Charting the course

Designing British Columbia's health care system for the next 25 years

BCMA Submission to the Select Standing Committee on Health
January 2012

BCMA
BRITISH COLUMBIA MEDICAL ASSOCIATION

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On June 2, 2011, the Legislative Assembly of British Columbia asked the Select Standing Committee on Health to:

1. Examine the projected impact on the provincial health care system of demographic trends to the year 2036 on a sustainable health care system for British Columbians.
2. Outline potential alternative strategies to mitigate the impact of the baby boomers on the provincial health system, and
3. Identify current public levels of acceptance toward the alternative strategies.

This is important work and the physicians of British Columbia support the Assembly's foresight on how to meet the needs of our population over the next 25 years. The critical question we must answer is, **"How do we build a health care system that will serve a population which will look dramatically different than the one it serves today?"**

Consider that:

- In 2015 one in six British Columbians will be over age 65.
- In 2018 there will be more people in BC over the age of 65 than under the age of 18.
- Between 2022 and 2036 the number of people in BC over age 80 will increase from 250,000 to 435,000.

The intent of this document is to help provide background information as the committee begins the process of investigating new strategies. Statistics are cited from agencies and provincial/federal governments, with references included. This document also includes recent public polling information on these issues conducted by Ipsos Reid, and the full report and details of the poll are also provided. Links to additional information, recommendations or papers are also provided.

1. British Columbia's population in 2036

British Columbia's growing population will undergo a significant shift in the next 25 years.[1] Overall we will see the proportion of people between 18 and 64 shrink, while those over age 65 grow dramatically. People over age 80 are the fastest growing segment of BC's population.

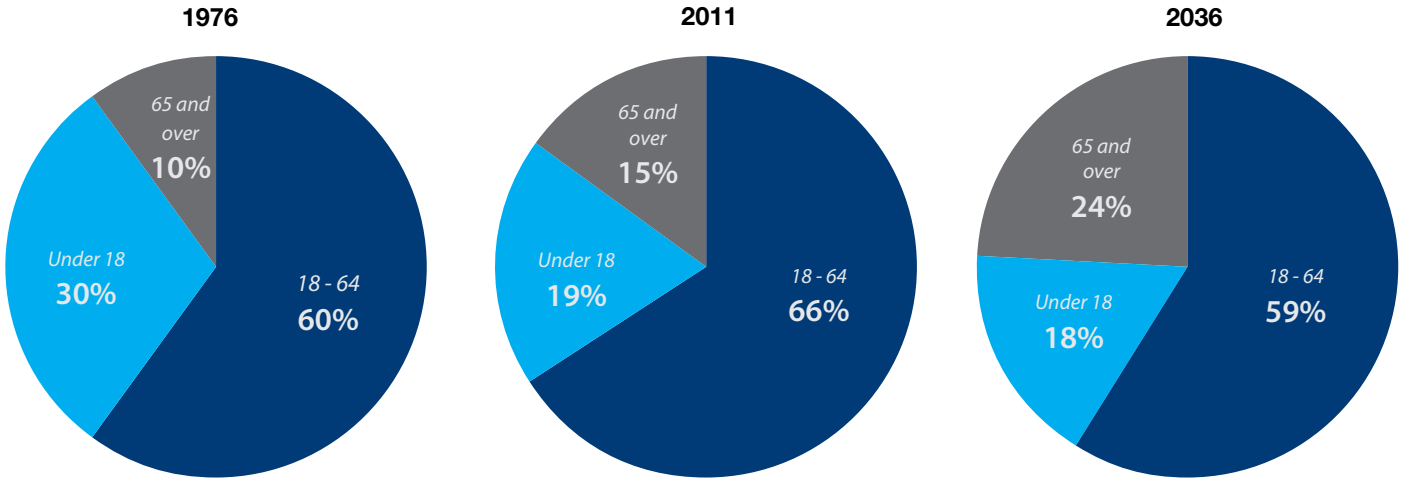
Key considerations

- In ten years over 1 million people in BC will be over age 65 (there are currently 678,000).
- BC's overall population is expected to grow at 1.2% per year, but the 80+ population is growing at 3.5% per year.
- Immigration will continue to be BC's primary source of population growth.

By 2036...

- People over age 65 will increase from 15% to 24% of total population.
- People over age 80 will increase from 4.2% to 7.4% of the total population.
- The proportion of people between 18 and 64 will drop from 66% to 59%.
- BC's population will grow by 1.2 million international immigrants and 300,000 Canadian migrants as the total provincial population approaches 6 million people.

BC population mix by age group: Year 1976, 2011 and 2036[1]



[1] *BC Stats PEOPLE 35, 2010*

Background – BC population growth

BC population, median age and mix by age group: 1980 - 2030[1]

			Percent distribution		
Year	**Population**	**Median age**	**Under 18**	**18 - 64**	**65 and Over**
1980	2.75 million	30	27%	63%	11%
1990	3.29 million	34	24%	64%	13%
2000	4.04 million	38	22%	65%	13%
2010	4.53 million	41	19%	66%	15%
2020	5.18 million	42	18%	63%	19%
2030	5.78 million	44	18%	60%	23%

BC population by health authority: 1990 - 2010[1]

	Total population			% Over 65		
	1990	**2000**	**2010**	**1990**	**2000**	**2010**
Interior Health Authority	0.56 million	0.68 million	0.73 million	14.3%	16.1%	18.6%
Fraser Health Authority	1.02 million	1.37 million	1.61 million	11.6%	11.6%	14.2%
Vancouver Coastal Health	0.83 million	1.00 million	1.14 million	13.0%	12.4%	13.0%
Vancouver Island Health Authority	0.59 million	0.68 million	0.76 million	15.9%	16.5%	18.2%
Northern Health Authority	0.28 million	0.30 million	0.29 million	5.3%	7.3%	11.1%
Total	**3.29 million**	**4.04 million**	**4.53 million**			

"The BC population will experience some significant shifts in its age structure over the next 27 years. . . . The growth in the senior population will place heavier demands on a number of societal institutions. Not the least of these is health care and housing, particularly as those 80 years and older, will make up an increasing proportion of the senior population over time."

- BC Stats PEOPLE 35, 2010

2. British Columbia's health expenditures

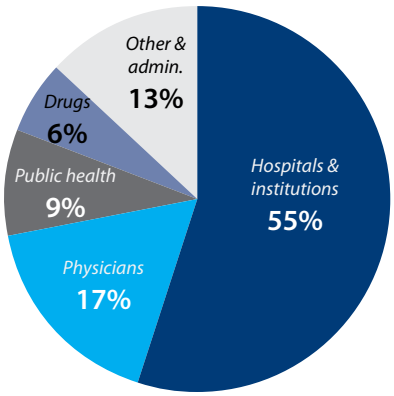
Health care is the largest public expenditure by the provincial government. In 2010 the BC government spent $16.15 billion on health care – 40% of the total provincial budget.[2]

Key considerations: 2000 - 2010

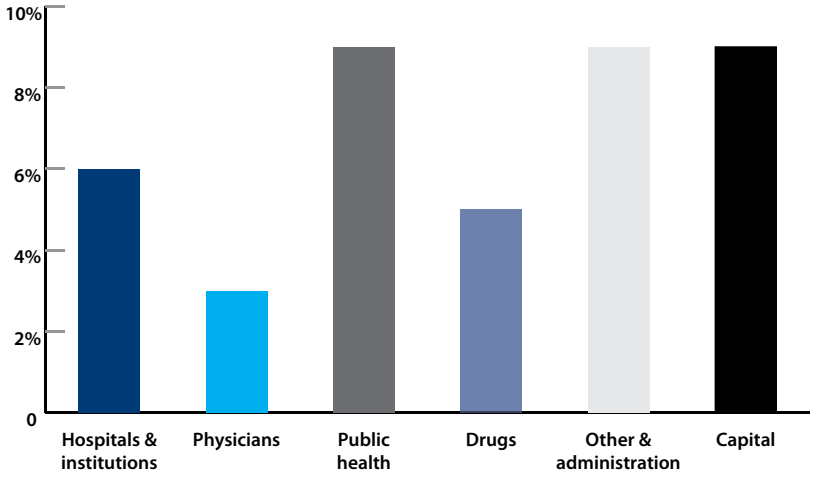
- Operating expenditures grew from $8.8 billion in 2000 to $15.1 billion in 2010.[3]
- Average growth of public health spending in BC was 5.8% per year from 2000 to 2010, the lowest of the 10 provinces (average was 7.0%). Future growth projected at 6% per year.[3]
- In 2008, the average cost of care for a person over age 80 was $15,137 each, five times the average cost of $3,333 per person.[3]

Background – Health expenditures in BC by program area and age

Provincial health expenditures 2010[3]



Average annual growth of health care costs 2000 – 2010[3]



BC public health expenditures: 2000 – 2010[3]

Category	2000	2010	% Increase	Total increase	Avg. annual % increase
Hospitals & institutions	$4.83 billon	$8.29 billon	72%	$3.46 billion	6%
Physicians	$1.93 billion	$2.57 billion	33%	$0.65 billion	3%
Drugs	$0.59 billon	$0.93 billion	56%	$0.33 billion	5%
Public health	$0.60 billion	$1.36 billion	126%	$0.76 billion	9%
Other & administration	$0.82 billion	$1.94 billion	138%	$1.13 billion	9%
Capital	$0.39 billon	$0.96 billion	143%	$0.56 billion	9%
Total	**$9.17 billon**	**$16.05 billion**	**75%**	**$6.89 billion**	**6%**

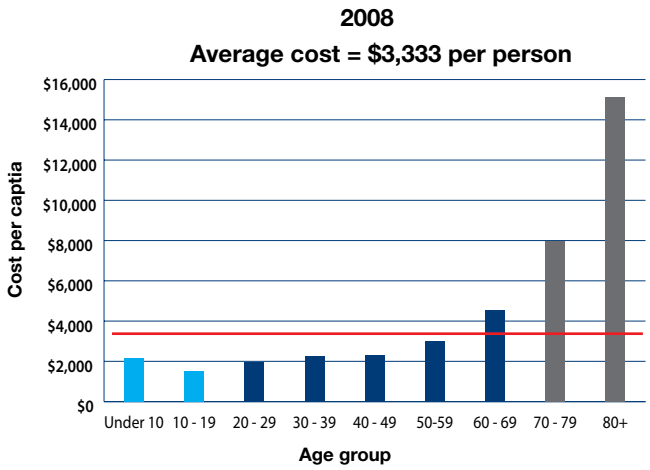
[2] *2011 British Columbia Financial & Economic Review, 71st Edition, April 2010 – March 2011. BC Ministry of Finance. July 2011. 72 pp. http://www.fin.gov.bc.ca/tbs/F&Ereview11.pdf*

[3] *National Health Expenditure Trends, 1975 to 2010. Canadian Institute for Health Information, Table D.4.10.1*

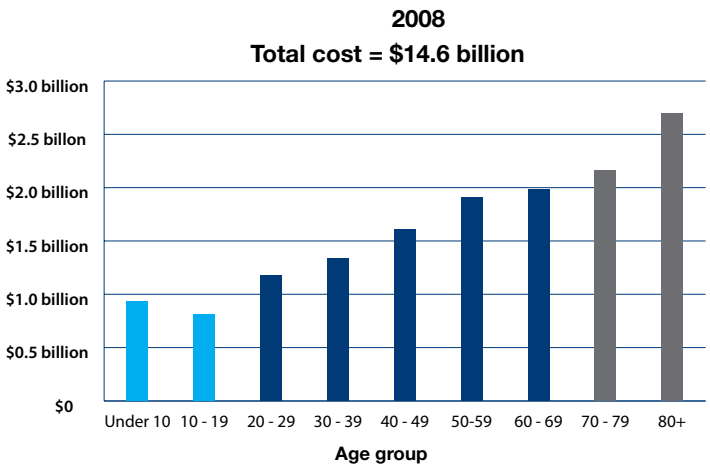
Expenditures by age group

- The average cost of public health care per person in BC was $3,333 per year in 2008[4]
- Those over age 60 account for nearly half of total health expenditures
- Patients over age 80 cost $15,137 per year
- Patients age 70 to 79 cost $7,950 per year

Average public health care costs per capita by age group[4]



Total public health costs by age group[4]



Average health cost per capita by age group 1998 vs 2008[4]

Cost per capita	Age 0 to 19	Age 20 to 59	Age 60+	All ages
1998	$959	$1,359	$5,471	$1,948
2008	$1,790	$2,390	$7,717	$3,333
Avg. annual growth	6.4%	5.8%	3.5%	5.5%
Dollar growth	$831	$1,031	$2,246	$1,385

Total health expenditures by age group 2008[4]

2008	Age 0 to 19	Age 20 to 59	Age 60+	All ages
Total expenditures	$1.74 billion	$6.03 billion	$6.84 billion	$14.62 million
% expenditures	12%	41%	47%	100%
% population	22%	58%	20%	100%

[4] *CIHI NHEX 2010. BC Stats PEOPLE 35, Provincial Expenditures by Age Cohort for 2008*

3. Chronic disease in British Columbia

While much is said about the increasing number of seniors in the BC population, the number of people with one or more chronic diseases is also increasing. This section provides a summary of the current number of British Columbians living with a chronic illness and provides a basic projection of that number to the year 2036. This section also provides a brief overview of some of the efforts already in place to assist in the management of these conditions in primary care.

Key considerations

- More than 1.3 million people in BC have one chronic condition. Over 90,000 people have four or more.[5]
- Mental health issues (depression, anxiety, and dementia) continue to be the largest diagnosed chronic health issue in BC.[6]
- By 2036 it is possible that an estimated 1 million new patients will be diagnosed with the top five chronic conditions in BC (depression, hypertension, osteoarthritis, diabetes and asthma).[6]
- A significant number of chronic conditions could be moderated by lifestyle or other changes – but not eliminated (see section 6, Prevention).

Background – chronic disease by the numbers

Below is a table of projections of conditions in BC from 2008/2009 to 2035/2036. This is a "status quo" projection that assumes prevalence stays the same and only adjusts for population growth *(no adjustments for aging are included).* The intent is to provide a straight-line, conservative projection.

Prevalent cases by disease type, BC 2008/2009 to 2035/2036[6]

Condition	2008/09*	2021/22	2035/36	Increase
Depression/anxiety	1,010,684	1,204,104	1,378,310	367,626
Hypertension	795,931	948,253	1,085,443	289,512
Osteoarthritis	353,092	420,665	481,525	128,433
Diabetes	310,762	370,235	423,799	113,037
Asthma	297,970	354,994	406,354	108,384
Osteoporosis	177,836	211,870	242,522	64,686
Ischemic heart disease	150,347	179,119	205,034	54,687
Angina (severe chest pain)	126,850	151,126	172,990	46,140
Strokes (hospital and non-hospital)	107,392	127,944	146,455	39,063
COPD (age 45+)	92,864	110,636	126,643	33,779
Congestive heart failure	86,963	103,605	118,595	31,632
Chronic kidney disease	66,471	79,192	90,650	24,179
Heart attack (AMI)	58,682	69,912	80,027	21,345
Dementia	53,538	63,784	73,011	19,473
Rheumatoid arthritis	49,973	59,537	68,150	18,177

[5] *BC Ministry of Health Services. B.C. Outlines New Vision for Primary Health Care (news release). 29 May 2007. 2007HEALTH0068-000698. www2.news.gov.bc.ca/news_releases_2005-2009/2007HEALTH0068-000698.htm*

[6] *Ministry of Health, March 2011. Note: 2021/2022 and 2035/2036 projections are calculated from PEOPLE 35 data. Population-Period is the number of people who were in BC for a full year, including births, deaths, immigration and emigration. Prevalent cases are based on an extrapolation of 2008/09 total population prevalence rates and forecast to 2035/36*

Obesity, inactivity, addiction

Many chronic conditions have factors such as obesity or inactivity as major contributors or causes. Other factors, such as an addiction, will affect the medical management of every chronic medical and mental health condition. While BC is healthier than other provinces, it is in many ways less healthy than it was a generation ago.

Obesity and inactivity

- BC has the lowest adult overweight and obesity rates in Canada at about 45%.[7] However, in 1985 only about 11% of British Columbians were overweight.[8]
- 51,000 children (7%) are obese and 138,500 (20%) as overweight in BC. The province has the lowest rate childhood obesity in the country, but falls in the middle when it comes to overweight children.[7]
- Obese Canadians are 4 times more likely to have diabetes, 3.3 times more likely to have high blood pressure and 56% more likely to have heart disease than those with healthy weights.[7]
- As many as 46% of British Columbians are not active enough to achieve the health benefits of regular activity.[9]

Addiction

- There are an estimated 400,000 people in BC today who show signs of an addiction to at least one substance. The most prevalent addicted substance is alcohol (344,000) followed by gambling (159,000), then illicit drugs (33,000).[10], [11]
- In 2006, substance abuse was estimated to cost BC $6 billion each year in direct and indirect costs. Of this 22%, or $1.32 billion, were in health costs.[12]
- A 2008 study showed that as many as one in 10 visits to Vancouver General Hospital's emergency room were for substance abuse.[13]

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[7] *BC Ministry of Health Services. Join the Conversation on Childhood Obesity (news release). 8 March 2011. 2011HSERV0012-000202. http://www2.news.gov.bc.ca/news_releases_2009-2013/2011HSERV0012-000202.htm*

[8] *Coleman R, Dodds C, Wilson J. Cost of Obesity in British Columbia. GPI Atlantic. January 2011. http://www.gpiatlantic.org/pdf/health/obesity/bc-obesity.pdf*

[9] *ActNow BC. Measuring Our Success, Baseline Document. November 2006. http://www.health.gov.bc.ca/library/publications/year/2006/ActNowBC_Baseline.pdf*

[10] *BC Ministry of Health of Health Services. Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction. May 2004. http://www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf*

[11] *Ipsos Reid Public Affairs, Gemini Research. British Columbia Problem Gambling Prevalence Study. 25 January 2008. http://www.bcresponsiblegambling.ca/responsible/docs/rpt-rg-prevalence-study-2008.pdf*

[12] *Rehm J, Baliunas D, Brochu S, Fischer B, Gnam W, Patra J, Popova S, Samocinska-Hart A, Taylor B. The Costs of Substance Abuse in Canada 2002. CCSA. March 2006. http://www.ccsa.ca/2006%20CCSA%20Documents/ccsa-011332-2006.pdf*

[13] *Brubacher JR, Mabie A, Ngo M, et al. Substance-Related Problems in Patients Visiting an Urban Canadian Emergency Department. Can J Emerg Med 2008;10:198-204*

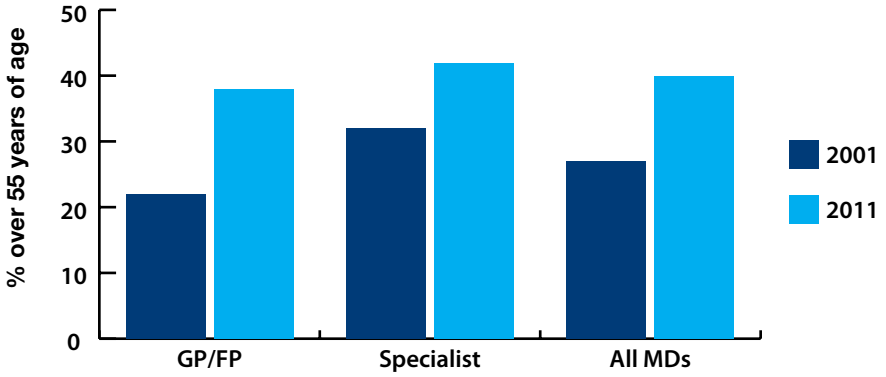
4. Physician resource planning

One of the key considerations in planning our health care system is ensuring we have an adequate number of trained health professions to provide care for the population. One of the challenges is that as our society ages, so do our health professionals. Training and recruiting health professionals takes time, and foundations need to be developed well ahead of the needs for the future to ensure the right number and mix of health professionals. This section looks specifically at physicians, but many other health professions face similar challenges.

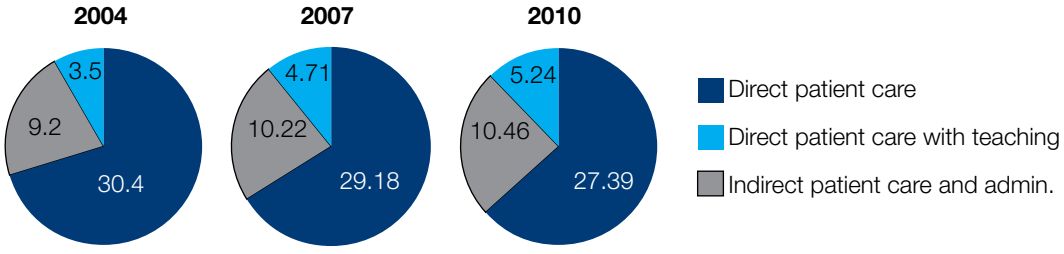
Key considerations

- In 2001 27% of BC physicians were over age 55; by 2011 this number rose to 40%,[14] and 43% of BC physicians who are 65 years or older are contemplating retirement in the next two years.[15]
- BC loses more than 400 physician each year due to attrition. BC trains 288 physicians per year, meaning BC continues to rely on recruitment from other jurisdictions to replace these physicians.[16]
- BC physicians reported that between 2004 and 2011, time on direct patient care dropped from 33.9 hours to 32.6 hours, while time on indirect care and administration increased from 9.2 hours to 10.5 hours.[17]

Percentage of BC physicians over 55 years of age: Years 2001 and 2011



Average physician hours per week direct patient care, indirect care, administration



[14] *Canadian Medical Association Masterfile, 2001 and 2011*

[15] *College of Family Physicians of Canada, Canadian Medical Association & Royal College of Physicians and Surgeons of Canada. National Physician Survey. 2010*

[16] *UBC Faculty of Medicine, http://www.med.ubc.ca/media/KGH_clinical_teaching_facility_opening.htm*

[17] *National Physician Survey, 2010, http://www.nationalphysiciansurvey.ca/nps/home-e.asp*

Breakdown of average physician weekly work hours (excluding call) in British Columbia

Activity	All BC physicians		
	2004	2007	2010
Direct patient care without a teaching component, regardless of setting	30.4	29.18	27.39
Direct patient care with a teaching component, regardless of setting	3.5	4.71	5.24
Teaching/education without direct patient care (contact with students/residents, preparation, marking, evaluations, etc.)	0.9	1.23	1.29
Indirect patient care (charting, reports, phone calls, meeting patients' family, etc.)	5.7	6.52	6.66
Health facility committees (academic planning committees)	0.8	0.97	0.76
Administration (management of university programs, chief of staff, department head, Ministry of Health, etc.)	2.0	2.0	2.06
Research (including management of research and publications)	1.1	1.33	1.03
Managing practice (staff, facility, equipment, etc.)	1.5	1.7	1.74
CME/professional development	3.0	3.02	3.01
Other (participation in professional or specialty organizations, medico-legal activities, etc.)	1.0	1.14	1.32
TOTAL	**49.8**	**51.8**	**50.49**

Source: National Physician Survey - 2004, 2007, 2010 - www.nationalphysiciansurvey.ca

Background – physician supply, training and recruitment

- **Physician workforce:** BC has 9,450 physicians including 5,139 GPs and 4,311 specialists who delivered at least one service paid on fee-for-service basis in 2010/2011. However not all physicians work full-time. Head counts can be an inaccurate means of physician workforce planning and should be used with caution.[18]
- **Aging physicians:** In 2011, 40% of all BC physicians were over 55 years old compared to 27% in 2001. 43% of BC physicians 65 years or older are contemplating retirement in the next two years.[19]
- **Undergraduate education:** The opening of another regional campus in 2011 increased first-year enrolment to 288 students across BC. In the year 2000 the medical class was 120 students.[18]
- **Residency training:** Between 2002 and 2011, the number of family practice residency positions in BC rose from 46 to 103, including 13 spots for international medical graduates (IMGs). The number of specialty residency positions increased from 80 in 2002 to 159 in 2011.[20]
- **Physician international migration:** Between 2000 and 2009 BC had a net gain of 978 physicians, largely due to the number of IMGs.[21] In 2010, 266 new IMG applicants were registered in BC, of which 175 were granted provisional registration and 91 were granted full registration.[22]
- **Physician interprovincial migration:** Between 2005 and 2009, net gains in BC ranged from a low of 26 physicians in 2007 to a high of 117 physicians in 2005. In 2009, BC gained 93 physicians through interprovincial migration.[22]

[18] *University of British Columbia Faculty of Medicine, UBC MD undergraduate program, www.med.ubc.ca/education/md_ugrad.htm*

[19] *College of Family Physicians of Canada, Canadian Medical Association & Royal College of Physicians and Surgeons of Canada. National Physician Survey. 2010*

[20] *Canadian Resident Matching Service (CARMS) 2004-2011*

[21] *Canadian Institute for Health Information. Supply, Distribution & Migration of Canadian Physicians, 2009. December 2010.*

[22] *College of Physicians and Surgeons of British Columbia. Strengthening Our Foundation – 2010 Annual Report. 2011. http://secure.cihi.ca/cihiweb/products/SMDB_2009_EN.pdf*

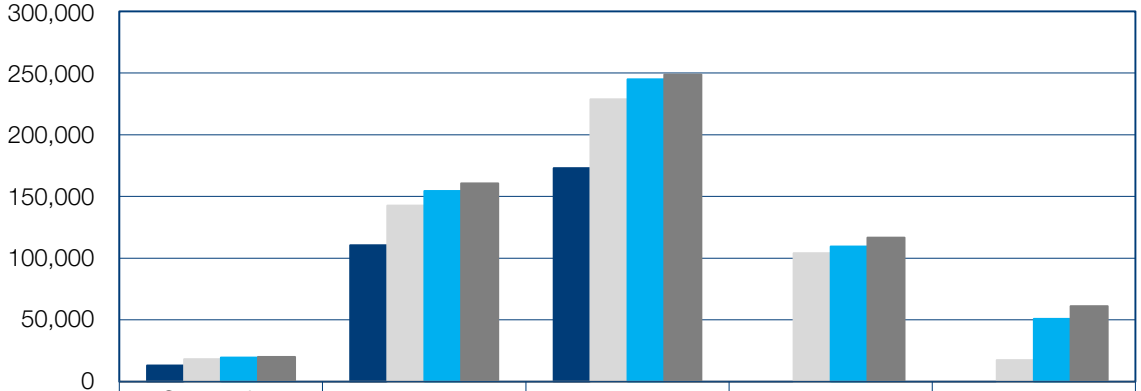
5. Primary care reform and chronic disease management

In 2002 BC initiated a joint effort looking specifically at chronic conditions and primary care. The General Practice Services Committee (GPSC) is a joint committee of the BC Ministry of Health and the BCMA. The GPSC supports primary care physicians and improves patient health outcomes in the delivery of guideline-based patient care, in such areas as chronic disease management, maternity care, mental health, and care for the frail and elderly. In these areas, BC is now seen as both a national and an international leader in primary care renewal.

Key considerations

- Today almost 600,000 patients with chronic illnesses are receiving better care as a result of GPSC programs.[23]
- 3,500 (90%) of BC's family physicians participate in these initiatives.[23]

Number of patients participating receiving care under GPSC initiatives[23]



	Congestive heart failure	Diabetes mellitus	Hypertension	Complex care	Mental health
2006/2007	12,969	110,622	172,968	-	-
2007/2008	18,101	142,584	228,719	104,147	17,390
2008/2009	19,440	154,503	245,087	109,498	50,818
2009/2010	20,071	160,728	248,769	116,769	61,054

Results

The results of these programs are significant as independent evaluation has demonstrated:

I. **Avoided health care costs (primarily reduced hospitalization and/or avoided ER visits)**

- British Columbia has the lowest hospitalization rate in Canada for seven medical conditions.[24]
- Up to $99 million in cost avoidance for patients with diabetes, congestive heart failure, and hypertension.[25]
- $10 million in cost avoidance from improved care of patients with depression/anxiety.[26]

[23] *MSP Claims, R &PB database, PHC disease registers*

[24] *Mazowita, G ,Cavers, W. Reviving Full-Service Family Practice in British Columbia, Issues in International Health Policy, Commonwealth Fund, August 2011 http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Aug/1538_Mazowita_restoring_fullservice_family_practice_BC_intl_brief_v3_CORRECTED_20110906.pdf*

[25] *Hollander MJ, Tessaro A. Evaluation of the Full Service Family Practice Incentive Program and the Practice Support Program. Presented to the BC Ministry of Health Services and the General Practice Services Committee. June 2011. 49 pp*

[26] *Hollander MJ, Tessaro A. Evaluation of the Full Service Family Practice Incentive Program and the Practice Support Program. Draft Report: Mental Health Incentives: Fiscal 2009/10. April 2011. 19 pp*

II. **Improved access**

- Family physician practices using advanced access scheduling processes have reduced wait times for appointments from 5.2 to 1.8 days.[27]

III. **Improved outcomes**

- Hospitalization days for diabetes patients of physicians using chronic disease management incentives are less than half the number for those of physicians not using the incentives.[28]
- Outcomes in congestive heart failure show a 29% drop in the age standardized mortality rate.[29]

Background – GPSC programs and initiatives

Family Practice Incentive Program
Program supports physicians who provide guideline-based primary care to patients with chronic diseases.
www.gpscbc.ca/family-practice-incentive/fp-incentive-program

4. **Practice Support Program**
Provides training sessions and resources for physicians and their MOAs to improve practice efficiency and enhance delivery of patient care. 55% of BC family physicians have participated to date.
www.gpscbc.ca/psp/practice-support-program

5. **Community Healthcare and Resource Directory (CHARD)**
CHARD provides a free, secure, web-based database for community health care referral resources. It includes all BC specialists and nearly 18,000 allied health professionals in cancer, cardiac, mental health and addiction, musculoskeletal, neurodegenerative, palliative, renal, and respiratory care.
http://info.chardbc.ca

6. **Divisions of Family Practice**
Divisions of family practice are community-based affiliations of FPs working together with Ministry of Health and their local health authority to achieve common health care goals. There are 25 divisions in BC that encompass 92 communities, and discussions are under way in up to another 12 areas of the province.
www.divisionsbc.ca

7. **Attachment**
This GPSC initiative is based on the goal of increasing the number of British Columbians who have a family physician, including those who may be hard-to-serve populations. The program does this through targeted support systems and efforts made by physicians at the community level.
www.gpscbc.ca/gp-me

[27] *Hollander M, Kadlec H. Evaluation of the Practice Support Program. Draft Report: End of Module Surveys ~ Report on the Original Four Learning Modules for the Period March 1, 2008 to March 31, 2011.June 2011. p.30. Note: refers this tracks "3rd next appointment"*

[28] *Chaudhry M. An Evaluation of Diabetes Incentive Payments in BC. Presentation to GPSC. April 19, 2010*

[29] *BC Ministry of Health Services. Primary Health Care, Medical Services Economic Analysis. November, 2009*

The following table outlines the scope of activity underway in BC per the list of chronic diseases outlined in section 3 of this report.

Programs and guidelines that support care for chronic diseases in BC:[30,31]

Chronic disease	GPSC/PSP program	BC guidelines
Depression/anxiety	Yes	Yes
Hypertension	Yes	Yes
Osteoarthritis	Coming in 2012	Yes
Diabetes	Yes	Yes
Asthma	Yes	Yes
Cardiovascular disease	Yes	Yes
Osteoporosis	No	Yes
Ischemic heart disease	Yes	Yes
Angina	Yes	Yes
Stroke	Yes	Yes
COPD (age 45+)	Yes	Yes
Chronic kidney disease	Yes	Yes
Acute myocardial infarction	Yes	Yes
Dementia	Yes	Yes
Addiction (problem drinking)	Yes	Yes

Specialist Services Committee

Not only is work being done with general practitioners, but improvements have been made through the Specialist Services Committee (SSC) to better manage patient care.

In 2010 the SSC launched new initiatives to facilitate improved communication and collaboration between family physicians and specialist physicians to help improve access and coordination of care for patients. Some of the initiatives include:

- Facilitating timely telephone calls between specialist physicians and family physicians to avoid an unnecessary referrals and emergency room visits.
- Allowing specialist physicians to conduct patient care follow-up by telephone when appropriate. This saves time for both the patient and the specialist from booking face-to-face appointments.
- Supporting specialist physicians who wish to participate in health system renewal and redesign initiatives led by health authorities.

[30] *To learn more, visit http://www.gpscbc.ca/ or http://www.gpscbc.ca/psp/practice-support-program*

[31] *BC Guidelines are developed by the Guidelines and Protocols Advisory Committee (GPAC), a joint committee of the BCMA and the Ministry of Health. GPAC has engaged practicing physicians in BC - including general practitioners and specialists - to evaluate clinical evidence, and publish clinical practice guidelines on numerous conditions, with particular focus on circumstances in British Columbia. To learn more, visit http://www.bcguidelines.ca/*

Shared Care Committee

The Shared Care Committee is a joint project between the BC Ministry of Health and the BC Medical Association, formed as part of the 2006 Physician Master Agreement. The purpose of the committee is to support family physicians (FPs) and specialist physicians (SPs) to work together to improve the flow of patients from primary to specialist care.
The committee works to ensure that:

- Primary care is delivered and managed by FPs with ready access to specialist advice and support, enabling physicians to more effectively meet their patients' primary care needs.
- By reducing the primary care currently handled in their offices, SPs are able to focus on diagnosis and treatment of more complex and complicated conditions and can be more accessible and responsive to their FP colleagues.

The benefits are two-fold

First, patients get the benefit of access to an inter-professional team that can provide coordinated, continuous, and comprehensive care from diagnosis, through treatment and recuperation. This means increased communication between specialists and family doctors and shorter waiting lists to see specialists.

Second, physicians benefit from specialists being able to spend more time on the diagnosis and treatment of more complex patients due to reduction in much of the primary care currently handled in their offices. At the same time there is an increased opportunity for specialists to provide advice and consulting services to their colleagues earlier, and to share treatment plans and follow-up requirements with FPs.

There are a number of programs underway through this committee. Some examples:

1. **Partners in Care referral program**
   This program puts in place telephone advice protocols, urgent and standard consultation mechanisms, care plans and re-referral criteria. This helps SPs and FPs coordinate care and improves access to specialist services as required. This program is underway in the Fraser Health Authority, Central Okanagan, Kootenay Boundary, Salmon Arm, South Okanagan, South Vancouver Island, and Providence Health Care. More than 1500 FPs and 125 SPs involved to date.

2. **Rapid Access to Psychiatry**
   Five psychiatrists are working in conjunction with the Mood Disorders Association of BC to change the traditional practice of care and create new capacity, with existing resources, for patients with mood disorders. With each psychiatrist working one day a week assessing new consultations and chairing one group medical visit, they're able to assess and provide care for approximately 1500 new patients a year while maintaining a follow-up cohort of 2000 patients. Demand is growing, and plans are underway to add a sixth weekly session. Group sizes range from eight to 12 patients and sessions include patients with a range of conditions, including depression, anxiety, and bipolar disorder, as well as patients with concurrent substance abuse issues and/or co-morbid psychiatric conditions.

Additional Shared Care programs

- Polypharmacy - supports physicians in identification and management of patients on multiple medications
- Transitions in Care - addresses challenges of patient transition into and out of acute care facilities
- Teledermatology - addresses access to dermatologist consults for FPs in remote or functionally isolated BC communities

6. Prevention

Prevention is a broad term that refers to the steps individuals or society can take to reduce the impact of illness on the population. Prevention takes many forms but can be summarized into lifestyle improvement (e.g., diet and exercise) and clinical prevention (e.g., screening and immunization) activities. There is significant evidence that improving both types of prevention can reduce the chance of getting a chronic illness and reduce overall costs to the health care system.

Key considerations

- People are aware of the benefits of a healthy lifestyle but many still perceive barriers, or are unwilling to change. Yet people who live a healthy lifestyle can decrease their chance of getting a chronic illness by almost 80%.[32]
- Evidence supports that when clinical preventative services, such as immunization and screenings, are done age appropriately, society can significantly reduce the burden of illness. These services are also very cost effective.[33]
- When elements of good primary care are in place, patients are more likely to receive evidence-based preventive care.[25,26,27]

Background – public opinion and evidence on prevention

A January 2011 poll conducted by Ipsos Reid found that:[34]

- 88% of British Columbians think adult obesity is cause for concern and 86% believe childhood obesity is a serious problem – however most parents said their own child's activity levels and eating habits were not a problem.
- 48% of British Columbians are satisfied with their weight and 45% satisfied with their level of fitness.
- The most common form of exercise among respondents is walking at 49%. Only 9% go to the gym, play on team sports, swim, or golf.
- The most common reason for not exercising was the lack of time, with lack of energy coming a close second. The main reason British Columbians said they were not eating healthier was that it is more expensive to do so and unhealthy food is easier to access.

Lifestyle improvement

A European study found that individuals who adopted healthy lifestyles (i.e., do not smoke, are physically active, and eat healthy foods) significantly reduced their risk of being diagnosed with a chronic disease (i.e., diabetes, coronary heart disease, stroke, and cancer) between 49% and 78%.[35]

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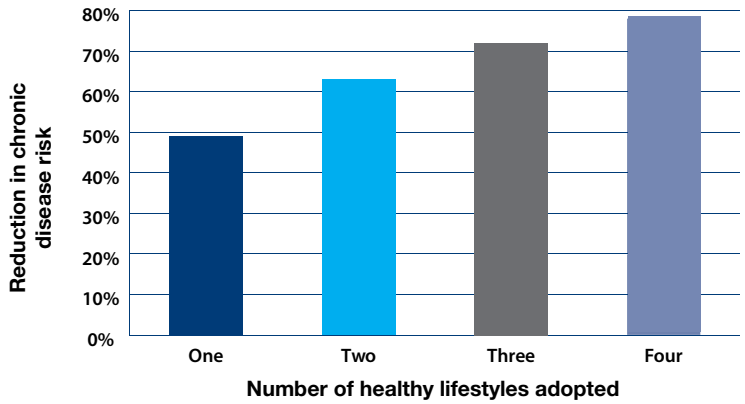
[32] *Ford ES, Bergmann MM, et al. Healthy Living is the Best Revenge: Findings from the European Prospective Investigation Into Cancer and Nutrition-Potsdam Study. Arch Intern Med 169(15): 1355-1362. 2009. http://archinte.ama-assn.org/cgi/content/full/169/15/1355*

[33] *Krueger H. Part II: How Best to Implement? Establishing Clinical Prevention Policy in British Columbia. H. K. Associates. Vancouver, Centre for Health Services and Policy Research: 64.2007*

[34] *Braid K. BC Reid Express Omnibus Survey of the BC Adult Population. I. Reid. Vancouver. 2010*

[35] *Ford ES, Bergmann MM, et al. Healthy Living is the Best Revenge: Findings from the European Prospective Investigation Into Cancer and Nutrition-Potsdam Study. Arch Intern Med 169(15): 1355-1362. 2009. http://archinte.ama-assn.org/cgi/content/full/169/15/1355*

Chronic disease: Reduction in risk



Clinical prevention

A recent review conducted on behalf of the BC Ministry of Health examined 30 studies of clinical preventive services.[35] In the study, the majority of evidence came from services provided by physicians or in physician-led practice settings. Patients have expressed a preference for receiving care from their physician. An August 2011 survey of the BC population from Ipsos-Reid found that 78% want their GP to coordinate their care. The following table provides a list of the rankings of the most effective services based on their clinically preventable burden and cost-effectiveness.

Rankings of preventative services

Clinical preventive service	Ranking	
	Based on BC data	Based on US data
Discuss daily aspirin use – men 40+, women 50+	1	1
Smoking cessation advice and help to quit – adults	2	2
Alcohol screening and brief counselling – adults	3	3
Hypertension screening and treatment – adults 18+	4	5
Colorectal cancer screening – adults 50+	5	4
Influenza immunization – adults 50+	5	6
Cholesterol screening and treatment – men 35+, women 45+	7	10
Pneumococcal immunizations – adults 65+	8	7
Cervical cancer screening – 20-75	9	9
Breast cancer screening – women 40+	9	7

7. Public opinion – What do British Columbians think?

The following is the complete report by Ipsos Reid regarding polling conducted in August 2011.

Ipsos Reid

Public Views of Health Care in BC

Vancouver, BC – This report presents the findings of a new Ipsos Reid poll in British Columbia that was conducted on behalf of the BC Medical Association (BCMA).

Top issues in health care

Top of mind issues

Wait times and doctor shortages are the two biggest top-of-mind problems or challenges that British Columbians think are facing health care in their province today. One-in-four (25%) residents mention "wait times/ waiting lists" while nearly two-in-ten (18%) mention "doctor shortages". Other top-of-mind health care issues include "aging population" (10%), "general staffing shortages" (9%) and "hospital overcrowding/ lack of beds" (8%).

Prompted issues

Similar items top the issue agenda when respondents were asked to select three items from a list of seven possible priorities for helping BC's health care system deal with the impact aging boomers will have on the system in the next few years. Number one on the priority list is "reducing surgical waitlists" which is selected by two-thirds (64%) of British Columbians as a top-three priority. Next highest is "ensuring everyone has a family doctor" (49%) and "ensuring quick access in emergency rooms" (43%).

Lower ranked priorities include "expanding prevention services" (35%), "building public long term care beds" (30%), "expanding prescription drug coverage" (30%) and "ensuring rural areas of the province have greater access to care" (27%).

Differences across demographics include the following:

- "Reducing surgical waitlists" is more likely to be selected by older residents (70% among 55+ years vs. 60% among 18-34 years, 63% among 35-54 years).
- "Ensuring everyone has a family doctor" is more likely to be selected by Vancouver Island residents (60% vs. 47% in Metro Vancouver, 45% in Interior/North) and women (53% vs. 44% of men).
- "Ensuring quick access in emergency rooms" is more likely to be selected by younger residents (45% of 18-34 years, 49% of 35-54 years vs. 35% of 55+ years).
- "Expanding prevention services" is more likely to be selected by older residents (36% of 55+ years, 38% of 35-54 years vs. 29% of 18-34 years).
- "Building public long term care beds" is more likely to be selected by older residents (37% of 55+ years vs. 23% of 18-34 years, 29% of 35-54 years).
- "Ensuring rural areas of the province have greater access to care" is more likely to be selected in the Interior/North (37% vs. 23% on Vancouver Island, 22% in Metro Vancouver).

Provincial government performance and spending

Health care approval

British Columbians generally disapprove of the job the current provincial government is doing when it comes to managing health care in British Columbia. Only one-third (35%) of residents say they approve of the government's performance, including 4% who 'approve strongly' and 31% who 'approve somewhat'. Six-in-ten (60%) say they disapprove, including 27% who 'disapprove strongly' and 33% who 'disapprove somewhat'.

- Government approval on health care is higher among men (42% vs. 28% among women).

Health care spending

British Columbians are split on the idea of whether the provincial government should set a limit on health care spending so that it does not increase beyond 50% of the budget. Nearly half (45%) of residents say they support this limit on spending, including 11% who 'support strongly' and 35% who 'support somewhat'. Four-in-ten (40%) oppose a 50% spending limit, including 16% who 'oppose strongly' and 24% who 'oppose somewhat'. Fourteen percent of British Columbians are undecided about this idea.

- Support for a 50% spending cap is higher among men (52% vs. 39% among women).

Personal health care accountability

Overall views

British Columbians are generally supportive of the provincial government taking action to make people more responsible for their own health. Three-quarters (76%) of residents agree that "the provincial government should do more to hold British Columbians accountable for the decisions they make that impact their personal health," including 28% who 'agree strongly'. Only two-in-ten (19%) disagree that the provincial government should be doing more in this regard (7% 'disagree strongly').

- Agreement with this statement is higher among men (81% vs. 70% among women).

Support for specifics

While British Columbians generally support the provincial government doing more to hold British Columbians accountable for their health related decisions, there is some variation in support depending on how that accountability is enforced or encouraged.

The vast majority of British Columbians like the idea of the government using financial incentives with nearly nine-in-ten (86%) agreeing "the provincial government should offer more financial incentives (e.g., tax credits and rebates) to encourage British Columbians to engage take actions that improve their health" (45% 'agree strongly'). Only 11% of residents disagree with this idea (2% 'disagree strongly').

A lesser majority, but still two-thirds (67%) of residents agree with using financial disincentives, as in "the provincial government should use more financial disincentives (e.g., tax surcharges) to encourage British Columbians to avoid actions that might worsen their health" (25% 'agree strongly'). About one-quarter (26%) disagree with using more financial disincentives (11% 'disagree strongly').

And residents are divided down the middle as to whether access to care should be restricted for those who knowingly engage in risky behaviours. Half (50%) agree that "in some cases, access to health care should be restricted for British Columbians who have engaged in behaviours known to put their health at risk" (16% 'agree strongly'), while 44% disagree with this idea (19% 'disagree strongly').

- Agreement with this statement is higher among men (57% vs. 43% among women).

Family doctors

Preferred first point of contact

Six-in-ten (62%) British Columbians say they want a 'doctor' as their first point of contact with the health care system. This places doctors well ahead of 'nurses' (13%), 'nurse practitioners' (12%) and 'pharmacists' (2%).

Preferred personal health coordinator

Nearly eight-in-ten (78%) British Columbians say they would most like to have a 'family doctor' coordinating their overall health care. This puts family doctors far ahead of 'nurse practitioners' (7%), 'nurses' (3%) and 'pharmacists' (1%).

Regular family doctor

Roughly one-in-ten (11%) British Columbians say they do not have a regular family doctor, but are looking for one. Eighty-three percent have a family doctor and 6% have no family doctor and are not looking for one.

- Younger residents are the most likely to be looking for a family doctor (17% among 18-34 years vs. 12% among 35-54 years, 3% among 55+ years).

These are the findings of an online Ipsos Reid poll of 822 adult British Columbians conducted using Ipsos Reid's online household panel between August 16 and 22, 2011. A survey with an unweighted probability sample of this size and a 100% response rate would have an estimated margin of error of ±3.5 percentage points, 19 times out of 20. The margin of error would be larger within regions and for other sub-groupings of the survey population. These data were statistically weighted to ensure the sample's regional and age/sex composition reflects that of the actual BC population according to 2006 Census data.

For more details on this release, please contact:

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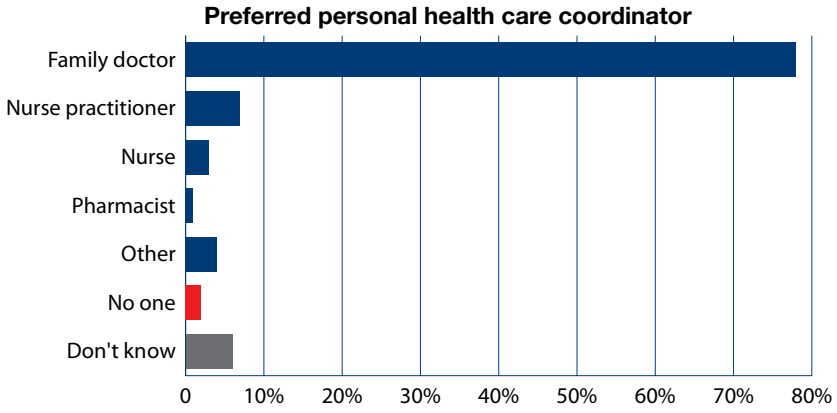
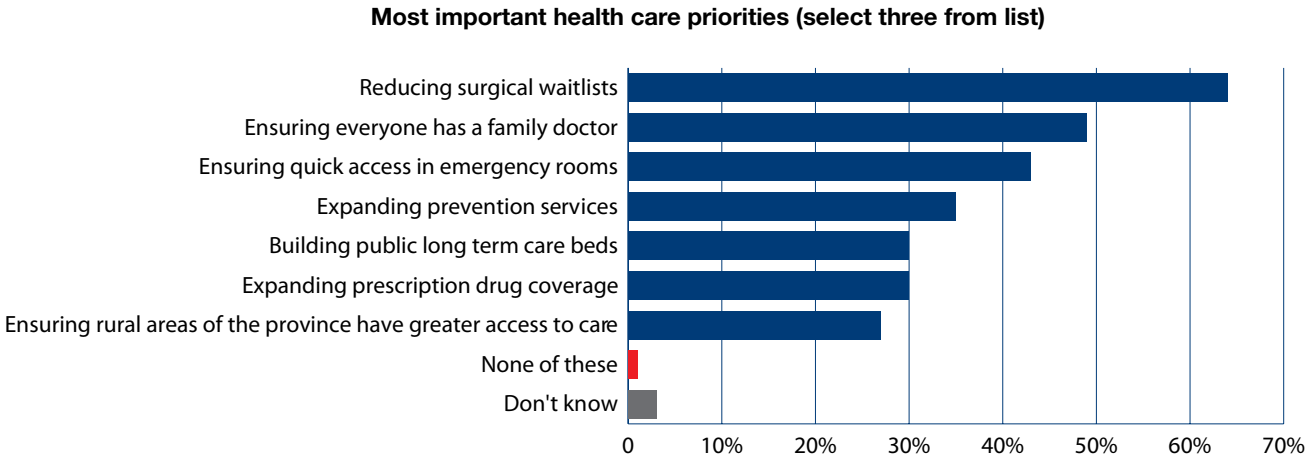
British Columbians want their family doctor to coordinate their overall health care.



Q. Which of the following would you most like to have coordinating your overall health care?

Base: All respondents (n=822)

On prompted basis, reducing surgical waitlists is top priority of British Columbians.



Q. The provincial legislature is currently looking at ways to help BC`s health care system deal with the impact aging baby boomers will have on the system in the next few years. While all of the items below are important, which three do you consider to be the most important priorities?

Base: All respondents (n=822)

Ipsos Reid

For full tabular results, please visit our website at **www.ipsos.ca.**
News releases are available at **www.ipsos-na.com/news.**

8. Recommendations

There is no single change that will solve the challenges in the health care system. Rather, to sustain and transform our system, there will need to be a series of changes ranging from system wide to the individual daily choices by British Columbians. Our system must continue to evolve from a reactive health care system to one that is proactive. Given the costs of long-term treatment of chronic conditions, we must do what we can to prevent or stave off those conditions for as long as possible as well as be prepared to care for what can't be prevented. This means we must move to a system that acts early and often. The evidence is overwhelming – early intervention, screening and treatment in almost every case reduces overall costs and improves outcomes and satisfaction for patients. British Columbians must also be encouraged and supported to make healthy lifestyle choices and increase their physical activity.

Over the past decade the BCMA has developed numerous papers and dozens of recommendations for reforming our system based on input from practicing front-line physicians. The following list of recommendations are the top level recommendations to help the initial discussion, and links to additional information.

I. Budgeting

The Select Standing Committee is responsible for looking at ways to ensure we have a sustainable health care system. There are clear fiscal challenges for the system – but we also need to look at how funding is budgeted and managed. For example, a significant amount of funding in our system is provided by block or global funding such as in hospitals and health authorities. This method does not reward improved access, outcomes or provide accurate accounting of the costs of care. Yet block funding is how the bulk of the health care system is funded. Lastly, sustainability must not be considered strictly as a financial issue, but must also include factors such as infrastructure, human resources and patient outcomes.

> **The BCMA recommends**
> Continuing to implement and expand patient-focused funding.

For more information please see:

- **Valuing Quality – Patient-Focused Funding in British Columbia** (Sept 2010)
- **Physicians Speak Up – BCMA Submission to the Conversation on Health** (June 2007)

II. Public health and lifestyle

One of the greatest challenges and opportunities in the years ahead relates to the scale of preventable illness in BC. Even with all the recent efforts, BC's population is in many ways unhealthier than it was a generation ago. Simple actions such as eating healthier, maintaining a healthy weight, and daily exercise can significantly reduce the onset of chronic illness. At the same time clinical prevention efforts can be undertaken to reduce and better manage chronic illnesses in our population.

The BCMA recommends

Pursuing and expanding healthier lifestyles options and clinical prevention strategies where there is the most significant impact, such as obesity, inactivity, mental health and chronic diseases of the circulatory system.

For more information please see:

- **General Practice Services Committee (www.gpscbc.ca)**
- **Partners in Prevention: Implementing a Lifetime Prevention Plan** (June 2010)
- **Stepping out of the Shadows: Collaborating to Improve Services for Patients with Depression** (August 2009)
- **Stepping Forward: Improving Addiction Care in BC** (March 2009)

III. Acute and community infrastructure

It is hoped that through our actions today our future seniors will be healthier. Given the sheer number of those over age 80, however, it will also be important for BC's health care system to adequately support British Columbia's frail elderly and other dependent people who require help with their day-to-day living. If not, costs will simply accrue in other forms that are potentially avoidable, such as hospital and emergency visits. As our population ages, the types of services and supports required to care for them will change. Moving forward, our system needs to reinvest, update and transform health infrastructure to adapt to the changing needs of BC's growing and aging population.

Changes must be made on a number of levels. Our system must continue to increase capacity in surgical and long-term care capacity. With an older population, the impact of longer wait times will also increase. Our system also needs to explore ways to support British Columbians at home so as to be less reliant on hospital infrastructure when care at that level is not required. The current levels of long-term, community and home-based care are not sufficient to meet the needs of our population today. Yet these services are the most cost-effective to maintain quality of life.

The BCMA recommends

The Province should continue to invest in health capital construction and community-based programs in order to meet the needs of our population. This includes updating current facilities and adding flexibility and capacity to areas such as surgical and long-term care services.

For more information please see:

- **Enhancing Surgical Care in BC: Improving Perioperative Quality, Efficiency, and Access** (June 2011)
- **Bridging the Islands: Re-Building BC's Home & Community Care System** (May 2008)
- **Improving Access to Acute Care Services** (August 2008)

IV. Health human resources

Health human resources will continue to be a significant challenge in the years ahead. Despite recent increases in training, BC continues to face the challenge of an aging physician population, growing demand and increasing patient expectations. BC will need to ensure it is involved in provincial and national physician workforce planning in order to provide the right number and mix of physicians. This includes ongoing reviews of recruitment, retention and retraining programs in the province.

Caution must be used when using simple head counts or per capita numbers for planning purposes. This will not provide a full depiction of physician supply because it implies that all physicians are equal in terms of their capacity to provide services. Physician headcounts must be considered in the context of other factors, including different workloads (e.g., part-time, full-time) and practice activities (e.g., clinical, teaching, administrative, research).

On average, physician workload is decreasing as younger physicians are adopting a different work/life balance than their predecessors. In addition, there are more women in medicine, which is positive. However this comes with its own challenges. For example, female physicians with children under the age of 6 work 24% less than their male counterparts. As the number of female physicians continues to increase, we will need more physicians to maintain current volume and service levels.

The BCMA recommends

Physician workforce planning should be better coordinated provincially and nationally to ensure BC has the right number and mix of physicians.

For more information please see:

- **Doctors Today and Tomorrow: Planning British Columbia's Physician Workforce** (July 2011)
- **Medical Student and Resident Debt Relief** (August 2010)
- **Working Together: Enhancing Multidisciplinary Primary Care in BC** (October 2005)
- **Joint Standing Committee on Rural Issues**[36]

V. Prescription drugs

Concern over prescription drug policy in BC is fuelled primarily by the growth in expenditures. Prescription drugs constitute one of the fastest growing components of health care expenditures. Of course, increases in prescription drug use and expenditures per se are not necessarily problematic. In many cases, the health of the population benefits from increased prescribing. In other cases, additional spending on prescription drugs may represent a poor investment. The challenge for health care policymakers is to determine if and when the investment in prescription drugs, particularly in light of continued growth, is worth the expected return.

Given the complexity of these issues, the key factor is ensuring coordination of efforts are done in way so that appropriate consultation occurs, and that the right information is provided to health professionals in the most effective manner.

The BCMA recommends

The provincial government should work with physicians and other health professionals to ensure patients are receiving the best possible outcomes from medications. At the same time the province should continue to pursue the greater overall efficiencies in terms of cost and supply of medications given current trends.

[36] *http://www.health.gov.bc.ca/pcb/rural.html, http://www.health.gov.bc.ca/library/publications/year/misc/rural_programs.pdf*

For more information please see:

- **Promotion of Prescription Drugs** (November 2010)
- **A Prescription for Quality: Improving Prescription Drug Policy in BC** (July 2007)

VI. Public funding of health care services

The foundation of our public health care system — the Canada Health Act (CHA) — dates back to 1984. It covers only doctor and hospital care and no longer reflects the needs of an aging population nor advances in medical technology. The CHA principles must be modernized to remain meaningful in today's health care environment.

Although BC has incorporated the principles of the CHA into the Medicare Protection Act (1996), the provincial government does not have the ability to independently alter these principles. It is, therefore, understood that action in this area would require dialogue and support from other provinces, in addition to the federal government.

The BCMA recommends

The Canada Health Act (CHA) principles of accessibility and comprehensiveness must be strengthened. This includes expanding services offered under the CHA to include such things as pharmaceuticals and long-term care, as well as introducing evidence-based wait time benchmarks for the timely delivery of health care services.

For more information please see:

- **Physicians Speak Up – BCMA Submission to the Conversation on Health** (June 2007)
- **Canada Health Act backgrounder** (July 2011)

Notes

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