

Four Initiatives for Healthcare Change in BC

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Executive Summary

Healthcare in British Columbia is a complex labyrinth of services and expectations. With growing demand due to an aging population, technology advances, and spiraling costs of delivery, solutions to the increasingly costly system are a political and social challenge.

This paper outlines four initiatives for healthcare reform in BC. These include increased accountability of providers and patients; the re-engagement of doctors within the system as partners, not employees; the realignment of the public's expectations; and finally an expansion of payer sources.

A sustainable public healthcare system requires swift change. It requires political fortitude, and an intimate understanding of the source of the issues, not just a look at the symptoms as are so often brought to the public's attention through the media. This paper seeks to identify some of the sources of the issues impacting healthcare, and provides specific examples. It seeks to find solutions to these problems, and ensure that they are addressed at the most fundamental level.

Introduction

There are no simple solutions to British Columbia's complex healthcare issues. Governed by federal legislation that was enacted prior to the introduction of advanced technologies such as laparoscopic surgery, CT and MRI, along with exponentially growing drug, supply and labour costs, the Canada Health Act provides for equal access for all Canadians regardless of their income, contributions, or health status. Combined with this, healthcare is effectively a provincial government responsibility, with provinces dedicating between 40 and 49% of all government spending towards the cost of healthcare. At the current rate of cost escalation, the province of British Columbia estimates that it will be allocating 75% of all government spending in 2017, to healthcare¹.

What is clear to all is that the current healthcare system cannot meet the needs of the population as it goes forward. In fact, a recent Avantis survey showed that 45% of Canadians don't believe that the healthcare system will meet their needs in just five short years².

¹ Government of British Columbia website: www.bcconversationonhealth.com

² Avantis Survey: 2006

With no simple solutions, we must look at some fundamental changes to our system. The changes presented here are broad sweeping and require something of everyone: patients, providers, and the government. These reform initiatives are focused on accountability, re-engagements of doctors in the system, a realignment of patient expectations, and increasing the number of payer sources.

1. Accountability

We must move towards a culture of accountability amongst providers and patients. With over 1,005,000 healthcare workers in Canada³, healthcare is the largest service sector in the country, serving more than 39 million clients. But who is responsible for the billions of dollars spent by the healthcare workers who provide care to the paying clients (they almost all pay, just in various ways through an elaborate tax system). The prevailing culture of healthcare foists responsibility for errors onto doctors, but doesn't routinely impart a sense of responsibility for the daily operations of the healthcare system.

Take for example the use of healthcare supplies in hospitals, the cost of which is rising at a rate in excess of the national inflation rate. In the average public operating room, every item (disposable or sterilized and re-used) which could potentially be required in a surgical case is brought into the operating room and opened. This means that single use disposables, used or not, are opened and at the ready, regardless of their need. In a private surgery centre, where costs are monitored, surgical supplies are brought into the operating room and opened as required. Wastage is kept to a minimum as supplies are only opened as required.

Another example is the high volume of the same test often ordered for the same patient because the results of the last test are not readily available. Tests are not available because we don't have an efficient means of sharing results. Given that "nobody pays" for the requisition for an additional test, it is simple to re-order the same test (providing it does not pose a risk to the patient). This doesn't include the impact upon patient outcomes resulting from a lack of access to healthcare histories. The lack of information systems across the healthcare system results *from* a total lack of accountability and results *in* higher healthcare costs

Patients need to be similarly accountable. It is estimated that the cost of smoking and unhealthy eating amounts to double the annual cost of the average other-wise-healthy individual's healthcare costs⁴. We can no longer deny our own responsibility in disease prevention such as heart problems and diabetes resulting from overeating and under-exercising. Many surgeons link the patient's outcome to health status prior to surgery, and most now require that the patients are below a certain weight in order to have joint replacement surgery, or that they cease smoking in order to have foot surgery (due to the impact of smoking upon the

³ Statistics Canada: June 2007 data

⁴ BC Government statistic: Act Now 2006

circulatory system). Other health services may need to be tied to personal accountability for health status.

Recommendation:

- That a culture of accountability become a cornerstone to public healthcare system and that an Accountability Office be established to create system-wide changes for adoption (e.g. policy on supply utilization)
- That the Ministry continues to focus on disease prevention through healthy living programs such as Act Now.
- That patients be issued regular statements indicating the cost of their care during the previous six months in an effort to help them understand the cost of healthcare, and thereby potentially impact their utilization.

2. Re-engagement of doctors

Re-engagement of physicians and surgeons in the healthcare system is critical to the future success of the public system. Sometime during the past ten years, doctors came to be seen as employees within the system. As fee-for-service providers, they entered a tenuous relationship with the globally budgeted hospitals and health facilities where they worked. Their perspectives were overshadowed by the requirements of administrators to plan and be accountable to budgets (not to patients). Doctors, conversely, were accountable to patients, not budgets. Administrators came to see doctors as financially irresponsible and more interested in their own salaries, and gradually assumed more power over the decision making. Many doctors have been reduced to participants in committees run by administrators.

Doctors are not employees of the system. They are the backbone of the system, accountable to their patients and their regulatory body (Colleges of Physicians and Surgeons). They have a minimum of 20 years of education and countless hours of practice and contribution. They share patient and emergency call and ensure that 24 hours a day, regardless of where administrators find themselves, they provide direct patient care to those in need.

Ensuring that doctors have a meaningful role in the planning and delivery of healthcare means that those with the most education in the profession are also those who are empowered to make decisions about the system. Re-engaging doctors in the system will allow doctors to take ownership, not be owned, and align their incentives with those of the public system. They would drive healthcare systems towards efficiencies based on effective ways of providing care.

Take for example a typical surgeon in Prince George, Vancouver, Surrey or Kelowna. Outside of their emergency call, most surgeons in these regions are allocated just one day of operating room time per week. When they are on vacation, they cannot just use the day at a future time, they (and their patients), lose it. After holiday closures, most surgeons are fortunate to have 42 surgical days per year. Many fear losing their skills, while others have closed their

consultation practice for fear of being sued for leaving patients on their lengthy surgical waitlists. Is this how we encourage doctors to stay in the system and provide 24 hour care to our population?

Current estimates provided by the Ministry of Health suggest that 10% of all healthcare expenditures are allocated to administration.⁵ In a single-payer system, 10% administration costs may be average, but represents a \$1.29 billion (2006 data) in administrative costs in BC.

Governments must recognize that doctors have options. They may choose to leave the system and either bill privately, or move to other jurisdictions. We can legislate them to work, however it would be more effective to provide them with the tools, and time, they require to do their job and maintain their skills. They are not adversaries in the system, they are partners in the system of healthcare.

Recommendation:

- That doctors be included in the decision making within hospitals, including the allocation of funding;
- That as a single payer system, the administration within hospitals and health authorities be reduced to not exceed 6% of total spending, creating a potential cost savings of \$516 million (based on 2006 total spending).

3. Realignment of the Public's Expectations

The public is going to have to accept that the status quo is not sustainable. We have to now determine what we are willing to forego in order to ensure access for life threatening illness or injury – or simply the daily events of health services such as labour and delivery.

With an aging population and a slightly increased average life span, we are going to have to make decisions about how and when we spend our precious healthcare dollars. If British Columbians don't take this opportunity to provide some direction, the decisions will be made for them. Take the de-listing of services such as physiotherapy, chiropractic and massage care as an example – all uninsured during one of the last healthcare “realignment” in the 1990's.

In addition to accepting that there will have to be changes to the system, British Columbians are going to have to accept that they own the future of their own healthcare: diet and fitness are the hallmarks of a healthy and sustainable society. Those who fail to take responsibility for those factors that are within their control, may have to face fewer services or longer waits for their access to care.

Finally, the public is going to have to expand their acceptance of private providers to include services traditionally provided by hospitals such as advanced diagnostic imaging (CT, MRI),

⁵ Government of British Columbia website: www.bcconversationonhealth.com

cancer screening, and surgical services. Private provision of healthcare services is already part of the system (virtually every GP and most medical and xray labs are private), and plays an expanding role in healthcare provision. On a fee for service basis, it offers accountability, increased throughput, and therefore higher efficiencies than globally budgeted public healthcare.⁶

Recommendation:

- That British Columbians receive financial incentives for memberships to community centres and sporting clubs (tax relief) as a means of reducing the financial burden of fitness.
- That private health services, working in concert with publicly funded services, be offered as an alternative to those who wish to maintain their own care and are prepared to accept the financial accountability for such.

4. Building Sustainability by Increasing Payer Sources

If we are to consider the above arguments in perspective, we have two options: reduce current levels of care and maintain the current budget, or maintain and potentially expand existing levels of care and seek alternate payer sources.

Government imposed waitlist guarantees for a few procedures simply don't measure up. With inflexible funds and healthcare human resources, waitlist guarantees simply serve to reallocate precious healthcare resources to issues at the top of the political agenda.

To date, public opinion in Canada has leaned towards a desire for access to all of the current services, and perhaps a few more (such as alternative and complementary medicine). To do so then, we must look for other payer sources.

At the current rate of unemployment (just 3.9% in April 2007⁷), employers are the most seriously impacted by waitlists and dysfunction in the public system. A veritable "labour chasm" has been created by a shortage of available, and healthy, labour.

While many insurers carry disability insurance for their employees, this only allows employees to be paid to stay at home and wait for care. Current healthcare legislation prohibits employers and disability insurers from paying directly for medically necessary care, such as injuries sustained off-the-job.

⁶ Anecdotal. Based upon information gathered during publicly funded outsourced surgical centre contracts in Vancouver, 2006.

⁷ BC Economic statistics, April 2007.

In order to sustain the economy and at the same time, find additional payer sources for the healthcare system, employers and disability insurers must become legitimate payer sources for a wide range of healthcare services for their employees. This will reduce the cost of attraction and training of temporary replacement workers, increase the number of payer sources for healthcare, and ensure that employees are well cared for.

Recommendation

- That disability insurers and corporations be permitted to participate financially in the healthcare of their employees. This requires legislative change to allow public and private providers to offer this care.

Conclusions

Healthcare reform in British Columbia and Canada is not simple. The complexities of the system, combined with an endless demand and escalating costs, ensure that the current system is not sustainable. By introducing a culture of accountability, re-engaging doctors in the system, re-aligning the public's expectations for health services, and introducing additional payer sources, we may find our way clear to a sustainable, and more robust, system for today and into the future.

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