OBTAINING EFFECTIVE MEDICAL INPUT INTO REGIONAL DECISION-MAKING

A Report by BC's Physicians

October 2000

EXECUTIVE SUMMARY

11 Regional Health Boards (RHBs) and 34 Community Health Councils (CHCs) were established in BC on April 1, 1997. These health authorities are responsible for the funding and governance of acute, long-term, and community-based health services and, collectively, allocate more than half of the BC health budget (more than $4.5 billion of a total $8.1 billion).

The ongoing lack of effective public and professional input into regional health care decision-making is of considerable concern. For example, although RHBs/CHCs have been in place for more than 3 years, at time of publication 6 of BC's health authorities still do not have functioning Regional Medical Advisory Committees (RMACs). Many RMACs have only recently been struck and there remain significant concerns regarding composition and the lack of a direct reporting relationship to the health board. Prior to regional governance, all BC hospitals had functioning Medical Advisory Committees that reported directly to the Board. This marks a significant loss of practising physician input into quality of care and policy decisions at the local level. The RMAC is a critical source of input into regional decision-making and, to be effective, must include a direct presence at the Board level. Experience in other jurisdictions has shown that, unless effective practising physician input is obtained, local health care governance cannot succeed.

Several medical decision-making structures exist, both locally and provincially, that must be incorporated into the regional health decision-making process. These bodies include local medical staffs, regional medical advisory committees (RMACs), local medical societies, and the BC Medical Association (BCMA). In addition to negotiations, which tends to draw most of the public's attention, the BCMA is a long-standing source of expertise in health policy development, communications, economic analysis and professional relations. The BCMA is an integral provincial resource for both practising physicians and regional health authorities. Local health decision-making can be enhanced through the input of the BCMA.

On a positive note, and as a result of significant public and provider pressure, BC's health authorities now include a physician as a voting member on the board of governors. This has served to improve the Boards' understanding of the implications of their decisions with respect to quality of care. Unfortunately, there is little transparency and considerable uncertainty regarding the re-appointment process of these physician representatives. It is crucial that physician board members have the confidence of their medical staff(s) through direct election by their peers.

To date, de-centralized health governance in BC has created considerable uncertainty regarding the decision-making process. It is recognized, however, that regionalization is also an opportunity for strategic alliances between the medical profession and regional health authorities. It is essential that both groups recognize each other's integral role and expertise in BC's evolving health system. We must collectively make strides to regain the necessary level of public and professional input into local decision-making to ensure the quality of patient care and the best use of scarce health care resources.

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This paper was commissioned by the British Columbia Medical Association Board of Directors in response to growing concerns over the lack of professional and public input into local health care decisions.

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LIST OF RECOMMENDATIONS

1. *That Regional Health Boards/Community Health Councils (RHBs/CHCs) involve actively practising physicians in health care decision-making including planning, management, and operational decisions.*

2. *That local physicians elect the physician representative on each RHB/CHC.*

3. *That the Ministry of Health require RHBs/CHCs to implement functional Regional Medical Advisory Committees (RMACs). RMACs must report directly to the Board and be comprised of actively practising physicians the majority of which are elected by their peers, including the chair.*

4. *That Regional Medical Advisory Committee (RMAC) Chairs must be actively practising physicians whose primary activities are the practice of medicine, not administrative duties. Furthermore, physicians who are full-time employees or members of the Board must not be RMAC Chairs.*

5. *That any recommendations coming forth from Community Health Advisory Committees to RHBs/CHCs be reviewed by competent medical personnel capable of providing high quality, evidence-based medical advice prior to being forwarded to the Board.*

6. *That, wherever program management is instituted, RHBs/CHCs include practising physicians in the management structure and ensure that programs are in keeping with departmental policies and rules.*

7. *That physicians be paid for their administrative functions at the local level.*

8. *That reference to the CMA Physicians' Charter be incorporated into all regional medical staff bylaws.*

LOCAL MEDICAL INPUT

Practising physicians are an integral component of the fabric of our health care system. In addition to their traditional clinical roles, physicians play important roles in monitoring the quality of care, human resource planning, utilization management and strategic planning. The need for practising physician involvement in regional decision-making is evidenced by the professional responsibility placed upon physicians and the legal framework in which physicians practice.

In 1998, the UBC Institute of Health Promotion Research surveyed regional authorities in BC. Health board members were asked to indicate various stakeholders' levels of support for RHB/CHC decisions. Those groups perceived to be least supportive were consumer groups (27%), the general public (26%), and physicians (25%) (Frankish et al. 1998). It is noteworthy that board members indicated that they felt that health care providers were under-represented, and should have "better communication, more involvement, and greater input" into regional decision-making. (p. iii)

Historically, BC hospitals received medical input through three primary channels: Medical Advisory Committees (MACs), the medical staff, and local medical societies. It is ironic that the Seaton Royal Commission (1991) and others have proclaimed the British Columbia health care system to be one of the finest in the world. This is despite the fact that at its very foundation, the medical input that has served the system so well for more than a century, is now being increasingly ignored. These channels must be maintained for health care to remain progressive and effective in British Columbia.

Practising physician input is necessary for effective regional decision-making that adequately accounts for patient needs. It is recognized that the addition of a physician appointee on each regional health authority in BC is an improvement from no physician representation. However, strong concerns remain regarding the appointment process for these physicians. Moreover, the physician representative on each health authority is not intended to represent the local medical community to the Board of Directors. It is imperative that a local practising physician elected by his/her peers, such as a regional MAC chair and/or president of the medical staff, attend and present regular reports to the regional board.

The Role of the Physician

Whether one views health care from a geographic, population, facility, or individual perspective, physicians serve several functions:

- providers of medical care,
- advocates for patients,
- overseers of the quality of medical care,
- explorers of new medical and surgical therapies and techniques,
- teachers,
- managers of medical programs,
- planners for medical services, and
- act as members and leaders within the community

Physicians perform some of these functions individually and others collectively. Overseeing quality of care, managing programs, and planning services are often done collectively, e.g. by medical advisory committees. Larger representative groups, including the BC College of Physicians and Surgeons and the BCMA, also undertake some functions on behalf of physicians.

Health care governors and administrators rely upon practising physicians to provide these necessary services. The public also depends upon physicians to ensure that high quality medical services are readily available and that facilities and organizations are capable of delivering needed medical care in an effective manner. This is particularly important in recent years, when fiscal restraint has been the principal emphasis in health care policy.

The American government's principal role in health care policy is regulation, rather than the direct provision and/or funding of health care services. These three roles are not as blurred in the United States as they have become in Canada, where regulators are often in a conflict of interest because of their extensive involvement in the provision and funding of health care. All three roles must be recognized as important balancing forces in the development and provision of high quality health services to the public. All complex public programs require ongoing feedback mechanisms that prevent any of these major roles from becoming dominant and thereby destroying the overall program. Practising physician input is critical to the long-term survival of British Columbia's health care system, just as an effective Official Opposition is essential to parliamentary democracy.

Physicians' Charter

In 1998, the CMA published the Physicians' Charter, intended to inform on the rights and responsibilities of practising physicians *(refer to Appendix B)*. The BCMA has included this Charter in its template regional medical staff bylaws. This Charter must be supported at the local level.

BC's REGIONAL GOVERNANCE MODEL

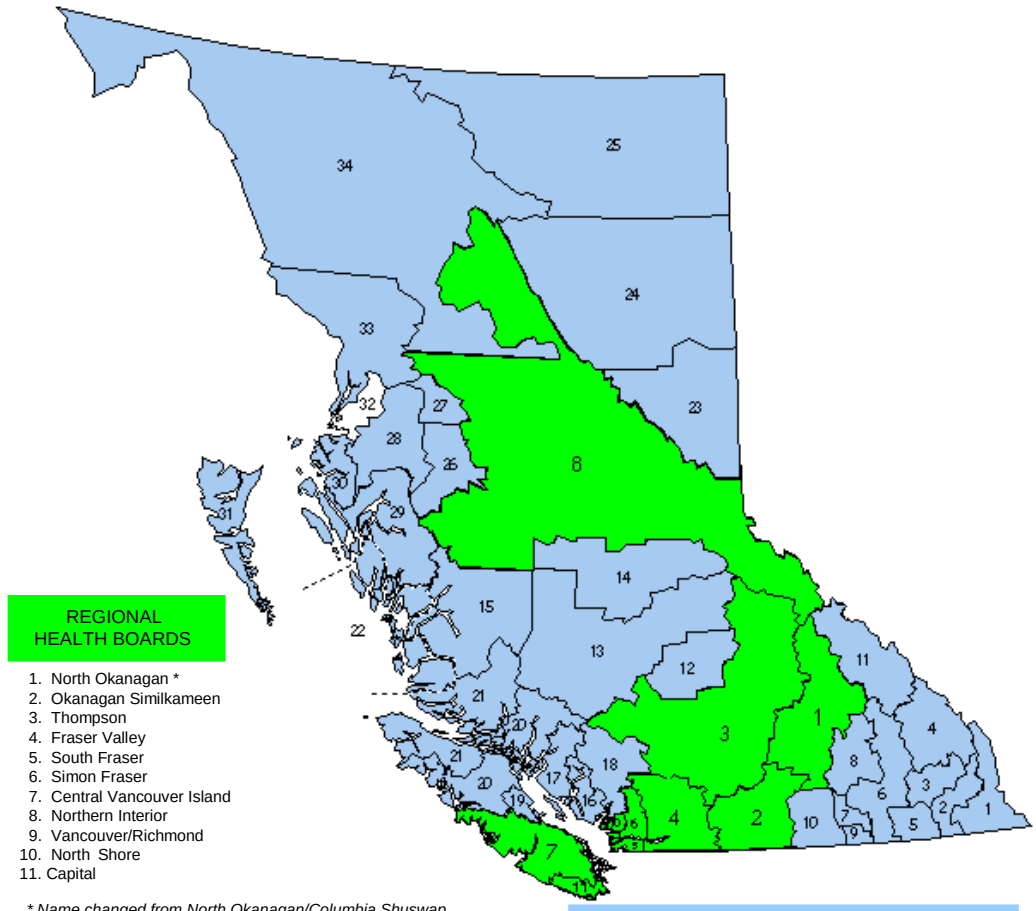
During the late 1980's and early 1990's, most provinces in Canada decentralized and integrated health services decision-making (Lomas et al. 1997). The stated intentions were to reduce costs, enhance health outcomes, integrate and coordinate services, and increase the flexibility and receptiveness of health service delivery. Regionalization of health services involves both centralization and decentralization of power. Much of the focus of health system reform in Canada has been on decentralization, specifically, transferring planning, budgeting and decision-making authority from the Ministry of Health to the local level (CMA 1993).

Prior to the introduction of regional health authorities in BC in 1997, formalized physician input was a long-established component of hospital decision-making. Practising physicians, elected by their peers, chaired hospital Medical Advisory Committees (MACs), were members of hospital boards, and were integrally involved in quality of care decisions and health policy development. Experience from other jurisdictions, which have previously shifted to a geographic governance model, shows that practising physician input is an essential element of effective decision-making (CMA 1993). With the shift to regional health authorities in BC, a wide range of approaches to incorporating physician input into regional decision-making is emerging without adequate direction from the Ministry of Health. As a result, the future for practising physician input is unclear.

Autonomous regional health care governance was officially established in BC on April 1, 1997, with the implementation of 11 Regional Health Boards (RHBs) in urban/semi-urban areas and 34 Community Health Councils (CHCs) in rural areas. The RHBs and CHCs are responsible for the funding and governing of acute, long-term, and community-based health services. Collectively, these boards are responsible for more than half of the BC health budget (more than $4.5 billion of a total $8.1 billion). Figure 1 on the next page depicts the geographic coverage of RHBs and CHCs.

Figure 1 - Map of Regional Health Boards (RHBs) and Community Health Councils (CHCs)

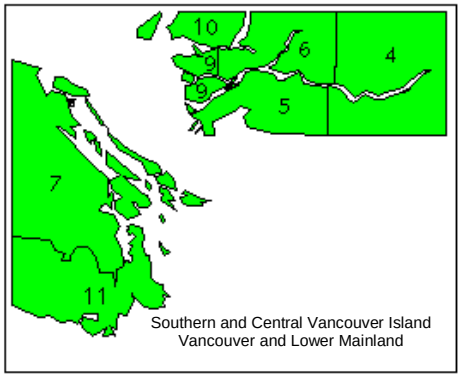
Regional Health Boards and Community Health Councils



REGIONAL HEALTH BOARDS

1. North Okanagan *
2. Okanagan Similkameen
3. Thompson
4. Fraser Valley
5. South Fraser
6. Simon Fraser
7. Central Vancouver Island
8. Northern Interior
9. Vancouver/Richmond
10. North Shore
11. Capital

** Name changed from North Okanagan/Columbia Shuswap to North Okanagan on Jan.21/1998*



Southern and Central Vancouver Island
Vancouver and Lower Mainland

COMMUNITY HEALTH COUNCILS

1. Elk Valley and South Country
2. Cranbrook
3. Kimberley
4. Columbia Valley
5. Creston and District
6. Nelson and Area
7. Castlegar and District
8. Arrow Lakes/Upper Slocan Valley
9. Greater Trail
10. Boundary
11. Golden
12. South Cariboo
13. Central Cariboo Chilcotin
14. Quesnel and District
15. Bella Coola and District Transitional *
16. Sunshine Coast
17. Powell River
18. Sea to Sky
19. Comox Valley
20. Campbell River/Nootka
21. Mount Waddington
22. Central Coast Transitional**
23. South Peace
24. North Peace
25. Fort Nelson-Liard
26. Bulkley Valley
27. Upper Skeena
28. Terrace and Area
29. Kitimat and Area
30. North Coast
31. Queen Charloote Islands/Haida
33. Snow Country
34. Stikine

32. Nisga'a (*not designated under the Health Authorities Act*)

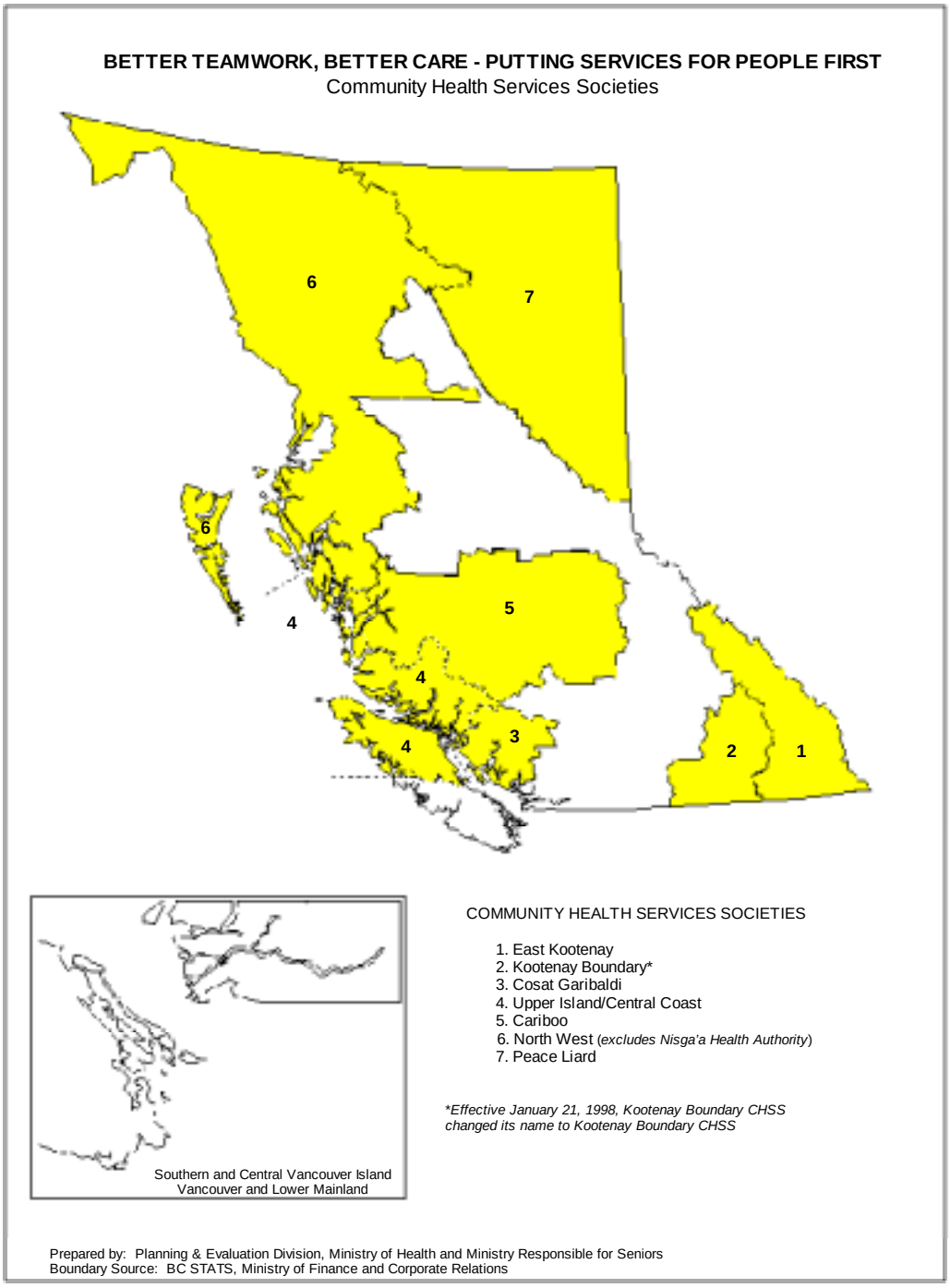
* Name changed from Bella Coola Valley and District to Bella Coola District Transitional Health Authority on Mar.19/1998

** Name changed from Central Coast to Central Coast Transitional Health Authority on Jun. 5/1998

Boundary Source: BC STATS, Ministry of Finance and Corporate Relations

On October 1, 1997, the Minister of Health established 7 Community Health Services Societies (CHSSs), which cover the same geographic areas as the 34 CHCs. The CHSSs are responsible for community-based health services. In urban/semi-urban areas, community-based services are incorporated into the RHB's mandates. Figure 2 depicts the geographic coverage of the 7 CHSSs.

Figure 2 - Map of Community Health Services Societies (CHSS)



RHBs, CHCs, and CHSSs have replaced the traditional hospital board structures. Theoretically, their geographic orientation and increased scope of services will improve service delivery. However, the BCMA remains concerned that there are too many local health authorities in BC. This was expressed in the 1994 BCMA Board policy paper, *Regionalization of Health Services in BC*. Our concerns were re-iterated to the government's Regionalization Assessment Team in 1996. At the 1999 annual meeting of the Canadian Health Economics Research Association (CHERA), evidence was presented that, to be effective, regional health boards must service a population of at least 10,000 for primary care planning, 120,000 for secondary care planning, and 450,000 for tertiary care planning.[1] Many of BC's regions do not meet these minimum population sizes.

BC Auditor General's Report

In 1998, the BC Auditor General released a report assessing the BC Ministry of Health's actions in ensuring the presence of appropriate governance and accountability mechanisms for health authorities. The Auditor General recommended that the Ministry needs to better communicate its vision and strategic direction for the health care system; to clarify the roles and responsibilities of all participants; to improve the appointment and selection of candidates; to develop clear performance goals and evaluation tools; and to reassess its reporting activities (Morfitt 1998). Specifically, the Attorney General found the following problems inherent in the current structure. Many board members lacked the necessary skills and training required. Rather, they were selected for demographic fit.

Impact of Regional Governance upon the Provision of Medical Services

Decentralization of health care decision-making in BC changes the method of resource allocation and funding. Although the majority of physicians are not employees of regional authorities, these changes impact directly on the ability of physicians to provide services to the public. Historically, practising physicians have been heavily involved in quality of care, planning, and operational decisions at the hospital level. Many of these decisions are now being shifted to the regional level. Consequently, it is essential that comprehensive, effective practising physician input be obtained by and for the regions.

Program Management

The shift towards Program Management in some of BC's larger health regions may be the result of the administrative appeal of reorganizing the control of patient care resources. However, such reorganization includes potential risks in terms of quality of care and related legal responsibilities. Program Management can result in a fragmentation of patient care as various professionals provide only their component. Patient care may be further fragmented as complex patients cross over into various program areas. Professional obligations and legal implications are more complex under Program Management as it can become more difficult to demonstrate under which medical practitioner's authority care was provided. It is critical that Program

[1] Presentation from Dr. Raisa Deber, University of Toronto, at the 8th annual Canadian Health Economics Research Association meeting, August 19, 1999, Edmonton, AB.

Management structures, policies and procedures recognize and are founded on those of the departments providing patient care. Services must be organized around the patients actually seen and the physicians actually responsible. Institutions must be organized around the doctor-patient relationship.

Department policies and procedures arise from experience of direct patient care and are based on assuring quality of care. Some new Program Management structures have failed to recognize the importance of this and, instead, have reversed departmental policies requiring departments to adhere to the policies of the Program. Such a reversal cannot be supported.

The value of practising physicians in a Program Management environment is even larger than in previous traditional models of care delivery. As well as providing medical expertise, practising physicians are essential patient advocates. Family physicians, and to a lesser extent specialist physicians, provide a broad perspective on health care services within the community, from acute and long-term care facilities, to office and home visits. Other health professionals do not have the breadth of experience of providing individual care to patients, in so many different settings over such a long period of time.

Meeting Attendance and Remuneration

Health regions cannot expect physicians to give their time freely to management activities without appropriate compensation, particularly when the other members of the management team are paid a salary to participate. Frequently, practising physicians are the only members at a local meeting who are not being remunerated for their time. Practising physicians are taking time out of their offices at their own expense. This is not appropriate and cannot continue. In addition, physicians must continue to pay staff when they are not there.

Perspectives

Public

A June 1998 BCMA public opinion poll found the following:

- Public perception of quality of health care has declined significantly
  - 1997: 72% said good or excellent
  - 1998: 47% said good or excellent

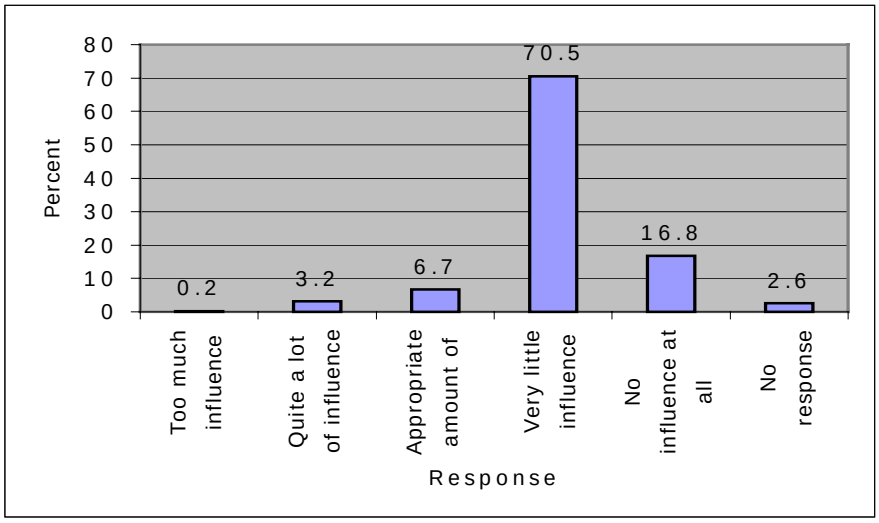
- Two-thirds say health care funding is insufficient.

- 91% want doctors actively involved in decision making.
  - 52% say that when it comes to making decisions affecting health care in BC, doctors and the provincial government should make decisions jointly.
  - Another 39% say government should at least consult with doctors before making decisions.
  - Only 3% think doctors should have little or no input.

Physician

In June 2000, the BCMA membership survey showed that practising physicians feel they have very little influence over management decisions in their local area.

Figure 3 - How Much Influence Do You Feel Practising Physicians Have On Management Decisions In Your Health Region?



A similar survey in 1998 revealed the following: *(the results of this survey are summarized in Appendix A)*:

- Nearly 2/3 of physicians said relationships between doctors and hospitals in their areas are good or excellent overall (higher percentages among young physicians and lower percentages in Vancouver).

- 44% thought regionalization had had no impact on improving community input to the medical system.

- Urban physicians (Lower Mainland and Capital Health Region) were more concerned with the implications of regional governance than their regional and rural colleagues.

- The current structure for medical input at the regional level was perceived to be ineffective in all areas of decision-making except for quality of patient care issues. Urban physicians were particularly concerned with their current level of input into regional decision-making.

Regional Administration

In July 1999, the BCMA conducted a survey of all 95 health authorities in BC, Alberta and Saskatchewan. The purpose of this survey was to compare governance structures, Board membership, level of public/provider participation, public/provider-input structures, and governance evaluation structures. The surveys were sent to chief executive officers of 95 regional health authorities. The survey had a 55% response rate.

Accountability through Elected Representation

Survey results show that Alberta and Saskatchewan are moving towards partially elected and fully elected Health Boards, respectively. In contrast, the government of British Columbia has not given any indication that it intends to do the same.

Board Autonomy

Regional CEOs were asked to rate Board autonomy with regard to budgetary allocation, policy issues, quality of care decisions and operational issues on a scale of 1-4, 1 being *no regional autonomy* and 4 being *exclusive regional autonomy*.

Figures 3-6 show that regional CEOs in all three provinces perceive more autonomy with respect to quality of care decisions and operational issues than with budgetary allocation and policy issues. BC CEOs had lower ratings with respect to all four decision-making domains.

Figure 4 - Board Autonomy with Regard to Budgetary Allocations

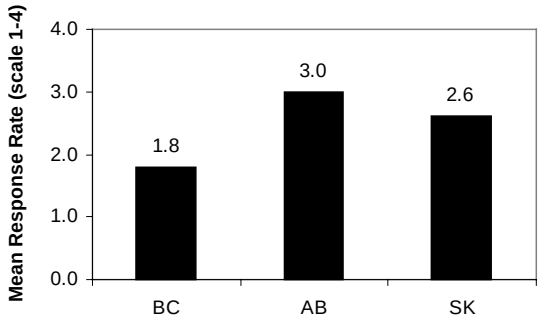


Figure 5 - Board Autonomy with Regard to Quality of Care

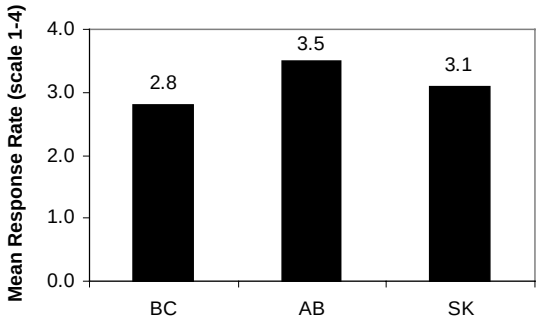


Figure 6 - Board Autonomy with Regard to Policy Development

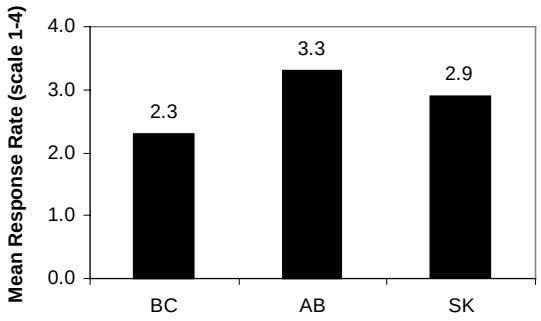
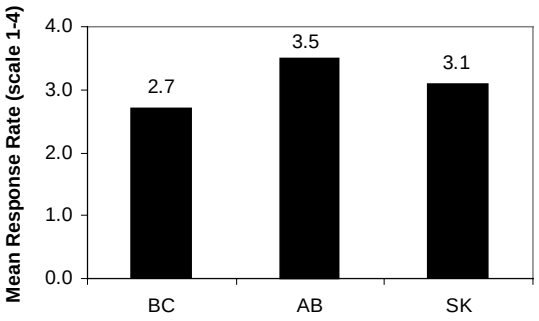


Figure 7 - Board Autonomy with Regard to Operational Issues



Medical Advisory Committees

Historically, hospital medical advisory committees (MACs) have provided input to boards and administration regarding quality of care, systems planning, and other operational issues as mandated by the *Hospital Act* (1979) and the *Medicare Protection Act* (1995). Similarly, the Regional Medical Advisory Committee (RMAC) should be concerned with the quality of medical care provided to patients in the health region.

Despite the fact that the Minister of Health mandated that Regional Medical Advisory Committees (RMACs) report to each RHB and CHC, there remain 6 health authorities without functioning RMACs (as of October 2000). This is a cause for great concern.

A process for effective medical input at the regional level must be rapidly facilitated. Experience worldwide (CMA 1993), as well as the failure of BC's *New Directions*, shows that administrative change without the support of the medical community is destined to fail. To try and streamline a very slow process, in November 1999, the BCMA President wrote directly to all Regional Health Board Chairs requesting that they ensure they have a functioning, effective and representative RMAC, acknowledging that administrative physicians must not be RMAC Chairs *(refer to Appendix C).* At that time, there were only 13 RMACs to service BC's 45 health authorities.

Physicians who are full-time employees or members of the regional board must <u>not</u> be RMAC Chairs. Full-time administrative physicians, who report to the CEO, are in a conflict of interest if they are expected, as part of their duties, to chair the RMAC. The RMAC Chair cannot effectively serve two masters, both the Board and the CEO. He/she must report directly to the Board. As such, the RMAC Chair must attend all Board meetings and report on the provision of medical care in the region.

Medical Staff

The Hospital Act (1979) provides the legislative authority for the governance of the medical staff within BC's health care institutions. Within the widely accepted governance model, the President of the Medical Staff is the democratically elected leader of the medical staff with the authority to express their collective views. This is an important conduit for communication to management and the Board.

If this conduit is not part of the regular day-to-day management and policy-making process, the medical staff's views are communicated in a more public manner, frequently through the local media. It is in the regional health board's and the medical staff's interests that such views not be communicated through the media. For this reason, it is vital that the medical staff is effectively involved in the decision-making process and this is best done through the elected leaders of the medical staff or their appointees. The medical staff must have confidence that their views are being presented without any filters and are considered during the decision-making process.

Regional Medical Societies

The BCMA has 33 geographically-based Regional Medical Societies (RMS). Their expertise in the provision of medical care at the local level is an important resource for regional authorities.

Community Health Advisory Committees

Several health regions have established community health advisory committees (CHACs) to provide informal input into regional decisions. CHACs can provide residents with a vehicle to inform regional health boards of the community's desire for specific health care services. However, the existing selection process for CHAC members is problematic. Depending upon their membership, these committees have the potential to become a political platform for special interest groups to lobby for services that may be of questionable medical value or efficacy as well as control the allocation of existing resources within the region.

It is important that competent medical personnel (either from within or outside the region), capable of providing high quality, evidence-based medical advice, review CHACs' recommendations before they are forwarded to Regional Boards.

THE BCMA

Founded in 1900, the British Columbia Medical Association (BCMA) is a voluntary association of British Columbia's medical doctors. BCMA membership is also open to post-graduate trainees in BC and to students enrolled in the Faculty of Medicine at UBC. Approximately 90 per cent of British Columbia's actively practising physicians are members of the BCMA which currently stands at approximately 7,000 members.

The objective of the BCMA, in a broad sense, is to advance the practice and science of medicine and the health of British Columbians by working for the improvement of medical education, health care legislation, and hospital and other health services.

Currently, the BCMA's collective bargaining role, which emerged in the 1960's, receives a tremendous amount of public attention. It must not be forgotten that the BCMA was established in 1900 and has a long record as an innovator in health policy. The BCMA is also heavily involved in quality of care issues through its Professional Relations department and the Council on Health Promotion.

The BCMA represents the collective view of the medical profession to the British Columbia government and offers recommendations about legislation that affects both health care and the practice of medicine. The BCMA produces a *Schedule of Fees* for medical services and negotiates a *Schedule of Benefits* paid by the Medical Services Plan (MSP). The BCMA also negotiates on behalf of physicians for sessional, fee-for-service, salaried, and other alternate payments.

Since 1993, the BCMA has worked collectively with the Ministry of Health to facilitate the BC Medical Services Commission (MSC). The MSC is legislatively mandated to govern the MSP budget of approximately $1.6 billion. The MSC is comprised of 9 members (3 government appointees, 3 BCMA appointees, and 3 public appointees).

The BCMA develops information programs for its members and on behalf of its members for the general public. The Association provides and administers numerous member benefits, including: group insurance programs, continuing medical education (CME), the Canadian Medical Protective Association (CMPA) dues rebate program, and the contributory retirement savings plan (CPRSP).

Philosophy

The BCMA is committed to the highest standard of health care and to the belief that physicians must be independently free to work for and on behalf of their patients to achieve that standard.

Mission

The mission of the BCMA is to promote a social, economic, and political climate in which members can provide the citizens of British Columbia with the highest standard of health care while achieving maximum professional satisfaction and fair economic reward.

Objective

To represent the collective view of the medical profession of British Columbia and communicate that view to the public, elected representatives of the public, members of the BCMA, and other groups.

Goals

The goals of the BCMA are to:

- maintain a Board of Directors and Executive which reflect the collective view of BC physicians,
- establish effective relationships with other health interest groups,
- develop and evolve public policy concerning health care delivery,
- be advocates of the health issues which concern the citizens of British Columbia,
- achieve appropriate compensation for professional services, and
- maintain the highest professional standards among physicians.

BCMA Board of Directors/Executive

The BCMA Board is comprised of 30 delegates representing 16 geographic districts, 3 Canadian Medical Association (CMA) directors who are usually selected from existing Board members, 1 representative from each of the Society of General Practitioners (SGP) and the Society of Specialist Physicians and Surgeons (SSPS), and the 5 elected officers, for a total of 37-40 voting members. The Chair of the Board is appointed by the Board and is non-voting. In addition, the Chairs of the Council on Health Promotion (COHP), the Council on Health Economics and Policy (CHEP), the Council on Public Affairs and Communications (CPAC); the President of the BCMA Auxiliary (BCMAA), the three BCMA appointees to the MSC; representatives from the Medical Undergraduate Society (MUS), the Professional Association of Residents (PAR), and the UBC Faculty of Medicine sit as non-voting members.

The 8 member Executive Committee consists of the 5 elected officers, the Board Chair, and 2 Board members appointed by the Board. The Executive's mandate is to carry out the operational aspects of policies set by the Board and to act on behalf of the Board between Board meetings.

BCMA Councils

Three councils serve members of the BCMA: the Council on Health Promotion (COHP), the Council on Health Economics and Policy (CHEP), and the Council on Public Affairs and Communications (CPAC).

COHP, established in 1957, oversees 15 committees, each dealing with specific areas of public health policy and health promotion. Current issues of special concern to COHP are violence in society, health education in schools, and community involvement in health promotion.

CHEP was established in 1993 to assess and formulate policy options relating to the economics, organization, and management of the health care system. Examples of CHEP's work fall under the issues of regionalization, health care financing, physician supply, utilization management, and the problems facing rural physicians. Much of CHEP's work is dedicated towards formulating BCMA Board policy in these areas.

CPAC was established in 1995 to direct the communications and public affairs activities of the BCMA. CPAC's goals are: to involve the BCMA in the political process; to ensure that government respects the role of practising physicians in the planning and management of BC's health care system; to develop and maintain communication programs to support BCMA policies; to communicate with the membership; and to promote mutual understanding and goodwill between the medical profession, the public and the media, in a continuing effort to strive for higher quality health care in BC.

The BCMA/MOH Master Agreement

The terms of the existing BCMA/Ministry of Health Master Agreement (1993) include the following:

- The BCMA is recognized as the exclusive bargaining agent for BC physicians who receive payment from MSP or agencies funded by MSP. This includes fee-for-service, sessional, and salaried payments derived from MSP funds.
- Physicians pursuing alternate payment contracts have the right to be represented by the BCMA, and must be informed of this right.
- The Continuing Medical Education (CME) fund, Physicians' Disability Insurance (PDI) premiums, and the Canadian Medical Protective Association (CMPA) Rebate Program are all enshrined in the Master Agreement.
- A modified form of binding arbitration is included as a dispute resolution mechanism for centralized fee-for-service negotiations.
- Transferring funds from the fee-for-service budget to alternative payments requires BCMA consultation and BCMA approval of the amount of funds being transferred. If agreement cannot be reached, the matter goes to binding arbitration.

Framework Agreement

In March 2000, the Government and the BCMA signed a Framework Memorandum that, amongst other things, establishes the procedures and timelines for the negotiation of other agreements between the two. That memorandum has no expiry date. One of the terms of the Framework Memorandum extends the term of the Master Agreement, which governs the overall relationship between the BCMA and the Government, until March 31, 2001. Third party binding arbitration is available to ultimately resolve any bargaining disputes on this agreement.

The Framework Agreement renews the provincial Sessional Agreement to March 31, 2001 and requires its re-negotiation to commence by October 1, 2000. If that renewal is not complete by March 31, 2001, it continues and binding arbitration is available to resolve any bargaining impasse.

The Framework Memorandum also requires that the parties negotiate provincial Rural, Salary and Service Contract Agreements. Binding arbitration is available to resolve bargaining impasses for all of these agreements. Future Rural, Sessional, Salary and

Service Contract agreements will be negotiated at the same time as future Working Agreements.

As well as redefining the architecture of the provincial agreements, the Framework Memorandum addresses the issue of funding for physician services in 1999/2000 and 2000/2001. It establishes that the Available Amount for 1999/2000 will be $1.545 billion and for 2000/2001, $1.585 billion plus the cost of the September 1 two-percent fee increase (approximately $31 million dollars). In addition, the Government agrees that it will not claw back fees during either of these years or in subsequent years for any services provided during those years.

The Framework Memorandum also resolved a series of arbitrations and court challenges between the BCMA and the Government. The approximately $23 million dollars of excess clawback from the 1998/99 fiscal year was returned to the membership.

Rural Agreement

In June 2000, the BCMA and Government were successful in negotiating the first Subsidiary Rural Agreement (June 9, 2000). This agreement makes some significant advances in supporting rural medicine. The total value of the agreement is approximately $8.5 million dollars and it achieves funding to compensate for on-call coverage by specialists in communities covered by the Northern and Isolation Allowance (NIA) program. This agreement also provides on-call compensation for general practitioners in 10+ physician NIA communities. The agreement also helps to further support physician services in the very smallest communities without a hospital, to increase the pool of rural locums in BC and to support initiatives in the training in rural practice. In addition to the new funding, the agreement also requires specified limits on the amount of call coverage that rural physicians can be required to provide.

BCMA Administration

Administratively, the BCMA is divided into 6 departments: Executive, Communications and Public Affairs, Economics and Policy Analysis, Finance and Administration, Negotiations, and Professional Relations.

Communications and Public Affairs

The Communications & Public Affairs department is responsible for media relations, public relations, advertising, health promotion, and publications, including the BC Medical Journal. The department is responsible for organizing the Annual General Meeting, the New Year's Baby Project, and administers a program called Club MD, which offers members discounts on various goods and services. Communications & Public Affairs also handles the maintenance of the BCMA web site (http://www.bcma.org). Department staff works closely with the Council on Public Affairs and Communications and the Council on Health Promotion.

Economics and Policy Analysis

The Economics and Policy Analysis (EPA) department provides the BCMA Board and Executive Committee with analytical research support in the areas of medical economics and health policy assessment. The department also incorporates many of the information systems functions of the association, including the compilation and analysis of MSP claims and other data, which aids BCMA decision-making. The Council on Health Economics and Policy (CHEP) and its various member-based project groups guide many EPA department tasks. CHEP has published two previous policy papers on the implications of regional health care governance in BC (1994) and (1997).

Finance and Administration

The BCMA administers the various benefit plans available to physicians under the agreements with the Medical Services Commission and government. These include the CMPA Rebate Program, the Physicians' Disability Insurance Program, the Continuing Medical Education (CME) Program, and the Contributory Professional Retirement Savings Plan (CPRSP). These benefits are also available to physicians who are not members of the BCMA, however, their benefits are reduced by the amount of the BCMA dues they would have paid, were they members of the BCMA. This fee compensates the BCMA for the costs of negotiating and administering the various benefit programs.

Negotiations

The BCMA Negotiations department represents members in various negotiations with government, e.g. the Master and Working Agreements, as well as negotiations with other agencies, including the Workers Compensation Board. In addition to organizing and leading negotiations, the department is actively involved in the administration of negotiated contracts, including the management of arbitrations and the provision of advice and representation to physicians with rights under those and other agreements. The Negotiations department also provides advice and agent services for individual physicians or groups of physicians involved in other contracts relating to the funding of medical services.

Professional Relations

The Professional Relations department deals with clinical and administrative issues relating to the practice of medicine.

Issues include:

- regional/hospital medical staff bylaws,
- regional health board representation,
- concerns with respect to WCB and ICBC issues,
- billing practices of physicians,
- fee mediation issues,
- protocols and clinical practice guidelines,
- physician health and well being,
- pharmaceutical policy, and
- continuing medical education.

These and other professional relations issues are addressed through numerous committees, including the Patterns of Practice Committee, Reference Committee, Physician Support Program, BCMA/WCB Liaison Committee, BCMA/ICBC Liaison

Committee, Pharmacy and Therapeutics Committee, and numerous Protocol Working Committees.

Regional Support

The BCMA has published 2 policy papers on the implications of regional health governance: *Regionalization of Health Services* (BCMA 1994) and *Regionalization of Health Care Continues, BC Style* (BCMA 1997). Recognizing the evolving role of local health boards, the BCMA struck a Regional Support Task Force in November 1998. The objectives of this Task Force are:

1. to establish working and communications links with regional authorities;
2. to enhance information exchange between the BCMA and local physicians; and
3. to coordinate regional issues among the BCMA administrative departments, emphasizing issues of greatest concern and regular follow-up to ensure that priority issues are dealt with in a timely fashion and enable a more coordinated response.

The Task Force utilizes staff resources from each of the BCMA departments and is guided by the physician-based Regional Support Advisory Committee, which reports to the BCMA Board of Directors.

The Association communicates regularly with members through President's Letters, the BC Medical Journal (BCMJ), and other forums. The BCMA website (www.bcma.org) informs members and the public on current issues. Approximately 130 physicians subscribe to the electronic physician chat group, or Regional Information Network (RIN), that has been operating for the past two years.

With its more than 7,000 members, the BCMA has collective expertise that should be called upon as a resource to health regions. For decades, the BCMA has provided expert advice to the Government of British Columbia with regard to many health care issues. This expertise must continue to be drawn upon following the transfer of authority for many health care services form the Ministry of Health to the health care regions, as it is an invaluable tool in informed decision-making.

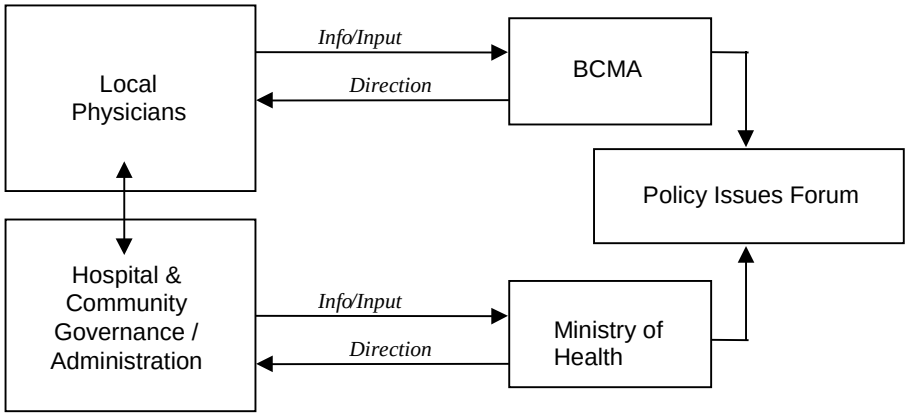
DE-CENTRALIZED GOVERNANCE, THREATS and OPPORTUNITIES

As the recognized representative of BC's practising physicians, the BCMA has historically worked with the Ministry of Health on behalf of physicians. The Association has well established lines of communication with Victoria for policy development, fee negotiations, etc. The BCMA is currently working to establish lines of communication and working relationships with BC's 45 health authorities. The process for developing health policy at the local level is much more complex than the previous direct forum between the BCMA and the MOH. Physicians faced with issues raised by the RHBs/CHCs require professional support, policy expertise, negotiation skills, and communications infrastructure.

The BCMA is an integral provincial resource, both for practising physicians and regional health authorities. At the local level, regional authorities need to utilize the physician representative on their Board, the VP Medicine/Regional Medical Director, the chair of the Regional Medical Advisory Committee, the President(s) of their Medical Staff(s), the Local Medical Society president(s), and the BCMA Board Delegate(s) as resources when making decisions. Only through the active involvement of practising physicians will regional decisions be made that adequately incorporate quality of care considerations as well as patient and professional needs. Figure 8 below illustrates the framework for health policy development before and after regional governance.

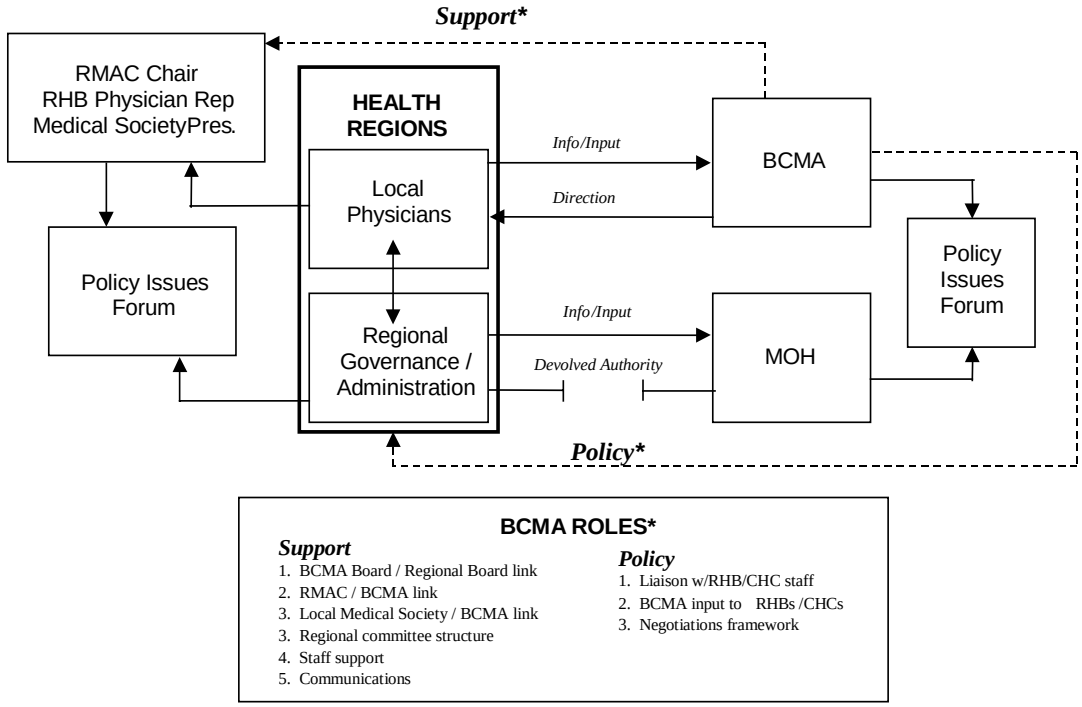
Figure 8 - Framework for Policy Development Before and After Regionalization

Before Regionalization



In the past, individual physicians have dealt with local hospital/community authorities directly on service delivery issues, leaving policy questions to be dealt with through their representative to the BCMA Board. The BCMA, in turn, has dealt with the Ministry of Health on these policy questions, with each party responding to their constituents directly.

After Regionalization



With the Ministry devolving authority, more policy issues will now be dealt with locally through the RHB/CHC. Local physicians will participate in this policy activity through their local bodies. There needs to be a direct link between these bodies and the BCMA Board representatives or the organization as a whole. Moreover, there needs to be a link between the BCMA and the RHB administration.

CONCLUSIONS and RECOMMENDATIONS

BC's health authorities are currently not adequately structured for inclusive regional decision-making. For health services to be delivered effectively under regional governance, appropriate accountability structures need to be in place and decision-making must reflect the public's needs and providers' technical expertise. The provincial government plays a critical role in ensuring that health authorities meet the necessary criteria for inclusive, effective decision-making. For BC, these criteria include ensuring the presence of the necessary authority and accountability.

Regionalization poses a series of challenges for both health governors and practising physicians. However, regional health governance also creates opportunities for new alliances and constructive change. The long-standing commitment to incorporate practising physicians into health care decision-making must not be lost as BC's health system de-centralizes.

> *In order to preserve and promote a quality health care system, Canadian physicians need to be consulted and involved meaningfully in health system reform and policy planning.* (CMA 1998, V24)

The BCMA makes the following recommendations to re-establish effective, necessary input into local health decision-making:

Recommendations

1. *That Regional Health Boards/Community Health Councils (RHBs/CHCs)involve actively practising physicians in health care decision-making including planning, management, and operational decisions.*

2. *That local physicians elect the physician representative on each RHB/CHC.*

3. *That the Ministry of Health require RHBs/CHCs to implement functional Regional Medical Advisory Committees (RMACs). RMACs must report directly to the Board and be comprised of actively practising physicians the majority of which are elected by their peers, including the chair.*

4. *That Regional Medical Advisory Committee (RMAC) Chairs must be actively practising physicians whose primary activities are the practice of medicine, not administrative duties. Furthermore, physicians who are full-time employees or members of the Board must not be RMAC Chairs.*

5. *That any recommendations coming forth from Community Health Advisory Committees to RHBs/CHCs be reviewed by competent medical personnel capable of providing high quality, evidence-based medical advice prior to being forwarded to the Board.*

6. *That, wherever program management is instituted, RHBs/CHCs include practising physicians in the management structure and ensure that programs are in keeping with departmental policies and rules.*

7. *That physicians be paid for their administrative functions at the local level.*

8. *That reference to the CMA Physicians' Charter be incorporated into all regional medical staff bylaws.*

REFERENCES

British Columbia Medical Association (BCMA). 1997. *Regionalization of health care continues, BC style.* Vancouver: BCMA.

_____. 1994. *Regionalization of health services.* Vancouver: BCMA.

Canadian Medical Association (CMA). 1998. *Charter for physicians*. Ottawa: CMA.

_____. 1993. *The language of health system reform*. Ottawa: CMA.

Crichton, Anne. 2000. *The evolution of the Vancouver/Richmond Regional Health Board, 1992 – 1998: a case study.* Ottawa: Canadian Healthcare Association.

Frankish, C. James, et al. 1998. *Community participation in health system decision-making*. Vancouver: IHPR Institute of Health Promotion Research, University of British Columbia.

Lomas, J., Wood, J., and Veenstra, G. 1997. Devolving authority for health care in Canada's provinces: 1. An introduction to the issues. *CMAJ* 156(3): 371-377.

Morfitt, G.L. 1998. *A review of governance and accountability in the regionalization of health services.* Victoria: Office of the Auditor General.

APPENDIX A - June 1998 Regional Issues Questionnaire

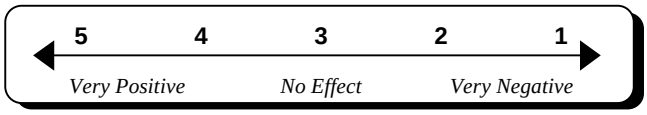
Summary of responses from BCMA Board delegates, chairs of regional/hospital medical advisory committees, presidents of medical staffs, presidents of local medical societies

53 responses / 110 sent (48% response rate)

Breakdown:

Lower Mainland	21 responses
Capital	6 responses
Regional	16 responses
Rural	10 responses

1. What have been the effects of Regionalization in your area on the following:



	Total	*Lower Mainland*	*Capital*	*Regional*	*Rural*
Quality of patient care	**2.6**	**2.6**	**2.7**	**2.8**	**2.3**
Community input into decision-making	**2.6**	**2.3**	**3.2**	**2.9**	**2.4**
Patient satisfaction	**2.6**	**2.5**	**2.4**	**2.8**	**2.6**
Physician professional satisfaction	**2.0**	**1.9**	**1.7**	**2.5**	**1.9**
Level of bureaucracy surrounding health issues	**2.0**	**1.7**	**1.8**	**2.4**	**2.1**

2. a) Do you have a functioning regional medical advisory committee (RMAC)?

	Total	*Lower Mainland*	*Capital*	*Regional*	*Rural*
❍ *Yes*	**36%**	**21%**	**80%**	**57%**	**13%**
❍ *No*	**64%**	**79%**	**20%**	**43%**	**87%**

b) Do you have a functioning hospital MAC(s) in your community?

	Total	Lower Mainland	Capital	Regional	Rural
❍ *Yes*	**92%**	**95%**	**60%**	**100%**	**90%**
❍ *No*	**8%**	**5%**	**40%**	**0%**	**10%**

c) Is the physician on your RHB/CHC viewed as being representative of practising physicians?

	Total	Lower Mainland	Capital	Regional	Rural
❍ *Yes*	**67%**	**55%**	**80%**	**67%**	**80%**
❍ *No*	**33%**	**45%**	**20%**	**33%**	**20%**

3. Is the current structure for medical input at the RHB/CHC level effective and timely with respect to:

	Total	Lower Mainland	Capital	Regional	Rural
a) Quality of patient care					
❍ *Yes*	**49%**	**20%**	**100%**	**64%**	**60%**
❍ *No*	**51%**	**80%**	**0%**	**36%**	**40%**
b) Resource allocation					
❍ *Yes*	**34%**	**7%**	**67%**	**60%**	**40%**
❍ *No*	**66%**	**93%**	**33%**	**40%**	**60%**
c) Purchasing					
❍ *Yes*	**36%**	**0%**	**67%**	**60%**	**55%**
❍ *No*	**64%**	**100%**	**33%**	**40%**	**45%**
d) Staffing					
❍ *Yes*	**35%**	**7%**	**67%**	**60%**	**40%**
❍ *No*	**65%**	**93%**	**33%**	**40%**	**60%**
e) Information systems					
❍ *Yes*	**37%**	**7%**	**67%**	**60%**	**50%**
❍ *No*	**63%**	**93%**	**33%**	**40%**	**50%**
f) Strategic planning					
❍ *Yes*	**44%**	**27%**	**67%**	**67%**	**33%**
❍ *No*	**56%**	**73%**	**33%**	**33%**	**67%**
g) Operational issues					
❍ *Yes*	**41%**	**15%**	**67%**	**67%**	**33%**
❍ *No*	**59%**	**85%**	**33%**	**33%**	**67%**

APPENDIX B – 1998 CMA Charter for Physicians

Approved by the CMA Board of Directors, September 9, 1998

Contents

Preamble

The goal of Canadian physicians, in partnership with their patients, is to provide the best health care possible. This Charter expresses what Canadian physicians need to achieve this goal. It complements CMA policies and the CMA Code of Ethics, which outlines the responsibilities of physicians to patients, society, the medical profession and themselves.

I. Patient–Physician Relationship

Canadian physicians regard serving the health needs of their patients as paramount, and put this at the centre of the patient–physician relationship. A strong patient–physician relationship is one based on trust, honesty, confidentiality, and mutual respect. In order to achieve the best patient–physician relationship, Canadian physicians need:

1. timely access to appropriate, quality health care for their patients

2. to be able to advocate for their patients` health care needs

3. patients to share appropriate information about their health so that they may receive the best quality care

4. to be able to hold information about patients in confidence, except when disclosure is consistent with the CMA's *Code of Ethics*

5. assurance that data generated by physicians in the context of clinical practice will not be compiled, sold, or otherwise used in a manner that compromises the privacy of patients or physicians, except as authorized by law

6. to be able to refuse to accept a patient, or to discontinue a professional relationship, except in emergency situations and consistent with the provisions of the CMA's *Code of Ethics*

II. Professional Integrity

Canadian physicians practice their profession in the service of their patients and society and collaborate with other health providers to this end. In order to discharge their professional responsibilities, Canadian physicians need:

7. to be able to practice medicine in accordance with professional and personal values, within the bounds of the CMA's *Code of Ethics*

8. to be unhindered from complying with the CMA's *Code of Ethics*

9. to continue to be regulated by self-governing, professional medical bodies

10. to be free to practice medicine, subject to licensure

11. to be free to inform patients of all appropriate options relevant to their care and to have clinical autonomy in recommending care

12. to have adequate time and opportunity for career maintenance and professional development

III. Fairness

Like all Canadians, Canadian physicians deserve fair treatment in matters concerning their individual and collective interests. Therefore, during training and in practice Canadian physicians need:

13. fair treatment with respect to access into, mobility and flexibility within, and exit from the health care training and delivery systems

14. procedural fairness with respect to policy, legal, contractual, administrative, and disciplinary decision-making concerning themselves

15. assurance that appointment and reappointment procedures will include effective medical representation and an appeal process, and that decisions will be based primarily on required professional credentials, competence and performance

16. to receive reasonable remuneration for the full spectrum of professional services, including administration, teaching, research and committee work

17. to receive reasonable consideration and compensation when facilities and programs are discontinued, reduced, or transferred

IV. Quality of Life

Canadian physicians strive to balance professional demands with their need for quality of life and personal health maintenance. Therefore, Canadian physicians need:

18. to be free from harassment, discrimination, intimidation, or violence, both in training and in practising medicine

19. access to appropriate resources for dealing with personal or professional problems that affect their medical practice

20. to be free from reprisal when they report in good faith unsafe practices or conditions bearing on patient care

21. reasonable access to information needed to safeguard their personal health and safety, while respecting patient confidentiality

22. scheduling in the provision of medical services and physician training to be limited to reasonable hours, both to safeguard their ability to provide quality care and in consideration of their need to have time for a personal life and health (in principle, they should not be required to provide on-call services more frequently than one night in five)

23. to be able to acquire adequate and affordable medical liability protection

V. Health System

Canadian physicians have a vital role in the health care system and can provide essential expertise about health system organization, funding, and service delivery. In order to preserve and promote a quality health care system, Canadian physicians need:

24. to be consulted and involved meaningfully in health system reform and policy planning, and on issues related to service delivery, payment, funding, and terms and conditions of work, and to be assured that changes to the health care system will respect individual medical practitioners' liberty to choose among payment methods

25. valid methods of assessment, such as properly evaluated pilot projects to be applied to any proposed changes to the health care system

26. the health care system to respect the patient–physician relationship, continuity of care, and the patient's freedom in the choice of a physician

27. data generated in the context of clinical practice and collected under legislative and administrative requirements to be interpreted with physician input and made readily accessible to physicians in a manner consistent with respect for the privacy of patients and physicians

28. to be free to associate for collective bargaining, and to be formally represented in negotiations on issues of health system reform, service delivery, payment, funding, and terms and conditions of work

29. resources and funding for physician services to be negotiated by provincial/territorial medical associations or federations and allocated directly to physicians

30. sufficient resources to allow for the efficient, effective and professional delivery and management of medical care under reasonable and humane working conditions

APPENDIX C – Letter from BCMA President to Regional Board Chairs, November 1999

November 19, 1999

Dear <RHB/CHC Chair/CEO>,

The BCMA continues to work with Regional Health Boards (RHBs) and Community Health Councils (CHCs) to establish effective, representative local medical input structures. Historically, BC physicians have been involved in local quality of care and policy decisions through hospital Medical Advisory Committees (MACs). With the introduction of regional governance in April 1997, it was intended that a similar advisory structure be implemented at the regional level. Unfortunately, establishing Regional Medical Advisory Committees (RMACs) to RHBs and CHCs has been an extremely slow process. Although BC's local health authorities have been in place for more than 2 years, we are aware of only 13 functioning RMACs to service the 11 RHBs and 34 CHCs. This is a marked reduction in practising physician input into local health decision-making and significantly undermines the effectiveness of local health decisions.

A particular concern is the fact that, in some regions, administrative physicians, e.g. VP Medicine, Chief of Staff, are acting in the dual role of RMAC chair. This dual role creates significant potential for conflict and does not generate the necessary support for the RMAC chair from within the local medical community. Consequently, at its October 29, 1999 meeting, the BCMA Executive moved the following:

That Regional Medical Advisory Committee (RMAC) chairs must be actively practising physicians whose primary activities are the practice of medicine, not administrative duties. Furthermore, physicians who are full-time employees or members of the Board must not be RMAC Chairs.

Your local physicians require an effective input structure into local health decision-making. This cannot take place solely through a Minister appointed physician on the Board nor through local administration. The Regional Medical Advisory Committee is the appropriate place for this input. Your RMAC chair must attend all Board meetings and present regular reports.

If you haven't already initiated this process, please work with your local physicians to ensure that a representative medical input structure is established as soon as possible. If you have any questions regarding this letter, please contact Dr. Dan MacCarthy, BCMA Director of Professional Relations, at (604) 638-2830.

Yours truly,

<original signed by>

Ian Courtice, MD
President

c. <RHB/CHC CEO/Chair>
<RHB/CHC Physician Rep.>
<BCMA Board>
<RMAC Chair>
<Regional Medical Society President>