

POSITIVE. PUBLIC.

10 steps to stronger health care

“Medicare ensures that care is available to all regardless of ability to pay”

The way forward

Canadians consistently support medicare. We believe that every Canadian deserves universal access to timely, quality health care, regardless of income.

Canadian medicare governed by the five tenets of the Canada Health Act – universality, portability, accessibility, comprehensiveness, public administration – ensures that care is available to all regardless of ability to pay.

Research, in Canada and around the world, continues to show that a universal health care system is the fairest and most cost-effective way to provide care. And it is sustainable now and in the long run, despite claims that it’s not.

Canada, with universal health insurance underpinning our public health care system, spends about half as much on health per capita as does the United States, yet Canadians live two to three years longer.

Our comprehensive, tax-based health coverage provides a competitive advantage to Canadian companies in comparison to their American counterparts.

However, support for public health care does not imply blind adherence to the status quo. There are some genuine problems that must be addressed – in particular the back log in hospital emergency rooms and in-patient departments, and the waitlists for orthopedic and other elective surgeries.

This document focuses on public sector solutions to these very real problems. It includes examples, from B.C. and elsewhere, of innovative models for delivering health services that have a proven track record in both reducing pressure on hospital and emergency services and controlling cost increases.

Better strategies for managing waitlists include dedicated funding for public specialty surgery clinics and enhanced community health services that include home care, home support, mental health, long-term and primary care.

When a more comprehensive, prevention-oriented, and community-based approach to the delivery of health services is introduced, reliance on hospital emergency and in-patient services declines and waitlists shorten.

Taken together, these solutions represent a way forward, a way to ensure the sustainability of an equitable and accessible public health care system for generations to come.



step 1

Shorten waitlists

Public sector initiatives to reduce waitlists are being implemented across Canada. Better waitlist management strategies and funding for specialty elective surgery clinics have been introduced. Many are successful and could be adopted across the country.

In North Vancouver, for example, five orthopedic surgeons work together in a “one-stop” joint replacement assessment clinic to better manage referrals and waitlists. They have reduced wait times to see a specialist from 50 weeks to between two and four weeks.

Similarly, a two-year old pilot project at Richmond Hospital, with dedicated operating rooms for orthopedic surgical procedures has reduced surgery waits by 75 per cent, the waitlist by 27 per cent and costs by 25 per cent.

If the provincial government funded and spread these and other successful public sector models across province, wait times could be dramatically reduced, long-term costs controlled and the need to provide public dollars for private surgery clinics eliminated.

“An orthopedic surgical pilot at Richmond Hospital has reduced surgery waits by 75 per cent.”

step 2

Restore and enhance home support

“Cuts to home support increase the use of more expensive hospital and long-term care.”

Supporting frail seniors and people with disabilities to remain in their homes is the foundation of any community health system. Home support includes helping patients with daily living activities such as cleaning and cooking, medication management, personal care, and social and recreational activities. As important, home support is an early warning system for health care that can identify and address emerging health problems before they reach crisis proportions.

Considerable research indicates that cutting home support services increases the use of more expensive hospital and long-term care services. In fact, one B.C. study from the late 1990s shows that cuts to basic support and preventative services (i.e. cleaning, cooking, socialization) resulted in overall costs increasing 34 per cent after three years.

Compare the different approaches taken in Denmark and in B.C. In 1998, the Danish government introduced legislation requiring municipalities to offer a home visit twice annually to all citizens 75 years and older. Legislators there were more concerned about the additional costs that would result if seniors did not get early help. This is in startling contrast to the B.C. experience where government has cut home support and home care, restricting access for people who require only limited support and focusing on a narrow range of medically-oriented services for people with higher needs.

Many programs in Canada – and a few in B.C. – demonstrate that a more comprehensive array of community-based health services, a focus on prevention, and better coordination between home support, home nursing and primary care make a huge difference in the quality of life of frail seniors and people with disabilities, and delay or avoid the use of more expensive, long-term care and hospital services.

step 3

Improve access, expand services, increase staff in residential care

Between 2001 and 2004, the government cut more than 2,400 long-term care beds across B.C. despite a population increase of about 3 per cent a year in seniors over 75 years of age. That's why we have a critical shortage of residential care beds for frail seniors who need around-the-clock nursing and personal care now. This bed shortage leaves seniors waiting to be placed in long-term care and frequently stuck in expensive hospital beds.

“The residential bed shortage leaves seniors waiting to be placed in long-term care.”

With the decrease in long-term care beds has come an increase in transfer rates of residents from care facilities to hospital emergency rooms. In 2005, 54,000 long-term care residents were transferred to ERs, or about 2.5 transfers for every publicly-funded, long-term care bed in the province. Of those, about half the people transferred were admitted to hospital, with many staying 10 days or more.

And the reason for the rising transfer rates is the low staffing levels of registered nurses, licensed practical nurses, therapists and care aides in residential care. Staff are also not receiving the training necessary to deal with the increased complexity of residents' physical and mental conditions and needs.

If there is not enough staff to properly monitor changes in residents' health, ensure that they get the proper nutrition and fluids, and assist with moving and activity, the likelihood that residents will end up with pressure sores, pneumonia, dehydration, malnutrition or broken bones from a fall increases. These conditions have serious health consequences, often resulting in a hospital admission.

Hospital transfer rates can be significantly reduced by increasing the current staff complement. And with the introduction of a multi-disciplinary primary care team – doctors, nurse practitioners, rehabilitation workers – these rates can be further reduced.

In the Netherlands, multi-disciplinary teams are part of the nursing home sector and transfer rates are below 10 per cent a year.

An adequate number of beds, appropriate staffing levels and multi-disciplinary teams are essential to ensuring that frail seniors and people with severe disabilities receive the care and attention they deserve and need. That will take the pressure off hospital emergency rooms and in-patient services.

step 4

Establish community health centres for better primary care

Community health centres or clinics provide an important primary care alternative to a traditional doctor's office; and they offer much more.

Community health centres have a team of health professionals – nurse practitioners, counsellors, outreach workers, doctors, pharmacists, therapists, dieticians, social workers – who provide greater access and a broader range of care to patients.

The health professionals working in community health centres work on salary rather than on a fee-for-service basis. As such, they are not driven by the number of patients seen and they provide a more comprehensive and individualized approach to care.

Today, individuals with multiple chronic conditions, (e.g. hypertension, diabetes, asthma, depression), are major users of health care services. In a community health centre, the method of payment and the presence of a multi-disciplinary team improve care for this complex client population.

A more comprehensive and prevention-oriented approach dramatically reduces the use of emergency, hospital and specialist services.

For example, the Sault Ste. Marie Group Health Centre, the largest community health centre Canada, serves 56,000 patients and employs 64 doctors, eight nurse practitioners, 96 registered nurses, nurse educators and licensed practical nurses, and 52 related professional health practitioners.

In recent years, the centre has focused on the care of people with chronic conditions. The result includes a reduction in hospital admissions of people with congestive heart failure by more than 57 per cent, and the development of the country's largest registry to support patients with diabetes.

International research shows that community health clinics with well-developed, multi-disciplinary primary health care teams – focused on continuity, prevention and comprehensive care – result in lower costs to the system and better health outcomes.

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step 5

Develop our health human resources

Health care means people caring for people.

Significant and growing shortages of skilled health care personnel threaten the sustainability of public health care.

B.C. already has lower ratios of registered nurses and licensed practical nurses per population than any other province – 18 per cent below the national average.

And while governments would have us believe that ‘importing’ health professionals is the answer, it’s not that simple. Educated health professionals are in short supply world-wide.

To resolve the skills shortage, the B.C. government could:

1. Provide additional funding for post-secondary health education programs, develop innovative approaches to educating health professionals and fully utilize the existing health care workforce.
2. Address the very serious shortage of front-line workers, particularly in home support, by improving the poor working conditions, training opportunities and wages in community and resident care.
3. Establish a one-stop access/information centre, and fund support for innovative training approaches for internationally-educated health professionals including nurses, doctors, pharmacists, dieticians and physiotherapists.
4. Remove barriers to working in health care for thousands of internationally-educated health personnel by funding English and other technical skills programs appropriate to the Canadian system.
5. Initiate work with the federal government to coordinate and implement a national strategy to address health human resources.

“B.C. has lower ratios of RNs and LPNs per population than any other province.”

step 6

Control drug costs

Drug costs are a major cost driver in health care and for individuals for two reasons: the introduction of new and more expensive drugs, and a higher level of prescription drug use. Adding to the problem is that most of these drugs are just new versions of less expensive, older drugs – and no more effective.

B.C.'s reference-based drug program covers five categories of drugs and makes sure that the most cost-efficient option is prescribed. This saves Pharmacare approximately \$44 million a year with no negative impact on patients' health. If this program was expanded to cover a broader range of drugs, additional money could be saved.

There's another made-in-B.C. program – versions of which have been introduced on a much broader level in Saskatchewan, Alberta and Nova Scotia – that our government needs to expand.

In 1993, a North Vancouver pharmacist began providing prescription drug education to area-doctors in their offices. The program is still in existence and saves \$1.50 for each dollar it costs.

B.C.'s Auditor General recommended the expansion of this program in his March 2006 report – noting that funding had not been increased since 1997 – along with other cost-reducing strategies such as bulk purchasing and more reference-based pricing options.

Further, B.C. must work with the federal government to implement a national Pharmacare program and other strategies to reverse ever-increasing drug costs.

“Drug costs are a major cost driver in health care. B.C.'s reference-based drug program saves Pharmacare approximately \$44 million a year.”

step 7

Put accountability back in health care

“Our health care system could be much more accountable to citizens.”

Our health care system could be more responsive to the needs of our communities, and much more accountable to citizens.

A good start would be to broaden health authority boards to include all sectors of society, especially health care workers and community voices. This could be supported by legislation to ensure that communities are consulted in health planning at the municipal and/or regional district levels.

To further ensure timely access to services and input into health care decision-making, there should be mandatory family councils in long-term care facilities. These councils would be run by family members and residents rather than owner/operators, and link with community-based advocacy services for seniors and people with disabilities.

There is evidence from other jurisdictions to show that involving citizens has improved the quality of health care decision-making. And in our own province, there are numerous examples from acute, residential and community care to show that service quality and efficiency improves when the health care workforce is consulted on a regular basis.

step 8

Invest in publicly-financed infrastructure

“There’s plenty of evidence that P3s actually drive up infrastructure costs, result in shoddy construction and reduce services.”

The provincial government insists that financing and building projects like hospitals and roads through public-private partnerships (P3s) will save taxpayers money.

Not so. The evidence from Britain, Australia and other parts of Canada show that P3s actually drive up infrastructure costs, result in shoddy construction and reduce services.

In the U.K. – where B.C. has turned for privatization mentoring – the accounting proves that projected P3 savings are hypothetical, and based on ‘risk transfer’ assumptions that had little basis in reality. The fact is, government can borrow money for less than the private sector.

Yet in 2006, despite the documented evidence, the B.C. government mandated that all public projects over \$20 million be public-private partnerships. That means that the proposed regional hospital on the north Island, and health facilities in Surrey and the Interior will be public-private partnerships.

step 9

Address the determinants of health

“Neglecting people’s basic needs adds to the pressure on our health care system.”

In November 2006, health authorities reported a sharp increase in the number of Vancouver Downtown Eastside residents being hospitalized for weeks with a severe strain of pneumonia. Officials believed that their living conditions – homelessness and cramped single room occupancy hotels, inadequate nutrition, untended chronic conditions and more – led to the outbreak and to the higher rate of hospitalization.

This outbreak could have been avoided if residents had more reasonable living conditions. It demonstrates that neglecting peoples’ basic needs adds to the pressure on our health care system.

Improving the health status of British Columbians – particularly at-risk groups such as First Nations people and children in poor families – cannot be achieved simply through innovations in health services. Many of the determinants of health – income, education, housing – require changes that go beyond the health system.

step 10

Care about mental health

In B.C. today, appropriate ‘round-the-clock services are not in place to support people with persistent and serious mental health and/or addiction issues to remain in their communities. Many community mental health and addiction services are inadequately funded and staffed, and only open nine to five, five days week.

More outreach services staffed by community health and community social services workers, and linked to teams of multi-disciplinary professionals available 24 hours a day/7 days a week, would reduce emergency room and hospital utilization in this population. Temporary, community-based residential services, specialized outreach services for youth and for seniors with dementia, and flexible employment options have also been shown to reduce hospitalization.

A community mental health plan for B.C. was developed in the late 1990s. It was based on innovations from other jurisdictions that reduce utilization of acute care services and improve the health and well-being of people with serious and persistent mental health issues. When mental health services were regionalized in 2001, no system was put in place to ensure that dedicated funding was available to enhance these services.

This plan needs to be updated, with an implementation and funding strategy that incorporates early detection and prevention programs, to ensure that people with serious and persistent mental health issues are supported in their communities.

“In B.C. today, appropriate ‘round-the-clock services are not in place to support people with mental health and addiction issues.”

Build on the successes in public health care

We need to keep improving medicare – and we can. By implementing these solutions, and adopting other proven, public sector innovations from within and outside Canada, we will continue to have the best universal health care system in the world.

“Let’s not forget that the ultimate goal of Medicare must be to keep people well rather than just patching them up when they get sick. That means clinics. That means making hospitals available for active treatment cases only, getting chronic patients out into nursing homes, carrying on home nursing programs that are much more effective... It means expanding and improving Medicare by providing pharmacare and dental care programs.

We can’t stand still. We can either go back or we can go forward. The choice we make today will decide the future of Medicare in Canada.”

Tommy Douglas



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