. Ministry of Education is proposing changes to requirements in the Graduation Program, which currently consists of Grades 11 and 12. The changes are designed to better support student achievement, and to improve the quality of the public education system. The proposed changes, which are now under a process of public consultation and review, would include making physical education mandatory in Grade 11 and 12. This and other changes would aim to better prepare B.C. youth for life beyond high school.

Focusing on falls

One in three seniors is estimated to fall each year either in their home and community or while a resident in hospital or long term care facility. A single hip fracture adds between $24,400 to $28,000 in health costs to the system.[8] Most importantly a fall, and particularly a hip fracture, marks a personal crisis for the elderly individual that often leads to a rapid decline in health, the need to enter a long-term care facility, or debilitating fear of falling again which restricts their activities and independence precipitating a further decline in health.[9] With the aging of the population in B.C. this problem is anticipated to increase in upcoming years. [10]

The province is co-funding three new initiatives totaling $362,000 that will focus on fall prevention by providing doctors with assessment tools; developing a training module for home care workers, and developing a surveillance system to monitor falls in long term care homes.

The Ministry of Health Planning notes that if these programs prevent just 12 to 14 seniors from fracturing hips, they will pay back the provincial contribution. In addition, the Provincial Health Officer is working on a special report on the incidence and prevention of falls in B.C. to be released sometime in 2003.

Clean Water

Between 1980 and 2000, B.C. had 29 confirmed outbreaks of waterborne disease, the highest rate in Canada[11] . B.C. has almost 3,000 water systems, with a handful of large systems supplying large populations and the majority of small systems supplying the rest of the province. In June 2002 the B.C. Government released its Drinking Water Action plan which identified safe drinking water as a health issue, under the Ministry of Health Services, and created clear lines of responsibility. Under the eight point plan, drinking water protection officers are being established in each regional health authority, quality will be both protected and monitored at the source and source-to-tap assessments will be carried out on all water systems to highlight deficiencies and plans for action. Upgrades for 42 water projects, totaling $109 million are already underway with more upgrades planned on a cost-recovery basis. New drinking water legislation was introduced in October 2002 that set standards for drinking water protection and supported the action plan.

Unhealthy lifestyle choices

Clearly, preventing illness and injury from occurring in the first place is far better than attempting to patch people up after the fact. Many unhealthy behaviours, however, such as smoking, drinking, and drug use are addictions that are hard to change. Some public health campaigns, health promotions and legislation, however, have been successful at altering behaviour. In particular some specific legislation can prompt widespread change, such as the helmet and seatbelt laws, and emerging bylaws for smoke-free environments. More effort needs to be aimed at developing effective prevention strategies that promote individuals to take action to maintain their health and that work to reduce the unacceptable toll of preventable illness and injury in B.C. Discussion at the national level could occur about possible incentives or disincentives to spur public response in this area

Children and youth can be the most receptive audiences for lifestyle messages and we must ensure we are putting adequate resources into effective health promotion initiatives in the schools. Injury prevention for children could be a very beneficial area for new prevention strategies.

Other avenues in which government action could make a difference and improve the population's health should be explored, such as clean air legislation, to see if its benefits would outweigh its costs.

Recommendation #14:

Your Committee recommends the Premiers' Council on Canadian Health Awareness undertake the discussion of how to promote "healthy lifestyles," including the appropriate use of incentives and disincentives to help influence public behavior.

THE CHALLENGE OF HUMAN RESOURCES

In B.C., as in the rest of Canada and the world, there is a severe shortage of almost every type of skilled health care provider, including family practitioners, specialists, nurses, pharmacists, physical and occupational therapists, speech therapists, technologists and more.

The shortages have arisen for a number of reasons. Like the rest of our population, health care providers are aging and they need to be replaced with younger workers. Decisions in the early 1990s to reduce training spaces have contributed to the shortages. The changing role of women in the workforce over the last 30 years adds complexity to the issues, in part because more women than men work part-time, take time off for family or seek flexible hours and working arrangements. Retaining our trained workers is also challenging when job stress is high.

In ***Patients First*** the Committee made a large number of recommendations to increase the number health providers being trained in B.C., speed up recruitment and credentialing of professionals from other jurisdictions, create more opportunities for training, and provide incentives for working in hard-to-staff locations.

B.C. Government Action

The government is developing a 10-year health human resources plan to address critical shortages in all health care areas. For all professions, the plan focuses on three criteria: training, recruitment, and retention.

Doctors' Shortages

B.C. actually has a higher doctor-patient ratio than either Alberta or Ontario and is above average for the country, although they are not evenly dispersed around the province. B.C., however, has never trained enough physicians and relies on recruiting them from other provinces or countries. The following actions have been taken or planned to help address the shortages.

Training

A new $134 million Life Sciences Initiative launched in March 2002 has:

- Increased the number of medical school places at the University of B.C., with 128 this year (six of which are reserved for aboriginal students) and almost double that, at 224, by 2005.
- Increased the number of residency positions.
- Established a new Life Sciences Centre at UBC at a cost of $110 million
- Established two satellite facilities
    - One at the University of Northern B.C. to focus on rural medicine, with 24 students a year and new $12 million facility to be finished by 2004
    - One at the University of Victoria to focus on geriatric medicine for a cost of $25 million.

Recruitment and Retention

- **Consolidation of specialist services** in regional centres is already proving to be a way to attract new specialists to the province and keep the ones we have. At least three doctors of the same specialty will work in a regional center and will draw on a large pool or surrounding patients. The result is a reasonable call and vacation schedule, less stress and burnout, better concentration of resources, and reduced physician frustration. GPs in the surrounding communities will have more specialist services to refer to for back-up and consultation.
- **Remote incentives:** MSP sponsors isolation allowances for doctors in Northern and rural practices, a recruitment and incentive package for small communities, travel assistance packages for specialists who have to travel to small communities and a northern and rural locum program to help find and financially support replacement doctors so physicians can go on vacation or education leave. Medical students who agree to work in areas of greatest need for five years will have all outstanding B.C. loans forgiven at a rate of 20 percent per year of practice.

- **Primary care networks:** Encouraging GPs in solo practice to join group practices with four or five other physicians will mean doctors will receive support from other health care workers such as nurse practitioners, and patients will have access to appropriate levels of care. Early studies show that physicians' job satisfaction increases and stress can go down in primary care networks.
- **Improving wages:** Recently, the government negotiated a $392 million agreement with doctors that included a 20.6 percent pay increase, on-call compensation and a mechanism to resolve future disputes.

Nursing Shortages

B.C. has fewer nurses per capita than every province and territory except Nunavut. The workforce is aging, with 50 percent of nurses between 45 and 65. Most nurses retire at age 58. Each week in B.C., 2,400 nurses are off the job due to illness.

During 2001, the government gave a 22 percent pay increase, making nurses in B.C. the highest paid in Canada. In addition $15 million was spent to purchase better equipment such as patient lifts and hospital beds, to reduce injury and improve the working environment.

Now a $21 million Provincial Nursing Strategy is underway to train, recruit, and retain nurses.

Training:

- **More spots:** 1,266 nursing seats have been added to B.C.'s educational institutions for 2001-2003.
- **Skills upgrade:** Nurses who wish to train for areas with shortages, such as intensive care and emergency, can have their training subsidized. So far 315 nurses are completing specialty training.
- **Refresher training:** Non-practicing RNs and under-employed foreign-educated nurses in B.C. can requalify for work. More than 465 nurses applied for funding and 404 have been approved for refresher programs to qualify for nursing jobs.

Recruitment :

- **Forgivable student loans:** In return for working in areas of greatest need for five years, nursing students will have all outstanding B.C. loans forgiven at a rate of 20 percent per year of practice. An undergraduate employment fund has created opportunities for student nurses undergoing undergraduate training to work during their course of studies and between semesters.
- **Attracting foreign-educated nurses with specialty training**. Recruitment drives in other countries, mostly Australia and New Zealand, have occurred for hard to fill positions.

Retention:

- **New roles for injured RNs:** A new program allows employers to customize positions and find new roles as mentors and preceptors (on-site teachers) for nurses on WCB.
- **Nursing grant program**: Mentors and preceptors can obtain a grant to work with new nurses, especially in rural areas, to help them feel less isolated and more supported.

Under the nursing strategy the Ministry of Health Planning and the Registered Nurses Association of B.C. are working together to develop a regulatory framework for nurse practitioners to perform many tasks done by family doctors. The province in conjunction with the RNABC could regulate nurse practitioners as early as 2003. Other innovative nursing projects to improve the working environment and give nurses new duties are being explored, such as First Call- where nurses treat non-urgent cases in rural emergency rooms - and the B.C. Nurse Line.

The Committee feels there is also room for Licensed Practical Nurses (LPNs) and nursing aids to assist and provide lower intensity nursing care, as long as the ratio of registered nurses to LPNs is monitored to ensure the safest and most effective mix of personnel.

OTHER HEALTH PROFESSIONS

The Ministry of Advanced Education has also increased education seats by 114 for health professionals including medical laboratory, respiratory therapy and midwives.

Some allied health professions – such as chiropractors, massage therapists, naturopaths, acupuncturists and others – contribute to the health and wellness of the people of B.C.

Where high quality evidence based research exists that their interventions can effectively treat certain health complaints, consideration should be given about how to better integrate these services in the future.

New draft legislation to amend the Health Professions act is in the process of public and stakeholder consultation. The new regulatory system aims to improve patient care through better coordination among health care providers and multidisciplinary approach to health care delivery.

PHARMACARE

The right medication can cure or tame a dangerous, debilitating and even deadly illness. Insulin for diabetes, antibiotics for bacterial infections, chemotherapy for cancer, antiviral medication for AIDS – these and other drugs have reduced death rates, improved patients' health and quality of life and reduced the money we spend on hospitalizations. It comes, however, at an enormous cost.

Prescription drug expenditures are growing faster than any other component of health care. As we noted in ***Patients First,*** in the last five years the Pharmacare budget has grown by 44 percent while the entire health budget grew by 28 percent. The complexity of the issues is

illustrated by the huge increase in the number of approved drugs available in Canada, which has grown from 639 medications in 1968 to 21,388 drugs in 2002.

In ***Patients First*** your Committee recommended a number of steps to help keep drug costs under control, to improve access to necessary medications for all British Columbians, to coordinate and make more consistent the drug approval process, and to expand the role of pharmacists to make better use of the knowledge and expertise about medications and their side effects.

B.C. Government Action

Changes to B.C.'s Pharmacare program to make it more equitable and based on recipients' ability to pay were discussed in more detail in the section on equity. The new program, Plan I will be introduced sometime in 2003.

National Common Drug Review

In each province before a new drug is covered by the provincial formulary, it must undergo a process of investigation and evaluation to ensure it will produce the desired health benefits to the population at an affordable price for the province. Over the last few decades, each province has established its own process of drug review, leading to a needless duplication of effort, inconsistencies in coverage and decisions that in some cases may not be adequately based in scientific evaluation.

A study[12] backed by the federal Health Transition Fund found that pharmaceutical manufacturers, eager to get their drug listed on the provincial formulary, will often use the fact that one province is covering it to exert public pressure on other provinces to list it before the complete evaluation is done. One of the study's recommendations was for provinces to pool their resources, as the Atlantic Provinces have done for a number of years, and come up with a single high-quality, scientifically-based, rigorous drug review process.

In 2002 all the Premiers in Canada agreed to start a national common review process. The process will incorporate a common assessment of cost effectiveness based on sound scientific and economic analyses. A common process to streamline the approval of generic drugs across the provinces is also under development.

This step will address a number of the Committee's early recommendations such as ensuring clinical outcomes are worth the cost incurred, negotiating as a block with drug manufacturers for the best possible price of the drugs, and creating a consistent ethical framework to help decide which new drug therapies will be introduced.

Increased deductibles

To spread the increasing cost of drugs across entire province**,** deductibles have been increased by $200 – every family must pay the first $1000 of drugs costs; Pharmacare will pay 70 percent of eligible costs between $1,000 and $2,000, and 100 percent of costs over $2,000. Those receiving MSP premium assistance must pay the first $800; Pharmacare will cover 100 percent of costs over that amount.

Low Cost Alternative and Reference Drug Programs

The Low Cost Alternative Drug program bases Pharmacare coverage on the price of the lowest cost brand among identical drugs, and pays for the least expensive generic drug. The Reference Drug program is a separate program that applies to drugs that are not identical but are part of the same drug category and used to treat the same conditions.

Since 1995, B.C. has controlled some of its drug costs through its reference drug program (RDP). When drugs within a certain category are known to be equally safe and effective, Pharmacare pays for the least expensive one – the reference drug – that will do the job. If the doctor really feels the patient needs the higher priced drug, the RDP program's special authority will enable that expense, although doctors and pharmacists have complained the process is cumbersome and a source of irritation.

RDP currently applies to just five common classes of drugs. As promised by the New Era document, RDP program underwent a review by an independent Committee to find potential cost-effective alternatives to the plan. The report of the review Committee, released December 3, 2002, found that RDP has saved about $12 million a year. The Committee suggested that the program should be retained for now until any alternatives are found and if they are not, then it should be potentially expanded. The government is keeping the RDP program in place but continuing to search for cost-effective flexible alternatives or modifications to the program.

Patient Education

The right drug used properly can save a patient's life; the wrong drug, or misuse of the right drug, however, can be fatal. Adverse drug reactions, misuse of medication (such as consuming alcohol while taking certain drugs) over reliance on addictive drugs, such as benzodiazepines for sleeping, are huge problems that undermine patient health. Failing to take the full course of prescribed antibiotics can promote the creation of antibiotic-resistant microbes. Non-compliance –such as stopping prescription without consulting the doctor can lead to poor outcomes. Non-compliance can increase drug waste when a person decides not to complete prescription and leaves an expensive drug sitting on the shelf.

Your Committee feels more patient education would be a beneficial investment that would lead to wiser, safer prescription drug use. The growth of patient information handouts with prescriptions is a positive trend. The Medication Info B.C. (formerly the Seniors Medication Information Line) is a toll-free telephone service operated from the University of B.C. for all residents of B.C. It will answer questions about:

- new medications,
- herbal therapies
- foreign medications,
- adverse reactions and contraindications for drugs
- complicated medical histories.

The line (822-1330 in Greater Vancouver and 1-800-668-6233 toll free) is staffed four days a week but a message can be left which will be returned. E-mail queries are also answered by one

of four pharmacists. However, once again this very valuable service is not well known by the public and should be promoted more widely.

Role of Pharmacists

In ***Patients First*** we recommended expanding the range of practice of pharmacists, particularly tapping into their expert knowledge about drugs as consultants with patients as a way of improving patient drug use and reducing adverse reactions. This consultation, of course, would require a reimbursement fee with the pharmacists and therein lies the problem. While community pharmacists have the knowledge of pharmaceuticals and the trust of the public to offer a real service, their expanded role would essentially mean taking funding away from physicians, who are already being paid to do drug consultation with patients, and sharing it with pharmacists.

Change will require that everyone, particularly doctors, recognize pharmacists could play a critical role in enhancing patient services and improving use of pharmaceuticals. The Committee notes that a greater focus on primary care teams, in which pharmacists can play an integral part, as well as on chronic disease management and electronic health records, will naturally lead to a greater use of pharmacists' knowledge. Pharmacists in B.C. are scientific experts in the interaction and use of therapeutic compounds and their knowledge and expertise could be greater utilized for the betterment of patient health.

Recommendation #15:

a) Your Committee recommends that the Medication Info Line of B.C. be more widely promoted and supported. Consideration should be given to coordinating the B.C. NurseLine with the Medication Info Line to make the services available with a single call and increase public awareness and use of the service.

b) Your Committee recommends that further discussion and negotiation occur about ways to better use the knowledge of B.C.'s pharmacists to improve patient health.

CHRONIC AND CONTINUING CARE

The goal of acute care medicine is to cure disease and manage immediate health crises. The goal of chronic and continuing care is to manage long-term illness and disability, assist with daily living, and prevent a sudden health crisis that returns patients to hospital.

During our 2001 hearings, the Committee was repeatedly told that acute care and chronic care are two highly different types of health care, requiring different types of services, that nevertheless must be coordinated and integrated within a larger system. As we noted in ***Patients First,*** a well-organized and well-supported chronic and continuing care system will not only lead to better quality of life and services for our most vulnerable populations – the elderly and those with chronic disease and mental illness – but it will decrease both the costs and demands on the acute care system. Your Committee made eight recommendations all with the goal of strengthening this essential component of our health care system.

CHRONIC DISEASE MANAGEMENT

According to the Ministry of Health Services, 50 percent of all the care provided in the province by doctors goes to just 10 percent of the population. This population consists mainly of patients with chronic diseases whose illnesses usually get progressively worse and whose health continues to decline.

Care can be coordinated to provide ongoing support and timely treatment to prevent the escalation of health crises. The individual can live a healthier, happier life.

B.C. Government Action

B.C. physicians have identified the following illnesses as priorities for chronic disease management (CDM):

- diabetes
- hypertension
- congestive heart failure
- asthma
- chronic lung disease
- depression
- renal failure
- liver disease
- arthritis/osteoarthritis

These illnesses are a continual cause of poor quality of life and serious health complications that often lead to death for the thousands of British Columbians who suffer from them. For society, they comprise the greatest burden of disease on the health care system. However, a great deal can be done proactively to lessen their terrible toll both on individuals and society.

CDM programs will focus on the following tools and activities:

Patient registries: individuals with chronic illness will be voluntarily invited to join a registry to allow health professionals to track their care, proactively schedule them for tests and contact them with information.

CDM collaboratives: Recognized experts, using the latest scientific research, will set standards of care, design flow sheets to manage each patient, set performance targets and identify patient actions that can lessen the severity of illness.

Performance monitoring: The number of tests will be monitored, patient satisfaction charted, hospital re-admission rates followed, and utilization of services determined; goals can be set and measured.

Evidence-based practice guidelines: CDM collaboratives will send doctors in the province current recommended actions for the care and treatment of different chronic disease populations.

Self-management products: Patient information guides, training programs, support groups, web-based access to information and other tools will help patients take charge of their illness.

Primary care and shared care models: promotion of GPs working with other health professionals such as dieticians, counselors, pharmacists, occupational therapists and specialists, to enhance the coordination of care received by patients with chronic disease.

The Ministry of Health Services has created a new website devoted to chronic disease management issues with information for patients, physicians and other providers. It includes emerging standards of care, patient information, utilization data and other important links. It can be accessed from the main page of the Ministry of Health Service website or directly at http://www.healthservices.gov.bc.ca/cdm/index.html

Your Committee is very encouraged by the increased focus on activities around chronic disease management and feels this is a very fruitful and worthwhile endeavor that will improve patient health and the use of resources. Communicating these developments and services to the patients and providers who can use them is of utmost importance.

Recommendation #16:

Your Committee recommends that chronic disease management programs continue to receive government support and attention, including effective communication to potential users of the program to increase awareness of these developments.

CARE TO THE ELDERLY

Right now in B.C., some 533,000 people are over the age of 65. According to Statistics Canada, the fastest growing portion of the province's population is the "old-old," those people 80 years of age and older. In the last 10 years the number of people over 80 in B.C. has grown by 54 percent and will continue to gain another 43 percent by 2011. Fortunately, now more than ever, many of those people are aging well, with good quality of life and many years free of disability and disease. Even the most successful aging, however, comes with a gradual decline of physical strength and abilities.

B.C.'s elderly residents want the same things from the health care system that everyone else in the province wants: respectful, high quality care at an affordable price that meets their individual needs and improves their quality of life. The difference lies not in what they want, but the types of services needed. A young person who becomes ill needs quick and responsive acute care services – usually in a hospital or doctor's office – to fix the problem and bring them back to health. An elderly person needs a series of supportive services – mostly in the community – to address their increasing frailty and help them manage their daily life.

Since our health care system is so geared to acute care services, elderly people who really need supportive services in their home or community often wait in acute care hospital beds because there is nowhere else for them to go. Or, without support in the community, they will enter long-term care institutions when they don't really need such high levels of care. Clearly, most

people would much prefer to stay independent at home for as long as possible, if they had a better range of options.

Numerous witnesses before the Committee during hearings in 2001 told us of the challenges of the existing fragmented, inconsistent and haphazard continuing care services available to elderly citizens. One witness, for example, told us only 2,500 of the 15,000 elderly patients who visited the Nanaimo General Hospital in the previous year were bona fide emergency cases; the rest needed help with daily living.

Witnesses told us of the often paternalistic care that did not recognize the autonomy and competence of elderly citizen able to make decisions for themselves. The Committee heard of arbitrary actions and rigid regulations designed to keep the elderly safe "for their own good" while ignoring the individual's wants. We heard about crippling bureaucracy governing the simplest actions – such as the memorable description by one witness about how the basic act of taking a vitamin becomes mired in red tape if a competent elderly person lives in long term care.

Your Committee recommended that a wider range of options be available for elderly citizens of all socio-economic levels to remove the inappropriate reliance on acute care, to promote independence and autonomy in the community for as long as possible and to give respectful, supportive care. The Committee recommended, for example, that long-term care, intermediate care, and assisted care be considered essentially as housing with a health care component, rather than health care with a housing component.

B.C. Government Action

Recognizing the importance of this area of the health care system, the position of Minister of State for Intermediate, Long-term, and Home Care was created in B.C. in June 2001, the first such position in Canada.

Now, under the auspices of the Ministry of Health Services, a fundamental shift in philosophy and type of services is now underway in B.C.'s $1.6 billion home and continuing care sector. Called the Continuing Care Renewal Plan, it will see the elderly spending less time in acute care beds and residential care facilities, and more time supported at home and in the community.

The regional health authorities have been given the mandate to develop five-year plans and have received initial investments of $23 million each to begin the renewal process. They will free up existing acute care beds, close down residential beds in outdated nursing home facilities and develop alternative care models. Each authority has been given the flexibility to determine the mix of services – home care, community programs, assisted living arrangements, long-term care beds – that it deems best suits the needs of its population.

The need to shift the focus from institutions to supported services in the community is supported by the following facts from the Ministry of Health Services:

- 70 percent of continuing care costs are consumed by the 30 percent of seniors who live in nursing homes.

- More than a quarter of institutionalized seniors don't need to be there: they could live in the community with moderate support.
- Every dollar spent on one client inappropriately placed in a facility could pay for two clients in the community
- The number of patients needing continuing care will increase by 1,600 people every year.

Since few, if any, elderly people would prefer to live in an institution if they had more options of supportive living in their own homes and communities, shifting resources not only treats more people for the same amount of money, it gives the elderly the services most would prefer.

The types of continuing care services that health authorities are devising include:

- **Home Care:** The elderly person lives in their existing home and receives care as needed whether home nursing support, support for daily living, adult day-care programs, meals –on-wheels, or home- based palliative care.
- **Supportive Living:** Consists of two related sub-categories determined by the level of personal care needed by the elderly resident:
    - o **Supportive Housing:** The elderly person, still competent to make his or her own decisions, lives in an apartment-like complex with other elderly individuals and receives some meals, light housekeeping, social activities, emergency medical care and a low level of personal care.
    - o **Assisted Living:** Similar to supportive living but emergency medical care and a higher level of personal care for help with daily living.
- **Residential Care:** The elderly person, often no longer competent to make his or her own decisions, lives in an institution with full-time professional health care 24 hours a day, seven days a week.

A fundamental shift in philosophy accompanies the development of these services, according to the Ministry of health services: the elderly will no longer be treated as "patients" whose individual needs are subjected to the needs of the institutions they live in. They will be residents living in their own homes, whether apartments or specially designed units, receiving the support they need, and the services they want, to promote their independence and quality of life.

Policy changes to support the shift in philosophy

A number of new policies have been introduced to enable more appropriate, supportive care to be delivered in the community and to ensure access to institutional service for those who need it.

- **New Community Care and Assisted Living Act:** New legislation, Bill 73, passed in early November, replaces the outdated and rigid *Community Care Facility Act* of 1969 and replaces an earlier bill first introduced in April 2002 which was withdrawn for more public consultation. The new Act clarifies the legislation and regulations needed to keep vulnerable and dependent people safe, sets results-based standards, clarifies the role of health authorities and local medical health officers in making licensing

decisions, and establishes a registration process for people living in assisted living arrangements.

- **Needs-Based Access Policy to Facility Care**. As discussed in the section on equity, clients with the highest need and urgency for residential care will have priority access into the first available, appropriate bed. Eligibility will be determined by a standardized, objective needs assessment that measures the persons' mental capacity and ability to perform certain physicals tasks. This will ensure access to residential care beds is based on need, not on the first-come, first-served criteria of a waitlist.
- **The B.C. Palliative Care Benefits Program:** Previously, the costs of expensive painkillers, medications, medical supplies and equipment would only be covered if the patient stayed in hospital. Now if the patient is dying these items will be covered in the patients' homes.
- **Payment to family caregivers in unique situations**: Under previous rules, family members could not be paid for looking after loved ones. A new B.C. policy will open the door to payments in special cases where no qualified caregiver can do the job because of isolation or remote location, cultural and language barriers, or behavioral problems of the client.

More supportive living arrangements for low-income British Columbians

Higher income elderly people in B.C. have always had a range of options for purchasing the kind of care they wanted or needed as they aged. Private assisted living arrangements have become so popular in recent years, B.C. communities have seen a flourishing of construction for high-end private assisted living facilities, many of which fill up immediately and have waiting lists. Assisted living options, affordable for those on limited income, however, were very hard if not impossible to find

Now, the government's "Supportive Living B.C." program will create 3,500 units over the next four years to serve low and modest-income seniors. Federal support of $62.5 million under the Canada/B.C. Affordable Housing Agreement will be matched by provincial funds. The initiative, in partnership with B.C. Housing, will:

- retrofit 1,000 existing units
- create 1,500 specially designed non-profit units
- provide 1,000 rent supplements in private market supportive living developments.

These places will augment the 800 supportive housing units from other programs either built or under construction through B.C. Housing and non-profit housing societies. More information about this program or how to enroll for services now being planned is available at www.bchousing.org/Supp_Liv/

Funding for the new supportive living programs is coming in part from a decommissioning of existing old and out-dated institutional beds around the province. According to the Ministry of Health Services, B.C. has 16,000 residential care beds that are more than 20 years old, no longer adequate and would cost $2 billion to replace. Most do not merit reinvestment over the next five years and are now being phased out. Funding from decommissioned residential-care

beds will be shifted to community living options where it can support two seniors in the community compared to one in a facility.

Your Committee recognizes that the philosophy at the heart of this shift in services for the elderly will ultimately lead to more respectful, appropriate and cost-effective care that will promote independence, autonomy and safe living in the community for as long as possible for elderly people of B.C. The Committee recognizes that few elderly citizens would choose to spend their last days of life in an institutional setting if there were other safe, respectful and affordable options available in their communities.

While the policy and goals of the Continuing Care Renewal Plan are laudable and the philosophy correct, the implementation of the policy over the last year has in some instances occurred with miscommunication and inconsistencies in application across the regions. Some locales did an exemplary job of consulting with affected people and coming up with a flexible, respectful deployment that considered individual needs. In other high profile cases, elderly individuals were moved without consultation or effective care plans in place. The reporting of these incidents fanned fear, confusion and backlash against the policy from elderly citizens, their families and the general public and tarnished the objectives of the policy and those who were doing a good job of implementing it.

The health ministers have stated numerous times that no facility should be closed and residents moved without consultation and without assurances that alternative plans are in place. All health authorities have been required to submit comprehensive transition plans to help ensure respectful moves for clients. However the instances in which precipitous moves occurred with no communication or discussion led to distrust among elderly citizens that the reassurances could not be believed. The public began to interpret these changes as motivated only by the need to cut costs and not as essential steps to create a better range of respectful, affordable care.

At the heart of the new Continuing Care Renewal Plan is the need to replace an old, out-dated paternalistic model of "one-size" institutional care for the elderly with a new model that respects the rights, autonomy and individual needs of our oldest citizens and supports them to be functioning members of our communities for as long as possible. Many people working in our continuing care sector are committed to that goal and are already giving a concerted effort to providing respectful, flexible care to the elderly. They are working very hard to provide excellent care. We must ensure that they are supported and that at the same time the system remains flexible enough to consider the individual needs of the elderly person and enables them to be informed participants in their own care.

There is a huge need to inform elderly citizens, their families and the public about the goals and philosophy of the Continuing Care Renewal Plan to reduce fear and confusion and to explain how the implementation will affect elderly individuals and their families in B.C. We consider this an urgent issue.

Recommendation #17:

Your Committee recommends:

a) Immediate steps be taken to better communicate the goals and rationale of the Continuing Care Renewal Program to elderly people of B.C., their families and the general public.

b) The philosophy of respectful supportive living that maximizes the ability of the elderly to make decisions for themselves must be in evidence in the words and actions of all those working in the continuing care system.

c) The regional health authorities, when creating their new continuing care plans, must ensure that sufficient supports and care plans are in place and functional before elderly patients are moved.

MENTAL HEALTH

Mental illness is second only to circulatory diseases in terms of impact on hospital resources. On average in B.C., hospital stays related to mental illness are 45.5 days, three times longer than the stay for any other disease. While the toll on the health system is large, the toll on the individuals and the families that mental illness affects is even larger. Four out of five people with mental illness are unemployed, many are homeless and many have combined mental illness and substance abuse problems. An estimated 120,000 people have a serious mental illness in B.C. Even more have mild or moderate depression or anxiety that affects the quality of their lives and their relationships with others. The economic burden of the disease is about $1.7 billion per year in B.C.

Recognizing the importance of improved mental health services, the B.C. Government in June 2001 created the first Minister of State for Mental Health with the explicit goal of assuring mental illness is a key component of the health care agenda.

In ***Patients First*** we did not make any specific recommendations regarding mental health in B.C., in part because we heard from only a few people who spoke specifically on the issues. In its way, this was evidence that despite the huge toll of mental illness, those it affects are often without a voice and their needs can go unrecognized.

B.C. GOVERNMENT ACTION

B.C. has launched a mental health plan that will see an additional $263 million spent on health care initiatives in the next six years. Like continuing care models for the elderly, the aim for the mental health plan is to maximize individuals' autonomy by supporting their ability to live and function well in the community.

Health authorities have been committed to meeting specific performance targets for their mentally ill residents, such as ensuring follow up care within 30 days of discharge from hospital and reducing the number of days mentally ill patients must wait in hospital for community services.

Key to more effective and cost-efficient treatment of the mentally ill will be a range of options for care, from public education to supportive community homes. Health authorities are considering:

- Supportive living facilities.
- Short-term crisis intervention
- Day hospitals
- Home care services
- Respite support for family caregivers.

The plan includes $138 million in new capital projects over the next six years. Construction has begun on two new rehabilitative mental health facilities in Kamloops that will enable clients now in Riverview in the Lower Mainland to live closer to their family and friends. The two home-like residences, each with 20 living units, have flexible designs that will adapt to the specific needs of each client. They will open in the spring of 2003. In addition a 44-bed psychiatric unit at Kamloops' Royal Inland Hospital will serve people whose mental illnesses are more acute.

In the Northern Health Authority, Iris House is a new 10-unit residence for mental health patients that has just opened in Prince George. Initially, all units were used by high needs patients from the north who were previously being cared for at Riverview Hospital in Coquitlam. However, being closer to home has already helped one patient move back into the community, with health care assistance. And a patient from Prince George Regional Hospital was able to move into the new and better accommodation, freeing up an acute care bed.

Over the next few years, another 30 units such as these will be provided in the north. The Northern Health Authority expects this approach will improve care for mental health patients while reducing pressure on acute care beds.

40 to 60 percent of mentally ill patients also have a substance abuse problem. Alcohol and Drug Services, formerly under the Ministry of Health, has been transferred to the health authorities, along with its budget of $64.7 million, where the regions can better target services to the direct needs of their population.

In October 2002, the Ministry of Health Services released two new mental health strategies that will help the regional health authorities with the planning tools they need to address two of the most prevalent forms of mental illness.

- **Provincial Anxiety Disorders Strategy Report:** Anxiety is increasingly common with an estimated 400,000 British Columbians suffering from some form of the affliction, and 100,000 of those finding the condition interferes with daily life. The report outlines ways to improve awareness and outcomes for those who suffer from severe anxiety disorders in B.C.
- **Provincial Depression Strategy Report:** One in 25 British Columbians every year will have a depressive illness. Depression and stress disorders now account for more than 30 percent of all disability at major corporations. The report outlines ways to improve awareness, appropriate treatment and outcomes. Its recommendations include the creation of chronic disease management models for depression, educational support

to people with depression and their families, and more support of primary care practitioners who must recognize, treat and manage depression.

Recommendation #18:

Your Committee recommends that care plans and community and residential services must be in place before people with mental illness are moved from facilities like Riverview.

ABORIGINAL HEALTH

Aboriginal people in B.C. suffer worse health, increased incidences of almost all common diseases, shorter lives and higher rates of violent and accidental death than others in B.C.

Representatives from aboriginal communities throughout B.C. – from tiny coastal communities to urban bands – were a consistent presence before the Committee in its hearings in 2001. They ensured their voices were heard and their message rang out loud and clear, such as the need for B.C. to assume clearer responsibility from the federal government for Aboriginal health, the need to place Aboriginal health concerns within the larger social and political framework and the need to involve Aboriginal communities themselves in tackling their own health problems.

In ***Patients First*** the Committee recommended working with aboriginal communities to develop and implement aboriginal health plans for each region that would improve access to services, promote education and prevention strategies, and target programs to deal with specific health issues.

B.C. Government Action

- **Aboriginal Health Plans:** Each Health Authority is in the process of developing Aboriginal Health Plans. These must be relevant to their regions, span three years and be updated annually. The plans are expected to provide a community profile outlining the nature of the aboriginal communities within each jurisdiction and to indicate active steps for co-operation and collaboration. Each health authority is required to have at least two Aboriginal health officers on their boards of directors. Each health plan must include concrete objectives to improve aboriginal health services within the region as well as means for evaluating services and programs.
- **Support for Aboriginal collaboration:** The Provincial Aboriginal Health Services Strategy (PAHSS), involving aboriginal health and community representatives, will recommend ways to improve access to health care, increase aboriginal involvement in decision-making and planning, and promote working relationships between aboriginal communities, governments and health authorities.
- **Promote Education in Health Fields:** There are fewer than 200 aboriginal doctors in Canada and only 1,000 aboriginal registered nurses. Last fall, UBC announced it will now reserve six spaces each year in its medical school for Aboriginal students. There are also college education programs, outreach programs, university-First Nations education partnerships and community health representative programs to help encourage and support Aboriginal students to enter into health fields. University College of the Cariboo received $75,000 for its Aboriginal Pre-Health Program, which helps Aborginal students gain the skills they need to successfully enter and do well in nursing programs. Camosun College received $56,000 for 2003/03 for its First Nation Health and Education Access Program development, also designed to help Aboriginal students enter and succeed in health careers.

Provincial Health Officer's Aboriginal Report

In October 2002, the Provincial Health Officer released its 2001 annual report *The Health and Well-being of Aboriginal People in British Columbia.* The 200-page report, which was two years in the making, was a highly collaborative document that involved input, consultation and critique from major aboriginal community groups in the province.

As Dr. Perry Kendall, Provincial Health Officer, told the Committee in November 2002, the overall findings are that aboriginal people continue to have a level of health that is below that of the general population and have a standard of living that is, on average, 20 percent lower than the provincial average.

However, there was good news: Aboriginal infant mortality is dropping and life expectancy is increasing. Immunization rates are equal to that in the general populations. Dr. Kendall says he believes two factors are contributing to these successes. One is targeting programs and implementing them in partnership with aboriginal people. The second is the political-cultural resurgence and sense of identity that aboriginal people have in B.C.

The Provincial Health Officer's landmark report provides much-needed information to help guide programs and policies. The report recommends improving the standard of living of aboriginal people and focusing on prevention and chronic disease management. As well, the report suggests setting formal targets for health improvement, focusing on healthy growth and

development for aboriginal children, and preventing injuries and conditions like diabetes. The report's recommendations include addressing the rising death rates from AIDS, and paying more attention to the non-medical, cultural and spiritual factors that influence health.

Other recommendations include building greater participation of First Nations people in the design, delivery and governance of culturally appropriate health services, and improving access to effective, culturally appropriate primary care.

The report notes that simply providing more money for hospitals or for more formal health services does not seem to be the answer. In fact, Aboriginal health status is highest in the northern areas of the province where formal health services are least available and lowest in Vancouver where major hospitals and services are readily available. Dr. Kendall told the Committee this interesting fact probably stems from the positive health protection that comes from having a well-functioning community that has social, cultural and political integrity.

Eight major Aboriginal health issues have been identified by the Provincial Health Office that need special attention:

- infant health,
- tobacco use
- alcohol and drugs
- HIV/AIDS
- diabetes
- injuries
- primary care.
- informational databases

These issues require a holistic approach to health as well as prevention strategies, community involvement, cultural sensitivity and outreach. The report suggests specific actions to be taken by health authorities in each of these areas, which have already been supported by aboriginal communities. In addition, coordination between the delivery of health services by various levels of government, particularly between the federal and provincial government, is greatly needed, as Dr. Kendall noted to the Committee "little progress has been made in this area."

The Committee applauds the thoroughness of Provincial Health Officer's Report and the detailed and strategic recommendations it proposes for further improvement in Aboriginal health status. The Committee notes that one of the long-standing issues is the fragmentation of Aboriginal programs among various levels of government. There is an urgent need to coordinate aboriginal programs between all levels of government.

Recommendation #19:

a) Your Committee recommends the actions recommended by the Provincial Health Officer be considered in consultation with the aboriginal health authorities for adoption by the government and the health authorities.

b) Your Committee recommends that emphasis be placed on the improving coordination and cooperation between levels of government to help improve the delivery of services and programs to Aboriginal people.

FINANCIAL STRATEGIES

In ***Patients First***, we discussed a number of financial strategies to deal with rising health care costs and debated some controversial issues, such as user fees and public private partnerships.

In this report these topics are discussed in greater detail in Part Two, as these challenging topics have formed have been a focus of much of the three new reports that were released in the last year.

PART TWO: RESPONDING TO THE WORLD AROUND US

As we noted in ***Patients First*** over the last decade there has been no shortage of committees, commissions, special advisory councils and forums struck in Canada to investigate ways to sustain or reform the Canadian health care systems. Some of these were:

- The Seaton Commission: (B.C. 1991)
- The National Forum on Health (federal 1994-1997)
- The Clair Commission (Quebec 2000)
- The Fyke Commission (Saskatchewan 2001)
- The Select Standing Committee on Health (B.C. 2001)

In the last year, three more in depth examinations of Canadian Health Care have been released:

- Mazankowski Commission (Alberta, January 2002)
- Kirby Commission (federal Senate, final volume of six reports, released October 2002)
- Romanow Commission (federal Royal Commission, released November 2002)

In general the reports tend to fall into two camps. One camp holds that there is enough money in the system and that improved efficiency and management are all that are needed. The second camp believes that while better efficiency and management are indeed needed, new money is necessary to meet rising cost pressures and increased demands.

EUROPEAN EXPERIENCE

Canada is not alone in its angst over the sustainability, quality and access of its health care system. All western countries that have a form of public insurance coverage for medical care are facing considerable challenges in trying to provide high quality, cost-effective health care at a reasonable price to its citizens.

The European Observatory on Health Care Systems published in April 2002 a survey of eight countries' health care systems (Denmark, France, Germany, the Netherlands, Sweden, the United Kingdom plus Australia and New Zealand). It found some countries have health care systems that are funded primarily by taxes, others have a mix of public and private insurance schemes. Countries such as Germany allow the most wealthy to choose whether to withdraw from the public system and purchase private insurance if their annual earnings exceed a ceiling. Most of the countries have forms of co-payment, deductibles or user charges on some or all of the services. The Observatory study notes, however, that no one country has found a perfect solution, and that all face challenges of one degree or another.

Along with European Observatory, the Canadian Standing Senate Committee on Social Affairs Science and Technology (The Kirby Commission) devoted one of its six volumes to the examination of health care systems in other countries and conducted a comparative analysis in its 100-pages. Its finding noted the same challenges in access, sustainable funding, equity, human resource management and cost pressures from pharmaceutical and new technologies.

Your Committee feels it is very enlightening and liberating to study how other countries and jurisdictions choose to organize, fund and manage their health care resources. Innovative ideas can be examined for their application in a B.C. setting. The pitfalls and limitations of schemes can also be examined to avoid introducing the same mistakes in B.C.

Recommendation #20:

Your Committee recommends studies, research and reports of how other countries are delivering health care or experimenting with reform be used as sources of inspiration and innovation for any relevant application to British Columbia.

MAZANKOWSKI REPORT

In January 2000, Alberta Premier Ralph Klein announced the formation of the Premier's Advisory Council on Health. Chaired by former Deputy Prime Minister Don Mazankowski, the 12-member council was assigned the task of determining the challenges Alberta's health care system faced, including coping with an aging population, addressing funding pressures, and introducing new medical technologies into the system.

On January 8, 2002, the Premier's Advisory Council on Health released its report. The report's recommendations fell into 10 categories for reforming Alberta's Health Care system, many of which mirror the recommendations first laid out in ***Patients First*.**

The Mazankowski Report placed itself firmly into the second camp, arguing that more efficiency is not enough to fix the system and new money is needed. While a small portion of that new money would come from increased premiums, it recommends the majority would come from internal market incentives such as allowing the private sector to both invest and shoulder some of the capital cost for a small slice of profits while still having services paid for by the public insurance scheme. More money would become available by delisting some services and making them available through private options.

The report was criticized by those who saw it as opening the door to more private care and putting too much faith in competition and internal market forces to cure health cares' woes. Some felt it would contravene the universality principle of the *Canada Health Act* and allow the emergence of a second tier of care for those able to pay. Others note that its recommendations, while pushing the margins of the *Canada Health Act*, still honor the five principles. The Alberta Government is implementing many of the recommendations and has developed a timetable for when the changes will be introduced.

Many of the actions Alberta has taken in the last year, or plans to make, are ones that have already been done in B.C., such as establishing a province-wide electronic medication record (like B.C.'s Pharmanet), introducing a 24 hour nurse-line (like our NurseLine) and increasing tobacco taxes (which B.C. did in the spring of 2002.) Alberta also intends to increase medical premiums, increase health promotion campaigns, and introduce an expert panel to review publicly funded services.

KIRBY COMMITTEE

The Standing Senate Committee on Social Affairs, Science and Technology, best known as the "Kirby Committee" after its chair Michael Kirby, was empowered by the Canadian Senate in December of 1999 to study the Canadian health care system and the evolving federal role in that system. The 11-member Committee, two of whom are prominent doctors and medical educators, set off on an exhaustive two-and-a-half year investigation, hearing from more than 400 witnesses. The Committee produced six thoughtful and refreshingly evenhanded volumes examining all aspects of the Canadian health care system, its challenges and options for the future.

The Kirby Committee also positioned itself squarely in the second camp, declaring new money is needed. As Chair of the Committee Michael Kirby said in a speech announcing its recommendations: "Ultimately, Canadians will need to balance their desire for more and better health care services against their willingness to pay for them." The Committee estimates than an extra $5 billion a year was needed but that this amount "must buy change" and not simply be sucked up by the existing system. The extra $5 billion, it recommended, should come from a designated health tax, based on income scale.

Along with the designated health tax – about 50 cents a day for low income Canadians up to $4 a day for those earning $103,000 or more – the major Kirby Committee recommendations were:

- **Health Care Guarantee:** If Canadians cannot receive proper medical care within a clearly specified, clinically determined waiting time, government should pay for the procedure or treatment in another province or even in the United States.
- **National Pharmacare program:** Individuals' out-of-pocket expenses for prescription drugs should be capped at 3 percent of his or her family income, with the federal government picking up the majority of drug costs in catastrophic cases.
- **National Home Care program:** Home care costs incurred as a direct result of discharge after hospital treatment should be publicly funded under Medicare, shared 50/50 by the federal government and provinces. Palliative home care for people who are dying should also be shared 50/50. Preventative home care for elderly or the disabled, however, is not part of the program.
- **Health Care Commissioner:** An independent national commissioner to monitor the performance of the system, oversee reform, issue report cards and ensure accountability from all players.
- **New financial arrangements with providers:** Hospital should receive service-based funding, not block funding, based on the type and number of services provided; doctors should receive capitated funding – an annual payment for the number and type of patients in their practices – not fee-for-service. (In essence, a complete switch from current practice, so that hospitals would switch to fee-for-service and doctors switch to block funding.) Internal market forces, competition and incentives for hospitals, doctors and patients to promote efficient use should be established.
- **Increased funding for infrastructure and personnel:** Canada's medical school should get a $4 billion boost over 10 years for capital investment and a $2 billion

increase for technology; information technology systems through Canada Infoway needs a $2 billion boost over five years to perfect electronic health records and health care information management systems; an extra $250 million a year should go to solving the health care personnel shortage across the country.

The Kirby Committee also recommends that the federal government dip into its surpluses to provide more money each year, but notes that many other worthy programs – education, national defense, aboriginal issues, transportation needs – are all requiring funding boosts from the same surplus funds.

Kirby's entire package of recommendations hinges on the public acceptance of the special designated health tax. Senator Kirby noted that if the Canadian public decides it is not prepared to pay more, the Committee believes that the necessary changes cannot be brought about. If the status quo is maintained, the Committee believes court challenges under the *Canadian Charter of Rights and Freedoms* will soon open up a second tier system of health care because Canadians cannot be denied the right to purchase services the government takes too long to provide.

In the weeks following the release of the Kirby report, the general public, the provinces and the federal government rejected the call for a new, special health tax. It seems for now that the public does not want to pay for it and the federal and provincial governments have rejected the idea of imposing it.

ROMANOW COMMISSION

In November 2002, after 18 months of anticipation, former Saskatchewan Premier Roy Romanow released a 400-page report examining his view about how to renew health care for the 21st Century. Prime Minister Jean Chrétien had given Romanow the mandate in April 2001 to lead a wide-scale investigation into the future of Canada's public health care system. Called the Commission on the Future of Health Care in Canada, its goal was to embark on a national dialogue with Canadians and to then recommend policies and measures to ensure health care remains universally accessible, publicly funded and sustainable.

Romanow's one-man royal commission (with a huge support staff) commissioned 40 discussion papers from academics and health experts across Canada on issues including human resource management, impact of international trade agreements on potential health care reforms, change management theory in health care, and impact of changing demographics. The discussion papers, while not reflecting the views of the commission itself, are a wealth of information and opinion, sometimes conflicting, about the recurring challenges facing the health care system and their potential solutions. The vast amount of material produce by the Romanow Commission is available at www.healthcarecommission.ca.

Romanow called for an infusion of $15 billion over the next four years from the federal government surplus, not new sources of funding. He made 47 recommendations, some of which dealt with foreign doctors, globalization, and Canada's role in health in developing countries. His most important recommendations were the following:

- **Establish a "Health Covenant"-** to confirm the collective national vision for health care and outline the responsibilities and entitlements of individual Canadians, providers and governments.
- **Create a Health Council of Canada –** formed from the backbone of the Canadian Institute for Health Information, (which already collects data, tracks health outcomes and issues reports). The council would play a key role in monitoring the health system, fostering collaboration between all the players and coordinating technology assessment. Some have called this a national "watchdog" for health.
- **Modernize the *Canada Health Act* —** add the principle of accountability to the five principles of the *Canada Health Act*, clarify portability as relating to services in Canada, and include diagnostics and priority home care under the principle of comprehensiveness.
- **Provide stable long-term funding —** separate the block money/tax points handed over to provinces through the Canada Health and Social Transfer (CHST) into a cash-only health transfer that includes a built-in increase within five years.
- **Establish five new targeted funds to be matched or exceeded by provincial contributions:**
    - **Rural and Remote Access Fund :** to improve timely access to care in rural Canada and recruit health providers to rural areas
    - **Diagnostic Services Fund:** to purchase equipment like magnetic resonance imagers (MRIs) and CT scanners; and to train the necessary operators and therefore reduce waiting lists for diagnostic services.
    - **Primary Health Care Transfer:** to be used to overcome obstacles and lure health providers into adopting primary health teams.
    - **Home Care Transfer:** to provide seed money for an eventual national home care program; start covering post-acute home care, mental health home care, and palliative homecare.
    - **Catastrophic Drug Transfer:** to allow provincial drug programs to expand to cover a greater portion of drug costs for seriously ill Canadians.
- **Set the federal government's funding floor at 25 percent of the cost of insured health services:** the provinces would make up the remaining 75 percent.
- **Promote Primary Care:** using the new fund as the impetus for change, building primary health care on the principles of continuity of care, early detection and action, improved information on needs and outcomes, strong incentives, health promotion and prevention;
- **National coordination of drug approval:** one body should evaluate and review all prescription drugs in Canada and create one national formulary; drug patent protection should be reviewed.
- **Consolidate Aboriginal health funding and management:** create one body, the Aboriginal Health Partnership, that pools resources into one organization run by Aboriginals that oversees, funds, organizes and delivers health services.

Reaction to the sweeping recommendations was highly mixed across Canada. Some felt it reaffirmed the universal, accessible vision of public health care; others felt it was an unrealistic throwback to a bye-gone era that entrenched health care in federal bureaucracy and control, and that will tie provinces' hands in determining their own needs and priorities. Some of the recommendations are in fact already being done: the premiers of the provinces decided to establish a national common drug review last year; CIHI is already collecting data and reporting to Canadians annually; and there seems little need to add more bureaucracy to the process by wrapping it up in a new Health Council.

Many were dismayed by what seemed at first to be the rejection in the report of any role for the private sector – even if it is paid for by the public system and delivers high quality, efficient care. Romanow was seen by many as ignoring the fact that 30 percent of all health services are now provided by the private sector and that new creative and innovative partnerships between government and private investors may be the best solution to some of our long-standing problems while resulting in better patient care. However, subsequent interpretation of the report found that while Romanow expressed the view that private providers are not the way to go, he did not outright ban their existence.

The call for an infusion of cash from the federal surpluses, not from new taxes or fees, was welcomed by almost everyone, but most provinces rejected the notion of being dictated to by Ottawa on how they must spend the funds. Quebec said pointedly if the funds came with strings attached they would refuse the money. Others felt that while Ottawa would be committed to funding up to 25 percent of the cost of insured services, rather than about 15 percent now, it would still be not enough to introduce home care, or prescription drug coverage and would saddle the provinces with *even greater debt in the future.*

Cautions were raised on a number of fronts about spending too much federal tax money fixing the health care system. The day before the final Romanow Report was released, the International Monetary Fund released its annual report card on Canada's spending warning Canada that health care reforms should be affordable and based on incentives that encourage cost containments[13]. The report congratulated Canada for its prudent policies that kept government spending under control during the 1990s and contributed to our strong economic performance during the downturns of that decade. Altering our fiscal policies, such as spending a higher proportion of our tax income on health care or incurring greater debt, could deter future economic performance.

SELECT STANDING COMMITTEE RESPONSE TO REPORTS

The detailed and thoughtful reports by Mazankowski, Kirby and Romanow have all done an admirable job in pointing out the considerable stresses, strains, inefficiencies and problems facing our health care system. As can be discerned above, there are numerous areas of commonality that can form the backbone of consensus for moving forward toward reforms. Some recommendations, however, the Committee and others are firmly against and actions in these areas the Committee believes should not proceed. And, finally, some recommendations fall into a third category of being unclear at this time about what they mean, what the impact would be on the province of British Columbia or whether they would be effective in achieving the intended aim. The Committee reserves judgment on these third category of

recommendations until it is more clear exactly what their adoption would entail. Appendix III of this report highlights the responses to the various recommendations

BUILDING ON AGREEMENT

A number of recommendations in all three reports cover common ground:

Need for increased federal contributions: The federal share of provincial health care spending has slipped from 50 percent of all costs in the 1970s to around 15 percent today. The federal government must provide a stable base of funding to the provinces and contribute its fair share to the provision of high quality health services in Canada.

Recommendation #21:
Your Committee recommends the federal government increase its contribution to health care provision in Canada and provide a stable base of funding to the provinces, which need the flexibility to determine their own funding priorities.

Accountability: Your Committee strongly supports the calls for more accountability and transparency in the system. Accountability must be the backbone of the system, but it must be meaningful accountability that is close enough to the provision of services to be able to make a difference. B.C. is already leading the provinces in its move to performance contracts with the regional health authorities based on achievable targets, regular reporting and access standards.

Recommendation #22:
Your Committee recommends a firm commitment to accountability in health care.

More focus on health promotion and prevention: Since the majority of injuries, illness and disease can be prevented, we must do more to help people live healthy lives and avoid sickness and injuries in the first place. The federal government, through Health Canada, is well poised to initiate and coordinate some national health promotions and prevention strategies. The provincial governments can explore the role of legislation in some areas, such as clean air bylaws, for its ability to translate into improved health.

Recommendation #23:
Your Committee recommends more attention be paid to health promotion and prevention strategies and the role of the federal government in coordinating national strategies.

User fees aren't the answer: For years debate has raged about whether charging user fees for medically necessary services would both increase funds to the health care system and serve as way to promote patient responsibility for use of the health care system. Over the last year, however, in part from examining the other countries' experience with user fees, a consensus has emerged in Canada that user fees don't achieve either aims. Administration costs around user fees are greater than the money they collect and instead of promoting patient responsibility they seem to prevent the neediest from seeking necessary care ultimately costing the system more in the long run.

Recommendation #24:
Your Committee recommends no user fees.

Increased funding for information technology: Your Committee recommends that Canada Health Infoway receive more funding to quickly address the need for health-related information systems for the management and coordination of health care delivery and patient care. As the lead pan-Canadian agency working to address create standardized, compatible electronic information systems and secure, confidential but shareable electronic health records, Canada Health Infoway needs to have the financial support to solve the problems of ensuring privacy, security, standardized formats and uniform data collection and comptatible formats. The development of effective information management systems will go a long way to improving accountability, measuring performance and patient outcomes, improving integration of services and reducing inefficiency.

Recommendation #25:
Your Committee recommends the federal government be encouraged to increase Canada Health Infoway's funding to enable the agency to coordinate the solutions to health information technology problems.

New money for equipment: Canada has a lower rate of MRIs and CT scanners per capita than most western countries. One MRI costs about $4 million. We need help from the federal government to buy these necessary items. However, it must be noted that capital cost of the equipment is just one expense. It also costs a significant amount each year to operate the equipment – about $1 million a year for an MRI. Therefore, there must be money available to purchase the machines and operate them well into the future.

Recommendation #26:
Your Committee recommends more federal funding which would allow the provincial government to purchase and operate diagnostic equipment as it sees fit.

Incentives and actions to promote primary care reform: As we stated clearly earlier in this document, building primary care networks that coordinate and integrate patient care is an essential step to improve health care services. All agree we need to get on with the job of primary care reform.

Recommendation #27:
Your Committee supports coordinated actions to promote faster transition to primary care reform.

Human resource strategies: Shortages of doctors, nurses and other health care providers are a serious problem across the country. We need to continue with a coordinated and long-term response to address this long-standing issue.

Recommendation #28:
Your Committee recommends coordinated national efforts to address human resource issues in health care.

IDEAS NEEDING CLARIFICATION AND DISCUSSION

Both Kirby and Romanow proposed some actions that are difficult to assess. Their intent may not be clear, their implementation uncertain and their impact on British Columbia not yet possible to judge. These recommendations include:

National Pharmacare Program: While your Committee firmly believes patients should be protected from catastrophic drug costs, in B.C., unlike other provinces, this protection already exists. We pay 53 percent of all drug costs, the highest in the country compared to the average of 43 percent. We welcome federal assistance to help offset these costs so we can use some of the money we spend on drugs to cover other necessary costs. But the Committee is concerned that because B.C. already covers so much, we may in fact be effectively penalized while the Atlantic provinces, who don't cover the drugs, may receive per capita more help for lagging behind. Your Committee recommends that drug policies be more uniform across the country and that the provinces work together to reduce drug costs. But without knowing how a national Pharmacare or catastrophic drug program would be funded and what the benefits and costs would be for B.C., we cannot accept or reject the recommendation at this time.

Recommendation #29:
Your Committee recommends more discussion and clarification about the details of any national catastrophic drug coverage or national Pharmacare program to see if it would benefit the people and the province of B.C.

National Post-acute Home Care Program: Like a national Pharmacare program, a national home care program for people discharged from hospital ideally would be a desirable addition to our health care program. However, with the federal government agreeing to contribute just 25 percent of the cost, and with other escalating costs not yet under control, B.C. cannot afford to shoulder 75 percent of this program without a new source of funding. We do agree, however, that the federal government should contribute more to help fund home care and mental health programs in the community.

Recommendation #30:
Your Committee recommends more discussion and clarification about the details of any national post-acute home care program to see if it would benefit the people and the province of B.C.

Addition of Accountability to the Health Act: Accountability is an essential principle of health care as the Committee has firmly stated in both ***Patients First*** and this subsequent document. However, it should not be enshrined in legislation as a sixth principle of the *Canada Health Act* until it has been properly discussed and defined. Otherwise, it has the potential to tie provincial legislators to federal oversight. We should work towards clearly defining the five principles we already have, such as the definition of "comprehensive" before adding another new, poorly defined principle to the list.

Recommendation #31:
Your Committee recommends more discussion and better definition of what accountability would entail in legislation before any consideration be given to enshrining it as a sixth principle of the *Canada Health Act*.

Health Care Council: The Committee supports the idea of a persistent national forum that would bring together all jurisdictions to share best practices and report back to Canadians our progress in improving health care delivery and outcomes. It is important both for accountability and for information sharing. We feel, however, that the Canadian Institute of Health Information (CIHI), is already one of the best sources of information today. Romanow suggested that CIHI form the backbone of his proposed new Health Care Council. We question, however, the need for a new agency and a new name – with the cost of new letterhead, website, and all the other sundry bureaucratic costs that come with a new organization. Why not just give CIHI the support it needs to use its expertise and experience to better serve the functions we need? Or the existing Premier's Council on Health Awareness could also serve this function. In addition is also unclear whether a Health Council would in fact serve as a "watchdog" as some have described, which we reject, as described in the next section.

Recommendation #32:
Your Committee recommends that the functions of a Health Care Council be further clarified and that it be explored whether existing organizations, such as CIHI, could serve this function without the need for the cost and bureaucracy of creating a new level of health management.

POSITIONS REJECTED BY THE COMMITTEE

New taxes: While we believe more new money is needed for health care, it cannot be raised by further taxation of already burdened Canadians. Whether a special designated health tax, increased GST percentage points or other outright or hidden ways of obtaining more money from Canadians, your Committee feels Canadians are not prepared to pay more money for health in this way.

Recommendation #33:
Your Committee recommends no new taxes.

Health Care Guarantees: Like Romanow, your Committee does not believe a health care guarantee would work to improve access or give Canadians better quality of care. Access to care must be based on priority of need – in which more urgent cases get in first. By introducing a time-element for care it brings in a "first come first serve" system, which is not good for health and not enforceable. In addition, those whose guarantee cannot be met would be sent to the US or another province – increasing cost of the service and using valuable funds needed in the home province here. Putting in place scientific, evidence-based criteria to assess urgency and using management systems to deal with waitlists can improve access to surgery, treatments, and diagnostic techniques.

Recommendation #34:
Your Committee recommends improved waitlist management not a health care guarantee

National Watchdog: Whether it is called a national health care commissioner or a national health council, the Committee believes we do not need a new layer of health care bureaucracy. We agree we must openly report to taxpayers, about how their money is being spent but we don't need yet another layer of bureaucracy to do that.

Recommendation #35:
Your Committee recommends that no new national "watchdog" be added to the health care system.

Health Care Covenant: While the meaning of a health care covenant is not entirely clear, Romanow described it in quasi-religious tones as a "tangible statement of Canadians' values and a guiding force for of the public funded system that outlines the entitlements and responsibilities of individual Canadians, health providers and governments." Covenant suggests a pledge over and above the day-to-day law and management of the health care system. The Committee feels spending time creating a "Covenant" would only complicate and muddy the discussion in Canada when we need to get on with the practical matters of reform.

Recommendation #36:
Your Committee recommends no effort be spent on defining and creating a Covent for health care.

Prohibition of diversification of the revenue stream. While Romanow discouraged an expanded role for private enterprise in health care, Kirby and Mazankowski suggested roles in which private financing and revenue might play a role. We agree with Kirby and Mazankowski and reject Romanow's view.

As the Kirby Commission noted, the debate about the role of private sector in Canadian health care, and the appropriate public/private mix, "is being conducted in a counter-productive fashion, and is often responsible for diverting attempts at reforming the health care system." We agree. There is room from private provision of services under clear guidelines and standards that are paid for by the public purse.

For years, about 30 percent of our health care system has been provided by private individuals or organizations. Some of these are not-for-profit charities, such hospitals and long-term care homes run by religious charities. Many of the providers, however, are "for-profit" enterprises, such as the medical laboratories that do the blood tests, swabs and urine tests. Few if any British Columbians care that the majority of medical laboratories are private firms in British Columbia as long as the service is fast, efficient and high quality and the bill is paid by public insurance.

In fact, B.C.'s two largest commercial laboratory services, B.C. Biomedical Laboratories and MDS Metro Laboratories, teamed up last year to invest in and create an electronic information management system, PathNet. The electronic system enables doctors to quickly access patient laboratories results over a secure Internet connection, enabling quick downloads, searchable files, the highlighting of abnormal results and other data management options. The companies absorbed the cost of the system, which they provide free to doctors, and patients ultimately receive test results faster. This is the sort of innovation that the private sector can introduce at no additional cost to government or the system.

As well, the long-standing relationship between doctors and patients is a private-public partnership. The physicians are independent for-profit private providers who treat patients' illnesses and send the bill to the government. The public has been happy with this relationship for years. Patients simply want to be assured that they are getting high quality, necessary care from a reputable physician who meets the standards and professional criteria set out by governing bodies.

Concern is often raised that some private-public partnerships may run afoul of the North American Free Trade Agreement (NAFTA) or the General Agreement on Trades and Services (GATS.) The Romanow Commission had two separate groups study these concerns[14].[15] The opinion of the authors is that while the trade arrangements have to be considered, the provision of health care services is largely shielded from NAFTA; however, expanding into some areas, such as private insurance for health coverage, could trigger some free trade rules if the market were closed to other legitimate private providers. Author Jon Johnson, a trade lawyer notes that "worst case scenarios" can be created which would bring NAFTA and GATS agreements into play but these scenarios are often unrealistic. He notes that compensation or challenges would only be launched if the private interests affected are considerable, otherwise the risks are negligible. A trade lawyer can assess impacts before a project is considered.

Your Committee agrees with the Mazankowski and Kirby reports that allowing access to new revenue streams of private investors can bring new money into our health care system. The key for the public is that these relationships be controlled by clear rules, accountable transactions, and enforceable standards, and that profits are not egregious nor do they undermine the sustainability of the public system.

Such a beneficial relationship might look like this arrangement provided by the Ministry of Health Planning:

> The government owns a piece of land and leases it to an investor for $1 a year. The investor can finance, build and own a hospital on the land, which the government leases back for a term. The developer can put in the corner of the lot a small shopping mall with a drugstore chain, a florist, a doctors clinic, a rehab clinic with physiotherapists, a home medical supply outlet, perhaps even a fitness facility. The public gets access to health related services all in one place, the developer gets the land, and the government-run health care system gets a new building and a percentage of the revenue stream from the lot.

Regional health authorities are examining the potential advantages of pursuing private partnerships to help deliver aspects of their health system. Guidelines for private-public partnerships are being developed that will ensure any increased role of private enterprise in health care will not undermine the equity and universality provisions of the *Canada Health Act*.

While there have been many private public partnerships in long-term care, in October 2002, The Vancouver Coastal Authority and the provincial government announced the first private-public partnership in a large integrated acute care facility on the Vancouver General Hospital site. A private company will design, build and operate the new building, which will house specialty clinics, doctors' offices, research laboratories and health related commercial/retail activities. All necessary medical services will continue to be paid for by public health insurance.

Your Committee believes that innovative private-public partnerships, if subjected to clear, transparent standards that ensure the quality and cost-efficiency of care, can improve access and affordability for the people of B.C.

Recommendation #37:

a) Your Committee recommend that standards for private-public partnerships be developed that ensure the accountability, affordability and quality of these new relationships.

b) Your Committee recommends that each new private-public partnership be carefully examined for it benefits and costs, including examination for trade implications and only be given the go-ahead to proceed if the benefits outweigh the costs. Projects should be carefully evaluated after implementation to ensure they conferred the predicted benefits.

PART THREE: FOSTERING EFFECTIVE CHANGE ON THE PATH TO REFORM

In Canada we have become very good at describing the problems of our health care system and proposing a series of solutions to deal with them. As the discussion following the release of the Romanow and Kirby reports illustrate, achieving consensus and implementing recommendations is difficult to do.

Fostering effective change in health care is so difficult that no less than six discussion papers were commissioned by the Romanow Commission to explore this very challenging and complex area[16]. As one author, François Champagne of the University of Montreal noted, change for all large organizations – not just health care – is a time-consuming, often unpredictable phenomenon that can be effected by a string of factors, especially stakeholders' fear and resistance to change. Champagne notes that change management is one of the most common themes in both popular and academic writing in business, management and policy fields. Almost 1,300 academic articles have been published since 1994 on implementing change in organizations. The four leading business best selling books in November 2002 featured change management as prominent or central themes.

Lessons from the Health Transition Fund

In 1997 one of the recommendations of the report of the National Forum on Health was the creation of a $150 million fund to support innovative projects in areas deemed crucial to the change and improvement of the health system and to gain insight into how to overcome the inertia and outright resistance to change in the health care culture.

The resulting Health Transition Fund (HTF), a joint effort of federal, provincial, and territorial governments, supported approximately 140 different pilot projects and/or evaluation studies across Canada between 1997 and 2001: $120 million for provincially and territorially sponsored projects, and $30 million for national-level initiatives. The initial mandate of the HTF was to support evidence-based research for change and transition that could be used to inform policy.

Some of the lessons emerging from the 140 projects and evaluation studies, many of which met with their own challenges of foster change, included the following:

- **Time to Plan:** It takes a great deal of time to make substantial changes. Details must be worked out in advance, problems in implementation anticipated, communication and consultation processes well in place. Even policies that are good and correct, if not given time to be put into play, can fail.
- **Getting People on Board:** Health care is an organizational culture that is unfavorable to the notions of change. Change often means one group, in particular stands to lose money, position or power. Compensation of loss or creating incentives for change can help get people on board; otherwise they may work to block the change.
- **Community Participation:** The communities most affected by the change should have a hand in the decisions and the directions of change.

- **Clear implementation plans:** Who is responsible for what? Who does what, when? The step-by-step logistical plans for how a change is carried out must be worked out in advance.
- **Commitment to consultation and communication:** Top down change, which pays no regard to the concerns and feelings and need for information from the individuals it impacts, often meets strong resistance. Concerns must be heard. Effort must be made to effectively communicate the rationale behind the change and seek input from the people it affects. People tend to accept the outcome of transparent process, even if it is not a solution they would have chosen.

Informing and involving the public

Central to achieving effective change is the need to both explain the rationale and involve the public in emerging policy. How to engage the public and stakeholders in constructive, deliberative dialogue was the focus of four academic discussion papers commissioned by the Romanow inquiry.[17],[18],[19],[20]. As one author, Harley Dickinson, of the University of Saskatchewan, notes:

> "In these turbulent times, nothing is more volatile than the health care system. Even experts in health policy and healthcare reform are hard-pressed to keep abreast of changes, let alone what they all mean. Is it any wonder that the public is concerned, if not confused about what's going on and what the future holds?"

Over the last 30 years the world has undergone an information revolution that has been as sweeping and dramatic in its impact as the Industrial Revolution Over of the 19th Century. The new fast moving world in which information is available at the click of a mouse means that the public demands access to information. This new world, too, is increasingly characterised by networks, rather than hierarchy. Author Joanne Caddy notes that citizen participation is essential to the new order, but they do not replace leadership and good governance:

> "The respective roles and responsibilities of the government (making a decision for which it is held accountable and on which its performance may be judged) and the citizen (providing input to the decision-making process) must be clear. Citizens are not government, they elect it and want to be served by it. But if they are to participate more than just via the ballot box, then they need proper access to information, meaningful consultation and opportunities to take an active part in policy-making."[21]

A commitment to public information and consultation does not mean that government is no longer leading the policy formulation or implementation. The responsibility for policy creation and the final decision rests with government, which must always show strong leadership in formulating the debate and setting the time frames and choosing the options. Consultation should take place in a well-structured deliberative process (with deliberate aims, goals, decisions and timeframes) to ensure closure and an ultimate decision, not an endless process in which the loudest interest group shapes the policy.

Sometimes governments must act quickly to implement policy without embarking on the time-consuming process of citizen participation, but they will still need to focus effort on explaining why their actions were necessary and what they intend to achieve.

As the OECD manual on public participation notes[22], a commitment to information, consultation and active participation between citizens and government has three mutually supportive benefits:

- More effective implementation: citizens that are well informed and have had a voice in the policy development support the implementation.
- Greater trust in government: involvement creates trust in the process and in the government undertaking the changes.
- Stronger democracy: information, consultation and participation makes government more transparent and accountable, leading to a stronger democracy.

Many of the documents on citizen participation note that the closer to the level of operation, the most effective the public participation. Author Dickinson suggested in his paper for Romanow, the process of public participation in healthcare decisions should be a uniform and consistent occurrence at the level of the regional health authorities or lower, such as the individual service delivery point such as a long-term care institution. Public participation at the provincial government level is appropriate for consultation on legislation, but for actual operational issues it can be too far removed for the actual delivery of services

Applying the lessons to B.C.

In the health care environment this commitment to clear objectives, transparency of the process, public information and consultation is time-consuming and sometimes expensive process. As such, in an atmosphere of constant need for money for patient care, the cost of communication and consultation for specific health care reforms can itself become a focus of criticism. It can become a no-win situation: damned if you don't communicate and damned for wasting precious resources if you do.

B.C. has participated and at times lead this emerging trend for increased public information and participation for a number of years through processes such as access to information legislation, legislation for referenda petitions, Ministry consultation papers (i.e., Ministry of Finance pre-budget consultation papers), consultations by legislative Committees and more.

The public need for easy access to information has been recognized to some degree already in B.C.'s NurseLine, the Medication Info line, the Ministry websites and B.C. Health Guide website, which allows patients as well as health providers access high-quality information about health. Each of the new regional health authorities has a website that not only relays detailed information about the performance and actions of the health authority but also supply contact numbers and opportunities for public feedback.

The B.C. government has recently concluded a successful structured public consultation, for the recent introduction of the Community Care and Assisted Living Act, which was part of a consultation process with care facility operators, community care groups and individuals. More than 500 people and groups contributed their thoughts and concerns through meetings, e-mails and individual submissions, which lead to a stronger, better accepted legislation that sets the groundwork for streamlined, locally based licensing decisions. Draft legislation to amend the Health Professions Act has also been part of a public and stakeholder consultation for the last year.

The successful consolidation of thoracic surgery, which in less than 10 months achieved consensus and new, well-designed systems for delivering the specialized surgery, is another example where the input of all the people affected created a fast and efficient change that is poised to lead to improved services for people undergoing thoracic surgery and improved working lives for those delivering the services.

The Committee applauds all these actions and encourages the provincial government, the regional authorities and health care service providers at the local level to constantly seek new ways to inform and involve the public in the decisions that affect them. The wealth of information available in the vast body of literature about change management and citizen participation can be fruitful source of ideas and applications. Each health authorities should seek methods that work for them and their communities.

The goal must be to create a better-informed public that feels heard and involved in the process and understands the benefits and trade-offs of the new policy. Ultimately the aim is to foster transparency and trust in the process of change and its ultimate goals on the path to reforming our health care system

SUMMARY OF RECOMMENDATIONS:

Recommendation #1:
Your Committee recommends that the impact of MSP premium increases be closely monitored.

Recommendation #2:
Your Committee recommends that the impact of Plan I be monitored for its impacts on seniors, families and low income British Columbians. The positive and negative effects of the policy should be carefully evaluated.

Recommendation #3:
Your Committee recommends that the impact, effectiveness and health authority compliance with the new access standards be monitored and evaluated.

Recommendation #4:
Your Committee recommends that regional health authorities and local service providers make efforts to explain the rationale and advantages of needs assessment to elderly citizens and their families and that their concerns be heard and questions answered.

Recommendation #5:
a) Your Committee continues to recommend that under the Ministry of Health Planning, the support and enhancement of evidence-based research and standards of care to be applied across the province.
b) Your Committee recommends that to further achieve an evidence-based culture for health services, all health care reforms go through a process of evaluation to ensure they are achieving their intended purpose.

Recommendation #6:
Your Committee recommends that realistic consequences be established for health regions that do not meet performance targets.

Recommendation #7:
Your Committee recommends that research that examines general compliance with clinical protocols and other forms of research that examine patterns of practice in B.C. be routinely conducted and reported.

Recommendation #8:
Your Committee recommends that more effort be made to promote the B.C. Health Guide, the 24-hour nurse line and the website.

Recommendation #9:
Your Committee recommends the existence of the Premiers' Council on Health Awareness and its website should be more widely publicized and the Council used as an effective forum for national debate on issues of health care reform.

Recommendation #10

a) Your Committee recommends consolidation of acute care services continue with flexible time frames for implementation that builds success stories with evidence-based results.
b) Your Committee recommends fact-based information be made available to the public about the evidence for improved services and physician retention through consolidation and that a forum be created to hear and respond to concerns.
c) Your Committee recommends the process of consolidation be monitored and evaluated to ensure it is achieving its intended aims.
d) Your Committee recommends long-term plans be established that use the access standards to eventually replace old facilities as needed with new facilities built in regionally appropriate locations.

Recommendation #11:

a) Your Committee recommends that it be given the opportunity to review the report of the core review of the B.C. Ambulance Service.
b) Your Committee recommends that training opportunities continue to be supported in order to eventually achieve the goal that all paramedics in B.C. achieve the Paramedic 1 status.

Recommendation #12:

a) Your Committee recommends that support continue for initiatives to create standardized, compatible information systems between B.C.'s health regions to improve the quality and efficiency of health care services and management.
b) Your Committee recommends the Provincial Government lobby for continued federal support and stable financing for Canada Health Infoways.

Recommendation #13:

Your Committee recommends that the Ministry of Health Services and the Regional Health Authorities move quickly to promote a flexible range of primary care models that promote integrated and coordinated care. Evaluation of the models must be a fundamental aspect of their implementation.

Recommendation #14:

Your Committee recommends the Premiers' Council on Canadian Health Awareness undertake the discussion of how to promote "healthy lifestyles," including the appropriate use of incentives and disincentives to help influence public behavior.

Recommendation #15:

a) Your Committee recommends that the Medication Info Line of B.C. be more widely promoted and supported. Consideration should be given to coordinating the B.C. NurseLine with the Medication Info Line to make the services available with a single call and increase public awareness and use of the service.
b) Your Committee recommends that further discussion and negotiation occur about ways to better use the knowledge of B.C.'s pharmacists to improve patient health.

Recommendation #16:
Your Committee recommends that chronic disease management programs continue to receive government support and attention, including effective communication to potential users of the program to increase awareness of these developments.

Recommendation #17:
Your Committee recommends:

a) Immediate steps be taken to better communicate the goals and rationale of the Continuing Care Renewal Program to elderly people of B.C., their families and the general public.
b) The philosophy of respectful supportive living that maximizes the ability of the elderly to make decisions for themselves must be in evidence in the words and actions of all those working in the continuing care system.
c) The regional health authorities, when creating their new continuing care plans, must ensure that sufficient supports and care plans are in place and functional before elderly patients are moved.

Recommendation #18:
Your Committee recommends that care plans and community and residential services must be in place before people with mental illness are moved from facilities like Riverview.

Recommendation #19:

a) Your Committee recommends the actions recommended by the Provincial Health Officer be considered in consultation with the aboriginal health authorities for adoption by the government and the health authorities.
b) Your Committee recommends that emphasis be placed on the improving coordination and cooperation between levels of government to help improve the delivery of services and programs to Aboriginal people.

Recommendation #20:
Your Committee recommends studies, research and reports of how other countries are delivering health care or experimenting with reform be used as sources of inspiration and innovation for any relevant application to British Columbia.

Recommendation #21:
Your Committee recommends the federal government increase its contribution to health care provision in Canada and provide a stable base of funding to the provinces, which need the flexibility to determine their own funding priorities.

Recommendation #22:
Your Committee recommends a firm commitment to accountability in health care.

Recommendation #23:
Your Committee recommends more attention be paid to health promotion and prevention strategies and the role of the federal government in coordinating national strategies.

Recommendation #24:
Your Committee recommends no user fees.

Recommendation #25:
Your Committee recommends the federal government be encouraged to increase Canada Health Infoway's funding to enable the agency to coordinate the solutions to health information technology problems.

Recommendation #26:
Your Committee recommends more federal funding which would allow the provincial government to purchase and operate diagnostic equipment as it sees fit.

Recommendation #27:
Your Committee supports coordinated actions to promote faster transition to primary care reform.

Recommendation #28:
Your Committee recommends coordinated national efforts to address human resource issues in health care.

Recommendation #29:
Your Committee recommends more discussion and clarification about the details of any national catastrophic drug coverage or national Pharmacare program to see if it would benefit the people and the province of B.C.

Recommendation #30:
Your Committee recommends more discussion and clarification about the details of any national post-acute home care program to see if it would benefit the people and the province of B.C.

Recommendation #31:
Your Committee recommends more discussion and better definition of what accountability would entail in legislation before any consideration be given to enshrining it as a sixth principle of the *Canada Health Act*.

Recommendation #32:
Your Committee recommends that the functions of a Health Care Council be further clarified and that it be explored whether existing organizations, such as CIHI, could serve this function without the need for the cost and bureaucracy of creating a new level of health management.

Recommendation #33:
Your Committee recommends no new taxes.

Recommendation #34:
Your Committee recommends improved waitlist management not a health care guarantee

Recommendation #35:
Your Committee recommends that no new national "watchdog" be added to the health care system.

Recommendation #36:
Your Committee recommends no effort be spent on defining and creating a Covent for health care.

Recommendation #37:
a) Your Committee recommend that standards for private-public partnerships be developed that ensure the accountability, affordability and quality of these new relationships.
b) Your Committee recommends that each new private-public partnership be carefully examined for it benefits and costs, including examination for trade implications and only be given the go-ahead to proceed if the benefits outweigh the costs. Projects should be carefully evaluated after implementation to ensure they conferred the predicted benefits.

APPENDICES

APPENDIX I - ENDNOTES

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APPENDIX II - AREAS OF ACTION

In Patients First, the Committee identified the following areas that required government action to solve some longstanding problems. Although government action in 2002 may not directly relate to the details of specific recommendations made by the Committee, the following are the areas the government implemented action in some way in the last year. In depth details of the specific actions to date are available in Part One of this document

	Committee Recommendation	Government Action
Equity	✔	✔
Accountability	✔	✔
Patient Centered Care	✔	✔
Evidence Based Care	✔	✔
Regional Restructuring	✔	✔
Restructuring Acute Care Delivery	✔	✔
Provincial Ambulance Services	✔	✔
Information Management Services	✔	✔
Primary Care	✔	✔
Preventative Health	✔	✔
Doctor Shortage	✔	✔
Nursing Shortage	✔	✔
Other Health Professionals	✔	✔
Chronic Care	✔	✔
Continuing Care	✔	✔
Aboriginal Health	✔	
Financial Strategies	✔	

APPENDIX III - CANADIAN REPORTS COMPARATIVE TABLE

	ROMANOW	MAZANKOWSKI	KIRBY	COMMITTEE
increased federal contributions	✓	✓	✓	✓
accountability	✓	✓	✓	✓
health promotion and prevention	✓	✓	✓	✓
user fees	×	×	×	×
more funding for information technology	✓	✓	✓	✓
new money for diagnostic equipment	✓	?	✓	✓
primary care reform	✓	✓	✓	✓
human resource strategies	✓	✓	✓	✓
national pharmacare program	✓	*	✓	*
national post-acute home care program	✓	?	✓	*
accountability in Canada Health Act	✓	?	?	×
Health Care Council	✓	?	?	*
new taxes	×	×	✓	×
health care guarantees	×	✓	✓	×
national watchdog	✓	×	✓	×
health care covenant	✓	?	?	×
expanded role for private enterprise	*	✓	✓	✓

	LEGEND
✓	yes
×	no
*	discussion needed
?	position unknown

APPENDIX IV - HEALTH RELATED WEBSITES

B.C. Health Guide
www.bchealthguide.org

Chronic Disease Management:
www.healthservices.gov.bc.ca/cdm/index.html

Medication Information Line
http://www.ubcpharmacy.org/MIBC/index.htm

Ministry of Health Services
www.gov.bc.ca/healthservices

Ministry of Health Planning
www.gov.bc.ca/healthplanning

Premiers' Council on Health Awareness
www.premiersforhealth.ca

Regional Health Authorities:
Vancouver Coastal Health Authority - www.vancoastalhealth.ca

Fraser Health Authority - www.fraserhealth.ca

Vancouver Island Health Authority - www.viha.ca

Interior Health Authority-www.interiorhealth.ca

Northern Health Authority - www.northernhealth.ca

Romanow Commission
www.healthcarecommission.ca

Senate Standing Committee on Social Affairs, Science and Technology
www.parl.gc.ca/common/
Committee_SenHome.asp?Language=E&Parl=37&Ses=2&comm_id=47

Legislative Assembly. Select Standing Committee on Health 2001 Report
Patients First: Renewal and Reform of British Columbia's Health Care System
www.legis.gov.bc.ca/cmt/37thparl/session-2/health/reports/healthtoc.htm

Supportive Living B.C.
www.bchousing.org/Supp_Liv/

APPENDIX V - REFERENCES

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