Premier Gordon Campbell
Address at the Canadian E-Health Conference
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Check Against Delivery

I appreciate the opportunity to speak with you about some of the things that we're trying to do in British Columbia. We're soon going to make a number of significant announcements with regard to our health care system, and I thought it might be useful to outline some of the issues that we have faced in the last year.

British Columbia, like all other provinces, is facing some real challenges in health care. We often talk about health care and about being for change, but we refuse to act. We say we want politicians to think long term but we demand short-term results. We say we want to focus on the patient, and then we immediately carry out our program as if the patient wasn't even there.

So one of the challenges that we face in government is to increase people's understanding of what is taking place in health care in Canada today.

I'm not for the status quo. When I ran for office last year, I said we were changing the status quo. We said we were going to have a new era where we actually focused our health care resources on care for patients in the province where they live.

We were going to try and make sure that as we used your dollars, and they're all your dollars in public health care, we would focus on patient care. That was a huge shift over what had been taking place.

You just have to rattle off the list of commissions and studies that are taking place – the Crown report in Quebec, the Fyke report in Saskatchewan, the Mazankowski report in Alberta, our own Legislative Committee's report, the Romanow Commission – and you know people are not happy with what's happening. They're worried about what's going to take place.

If we're not getting the results we want, then surely we should change what we do – in the hopes that we will get the results we want. It's what we all have to do in our real lives, and it's what we should be doing in public life as well.

We now have new tools that weren't here when we were creating and building the health care system across our country. New technologies are available to us, opening up whole new worlds of opportunity to actually connect care and caregivers with people.

We often forget that Canada is a vast place. British Columbia is larger than England, France and Germany combined, and vast areas of our province have a very dispersed population. So we have a challenge to meet.

For the first time we have an opportunity to meet that challenge: the tools are available, if we can just get ourselves out of the institutional inertia that holds us back.

The new health care is not just all about great big hospitals – there's a whole range of things other than physical infrastructure that we have to do. We have to understand that people are the most important part of the health care system.

Our government was elected 11 months ago. The first thing we learned is that our health care system is not being driven by the discipline of outcomes; it's being driven by the discipline of inputs, and how much we spend.

One of the problems that we faced when we were elected was the challenge of supply and demand: in human resources, in hospital facilities, in intermediate and long-term care facilities, in medical machinery and equipment, and ultimately in terms of service for patients. We weren't producing enough doctors and nurses. We didn't have enough long-term care beds. Older patients were forced to be in wards with acute care beds because there were no long-term facilities available to them in their communities. And our waitlists grew.

British Columbia is a perfect example of inputs not outputs. Every year the government would face the challenge of growing wait-lists. Every year the government's response was to spend more money. And every year the wait-lists kept growing. That makes no sense. We have to have the courage to stand up to the problems and say maybe we should try something different.

We also had a huge management problem, because there was no proper planning being done in the province.

The largest single building in Vancouver, which is the largest municipality in British Columbia, is the Vancouver Health Sciences Centre at the corner of Oak and 12th Street. In 1983 it was agreed that this hospital should be built. There was a political announcement, lots of excitement – and the hospital shell was built.

Today the largest single building in Vancouver is a hospital shell. They didn't have any money for equipment or personnel. They didn't think about what they were going to have to spend to actually make this shell do something for a patient.

A little while later a structural engineer came along and said, you guys are in trouble. You've built a shell and you're not putting anything in it. If you don't start heating the shell, the structural integrity of the building is going to start to deteriorate. So a genius decided it was time to heat the shell. At the same time the shell was getting really nice and heated, there were people in Vancouver who didn't have the type of accommodation that they wanted. Then the hospital had to pay for security to keep those people from using the heated shell.

It was almost a decade ago that this was taking place. We now believe that it may be possible that the shell will actually be a facility providing care to patients by the year 2003. It will have cost the health care system over $100 million because there was no plan, no foresight, and no recognition that without people in the hospital the hospital doesn't do anything for health care.

We have to change that. Our health care system had about 100,000 people in it, yet there was not one senior ministry official who was responsible for health planning when we were elected. We had a budget of $9.3 billion and not one single official was responsible for planning human resources, physical resources, technological resources, or machinery and equipment resources.

We had 52 separate health regions. We had regional authorities, community health councils, community health service centres – but there was no coordination, so one was fighting the other for personnel, for equipment, for resources.

We faced another challenge in British Columbia, and I know the other premiers face it in every province. Our health care spending in British Columbia has increased by 20 per cent in the last two budget cycles while our economy grew by about 2 per cent. It doesn't take much to figure out that's not sustainable in the long term, if you want to have any other public sector services besides health care.

We couldn't afford the status quo. We decided it was time to take a new approach, to look at things with fresh eyes, and actually set some goals for ourselves and work our way through them.

During last year’s election campaign we itemized over 40 separate, specific recommendations we intended to accomplish. While over 41 per cent of the provincial budget goes to health care, there was only one health minister. So we decided to change the structure of cabinet. We now have a minister for health services, a minister for health planning, a minister of state for mental health and a minister of state for intermediate, long term and home care.

A decade ago intermediate and long-term care was identified as a huge problem in B.C. yet nothing happened. The previous government announced a mental health program and then didn't fund it.

We're going to make sure that the things we know are going to provide long-term benefits are actually on the agenda. That’s why we have to have strong advocates and voices at the cabinet table. In the last year we've announced a $263- million action plan to revitalize services and facilities for people with mental health problems. Mental illness is a problem that is too often put in the back closet. We don't understand it, the public doesn't understand it. It's frustrating and it's frightening and we say, maybe we can forget it. Well, we can't forget it because it's generating all sorts of pressure throughout the system.

We also made a start on meeting our intermediate and long-term care objectives. We announced that we would be building 5,000 new community care spaces over the next five years, and we are going to reach that goal. This will reduce the pressures on the acute care system.

We haven't gotten used to talking about what is an appropriate level of care. Let me ask you to look at the person next to you, and tell me if they look like they're getting younger. That's the kind of pressure that we have to deal with. The largest percentage of health care dollars are spent on the last year of life.

No matter how healthy we are, we're going to get to that last year of life. We haven't given people the tools they need to make their own decisions about what happens in their last years. What we end up with is a society that tries to make horribly difficult choices for people and we expand our costs enormously.

Dr. Meloy from McMaster University in Hamilton says that when we get authority to act on our own behalf we can actually save the system a fortune. How many people look forward to spending the last year of their life in a hospital setting? Most people would like to be independent as long as possible and remain in their homes. When they can't, they may have to move somewhere else.

My mom was in a single-family home in Vancouver and got to the stage where she couldn't keep it up. She then moved to a condominium in Vancouver, which happened to be outside the community where she had raised her family. Things started to change. She become more and more isolated as her social connections started to go. We sat down as a family and she decided to move into intermediate care facility for independent living, where people are allowed to make their own decisions.

My mom moved in there about 18 months ago and her health – her mental health, her intellectual acuity, everything – is up because they gave her the support she needed. I know that if we'd put her in a hospital she would have kept on going downhill.We put her in this facility and suddenly she's my mom again – lively, talkative, it's great.

We need to think about how we can provide that to people in communities all over the province. We've invested in the creation of more caregivers, more nurses and doctors. We've just announced that we're going to create the BC Life Sciences Centre, which will almost double the number of physicians that we graduate in British Columbia.

The center will be at UBC, and there will be a collaborative campus at the University of Victoria, specializing in geriatric medicine, and another collaborative campus at the University of Northern British Columbia, specializing in rural and remote medicine, as well as the development of e-health initiatives.

We have also provided special bursaries for nurses and doctors going to rural and remote parts of our country. If they serve five years in a rural or remote institution, their students loans will be forgiven at 20 per cent a year. And as we move forward you are going to see

accountability contracts in place – provincewide standards of care, regardless of the region that you live in.

I mentioned earlier that we had 52 health regions in the province. We brought them down to six. For the first time, every region of the province will be represented by a provincial health authority so we can talk about how we deliver care.

One of the tools we can use is what you may call tele-health or e-health.

In February we announced the $8-million BC tele-health program, including an emergency/trauma program that connects Terrace and Cranbrook with our larger care centres on a 24/7 basis. In its first month of operation we were able to treat 17 seriously ill or injured patients in their own communities through tele-health.

Let me give you an example. A man was in a car accident the day before his 60th birthday. He had two leg fractures, a dislocated shoulder and a possible broken clavicle. Normally his physician would have immediately called the air ambulance and sent him to Vancouver. Because of the new tele-health project, his physician was able to connect with specialists, who were able to provide service. The man ended up getting the care he needed, and he was in his home community on his birthday. What's great about that is he got a better quality of care: he stayed in his community where his family supported him – and we saved the government $30,000.

When we say we're saving money in our health care budget that doesn't mean we don't spend it. We're saving money so that we can focus dollars on patient care.

For the first time, we've told to health authorities what they're going to get over the next three years. Believe it or not, just two years ago health authorities didn't get their budgets until six and a half months into the budget year. We will have saved 43 per cent on administrative costs, because we actually believe people in the regions of the province can spend those dollars better on patients. .

The second e-health initiative we've undertaken is the BC Bed Line, a provincial bed management system instituted last September. We'd been told by physicians all over the province that they were spending hours trying to find a bed. The BC Bed Line has a Web site registry and a 24-hour call center. We've already had 2,200 calls on the bed line and it makes a huge difference in the management of the system.

We believe all of these things are steps in the right direction. We also believe that we are fortunate to have 10 provinces in Canada, because different provinces may try different programs and it really takes no effort to share what works with the other provinces so their patients can benefit.

We are going to continue to work to build a health provider registry that connects the network of caregivers across the province and indeed across the country. At the premiers conference in January we agreed to work with the Canadian Institute of Health

Information on an across-Canada human resource database. Human resources are a critical component of health care. We need to know what kinds of training and education are needed to provide the quality of care that patients deserve.

We have also made significant changes in how we're dealing with issues like pharmacare. We changed our pharmacare system so that the 238,000 lowest income British Columbians had their drug costs reduced. We agreed in January to work together not just to share human resource development but also to look at how we could manage pharmacare costs, to make sure that the dollars we're spending are maximized.

In the last 15 years health care spending has tripled in British Columbia, and I'm sure the statistics are similar in other provinces. Health spendingin British Columbia now accounts for all of our revenues from personal income tax, all of the dollars we get from federal CHST transfers, all of our tobacco tax, all of our MSP premiums, and more than half a per cent of our provincial sales tax.

So we have a challenge in front of us, and our challenge is to tap into the expertise of people like you. It's to make the system open enough that we actually can learn. It's to take the myths that are holding us back and hold them up to the light of fact and ask ourselves how we meet patients' needs and how we use new technologies and new information to develop the kind of factual based review that gets the outcomes we want.

We have enormous assets in health care in Canada but we are in danger of losing those by not being willing to ask fundamental questions of ourselves and of our institutions. We have to be willing to look at the results of that questioning in terms of what will be best for people, not just what's best for a provincial or federal government but what's best for you and your family when you're sick and you need care.

How can we focus our resources and change our institutions so they meet the needs of the people that we serve? We can't answer that question without taking a look at the new opportunities in front of us, in terms of information technology and technological improvements, and applying them to the challenges we face.

We have been given the tools. Now we have to have the courage to use them. Thank you very much.