To the British Columbia Select Standing Committee on Health

From Edward Staples, President, Support Our Health Care (SOHC) Society of Princeton

December 30, 2014

As President of the Support Our Health Care (SOHC) Society of Princeton, I have been actively involved in health care issues and concerns in our community since April, 2012, when Interior Health announced that due to a shortage of doctors they would be closing our hospital's emergency room four nights a week. This prompted an outcry of concern from our community that led to the development of the Princeton Health Care Steering Committee, a collaborative partnership between Interior Health, our local health care practitioners, elected officials, and community leaders. The Committee is in its second year of operation and is working to develop and sustain an effective model of health care for people living in and around Princeton. It's within this context and background that I respond to the questions outlined in your call for written submissions.

Executive Summary

Access to health care services is the primary concern for people living in rural BC. Addressing the chronic shortage of health care professionals will do much to address this concern. Although there seems to be no "quick fix", long term solutions might found through:

- support for the UBC Distributed MD program
- streamlining procedures to bring foreign doctors into the province
- initiating a Physician Assistant program
- expanding the Nurse Practitioner scope of practice
- improvement of recruitment efforts through effective and accurate online information

At the local rural level, access to health care services could be improved by addressing the following:

- increased transportation service for rural remote communities
- home care for seniors
- greater access to e-health - telehealth, telemedicine, home monitoring programs
- promotion and expansion of specialist care within rural communities

At the provincial level, the following initiatives are submitted:

- redistribution of services from the regional to the local level
- establishment of local health care steering committees to address concerns at the community level
- pilot projects to evaluate the potential of innovation in health care

At the joint provincial/federal level, the following need attention:

- revitalization of Canada's public health system through a new health accord between the provinces and the federal government
- illegal for-profit clinics and the legal challenge to public health care brought about by Dr. Brian Day and the Cambie Clinic

To address potential cuts in federal health transfer payments, the following cost saving measures are suggested:

- the establishment of a national pharmacare program
- implement innovative, evidence-based programs that will allow provinces to do “more with less”
- poverty reduction programs that address the root causes of poor health

The development of interdisciplinary teams to create a cost-effective system of primary and community care will first require an administrative restructuring that breaks down the ineffective “silo” system that presently exists.
End-of-life care will be improved through universal access to hospice care and effectively administered pain management programs.
Effective addiction recovery programs will require investment in community-based programs that recognize the interaction between poverty, mental illness, and drug and alcohol abuse.

How can we improve health and health care services in rural British Columbia? In particular, what long-term solutions can address the challenges of recruitment and retention of health care professionals in rural British Columbia?

To improve health and health care services in rural BC, the Ministry of Health and other government ministries need to address the following:

<u>Shortage of Health Care Professionals</u>
Although there are shortages in most areas, the greatest impact felt by rural communities is the chronic shortage of General Practitioners. According to advertisements on the Health Match BC website, there are presently 333 General Practitioner vacancies in the province (December, 2014). In Interior Health (where I live), there are 33 communities looking for 66 GPs. The present problem is not one of recruitment and retention but quite simply one of supply and demand.

Rural communities can endeavor to develop a recruitment and retention program but this becomes an exercise in futility when so many communities are competing for such a small number of candidates. Making your community more “attractive” or “special” only works when there are sufficient numbers of physicians available to fill all the vacancies. In this environment, communities are tempted to offer incentive programs that can turn into unethical “bidding wars” where only the richest communities attract doctors.

To increase the supply, the Ministry of Health needs to support present efforts being made by our universities such as the UBC’s Distributed MD program, an innovative approach to training physicians in communities outside the city centres. The program recognizes the importance of building a more diverse student base that represents the diversity of BC’s communities, particularly among areas that have been traditionally underrepresented, i.e. aboriginal and rural communities. To achieve this diversity, UBC developed the Health Care Traveling Roadshow and the Aboriginal MD Admissions program to attract students who are not only familiar

with the challenges of rural remote living but who are also more likely to return to their rural roots to set up their practise after graduation.

The hiring of foreign physicians may provide temporary relief for rural communities but it has limited potential as a long term solution for rural communities. Using Princeton as an example, we have had two foreign doctors provide excellent service to our community over the past four years. To achieve their permanent accreditation they are required to complete two years on probation. One of these doctors set up his family base in the lower mainland and established temporary residency in our community until his probation period was completed and then left Princeton to set up a practice close to his family. It is expected that the other doctor who is into her second year at our medical clinic, will leave our community in July. Rural communities provide convenient openings for foreign doctors to enter our province but based on our experience in Princeton, a long term commitment to rural medicine is unlikely.

One of the problems with recruitment is the difficulty in finding information on the websites that post health care vacancies. Health Match BC is responsible for maintaining a list of health care vacancies in the province and the six provincial health authorities maintain websites that list other openings in the communities they serve. These websites are very cumbersome and accessing information is very difficult. For example on the Health Match BC websites, the list is not kept up-to-date, contains discrepancies between listings, and does not include vacancies in such areas as nursing. I would encourage members of the Committee to go to https://www.healthmatchbc.org, click on “Find a Job in BC” and “Refine Search” to “Physician; Family Practitioner/General Practitioner; The Interior; Princeton” to determine for themselves the nature of this problem.

Physician Assistants

The Ministry of Health is encouraged to follow the lead of Manitoba and Ontario and establish an accredited Physician Assistant program in BC. According to the the Canadian Medical Association (CMA) physician assistants are "highly skilled health care professionals who work alongside physicians to improve access to care, reduce wait times, and enhance the quality of care." They have the potential to provide a long term solution to our doctor shortage problem.

Nurse Practitioners

Nurse Practitioners serve an important health care role in rural communities. However, their scope of practice prevents them from dealing with patients with complicated conditions or performing duties such as ER and obstetrics. Expanding the NP scope of practice to include training in these areas would increase the services available through a coordinated interdisciplinary approach.

Transportation

For people living in rural communities, access to health care services requires access to transportation. As our population ages, this requirement means a greater

dependency on transportation provided by others. Public transportation service is limited and for many elderly residents needing specialist care, an all-day trip to a regional hospital is a daunting proposition, not to mention the out-of-pocket costs that may be a significant hardship for some seniors. There are two options for improving this situation; make it easier for the patient to get to the specialist or bring the specialists to the patient.

Although it is understood that the Ministry of Health is not responsible for public transportation, improved services for rural communities would have a profound impact on the health outcomes of rural residents. The *Princeton Health Care Action Plan* outlines a pilot program to include scheduled everyday local HandiDart bus service to locations such as our hospital and medical clinic. It also calls for improved service to regional health care facilities in Penticton and Kelowna; at present HandiDart provides service to Penticton twice a week; there is no service to Kelowna where many specialist services are provided.

Access to Specialist Care

This past year, the *Princeton Access to Specialist Care Project* was established to improve and sustain access to specialist care and to support Princeton physicians in providing optimal care to their patients. This pilot project has been an outstanding success and is funded by the Shared Care Committee, a joint collaborative committee of the Doctors of BC and the Ministry of Health. Continuation of this program in Princeton and expansion into other rural remote communities is vital to the improvement of access for rural patients. For further information, see *Specialist Doctors for Princeton* at http://sohc.ca/?paged=3.

Seniors Home Care

In 2012, the United Way, in partnership with the provincial government, launched their *Better at Home* program. Its purpose is to provide non-medical care to seniors through community based programs that allow seniors to live longer in their own homes while remaining connected to their community. In their recently released program evaluation, *Better at Home* demonstrates that the program "is having a positive impact on seniors. According to the seniors, Better at Home is contributing to a number of key quality of life indicators such as: helping seniors to remain living in their homes longer; making life easier for seniors overall; providing greater peace of mind; and helping seniors to manage activities of daily living." (Better at Home Program Evaluation - Summary of Evaluation Findings and Recommendations).

Although the benefits of at-home care are proven, a lack of funding prevents province-wide implementation of the *Better at Home* program. Expansion of the program is still in the pilot project stage and it's hoped that the Ministry of Health will soon recognize the long term benefits to the health of seniors and the cost-effectiveness in terms of savings to the provincial health care budget.

E-Health

Accessing and delivering health care services through the internet has great potential to improve access for residents in rural remote communities. Programs such as telehealth, telemedicine (Medeo), and home monitoring programs are in their infancy and need to be expanded and promoted to become more viable. There are several ways that these programs could be improved. Practitioners and support staff need on-going training to keep them up to date on new technological developments. Patients need to be educated in the use of e-health options and where they can be accessed. A step by step information package for practitioners and patients would provide a simple and effective tool for the promotion and use of telehealth.

Rethinking Regionalization

Re-examination of the distribution of services available at the local and regional levels might address access concerns for rural communities and alleviate the problems of overcrowding at larger urban hospitals. Most local hospitals have unused space that might be used to provide services presently only available at the regional level. An example of such service would be convalescent care; instead of keeping surgical patients in convalescent care at regional (centralized) hospitals, they could be transferred to their “home” community to receive the care they need. In addition to reducing overcrowding at the regional hospital, it would put patients in closer contact with friends and family.

Community Health Care Steering Committees

The Princeton Health Care Steering Committee is a model where community stakeholders are working collaboratively with health care practitioners and Interior Health administrators to improve the delivery of health care to the residents of Princeton and Area. In an atmosphere of cooperation and respect, the Committee has implemented several improvements that have impacted the health outcomes in the community. The Ministry of Health might consider the establishment of this model of change in other receptive communities in rural BC.

Support for Public Health Care

In April of this year, the Canada Health Accord was allowed to expire. A ten year agreement between the federal and provincial governments, the Accord was supposed to improve surgical wait times, drug coverage, home care, primary health care, and electronic medical records. With its demise, Canadians also lost the Canada Health Council, the independent body charged with the responsibility to collect information about the performance of our health care system, to provide provincial and federal governments with guidance on health care reform, and to direct reforms associated with the $40 billion included with the agreement. In its final report, the Council described the years of the Canada Health Accord as “a decade of failing Canadians.” The blame for this failure rests not with the Health Council, but with the signatories of the agreement.

Instead of renegotiating a new agreement with targets and timelines for innovation and cost-savings, the federal government walked away from rebuilding our national health system and instead imposed a unilateral financial position that will remove $36 billion from our health care system over the next ten years. This cut, along with the removal of the equalization system of federal transfer payments, will result in a reduction of over $5 billion for BC alone.

Health Care Budgets

Although proposed federal health care cuts may be reversed after the next federal election, stress on provincial health care budgets should be expected. The following are practical ways that budgetary stress might be alleviated:

- Support the establishment of a national pharmacare program, recognizing that such a program will provide easier access to prescription drugs and a net savings to our provincial health care budget.
- Initiate a consolidated program aimed at reducing poverty in British Columbia. Poverty is the main driver of poor health outcomes in the province. Investment in programs to raise the overall standard of living will provide a net savings in public health care costs.
- Explore innovative ways to do “more with less”. To improve our public health care system, we need to explore successful innovations that have been implemented in other provinces and other countries.

Legal Challenge to Medicare

In a 2012 audit of Dr. Brian Day’s Cambie Surgeries Corporation and Specialist Referral Clinic by the BC Medical Services Commission, it was determined that in the period of one month, the clinic had illegally billed patients over $500,000 for services covered under the BC Medical Services Plan. Dr. Day ignored an order to stop the practice and instead filed a law suit against the BC government claiming that the order violates his rights under the Canadian Charter of Rights and Freedoms. Instead of going to the BC Supreme Court at the scheduled September 8, 2014 date, the provincial government announced in August that they had begun negotiations with Dr. Day to hopefully achieve an out-of-court settlement.

If those harmed by Dr. Day’s clinics are to be treated fairly and if others are to be deterred from breaking the law, the BC government must hold the clinics accountable for these violations. At minimum, the BC government should do so by:

- Requiring restitution to patients for the cost of services for which they were unlawfully billed at CSC and SRC.
- Conducting a full audit of the clinics to cover the period from 2001-present.
- Requiring a commitment from Dr. Day and all physicians operating at his clinics assuring strict compliance with the Medicare Protection Act.
- Instituting a permanent injunction restraining the clinics from contravening the Act
- Referring the cases of practitioners who have engaged in unlawful billing to appropriate disciplinary bodies.

- Requiring the practitioners, owners of the facility, or representatives of the corporations, to reimburse the Medical Services Commission for any costs associated with the audit and violations committed by the clinics

Research: Making the Case for Change

In situations where the Ministry of Health may be reluctant to establish unproven province-wide change, it is suggested that pilot projects/programs be established in communities that are receptive and ripe for research. Princeton is one community that has demonstrated that it is "fertile ground" for such innovation. The establishment of the Princeton Health Care Steering Committee, the collaborative, respectful relationship that the community has with Interior Health, and the presence of a young, energetic team of health care professionals makes Princeton a perfect location to initiate innovative programs that could help to maintain a sustainable health care system for British Columbians.

Pilot projects could include:

- a Physician Assistant program
- restructuring local management through department consolodation
- convalescent care at the local level
- interdisciplinary team development with a focus on home care for individuals living with life-limiting chronic illness
- the effect of a telehealth education and promotion program

How can we create a cost-effective system of primary and community care built around interdisciplinary teams?

At the rural remote level, the best way to build interdisciplinary teams is to break down the "silos" that exist at the administrative level. Princeton is served by many managers, most of whom administer their departments off-site. Communication between managers is limited or non-existent, resulting in staffing, equipment and material decisions being made independent of each other. Consolidation of part-time off-site managerial positions into full-time on-site positions would streamline decision making and transfer responsibility and accountability from the regional level to the local community level.

Creating a cost-effective interdisciplinary approach also requires that all health care vacancies are filled. Overworked GPs who are struggling to keep up with the day-to-day demands of the community will find it difficult to make time to work on innovative approaches in their practise. Until chronic shortages are alleviated, for rural remote communities, this question may be premature.

Promotion and expansion of the *Access to Specialist Care Project* may be an important part of developing interdisciplinary teams. Princeton doctors involved with the project report that involvement with the program results in high levels of satisfaction for both patient and doctor. Direct contact between local GPs and visiting specialists provides a stimulating environment where practitioners can discuss innovations and strategies for improved health outcomes for their patients.

What best practices can be implemented to improve end-of-life care?

The most important issue for people at the end of their life is being able to access a full range of services that could ease their final days. These services include hospice facilities, pain management, support for family and friends, and home care options. Care coordination should be managed be a team of care givers that includes, but not limited to a family physician, a pain management specialist, community services, and volunteer hospice organizations.

Since end-of-life often involves pain associated with a chronic illness, pain management administered by a qualified specialist is a critical best practice that would improve end-of-life for both the patient and family members. Where access to this service is unavailable or not part of a family physician's expertise, overmedication is common. Although this may control the pain, it often renders the patient comatose and unresponsive to other forms of palliative support provided by family or volunteers. One way to improve access to this service would be through on-line programs such as tele-health.

Social sensitivities to end-of-life often result in avoidance or deferral of care that may be readily available in the community. Public education of available services could remove the stigma attached to death and dying and allow care givers to develop a coordinated palliative care plan in the earliest stages of end-of-life.

How can we enhance the effectiveness of addiction recovery programs?

Take the following steps:

- recognize the correlation between mental illness and drug and alcohol abuse.
- invest more in community-based services
- focus on poverty reduction and enhancement of self worth