Turning the Tide – Saving Medicare for Canadians

Part II of II
A New Course for Health Care

A Discussion Paper by BC's Physicians

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Part I, "Laying the Foundation for Sustaining Medicare", may be found at www.bcma.org

This paper was commissioned by the British Columbia Medical Association Board of Directors in response to growing concerns over the state of the health care system.

The BCMA Council on Health Economics and Policy (CHEP) reviews and formulates policy through the use of project oriented groups of practising physicians and professional staff. The Project Group for this paper includes Dr. Arun Garg, Pathologist, New Westminster; Dr. Brian Gregory, Dermatologist, Vancouver; Dr. Michael Lawrence, General Practitioner, Vancouver; and Dr. Heidi Oetter, General Practitioner, Coquitlam. Staff support was provided by Mr. Darrell Thomson, Director of Economics and Policy Analysis, Mr. Robert Hulyk, Policy Analyst and Ms. Linda Kowalski, Administrative Assistant.

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Executive Summary

British Columbia's health care system is in urgent need of renewal. This report proposes 29 recommendations and 48 specific actions to address that need.

In a companion paper completed in July of 2000, the doctors of British Columbia concluded that the current health care system was unsustainable, and proposed a new framework for a sustainable and accountable health care program. The proposed framework entailed the integration of a set of patient care, system and management objectives that could be clearly understood by the public and that would strengthen, enhance and clarify the principles of the Canada Health Act. Since that paper was released, waning provider morale and public confidence has emphasized the need for a long overdue dialogue on the future of health care in British Columbia.

A Philosophy of Responsible Caring

There is a desperate need for practical, quality leadership in the health care sector. British Columbians deserve a clear vision statement for their health care program that incorporates meaningful guidance for patient care, across the continuum of available services, in an honest and explicit manner. Within that continuum, doctors assert that while prevention initiatives are important, they should never take precedence over necessary treatment.

Closely tied to the need for a comprehensive vision statement is a decision on the scope of services to be covered by the publicly funded health care program. Medicare now includes an expanding array of health services and a sustainable program will require a public review of those services. Once the scope of service coverage has been defined, the government must further work with the public to establish criteria that describe reasonable access to those services, in the form of a Patient Charter. The Charter should address the legitimate expectations of the BC public for health care delivery, concentrating on the issues of availability, accessibility, timeliness and quality. The Charter should also clearly lay out the responsibility and accountability of the individual, within and for, the health care system.

These tasks require a more realistic view of the capacity of the health care system and an assessment of the collective ability to pay. Consequently, systematic and regular reporting on capacity and cost must be made available if a better informed public is to make effective choices concerning health and health care delivery. Mechanisms must also be available to monitor and assess how the system is progressing.

Creating processes to ensure effective leadership, collaborative decisions and practical accountability mechanisms is key to restoring public and provider confidence and progressing towards a new future. These processes will not appear overnight and will take time to develop and implement. In the interim, immediate system stabilization is required.

A Process for Care Renewal

The September 11, 2000 First Ministers' Agreement has committed the federal government to a significant re-investment of federal transfer payments over the course of the next five years. However, this re-investment will mean little without a concurrent commitment from the provincial government to address needed areas. A priority for the provincial government must be an investment in acute and chronic care services, including hospital, home care and long term care

programs. To accommodate this critically important investment, immediate priority must be given to expanding British Columbia's professional training and recruitment programs for physicians, nurses and other health care providers.

Apart from these immediate endeavours, there is an overriding need to commit to a longer term planning strategy for the health sector. A concerted effort is required to identify unmet needs. This identification should be developed in collaboration with health care providers, managers and the public in order to promote a common understanding.

A major component of a long-term planning strategy will involve the development of a provincial level service plan. Delivering health care in the ways British Columbians are accustomed to cannot be sustained into the future. Alternative approaches to delivering care are required and inevitable. The aging population, the challenges posed by the province's geography, rapidly expanding high-cost technologies, and the shortage of health care providers necessitate a change in thinking.

The province has already reached the point where care of certain types is not universally available. The acute shortage of specialists and the high cost of technology will extend those circumstances. The future challenge will be to design delivery systems that are built around a series of regional care centres, without abandoning the principle of 'reasonable access'. Determining where care is made available will become an increasingly relevant policy issue. Efforts will be required to optimize the use of the province's scarce specialist services, improving care, availability, continuity and provider morale by encouraging practice in close proximity to each other. It is no longer realistic to expect to receive the best available care in every corner of the province. New information and communication technologies will assist, but future care will increasingly involve service delivery by a 'remote' individual.

As a corollary to the concept of regional centres, family and general practitioners will be called upon to provide more specialized care in areas of the province where specialist services are not available. This will require specific programs to support new and existing general practitioners in obtaining enhanced skill training. Furthermore, as the physician shortage deepens, it will be necessary to ensure the practical and successful integration of other service providers into the physicians' practice in a coordinated and flexible fashion, while supporting the public's desire to maintain their doctor as the first point of contact for primary care. The development of full spectrum primary care practice must be promoted.

Restructuring will also entail a rationalization of how the public and private delivery sectors can be more effectively integrated. Canadian health care delivery currently employs the use of many private facilities to deliver publicly funded services. These facilities include physician offices, diagnostic centres, long-term care residences, home care agencies and pharmacies. The debate will not be one of whether private delivery should exist, but rather how society can make the most efficient and effective use of the private and public facilities that make up the entire health care delivery system. Due primarily to technological advances, services that traditionally have been performed within a hospital setting can now be safely and effectively done in a different type of facility. These opportunities raise important issues concerning both efficiency and system capacity that should be explored.

An Approach to Sustainable Caring

The future holds many challenges. The federal government has now committed (in principle at least) to build in Canada Health and Social Transfer escalators for population growth and aging.

The provincial budget process for health and health care services should reflect that same principle in order to ensure stable and predictable operational funding.

At the provincial level, funding sources should continue to include premiums and co-payment charges. Premiums impart a degree of cost consciousness in a system otherwise devoid of public accountability mechanisms for basic hospital and medical care and, as a consequence, should be increased to account for a larger share of actual health care costs. Co-payments should be applied in a fair and equitable manner that minimize the risk of impeding an individual's access to care, yet encourage appropriate use of the system.

It is difficult to imagine a situation where the proportion of private versus total health care spending will not rise in the future. According to Canada-wide data from the Canadian Institute for Health Information, the private pay component of some services is excessive, reaching as high as 67% for drugs and 90% for non-physician providers. At present, the only relief available from these charges, outside of private extended health insurance, is limited to a tax credit of 17% of those expenditures beyond 3% of a person's net income. Accordingly, government should examine a variety of tax based mechanisms that could be employed to help offset the individual burden of out-of-pocket costs. The concept of medical, or health care savings accounts, should be considered as an option.

To further support long term planning, the annual health budget process should be based on a minimum three year funding horizon, with a requirement to include plans for capital replacement. Replacement planning has become virtually non-existent during the past decade. As a result, the system is currently facing a serious infra-structure problem, necessitating a massive monetary injection. Better management principles must be employed.

An Effective Governance Model

Developing strategic plans is one thing; implementing them another. Many good ideas have failed for want of leadership. Medicare has developed into a part of the social fabric of Canada, in large part defining Canadian's societal values. As a consequence, health issues frequently dominate the political landscape. In fact, the health care system has become overly susceptible to the *politics* of decision making, with political expediency frequently interfering with practical management. While it would be naive to think that Medicare could be entirely immune from political interference, minimizing those occurrences should be a priority.

De-politicizing decision making requires a re-examination of the roles, responsibilities and lines of authority of the various governance bodies. The doctors of BC believe that the government must assume responsibility for providing overall guidance to the health sector. It should concentrate on policy, not management. There is a concurrent need to fully and openly examine the effectiveness of the existing regional structure. Regionalization in British Columbia has had a troubled past involving changes in boundaries, vague direction and uncertain authority. BC doctors believe the correct formula is yet to be found. Regional structures make sense, but not in their present form. Amalgamation into larger geographic areas should be considered, in consultation with local communities.

A more efficient regional structure and a clarification of respective roles and responsibilities are necessary, yet insufficient, conditions for successfully charting a new course for health care. The necessary initiatives to restore quality care require radically different attitudes and practices. Given the tendency of elected officials to view health care as a political matter, it seems highly unlikely that any government would be willing to apply the necessary rigour

without resorting to political interference. Without the effective application of management principles, and the ability to make and adhere to long term plans, health care renewal will not succeed.

For this reason, the management of the health care system should be turned over to an arms-length Health Care Services Authority (HCSA). This body should have a legislated mandate to translate the government's vision and core program into an operational plan, managing the same through the development and application of appropriate financing and delivery policies. The regional structure would remain, with the regional administrators reporting directly to the HCSA.

One of the key advantages of the HCSA would be the ability to plan and operationalize the health care system from a province wide perspective. The existing shortage of health care personnel, the pending demographic pressures and the high cost of future technology requires that provincial planning take priority over regional planning. This direction is contrary to current trends, but is essential to the future vitality of health care in the province.

The inevitable consequence of this new HCSA structure would be the elimination of existing regional and community health boards as decision-making entities. These boards have done an admirable job under very adverse conditions, however, they should be converted to bodies that are advisory to both the Authority and the regional administrators, in order to maintain current and continuous public input. The opinion of community leaders is essential and their mandate should include a requirement for public consultation and discussion with respect to policy issues and financing and delivery initiatives.

This report calls for bold change involving strong political leadership and greater public involvement, the latter of which is key to shaping the health care future in effective and lasting ways. Important choices lie ahead. The doctors of British Columbia assert that the recommendations proposed herein are critically important. By involving the public in meaningful dialogue and decision processes, physicians are confident that the future of the health care system can be improved.

List of Recommendations

1. *The government of British Columbia should immediately articulate a clear vision for the health care system; one that includes identifiable system goals and objectives. The vision must:*

    a) *restore an appropriate focus on patient care*
    b) *promote care delivery as the core achievable value*
    c) *commit to long term planning and stabilization*
    d) *engender the application of patient care and management objectives in the planning and care processes*
    e) *be based on today's economic reality*
    f) *identify the critical issues in an honest and forthright manner*
    g) *specify the principles under which system renewal will occur*
    h) *provide meaningful operational guidance for managers and decision makers*
    i) *establish collaboration as the operative policy development model.*

2. *The government of British Columbia should immediately establish the nature and scope of services to be included as part of the publicly funded health care program, including, but not limited to, the specification of those services considered to be "medically necessary" as defined by the Medicare Protection Act and the Canada Health Act.*

3. *The government of British Columbia should immediately create a process for developing and applying a Patient Charter, for completion within the next three years. The Charter should address the public's legitimate expectations for health care delivery, as well as outline individual responsibilities and accountability mechanisms.*

4. *The government of British Columbia should immediately create opportunities to engage the public in meaningful dialogue concerning the health care system. The objective of the dialogue should be to:*

    a) *enable a comprehensive review and assessment of the vision statement*
    b) *review the nature and scope of services the government designates as part of the publicly funded health care program, including ways and means of making adjustments to that designation*
    c) *provide input into the development of the Patient Charter*
    d) *examine other issues as identified by the dialogue participants.*

5. *The governments of British Columbia and Canada must ensure that the public is provided with regular, factual information as to the cost and capacity of the health care system. The purpose of this information is to:*

    a) *provide an objective understanding of service availability and the collective ability to fund those services*
    b) *foster realistic expectations about existing and future system capacity*
    c) *facilitate the necessary public dialogue concerning the health care system.*

6. *The government of British Columbia must ensure that the public and health care providers are presented with regular monitoring reports on "health system performance," with a particular emphasis on outcome assessment and unmet need. The reports must include accurate information on emerging health issues, social policy and public concerns.*

7. *The government of British Columbia should immediately initiate a Task Force to make recommendations concerning appropriate, effective and practical accountability measures that may be implemented at all levels of financing and care delivery, covering each of:*

    a) *political accountability*
    b) *governance accountability*
    c) *payer accountability*
    d) *administrative accountability*
    e) *provider accountability, and*
    f) *public accountability*

8. *The government of British Columbia, and all other governing bodies that exercise decision making power at the local, regional or institutional level, must create formal and practical mechanisms that afford practising health care providers the opportunity to provide planning, operational and policy direction.*

9. *The governments of British Columbia and Canada must, as an immediate priority, focus their collective energies on stabilizing the health care system and restoring the confidence and morale of those who provide, administer and use health care services. This activity must provide for:*

    a) *a significant reinvestment in the acute care sector, including hospital beds, equipment, infrastructure, staff and home care programs*
    b) *a concurrent investment in the chronic, long term and rehabilitation/transitional care sectors, including construction of, and operational funding for, new and desperately needed beds and facilities*
    c) *a standard application of publicly funded health care benefits, regardless of whether care is provided in a hospital or a community/home environment*
    d) *the development and rapid implementation of a coordinated plan for mental health services*
    e) *expanded and enhanced professional training programs for physicians, nurses and health care technicians, including enhanced opportunities for those providers already working in the system through the strategic application of re-entry training initiatives*
    f) *increased flexibility in medical training, through the introduction of a more generic curriculum in the first post-graduate training year (PGY1), with the ability to alter post-graduate specialization selection following the completion of that year. This initiative must be coordinated through Canada's medical schools and licensing bodies.*
    g) *expanded and enhanced advanced skills and training opportunities for Family and General Practice Physicians practising in communities distant from established regional centres. These initiatives will require the development and application of basic support programs, including locum, office overhead, travel and accommodation assistance where training occurs away from the home community*
    h) *the implementation and augmentation of incentive mechanisms to promote the recruitment and retention of providers in areas of demand*
    i) *an acceleration in the development of infrastructure and applications in the field of tele-medicine and electronic patient record storage and management*
    j) *in collaboration with providers, improved connectivity of physicians' offices and facilitation of the electronic transfer of appropriate patient care information. This activity must include an accelerated development of systems, infrastructure, software applications and training, while based on clear agreements addressing the issues of consent, use and stewardship of electronic based patient information.*
    k) *the adoption of a charter of rights for health care providers, such as the Charter for Physicians produced by the Canadian Medical Association.*

10. *Concurrent with the stabilization activity, and based on their vision statement, the government of British Columbia should create the necessary fiscal and policy environment to ensure the development and application of a long term planning strategy for the health care system.*

11. *The government of British Columbia must facilitate the development of a provincial service plan in order to coordinate the most efficient access to scarce treatment and diagnostic services. This plan should include as key components:*

    a) *the creation of defined regional centres, where secondary and tertiary specialist physicians would be available, so as to optimize the availability of scarce specialist services*

b) an extended role for family and general practice physicians with additional training, to provide needed care in areas where specialist services are not available.

12. As a further step to coordinate improved patient access, the government of British Columbia should develop, with family and general practitioners, primary care delivery models that:
a) encourage and support the provision of a full spectrum of primary care services
b) advance collaborative practice and productive alliances amongst FP/GPs
c) promote the use of funded nursing and other ancillary personnel within family physician offices under the physician's management and jurisdiction.

13. The government of British Columbia must rationalize the integration of the public and private care delivery sectors within the existing framework of the publicly funded program. This integration should include:

a) the regulatory framework within which both public and private care facilities must function
b) the establishment of transparent performance and delivery standards for each facility
c) the introduction of competitive bidding processes between facilities for care and treatment, regulated under the authority of the appropriate governing agency.

14. The governments of British Columbia and Canada must ensure that there is a stable, predictable and long term financial commitment to the province's publicly funded health care system, that reflects the convergence of need versus ability to pay.

15. The government of Canada should ensure that the Canada Health and Social Transfer (CHST) is appropriately indexed to reflect the status of Canada's economy, population growth and population aging.

16. Health care related revenue received under the Canada Health and Social Transfer (CHST) should be clearly designated for use in the health care sector. In this regard, and to enhance transparency, the government of British Columbia should fix the proportion of CHST so designated.

17. Provincially raised revenue for publicly funded services should remain a blend of premiums, general revenue, private co-payment and public charitable donations.

18. As a mechanism to enhance transparency and cost accountability, the level of health care premiums should more closely reflect the total cost of program delivery.

19. The inconsistent and uneven application of co-payment charges across current health care programs should be rationalized immediately. Co-payments should be applied in a fair and equitable manner that does not impede access to necessary care, yet encourages appropriate use of the health care system.

20. The annual health care budget process should be based on a minimum of a three-year horizon. Operational and capital budgets must be identified three years in advance, with adjustments made only on a compelling basis. Annual surpluses should remain in the system for discretionary or long-term use, within prescribed limits by the appropriate governing agency.

21. *The provincial health care budgeting process must reflect a commitment to the government's stated vision and adequately reflect decisions made concerning the scope of coverage of publicly funded services. The budget process should incorporate:*

    a) *defined system goals and objectives*
    b) *a plan for resource for allocation between regional and program areas*
    c) *predictable growth in health care use*
    d) *escalators for population growth and aging*
    e) *adjustments for wage and price negotiations with providers and support staff*
    f) *a defined and consistent level of funding for the maintenance and replacement of capital infrastructure and equipment and communications technology.*

22. *The governments of British Columbia and Canada should immediately review the creation of tax related programs that will help health care consumers offset the out-of-pocket cost of health care services and promote the judicious use of services. Elements could include:*

    a) *an increase in the currently allowable tax credit*
    b) *temporary adjustment to an individual's annual personal tax exemption status where anticipated health care expenses would result in a tax credit*
    c) *a health care savings plan program, similar to the RRSP program, for application to anticipated and significant future expenses such as long term care and home care*
    d) *tax credits related to lower levels of health care use.*

23. *The government of British Columbia must immediately review the effectiveness of the existing health care management process and clarify the roles and responsibilities of the various levels of health care governing authorities. These roles should be classified in terms of policy, funding, operational management and program administration functions.*

24. *The government of British Columbia should retain responsibility and accountability for establishing health care policy and for funding the health care system. These roles entail:*

    a) *a clearly articulated health care vision statement*
    b) *a determination of those services to be included in the publicly funded system*
    c) *establishing overall system goals and objectives*
    d) *establishing performance standards*
    e) *monitoring progress against those performance standards*
    f) *facilitating health and health related research*
    g) *directing the development of a human resource plan (training and distribution)*
    h) *facilitating the use and application of electronic records and communications*
    i) *negotiation of wage and price adjustments for the health care sector*
    j) *ensuring funding levels that support the identified goals and core services by, amongst other activities, implementing those initiatives listed above in the section, An Approach to Sustainable Caring*

25. *The existing regional structure of management should be retained, but in a modified form. The number of regional authorities should be significantly reduced, to a maximum of eighteen and fewer if possible.*

26. The government of British Columbia should assign the operational management of the health care system to an independent arms-length body. This Health Care Services Authority (HCSA) would be:

a) created with a clearly defined legislative mandate, similar in nature, but broader in scope, to that of the existing Medical Services Commission
b) responsible to the Legislative Assembly through an all party committee
c) appointed by the government of British Columbia for multi-year terms, from lists of nominees advanced by the all party committee, health care provider groups/agencies and the general public
d) representative of the public, business, provider and health care agency communities
e) responsible for selecting its own Chair and a Chief Executive Officer.

27. The Health Care Services Authority should be given a mandate to:

a) implement the government's vision for health care
b) prepare an operational plan based on the government's goals and objectives, including the establishment of individual goals and objectives for each region
c) develop plans to operationalize directions 10, 11 and 12 listed above in the section entitled A Process of Care Renewal
d) support and centrally administer a plurality of provider payment mechanisms
e) allocate funding to the regions of the province based on the operational plan
f) provide overall management guidance to the system
g) make recommendations to the government with respect to the level of funding required to deliver publicly funded services
h) exercise authority, where necessary to offset any budget shortfall, including temporary deinsurance of services and adjustment of premiums and co-payment charges.

28. Regional administrators would become employees of, and report to, the Health Care Services Authority. Administrators would have responsibility, and be held accountable, for:

a) meeting the regional goals and objectives of the HCSA operational plan
b) funding allocation within the region
c) program administration within the region
d) making recommendations to the HCSA with respect to the level of funding required to implement the operational plan

29. The government of British Columbia should act to ensure that regional health boards are realigned and are converted to advisory bodies to maintain the necessary level of community input into health care policy and operational decision processes. The new Advisory Boards should provide advice:

a) to regional administrators concerning local area needs, issues and programs
b) to the HCSA concerning access problems and program successes
c) to the government concerning the performance and responsiveness of the HCSA.

TURNING THE TIDE – SAVING MEDICARE FOR CANADIANS

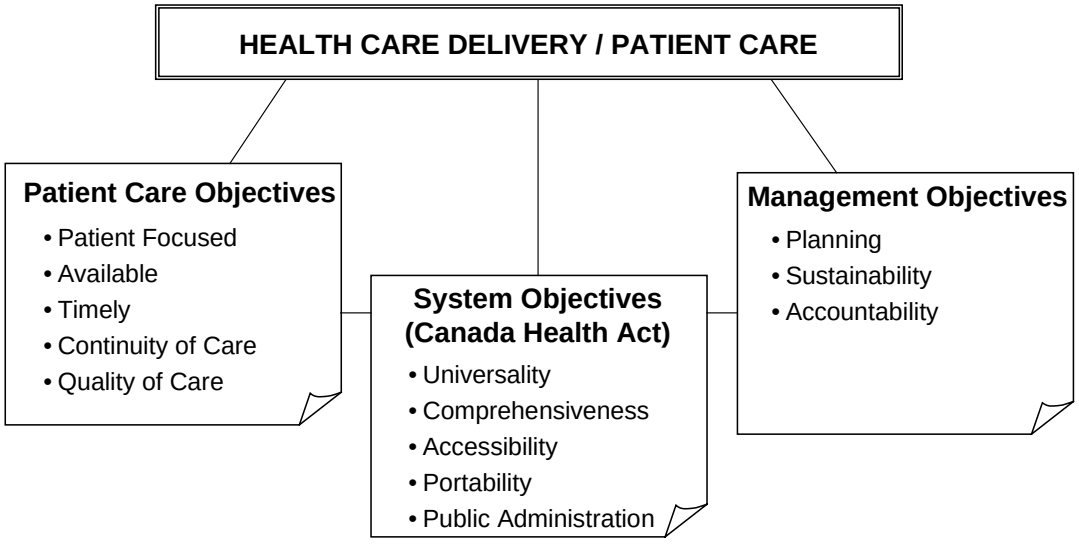
A NEW COURSE FOR HEALTH CARE

Chapter 1 Introduction

This is the second of a two part document prepared by the British Columbia Medical Association, proposing a series of reform initiatives for British Columbia's health care system.

In Part I of *"Turning the Tide; Laying the Foundation for Sustaining Medicare"* (July 2000), BC physicians identified the most significant factors influencing health care policy and summarized the existing challenges and problems in the health care sector. Part I concluded that the current health care system was unsustainable, and proposed a new framework for a sustainable and accountable health care program[1]. The proposed framework entailed the integration of a set of patient care, system and management objectives that could be clearly understood by the public and that would strengthen, enhance and clarify the principles of the Canada Health Act. A graphic representation of this framework is provided in Figure 1 below.

Figure 1
A Framework for a Sustainable and Accountable Health Care Program



Necessary system objectives encompass the five principles of the Canada Health Act (universality, accessibility, comprehensiveness, portability and public administration). However, these principles require further refinement through a more precise definition and a clear articulation of their scope and limits. Nevertheless, striving towards a set of mere system objectives is not sufficient. The health care system must become more patient focussed and deliver more available, timely and continuous care of high quality. The application of necessary patient care and management objectives would help establish a needed transparency and

[1] Readers would benefit from a review of Part I of the document, particularly Chapter 4 (found at www.bc.a.org). For those who are not so inclined, this introduction provides an abbreviated account.

clarity to the principles of accessibility and comprehensiveness, thus better defining the requirements of modern health care.

Successful application of the proposed framework can be accomplished through a well articulated, comprehensive and multi-year plan that matches public demand, need and expectations with system capacity, in a sustainable and accountable manner. The Conference Board of Canada has projected that if the status quo were to prevail, by the year 2020 fifty-three cents of every BC tax dollar would be needed for publicly funded health care[2]. This would come at the sacrifice of the quality of other "social safety net" and public programs. On the whole, this is not seen as consistent with Canadians' values.

A new framework for the delivery of health care means change. Tough choices are required. Attitudes need to soften. Political leaders must be open-minded with respect to current and anticipated deficiencies in the health care system. This paper proposes an array of needed initiatives to replace a failing system with one that can create a renewed level of public and provider confidence. Many of the proposed initiatives are controversial in nature. Ultimately, the public must decide which of these avenues they are prepared to pursue. It is their health care system and their choice to make.

The doctors of British Columbia believe that full public involvement in a meaningful dialogue on the health care system is long overdue. This dialogue must include an objective discussion of the complete range of health issues, covering a spectrum beginning with basic societal values and extending through to the delivery, management and payment of future care. This document's purpose is to stimulate and advance such a discussion.

It is time to chart a new course for health care in British Columbia.

> *"It is time for a dialogue on choices for the 21st century -- based on real and serious ideas, not empty soundbites."*
>
> *Allan Rock, Federal Minister of Health*
> *Presentation at the Launch of the Commission*
> *on the Future of Health Care in Canada*
> *April 4, 2001*

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2 The Conference Board of Canada, *The Future Cost of Health Care in British Columbia, Challenges to Sustainability*, April 2000, p 16.

Chapter 2 Turning the Tide

The challenges facing the health care system are daunting.[3] Most providers have concluded that not only is the current publicly funded Medicare program unsustainable, it is also unacceptable, providing unsafe and inadequate care on too many occasions. The Canadian Association of Radiologists recent exposure of the serious inadequacy of up to 63% of Canada's x-ray and diagnostic imaging equipment serves as a prime example of a health care system in severe distress and putting patients at risk.[4]

Evidence from opinion polling suggests that the public shares this view. In March of 2001, Ipsos Reid reported that 64% of British Columbians felt the current health care system provided worse care than ten years ago, an attitude that reflects a steady erosion of public confidence over the past decade.[5] In further support of this view, Dr. Scott Evans of Goldfarb Consultants presented material to the Standing Senate Committee on Social Affairs, Science and Technology, indicating that the percentage of Canadians who perceive the health care system to be working well had declined from 45% in 1989, to 14% in 1999[6].

These are telling sentiments. The public's confidence in the system's capacity to deliver high quality care is waning. The same can be said for provider morale.

The litany of access and care problems is simple enough to describe, but practical solutions are significantly more difficult to identify. Many health sector analysts are employed in pursuit of this objective, dealing with aspects such as quality improvement and utilization management, aimed at improving the efficiency of a variety of individual components of the health care system. Although these represent important efforts, more energy must be expended on broader systemic issues. Beyond primary care renewal, meaningful debate of issues such as scope of coverage, private financing and delivery and long-term sustainability is virtually non-existent. In some circles, such discussions are considered taboo.

Yet, health care problems are sufficiently serious that consideration must be given to these matters. At the May, 2000 Medicare Forum, *"Sustainability and Accountability in the 21st Century"*, an open dialogue occurred around some of these very issues.[7] Participants called for leadership and innovation in meeting the many challenges ahead. At approximately the same time, the Canadian Medical Association heard a similar challenge from the Institute for Research on Public Policy. The Institute called for a debate on opening up the health care system to new approaches that are patient, consumer, and market sensitive, yet continue to reflect a commitment to universal access, concentrating on design, finance, structure and adaptability.[8]

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3 For an overview, see Part I*, Laying the Foundation for Sustaining Medicare*, p. 20-49.

4 Canadian Association of Radiologists, *Timely Access to Quality Care*, March, 2001.

5 Ipsos-Reid, *Healthcare in Canada,* March 12, 2001.

6 Goldfarb Consultants, presentation to the Standing Senate Committee on Social Affairs, Science and Technology, March 22, 2000, Slide 6.

7 May 11-12, Robson Square Conference Centre, Vancouver. BC. Jointly sponsored by the British Columbia Medical Association (BCMA) the Canadian Medical Association (CMA), the Health Association of British Columbia (HABC) and the Registered Nurses Association of British Columbia (RNABC).

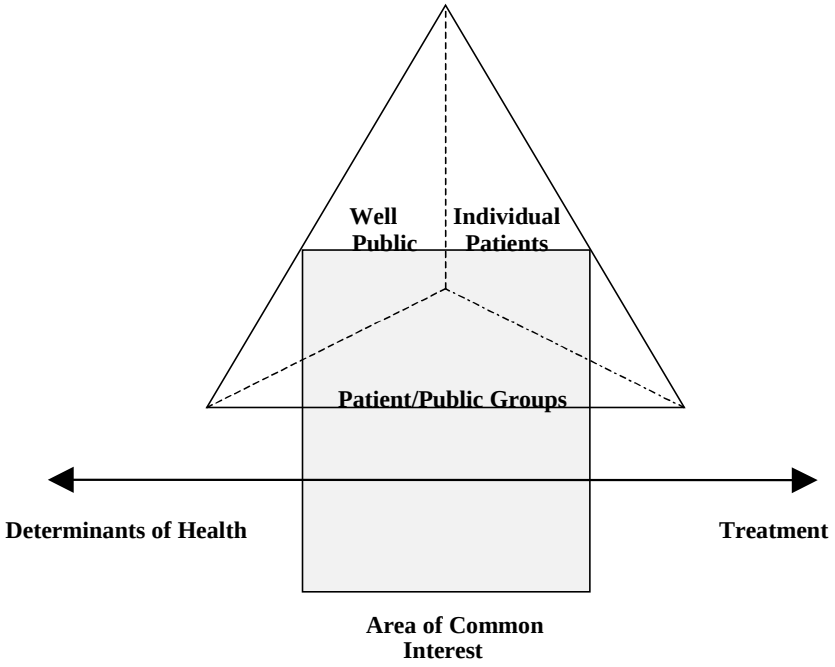
8 Institute for Research on Public Policy, *Breaking Down the Barriers to Change in Our Health Care System*, Hugh Segal, President, Address to the CMA Leadership Conference 2000, March 2, 2000, Westin Hotel, Ottawa Ontario, p. 5.

These calls for leadership and innovation could not have come at a more critical time. Action is required now if the scenario of 53% of revenue in 2020 projected by The Conference Board of Canada is to be averted. Clarity of purpose and bold initiative is necessary.

The foundation for addressing these issues was clearly laid out in Part I of this report. However, a foundation without a comprehensively developed structure is of little value. The first step in formulating that structure requires the development of a more fundamental understanding of the variety of health care constituencies and interests that shape the decision process.

Within the context of the total health care system, three distinct constituencies exist at any given point in time: the generally well public, individual patients and their families who are sick and/or in need of care, and a variety of patient or public cluster groups who have organized themselves for a common purpose (such as AIDS Societies). Each of these constituency groups has a varied interest in health and health care services, that cut across a broad spectrum of activities. This interaction of constituencies and interests is illustrated in Figure 2.

Figure 2
Health Constituency and Interest Interaction



The three distinct public/patient constituencies can be visualized as a pyramid, with each of the three sides, or sectors, representing a different group. At the risk of oversimplification, in one sector is the well public, whose focus is primarily on staying well. Although this group has an expectation that they will receive rapid access to quality care should they fall ill, they are likely to view prevention, health promotion and the societal determinants of health as key elements for government funding. In the second sector are individual patients, in immediate need of treatment or care. These individuals are more inclined to be interested in the accessibility, timeliness and quality of treatment programs. They tend to focus more on the 'here and now' aspects of health care. This group is the most vulnerable and failure to deliver adequate or timely services has a direct and immediate impact on their lives. The third sector is made up of

a variety of groups who are dedicated to advancing the special interests of a particular program or care need and can muster very successful lobbying and fund raising efforts to do so.

These sectors are very fluid and are constantly changing. While individuals in the well public and individual patient sectors are, at any given point in time, mutually exclusive, the special interest cluster can draw members from each of the first two categories. Individuals will shift between sectors on more than one occasion during the course of their lifetime and their immediate health interests will be affected by such shifts.

These health interests are depicted by the service vector that runs across the base of the pyramid, which represents the available continuum of care in the broadest sense. On one extreme are programs that affect the health of the population, but are not health care services per se, most frequently referred to as the 'determinants of health'. Dr. Fraser Mustard has described these to include the "social, economic and cultural factors under the headings of physical environment; family structure; life experiences; situations at home, in the neighbourhood and at work; psychological factors such as ambition and motivation; social acceptance or rejection; economic factors related to employment, earnings, housing and income support for vulnerable groups."[9]

On the other extreme end of the vector, is the treatment of patients who are ill and in need of high intensity, acute care services. In between these two extremes lies an array of educational, support and intervention/care activities, representing the full health service continuum. This continuum includes public health, health promotion, illness prevention, wellness, ambulatory, chronic, long term, home care and acute services. The continuum is often more simply expressed as consisting of "wellness" services at one end and "illness care" at the other.

Viewing the array of available health services in this manner provides a useful discussion framework, albeit an overly linear one. In reality, complications arise because it is frequently difficult to make a clear distinction between those services that are prevention or wellness based, and those that are part of a regimen of treatment. An example is a dietary and exercise program for the post-surgical cardiac patient; this is simultaneously both a prevention and a treatment activity. Shah provides a valuable discussion of this issue, identifying three levels of prevention: primary, preventing disease before it occurs; secondary, early detection (e.g. screening) enhancing the success of treatment, and; tertiary, reducing complications by treatment and rehabilitation.[10]

Equally difficult is superimposing the complexity of interactions amongst provider groups and agencies across the continuum. Individual providers or agencies will be involved in delivering elements of several of these service components, in a variety of practice settings. There is little "exclusivity" here. For example, the physician's role is not limited to treatment activities. Physicians play a lead delivery role with respect to virtually the entire range of services on the continuum, including health promotion activities that enhance health through counselling, risk avoidance and risk reduction (such as the use of bicycle helmets and anti-smoking initiatives), early disease identification through screening procedures, and complication reduction through the use of specific therapies.[11]

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[9] Canadian Institute for Advanced Research, *The Health of Populations and the Program in Population Health*, CIAR #1, January 1989, p. ii.

[10] Shah, C.P., *Public Health and Preventive Medicine in Canada*, University of Toronto Press, 1994, page 26.

[11] Canadian Medical Association, *The Role of Physicians in Prevention and Health Promotion,* approved by the CMA Board of Directors, July 15, 1995, www.cma.ca/inside/policybase/1995/7-15.htm, May 2001.

Notwithstanding these complexities, Figure 2 assists in demonstrating an important principle. If it were possible, a simultaneous mapping of the public/patient constituencies against their varied interests would guide health administrators in the resource allocation process. In general, such a mapping would reveal a zone of common interest that includes a mix of services from the continuum, involving both health determinant/prevention priorities and those of treatment and care. However, there would also be interests that would be mutually exclusive to each of the constituencies.

Although the continuum of services is integral to a long term health outcome, in the short term the sectors do actually compete with one another for resource allocation and, in a very real sense, each possible allocation will benefit different patient and public groups. The optimum allocation depends on established system objectives, but good public policy dictates a proper balancing of interests, guided by the demands of society.

Fittingly, these competing interests have been recently noted by the Standing Senate Committee on Social Affairs, Science and Technology who, at Section 6.2 of their Interim Report queried very directly the best balance between prevention and treatment. In particular, the Senate Committee noted the presentation of Dr. John Millar of the Canadian Institute for Health Information (CIHI) who stated, "The more money that goes into the health care sector …, the less that is available for other things like early childhood care. There is always that balance that one has to trade off, and that is very important."[12]

Successful restoration of the health care system will need to acknowledge the diversity of interests noted from the above discussion, blending them with the necessary system, patient care and management objectives.

In the final analysis, society must decide whether they want their publicly funded health care system to have a primary focus on prevention or treatment. Concurrently, direction is needed with respect to the corresponding service delivery and financing trade-offs. Available evidence would suggest that the public places a primary emphasis on care and treatment over prevention and promotion. Angus Reid reports that regional polling responses vary from 57% to 74% in support of treatment initiatives over health promotion,[13] while the Standing Senate Committee concludes that public interest for community based activities are secondary, with non-care related activities receiving a low priority for new health care funding.[14]

Whether this is an emphasis that British Columbians truly support is a fundamental question. The doctors of BC believe the polls accurately reflect societal interests. Accordingly, this paper charts a new course for the health care system; one that is founded on responsible and sustainable caring, provides a structured plan for care renewal and manages the renewal process within an effective governance model.

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12 The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role, Interim Report, Vol. One - The Story So Far*, Hon. Michael J.L. Kirby, Chair; Hon. Marjory LeBreton, Deputy Chair, March 2001, Chap. 6.2, p.3.

13 Angus Reid, *The Public Domain: Current Public Opinion Attitudes and Expectations on Canada's Healthcare System*, May 11, 2000.

14 The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role*, *Interim Report, Vol. One - The Story So Far*, Hon. Michael J.L. Kirby, Chair; Hon. Marjory LeBreton, Deputy Chair, March 2001.

Chapter 3 A Philosophy of Responsible Caring

A prerequisite to moving forward is knowing where one wants to go. It would appear that the answer is far from certain. Mandates and responsibilities of the provincial government, regional authorities and health care providers are not at all clear, as evidenced by the calls for greater emphasis on the determinants of health amidst the obvious delays and impediments to accessing care today. Present and looming provider shortages make the future even less certain. The health care system is desperate for practical, quality leadership.

Government must provide this needed leadership and they must do it now. British Columbians, whether they be patients, providers or the general taxpaying public, deserve a clear vision statement for their health care program. The vision must go beyond the generalities of broad system objectives and provide meaningful guidance for patient care, direction for management initiatives and promote understanding amongst all.

The idea is not new. There are two existing health care vision statements that are particularly relevant to review. The first belongs to the BC Ministry of Health:[15]

> *"Our provincial health care system embraces the five principles of Medicare and the Canada Health Act: comprehensiveness, universality, accessibility, portability and public administration.*
>
> *Through a broad range of programs, services and public funding, the Ministry (of Health) is responsible for ensuring the maintenance of high quality, accessible, affordable health care for British Columbians.*
>
> *The provincial government has approved the Health Goals for British Columbia. These goals[16] set out the province's vision for a healthy population and provide a framework for action to improve the health of British Columbians and reduce inequalities in the province."*

The second vision statement is that of Canada's First Ministers, drafted during their September, 2000 meeting:[17]

> *"Canadians will have publicly funded health services that provide quality health care and that promote the health and well-being of Canadians in a cost-effective and fair manner."*

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15 BC Ministry of Health, *Mission Statement*, last revised Jan. 2, 2001, www.hlth.gov.bc.ca/cpa/mission.html, May 2001.

16 The goals are six in number: (1) positive and supportive living and working conditions in all our communities; (2) opportunities for all individuals to develop and maintain the capacities and skills needed to thrive and meet life's challenges and to make choices that enhance health; (3) a diverse and sustainable physical environment with clean, healthy and safe air, water and land; (4) an effective and efficient health service system that provides equitable access to appropriate services; (5) improved health for Aboriginal peoples, and; (6) reduction of preventable illness, injuries, disabilities and premature deaths. These are available on the Ministry of Health website at www.hlth.gov.bc.ca/pho/hlthgoal/goals.html, *Health Goals for BC,* (accessed May 2001).

17 First Ministers on Health Renewal and Early Childhood Development (ECD), *First Ministers' Communiqué on Health*, September 11, 2000.

And, as a corollary:

> *"First Ministers believe that the key goals of the health system in Canada are to: preserve, protect and improve the health of Canadians; ensure that Canadians have reasonably timely access to an appropriate, integrated and effective range of health services anywhere in Canada, based on their needs, not their ability to pay; and, ensure its long-term sustainability so that health care services are available when needed by Canadians in future years."*

These vision statements provide useful information to the public. Although similar in some respects, they contain distinct differences and provide valuable insight into the mindset of Canadians' current political leadership.

The existing BC government vision is focussed on (a) maintaining system objectives (i.e. the principles of the Canada Health Act) and (b) enhancing the determinants of health (educational, living, income, prevention and environmental factors). Indeed, there is only passing mention of the term "health care" and no reference at all to "patient care." Neither do the issues of accountability and sustainability appear. Of the six stated health goals of the BC Ministry, only one deals with the health service system and the general thrust of that is to eliminate unnecessary or ineffective health care, so as to prevent harm to people's health.

It is self-evident that no one would want to promote unnecessary care, or do things to harm the health of the population. Enhancing the general level of health of the population is a laudable goal of the government and requires effort and attention. But, in a publicly funded health care system the business of care, of ensuring available and equitable access to quality services, is also important. Should the province's vision and goals not include some substantive statements about care for those in acute need, chronically suffering or in long-term care institutions? The existing provincial vision provides little in the way of solace for those in need of treatment or assistance.

In this respect, the First Ministers' vision offers some improvement, providing significantly more emphasis on the ***health care*** component. In addition, the First Ministers at least note the issue of long-term sustainability. In effect, this vision incorporates at least some of the elements of each of the fundamental system, patient care and management objectives detailed in Part I of this report.

However, this vision remains inadequate, as it omits important elements of the health determinants philosophy, ignores the important existing role that is played by the private sector and is weak on key aspects of the patient care and management objectives which are necessary to sustain the publicly funded health care program. British Columbians and all Canadians need something better, something that creates a stable framework within which all can move forward with a set of reasonable expectations and an understood purpose.

A vision statement should be clear, establish guidelines, provide a sense of purpose and instill a long-term focus. It should also include the legitimate claims of relevant stakeholders. The extent to which the two government visions reflect these qualities is open to interpretation, however, there are two things that are fairly apparent from a careful review:

a) they are less than forthright. No mention is made of the fact that there is a private pay portion of many publicly funded health care services and that these private payments are neither uniform nor equitable;

b) they portray an optimistic, and perhaps unattainable, picture of the present and future state of the health care system and create unreasonable expectations as to what can be delivered and where.

The doctors of British Columbia believe the problems facing the health care system are real and they are pervasive. If there is hope for sustaining Medicare, now is the time for a realistic and in-depth look. A vision of value must be explicit and honest. It must have real operational usefulness and not raise expectations for services and programs which are not affordable. The following is one such possible vision.

Proposed Health Services Vision Statement

The goal of the health services system is to preserve, protect and improve the health and well being of each British Columbian. This goal is pursued by the application of a continuum of services that seeks both to keep people well and to improve the longevity and the quality of life of individuals with acute and chronic care needs. Quality patient care is the paramount objective. In general, the needs of the individual who requires care supersede the overall needs of the well public.

British Columbia's health services system respects the principles of the Canada Health Act, and promotes the application of patient care and management objectives in order to sustain Medicare into the future as a predominantly single payer public program.

British Columbians can expect a health services system that promotes timely access to an appropriate, integrated and effective range of quality health services. These services will continue to be provided through a planned, responsive, and regulated blend of public and private delivery and financing. The scope and mix of public and private financing and delivery will be determined by public choice, applying transparent processes, and regularly assessed against a combination of public demand and fiscal sustainability.

Publicly financed programs will be provided with stable long term funding that will be adequate to maintain safe and acceptable levels of human and capital infrastructure, permit the cost-effective use of modern technology and to provide for uniform benefits.

Effective short and long term health care policy development will be achieved through the application of a collaborative model, with broad-based provider, public and government involvement.

With the joint responsibility for policy development comes a corresponding requirement to be held collectively accountable for choices and directions chosen. Government, providers and the public are accountable to each other for all aspects of the effective provision and use of health services.

The reader will note that this vision places a primary emphasis on care over prevention. This position is not to suggest that spending on preventive programs is unimportant, or even that prevention initiatives should always be secondary to treatment, with childhood vaccination programs a classic example of a prevention priority. But, in general, when faced with alternative uses for the next health dollar, this vision statement calls for expenditure on treatment and care over prevention and health determinant initiatives.

Of equal importance in this vision is the call for leadership and accountability from political leaders. In a December, 2000 Pollara Research poll, 87% of Canadians expressed an interest in the federal and provincial governments working to develop national health goals, while 65% said they were not satisfied with how accountable governments are to the public.[18] The statement proposed herein makes it clear where government would stand on the treatment versus prevention issue, commitment to core values, public/private partnerships, fiscal sustainability, collaboration and accountability.

Without a clearly stated vision, managers will continue to flounder, applying patchwork solutions to an unsustainable system. The vision must address the health of the population as well as the health care system, be transparent, practical, avoid raising false expectations and provide a direction for initiative at the managerial level.

RECOMMENDATION 1

The government of British Columbia should immediately articulate a clear vision for the health care system; one that includes identifiable system goals and objectives. The vision must:

a) restore an appropriate focus on patient care
b) promote care delivery as the core achievable value
c) commit to long term planning and stabilization
d) engender the application of patient care and management objectives in the planning and care processes
e) be based on today's economic reality
f) identify the critical issues in an honest and forthright manner
g) specify the principles under which system renewal will occur
h) provide meaningful operational guidance for managers and decision makers
i) establish collaboration as the operative policy development model.

Closely tied to the articulation of a comprehensive vision statement are the issues of identifying the scope of services to be included in the publicly funded health care program and the public's reasonable expectations with respect to access to those services.

When Medicare began, it was fairly easy to understand what the program was about; medical and hospital services, with minor exclusions, were covered under the plan. Much, however, has changed since then. The 1984 Canada Health Act opened up coverage possibilities to non-

[18] Pollara Research, *Health Care in Canada Survey,* September 2000, www.pollara.ca/new/POLLARA_NET.html (accessed May 8, 2001).

physician providers under the comprehensiveness principle and all provinces have ramped up coverage of additional services as part of the publicly funded program. To Canadians, Medicare is now broadly interpreted as referring to any health or health care service funded by government that can be fitted into the continuum of care discussed in Chapter 2.

Maintaining a sustainable publicly funded health care program will require a determination of which services across the continuum should be available under the public program. Discussion of this matter has been occurring for some time, variably concentrating on the broad issue of all services, commonly referred to as "core services," and the more narrow issue of those services deemed to be "medically necessary," and thus provided by physicians. The terms "medically necessary" and "core services" are not synonymous and should not be used interchangeably. In general, medical necessity should refer to whether there is a sufficient health benefit to the patient resulting from the provision of a service. Alternatively, core services should refer to the identification of a group of services that are to be provided under the publicly insured program. Both are important, but a clear distinction must be made.

The term "medically necessary" is grounded, but does not specifically appear, in the language of the Canada Health Act (CHA, 1984). The British Columbia Medicare Protection Act (MPA, 1996) is similarly configured. Interpreting the definitions contained in the CHA leads most reviewers to conclude that any services rendered by medical practitioners are insured services, unless otherwise stipulated in provincial legislation. By inference, therefore, arguably all physician services provided are medically required. The Acts provide no useful guidelines or suggestions as to exactly what is, or is not, "medically required", or "medically necessary," yet, by law require such services to be insured.[19]

Thus, policy makers have been handed a dilemma. Although the issue of what services should be covered under a public program is critically important, they must work within a fairly confined legislative framework, with the permissible scope for decision making being anything but clear. Consequently, numerous methodologies for defining medically necessary and core services have been considered, falling into five basic categories:

1. *Condition related* - assessed by general diagnosis or treatment group
2. *Service related* - assessed by specific service to a particular person
3. *Volume dependent* - limitation of the number of procedures performed over a specific period of time to meet specific budgetary targets
4. *Utility based* - assessed by urgency/degree of dysfunction vs. potential benefit from treatment
5. *Service provider specific* - determination based solely on who provides the services

Each approach raises a different set of issues and difficulties and there is no simple solution. Deber et.al. have proposed utilizing a decision framework based on the criteria of effectiveness, appropriateness, informed decision making and, finally, a decision to insure.[20] While it is

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[19] One of the bedevilling aspects of the term 'medically necessary' is that it reflects a black or white view that something is, or is not, necessary in absolute terms. In fact, medical services should be viewed as a continuum of interventions, reflecting varying degrees of benefit, that can potentially be subjected to a value judgement where rationing is required.

[20] University of Toronto, Department of Health Administration, *Comprehensiveness in Health Care*, Deber, R., Ross, E. and Catz, M., April 1994.

difficult to deny the logic of this approach, the shear magnitude of the required effort has made most analysts intuitively cautious.

The doctors of BC do not believe there are any objective clinical criteria that would, in themselves, enable the development of a priority preference list of services, a position supported by the 1997 National Forum on Health.[21] A decision to restrict the scope of services covered under health insurance must be a policy choice implemented by government, based on economic factors, public opinion, and medical input. Ultimately, however, this decision is one of economic rationing, not medical necessity, and the choice of rationing methods must be determined by the public through an explicit and transparent process.

Within the context of sustainability, the publicly funded program cannot be all things to all people. Unlimited service provision within constrained budgets is not a viable position. Society must make a clear statement about what Medicare means to them and how they will shape it for the future.[22]

It is encouraging to note that Mr. Roy Romanow, recently appointed head of the Commission on the Future of Health Care in Canada, has expressed a similar view. [23] Mr. Romanow now has the opportunity to make that effort a reality.

RECOMMENDATION 2

The government of British Columbia should immediately establish the nature and scope of services to be included as part of the publicly funded health care program, including, but not limited to, the specification of those services considered to be "medically necessary" as defined by the Medicare Protection Act and the Canada Health Act.

Once having defined the available scope of services, it will be incumbent upon government to work with the public to establish a set of criteria describing reasonable access to these services. This work could form the basis for a Patient Charter.

The Charter should eventually address the legitimate expectations of the BC public for health care delivery, concentrating on the issues of availability, accessibility, timeliness and quality. It should also clearly lay out the responsibility and accountability of the individual, within and for, the health care system. This process should entail a "grassroots" philosophy, built from the ground up, involving widespread consultation and public dialogue.

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21 National Forum on Health, *Canada Health Action: Building on the Legacy - Vol. II: Synthesis Reports and Issues Papers,* Striking a Balance Working Group (SBWG), Ottawa, p. 42 (of SBWG report).

22 In *Healthcast 2010, Smaller World, Bigger Expectations* (1999), PriceWaterhouse Coopers provides a futuristic look at Canada's health care system and reaches a similar conclusion.

23 Toronto Star, *Looking for Vital Signs*, Walkom, T., May 5, 2001.

RECOMMENDATION 3

The government of British Columbia should immediately create a process for developing and applying a Patient Charter, for completion within the next three years. The Charter should address the public's legitimate expectations for health care delivery, as well as outline individual responsibilities and accountability mechanisms.

The processes of establishing a core set of publicly funded services and of Patient Charter development cannot be accomplished without significant public input. The Canadian Medical Association has clearly identified this need through their Futures Project, noting that, "Health, health care and medicine are shaped by the society of which they are a part, with its cultural values, social systems, environmental and economic conditions and technological sophistication. The health care system of the future, and the practice of medicine within that system, will reflect society, not the other way around."[24] At present, however, there appears to be a disconnect. According to the December, 2000 Pollara research, 64% of the public are not satisfied with the input they have on the future direction of the health care system.[25]

In the same Pollara poll it was reported that 95% of Canadians think it is important that those people who decide which health services are covered by Medicare be held accountable to the public for their decisions. Delegating responsibility for shaping the health care system to policy analysts within, or contracted by, the government is the way of the past. Overall, health care advisors need to focus on less directing and more listening. It is the public's health care system; they need and expect a stronger voice. The doctors of British Columbia support the premise that the public has a right to be involved in the decision process and, concurrently, to assume a degree of responsibility and accountability for the decisions they help make.

RECOMMENDATION 4

The government of British Columbia should immediately create opportunities to engage the public in meaningful dialogue concerning the health care system. The objective of the dialogue should be to:

a) enable a comprehensive review and assessment of the vision statement
b) review the nature and scope of services the government designates as part of the publicly funded health care program, including ways and means of making adjustments to that designation
c) provide input into the development of the Patient Charter
d) examine other issues as identified by the dialogue participants.

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[24] Canadian Medical Association, *Looking at the Future of Health, Health Care and Medicine*, August, 2000, p.3

[25] Pollara Research, *Health Care in Canada Survey,* September 2000, www.pollara.ca/new/POLLARA_net.html, (accessed May 8, 2001).

The requirement for public involvement is of critical importance and is directly relevant to each of the recommendations contained in this report. Without greater public participation, effective change will not occur. In cases where the recommendations contained herein call for immediate and direct action, it is intended that those actions are subjected to open public dialogue and review. Where practical, that dialogue should occur prior to any implementation, but where not, as part of an ongoing review process.

Obtaining effective public input is not an easy task. Protection against the many opportunities for special interest factions to capture the agenda is particularly difficult. However, there are models of success to draw from. Two of particular note are the *"Dialogue on Health Care"* series organized by the BC Liberal Party in the fall of 2000 and the Alberta government's *"Health Summit"* held in February of 1999. These efforts employed two different approaches; the BC Liberals traveled to communities for town hall style meetings, while in Alberta randomly chosen citizens were brought to a central location for three days to discuss specific issues. Each initiative poses its own set of unique challenges, but the very fact they were undertaken is a positive development. These public dialogue opportunities need to be expanded and improved.

A key feature of the public dialogue sessions must be to advise the public as to the state and cost of their health care system. The public knows little about the cost of health care and understands less about issues concerning system capacity and service availability. If the expectation is for a better informed public to make effective choices concerning health and health care delivery, they must systematically and regularly receive relevant information. The public needs a better understanding of the issues in order to frame more realistic expectations for the health care system. While the province expends considerable effort and expense on educating the public with respect to health promotion and illness prevention activities, little is done to advise them of the cost, or the state, of the health care system.[26] This is a deficiency that must be corrected.

Equally important, the information must be factual and be communicated in a manner that is readily understood. Because the health care system has become so tied to political processes, it frequently appears that there is greater effort to conceal information, particularly that which might point to system deficiencies, than to reveal it. It is hoped that the recent commitment to clear and accountable reporting that is contained in the First Ministers' Agreement will deliver a greater degree of openness from governments.[27]

In addition to providing accurate information on capacity and cost, mechanisms must also be made available to monitor and assess how the system is progressing against the goals established by government. In this regard, the Provincial Health Officers' Annual Report provides an example of what can be done, as it tracks progress against the BC government's six stated health goals.[28] However, apart from the general inadequacy of the goals for those individuals in need of care and treatment, the existing Health Officer's report falls short of the

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[26] The notable exception is the BC Surgical Waitlist Registry, although concerns have been raised over both its accuracy and reporting methodology. The Registry does not include the time patients must wait for a specialist appointment or for any pre-surgical diagnostic tests, factors that can add considerable time to the length of a wait.

[27] First Ministers on Health Renewal and Early Childhood Development (ECD), *First Ministers' Agreement on Health Renewal and Early Childhood Development*, September 11, 2000, obtained from www.scics.gc.ca/cinfo00/800038004_e.html (accessed May 2001).

[28] Office of the Provincial Health Officer, *Report on the Health of British Columbians,* 1999, www.hlth.gov.bc.ca/pho/ar/index.html.

necessary process to adequately inform the BC public about the state of their health care system. While providing a rather extensive list of health indicators (health status, living/working conditions, physical environment, etc), there is little information with respect to system capacity, availability and access and cost.

This is not intended to be critical of the Provincial Health Officer. Such issues are beyond his mandate, but it is reflective of the preoccupation with the matter of health determinants, while the health care delivery system remains somewhat of an unknown quantity to the average British Columbian. Readily accessible and comprehensible information with respect to the state of health human resources, technology and capital infrastructure simply doesn't exist. Neither is there regular information addressing what the public views as current and emerging health and health care issues. More relevant information is required and more must be shared. Much of the data reviewed by the Provincial Health Officer is unavailable to the public and, he notes, is reserved for staff of the Ministries of Health and Children and Families, and that of local health authorities. Such selective viewing of data and information, regardless of the rationale, must be made more open if decision makers are to become more accountable for their actions.[29]

Periodic, large, comprehensive reports are, however, not the only mechanisms for introducing information to the public. This activity should be viewed as an ongoing process, capturing a variety of opportunities. These opportunities range from high profile, targeted media programs to things as mundane as receiving "receipts" for the cost of the services provided. Moreover, more effective use of the worldwide web for displaying comparative data and information is well within reach. All alternatives must be explored.

The complexities of the health care system can make it difficult for the general public to be adequately informed of the issues. However, the public is demonstrating an increasing appetite for information, and planners all too frequently underestimate their interest and ability to contribute to the planning process. Where understanding is incomplete, efforts should be made to educate. Where avenues for public input are absent, opportunities should be created. Public discussion and dialogue around the problems and potential solutions for the health care system should not be deterred.

RECOMMENDATION 5

The governments of British Columbia and Canada must ensure that the public is provided with regular, factual information as to the cost and capacity of the health care system. The purpose of this information is to:

a) provide an objective understanding of service availability and the collective ability to fund those services
b) foster realistic expectations about existing and future system capacity
c) facilitate the necessary public dialogue concerning the health care system.

[29] The recent report of the Canadian Institute for Health Information, *Health Care in Canada, 2001,* provides another example that is progressing in the right direction, but could be further improved with respect to reporting on system capacity and access issues.

RECOMMENDATION 6

The government of British Columbia must ensure that the public and health care providers are presented with regular monitoring reports on "health system performance," with a particular emphasis on outcome assessment and unmet need. The reports must include accurate information on emerging health issues, social policy and public concerns.

Development efforts in this regard are underway and need to be continued. Saskatchewan's Health Services Utilization Research Commission (HSURC) has proposed that monitoring the system should involve a six dimensional assessment based on effectiveness, equity, accessibility, acceptability (to users, non-users and providers), relevance and efficiency.[30] This approach is similar to that recommended by the Canadian Medical Association, who include the additional issue of accountability.[31]

The inclusion of accountability measures in system performance is an important one.[32] In recent years, there has been a groundswell of public interest in improved accountability mechanisms to ensure that tax dollars are spent wisely, as public tolerance for deficit spending has evaporated. Still, true accountability in BC's health care system is lacking.

While there are mechanisms in place at the service delivery level to ensure accountability amongst providers and hospitals in specific areas, accountability at the management and governance levels is less obvious. The impact of this problem is apparent to those working in the system; provincial health objectives are too general to apply in a meaningful way, monitoring mechanisms are woefully inadequate, market relevant incentives for performance-based funding are absent, and the public has been generally unresponsive to direct accountability initiatives to make them more cost-conscious or to assume greater responsibility for a healthy lifestyle. [33]

In this regard, Justice Emmett Hall noted In the 1964 Royal Commission on Health Services the need for personal, public and government accountability within the health care system, which he outlined in the "Health Charter for Canadians."[34] The doctors of British Columbia believe Justice

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30 Health Services Utilization and Research Commission (Saskatchewan), *System Performance Indicators: Toward a Goal-Based Health System,* August 2000, www.hsurc.sk.ca/

31 Canadian Medical Association, *Guidelines for Assessing Health Care System Performance,* July 2000.

32 Part I of this report identifies that "accountability is about ensuring that the system provides for the right services, at the right time, in the right place, by the right individual, at the right price. Specifically: (1) The health care system should be outcome driven. (2) The public is accountable for ensuring their access of the system is appropriate. (3) Providers are accountable for ensuring that only appropriate and beneficial services are provided, in a cost-effective manner. (4) Government is accountable for ensuring that services insured under the public program are clearly defined, that the necessary support resources and infrastructure required to deliver those services (including information systems) are in place and that the funding is adequate to support that service level.

33 There are numerous examples of the public's somewhat complacent attitude. For some, see Canadian Medical Association Journal, *Predictors of mammography use among Canadian women aged 50-69: findings from the 1996/97 National Population Health Survey,* Colleen J. Maxwell, Christina M. Bancej, Judy Snider, CMAJ February 6, 2001;164(3):329-34; and, Canadian Institute for Health Information, *Health Care in Canada*, 2001, Chap. 2.

34 The complete version of the 1964 Royal Commission's *Health Charter for Canadians* is contained in Part I of *Turning the Tide: Saving Medicare for Canadians*, BCMA, 2000.

Hall had it right; in order to develop and maintain the health care system, everyone has a duty to be responsible and accountable. Evolution to a system where all individuals are accountable to each other is a goal worth pursuing. However, this will not be an easy, or a particularly smooth road to travel.

RECOMMENDATION 7

The government of British Columbia should immediately initiate a Task Force to make recommendations concerning appropriate, effective and practical accountability measures that may be implemented at all levels of financing and care delivery, covering each of:

a) political accountability
b) governance accountability
c) payer accountability
d) administrative accountability
e) provider accountability, and
f) public accountability.

If, in fact, the various component pieces of the system are to become more accountable to each other, individuals must also become more actively involved in the decisions that will guide the health care system into the future. Recommendation 4 provides a much needed avenue for the public to gain access to this process. However, without an equal level of involvement for health care providers, a deficiency remains. Providers possess important and needed expertise, yet have been effectively marginalized in the decision process over the past decade.[35] This has occurred at both the policy and operational levels. Given their experience, commitment and patient/client confidence, they can and should play a positive and constructive role. Collaborative effort is required for effective delivery mechanisms.

RECOMMENDATION 8

The government of British Columbia, and all other governing bodies that exercise decision making power at the local, regional or institutional level, must create formal and practical mechanisms that afford practising health care providers the opportunity to provide planning, operational and policy direction.

[35] British Columbia Medical Association, *Obtaining Effective Medical Input into Regional Decision-Making,* October 2000.

Chapter 4 A Process of Care Renewal

Creating processes to ensure effective leadership, collaborative decisions and practical accountability mechanisms is key to restoring the public and provider confidence necessary to move toward a new future. However, these processes will not appear overnight. They will take time to develop and implement.

In the meanwhile, the existing health care system is enduring unprecedented stress. Physician, nursing and technical human resources are in critically short supply, with a concomitant effect on morale. Imposing challenges of recruitment of health personnel, initially felt mostly in rural BC, have now expanded to urban areas. Other symptoms are readily apparent; emergency departments are regularly on diversion, acute care beds are inadequate/inaccessible and transition, rehabilitative and long-term care beds are not available. Once patients do get access to the system, they face a bewildering situation of long waits, a confusing set of rules governing what is publicly funded and what is not, and an incomprehensible application of user fees/co-payment charges for some services.

Some immediate stabilization is required.

The September 11, 2000 First Ministers' Agreement has committed the federal government to significant re-investment in federal transfer payments over the course of the next five years. A small portion of these transfers has been earmarked for improvements in medical equipment, health information technology and primary care. As welcome as this re-investment is, it will mean little without a concurrent commitment from the provincial government to address needed areas.

Government should, as a priority, invest in acute and chronic care services, including hospital, home care and long term care programs. A decade of inadequate funding allocations to these areas has left huge gaps in the system's ability to respond to patient needs. At 2.22 beds per 1,000 population,[36] the acute care bed supply is critically low. This ratio translates into 2,150 fewer beds than was recommended by the Seaton Commission in 1991.[37] In addition, there is a growing consensus that 2,000 long term care beds are immediately required and estimates of up to 10,000 are needed over the course of the next fifteen years.[38] Adequate home care programs, designed to assist patients to recuperate outside of hospital and to live more comfortably in their own residences, have not materialized. Finally, a comprehensive and coordinated strategy for dealing with mental health issues remains largely unimplemented and access to needed services is fragmented at best.[39]

British Columbians expect a more reasoned approach to these growing problems.

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[36] BC Ministry of Health, *Approved Operating Capacity,* March 31, 2000.

[37] The BC Royal Commission on Health Care and Costs recommended a provincial average of 2.75 acute care beds be reached by 1995 *(Closer to Home, The Report of the British Columbia Royal Commission on Health Care and Costs, 1991, B-100).* Beds per 1,000 based on approved acute care bed data provided by the Ministry of Health and BC Stats population statistics for 2000.

[38] Vancouver Hospital and Health Sciences Centre, *Sustaining the Canadian Health Care System*, a presentation by Murray Martin, then CEO and President, to the Vancouver Board of Trade, April 6, 2000.

[39] For example, in a November 3, 2000 Vancouver Province article, Dr. Sheldon Zipursky, Acting Head of Psychiatry at St. Paul's Hospital in Vancouver, estimated there were at least 2,200 psychiatric patients awaiting placement in a licensed treatment facility.

These gaps have had a direct impact on the quality of patient care, and have eroded the confidence and morale of health care providers across the province. This erosion has, in turn, led to many providers leaving the field for other pursuits.

To accommodate this critically important investment , immediate priority must be given to expanding British Columbia's professional training and recruitment programs for physicians, nurses and other health care providers. There are existing and predictable shortages in virtually every provider category. For example, in the past decade the number of registered nurses employed in the profession has dropped 7.2%,[40] 19% of year 2001 family practice residency positions went unfilled[41] and BC is losing 200 general practitioners annually, leaving patients without a physician.[42] Health Match BC, BC's government-funded recruitment and retention service, lists over 100 permanent physician vacancies for rural and semi-urban communities.[43]

Recruitment initiatives and training programs must begin now to ensure that individual providers are available as quickly as possible. These programs should recognize the need for re-entry positions, permitting existing providers opportunities to enhance their training. Once trained or recruited, the proper incentives and supporting care infra-structure, health information and communication technologies and a recognition of the health care provider's rights must be in place to ensure these individuals are encouraged to locate and remain in areas of the province where they are most needed. It is particularly important that the government quickly address the growing dissatisfaction amongst physicians concerning retention and on-call issues.

Solving the personnel issue requires aggressive programs and there are examples of innovative approaches that are heading in the right direction. One such example is the Rural Medical Education Action Plan, a joint effort between the BCMA, Ministry of Health and the University of British Columbia Medical School. This program provides ground level solutions that address the problems of training, recruitment and retention of rural physicians, providing financial support to medical students for training in rural communities, as well as to established rural physicians who are seeking opportunities to take advanced skills training. In addition, the program provides for an exchange between rural and university based physician educators.

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40 Canadian Institute for Health Information, *Health Care in Canada, 2001.*

41 Canadian Medical Association Journal, *Family medicine loses lustre as students "vote with feet" in 2001 residency match,* Patrick Sullivan, CMAJ, April 17, 2001; 164(i), p. 1194.

42 The Province, *100,000 Patients Can't Find Doctors,* Don Harrison, May 7, 2001, p.A3.

43 www.healthmatchbc.org (accessed April 2001).

RECOMMENDATION 9

The governments of British Columbia and Canada must, as an immediate priority, focus their collective energies on stabilizing the health care system and restoring the confidence and morale of those who provide, administer and use health care services. This activity must provide for:

a) a significant reinvestment in the acute care sector, including hospital beds, equipment, infrastructure, staff and home care programs
b) a concurrent investment in the chronic, long term and rehabilitation/transitional care sectors, including construction of, and operational funding for, new and desperately needed beds and facilities
c) a standard application of publicly funded health care benefits, regardless of whether care is provided in a hospital or a community/home environment
d) the development and rapid implementation of a coordinated plan for mental health services
e) expanded and enhanced professional training programs for physicians, nurses and health care technicians, including enhanced opportunities for those providers already working in the system through the strategic application of re-entry training initiatives
f) increased flexibility in medical training, through the introduction of a more generic curriculum in the first post-graduate training year (PGY1), with the ability to alter post-graduate specialization selection following the completion of that year. This initiative must be coordinated through Canada's medical schools and licensing bodies.
g) expanded and enhanced advanced skills and training opportunities for Family and General Practice Physicians practising in communities distant from established regional centres. These initiatives will require the development and application of basic support programs, including locum, office overhead, travel and accommodation assistance where training occurs away from the home community
h) the implementation and augmentation of incentive mechanisms to promote the recruitment and retention of providers in areas of demand
i) an acceleration in the development of infrastructure and applications in the field of tele-medicine and electronic patient record storage and management
j) in collaboration with providers, improved connectivity of physicians' offices and facilitation of the electronic transfer of appropriate patient care information. This activity must include an accelerated development of systems, infrastructure, software applications and training, while based on clear agreements addressing the issues of consent, use and stewardship of electronic based patient information.
k) the adoption of a charter of rights for health care providers, such as the Charter for Physicians produced by the Canadian Medical Association.

These actions represent a significant commitment from the provincial government to act quickly and decisively in some critical areas. The magnitude and associated logistics of the necessary actions will require collaborative effort. There are some obvious opportunities for public/private partnerships that should be encouraged, particularly given the extensive financial investment

that will be required in the areas of long-term care facility construction and electronic communication.

The initiatives contained in Recommendation 9 address immediate needs for system stabilization, however, there is an overriding need to commit to a longer term planning strategy for the health sector. All too frequently, policy reversals and derailment of new initiatives have occurred, some even prior to implementation. The vacant tower at the Vancouver General Hospital is perhaps the most recognizable case, but others would include the government's on-again, off-again interest in health human resource strategies, mental health programs and the management chaos associated with the 'New Directions' and 'Better Teamwork' initiatives of the mid-nineties.

A more consistent approach is required and that can only come about through a commitment to long term planning. A concerted effort is required to identify unmet needs in concert with the government's stated vision. This identification should reflect known variables such as population growth and aging, while planning for the continued rapid advances in technology. These plans need to be developed in collaboration with health care providers, managers and the public and be communicated to all in a manner that promotes a common understanding.

Once unmet needs are identified, they must be addressed through a long-term strategy. The health care sector cannot survive year-to-year budget variations that make it impossible to operationalize plans requiring multi-year implementation. Moreover, regional and facility operating budgets have frequently been unknown until well into the fiscal year. These practices must stop.

Multi-year budget cycles are required so that a stable and predictable funding base can be established. Equally important, budget allocations should be converted to a basis that rewards innovation and productivity, thereby promoting initiative and positive action at the managerial level. Government has recently made some initial commitments with respect to multi-year budget cycles. Those commitments need to be made a reality.

RECOMMENDATION 10

Concurrent with the stabilization activity, and based on their vision statement, the government of British Columbia should create the necessary fiscal and policy environment to ensure the development and application of a long term planning strategy for the health care system.

A second major component of a long-term planning strategy will involve the development of a provincial-level service plan. As important as illness prevention, health promotion and social factors may be to the long term improvement of the health status of the population, the health care delivery system needs the full and immediate attention of government. Patient care should be the primary objective of the health sector, at least until the system is stabilized and placed on a solid long term footing.

Recommendation 9 calls for an immediate cash infusion and the resolution of existing training and retention issues, however, the need for a longer term vision is not obviated. Care delivery

must become more integrated, planned, efficient and responsive to patients needs. At the same time care delivery plans, across the entire spectrum of available services and programs, must respect the collective and individual ability to pay, as well as the realities of the future capacity to provide such care.

As care and treatment technology has advanced, there has been increasing pressure on the system to provide the best available care in all areas of the province. Delivering health care in the ways British Columbians are accustomed to cannot be sustained into the future. Alternative approaches to delivering and receiving care are both required and inevitable. The aging population, the challenges posed by the province's geography, rapidly expanding high-cost technologies, and the shortage of health care providers necessitate a change in thinking.

This goes well beyond the issue of primary care renewal. Specialty, acute, chronic and long-term care issues are, in fact, of equally immediate importance, but are being largely ignored in the current policy debate. Structural issues, concerning system capacity in the capital, technological and human resource areas need to be assessed and a strategic plan developed.

The province has already reached the point where care of certain types is not universally and readily available. The shortage of specialists and the high cost of technology will extend those circumstances. The future challenge will be to design delivery systems that are built around a series of regional care centres, without abandoning the principle of 'reasonable access'. Determining where care is made available will become an increasingly relevant policy matter. In particular, efforts will be required to optimize the use of the province's scarce specialist services, improving care, availability, continuity and provider morale by encouraging practice in close proximity to each other.

While it may have been a desirable goal for the eighties and nineties, it is simply no longer realistic to expect to provide (or receive) the best available care in every corner of the province.[44] New information and communication technologies will assist, but future care will, of necessity, increasingly involve service delivery by a 'remote' individual. Patients can expect to either travel more frequently for specialized services, or receive those services through the use of 'tele-medicine' technology, under the care and guidance of their chosen family physician. As a consequence, much more effective patient transfer mechanisms, strategies and support programs will be integral to success.[45]

Accordingly, a strong primary care sector is essential to a properly functioning health care system. The second leg of the necessary restructuring of care delivery is very much dependent on a resolution to the 'primary care renewal' matter. As a corollary to the 'regional centre' concept described above, family and general practitioners will be called upon to provide more specialized care in areas of the province where specialist services are not available. This will require specific programs to support new and existing general practitioners in obtaining enhanced skill training.

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[44] The importance of this issue has been identified in the report of the Saskatchewan Commission on Medicare, although the focus on cost control may have been overemphasized relative to the practical issue of human resource constraints.

[45] One policy implication of this restructuring in delivery will involve a new assessment of the population based funding model that has been under development by the Ministry of Health. This model, advanced as a method to enhance equity of service access in various regions of the province will need to be reviewed within a completely different context.

Moreover, family practitioners are not immune to supply problems. There are already signs that the numbers of family practitioners are dropping relative to population, and many patients are being left without a permanent family physician. As the physician shortage deepens, it will be necessary to ensure the practical and successful integration of other service providers into physicians' practices. This must be accomplished in a coordinated and flexible fashion, and in ways in that respect the patients' desire to maintain their physician as their first point of contact for primary care. Full spectrum primary care practice must be promoted, ensuring the maintenance of the following principles:

1. *Patient-Focused* - Care is based upon the needs of the individual patient, including his/her biological, psychological and/or social needs. The patient is actively involved in the care process. To the degree possible, care is provided in the context of the patient's cultural and community framework. Patient-focused care allows for a mutually agreed upon patient-provider relationship.
2. *Accessible* – Ensuring the equitable and timely access to core health services for the entire population.
3. *Co-ordinated* – The primary care delivery system facilitates the effective identification and mobilization of appropriate resources as well as prevents the unnecessary use and duplication of services. The most qualified generalist (in most cases the general practitioner) acts as the patient's first point of contact with the health care system and integrates services along the continuum of patient needs.
4. *Continuous* - The ability to provide and nurture an ongoing relationship between the patient and the health care professional.
5. *Comprehensive* - The provision of a wide range of health services in a variety of settings to meet patient's needs such as: health promotion and illness prevention, diagnostic, therapeutic, rehabilitative and palliative care.
6. *Appropriate* - The provision of beneficial, evidence-based health services, facilitating the delivery of the correct service in the best-suited place at the right time by the provider with the required clinical competencies.
7. *Accountable* - Actions are validated in accordance with accepted standards to ensure ongoing quality of care and decision-making. Accountability incorporates appropriate resource management, evaluation, governance and monitoring. Decision-making is inclusive and transparent.
8. *Sustainable* - The primary care delivery system effectively balances the needs of individual patients against the ability to finance and provide core health services on a continuing basis.

Facing these structural challenges will involve attitudinal change. Altering traditional accessibility patterns will not be a particularly palatable one for either the public or providers. Residents of smaller urban and rural communities have been very vocal about maintaining a comprehensive core of health personnel as a means of ensuring a desirable level of service availability, and an economically viable community. These are important considerations, but new approaches to the issues will need to be discussed. A common understanding of the challenges and a collaborative plan to proceed requires a concerted effort to inform and exchange through open dialogue. As difficult as this may be, it is a critically important task to undertake.

RECOMMENDATION 11

The government of British Columbia must facilitate the development of a provincial service plan in order to coordinate the most efficient access to scarce treatment and diagnostic services. This plan should include as key components:

a) the creation of defined regional centres, where secondary and tertiary specialist physicians would be available, so as to optimize the availability of scarce specialist services
b) an extended role for family and general practice physicians with additional training, to provide needed care in areas where specialist services are not available.

RECOMMENDATION 12

As a further step to coordinate improved patient access, the government of British Columbia should develop, with family and general practitioners, primary care delivery models that:

a) encourage and support the provision of a full spectrum of primary care services
b) advance collaborative practice and productive alliances amongst FP/GPs
c) promote the use of funded nursing and other ancillary personnel within family physician offices under the physician's management and jurisdiction.

A further component of the needed restructuring will entail a rationalization of how the public and private delivery sectors are to be more effectively integrated. Canadian health care delivery currently employs the use of many private facilities to deliver publicly funded services. Examples include physician offices, diagnostic centres, long-term care facilities, home care agencies and pharmacies. The system would simply not function without this involvement. The question is not one of whether private delivery should exist, but one of how society can make the most efficient and effective use of the private and public facilities that make up the entire health care delivery system.

Invariably, whenever this issue is raised, the rhetoric spins out of control, with immediate allegations of "two-tiered health care" capturing the headlines. In reality, the 'two-tier' issue occurs within the context of financing, not delivery mechanisms.[46] Although it is understandable that some confusion exists, capitalizing on that confusion to prevent objective discussion is not an approach that leads to reasoned conclusions. A simple diagrammatic presentation can alleviate any potential misunderstanding.

Figure 3 portrays, with common examples, the various relationships that exist between the public and private sectors with respect to care delivery and financing. Within the current health

[46] The recent debate concerning the expansion of private sector delivery for certain diagnostic and surgical care, both in BC and in Alberta, has badly blurred the distinction between private care delivery and private financing. These are distinctly separate issues.

care system, there are examples of every possible combination. The public purse pays for care that is both publicly and privately delivered. Similarly, there is public care delivery that is financed privately and other care that is entirely in the domain of the private sector.

Figure 3
Public/Private Relationships in Health Care

		CARE DELIVERY	
		PUBLIC	**PRIVATE**
FINANCING	**PUBLIC**	PUBLIC DELIVERY/ PUBLIC FINANCING *(e.g. hospital stay)*	PRIVATE DELIVERY/ PUBLIC FINANCING *(e.g. doctors' office care)*
	PRIVATE	PUBLIC DELIVERY/ PRIVATE FINANCING *(e.g. co-payment charges for ambulance services)*	PRIVATE DELIVERY/ PRIVATE FINANCING *(e.g. cosmetic surgery)*

Due primarily to technological advances, there are increasing examples to be found in the diagnostic, therapeutic and surgical areas, where services that traditionally have been performed within a public hospital setting can now be safely and effectively done in a different type of private facility. These new-found opportunities raise important issues concerning both efficiency and system capacity that should be explored.

British Columbia is facing a considerable challenge with respect to its capacity to provide acute and long term care. On any comparative criteria, BC has a relatively low number of acute care beds at 2.22 per thousand population.[47] According to data from the Canadian Institute for Health Information, British Columbia is close to the middle relative to other Canadian provinces,[48] with Canada placing amongst the lowest of OECD countries.[49]

The prevailing policy advice to the provincial government is that there are sufficient numbers of acute care beds in the system if the "bed blockers" (those occupying acute care beds who should be in rehabilitative or long-term care beds) could be relocated. While the general principle is sound, BC doctors do not accept the finality of that judgement. However, even if that position were completely defensible, the system's ability to absorb those "bed blockers" could not be realized for several years should the province begin construction of all required long-term care facilities immediately.

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47 BC Ministry of Health, *Approved Operating Capacity,* March 31, 2000.
48 Canadian Institute for Health Information, *Annual Hospital Survey: Approved Beds in Hospitals per 1,000 Population,* 1997/98.
49 Organisation for Economic Co-operation and Development (OECD), *Health Data,* 2000.

Moving beyond the issue of the shortage of acute care beds, there is an equally important deficiency with respect to diagnostic and therapeutic capacity. Canada's woefully inadequate diagnostic infra-structure has been well documented.[50] Action is required to deal with the capacity issue and that action should include an assessment of employing private facilities where it makes sense to do so.

There is an economic logic that would suggest that smaller facilities, designed for a specific procedural purpose, are capable of delivering services in a more efficient manner than large hospital institutions. In fact, information included in the recent Canadian Institute for Health Information release would suggest that high volume facilities can produce better outcomes.[51] If quality and efficiency can both be enhanced, there is even greater reason to examine such an option. However, there remains considerable debate on this matter.[52]

A functioning local example exists in the form of the partnership between the North Shore Health Region and the Northmount Eye Surgical Centre. The Northmount Centre provides cataract procedures under direct contract to the Region. The contract is established so that the Centre functions as an extension of the Regional (Lion's Gate) Hospital. Surgical booking is done through the hospital, and the surgeons are required to have hospital privileges. Payment for cataract surgery at the Northmount Centre is on a per procedure basis, with a cap on total funding for a fixed number of procedures. Payment is made by the Region, which claims improved efficiency and additional capacity.

Successes like this can and should be repeated, subject to systematic review. Moving services from the upper left public delivery/public finance portion of Figure 3, to the upper right private delivery/public financing quadrant should be more openly considered. If publicly insured services can be delivered more efficiently through the private sector, while avoiding private payment for those services, the option should be pursued. Provided it is done within a properly regulated framework, there is no *a priori* reason to reject it. The Alberta Medical Association has explored this issue and has developed a set of contracting rules and principles that could form the basis for a similar initiative in BC.[53]

In this regard, now is the opportune time to reassess the role of public hospitals. These facilities might be better utilized if there were a greater focus on high-intensity/acuity surgical and medical treatments and interventions. To a large extent, hospitals have been evolving along this path over several years, as a result of funding cuts and a lack of capital resources. This evolution might best be formalized, with a concurrent plan for addressing lower acuity cases through competitive bidding processes regulated by the appropriate governing authority. While there are several complex issues associated with this approach, including those related to efficacy, economies of scale, critical procedural mass and maintaining sufficient procedural variety to accommodate teaching needs, these should not deter an in-depth assessment of the potential benefits.

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50 Canadian Association of Radiologists, *Timely Access to Quality Care, March 2001;* Organisation for Economic Co-operation and Development (OECD), *Health Data,* 1999.

51 Canadian Institute for Health Information, *Health Care in Canada,* 2001.

52 Institute of Health Economics*, The Public Purchase of Private Surgical Services: A Systematic Review of the Evidence on Efficiency and Equity*, Donaldson, C. and Currie, G., Working Paper 00-9. Based on an extensive literature review, the authors point out the equivocal nature of existing studies, but note the potential access inequities of these arrangements within a publicly funded system. They conclude with a call for ongoing evaluation and the need for careful regulation.

53 Alberta Medical Association, *AMA Position Statement: RHA Contracting with Private Surgical Facilities,* March 10, 2000.

RECOMMENDATION 13

The government of British Columbia must rationalize the integration of the public and private care delivery sectors within the existing framework of the publicly funded program. This integration should include:

a) the regulatory framework within which both public and private care facilities must function
b) the establishment of transparent performance and delivery standards for each facility
c) the introduction of competitive bidding processes between facilities for care and treatment, regulated under the authority of the appropriate governing agency.

As this rationalization work proceeds, careful attention must be given to the potential implications of the North American Free Trade Agreement (NAFTA) and the General Agreement on Trade in Services (GATS). Although there is much speculation, little is actually known about if, and how, these agreements may impact the Canadian health care system should private delivery options be expanded. Although the discussion level peaked during the debate in the Alberta Legislature over Bill 11, The Health Protection Act, little enlightenment was provided.

In the case of the NAFTA, the language remains ambiguous, notwithstanding a general revision clause that was added by Canada in 1996, specifically to protect health and social services from foreign intrusion. This ambiguity is greatest in cases where there is a mix of public and private funding involved for the same service. The implications of the GATS are similarly difficult to interpret. Some legal experts suggest that only a real test case will provide any clarity.

Not surprisingly, opinions vary over how these agreements will ultimately affect Canadian health care.[54] On the one hand, it is suggested that there are too many loopholes in these agreements to risk opening up the private delivery option any further, while on the other hand, proponents argue that the government's ability to regulate financing and service provisions will ultimately provide the necessary protection. It appears that the key to protection will be to ensure that all health care 'suppliers' are treated equally, regardless of country of origin. On one point, however, all parties concur; a more comprehensive review of this matter is required.

[54] Canadian Centre for Policy Alternatives, *Reckless Abandon: Canada, the GATS and the Future of Health Care* Sanger, M., March 2001; Canadian Medical Association Journal, *Debate Over NAFTA's Effect on Health Care*, Gray, C., 1996, p.154; and Canadian Medical Association, *GATS and the Canadian Health Care System*, December 15, 2000.

Chapter 5 An Approach to Sustainable Caring

The Canadian Medical Association has reported on four 'schools of thought' with respect to the long term sustainability of Canada's health care system.[55] These 'schools' reflect vastly different outlooks for the future. The four alternate scenarios suggest:

1. total health costs will increase, but only gradually and will be easily absorbed by economic growth;
2. increases in efficiency will offset increases in the demand for health care;
3. demand for health care will decrease as the future elderly population enjoys better overall health status; and,
4. total health costs will increase significantly, requiring an increased share of revenue.

BC doctors see little meaningful evidence to support the premises of scenarios one through three. Scenario one may be feasible, but requires an exceptional forecast of the future economic environment. Scenario two relies on an unrealistic optimism; the decade of cost-cutting of the nineties has forced most efficiencies out of the system already and future technological advances will vastly expand treatment capabilities and options, thereby escalating costs. The same observation applies to scenario three; although the elderly may enjoy better health status, new treatment options that will enhance their quality of life will arguably offset any gains. In any event, there are no signs that health care expenditures in British Columbia are declining over time for senior age groups. In fact, only scenario four appears realistic, a scenario that is supported by the previously mentioned work of the Conference Board of Canada[56] and the C.D. Howe Institute[57].

This conclusion presents several implications. BC doctors assert that the health care system is currently under-funded for what it needs and is expected to provide. A forecasted future of even higher costs is not a hopeful sign. In preparation, health care funding arrangements need to be placed on a stable and predictable footing now; one that reflects the convergence of need versus ability to pay.

Over the course of the past two decades British Columbians have witnessed a continued expansion of the list of health care services that are insured under the public program, even in the face of severe federal funding cutbacks. This expansion has fostered an expectation amongst many that unlimited services can be provided within a limited budget. Clearly, continued pursuit of such a fallacy would generate a health care system that, at best, would be doomed to mediocrity. As ability to pay becomes a more significant issue, the level of coverage of insured services must be revisited.

Under these circumstances it is difficult to imagine a situation where the proportion of private versus total health care spending will not rise in the future. Although the health care sector will, and should, remain under a fundamentally single payer system, a clear recognition is required of the role that private financing plays. However, the recognition of this role does not mean that the burden of these private charges should be shouldered entirely by those who receive the

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55 Canadian Medical Association, *In Search of Sustainability, Prospects for Canada's Health Care System,* CMA Series of Health Care Discussion Papers, 2001.

56 The Conference Board of Canada, *The Future Cost of Health Care in British Columbia, Challenges to Sustainability*, April 2000.

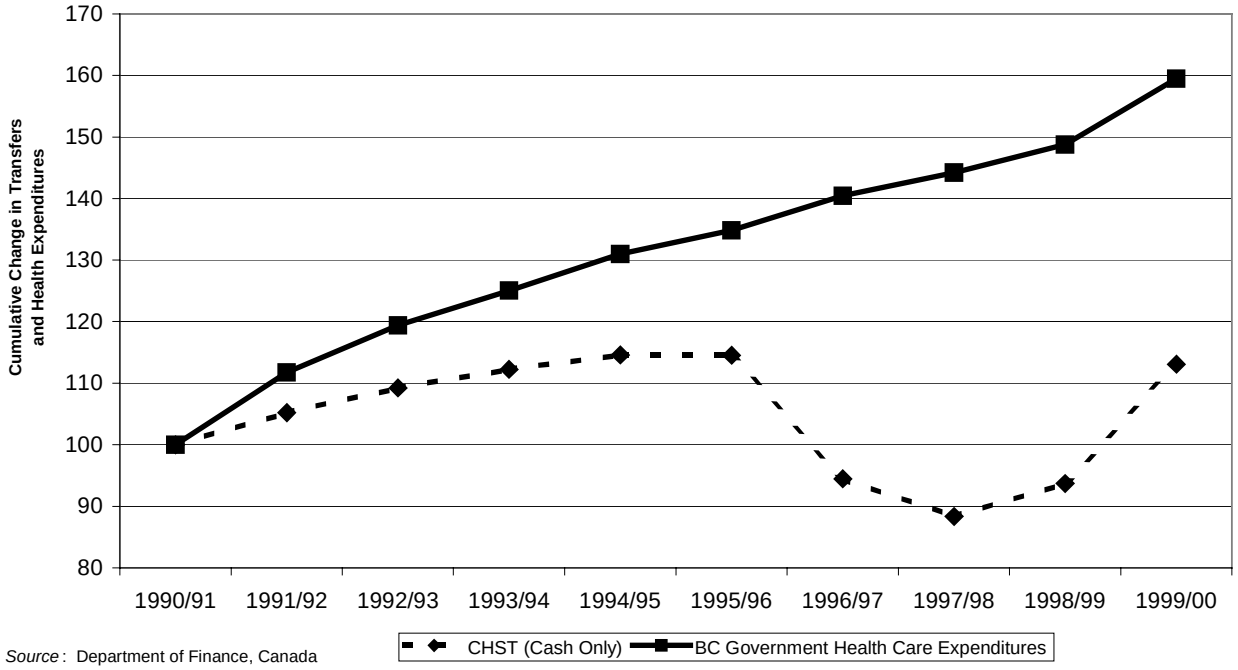
57 C.D. Howe Institute, *Will Baby Boomers Bust the Health Budget?*, Robson, W.B.P., Commentary No. 148, February, 2001.

service. As a priority, government should examine a variety of mechanisms that could be employed to help offset the individual impact of out-of-pocket costs.

Ultimately, these are matters that must be sorted through by the public, using the mechanisms recommended in Chapter 3. In the interim, however, a number of actions are required that are predicated on the goal of protecting patient care through the prudent application of management objectives. Several of the required actions would appear to be self-evident, although they have defied implementation over the three decades of Medicare's existence.

As with the care renewal plan, the first task is to stabilize the present situation, laying the appropriate groundwork for moving into the future on a secure financial footing. Funding for health care in Canada has been a roller coaster ride over the past decade, resulting from deep cuts in federal government cash transfers throughout the nineties.

Figure 4
BC Government Health Care Expenditures
and Canada Health and Social Transfers
(Cumulative Change)



Source: Department of Finance, Canada
BC Financial and Economic Review

These federal actions placed provincial governments in a very difficult position, on relatively short notice. The British Columbia government responded to the cuts in transfer payments by attempting to maintain and expand existing programs and services (with minor exceptions), rather than reducing services. The wisdom of that decision may be debated, but predictably, significant stress has resulted in health care and other government programs. The stresses imposed by fluctuations in federal transfer payments must be avoided.

RECOMMENDATION 14

The governments of British Columbia and Canada must ensure that there is a stable, predictable and long term financial commitment to the province's publicly funded health care system, that reflects the convergence of need versus ability to pay.

RECOMMENDATION 15

The government of Canada should ensure that the Canada Health and Social Transfer (CHST) is appropriately indexed to reflect the status of Canada's economy, population growth and population aging.

The federal government has now committed (in principle at least) to build in Canada Health and Social Transfer (CHST) escalators for population growth and aging. In order to enhance the likelihood of stable and predictable funding at the operational level, the provincial budget process for health and health care services should reflect that same principle. Although the Saskatchewan Commission on Medicare warns that it is impossible to calculate with precision what the health budget *should* be,[58] it is certainly feasible to predict with a degree of accuracy what the budgetary requirements *will be*, based on some reasonable assumptions. Imparting a higher degree of certainty with respect to future funding allocations would significantly improve the ability to plan and implement program enhancements.

Specification of a portion of the CHST for use exclusively by the health sector is another approach that would assist at the provincial level. The CHST is a 'block funding' arrangement, covering health, education and social services. Provinces receive these federal funds en masse into general revenue and exercise discretion over how they will be allocated amongst the various public programs. Although fixing a portion of the CHST for health would reduce some of the flexibility associated with the block funding approach, the provincial government could choose to adjust the proportion designated from time to time. Knowing precisely what proportion of the CHST was being allocated to *health care* would go a considerable way towards improving funding transparency and accountability. It would also stimulate more open and understandable discussion between the federal and provincial governments concerning their respective commitments to health care services.

[58] Government of Saskatchewan, *Caring for Medicare: Sustaining a Quality System,* Commission on Medicare, Commissioner Kenneth J. Fyke, April 2001, p. 74.

RECOMMENDATION 16

Health care related revenue received under the Canada Health and Social Transfer (CHST) should be clearly designated for use in the health care sector. In this regard, and to enhance transparency, the government of British Columbia should fix the proportion of CHST so designated.

Federal cash contributions under the CHST are only one funding source for the province's health care programs. Presently, CHST contributions are estimated (since they cannot be determined from the block funding mechanism) to contribute approximately 14% of BC's government health expenditures. The remainder of the necessary funding is allocated from provincial sources, a combination of general tax revenue, health care premiums and direct patient co-payment for certain services. An additional and important funding source for several public programs is the various hospital foundation organizations and other community charitable groups. Charitable contributions will continue to be an important source of revenue, particularly for institutions, where they support a variety of capital equipment purchases. In 1996/97 Canadians donated about $773 million to health organizations.[59] Without the effort of the many charitable groups and foundations working with the health sector, the system would be under even greater duress.[60] In fact, each funding source will continue to be important in the face of the predicted rising demand and cost of health care services. In this regard existing funding sources should continue.

RECOMMENDATION 17

Provincially raised revenue for publicly funded services should remain a blend of premiums, general revenue, private co-payment and public charitable donations.

As for premiums, BC remains one of only two provinces to collect revenue in this manner, and Alberta is considering eliminating theirs in the face of large budget surpluses. While there are many points of view about the value of a premium system, the doctors of BC believe that it should be retained. Premiums impart a degree of cost consciousness in a system otherwise devoid of public accountability mechanisms for basic hospital and medical care. The degree of accountability obtained is a middle ground between that of direct patient pay options and a system supported entirely by general taxation. Although Medicare is not an insurance scheme in the strict sense, there are sufficient parallels to consider that premiums make sense. The positive accountability effects should not be lost.

At present, there is considerable public confusion over premiums with respect to their intended application. Technically, they are payable to the Medical Services Plan and could, therefore, be interpreted to apply only to physician and other provider services. If this were the intended

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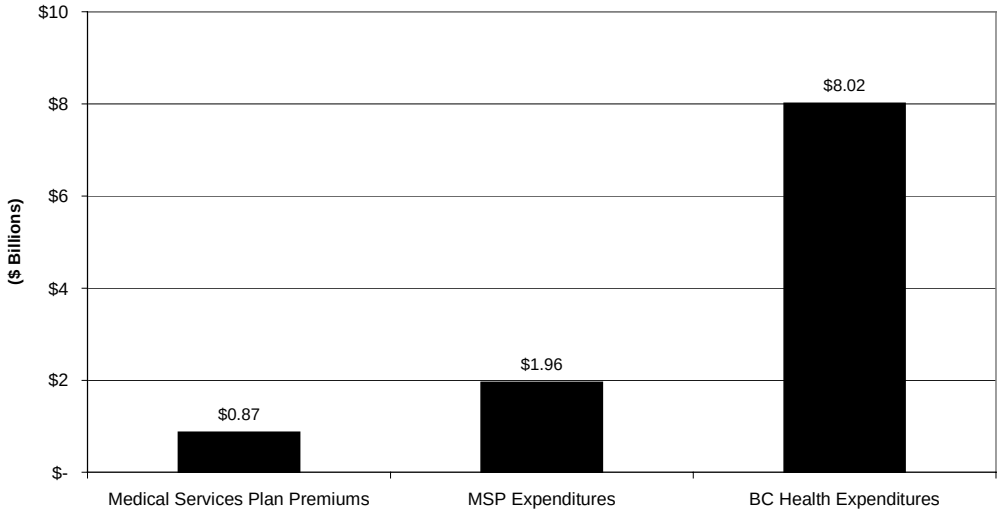
59 Canadian Institute for Health Information, *Health Care in Canada*, 2001.

60 In Britain, the role of the voluntary sector is recognized in government policy and is noted as of key importance for their non-financial role, through direct provision of service. See the report of the British Medical Association Funding Task Force, *Healthcare Funding Review,* February, 2001, Chapter 5.

case, premium revenues would cover roughly 50% of actual costs. However, a person's Care Card is dependent on premium payment and a valid Care Card is required for virtually every publicly funded health care service. If premiums are intended to apply to all services, then only about 10% - 15% of actual costs are supported through premiums. In either case, accountability could be further enhanced if premium revenue more closely reflected actual costs.

Figure 5

Medical Services Plan (MSP) Premium Revenue Compared with MSP Expenditures and Total BC Government Health Expenditures 1999/2000



Note: MSP Expenditures cover physicians and supplementary benefit practitioners and operations.
SOURCE: BC Financial and Economic Review, 2000; Public Accounts, 1999/00

RECOMMENDATION 18

As a mechanism to enhance transparency and cost accountability, the level of health care premiums should more closely reflect the total cost of program delivery.

The final revenue source, co-payment charges must also remain as a viable option. Canadians have consistently stated they want and expect a predominantly public, single payer health care system. However, they are prepared to, and do, pay for some health care services entirely out of pocket, and partially pay for others through a variety of co-payment charges.

There is a considerable body of literature with respect to co-payment charges and their impact on health care utilization. Most research studies conclude that the application of co-payment charges deters the utilization of health care services, but does so in a way that falls disproportionately on the poor. They also conclude that co-payment charges deter use indiscriminately; that they deter necessary, as well as unnecessary care. Consequently,

co-payment charges are not permitted for medical or virtually all hospital care. Canada is the only industrialized nation in the world that maintains such a policy.[61]

Co-payment charges are, however, widely applied to other health care services in the province, such as physiotherapy, ambulance and prescription drugs. The actual total value of co-payment charges is difficult to ascertain, but it amounts to significant millions of dollars. What is troubling is that, if asked, most people would likely be unaware of those services that are covered entirely by the provincial program and those that are not. They would likely be even less well informed about the nature and extent of any charges that would apply. This should not be surprising, since current co-payment charges vary significantly by program and there is little evenness in their application. In some cases, their application depends on whether the service is provided in or out of a hospital. This is not only confusing, but inequitable.

From the system perspective, the questions of why some services are subjected to co-payment charges and others not, and why the proportions of these charges vary so significantly from service to service, need to be addressed. This inconsistent and uneven application of co-payment charges across health care programs should be rationalized. Of particular concern is the non-standard application of charges, notably prescription drugs provided in or out of hospital.

Co-payments will remain an integral part of health care financing and should be applied in a fair and equitable manner. They should also be applied in a manner that minimizes the risk of impeding an individual's access to care, yet encourages appropriate use of the system. These inequities require immediate attention.

RECOMMENDATION 19

The inconsistent and uneven application of co-payment charges across current health care programs should be rationalized immediately. Co-payments should be applied in a fair and equitable manner that does not impede access to necessary care, yet encourages appropriate use of the health care system.

The above noted processes for stabilizing funding and establishing a general framework for revenue generation must be advanced and converted into budgetary provisions that promote long-term planning and fiscal accountability.

To support long term planning, the annual health budget process should be based on a minimum three year funding horizon for operational and capital budgets, with adjustments to previously committed amounts made only on a compelling basis. Any year over year budget surpluses should remain in the system for discretionary use, within prescribed limits. Moreover, a requirement for regional and facility budgets to include a specific item for capital infrastructure and technology maintenance should be mandatory. Replacement planning has become virtually non-existent during the past decade. As a result, the system is currently facing a

[61] In a 1998 paper on managed care, the BCMA examined the use of co-payment charges and rejected their general use for physician services, but acknowledged their application to direct care to the appropriate provider facility and away from the emergency department of hospitals.

serious infra-structure problem, requiring a massive monetary injection. Better management principles must be employed. A lengthier budget cycle would bring needed stability and predictability, allowing administrators a sufficient time horizon to implement, monitor and improve programs as required.

Furthermore, funding allocations across the continuum of services should be transparent and reflect the government's, and the public's, funding priorities for the "wellness" and "illness care" areas. This clarity would be attained if the government consistently and regularly reported on those appropriations that address health services and programs dealing with the determinants of health, wellness initiatives, health promotion and primary level prevention programs, and those that address services and programs dealing with treatment and care activities. While in the long run these health service sectors are complementary, in the immediate term they are clearly competing, impacting on the population groups described in Figure 2 in very different ways.

RECOMMENDATION 20

The annual health care budget process should be based on a minimum of a three-year horizon. Operational and capital budgets must be identified three years in advance, with adjustments made only on a compelling basis. Annual surpluses should remain in the system for discretionary or long-term use, within prescribed limits by the appropriate governing agency.

RECOMMENDATION 21

The provincial health care budgeting process must reflect a commitment to the government's stated vision and adequately reflect decisions made concerning the scope of coverage of publicly funded services. The budget process should incorporate:

a) defined system goals and objectives
b) a plan for resource for allocation between regional and program areas
c) predictable growth in health care use
d) escalators for population growth and aging
e) adjustments for wage and price negotiations with providers and support staff
f) a defined and consistent level of funding for the maintenance and replacement of capital infrastructure and equipment and communications technology.

Finally, it is a certainty that private out-of-pocket health care costs will continue to apply. In fact, there is a high probability that private charges, as a proportion of total health care spending, will increase beyond the current level of approximately 27% in British Columbia. That proportion has grown steadily over time and there is no evidence to suggest the trend will be reversed. According to Canada-wide data from the Canadian Institute for Health Information, the private

pay component of some services is excessive, reaching as high as 67% for drugs and 90% for non-physician providers.[62]

The high percentages reported by CIHI are a result of a combination of variations in coverage and co-payment requirements, reflecting conscious policy decisions by governments. These decisions should be subjected to a thorough public review, as called for in Chapter 3. Notwithstanding the results of that review, there will inevitably be a disproportionate and inequitable burden placed on certain individuals who are more reliant on those health care services not fully insured. This situation should be addressed. In particular, as greater private costs loom in the future for the increasing proportion of elderly in society, financial planning for those future costs should be encouraged.

In the case where society is not able to fully insure all health services under the public program, mechanisms are required that balance the accountability associated with direct private payment and the income redistribution effects that Canadians have endorsed as part of the Medicare philosophy.

At present, the only relief available from out-of-pocket charges, beyond private extended health insurance, is limited to a tax credit of 17% of those expenditures beyond 3% of a person's net income. If the vestiges of a universal health care plan are to remain, a greater level of relief is warranted and a thorough review of options to assist those facing private charges, both now and in the future, should be undertaken.

RECOMMENDATION 22

The governments of British Columbia and Canada should immediately review the creation of tax related programs that will help health care consumers offset the out-of-pocket cost of health care services and promote the judicious use of services. Elements could include:

a) an increase in the currently allowable tax credit
b) temporary adjustment to an individual's annual personal tax exemption status where anticipated health care expenses would result in a tax credit
c) a health care savings plan program, similar to the RRSP program, for application to anticipated and significant future expenses such as long term care and home care
d) tax credits related to lower levels of health care use.

This list of ideas is by no means exhaustive, nor particularly new. However, consideration of employing tax based programs to support or influence health care behaviour has received little attention from policy advisors since the mid-eighties. The exception has been the concept of medical and health care savings accounts.

A health care savings account is a government regulated, defined purpose (health care) account created to assist in funding the health care needs of an individual or family. The

[62] Canadian Institute for Health Information, *National Health Expenditure Trends,* 1975-2000.

account is controlled by the individual and the general theory is that consumers will make more judicious and cost-effective decisions if they are spending their own money, rather than that of the public purse. There are several different ways of structuring these accounts and the merits of the initiative very much depend on this structuring. However, in general, the supporting arguments include promoting personal responsibility and accountability, a reduction in 'unnecessary' service use, price competition and future financial planning.[63] Those in opposition to the idea caution that these accounts are unlikely to control expenditures or utilization effectively, will disadvantage the poor relative to the wealthy and will present risk selection issues for companies offering such accounts.[64]

It is acknowledged that any savings account plan proposal would require careful scrutiny, however, it is not unreasonable to expect that a plan could be developed that avoids the potential pitfalls. The plan contemplated herein could begin with a rather limited application, such as for use to pay for long term care facilities, where the private out-of-pocket charges are significant. A tax deferral plan would encourage the necessary advance saving and reduce the expected pressure on the public purse as the proportion of elderly rises over the coming decades.

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63 Gratzer, D., *Code Blue, Reviving Canada's Health Care System*, 1999, Toronto; ECW Press; C.D. Howe Institute, *Will the Baby Boomers Bust the Health Budget?*, Robson, W., Commentary, No. 148, February, 2001; Consumer Policy Institute, *Feasibility of Health Care Allowances in Canada*, Litow, M. and Muller, S., June 10, 1998.

64 Journal of Health Services Research Policy, *Medical Savings Accounts: Approach With Caution*, Hurley, J., July, 2000; Deber, R., *Getting What We Pay For: Myths and Realities About Financing Canada's Health Care System*, February 2, 2000.

Chapter 6 An Effective Governance Model

Developing strategic plans is one thing; implementing them another. Many good ideas have failed for want of leadership.

British Columbia now spends $9 billion a year on publicly funded health services. By all public accounts the product is seen to be mismanaged, diffuse and undirected and there is no commonly understood plan for where, or even what, services should be delivered. It frequently appears as if decisions are made in a vacuum, without any overall practical direction. The health care system may be complex, but it is not impervious to order! More effective governance is needed and, to do that, new governance structures must be entertained. These structures must be based on the principles of stability and collaboration and encourage planning and the application of sound management practices.

Medicare has developed into a part of the social fabric of Canada, in large part defining Canadian's societal values. As a consequence, health issues frequently dominate the political landscape. In fact, the health care system has become overly susceptible to the *politics* of decision making, with political expediency frequently interfering with practical management. While it would be naive to think that Medicare could be entirely immune from political interference, minimizing those occurrences should be a priority.

The implementation of long-term planning requires a new discipline from BC's political leaders. Health care priorities that reflect a response to yesterday's media headlines are not effective. Providers and administrators must be given every opportunity to implement their long-term plans without fear of being overtaken by political expediency.

This is not to suggest that the health care system should be unresponsive to unanticipated needs, nor slow to react to unexpected crises. But if a collaborative and rigorous approach to planning can be accomplished, based on a clearly articulated vision statement, these unexpected events can be effectively minimized. The challenge is to create an effective planning environment. The initial step requires a re-examination of the roles, responsibilities and lines of authority of the various governance bodies.

RECOMMENDATION 23

The government of British Columbia must immediately review the effectiveness of the existing health care management process and clarify the roles and responsibilities of the various levels of health care governing authorities. These roles should be classified in terms of policy, funding, operational management and program administration functions.

The doctors of BC believe that, first and foremost, the government must assume the responsibility for providing overall guidance to the health sector. It should concentrate on policy, not management. This role must include the production of a clear health services vision statement, an identification of the set of core health services to be delivered, establishment of

necessary standards, and ensurance that the level of public funding is sufficient to deliver on the stated programs and objectives.

RECOMMENDATION 24

The government of British Columbia should retain responsibility and accountability for establishing health care policy and for funding the health care system. These roles entail:

a) a clearly articulated health care vision statement
b) a determination of those services to be included in the publicly funded system
c) establishing overall system goals and objectives
d) establishing performance standards
e) monitoring progress against those performance standards
f) facilitating health and health related research
g) directing the development of a human resource plan (training and distribution)
h) facilitating the use and application of electronic records and communications
i) negotiation of wage and price adjustments for the health care sector
j) ensuring funding levels that support the identified goals and core services by, amongst other activities, implementing those initiatives listed above in the section, An Approach to Sustainable Caring.

As a second step, there is a need to fully and openly examine the effectiveness of the existing regional structure. Regionalization in British Columbia has had a troubled past involving changes in boundaries, vague direction and uncertain authority. BC doctors believe the correct formula is yet to be found. Regional structures make sense, but not in their present form. There are 52 separate regional and community health authorities in British Columbia; 11 regions, 34 Community Health Councils (CHC) and 7 Community Health Services Societies (CHSS). This is simply too many to be efficient. In some cases the regions are exceedingly small, making it difficult to find a sufficient critical mass to operate programs. The budget for the Vancouver/Richmond region exceeds that of all 34 Community Health Councils combined by a factor of four. Although it is recognized that British Columbia's geography poses some unique challenges, more consolidation is necessary. At a minimum, the 34 CHC bodies should be amalgamated into the 7 existing CHSS areas. However, further amalgamation should be considered in consultation with local communities.

RECOMMENDATION 25

The existing regional structure of management should be retained, but in a modified form. The number of regional authorities should be significantly reduced, to a maximum of eighteen and fewer if possible.

A more efficient regional structure and a clarification of respective roles and responsibilities are necessary, but insufficient, conditions for successfully charting a new course for health care. Without the effective application of management principles, and the ability to make and adhere to long term plans, health care renewal will not succeed. The needed initiatives to restore quality care require radically different approaches to current attitudes and practices. Given the tendency of elected officials to view health care as a political matter, it is extremely unlikely that any government would be willing to apply the necessary rigour to introduce these approaches, without resorting to political interference.

For this reason, the health care system should be turned over to an arms-length Health Care Services Authority (HCSA), with a legislated mandate to translate the government's vision and "core" program into an operational plan, managing the same through the development and application of appropriate financing and delivery policies.

The HCSA would possess defined powers and be given the independence to manage the health care system.[65] The Authority would be appointed by government, with a representative mix of members reflecting the public, business, provider and health care agency communities, thus providing the necessary degree of interest and expertise. Member nominations would be open to the public, as well as the other respective groups making up the HCSA, so as to ensure that the Authority possesses an all-encompassing view of problems, needs, attitudes and interests. Appointments would be for a specified term (staggered to provide continuity) and members could be removed only for demonstrated cause. The HCSA would appoint its own Chair, and hire its own Chief Executive Officer, so that its independence from government could not be jeopardized. The Authority would be responsible to the Legislative Assembly as a whole, reporting through an all-party committee so as to further minimize the opportunities for political interference.

The powers of the Authority would include the ability to exert some influence, but not control, over the funding decisions taken by government. This is seen as an important safety valve in protecting the integrity of the HCSA. Managing the health sector without input into the process for determining the necessary funding would make for an impossible task. Consequently, the HCSA would be given the power to make an initial recommendation with respect to the provincial health budget, based on its own projections of need for a three year time horizon. In addition, the HCSA would recommend any financial initiatives, such as health care premium and co-payment adjustments (up or down), as part of the budgetary plan. As a corollary, where yearly funding was found to be inadequate to maintain a viable system, the Authority would be given the ability to make *temporary* amendments to service coverage, co-payment charges and health care premium levels, which would be subsequently reviewed by government.

An independent, arms-length authority would be in a much better position to implement the necessary system changes, free from political pressure and influence, yet adhering to the general policy goals and objectives of government. Creating such a transparent and open process can only serve to enhance accountability in the system.

It is also felt that within a more secure environment, maintaining a continuity of leadership and purpose would be more likely to occur. The constant turnover of Health Ministers and Deputy Ministers has undermined the capacity for long term planning and stabilization of the system. During the 1990s, British Columbia experienced nine individual Health Ministers and six

[65] Similar in concept, but not identical, to The University Act for post-secondary education.

Deputies. The average length of time in office was thirteen and twenty months respectively, with some terms as short as four months. Effective system restructuring cannot occur in that kind of environment.

RECOMMENDATION 26

The government of British Columbia should assign the operational management of the health care system to an independent arms-length body. This Health Care Services Authority (HCSA) would be:

a) created with a clearly defined legislative mandate, similar in nature, but broader in scope, to that of the existing Medical Services Commission
b) responsible to the Legislative Assembly through an all party committee
c) appointed by the government of British Columbia for multi-year terms, from lists of nominees advanced by the all party committee, health care provider groups/agencies and the general public
d) representative of the public, business, provider and health care agency communities
e) responsible for selecting its own Chair and Chief Executive Officer.

RECOMMENDATION 27

The Health Care Services Authority should be given a mandate to:

a) implement the government's vision for health care
b) prepare an operational plan based on the government's goals and objectives, including the establishment of individual goals and objectives for each region
c) develop plans to operationalize directions 10, 11 and 12 listed above in the section entitled A Process of Care Renewal
d) support and centrally administer a plurality of provider payment mechanisms
e) allocate funding to the regions of the province based on the operational plan
f) provide overall management guidance to the system
g) make recommendations to the government with respect to the level of funding required to deliver publicly funded services
h) exercise authority, where necessary to offset any budget shortfall, including temporary deinsurance of services and adjustment of premiums and co-payment charges.

The idea of an independent management body is one that is receiving increasing support and attention across the country. Both the Clair Commission in Quebec[66] and the Sinclair Commission in Ontario[67] have recently spoken in support of a similar structure, though stopping

[66] The Quebec Commission of Study for Health and Social Services, January 2001, Michel Clair, Chair.
[67] The Ontario Health Services Restructuring Commission, March, 2000, Duncan Sinclair, Chair.

short of the specificity in this report. The rationale advanced by these Commissions is, however, similar, with both citing a need to de-politicize the decision process in health care.

One of the key advantages of the HCSA is the ability to plan and operationalize the health care system from a province wide perspective. The existing and looming shortage of health care personnel, the pending demographic pressures and the high cost of future technology create a priority for a provincial plan rather than a series of regional plans. This direction is contrary to much of the current thinking, but is essential to the future vitality of health care in the province. At least one health care analyst has suggested the notion of regional boundaries may have been obsolete before it was implemented.[68]

Notwithstanding the need for an overall provincial service plan, it will be necessary to execute that plan at the community level and within the context of community values and expectations. Consequently, the regional administrative and service structure should be maintained. However, the doctors of BC believe that regional administrators should become employees of the Health Care Services Authority and be responsible to that body. They should be held accountable for the regional component of the provincial plan, as approved by the HCSA, but afforded the necessary latitude to exercise initiative and flexibility with respect to program implementation.

The inevitable consequence of this new HCSA structure is the elimination of existing regional and community health boards as decision-making entities. These regional health boards have done an admirable job under very adverse conditions. However, these boards should be converted to bodies that are advisory in nature, assisting both the Authority and the regional administrators in order to maintain current and continuous public input. The opinion of community leaders is essential and their mandate should include a requirement for public consultation and discussion with respect to policy issues and proposed financing and delivery initiatives.

RECOMMENDATION 28

Regional administrators would become employees of, and report to, the Health Care Services Authority. Administrators would have responsibility, and be held accountable, for:

a) meeting the regional goals and objectives of the HCSA operational plan
b) funding allocation within the region
c) program administration within the region
d) making recommendations to the HCSA with respect to the level of funding required to implement the operational plan.

[68] Canadian Medical Association Journal, *Wrong Answers at the Wrong Time?*, Deber, R., December 15, 1997.

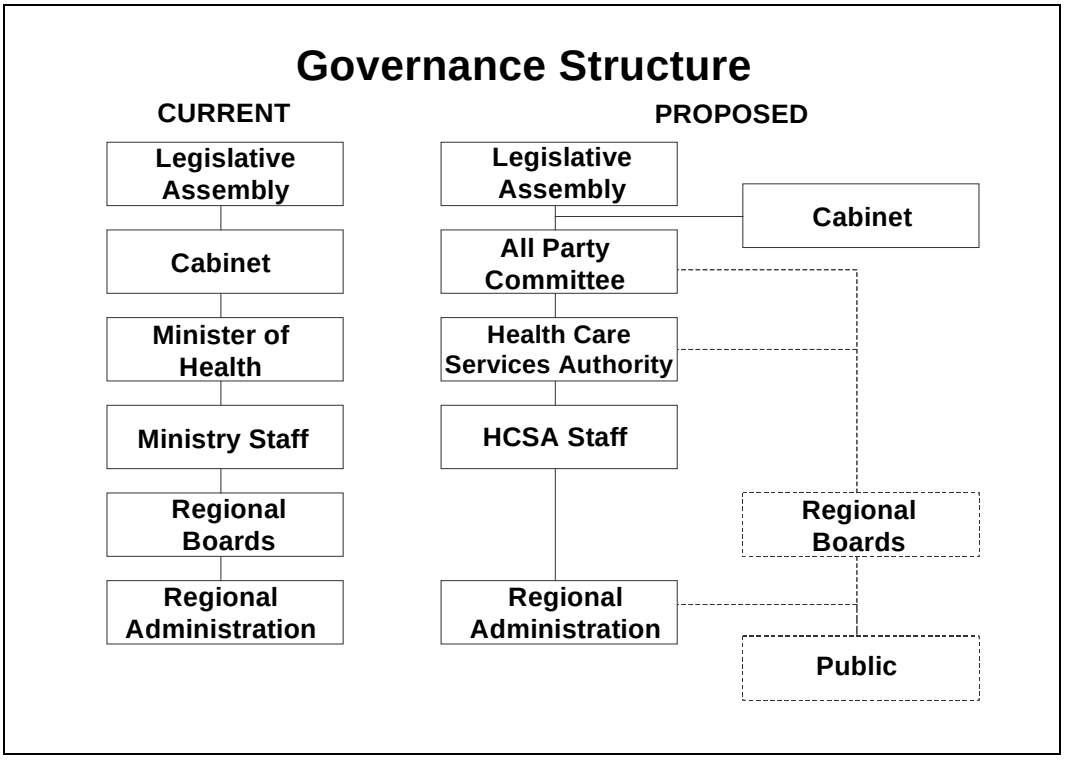
RECOMMENDATION 29

The government of British Columbia should act to ensure that regional health boards are realigned and are converted to advisory bodies to maintain the necessary level of community input into health care policy and operational decision processes. The new Advisory Boards should provide advice:

a) to regional administrators concerning local area needs, issues and programs
b) to the HCSA concerning access problems and program successes
c) to the government concerning the performance and responsiveness of the HCSA.

It is essential that the new health governance structure does not become overly complicated and cumbersome. Figure 6 demonstrates that the lines of authority and decision making, while different, are no more complex than what currently exists. In fact, Figure 6 identifies a one-for-one exchange between the existing and the proposed structure, for each level of management. Consequently, this proposal is eminently attainable, if the political will exists to make it happen.

Figure 6



Chapter 7 Concluding Remarks

This report has identified 29 recommendations and 48 specific actions for restoring the quality of British Columbia's health care system. The actions address short and long term needs, include both process and system initiatives and are premised on incorporating patient care and management objectives as a strategic priority. A fundamental principle of the report is placing the needs of those individuals requiring treatment and care ahead of other priorities for publicly funded health programs.

Some readers might conclude that this report is an attempt to turn back the clock on health and health care policy. To a limited extent, that is true. The doctors of BC believe that if the clock is not set properly, it needs to be corrected. A renewed emphasis on timely, accessible patient care is what the public wants and expects. However, in most respects, this report is about bold change for the future; pragmatic vision statements, a patient charter, collaborative efforts on policy development, fiscal planning, accountability initiatives, provincial service plans and governance restructuring are all examples. Health care decision-making must be de-politicized.

Prerequisites for these changes are political leadership, long-term planning and greater public involvement, the latter of which is key to shaping the health care future in effective and lasting ways. The recommendations of Chapter 3 focus on the need for initiative in this area, calling for the creation of a variety of consultative processes. In cases where the recommendations contained herein call for immediate and direct action, it is intended that those actions are subjected to open public dialogue and review. Where practical, that dialogue should occur prior to any implementation, but where not, as part of an ongoing review process.

Many of the recommendations will generate controversy. The new governance model, the role of the private sector in health care delivery and the increased importance of premiums are notable examples. Controversy is a necessary element of change and should not be feared.

Important choices lie ahead. The doctors of British Columbia assert that the changes proposed herein are required. By involving the public in meaningful dialogue and decision processes, physicians are confident that the future of the health care system can be improved.

> *As we examined the hundreds of briefs with their thousands of recommendations we were impressed with the fact that the field of health service illustrates, perhaps better than any other, the paradox of our age, which is, of course, the enormous gap between our scientific knowledge and skills on the one hand, and our organizational and financial arrangements to apply them to the needs of man, on the other.*
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> *Justice Emmet Hall, 1964*

List of References

Alberta Medical Association, *AMA Position Statement: RHA Contracting with Private Surgical Facilities,* March 10, 2000

Angus Reid, *The Public Domain: Current Public Opinion Attitudes and Expectations on Canada's Healthcare System*, May 11, 2000

Barrett, P., *Rethinking Medicare: Response from the Canadian Medical Association,* Health Care Papers, Fall 2000, p. 188, obtained from www.longwoods.com.hp/fall00 (accessed May 2001) or at www.healthcarepapers.com/

British Columbia Medical Association, Canadian Medical Association, Health Association of British Columbia, Registered Nurses Association of British Columbia, *Summary of Proceedings, Sustainability and Accountability in the 21st Century,* May 11-12, 2000 Medicare Forum, Vancouver, British Columbia

British Columbia Medical Association, *Obtaining Effective Medical Input Into Regional Decision-Making,* October 2000

British Columbia Medical Association, *Turning the Tide - Saving Medicare for Canadians, Part I of II, Laying the Foundation for Sustaining Medicare,* July 2000

British Columbia Medical Association, *The World of Managed Care, Shopping for Solutions,* BCMA E98:02, September 1998

British Columbia Ministry of Health, *Approved Operating Capacity,* March 31, 2000.

British Columbia Ministry of Health, *Health Goals for BC,* obtained from www.hlth.gov.bc.ca/pho/hlthgoal/goals.html (accessed May 2001)

British Columbia Ministry of Health, *A Report on the Health of British Columbians, Provincial Health Officer's Annual Report 1999,* October 6, 2000

British Columbia Ministry of Health, *Mission Statement,* Jan. 2, 2001, obtained from www.hlth.gov.bc.ca/cpa/mission.html (accessed May 2001)

British Columbia Ministry of Health and Ministry Responsible for Seniors, *1999/2000 Annual Report,* February 9, 2001

British Columbia Royal Commission on Health Care and Costs, *Closer to Home,* 1991, B-100

British Medical Association, *Healthcare Funding Review, British Medical Association Funding Task Force,* Chap. 5, obtained from http://web.bma.org.uk/public/polsreps.nsf/hcfrdocsvw/DBUL-4TPFUV (accessed February 9, 2001),

British Medical Journal, *Another healthcare funding review,* Editorial, February 10, 2001, BMJ2001;322:312-313, obtained from www.bmj.com/cgi/content/full/322/7282/312 (accessed February 9, 2001)

Canadian Association of Radiologists, *Timely Access to Quality Care*, March 2001

Canadian Centre for Policy Alternatives, *Reckless Abandon: Canada, the GATS and the Future of Health Care,* Sanger, Matthew, March 2001

Canadian Institute for Advanced Research, *The Health of Populations and the Program in Population Health,* January 1989

Canadian Institute for Health Information (CIHI), *Annual Hospital Survey: Approved Beds in Hospitals per 1,000 Population,* 1997/98.

Canadian Institute for Health Information (CIHI), *Health Care in Canada,* 2001

Canadian Institute for Health Information (CIHI), *National Health Expenditure Trends,* 1975-2000

Canadian Institute for Health Information (CIHI), *Physician Workforce Aging Reports,* August 9, 2000

Canadian Medical Association/Angus Reid, *The Public Domain: Current Public Opinion Attitudes and Expectations on Canada's Healthcare System",* May 11, 2000

Canadian Medical Association, *CMA Charter for Physicians* (Update 1999), November 27, 1999, obtained from www.cma.ca/inside/policybase/1998/09-09.htm (accessed April 25, 2001)

Canadian Medical Association, *GATS and the Canadian Health Care System,* December 15, 2000

Canadian Medical Association, *Guidelines for Assessing Health Care System Performance*, July 2000

Canadian Medical Association, *In Search of Sustainability, Prospects for Canada's Health Care System,* CMA Series of Health Care Discussion Papers, 2001, obtained from www.cma.ca/advocacy/discussion%5Fpapers/sustainability/sustainability.htm

Canadian Medical Association, *Looking at the Future of Health, Health Care and Medicine,* CMA Series of Health Care Discussion Papers, 2000, p.3

Canadian Medical Association, *The Public Domain: Current Public Opinion Attitudes and Expectations on Canada's Healthcare System*, May 11, 2000

Canadian Medical Association, *The Role of Physicians in Prevention and Health Promotion,* approved by the CMA Board of Directors, July 15, 1995, obtained from www.cma.ca/inside/policybase/1995/7-15.htm (accessed May 1, 2001)

Canadian Medical Association Journal, *Debate Over NAFTA's Effect on Health Care,* Gray, C., 1996; 154

Canadian Medical Association Journal, *Family medicine loses lustre as students "vote with feet" in 2001 residency match,* Patrick Sullivan, CMAJ, April 17, 2001; 164(8), p. 1194

Canadian Medical Association Journal, *The Future of Medicine,* September 19, 2000; 163(6)

Canadian Medical Association Journal, *The illegality of private health care in Canada,* Colleen M. Flood, Tom Archibald, March 20, 2001; 164(6)

Canadian Medical Association Journal, *Predictors of mammography use among Canadian women aged 50-69: findings from the 1996/97 National Population Health Survey,* Colleen J. Maxwell, Christina M. Bancej, Judy Snider, CMAJ February 6, 2001, 164(3):329-34, obtained from www.cma.ca/cmaj/vol-164/issue-3/0329.htm

Canadian Medical Association Journal, *Wrong answers at the wrong time?*, Raisa Deber, December 15, 1997; 157 (12)

Canadian Medical Association Leadership Conference 2000, *"Breaking Down the Barriers to Change in our Health Care System"*, March 2, 2000

C.D. Howe Institute Communiqué, *Innovative financing for health care system would encourage efficiency, improvements in care, says D.D. Howe Institute study,* April 26, 2001

C.D. Howe Institute, *Will Baby Boomers Bust the Health Budget?,* Robson, W.B.P., Commentary No. 148, February 2001

College of Family Physicians of Canada, *National Family Physician Survey,* 1997, Toronto, Ontario

The Conference Board of Canada, *Canadians' Values and Attitudes on Canada's Health Care System: A Synthesis of Survey Results*, October 6, 2000

The Conference Board of Canada, *The Future Cost of Health Care in British Columbia, Challenges to Sustainability,* April 2000

Consumer Policy Institute, *Feasibility of Health Care Allowances in Canada,* M. Litow, S. Muller, June 10, 1998

Deber, Raisa, *Getting What We Pay For: Myths and Realities About Financing Canada's Health Care System,* February 2, 2000

Directions for Canadian Health Care, *Health for All, Setting Targets for the 21st Century,* Proceedings of an International Conference, Calgary, Alberta, October 7-8, 1999

First Ministers on Health Renewal and Early Childhood Development (ECD), *First Ministers' Agreement on Health Renewal and Early Childhood Development*, September 11, 2000, obtained from www.scics.gc.ca/cinfo00/800038004_e.html (accessed May 2001)

First Ministers' Communiqué on Health, September 11, 2000

The Globe and Mail, *Behind Closed Doors: The struggle over homecare,* Anne McIlroy and André Picard, March 20, 2000

The Globe and Mail, *Health care: going under,* Rod Mickleburgh, March 27, 2001, obtained from www.globeandmail.com/gam/Health/20010327/COHEAL.html (accessed March 27, 2001)

The Globe and Mail, *Nation needs health-care 'revolution,' Harris says,* Richard Mackie, April 27, 2001, obtained from www.thegolbeandmail.com/gam/Health/20010427/UHEALM.html (accessed April 27, 2001)

The Globe and Mail, *Ontario weighs in on Great Health Debate,* John Ibbitson, April 27, 2001, obtained from www.theglobeandmail.com/gam/Health/20010427UIBBIM.html (accessed April 27, 2001)

Goldfarb Consultants, Presentation to the Standing Senate Committee on Social Affairs, Science and Technology, March 22, 2000, Slide 6

Government of British Columbia, *University Act*

Government of Canada, Ministry of Health, *At the Launch of the Commission on the Future of Health Care in Canada,* Allan Rock, Federal Minister of Health, Ottawa, Ontario, April 4, 2001, obtained from www.hc-sc.gc.ca/english/archives/speeches/4apr2001mine.htm (accessed May 14, 2001)

Government of Saskatchewan, *Caring for Medicare: Sustaining a Quality System,* Commission on Medicare, Commissioner Kenneth J. Fyke, April 2001

Gratzer, D., *Code Blue, Reviving Canada's Health Care System,* Toronto, ECW Press, 1999

Health Canada, *Taking Action on Population Health, 1998*

Health Match BC, obtained from www.healthmatchbc.org (accessed April 2001)

Health Policy, *All rights reserved, or can we just copy? Cost sharing arrangements and characteristics of health care systems,* Corina C. Ros, Peter P. Groenewegen, Diana M.J. Delnoij, Elsevier Science Ltd., Health Policy 52 (2000) 1-13

Health Policy Forum, *Opening up the Canada Health Act: Can its Principles Remain Intact?*, June-July 1998

Health Services Utilization and Research Commission (Saskatchewan), *System Performance Indicators: Toward a Goal-Based Health System,* August 2000, obtained from www.hsurc.sk.ca/

Health Summit '99*, Think About Health, Final Report and Recommendations*, April 1999, obtained from www.healthsummit.gov.ab.ca/finalreport.html (accessed April 24, 2001)

Institute of Health Economics, *The Public Purchase of Private Surgical Services: A Systematic Review of the Evidence on Efficiency and Equity,* Cam Donaldson and Gillian Currie, Working Paper 00-9

Institute for Research on Public Policy, *Breaking Down the Barriers to Change in Our Health Care System,* Hugh Segal, President, Address to the CMA Leadership Conference 2000, March 2, 2000, Ottawa, Ontario

Ipsos-Reid, *Healthcare in Canada*, March 12, 2001

Journal of Health Services Research Policy, *Medical Savings Accounts: Approach with Caution,* J. Hurley, July 2000

MarkTrend Research, *A Public Assessment of Medicare,* June 28, 1999

The Milbank Quarterly, *Medical Necessity in Canadian Health Policy: Four Meanings and … a Funeral?,* Cathy Charles, Johathan Lomas, Mita Giacomini, et. al., McMaster University; Canadian Institute for Advanced Research, Hamilton, Ontario, Vol. 75, No. 3, 1997, p. 365-394

National Forum on Health, *Canada Health Action: Building on the Legacy - Volume II: Synthesis Reports and Issues Papers,* Striking a Balance Working Group (SBWG), 1997, Ottawa, p.42 of SBWG report.

National Post, *Harris favours private health,* Robert Benzie, April 27, 2001, obtained from www.nationalpost.com/home/story.html?f=/stories/20010427/545537.html (accessed April 27, 2001

North Shore Health Region, *Public Contracting for Private Surgical Services*, Ellen Pekeles, March 9, 2000

North Shore Health Region, *Proposal for Continuation of Cataract Surgery at Northmount Eye Surgical Centre,* March 8, 2000

Office of the Auditor General of British Columbia, *A Review of Governance and Accountability in the Regionalization of Health Services,* 1997/98:Report 3

Office of the Provincial Health Officer, *Report on the Health of British Columbians,* 1999, obtained from www.hlth.gov.bc.ca/pho/ar/index.html

Ontario Health Services Restructuring Commission, Duncan Sinclair, Chair, March 2000

Organisation for Economic Co-operation and Development (OECD), *Health Data,* 1999 and 2000

Pollara Research, *Health Care in Canada Survey,* September 2000, obtained from www.pollara.ca/new/POLLARA_NET.html (accessed May 8, 2001)

PriceWaterhouse Coopers, *HealthCast 2010, Smaller World, Bigger Expectations,* 1999

The Province, *100,000 Patients Can't Find Doctors,* Don Harrison, May 7, 2001, p.A3

The Province, *Mental care 'in crisis',* Dr. Sheldon Zipursky, November 3, 2000, Page A-6, www.vancouverprovince.com/newsite/news/001103/4802468.html (accessed November 3, 2000)

The Quebec Commission of Study for Health and Social Services, Michel Clair, Chair, January 2001

Royal Commission on Health Services, Justice Emmett Hall, Chair, 1964

Shah, Chandrakant P. *Public Health and Preventive Medicine in Canada,* University of Toronto Press, 1994 (third edition)

Social Science & Medicine, *Cost containment, solidarity and cautious experimentation: Swedish dilemmas,* Ronald Andersen, Björn Smedby, Denny Vågerö, Elsevier Science Ltd., Social Science & Medicine 52 (2001), p. 1195-1204

The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role Interim Report*, *Volume One - The Story So Far*, Hon. Michael J.L. Kirby, Chair, Hon. Marjory LeBreton, Deputy Chair, March 2001, obtained from www.parl.gc.ca/37/1/parlbus/commbus/senate/com-E/SOCI-E/rep-e/repintmar01-e.htm (accessed March 2001)

Toronto Star, *Looking for vital signs,* Thomas Walkom, National Affairs Writer, May 5, 2001

University of Toronto, Department of Health Administration, *Comprehensiveness in Health Care*, *Report to The Heal Action Lobby*, Raisa Deber, Eleanor Ross and Mariana Catz, April 1994

Vancouver Hospital & Health Sciences Centre, *Sustaining the Canadian Health Care System,* Murray Martin, Presentation to the Vancouver Board of Trade, April 6, 2000

The Vancouver Sun, *Premiers suggest looking at scaled-back medicare,* Mark Kennedy and Norm Ovenden, February 5, 2000