J. Jones #1
Sworn: August 13, 2009

No. S090663
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

CANADIAN INDEPENDENT MEDICAL CLINICS ASSOCIATION, CAMBIE SURGERIES CORPORATION, DELBROOK SURGICAL CENTRE INC., FALSE CREEK SURGICAL CENTRE INC., OKANAGAN HEALTH SURGICAL CENTRE INC. and ULTIMA MEDICAL SERVICES INC.

PLAINTIFFS

AND:

MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA, MINISTER OF HEALTH SERVICES OF BRITISH COLUMBIA and ATTORNEY GENERAL OF BRITISH COLUMBIA

DEFENDANTS

AND:

SPECIALIST REFERRAL CLINIC (VANCOUVER) INC.

DEFENDANT BY COUNTERCLAIM

AFFIDAVIT

I, Joyce Jones, retired, of 206 - 4001 Mount Seymour Parkway, of the District of North Vancouver, in the Province of British Columbia, MAKE OATH AND SAY AS FOLLOWS:

1. I was a founding member of the BC Friends of Medicare Society (hereafter referred to as "the BCHC" or "the Coalition"), and until recently, and for several years served as its community co-chair. I currently sit on the Board of the Coalition representing the BC Seniors Advocacy Network As such I have personal knowledge of the facts and matters hereinafter deposed to, save and except where same are stated to be made on information and belief, and where so stated, I verily believe them to be true.

2. The BCHC champions the protection, expansion and improvement of a universal, single-payer public health care system. As described by its Constitution, the Coalition's mandate is to:

a. ensure that health care is a right – everyone must have the right to high quality, responsive and appropriate health care which is publicly funded, publicly accountable and publicly controlled;

b. protect and expand public health care;

c. ensure equitable access to health care – regardless of an individual's income, level of ability, age, cultural heritage, sex, sexual orientation or geographical location;

d. address issues that are basic to good health – food, education, income, housing, social support and personal safety determine an individual's ability to achieve and maintain good health.

A true copy of the Constitution and Mission Statement are attached hereto and marked as **Exhibits A and B**, respectively, to this my Affidavit.

3. Founded in 1995, the BCHC is a network of organizations and individuals from across British Columbia dedicated to the preservation of medicare. The BCHC represents over 50 member organizations representing seniors, women, people with disabilities, anti-poverty activists, health care providers, patients, members of faith-based organizations and labour unions. A list of member organizations is attached hereto and marked as **Exhibit C** to this my affidavit. Either as individuals or as of members of affiliated groups the BCHC speaks for over 600,000 British Columbian residents.

4. The BCHC's work is overseen and its staff directed by a twelve-member Steering Committee, which is composed of representatives of community organizations and several trade unions. The BCHC's work is conducted in a democratic, inclusive and consensus-based manner. Working groups or sub-committees are established as issues and events arise. There are

currently four sub-committees at work within the BCHC: one is assigned to the issue of continuum of care, one to so-called "Public-private partnerships" (P3s), one to the emergence of private clinics, and one to election-related matters. The overarching goals of the BCHC's work are to raise public awareness on health care, to encourage citizen participation in public policy formulation and program development concerning health care. The BCHC's ongoing priorities are to support public health care, to campaign in support of seniors, home support and long-term care, to stop the privatization of health care delivery and to advocate for public solutions to the challenges facing British Columbia's health care system.

5. In 2007, the BCHC launched its "Friends of Medicare" ("FOM") campaign to raise public awareness about the risks of for-profit medicine. The FOM campaign invites individuals to join the campaign and provides them with information about the issues and opportunities for getting involved in the debate on health care in British Columbia. Through the BCHC's website [www.bchealthcoalition.ca], members of the FOM campaign can contact government and public officials to share their views on user-fees and extra billing by for-profit health care providers, the importance of home care, P3s, positive public solutions to health care challenges, and other issues important to the health care debate. The website also gives members of the FOM campaign access to valuable resources such as health care-related legislation, news stories, media releases and documents outlining the positive public solutions that the BCHC advocates.

6. In 2008, the BCHC launched its Private Clinics campaign to confront the proliferation of for-profit health clinics across British Columbia. The goals of this campaign are to:

a. resist the encroachment of for-profit surgical clinics into our health care system and promote public sector specialty elective surgery clinics;

b. ensure federal enforcement of and provincial compliance with the *Canada Health Act* in order to prohibit the charging of user-fees and extra billing by any health care provider for insured medical services; and

c. resist private health insurance and promote public, single-payer universal health care coverage.

7. The BCHC has taken numerous steps to achieve the goals of its Private Clinics campaign, including developing a private clinics workshop which was presented to several member organizations, hosting a physicians panel in April 2008 on the subject of private clinics and private insurance, co-sponsoring a national paper on private clinics, and launching various on-line campaigns encouraging citizens to send letters to the Premier and to Federal and Provincial Health Ministers to express their opposition to health care privatization. The BCHC has further engaged in a review of the statutory authority of local governments to regulate private clinics and has encouraged local governments to address the issue of private clinics in their communities.

8. The BCHC also advocates on behalf of members of the public who have been asked to pay user fees and other charges for health care services that should be publicly funded. It has also pressed the British Columbia Medical Services Commission (the "BCMSC") to investigate private clinics and to release the results of those investigations. For example, the BCHC the BCMSC sought redress the BCMSC's failure to address the concerns of individual complainants in its audit of the Copeman Healthcare Centre's extra-billing practices. True copies of BCHC news releases and a letter to the BC Minister of Health dated February 7, 2008, are attached hereto and marked as **Exhibit D** to this my Affidavit.

9. The BCHC also engaged in a public communication campaign in response to the British Columbia Automobile Association's attempt in October of 2008 to offer private medical access "wait list" insurance to its members. By raising awareness of the issue through news releases and by initiating an email writing campaign, the BCHC played an important role in convincing the British Columbia Automobile Association to abandon its plan to offer this type of for-profit health insurance to its members.

10. The BCHC has endeavoured to participate actively in the health care debate and worked with citizens, professionals and experts in the field of health care to produce a report titled

"Positive. Public. *10 steps to stronger health care*." which takes an in-depth look at the challenges faced by British Columbia's health care system and suggests positive and public solutions that ensure the sustainability of an equitable and accessible public health care system for the future. A true copy of the report is attached hereto and marked as **Exhibit E** to this my Affidavit. The report highlights public approaches that, among other things, shorten waitlists, enhance residential care, control drug costs and increase accountability within the public system.

11. The BCHC further contributed to this important debate by co-authoring, along with the Canadian Centre for Policy Alternatives – BC Office, a 2007 paper titled "WHY WAIT? PUBLIC SOLUTIONS TO CURE SURGICAL WAITLISTS." A true copy of the paper is attached hereto and marked as **Exhibit F** to this my Affidavit.. This paper extensively reviews the issue of waitlists for medical services, and examines groundbreaking projects in British Columbia, Alberta, Saskatchewan and Ontario that have been successful at reducing wait times for various procedures, including hip/knee replacement, cataract surgeries and others. The paper concludes that public solutions to the wait lists problem are preferable to private insurance and delivery, and outlines the problems that a private system would create for British Columbians, such as higher cost, less accountability and, in the end, longer wait times.

12. The BCHC also provides its members and the public at large with various resources in support of public health care. Through its website the BCHC makes available outside reports and studies, facts sheets, speech transcripts and links to other resources from various organizations. The BCHC also makes regular media releases on pertinent health care-related news.

13. The BCHC has also been actively involved in raising public awareness about this litigation, and the implications that this constitutional challenge to the framework for medicare has for access to necessary health care for most residents of BC. We have convened several meetings of our membership and routinely discuss this litigation to coordinate the responses of groups who wish to respond to it.

14. The BCHC is concerned that it is important that organizations or individuals other than the B.C. government participate as parties in this litigation, so as to ensure that the court is provided with a full and adequate evidentiary record canvassing all of the public interest considerations relevant to determining the constitutionality of the legislation under challenge, which in the BCHC's view is critical to ensuring equitable access to quality health care. In this connection, the BCHC has often differed with the provincial government on various matters relating to the delivery of health care services in the province, including those that are at the centre of the plaintiffs' challenge to essential elements of the provincial health care insurance plan. In particular, the BCHC has taken the position that the province has, on various occasions, failed to adequately enforce the letter and honour the spirit of the *Canada Health Act*, and of provincial health care legislation, and has permitted or condoned the operation of private payment and for-profit delivery which undermines and is in conflict with provincial and federal legislation.

15. One indication of these concerns can be found in the annual reports which the federal Minister of Health is obliged under the *Canada Health Act* to present to Parliament, relevant excerpts of which are attached hereto and marked as **Exhibit G** to this my affidavit. A review of the most recent annual report indicates that British Columbia and Quebec are singled out for being lax in their enforcement of provincial laws that prohibit queue jumping and charges to insured persons at private surgical clinics. Moreover a review of the history of deductions in federal transfers to the provinces because of their failure to meet the requirements of the *Canada Health Act* shows that British Columbia has been penalized more frequently than any other province.

16. The BCHC's concern about the degree to which the provincial government is committed to the enforcement and defense of the *Medicare Protection Act* was underscored by a recent media interview with the present Minister of Health for British Columbia, in which the Minister was quoted as saying that patients should be able to use their own money to buy expedited treatment in private surgery clinics, as follows:

> "I don't have an objection to people using their own money to buy private services just as they do with dentists, just as they do with other decisions they make - you know, sending their kids to private school or what have you.
>
> I think choice is a good thing, actually - reducing choice I don't think is a good thing."

17. The BCHC is concerned that the Minister's remarks, which essentially condone queue jumping, reflect a fundamental misapprehension about the basic principles of medicare and the laws he is charged with responsibility to administer and enforce. While the Minister subsequently qualified his remarks by saying that they were only intended to apply to non-medically necessary procedures such as plastic surgery, his initial comments are consistent with comments he has expressed on other occasions. Attached hereto and marked as **Exhibit H** to this my Affidavit are true copies of two media stories that report on the Minister's comments.

18. Moreover, the Minister's initial response to questions about privatizing health care, the very issue at the heart of this litigation, are not only consistent with its failure to adequately enforce existing provincial laws and to abide by the requirements of the *Canada Health Act*, but also with other pro-privatization policies the government has supported in respect of other aspects of health care service delivery. In fact, the BCHC has had to repeatedly engage with the provincial government in efforts to dissuade it from favouring privatization as an answer to present health service delivery issues. Attached hereto and marked as **Exhibit I** to this my affidavit are true copies of fact sheets which illustrate these efforts.

19. Given the broad representative status of the BCHC, and its extensive involvement and expertise in the issues which lie at the core of this legal challenge, the BCHC believes that it can be of significant assistance to the Court in these proceedings. Indeed, in the BCHC's view, there are issues, particularly concerning the record of provincial enforcement of health care law, in respect of which the Coalition and the provincial government have significantly different perspectives and positions. While the BCHC has no desire to duplicate the efforts made by the Province in defending this action, it is ready, able and willing to present both evidence and

argument in order to be of assistance to the Court in determining the purpose, effect, and constitutionality of the legislation under challenge.

20. Furthermore, not only does the BCHC have a genuine and substantial interest in the outcome of this case, but its member organizations (including seniors, women, people with disabilities, and anti-poverty organizations) are comprised of thousands of individuals like Glyn Townson and Tom McGregor, who I understand are also applying for standing in this proceeding, are members of disadvantaged groups, and who for reasons of income and health status, are uniquely reliant on the public health care system to provide them with access to timely and quality health care services. The groups which represent these individuals are members of the BCHC because of their fundamental concern that allowing or encouraging increased private insurance and delivery, and failing to maintain and enforce existing restrictions – the fundamental issues in these proceedings - will undermine their members' access to health care and the quality of care they receive in the public system.

21. As a result, the BCHC seeks to be added as a party, or in the alternative an intervener with the right to participate in the evidentiary process, in order to assist the Court in deciding questions of direct interest to, and directly affecting access to health care for, the thousands of individuals represented by our member organizations.

SWORN BEFORE ME at the City of Vancouver, in the Province of British Columbia, this 13th day of August, 2009.	)	
A Commissioner for taking Affidavits for British Columbia.	)	**JOYCE JONES**

Bruce Elwood
Arvay Finlay
Barristers
1350 - 355 Burrard Street
Vancouver, BC V6C 2G8
Phone 604.689.4421
Fax 604.687.1941

BC Health Coalition

Supporting positive, public solutions to make Medicare stronger in British Columbia!

FIND YOUR LOCAL HEALTH COALTION!

Constitution

Society Act

CONSTITUTION

- The name of the society is: BC Friends of Medicare Society
- The purposes of the society are:

1. To ensure that health care is a right - everyone must have the right to high quality, responsive and appropriate health care which is publicly funded, publicly accountable and publicly controlled.
2. To protect and expand public health care.
3. To ensure equitable access to health care - regardless of an individual's income, level of ability, age, cultural heritage, sex, sexual orientation or geographical location.
4. To address issues that are basic to good health - food, education, income, housing, social support and personal safety determine an individual's ability to achieve and maintain good health.

[Back]

This is Exhibit....A.....referred to in the affidavit of ....Joyce Jones.... sworn before me, this ....13th.... day of ....AUGUST.....20.09

.....
A COMMISSIONER, ETC.

TAKE ACTION to promote POSITIVE PUBLIC SOLUTIONS today!

Donate to our Friends of Medicare Campaign!

Read about public innovation and positive public solutions

Write to Premier Campbell and demand he improve the lives of seniors and people with disabilities

Watch our new video outlining our seniors' care campaign demands!

Call for an end to user-fees and extra billing by for-profit health care providers in BC

Ask the Federal Health Minister to investigate suspected B.C. violations of the Canadian Health Act

Register your complaint about Senior's Care in BC with the Provincial Ombudsman

Email the Premier to Restore Home Support

Tell Premier Campbell how you feel about P3s in your community

Sign a Petition to Support Public Health Care

BC Health Coalition | 411 Dunsmuir Street Vancouver, BC V6B 1X4 | P: 604-681-7945 | F: 604-681-7947 | Email: info@bchealthcoalition.ca |

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BC Health Coalition

Supporting positive, public solutions to make Medicare stronger in British Columbia!

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About BCHC
Take Action
News
BCHC Resources
Donate to the BCHC
Contact Us
Event Calendar

FIND YOUR LOCAL HEALTH COALTION!

Home • About BCHC • Mission Statement

Mission Statement

PRINT EMAIL

The BC Health Coalition champions the protection and expansion of a universal public health care system. We believe:

1. Health care is a right - everyone must have the right to high quality, responsive and appropriate health care which is publicly funded, publicly accountable and publicly controlled.

2. Access to health care must be equitable - regardless of an individual's income, level of ability, age, cultural heritage, sex, sexual orientation or geographical location.

3. Issues that are basic to good health must be addressed - food, education, income, housing, social support and personal safety determine an individual's ability to achieve and maintain good health.

To learn more about the BC Health Coalition watch our video and visit:

- Who We Are
- How We Work
- What We Do

[Back]

This is Exhibit....B.....referred to in the affidavit of ...Joyce Jones.
sworn before me, this .....12th.....
day of ....AUGUST.....20.09

.....
A COMMISSIONER, ETC.

TAKE ACTION to promote POSITIVE PUBLIC SOLUTIONS today!

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BC Health Coalition

Supporting positive, public solutions to make Medicare stronger in British Columbia!

FIND YOUR LOCAL HEALTH COALTION!

Coalition Members

The BC Health Coalition is a strong network of organizations and individuals, which in total represents over 600,000 British Columbians. The members of the BC Health Coalition are:

- 411 Seniors' Centre Society
- BC Federation of Labour
- BC Federation of Retired Union Members
- BC Government & Service Employees' Union
- BCGEU Component 2
- BCGEU Component 12
- BC Nurses' Union
- BC Persons with AIDS Society
- BC Retired Teachers' Association
- BC Seniors' Advocacy Network
- BC Synod of the Evangelical Lutheran Church in Canada - Social Justice Committee
- BC Teachers' Federation
- BCYT-Building & Construction Trades Council
- Campbell River & Courtenay District Labour Council
- Canadian Union of Public Employees - BC
- CUPE Local 409
- Castlegar & District Health Watch
- Check Your Head: Youth Global Education Network
- Compassion Club
- Concerned Citizens of BC
- Confederation of Canadian Unions
- COPE 378
- Council of Canadians - BC/Yukon Region
- Council of Canadians - Vancouver Chapter
- Council of Canadians - New Westminser Chapter
- Council of Canadians - Victoria Chapter
- Council of Canadians - Campbell River Chapter
- Council of Canadians - Surrey, Langley and White Rock Chapter
- Council of Canadians - Cowichan Valley Chapter
- Council of Senior Citizens' Organizations of BC
- Diocese of New Westminster - Anglican Church of Canada
- East Kootenay Railway Pensioners' Association
- Elk Valley & South Country Health Care Coalition
- Federation of Post-Secondary Educators of BC
- Greater Victoria Seniors
- Health Sciences Association of BC
- Hospital Employees' Union
- Hospital Employees' Union - PVP Local
- Kamloops & District Labour Council
- Nanaimo, Duncan and District Labour Council
- Nelson and Area Society for Health
- Network of Burnaby Seniors
- New Westminster and District Labour Council
- North Okanagan Labour Council
- Pharmawatch
- Quenel and District Labour Council
- REACH Centre Association
- Save our Northern Seniors
- Seniors on Guard for Medicare
- Society for the Prevention of Cruelty to Seniors
- South Island Health Coalition
- South Okanagan Boundary Labour Council
- Synod - Lutheran Church of BC
- Union of Psychiatric Nurses
- Unitarian Church of Vancouver Social Justice Committee
- United Food and Commercial Workers' Local 1518
- Vancouver and District Labour Council
- Vancouver Native Health Society
- WE*ACT

To learn more about membership in the BC Health Coalition and how to join:

- Watch the BCHC video
- Become a Friend of Medicare

TAKE ACTION to promote POSITIVE PUBLIC SOLUTIONS today!

Donate to our Friends of Medicare Campaign!

Read about public innovation and positive public solutions

Write to Premier Campbell and demand he improve the lives of seniors and people with disabilities

Watch our new video outlining our seniors' care campaign demands!

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Sign a Petition to Support Public Health Care

This is Exhibit "C" referred to in the affidavit of Joyce Jones sworn before me, this 13th day of AUGUST 2009

A COMMISSIONER, ETC.

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- Take out a membership in the BCHC

[Back]

BC Health Coalition | 411 Dunsmuir Street Vancouver, BC V6B 1X4 | P: 604-681-7945 | F: 604-681-7947 | Email: info@bchealthcoalition.ca | [redacted]

This is Exhibit ....D.... referred to in the affidavit of ....Joyce Jones.... sworn before me, this ....13th.... day of ....AUGUST.... 20..09

.....
A COMMISSIONER, ETC.

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news release

November 29, 2007

FOR IMMEDIATE RELEASE

Copeman Decision: Health Coalition Demands immediate disclosure of government review

The BC Health Coalition is calling on the provincial government to fully disclose the contents of a recent Medical Services Commission review that exonerates the for-profit Copeman Healthcare Centre.

Health Coalition co-chair Joyce Jones says the decision is unbelievable, and questions the objectivity of an audit—only part of which has been released that found no evidence of extra billing or enhanced services despite the annual fees in the thousands that the Copeman clinic charges its patients.

"We must have a full release of the review to understand how a decision could have been made that allows a clinic like Copeman's to operate freely under the Medicare Protection Act," says Jones.

Jones notes that Medical Services Commissioners responsible for the audit have openly advocated more for-profit health care or been personally involved in their own private health care enterprises.

"It is outrageous that we are left having to content ourselves with the sanitized results of a secret investigation undertaken within a government body, many of whose members appear clearly behind the expansion of for-profit health care provision," says Jones.

"Instead of giving the green light to exclusive member-only for-profit medicine that undermines the public system, the government needs to build on the successes of many positive public solutions to health care challenges, such as innovative public community health centres that provide comprehensive, team-based care, and which are proven to result in lower costs to the system and better health outcomes," she added.

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For more information contact:

Joyce Jones, co-chair, BC Health Coalition; 604-987-0168; 604-786-7530 (cell)

Supporting positive, public solutions to make Medicare stronger in British Columbia!

phone: 604.681.7645 • fax: 604.681.7947 • email: info@bchealthcoalition.ca • website: www.bchealthcoalition.ca

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BC Health Coalition 411 Dunsmuir Street, Vancouver, BC V6B 1X4
phone: 604.681.7945 • fax: 604.681.7947 • email: info@bchealthcoalition.ca • website: www.bchealthcoalition.ca

February 7, 2008

Hon. George Abbott
BC Minister of Health,
Room 346
Parliament Buildings
Victoria, B.C.
V8V 1X4

Dear Minister Abbott,

The BC Health Coalition is a broad-based network of organizations and individuals who support public health care. We represent the public's interest in ensuring that our health care system operates according to the principles of the Canada Health Act and works for the well being of all British Columbians.

We are writing to express serious concerns about your government's recent investigation of the fee-based Copeman Healthcare Centre in Vancouver and to request that you overturn the recent Medical Services Commission decision that apparently found no fault with the billing practices of the Centre.

Through the practice of extra-billing and charging of user fees, the Copeman Health Centre is in clear violation of the Canada Health Act. In 2006 your own Ministry informed the Copeman Health Centre that it was operating in contravention of the Canada Health Act. When the Centre refused to stop charging fees, the Ministry referred the issue to the Medical Services Commission.

The BC Court of Appeal has ruled that the principles of the Canada Health Act are part of, and affect the interpretation of the BC Medicare Protection Act.
Your obligation now is to uphold existing laws in BC and to ensure our province complies with the Canada Health Act.

We also request that you work to ensure full public disclosure of the Medical Services Commission's investigation of the Centre in order that we can properly understand how such a conclusion was reached.
We are faced with many unanswered questions about this investigation. How many on-site visits did the Medical Services Commission carry out during its investigation? Were any of these unannounced? How many members of the public who access the Copeman Healthcare Centre were contacted by the Medical Services Commission? Was it determined whether or not they paid annual fees?

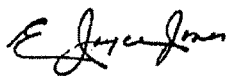
Only when we have answers to such questions will we be able to evaluate a decision that allows a primary care centre to require patients to pay large fees to physicians who provide publicly insured medically necessary services.

We remind you that our public health care system in BC and across Canada is based on the principle that access to insured medical services is available to everyone equally based on medical need, not on ability to pay. The model promoted by the Copeman Healthcare Centre violates this principle and sends us down the road to US-style health care where those with higher credit card limits or better health insurance get better care.

It is time for the BC government to build on the successes of the many positive public solutions to our health care challenges. Instead of giving the green light to exclusive member-only, for-profit medicine which erodes the public system, the government needs to promote public innovations such as public community health centres that provide comprehensive, team-based care, and which are proven to result in lower costs to the system and better health outcomes

We look forward to an early reply to indicate when the actions requested in this letter will be taken and what other measures the government is contemplating to address this serious situation.

Yours truly,



Joyce Jones, BC Health Coalition Co-Chair

Anne Shannon, BC Health Coalition Co-Chair

cc: Hon. Tony Clement, Federal Minister of Health
cc: Hon. Adrian Dix, BC Opposition Critic for Health
cc: BC Medical Services Commission

Supporting positive, public solutions to make Medicare stronger in British Columbia!

8

BC Health Coalition

news release

February 8, 2008

FOR IMMEDIATE RELEASE

Copeman Clinic: Health Coalition Calls on Health Minister to overturn Medical Services Commission decision

Letter to George Abbott demands the government release the details of the Copeman investigation that concluded the centre is not violating medicare laws even though it requires patients to pay large fees to receive its services

The BC Health Coalition is calling on the provincial government to overturn a Medical Services Commission decision that found Vancouver's Copeman Healthcare Centre is in compliance with the laws of medicare, even though the facility charges thousands of dollars in annual membership fees.

In a letter to Health Minister George Abbott, the Coalition reminds the government that the public health care system in BC and across Canada is based on the principle that access to medical services is available to everyone based on medical need, not on ability to pay.

The letter warns that the model promoted by the Copeman Healthcare Centre violates prohibitions on user fees for publicly insured services, and reminds the government that the BC Court of Appeal has ruled that the principles of the Canada Health Act are part of, and affect the interpretation of the BC Medicare Protection Act, the law governing Medicare in BC.

"Your obligation now is to uphold existing laws in BC and to ensure our province complies with the Canada Health Act," says Joyce Jones, BC Health Coalition co-chair.

The BCHC is also demanding that the provincial government release the complete details of the Medical Services Commission investigation of the Copeman Healthcare Centre and the full reasons for its conclusions.

"We request that you work to ensure full public disclosure of the Medical Services Commission investigation of the Centre in order that we can properly understand how such a conclusion was reached," says Jones.

"We are faced with many unanswered questions about this investigation. How many on-site visits did the Medical Services Commission carry out during its investigation? Were any of these unannounced? How many members of the public who access the Copeman Healthcare

Centre were contacted by the Medical Services Commission? Was it determined whether or not they paid annual fees? "

"Only when we have answers to such questions will we be able to evaluate a decision that allows a primary care centre to require patients to pay large fees to physicians who provide publicly insured medically necessary services," says Jones.

"It is time for the BC government to build on the successes of many positive public solutions to our health care challenges. Instead of giving the green light to exclusive member-only for-profit medicine which erodes the public system, the government needs to build on the successes of many public innovations such as public community health centres that provide comprehensive, team-based care, and which are proven to result in lower costs to the system and better health outcomes," added Jones.

Visit the BCHC website view the letter: www.bchealthcoalition.ca

For more information contact:

Joyce Jones, co-chair; BC Health Coalition: 604-987-0168 or 604-786-7530 (cell)

Supporting positive, public solutions to make Medicare stronger in British Columbia!

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phone: 604.681.7645 • fax: 604.681.7947 • email: info@bchealthcoalition.ca • website: www.bchealthcoalition.ca

POSITIVE. PUBLIC.

10 steps to stronger health care

10

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.

"Medicare 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.

This is Exhibit E referred to in the affidavit of Joyce Jones sworn before me, this 13th day of August 2009

A COMMISSIONER, ETC.

www.bchealthcoalition.ca

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.

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

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.

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 clinics with well-developed, multi-disciplinary primary health care teams result in lower costs to the system and better health outcomes."

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.

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. has lower ratios of RNs and LPNs per population than any other province."

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.

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 thate most of these drugs are just new versions of less expensive, older drugs – and no more effective.

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

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.

step 7

Put accountability back in health care

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

"Our health care system could be 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.

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

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.

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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10 steps to stronger health care

WHY WAIT?

PUBLIC SOLUTIONS TO CURE SURGICAL WAITLISTS

By Alicia Priest,
Michael Rachlis
and Marcy Cohen

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This is Exhibit F referred to in the affidavit of Joyce Jones sworn before me, this 13th day of AUGUST 20 09

A COMMISSIONER, ETC.

BC Health Coalition

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BC Office

CCPA-BRITISH COLUMBIA 10th ANNIVERSARY

MAY 2007

A SUBMISSION TO THE BC GOVERNMENT'S CONVERSATION ON HEALTH

WHY WAIT? | PUBLIC SOLUTIONS TO CURE SURGICAL WAITLISTS

By Alicia Priest, Michael Rachlis and Marcy Cohen

May 2007

A Submission to the BC Government's Conversation on Health

Co-published by the Canadian Centre for Policy Alternatives and the BC Health Coalition

ACKNOWLEDGEMENTS

The authors would like to thank Shannon Daub, Colleen Fuller, Michael Klein, Seth Klein, Margaret McGregor, Bob McMurtry, Ben Parfitt, Patricia Wejr and Gavin Wilson for their helpful feedback on this report.

Thanks to the Hospital Employees' Union for their financial contribution to this work.

Any errors and the opinions presented in this paper are those of the authors, and do not necessarily reflect the views of the Canadian Centre for Policy Alternatives or the BC Health Coalition.

Copyedit and layout: Nadene Rehnby, www.handsonpublications.com

ISBN: 978-0-88627-532-7

Printed copies: $10. Download free from the CCPA website.

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Summary

Waiting for elective surgery is the hottest political issue facing Canadian health care today. In fact, it's no exaggeration to say that how waitlists are managed – or not – could seal the fate of Medicare.

The central point of this paper – and the good news – is that better management is happening right now in BC and elsewhere, and as a result waitlists for certain surgical procedures have decreased dramatically. Changes to public health care policies and practices by dedicated health professionals have cut months from wait times while reducing lengths of stay in hospital and increasing patient satisfaction.

Positive information of this nature deserves to be celebrated, especially in these times of health care gloom and doom. The public needs to know that these projects exist; that there are viable, economically achievable solutions, and that they hold great promise for improving Medicare.

- The Richmond Hip and Knee Reconstruction Project, for example, introduced system and surgical innovations that slashed median wait times by 75 per cent. By staggering operations between two dedicated surgical rooms focused on hip and knee reconstruction, standardizing practices, and investing in new equipment, the Richmond project has been able to capitalize on the efficiencies that come with specialization (just like the for-profit clinics), but without public dollars being siphoned off to private owners' profits.

  What's more, operating room efficiency increased by 25 per cent allowing team members to complete 136 per cent more cases. At the same time, average lengths of stay in hospital fell from five days to four for hips and four days to three for knees.

- At North Vancouver's Lion's Gate Hospital, the Joint Replacement Access Clinic – a one-stop, centralized booking service for pre-operative and post-operative appointments – cut times for patients waiting for their first surgical consult from over 11 months to just two to four weeks.

- At Vancouver's Mount Saint Joseph Hospital, operating room efficiencies and investments in technologies have allowed ophthalmologists to perform 50 per cent more cataract surgeries – taking 50 per cent more people off their waitlists – without any increase in operating room time.

The provincial government needs to embrace these successes and make them the rule, not the exception. However, so far, that has not happened. Instead, when Premier Gordon Campbell announced BC's Conversation on Health, he suggested that public involvement in health is no longer financially sustainable, implying that we should consider a larger role for private insurers and private providers. Yet choosing that path flies in the face of evidence showing that private, for-profit care costs society more, is less safe for patients and compromises the public system. There is further reason for concern due to the government's favourable response to Canadian Medical Association president-elect Brian Day's proposal for a competitive market in health care based on recent reforms in the United Kingdom. Based on evidence from Britain, such changes would undermine rather than sustain public health care and undo the very real gains made by the BC waitlist strategies profiled in this report.

The government needs to shift direction and, instead of promoting private solutions, become the champions of public waitlist reforms. Several public sector initiatives in other provinces point out specific actions BC can take to ensure that the innovations already underway in BC are scaled up to a provincial level. For example:

- The Alberta Hip and Knee Replacement Project, where simple, common-sense changes in processes of care cut joint replacement wait times from 19 months to 11 weeks;
- Saskatchewan's Surgical Care Network, a comprehensive, pro-active surgical database used by health authorities in cooperation with surgeons to shorten wait times for surgery; and
- Ontario's Wait Times Strategy, an ambitious, multi-pronged effort aimed at reducing wait times in five high-demand areas by increasing funding, boosting hospital accountability, investing in information technology and improving quality.

The big story that emerges out of all these projects is that better management of waitlists requires two major changes. The first calls on physicians to make the shift from working mainly on their own, to working in teams – with their own specialty group, with other physicians (especially in primary care), and with other health care workers. Doctors play a central role in health care delivery, and their support is critical. When physicians work in high-functioning teams, as in the examples cited in this paper, the system functions more efficiently and waiting lists shrink. For example, access to surgery improves when advanced practice nurses are able to work to their full scope of practice in capacities such as nurse anesthetists.

The second change involves transferring accountability for waitlist management from individual surgeons to health authorities working with groups of surgeons and other health professionals. This involves putting patients on a single, common waitlist rather than on a multitude of individual doctors' lists. However, this reform does not prevent patients from taking advantage of a long-established strength of the Canadian health system: the right to choose a surgeon.

In British Columbia, the Ministry of Health, health authorities and the BC Medical Association (BCMA) recently attempted to create such a common surgical waitlist: the BC Surgical Patient Registry. However, unlike their counterparts in Saskatchewan and Ontario, the government of BC chose to negotiate key terms of the registry with the BCMA. These conditions included how registry information could and could not be used. Instead of supporting physicians such as those featured in this paper who are actively engaged in real system change by, among other things, working in teams, the agreement appears to leave most waitlist management and coordination to individual physicians. It also appears to restrict the ability of health authorities to re-direct patients. Understandably, such a shift is a huge cultural change that some surgeons may resist. Given that probable opposition, the provincial government needs to take charge because, as this paper consistently shows, there are substantial benefits to patients and the system from team-based care.

This report concludes that the BC government must make a choice. It can significantly reduce surgical waitlists across the province by building on and scaling up the public sector initiatives already underway. Or it can throw up its hands, declare the system unsustainable, and replace our cherished public system with a private health care market. If it does the latter, waitlists in the public system will only grow longer and the prediction of unsustainability will become a self-fulfilling prophecy.

Recommendations to the Province

- Replicate and expand on the successes achieved in pilot projects in North Vancouver, Richmond, UBC and elsewhere by providing dedicated resources and oversight so that these initiatives become the rule rather than the exception.
- Shift accountability for ensuring smooth surgical flow and waitlist management from individual surgeons to a regional group of surgeons, and from individual hospitals to health authorities.

Introduction

No conversation about Canadian health care can avoid the topic of lengthy waitlists. Although close to 85 per cent of Canadians say they are "very satisfied" or "somewhat satisfied" with the overall way health care services are delivered,[1] too many are anxious, frustrated and angered by untimely waits to see a specialist, get diagnostic tests or undergo elective surgery. Most of us either know someone who has experienced a long wait or have endured one ourselves. Bottlenecks, roadblocks and delays can exist at almost every step of the journey to the operating room – and even after on the road to recovery. That's troubling because undue waiting can aggravate health problems and in some cases increase surgical risk and compromise full recovery. No wonder long waits are the hottest political issue facing Canadian health care today.

It is no exaggeration to say that how waitlists are managed – or not – could seal the fate of Medicare. Unacceptable wait times have been described as the Achilles heel of the Canadian health care system.[2] The metaphor, used to describe vulnerabilities so vital they can lead to a system's downfall, is fitting in the case of creeping privatization of health care at the expense of the public system (see *Why Not Go Private?* on page 12). As health care commissioner Roy Romanow reported to the federal government in 2002, "long waiting times are the main, and in many cases, the only reason some Canadians say they would be willing to pay for treatments outside of the public health care system."[3]

The first step toward fixing a problem is understanding why it exists. But while citizens are acutely aware of the existence of untimely waits for elective surgery in the public system, they know little about why they occur and even less about how to reduce them. Although much fuss is made about how the growth in aging populations increases demand for surgery, we rarely hear about how advances in surgical techniques drive demand. Thanks to widespread use of far less invasive procedures, an 80-year-old British Columbian today is twice as likely to have a knee replacement, cataract surgery or a coronary bypass than he or she would have 15 years ago. To a significant degree, the health care

system is asked to perform more surgeries simply because it is more capable than ever of relieving patients' pain and suffering and increasing their quality of life.[4] Of course, this is a good thing, but the effect of more people demanding more surgery is longer waits.

Another key contributor to waitlists must be thoroughly examined precisely because it is one that can be addressed. The surgical process – before, during and after an operation – is technically complex and multi-faceted. It includes preparation for surgery, hospital admission, anesthesia, surgical procedure and recovery, and involves a wide range of health professionals working in different areas of a hospital and a number of community settings. Traditionally, the system has relied on individual physicians and their office staff to manage and direct the many steps in the process. For example, it is up to surgeons and their office staff to make multiple appointments for patients at other specialists' offices, laboratories, radiology facilities and operating rooms. Because one appointment is often dependent on the outcome of another, and because no one is organizing patient traffic as a whole, congestion can occur at every stage.

One of the most frequently neglected steps in the surgical process is pre-surgical screening. Preparing patients for surgery – socially, psychologically and physically – and making sure they can cope at home after surgery reduces cancellations of operations. It also increases the likelihood that operations will be successful, recovery rapid and re-admission minimized. Yet, historically, no one is responsible for ensuring that all patients be fully screened and educated before surgery. This is largely due to the fact that most surgeons do not work as a team with nurses and other allied health professionals.

Another largely ignored part of the surgical process is practices that ensure the right patient has the right procedure. At times, that means not having the procedure at all. Although seldom discussed in the media, some medical interventions are inappropriate because they either are needless or actually do some patients harm. For example, a 2002 study by UBC medical researcher Dr. Charles Wright found that while 70 per cent of cataract surgery patients had improved vision after the procedure, for more than one quarter vision had worsened.[5] If patients who wouldn't benefit from surgery were screened out, waitlists would be shorter.

However, while there are reasons for concern, the good news is that some people in BC and elsewhere are doing things differently, and in so doing have dramatically reduced waitlists and wait times. If their reforms were embraced more widely, we could eliminate almost all untimely waiting. These changes involve fundamental organizational innovations, many of which are detailed below. Because physicians play the central role in health care delivery, many of these reforms are contingent on them. As these projects demonstrate, when physicians make the shift from working solo to working in teams – both within their own specialty groups and with other health care workers – the system functions smoother, quicker and waiting lists shrink. Team-based care enables nurses and other allied health professionals to assume broader clinical and coordinating roles while still working within their scope of practice. Under certain circumstances it can also help alleviate health care personnel shortages.

In December 2005 the Canadian Centre for Policy Alternatives released health policy analyst Dr. Michael Rachlis' research report *Public Solutions to Health Care Wait Lists*. That report was the impetus and foundation for this one.

Rachlis looks at how innovations in public delivery can significantly reduce wait times for health care.

Rachlis' central point is that delays for care are not usually due to a lack of resources but to poorly organized services. Shoddy or non-existent coordination, lack of flow and lack of consistency are some of the organizational problems contributing to health care bottlenecks. Inconsistencies or variations slow the flow and delay needed interventions. For example, every day valuable operating room time is taken up by the re-making and re-supplying of operating rooms according to the individual preferences of surgeons, even those doing identical procedures. Variation on any point along the continuum of care slows the system down. Most variation, however, arises from inefficiencies in the system and not from unpredictable elements such as changes in patients' condition.

Aiming to reduce variation and dramatically cut wait times, Rachlis offers a key innovation – the application of queuing theory. Queue-management theory is a branch of mathematics that has practical use in health care. Anyone who has ever lined up at a bank knows that single lines that feed into multiple tellers have better flow and are fairer than multiple line-ups feeding into multiple tellers. Yet generally in health care, surgeons maintain their patients on their own independent lists with no-one overseeing all lists. Most patients would welcome entering a pooled list so they could see the first specialist available, especially if that would cut months off their wait. If patients choose to stay with the same surgeon they can, although they may wait longer than others.

The good news is that some people in BC and elsewhere are doing things differently, and in so doing have dramatically reduced waitlists and wait times. If their reforms were embraced more widely, we could eliminate almost all untimely waiting.

A common waiting list is just one of several queue-management techniques applicable to health care. Another is stand-alone, specialized, short-stay clinics. Geared for low-risk elective surgery, stand-alone clinics allow for better flow, increased efficiency and ultimately shorter waits. Rachlis describes the workings of well-established public clinics in Manitoba and Ontario. These clinics achieve the efficiency benefits of specialization and innovation often ascribed exclusively to the private sector, while maintaining the public sector long-standing advantage of low overall administrative costs and broader societal benefits (see *Why Not Go Private?* on page 12).

Another form of queue management is the one-stop, multidisciplinary pre-surgery centre. Instead of forcing patients to ping-pong around town over a number of weeks in an effort to obtain various diagnostic tests or see various specialists, it makes more sense to consolidate as many services as possible under one roof.

Other helpful queuing management strategies Rachlis recommends are updated electronic information systems, standardized surgical procedures and a uniform way of allocating operating room time.

Whatever form public sector changes take, the bottom line, Rachlis says, is that they be driven by patient needs and not the needs of organizations or individual practitioners. Although technological advances have revolutionized the science of medicine, health care delivery has not kept up. Nonetheless, Rachlis concludes that public health care can deliver consistency, quality and timeliness, but only if these innovations are implemented on a larger scale.

Another recent report informs this paper. In June, 2006, the federal government released the report of the National Wait Time advisor, Dr. Brian Postl. Postl, who is also the chief executive officer of the

Winnipeg Regional Health Authority, noted that waiting times are not as bad as popularly portrayed, but are bad enough. He believes the public system, if properly funded, can reduce them. Echoing Rachlis, he points out that long wait times do not exist in isolation but are a symptom of archaic, deeply entrenched dysfunctions within the system. Drastically reducing and in some cases ending unreasonable wait times requires transforming the system to put patients at the centre of the action. While that task may sound overwhelming, Postl asserts that it isn't. His proof lies in the fact that the revolution has already begun.

"Examples from across the country and around the world demonstrate that it is possible..." Postl writes. "Canadians could potentially have same day access to primary health care, one or two weeks access for appointments with medical specialists, and almost no waiting for tests and surgeries."[6]

Postl urges all provinces and territories to adopt the following wait time strategies:

- A single common waiting list, rather than a multitude of lists managed by individual doctors or facilities;
- A wait-time champion to prod politicians and inspire care providers to address wait times;
- Queuing strategies to improve current organizational processes;
- A public-awareness campaign that helps people understand that some waiting for some procedures is not unreasonable;
- Team-based care that enables providers such as nurses to assume broader clinical tasks while working within their scope of practice;
- Practices that ensure the right patient has the right procedure; and
- Pre-surgical programs that prepare patients – physically and mentally – for surgery.

This paper focuses on six examples of BC innovations in managing surgical care within the public system that have successfully reduced waitlists or are designed to do so. As well, it looks at three innovations elsewhere in Canada: in Alberta, Saskatchewan and Ontario. Because very little of this information has been discussed in health care system literature, this report draws heavily on personal interviews with key players.

The range and extent of these projects are astounding, as is the excitement, commitment and dedication of their clinical and administrative leaders. Their results speak for themselves. The people involved are public health care champions. For the benefit of all Canadians, they deserve to be acknowledged, encouraged and supported in their work.

The following sections present BC queue-management projects addressing waitlists within the public system, divided into three categories:

- System redesign;
- Modernized information systems; and
- Improved waitlist registries.

Why Not Go Private?

Is more private care the answer to wait time woes? Some people, spurred by media stories of patients suffering from long waits for care in the public system, would say yes. Private facility owners assert they have the resources, the incentive and the know-how to meet patient needs far more efficiently and effectively than the public system – so why not let them? Proponents of this option envision a system of private providers who cater to people who can pay, and a public system that caters to people who can't. In fact, they say, if you have a public system with a parallel private system, the public system will actually function better. By acting like a valve on a pressure cooker, private providers siphon off patients that would otherwise overcrowd and overheat the public system. Furthermore, proponents say, the *only* way to solve the public waitlist problem is to introduce a mixed system with parallel public and private delivery.

Let's look at those claims. The pros and cons of a parallel private delivery system have been thoroughly studied by researchers around the world. Indeed, an essay by the Canadian Health Services Research Foundation refers to a peer-reviewed "mountain of evidence" against parallel public and private health care systems.[7]

This evidence tells us four things:

1. Public sector wait times are longer when there is parallel for-profit health care delivery

International studies show that countries with parallel public and private health care systems have longer, not shorter, public-sector waiting times than other nations.[8]

Canadian studies point to similar results. A 1998 study from the University of Manitoba found that cataract patients whose surgeons worked in both the public and private sectors waited 23 weeks for surgery, more than twice as long as patients whose doctors only worked in the public hospital system.

The problem stems from the fact that there is a finite pool of health professionals – both doctors and nurses. Private hospitals and clinics draw scarce human resources out of the public system, lengthening wait times for patients who want to access public services. As the Manitoba cataract example suggests, waitlists are longest for patients of doctors who work in both the public and private systems.[9] One reason is that doctors who work in both systems have an incentive to keep public waits long – that way they have a steady pool of patients willing to pay for private service.

2. Cream-skimming of easy-to-treat patients is common where there is parallel for-profit delivery

Cream skimming refers to the fact that for-profit clinics have a material interest in serving patients for whom procedures are less complex, outcomes more predictable and costs lower. It allows for-profit clinics to minimize their risk and maximize their profit. It also results in an increase in the average level of severity among patients who remain in the public system, and in the costs associated with their treatment. Consequently, the average cost of treating patients in public institutions rises. If payments

to the public system do not increase to reflect these higher costs, the public system becomes less sustainable. Evidence suggests that when public authorities are confronted with deteriorating health among patients waiting for care, they will divert patients to private clinics to relieve their suffering even when this may threaten the sustainability of the public system in the long run.[10]

3. Care delivered in for-profit facilities is less safe

A key reason for poorer quality of care and health outcomes in for-profit facilities is the lower number of skilled personnel employed. In 2002, a study in the Journal of the American Medical Association reported that patients at for-profit dialysis clinics had an 8 per cent higher death rate than those attending non-profit clinics,[11] and a lower chance of being referred for a kidney transplant.[12] But it wasn't the only study to find such sobering outcomes. The same group also published an overview of all individual studies comparing mortality rates for 26,000 for-profit and non-profit hospitals serving 38 million patients. They found that adults had a 2 per cent higher death rate in for-profit hospitals, while newborns had a 10 per cent higher rate.[13] They concluded that concerns that the profit motive may adversely affect patient outcomes in for-profit hospitals were justified. The investigators estimated that if all Canadian hospitals were converted to for-profits, there would be an additional 2,200 deaths a year.

The recently established for-profit surgery clinics in the UK, Independent Sector Treatment Centres (ISTCs), have had similar problems with less safe care. In a House of Commons Health Committee report on ISTCs both the Royal College of Surgeons and the British Medical Association voiced concerns about the quality of care in the ISTCs.[14] And in a survey by the British Medical Association of clinical directors in the National Health Service (NHS) working in orthopaedics, ophthalmology and anesthetics, two thirds reported patients had returned to NHS for after-care with higher readmission rates from the for-profit ISTCs than from NHS-run clinics.[15]

4. For-profit care costs more

The international experience with private surgical facilities is that they tend to charge higher prices for the same surgery in a publicly-funded hospital. Much higher.

The British Medical Journal reported in 2004, for example, that the National Health Service was charged 47 per cent more for hip replacements performed in private surgical clinics than for the same procedures provided in public hospitals. In 2002/03, a coronary bypass operation cost an extra 91 per cent in a private clinic in England compared to a non-profit hospital.[16]

The experience in Canada is similar. For example, hip replacement surgery in a non-profit hospital in Alberta last year cost a reported $10,000.[17] Hip replacement surgery in a for-profit clinic, according to Timely Medical Alternatives (which facilitates access to the clinics), can cost up to $21,780.[18] In Canada's public hospital system, knee replacement surgery, according to the Canadian Institute for Health Information, averages $8,002[19] compared to between $14,000 and $18,000 in a private surgical facility.[20]

The evidence is clear – private for-profit care is less fair, more costly and poses a greater risk to patients than not-for-profit care.

System Redesign Projects

Richmond Hip and Knee Reconstruction Project

More than two years ago, the Richmond Hip and Knee Reconstruction Project set out to decrease the number of people waiting for hip and knee replacement surgery in the Lower Mainland while learning from the best practices in the world. The pilot project was a collaboration within the public sector, including the Provincial Surgical Services Project (see page 23), the Vancouver Coastal Health Arthroplasty Team, the Provincial Arthroplasty Collaborative, and Vancouver Coastal Health's Centre for Clinical Epidemiology and Evaluation.

In addition to decreasing wait times, other project goals included decreasing lengths of stay in hospital and improving patient outcomes, all in a community hospital setting. The project's success is unequivocal, and the program is now an entrenched part of Richmond Hospital. The project's accomplishments include:

- Median wait times down by 75 per cent, from 20 months to five months;
- Overall numbers on waitlists shrunk by 27 per cent;
- Number of people waiting more than 26 weeks decreased by 63 per cent;
- Cases completed increased by 136 per cent;
- Average lengths of stay in hospital down by 25 per cent, from five days to four for hips and four days to three for knees (when the project began, average lengths of stay in BC were eight days for hip replacements and six for knee replacements); and
- Operating room efficiency increased by 25 per cent.

So how did they do it? Dedicated funding of $1.3 million meant the project had a full-time manager, equipment, research and evaluation tools, a newly-renovated operating room and new operating suite equipment. Funding came from the provincial government, the Vancouver Coastal Health Authority

and the Richmond Hospital Foundation. But as numerous health care analysts know, money alone can't buy success. In this case, however, money combined with numerous surgical efficiencies did.

Operation start times were staggered and scheduled between two rooms, so surgeons could "swing" between rooms as their patients were ready. This allowed operating teams to complete eight joint replacements or reconstructions per day instead of six. Surgical procedures and clinical practices were standardized, eliminating previous idiosyncratic variations. For example, previously the group of surgeons used nine types of prosthetic devices between them, depending on each surgeon's preferences. During the project all surgeons used the same one, making work smoother for nurses and others assisting procedures. The move also resulted in significant savings for the hospital as it could negotiate better deals on bulk purchases.

Project co-leader Cindy Roberts says the initiative's core strength was that it included everyone, from cleaners to community care workers. Her co-leader was Richmond orthopaedic surgeon Ken Hughes.

"We educated all involved, including the surgeons as to how their work affects everyone else down the line," Roberts says.

Like in many private clinics, the two Richmond project operating rooms are able to capitalize on the efficiencies that come with specialization. However, unlike with private clinics, public dollars are not siphoned off to private owners' profits.

UBC Centre for Surgical Innovation

Another project achievement coming out of the Richmond Hip and Knee Reconstruction Project was the development of The Arthroplasty Plan (TAP), a model available as a toolkit allowing other sites and health authorities to share what the Richmond team learned. The University of British Columbia Hospital took up the challenge in April 2006, and opened its Centre for Surgical Innovation (CSI), a $25 million, one-year provincial pilot project dedicated to fast tracking patients for hip and knee replacement surgery. CSI is specifically geared to serve low-risk patients who have been on a waiting list for more than 26 weeks. The project has two dedicated operating rooms and 38 inpatient beds, and aims to perform 1,600 surgeries a year. As of late January, CSI had carried out more than 1,100 procedures.

CSI differs from the Richmond program in that it is a province-wide service, involving about 25 orthopaedic surgeons, and their patients, from Vancouver Island, Interior Health, Northern Health, Fraser Health and Vancouver Coastal Health regions. Based on the TAP model, the centre applies similar practices such as "swing" operating rooms, standard clinical pathways and patient outcome measures. Some surgeons have picked up the swing concept and introduced it to their home communities. Even though out-of-town patients are not compensated for their travel to Vancouver, they are eager to come, says CSI project leader Laurie Leith.

"Some have been on a surgical wait list for one to two years," Leith says. "Ideally, they would like it done in their home community. However, they're so happy they're willing to do whatever it takes to have it done."

Although it's too early for a final evaluation, CSI's achievements are obvious. Average stays have fallen below their target of four days for hips (3.25 days) and are on target at three days for knee procedures, demonstrating the important connection for success between in-hospital patient care and pre- and post-hospital care. All patients receive pre-operative teaching – some in their home communities – to ensure they are well-prepared for surgery. Post-operatively, every patient receives a follow-up call after discharge to determine how satisfied they are with the program. So far patients are rating the program an average of 4.7 out of 5.

Leith says there is no doubt the program has made a significant dent in wait times for hip and knee replacement surgery throughout BC and she is optimistic it will receive on-going, sustainable funding.

North Shore Joint Replacement Access Clinic

The North Shore Joint Replacement Access Clinic (JRAC) exemplifies a slightly different but equally effective way to decrease wait times for hip and knee replacement surgery. By focusing on the front end – the preparatory work before patients undergo surgery – the JRAC has dramatically reduced wait times both before a first surgical consult and before the surgery.

Twelve other BC sites have visited the North Shore clinic and are interested in establishing similar practices. Says project co-founder and nurse Chantel Canessa, "You have to look at what you're doing, think outside the box, and listen to the patients – they have some great ideas."

JRAC is a one-stop, centralized booking service for pre- and post-operative appointments and procedures. It opened as a pilot project in May 2005 and is now a permanent facility at Lions Gate Hospital. Lions Gate orthopaedic surgeon Paul Sabiston was a driving force behind the changes, along with clinic co-founder and orthopaedic nurse Chantel Canessa. Canessa says the idea originated from a survey asking former hip and knee patients about their greatest concerns. After lengthy wait times, patients complained of the last-minute anxiety they experienced when, after waiting for up to two years, they suddenly were given a surgery date and had two or three weeks to undergo all of their pre-operative appointments, including x-rays, lab work and visits with anesthetists. Family doctors were also frustrated that their patients had to wait so long before their first visit to a specialist.

Solving some of those concerns did not require a huge infusion of provincial health care dollars. Instead it involved applying a few simple, common sense ideas that accelerated patient flow. As Canessa says, "We didn't have any money to open the clinic, so we had to be creative." The clinic took over space formerly used as an overflow clinic and staff donated tables and used furniture.

Waitlists were immediately shortened by pooling patients on a common list and having patients agree to accept either the first surgeon available or one of their choice. Then wait times were tackled by creating a central, hospital-based clinic dedicated to prospective joint replacement patients. This allowed clinic staff to coordinate and streamline dates for tests such as X-rays and laboratory tests, and physiotherapy and pharmacy consults. Anesthetists now see high-risk patients two months

before surgery instead of two days before so they can identify and address problems well in advance. Significantly, no joint replacement surgeries have been cancelled since that practice began, says Canessa. The clinic also screens and prioritizes patients before surgery and refers appropriate patients to community resources such as exercise programs and nutritional counseling.

"It was just little things," Canessa says. "We moved the workload ahead."

The project received an additional $5 million from the provincial government, which allowed a formally idle operating room at Lion's Gate Hospital to be re-opened, dramatically increasing the number of operations performed.

To date, JRAC's accomplishments include:

- Reduced wait times for first surgical consult from almost a year to just two to four weeks;
- Reduced wait times for surgery for most patients from up to two years to six months or less;
- A 140 per cent increase in the number of hip and knee surgeries between 2003 and 2005; and
- A post-operative patient survey yielding a satisfaction rating of 97 per cent.

Twelve other BC sites have visited the clinic and are interested in establishing similar practices. Says Canessa, "You have to look at what you're doing, think outside the box, and listen to the patients – they have some great ideas."

Mount Saint Joseph Hospital Cataract and Corneal Transplant Unit

Mount Saint Joseph Hospital is a 140-bed, acute-care, community-based hospital in East Vancouver best known for its multicultural approach to care delivery, especially for the city's large Chinese community. Over the past three years it has become renowned for something else – a cataract and corneal transplant program that outperforms every hospital in the province. By completing more than 6,300 procedures a year, the program has cut wait times in half (from six to eight months to three to four months), with many patients having the procedure within 10 weeks.

Head ophthalmologist Pierre Faber explains that because there is little variation with cataract surgery, it lends itself well to production-line efficiencies without loss of quality. A decision to invest in the best technology, and in more equipment so that surgeons don't wait for tools to be sterilized, allowed them to immediately get up to speed. Faber boosted the number of procedures he performs from 12 a day to 17.

"Basically, we've been able to eliminate a lot of the downtime," he says. "So by 1:30 in the afternoon the instruments I used at eight in the morning have been through the system and are ready for their second go. Without giving me any more actual operating room time, they've given me 50 per cent

more surgery. So therefore I'm going to take 50 per cent more people off my waitlist. And that's true of everyone, not just me."

Other moves that increased efficiency were bulk buying of supplies and moving the procedure out of high-intensity operating rooms to a specifically designed procedure room. All surgeries are done as day-surgeries and without the use of a general anesthetic.

Although the group of eight ophthalmologists does not have a common waiting list, they monitor their lists together. Operating time is allocated according to the amount of time each patient waits, not by how many are on a particular surgeon's list.

"The idea," Faber says, "is that no matter who you go to in this group of eight, you will probably wait the same amount of time."

As for pre-surgical screening, the group looked to research literature that supported their decision to eliminate routine blood tests and EKGs for low-risk cataract patients. Ironically, a shortage of anesthetists has resulted in another saving to the system. The hospital now uses OR nurses trained to administer and monitor the low levels of sedation used in cataract surgery.

On the whole, Faber says patients and surgeons are thrilled with the program's smooth and successful operation. In fact, seeing what sufficient funding and the application of efficiencies can do has given him new faith in the public system.

But Faber is frustrated by the current financial set-up, which makes nurses more expensive for hospitals than doctors. That's because nurses are paid out of a hospital's budget while anesthetists are paid through the Medical Service Plan and are therefore a freebie for the hospital. Yet from a business perspective, it doesn't make sense to hire a $250,000 anesthetist when you could hire two or three nurses for the same money.

"It all comes out of the same Ministry of Health pot," Faber says. "It's just coming out of a different pocket."

On the whole, Faber says patients and surgeons are thrilled with the program's smooth and successful operation. In fact, seeing what sufficient funding and the application of efficiencies can do has given him new faith in the public system.

"I've worked in the [for-profit] Cambie [Surgery Centre] clinic and I've taken my patients there, but I don't do that anymore because there's no reason to," Faber says. "We have everything – there's no reason to go to the private sector."

Modernized Information Systems

Interior Health Authority's Redesign of Surgical Services

With an area population of about 700,000, the Interior Health Authority (IHA) serves 54 communities and 35 acute care facilities across a sprawling region of BC's southern interior, stretching from Williams Lake in the north to the US border in the south, and from Anaheim Lake in the west to the Alberta border in the east.

Three years ago IHA had six operating room booking systems at nine sites. Now one system serves 11 sites.

The scheduling of patients for surgery is a far from simple task. In fact, a 2004 review of IHA's surgical services by Sullivan Healthcare Consulting – the first ever done – stated: "The scheduling of surgical patients is one of the most complex non-clinical activities that can occur in the hospital. The goal of a scheduling/booking program is to bring all the necessary resources together at the same time and place while communicating expectations to everyone involved, and balancing cost, utilization, and convenience."[21]

The surgical review identified three major problems with IHA's former booking system: inconsistent practices, inconsistent implementation of medical information, and the fact that different surgeons and sites used different names for the same procedure. In other words, when people needed to discuss which doctor performed which operation on whom, when and where, they were in a Tower of Babel – not everyone spoke the same language. Without accurate information about resources, management cannot ensure that health care delivery is sustainable, accountable and centred on patients.

The 2004 Sullivan review recommended that IHA standardize its entire peri-operative management system (the time surrounding a person's surgical procedure, including admission, anesthesia, surgery and recovery). The health authority decided that modernizing the operating room booking system

was the number one priority in that process. As a result, by November 2006 all surgical facilities capable of electronic booking had installed the *Picis OR Manager* software program. The cost to the public health care system was not onerous – just $1.5 million out of a total budget of $1.25 billion – and the change took only 18 months to implement.

IHA project leader Janine Johns describes the effort as "huge." Although there has been some resistance, Johns says once booking clerks and nurses get accustomed to the new program, it will make their work easier and give management the tools to "look at how we do business instead of looking at a bunch of numbers that don't agree."

One simple but far-reaching improvement is the electronic recording of surgeons' "preference cards," necessary because surgeons have their own way of doing procedures and their own preference for equipment. Previously, information was kept in notebooks, on bits of paper, or in a particular nurse's memory, assuring lost time and energy if the paper was lost or a nurse was off-duty. Now it's all in the system.

When patients are fully prepared and informed about their surgery, there are fewer delays or cancellations, better outcomes, better use of surgical resources and reduced wait times.

In addition to easing practices for health care workers, the new booking system also benefits patients. "They won't get lost," Johns says. "It will lead us to the point where we can better plan when and where to have our services."

Another critical element in IHA's surgical redesign is the establishment of a pre-surgical screening program (PSS). The IHA 2004 Surgical Services Review states that pre-surgical screening offers a greater "return on investment" than any other recommendation made in the report.[22] That's because when patients are fully prepared and informed about their surgery, there are fewer delays or cancellations, better outcomes, better use of surgical resources and reduced wait times. IHA has now implemented PSS for about 75 per cent of elective surgical cases. Its goal is to screen every elective surgical patient before surgery.

Johns says none of this would have happened without the remarkable teamwork that emerged between managers, nurses and particularly physicians. IHA's surgical council is a mix of administrators, nurses, surgeons and anesthesiologists, with the majority being physicians. Their project team has two paid physicians – one surgeon and one anesthesiologist – and a surgeon chaired the committee that guided the implementation of the new OR booking system.

"I don't know of any other health authority where physicians have led these types of initiatives for a health authority implementation," Johns says. "It's the commitment of these guys, and the commitment of key surgeons and administrative leaders in Interior Health, that has got us to this point, and in addition to dollars, we think this is the most important aspect of our success."

Full integration and improvement of surgical services, however, demands action in several other priority areas, including safety and standards, staff roles and ensuring appropriateness. One big step in the right direction is IHA's participation with other BC health authorities in the provincial government's new and still evolving Provincial Surgical Services Project (see page 23).

As for the other priorities, Johns says the ability to move forward depends primarily on two things: recruiting and retaining staff, particularly nurses, and having secure funding. The first phase of the surgical redesign received one-time funding that runs out at the end of the fiscal year (March 31, 2007). The next phase will have to compete with all other IHA programs.

"I'm excited with what we have built," Johns says, "but will we have enough dollars and people to continue moving forward?"

Ironically, while Johns remains uncertain about prospects for long-term funding to support the surgical registry, the Interior Health Authority has issued an RFP (Request for Proposal) for a private surgery clinic with a guarantee of 10 years funding for a minimum of 1,700 cases annually. However, in a January budget announcement for 2007/08, the provincial government would commit only to one year of funding for health authorities.

Although private interests may be able to establish a health clinic quicker than their counterparts in the public system, the existence of such a clinic creates several problems (see *Why Not Go Private?* on page 12). First, it lures precious health care workers, in particular nurses, away from the public system where they are desperately needed. Second, depending on the clinic's contract, its existence could compromise the effective management of the waitlists of doctors who practice in both public and private facilities. Finally, a privately-run surgical centre will likely serve only low-risk patients, leaving the more complex and acutely ill patients for the public system to care for. Yet if the private clinic is paid the standard rate per case, the public system could end up overpaying the clinic for its services.

Surgical Efficiencies

The surgical process – a person's pre-operative tests, hospital admission, anesthesia, surgical procedure and recovery – is one of the most complex parts of patient care and consumes the bulk of a hospital's budget. Drawing on nearly every area of the hospital, from radiology to laboratory to nursing to medicine to administration, surgical practices determine a hospital's ability to operate safely and efficiently. Cancelled, delayed or inefficient surgeries not only cost the system money, they increase bed utilization, back up emergency departments, decrease patient safety and staff morale, and increase frustration for everyone involved.

As the projects profiled in this report show, there are a wide range of relatively simple, common sense and often inexpensive ways to make the surgical journey more efficient. They include:

- Pooling patients onto a common waitlist. This simple step has immediate and dramatic benefits because it allows patients to see the next surgeon available. It does not, however, prevent them from seeing the surgeon of their choice.
- Pre-screening and educating all patients facing surgery. This not only means identifying high-risk patients well before surgery so that anticipated complications can be addressed, but providing support to those who need to make changes such as quitting smoking. It also involves co-ordinating all pre-op analysis such as blood tests, X-rays and opportunities to assess appropriateness.
- Discharge planning before surgery. Ensuring that home care arrangements are in place decreases the chance patients will need re-admission.
- Beginning all surgeries on time, particularly the first one of the day, lessening the chance of back-up.
- Standardizing surgical equipment by procedure rather than by surgeon. This makes assisting operations easier and allows for bulk buying of equipment. When appropriate, physician preference information needs to be current and easily accessible.
- Booking groups of similar procedures together. This enhances efficiencies, allows staggering of OR start times, and streamlines patient flow. For instance, one surgeon starts a case at 2:15 p.m., while another starts the same procedure in a room across the hall at 3 p.m. The surgeons or surgical assistants can move back and forth to help each other with incisions and stitching up and closings while cleaners are ready to sanitize the rooms when each case is over.
- Modernizing electronic information systems so that physicians, hospitals and health authorities can access accurate, consistent and up-to-date data on patients waiting for surgery and so better manage their surgical process.
- Standardizing patient care protocols to ensure all patients receive the best post-operative care. For example, helping patients stand or walk a few hours after surgery instead of the next day, or ensuring that patients receive adequate pain management.
- Supporting advanced practice registered nurses and nurse practitioners who can be trained for such roles as anesthesia or surgical assistants.

Improved Waitlist Registries

BC's Surgical Patient Registry

BC's current Internet waitlist registry is inaccurate and inconsistent and thus difficult to use as a management tool. On the whole, information on surgical services in this province is out-dated, as it is elsewhere. But BC is in the process of changing that situation. Two years ago, the province launched the Provincial Surgical Services Project (PSSP), an ambitious collaborative effort between the Ministry of Health, the province's six health authorities, practicing surgeons, the BC Medical Association, UBC's Faculty of Medicine and the BC Medical Services Commission. While the project is co-coordinated by the Provincial Services Health Authority (PHSA), it has no designated provincial leader.

The goal of the PSSP is to reorganize surgical care to make it fairer, timelier and more appropriate for patients. After more than two years and $5 million in capital funding, its new BC Surgical Patient Registry (SPR) is approaching completion. This real-time, web-based registry is capable of reliably tracking all patients waiting for all elective surgeries in BC. Modeled on Saskatchewan's successful registry (see Saskatchewan Surgical Care Network on page 27), BC's version had to be significantly modified for a much larger, busier population.

"The goal is to dramatically reduce waiting times," says Brian Schmidt, PHSA senior vice president for provincial services, public and population health, and leader of the PSSP steering committee. "And if we can't deliver accurate information, we'll never get it right."

The new Surgical Patient Registry has been successfully piloted and promises to have huge advantages over the current system. As Schmidt says, "we'll be able to compare apples with apples." The project hoped to have the registry fully up and running by the end of March 2007, but due to a slower than anticipated consultation process between BC doctors and SPR leaders is now aiming toward the end of

the year. Unlike their counterparts in Saskatchewan and Ontario, the BCMA had a significant hand in shaping the registry. Doctors in this province negotiated the conditions determining how the registry information can and cannot be used. Those conditions underlie nine BCMA-forged principles, the details of which are not publicly available.

At stake is exactly how information gathered through an electronic form, called a "clinical prioritization tool," will be used. The tool is meant to enable health authorities, together with surgeons, to ensure that those who need surgery most get it first. As such, it will affect some surgeons' work patterns. Surgeons working with PSSP have developed these tools for 13 surgical specialty groups, such as orthopaedics, ophthalmology and neurosurgery. One specialty remains to be finalized.

BCMA President Elect Dr. Geoff Appleton says the nine principles include conditions that the registry be publicly accessible, guarantee patient privacy and ensure "physician independence."

"There are two or three [principles] that basically surround the surgeon-patient relationship that we want to keep intact," Appleton says.

The agreement also includes an incentive of $4 million over two years from the provincial government to compensate surgeons for time spent filling out clinical assessment forms. Appleton says by the end of December, BC surgeons will complete a clinical assessment tool as a condition of having their patients placed on the provincial registry.

Now, only about one quarter of surgeons in the province contribute to the registry. All surgeons performing publicly-funded procedures, whether in private or public facilities, are eventually expected to take part.

On a positive note, Schmidt says the provincial government has assured him that the SPR will receive funding for next year. Also positive is the fact that surgeons will have to participate in the registry in order to book surgery. However, at this point it appears that the registry will not be as pro-active as those in Saskatchewan and Ontario (see pages 27 and 29). And, if that turns out to be the case, it could compromise BC's efforts to implement progressive health care reforms.

IN SUMMARY, WHILE THERE ARE A NUMBER OF OUTSTANDING INITIATIVES IN BC TO REDUCE WAIT times for elective surgeries, provincial leadership has not appeared. Many of these projects exist in pockets of the system rather than throughout its entire fabric. Even the Provincial Surgical Services Project, which is nominally a provincial initiative, is fundamentally a responsibility of individual health authorities working within the principles set out with the BCMA, rather than of the Ministry of Health. That's why, in terms of moving toward full provincial implementation, it is necessary to turn to initiatives in other provinces.

Public Sector Innovations Outside BC

Alberta Hip and Knee Replacement Project

As the above examples illustrate, BC has reason to be proud of its efforts to renew public health care. Of the several initiatives in other provinces also worth attention, none is more deserving than the Alberta Hip and Knee Replacement Project, a joint effort by the Alberta Bone and Joint Health Institute, orthopaedic surgeons, health regions and the Alberta government. Heralded across the country as a prime example of how relatively simple, common sense changes can solve seemingly intractable problems, the now-completed year-long pilot project combines elements of North Vancouver's JRAC and the Richmond and UBC hip and knee reconstruction projects. It then adds even more progressive ideas. The project is now the standard of care for hip and knee replacement in the Calgary, Capital and David Thompson health regions, and three other regions have expressed interest in adopting the model.

The pilot project was jump-started in April 2005 with a $20 million grant from the Alberta government. Its model of care is built on the concept of stand-alone, community-based care, with central clinics functioning as one-stop shops for assessment, diagnosis and treatment. Clinics are located in Edmonton, Red Deer and Calgary.[23] Patients arrive already having been partially "worked up" by their family doctors, who complete a two-page referral template covering such things as patient history and past treatments. Patients are given the option of going with the first-available surgeon or a surgeon of their choice. The template also allows family doctors to alert the orthopaedic surgeon or clinic if the patient is an urgent case.

At the clinic, a multidisciplinary team assesses patients for their need and/or fitness for surgery. If changes need to be made before surgery (such as losing weight or quitting smoking), supports are provided. If patients are worried about how they'll cope after surgery, home care services are arranged prior to their operation. Patients are matched with a case manager who helps navigate them through

the process. The result of all of this up-front work has been dramatic reductions in total wait times, delays and last-minute surgery cancellations. As a recent Canadian Institute of Health Information study revealed, hip and knee replacement patients spend nearly one-third of their overall wait time waiting for their first visit with an orthopaedic surgeon.[24]

The Alberta project boasts of another simple but potent action. At the start of the health care journey, all patients sign a contract making them full partners in that process. That's because one of the core tenets of the project is that we are all responsible for improving our health care system. Project leaders argue that the public needs to do more than just hope someone is looking after their best interests. The project encourages patients to ask questions and expect answers, and in so doing "be held accountable at an individual level for their own care and for the success and failures of our health care system."[25]

Using the best evidence in the world for hip and knee replacements, the project standardized all aspects of care, from operating equipment to post-operative pain management to frequency of follow up visits. All services are continually evaluated for access, quality and cost. The model incorporates two other benefits: public release of all performance reports and an arrangement whereby publicly-funded services that are not supported by medical evidence lose their funding, with funds being redirected to evidence-based public care. Ideally, the system will move to that level.

Physicians have a long history of independent practice. That makes them reluctant to change their practices until they see evidence that doing things differently is better.

Dr. Cy Frank, co-vice chair of the Alberta Bone and Joint Institute and one of the project's architects, says the goal was to reduce variations to make the system as predictable as possible. For example, Frank, who is also a University of Calgary professor, says in a sports medicine setting he found that each of the seven surgeons doing arthroscopy (the insertion of a small telescope into a joint to permit visualization of the structures) did the procedure differently.

"They were all using different drapes, different instruments," Frank says. "Then we told them their numbers and asked how they can justify this. Within a month they all gravitated to within 10 per cent of the lower case costs."

If and when this model becomes established province-wide, Frank foresees potential cost savings to the whole system because, he says, best practices cost less. The trick is how to take the project to a larger scale. Physicians have a long history of independent practice. That makes them reluctant to change their practices until they see evidence that doing things differently is better. The project measured everything: total wait times – from the moment a family doctor advises a patient to see a surgeon until a year after the surgery – to patient outcomes, patient satisfaction, safety, compliance and quality of life. The interim evaluation revealed:

- Wait times from first referral from a family doctor to a first visit with an orthopaedic surgeon dropped 80 per cent, from over eight months to just six weeks. These improvements at the front end were responsible for 41 per cent of the overall reduction in wait times.
- Wait times from first visit with an orthopaedic surgeon to surgery plummeted 90 per cent, from 11 months to 4.7 weeks.

- Length of stay in hospital fell 30 per cent, from six days to four.
- Patients surveyed expressed increased satisfaction.

Despite the obvious benefits to patients, and the fact that the program's surgical roster has more than tripled (from 13 to 45 participating surgeons), it continues to face resistance from some physicians. Some balk at the inconvenience of having to set up and run a second office in the community clinics. Others oppose the model because of a deep-seated affinity in medical culture to practice solo.

"Our system has gravitated to independent practices where everyone does things their way. There is resistance to change because everyone believes doing it their way is the best way. But with evidence, people will accept a common way. Surgeons who weren't part of the project now want to be part of the new way. They are changing voluntarily because we have the evidence." Frank explains.

The challenge is to attract more surgeons by making the model more effective and efficient for them. As for public funding, Frank says the institute is working closely with health regions for further service agreement contracts.

"I am very optimistic," Frank says. "This is the thin edge of the wedge to changing the system to focus on access, quality and cost – they are all linked. We already have a great system and we can do better."

Saskatchewan's Surgical Care Network

The Saskatchewan government was the first in the country to establish a province-wide system to rate and follow all patients waiting for all surgeries. Launched in March, 2002, the Saskatchewan Surgical Care Network (SSCN) is the most comprehensive surgical database in Canada and the foundation for several other provinces currently implementing their registries. What makes it so laudable is its pro-active rather than passive nature. Traditional surgical waitlists post numbers of patients waiting for particular surgeries on the Internet. That's about all they do. The hope is that patients viewing the list move to a surgeon who has shorter waits or that surgeons with long lists suggest patients move to another surgeon. But neither scenario tends to happen. Patients are extremely reluctant to switch doctors on their own and surgeons rarely share lists. A further problem is the outdated, inconsistent and unverifiable data on passive waitlists – a product of variable reporting methods. Studies have shown that more than 30 per cent of names on waitlists are not valid because they are either duplications, or list patients who no longer need surgery, have moved, had the procedure or died.[26] Most significant, passive registries hold no-one accountable for using the data to actively shorten wait times.

Pro-active registries, on the other hand, start with firm and daily-updated data gathered in a consistent and standardized way. This information can then be used by patients, physicians and more importantly health authorities to shorten wait times for care. Active registries are more about *managing* wait times than they are about *reporting* wait times. It must be emphasized, however, that no registry and no waitlist – active or passive – prevents patients from choosing a specific surgeon. Patients always have the right to choose who will perform their particular procedure. However, depending on their choice, they may have to wait longer.

Peter Glynn, founding chair of SSCN and co-chair for the past five years, who is also a Kingston-based consultant on health care policy, planning and governance, says the registry was triggered by the realization that when it came to waitlists nobody had accurate data and so no one agreed on what to do.

Wait times were discussed in an environment where "everyone was using opinion, conjecture and nobody had any facts," Glynn says. "Our goal was to get the facts and be able to measure and monitor and, most importantly for the health authority/hospital, to manage access using information on who is waiting for what."

Previously, individual surgeons kept that information filed anywhere from computers to index cards. Improvements began to appear when government gave health authorities the technology, the standardized rules and the consistent prioritization criteria to produce firm and factual data. That in turn obligated them to be accountable for ensuring patients receive timely care. Defining who is in charge, Glynn emphasizes, was key. Although surgeons are intricately involved in all aspects of the process, regional health authorities are now expected to manage access in partnerships with surgeons. Equally important, surgeons must participate in the registry before they can book their operations in hospitals. Most important of all, this new accountability arrangement is backed up by provincial legislation. While there is some angst on their part, surgeons have seen that if they operate efficiently and their patients still wait too long, government will provide money to deal with that issue.

No registry and no waitlist – active or passive – prevents patients from choosing a specific surgeon. Patients always have the right to choose who will perform their particular procedure. However, depending on their choice, they may have to wait longer.

Says Glynn: "This is about patients." Every health authority in Saskatchewan has a surgical care coordinator. Patients can phone designated contacts and find out where they stand on the list, which surgeons in their region or elsewhere in the province have shorter lists and what their assessed priority level is. Traditional classifications of priority use the terms emergent, urgent and elective. But not everyone understands or uses those terms the same way. The new system, created by a committee of physicians and other health care workers, assesses patients and places them in one of five categories, each of which is assigned a target time frame. For example, emergency patients are to be treated within 24 hours, while 90 per cent of Level 1 patients – those with the second highest level of need – are to be treated in three to six weeks.

The SSCN provides a range of information, including wait times and waitlists, physician location and physician specialty. Since it began, waits measured from the time of decision for surgery to the time of surgery have declined steadily while the numbers of surgeries have gone up. Once the decision to operate is made, half of all patients wait less than five weeks, and more than 80 per cent wait less than six months.

Still, some Saskatchewan patients continue to wait too long, particularly for orthopaedics, plastic surgery and ophthalmology. The province's biggest challenge now is how to implement further initiatives while struggling with the world-wide shortage of health care workers. Glynn says some of those problems can be addressed by doing things differently, such as reducing lengths of stay in

hospital and expanding some roles, such as training nurse anesthetists. Government is also looking at ways to reduce hospital occupancy rates by increasing the number of day surgeries.

Given that former Saskatchewan premier Tommy Douglas is credited for founding Canada's universal health care system, the prairie province's leadership position in health care reform is most fitting. But like other jurisdictions, it has a lot more work to do. Glynn says improvements in health care system efficiencies are still far behind those used in industry for many years. Nevertheless, he has seen that when the public system implements similar improvements it can gain similar efficiencies.

Ontario's Wait Time Strategy

In 2004, Ontario launched its Wait Time Strategy (WTS), an ambitious, almost billion dollar, multi-pronged effort to reduce wait times. While that amount sounds huge, it represents only about 3 per cent of Ontario's health care budget. The province has targeted five high-demand areas: cardiac revascularization procedures, cancer surgery, cataract surgery, hip and knee joint replacements, and MRI and CT scans. The strategy's first goal was to reduce times for 90 per cent of patients waiting for treatment in those areas by December 2006. That goal has been achieved, albeit more successfully in some areas than others. According to the government's latest update (September 2006), it met all targets for cancer and cardiac bypass surgery, but has not yet for other areas.[27]

It is important to look at how much of these improvements are due to the dollar deluge and how much to genuine improvements in system efficiency. After all, research offers many examples of how money alone has failed to sustain improvements, and even in some cases made things worse by, for instance, encouraging unnecessary surgeries.[28]

"In the beginning it's simply cash buying more cases," says WTS lead Dr. Alan Hudson. "But as you move along you get more and more efficient because as you start getting more reliable data, you can start managing better."

These early wait time reductions are only the first step in what promises to be an ambitious and lengthy journey forward. Ultimately, the WTS aims to markedly improve access and reduce waiting times for a far wider range of services well beyond the end of last year.

As Hudson says, "This is not about wait times. It's about totally introducing new systems of care for Ontario."

Such a monumental task requires an equal amount of commitment and cooperation from government, hospital boards, health care providers, the public, and Ontario's new regional coordinating structures, known as Local Health Integration Networks or LHINs. As WTS leaders recently wrote, if the government-led initiative is to succeed it must activate, develop and support "a behavioural shift that makes everyone responsible for achieving wait times results."[29]

The following elements are fundamental to Ontario's WTS plan:

- FOCUSED DOLLARS. Over the past two years Ontario has devoted an additional $614 million for about 657,000 additional medical procedures. If bulk purchases of MRIs and CTs are included, spending approaches $1 billion.

- ACCOUNTABILITY. Hospital boards are now accountable for managing access. In order to receive additional case funding, they must sign a contract to that effect. Hospitals that do a greater number of surgeries receive more money, contrary to most traditional arrangements where more procedures result in increased costs to hospitals.[30]

- INFORMATION TECHNOLOGY. Standardized data collection is producing a single waitlist allowing management to track, monitor and improve access while giving patients the ability to compare wait times with those across the province. The effort involved switching from 150 IT systems province-wide to one. The system now collects about 80 per cent of provincial surgical waitlist data with the participation of about 60 per cent of Ontario surgeons.

- PERI-OPERATIVE COACHING TEAMS. Usually made up of an experienced operating room nurse manger, an anesthetist and a surgeon, these teams advise operating room, medical and hospital staff how to become more efficient. The first round was voluntary, but now government sends in coaching teams whether hospitals ask for them or not.

As impressive as the strategy's first milestone is, it faces many obstacles. With a provincial election set for October 2007, the WTS has become a sensitive and hotly-debated political topic. Critics point out that information on patient outcomes, appropriateness of surgery, and quality and safety of procedures has yet to come. This information is vital for any true evaluation – doing more surgeries faster does not necessarily mean doing them better. Also delayed is full participation by the 14 LHINs, which now have the legal status to be regional overseers of the process. As if that weren't enough, the strategy is hampered by the pervasive shortage of non-physician health care workers, in particular nurses, nurse practitioners, respiratory technicians and MRI technicians.

Although Ontario's experiment may not be unfolding as completely or as quickly as planned, its efforts are unprecedented and its accomplishments are many. The strategy is about to tackle wait times for all general surgery, all orthopaedics (not just hip and knee replacements) and all ophthalmology (not just cataract surgery). A WTS-contracted report by the Institute for Clinical Evaluative Sciences (ICES) on the appropriateness of imaging services will be out shortly, Hudson says, adding that appropriateness studies on imaging could eliminate wait times for these services altogether. (For example, 90 per cent of imaging studies for headaches are negative, he says.)

There's no doubt that Ontario has created a momentum of change. The challenge now is to ensure that these initiatives promote quality outcomes, ways to measure appropriateness, and collaboration within a publicly funded and delivered system.

Beyond Waitlist Management

Although the practice and policy changes discussed in this paper may initially seem onerous, other jurisdictions have proved they are not. They represent a significant step toward eliminating unreasonable waits for care, but they are only the first of several. A critical yet frequently ignored contributor to long waitlists is the dynamics of hospital use. Long term solutions must be found to take the pressure off hospital services so they can respond to fluctuating demands for acute care while simultaneously meeting their elective surgery targets. In fact, according to a recent position paper by the Canadian Association of Emergency Physicians, upwards of 20 per cent of hospital beds are occupied by patients who would be better off cared for in a long-term care facility or at home with quality home care.[31]

Emergency overcrowding is very much related to hospital occupancy rates. A recent British study found that when bed occupancy rates exceed 85 per cent, risks to patients increase, and acute care hospitals experience regular bed shortages. When occupancy rates rise to 90 per cent or more, bed crises result.[32] In the Canadian experience, more often that not, bed crises result in cancelled elective surgeries. Making matters worse, is the scarcity of community-based clinics that are open 24/7. This results in many people with non-urgent problems using emergency departments.[33]

Another British report noted that the single most important way to improve wait times in emergency and to reduce the number of cancelled surgeries is to ensure more beds are available. And one of the main ways to guarantee more beds is to improve community care.[34] Yet BC has moved in the opposite direction. According to a 2005 report by the Canadian Centre for Policy Alternatives, access to long-term care and home health services decreased significantly between 2001 and 2004, in spite of an aging population and cuts to the acute care system.[35] Thus, expanding community health care represents another vital means of taking pressure off the more expensive acute care system and enhancing the flow of elective surgeries. Ways to do this within the public system will be further explored in a forthcoming CCPA report.

Conclusion

There is no quick and easy solution to shortening wait times. As this paper demonstrates, it takes hard work and a willingness to abandon long-held habits.

As this report also shows, there are people in the public system intensely engaged in doing just that. People at all levels are marshalling a range of strategies that – slowly in some places and more quickly in others – are transforming health care. Especially encouraging are initiatives such as the Richmond Hip and Knee Reconstruction Project, North Vancouver's JRAC and the Alberta Hip and Knee Replacement Project. These efforts have proved their worth. According to the Canadian Institute for Health Information, surgical teams across the country performed 40,000 more operations last year than in 2005 in waiting-time priority areas. In one year, hip and knee replacements jumped 12 per cent and cataract operations rose 10 per cent. Even non-priority areas such as non-cataract eye surgery and other orthopaedic surgeries increased significantly.[36] This good news, commented a cautious but optimistic Globe and Mail editorial, may not be definitive proof that the system is more efficient, but it does suggest that "medicare is turning the corner."[37]

While those involved in these projects and others know how to keep that momentum going, the key question in BC is whether government will follow their lead. The champions of public sector reform need help. Given the absence of any national health human resource planning, they work in the midst of an ongoing shortage of health professionals, and although reforms will not resolve that shortage, they can partially alleviate it by allowing workers to take on expanded roles, increasing efficiencies and testing patients for appropriateness and thus decreasing demands for surgery.

The health care system is extremely complex. On the one hand, it is an often discordant mix of provincial-federal politics, professional turf wars, corporate battles and academic positioning. On the other, it is made up of highly-skilled, compassionate and committed teams of professionals engaged in a treasured Canadian tradition – furthering the public good. Reality, of course, includes both these scenarios.

If patient-centered care is a priority, it's clear which side of the equation must prevail. The BC government must take a leadership role and declare who it will support. Right now that choice is not clear. When Premier Gordon Campbell announced BC's Conversation on Health, he suggested that public involvement in health is no longer financially sustainable, implying that we should consider a larger role for private insurers and private providers. But is that what British Columbians want? More

to the point, does the evidence tell us that for-profit schemes such as contracting out and private day surgery clinics provide better care to the majority of people? To the contrary, the evidence shows that private, for-profit services cost society more, are less safe for patients and compromise the public system. Additionally, in our view there is considerable reason for concern based on the government's recent support of Canadian Medical Association president-elect Brian Day's proposal for a new funding model for hospitals based on UK style reforms. These concerns are discussed in the Appendix.

The BC government needs to shift direction and instead of promoting private clinics, become the steward of public waitlist reform. They can do so by:

- Replicating and expanding on the successes established in North Vancouver and Richmond/UBC by providing dedicated resources and oversight so that these initiatives become the rule rather than the exception in BC. Although most of these projects pertain only to hip and knee reconstruction, there is no reason the efficiencies they employ can't be expanded to a range of surgical specialties.

- Shifting accountability for ensuring smooth surgical flow and waitlist management from individual surgeons to a regional group of surgeons, and from individual hospitals to health authorities. As noted throughout this document, most Canadian waitlists are managed by individual surgeons who view this role as part of their traditional professional autonomy. Shifting responsibility for waitlist management from individual surgeons to health authorities working with groups of physicians and other health professionals is a huge cultural change that some surgeons may resist. Given that probable opposition, the provincial government must take charge because, as this paper consistently shows, managing waitlists based on the needs of patients in an entire region significantly reduces the time people spend waiting. In Canada this has most effectively been done in Saskatchewan where there is provincial leadership and resources, and where regional leaders ensure that standardized rules and evidence-based practices are used to manage the registry. In Ontario, peri-operative coaching teams made up of nurse managers, anesthetists and surgeons are intent on achieving similar goals.

However, the recent agreement between the BCMA, the BC Ministry of Health and health authorities may significantly limit the province's ability to rectify the waitlist problem. While this paper features physicians who are actively engaged in real system change by, among other things, working in teams, the agreement appears to leave much of waitlist management and coordination to individual physicians. It also appears to restrict the ability of health authorities to re-direct patients. If there is no transfer of accountability to groups of surgeons responsible for managing waitlists along with health authorities and other health professionals, not much will change. Yet the benefits of team-based care – to patients and to the system as a whole – are overwhelming.

In effective public sector and private sector organizations, senior leaders set specific conditions of employment to maintain quality and efficiency standards. When it comes to efficiency and effectiveness, public health care is no different. Where are the leaders our health care system so urgently needs? Will the BC government take up the challenge of actively managing waitlists through its health authority partners or will it throw up its hands as it has done recently and declare that the public health care system is simply "unsustainable"?

We hope this contribution to the Conversation on Health will persuade the government to give British Columbians the right answer to that question.

APPENDIX

Undermining Recent Waitlist Gains in BC: Brian Day's Proposal for a UK-Style Competitive Market in Health Care

While research for this paper was underway, a new proposal for how to address waitlist issues was put forward by Brian Day, President-elect of the Canada Medical Association, owner of a private surgery clinic and outspoken advocate for private delivery. Day's proposal has the attention of the provincial government, with the Premier, Finance Minister and Health Minister all expressing a keen interest in his ideas.[38] Day's proposal calls for the creation of a competitive market in health care based on recent reforms in the United Kingdom, where public National Health Service (NHS) hospitals must compete with each other and with private surgery clinics for patients and funding. In Canada, this model has variously been called "activity-based funding," "service-based funding" and "patient-focused funding." In the UK, it is known as "funding by results."

What are the UK Reforms?

Three UK reforms have created market-like conditions in health care. The first was the decision in 2003 to provide public funding for private surgery clinics, otherwise known as Independent Sector Treatment Centres (ISTCs). The second was a shift from a globally-funded system in which NHS hospitals received a guaranteed level of funding each year, to a "results-based" funding model where funding is provided only after the fact based on the volume and type of service provided (the implementation of this new model began in 2004 and will be fully operational by 2008). The third change was a new "patient choice" model introduced last year, whereby family doctors were mandated to offer patients requiring planned (i.e. elective) hospital care a choice among four or more hospitals, one of which could be a private surgery clinic (ISTC). As a result, public hospitals now compete with each other and with private clinics for patients. In November, public hospitals received approval to advertise their services using celebrity figures.[39]

Ironically, the private clinics or ISTCs are not funded using this new "payment by results" model, but instead receive guaranteed levels of funding no matter how many patients they serve. In other words, while NHS hospitals must now compete for patients to ensure an adequate revenue stream to stay out of debt, private clinics are assured stable funding levels until at least 2008. It is also important to note that, as part of this reform package, government increased the overall funding for health care by

7 per cent each year for five years – from March 2002 to March 2007. These higher levels of funding have made it possible to make some reductions in waitlists.

The stated goal of these reforms is to improve efficiency and reduce waitlists through the creation of a health care market. As Day put it in a recent column for the Vancouver Board of Trade, if this new form of funding results in some less efficient hospitals closing down, then "so be it."[40] But does it make sense to close down hospitals given the shortage of hospital beds in BC? Does it not make more sense to develop collaborative strategies (among hospitals and health authorities) to improve efficiencies in poor performing hospitals? Are collaborative strategies even possible in an environment where hospitals are competing against one another for patients, and patients are asked to choose a hospital based on information from celebrity or other ad campaigns?

Arguments Against UK-Style Reforms

Since these reforms came into effect, a number of professional organizations and academic journals in the UK have raised alarm bells. A 2005 study published in the British Medical Journal on the implications of the "payment by results" financing system warned of the potential danger of over-servicing (i.e. providing unnecessary care).[41] In a comparison of short-stay emergency admissions between hospitals that had introduced the new funding arrangement and those that had not, researchers found more admission in hospitals with "results-based funding." The explanation – short-stay admissions attract higher payments (under the new system) than outpatient emergency care, so hospitals have an incentive to increase admissions.

In the area of administrative overhead, there is also evidence of rising costs and a reduction, rather than increase, in system efficiency. A study published in Health Policy comparing transaction costs before and after the introduction of "payment by results" found that, while costs per procedure went down, overall costs went up.[42] This was due to the higher costs for price negotiation, data collection, monitoring and enforcement with "payment by results," as each procedure had be priced, checked, recorded and rechecked.

In addition to higher administrative costs and over-servicing within the NHS, questions related to quality of care and costs in the private clinics have been raised. In the main body of this report there is a reference to concerns raised by the College of Surgeons and the British Medical Association (BMA) about the quality of care in ISTCs and the higher public hospital readmission rates from private ISTC clinics. On the cost side, the Department of Health has acknowledged that procedures purchased in the private ISTC cost on average 11.2 per cent more than the NHS equivalent services.[43] A House of Commons report on ISTCs suggests that the costs of contracting with the ISTCs could be even higher, but because contracts are subject to commercial confidentiality no one knows for sure.[44]

A cornerstone of the new UK system of payment is "choice." This is yet another area where serious shortcomings have been identified. A study commissioned by the UK Department of Health (DOH) found that people did not want to select a hospital while they were seriously ill, preferring that such decisions be made by a trusted family doctor. The study concluded that there was no evidence that greater choice would improve quality of care, and good reason to fear that it would benefit only the wealthy and articulate. According to the BMA, the report, which discredited government policy on choice, mysteriously disappeared from the DOH website.[45]

The BMA's opposition to this new competitive model was clearly articulated at its 2005 annual meeting when delegates passed a unanimous resolution that "more emphasis should be placed on collaboration as opposed to competition."[46] Chris Ham, a professor of health policy at Birmingham University and former director of strategy at the Department of Health (2001–2004), made a similar observation in a recent article in the Guardian. Ham noted,

> *With healthcare organizations competing with each other for a bigger share of the NHS budget, there is little incentive for them to collaborate and to substitute care in the community for care in hospitals.*[47]

Ham goes on to say that the new funding system does not incorporate the incentives needed to improve productivity and performance, and he predicts that without a change in policy the NHS will not survive as a universally tax-funded service.[48]

An early report on "payment by results" from Audit Commission (an agency similar to our Auditor General) makes an equally negative prediction. It warns that the uncertainty of funding under the results-based system will increasingly destabilize NHS hospitals.[49] Evidence of rising levels of instability within the NHS over the last year or more can be seen with rising levels of debt in NHS institutions, service cuts and recent announcements of pending hospital closures.[50]

Implications for BC

Based on the evidence from Britain, there is every reason to fear that Day's proposal will undermine rather than ensure the sustainability of the public health system in BC. The efficiency gains made in recent waitlist strategies in BC and elsewhere in Canada depend on more – not less – collaboration. Having multiple hospitals and clinics compete for the same procedures constitutes a move in the opposite direction. Our report outlines a number of ways of achieving efficiency gains: by ensuring better coordination of waitlists across a region, developing multidisciplinary community clinics and processes for sharing best practices as well as coaching programs to support hospitals where waitlists are longer. But Day's proposal represents a disincentive for hospitals and clinics to engage in such cooperation.

This is not to say, however, that the current funding model for hospitals in BC is problem free. There is clearly a perverse incentive embedded in the global funding model, whereby hospitals manage to stay within budget by closing operating rooms and beds. There is certainly merit in looking to a new funding model that rewards hospitals for doing more, not less, as long as the model takes into account the benefits of community-based team care and is guided by the principles of collaboration, quality and appropriateness. It is an area where further work is required, work that builds on the waitlist successes in BC and elsewhere, and focuses on sustaining rather than undermining public health service delivery.

Notes

1 Health Canada, 2006.

2 Postl, 2006; Rachlis, 2005.

3 Romanow, 2002.

4 Lee, 2006.

5 Wright, 2002.

6 Postl, 2006.

7 Canadian Health Services Research Foundation, 2005.

8 Tuohy et al., 2004.

9 Armstrong, 2000; Lomas, 2007.

10 Gonzalez, 2004.

11 Devereaux et al., 2002.

12 Garg et al., 1999.

13 Devereaux et al., 2002.

14 House of Commons, 2006.

15 Zocia, 2006.

16 Dyer, 2004.

17 Lang, 2005. A 2004 comparison of Canadian and US hospital costs also found wide disparities. Total hip replacement in Canada was $6,080 compared to US$12,846. See Antoniou et al., 2004.

18 Shimo, 2006. The article lists hip replacement surgery at US$19,000.

19 Canadian Institute for Health Information, 2005a.

20 Shimo, 2006. Prices may include hotel for an accompanying family member for up to four nights, but do not include travel costs. Residents of BC pay less because the surgeon's fee is paid by the provincial health plan, a practice which is illegal under the Canada Health Act if a physician is also charging private payers.

21 Sullivan Healthcare Consulting Canada Co., 2004.

22 Interior Health Authority, 2004.

23 Some say the project's success depends on use of Calgary's private surgical clinic Health Resource Centre (HRC). But while Edmonton and Red Deer have available space in public facilities, Calgary does not. The project was forced to contract HRC for some of their space and operating room costs. All physicians and other health care providers are paid through the public system and each region receives the same amount of money per case to cover facility fees.

24 Canadian Institute of Health Information, 2006.

25 Frank et al., 2006.

26 Health Council of Canada, 2005.

27 One year after September 2005, wait times in the five priority areas had fallen by 33 per cent for cataract surgery, 19 per cent for knee replacement surgery, 21 per cent for hip replacement surgery, 54 per cent for angiography (a type of X-ray of the blood vessels or chambers of the heart), 29 per cent for angioplasty, 6 per cent for MRI scans, and 14 per cent for CT scans.

28 Harrison and Appleby, 2005.

29 Trypuc et al., 2006.

30 This shift to volume-based funding is controversial because measures for appropriateness and quality are not yet in place. See Brian Day in Appendix.

31 Canadian Association of Emergency Physicians, 2007.

32 Bagust et al., 2005.

33 Canadian Institute for Health Information, 2005b.

34 British Medical Association, 2002.

35 Cohen et al., 2005.

36 Canadian Institute for Health Information, 2007.

37 *Globe and Mail*, 2007.

38 Brian Day, "Guest Column: Patient Focused Funding", *Sounding Board*, Vancouver Board of Trade, January 2007, Vol. 47, No. 1. This column is a summary of Brian Day's presentation at the BC government's opening conference for the BC Conversation on Health, October 10, 2006; Camille Bains, "Funding hospitals by patient count, CMA prescribe", *Globe and Mail*, January 24, 2007; Gary Mason, "BC is refreshingly candid on private sector health care", *Globe and Mail*, March 6, 2007, A7.

39 "NHS hospitals can use celebrities to advertise – but there is a question over payment", *Guardian*, November 28, 2006.

40 Day, Op cit.

41 R. Rogers et al. "'HRG drift' and payment by results", *British Medical Journal*, March 12, 2005, 330:563.

42 G. Marini and Andrew Street, "A transaction costs analysis of changing contractual relations in the English NHS", *Health Policy*, 2006.11.007.

43 House of Commons Health Committee, *Independent Sector Treatment Centre, Fourth Report Session 2005*-06, Volume 1, pp. 37-38.

44 Ibid.

45 "Doctors claim study of patient choice suppressed", *Guardian*, January 1, 2007.

46 Annabel Ferriman, "BMA condemns competition and payment by results in NHS", *British Medical Journal*, July 2005, Vol. 331, p. 9.

47 John Carvel, "Health guru urges change of tack on funding to save NHS", *The Guardian*, February 26, 2007.

48 Ibid.

49 Audit Commission, *Early Lessons from Payment By Results*, October 2005, pp. 4-5.

50 UNISON, *In the Interests of Patients? The impact of the creation of a commercial market in the provision of NHS Care*, January 2007, pp. 9-10.

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About the CCPA

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The Canadian Centre for Policy Alternatives is an independent, non-partisan research institute concerned with issues of social and economic justice. Founded in 1980, it is one of Canada's leading progressive voices in public policy debates.

The CCPA works to enrich democratic dialogue and ensure Canadians know there are workable solutions to the issues we face. The Centre offers analysis and policy ideas to the media, general public, social justice and labour organizations, academia and government. It produces studies, policy briefs, books, editorials and commentary, and other publications, including *The Monitor,* a monthly magazine. Most of these resources are available free at www.policyalternatives.ca.

Established in 1997, the CCPA's BC Office offers policy research and commentary on a wide range of provincial issues, such as: BC finances, taxation and spending; poverty and welfare policy; BC's resource economy; privatization and P3s; public education financing; health care; and more.

The CCPA is a registered non-profit charity and depends on the support of its more than 10,000 members across Canada.

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About the BC Health Coalition

www.bchealthcoalition.ca

The BC Health Coalition is a coalition of more than 70 groups that works to protect and expand public health care. For more information contact: coordinator@bchealthcoalition.ca or call 604.681.7945.

BC Health Coalition

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Jake Epp
Attachments

Following is the text of the letter sent on January 6, 1995 to all provincial and territorial Ministers of Health by the Federal Minister of Health, the Honourable Diane Marleau.

Minister of Health and Welfare - Ministre de la Santé et du Bien-être social
Ottawa, Canada
K1A 0K9

This is Exhibit G referred to in the affidavit of Joyce Jones sworn before me, this 13th day of AUGUST 2009

A COMMISSIONER, ETC.

January 6, 1995

Dear Minister:

RE: *Canada Health Act*

The *Canada Health Act* has been in force now for just over a decade. The principles set out in the Act (public administration, comprehensiveness, universality, portability and accessibility) continue to enjoy the support of all provincial and territorial governments. This support is shared by the vast majority of Canadians. At a time when there is concern about the potential erosion of the publicly funded and publicly administered health care system, it is vital to safeguard these principles.

As was evident and a concern to many of us at the recent Halifax meeting, a trend toward divergent interpretations of the Act is developing. While I will deal with other issues at the end of this letter, my primary concern is with private clinics and facility fees. The issue of private clinics is not new to us as Ministers of Health; it formed an important part of our discussions in Halifax last year. For reasons I will set out below, I am convinced that the growth of a second tier of health care facilities providing medically necessary services that operate, totally or in large part, outside the publicly funded and publicly administered system, presents a serious threat to Canada's health care system.

Specifically, and most immediately, I believe the facility fees charged by private clinics for medically necessary services are a major problem which must be dealt with firmly. It is my position that such fees constitute user charges and, as such, contravene the principle of accessibility set out in the *Canada Health Act*.

While there is no definition of facility fees in federal or most provincial legislation, the term, generally speaking, refers to amounts charged for non-physician (or "hospital") services provided at clinics and not reimbursed by the province. Where these fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act (section 19).

Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. This subsidization of two-tier health care is unacceptable.

The formal basis for my position on facility fees is twofold. The first is a matter of policy. In the context of contemporary health care delivery, an interpretation which permits facility fees for medically necessary services so long as the provincial health insurance plan covers physician fees runs counter to the spirit and intent of the Act. While the appropriate provision of many physician services at one time required an overnight stay in a hospital, advances in medical technology and the trend toward providing medical services in more accessible settings has made it possible to offer a wide range of medical procedures on an out-patient basis or outside of full-service hospitals.

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The accessibility criterion in the Act, of which the user charge provision is just a specific example, was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and regardless of venue. It must continue to mean that as the nature of medical practice evolves.

Second, as a matter of legal interpretation, the definition of "hospital" set out in the Act includes any facility which provides acute, rehabilitative or chronic care. This definition covers those health care facilities known as "clinics". As a matter of both policy and legal interpretation, therefore, where a provincial plan pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges.

I recognize that this interpretation will necessitate some changes in provinces where clinics currently charge facility fees for medically necessary services. As I do not wish to cause undue hardship to those provinces, I will commence enforcement of this interpretation as of October 15, 1995. This will allow the provinces the time to put into place the necessary legislative or regulatory framework. As of October 15, 1995, I will proceed to deduct from transfer payments any amounts charged for facility fees in respect of medically necessary services, as mandated by section 20 of the *Canada Health Act*. I believe this provides a reasonable transition period, given that all provinces have been aware of my concerns with respect to private clinics for some time, and given the promising headway already made by the Federal/Provincial/Territorial Advisory Committee on Health Services, which has been working for some time now on the issue of private clinics.

I want to make it clear that my intent is not to preclude the use of clinics to provide medically necessary services. I realize that in many situations they are a cost-effective way to deliver services, often in a technologically advanced manner. However, it is my intention to ensure that medically necessary services are provided on uniform terms and conditions, wherever they are offered. The principles of the *Canada Health Act* are supple enough to accommodate the evolution of medical science and of health care delivery. This evolution must not lead, however, to a two-tier system of health care.

I indicated earlier in this letter that, while user charges for medically necessary services are my most immediate concern, I am also concerned about the more general issues raised by the proliferation of private clinics. In particular, I am concerned about their potential to restrict access by Canadian residents to medically necessary services by eroding our publicly funded system. These concerns were reflected in the policy statement which resulted from the Halifax meeting. Ministers of Health present, with the exception of the Alberta Minister, agreed to:

> *take whatever steps are required to regulate the development of private clinics in Canada, and to maintain a high quality, publicly funded medicare system.*

Private clinics raise several concerns for the federal government, concerns which provinces share. These relate to:

- weakened public support for the tax funded and publicly administered system;
- the diminished ability of governments to control costs once they have shifted from the public to the private sector;
- the possibility, supported by the experience of other jurisdictions, that private facilities will concentrate on easy procedures, leaving public facilities to handle more complicated, costly cases; and
- the ability of private facilities to offer financial incentives to health care providers that could draw them away from the public system - resources may also be devoted to features which attract consumers, without in any way contributing to the quality of care.

The only way to deal effectively with these concerns is to regulate the operation of private clinics.

I now call on Ministers in provinces which have not already done so to introduce regulatory

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frameworks to govern the operation of private clinics. I would emphasize that, while my immediate concern is the elimination of user charges, it is equally important that these regulatory frameworks be put in place to ensure reasonable access to medically necessary services and to support the viability of the publicly funded and administered system in the future. I do not feel the implementation of such frameworks should be long delayed.

I welcome any questions you may have with respect to my position on private clinics and facility fees. My officials are willing to meet with yours at any time to discuss these matters. I believe that our officials need to focus their attention, in the coming weeks, on the broader concerns about private clinics referred to above.

As I mentioned at the beginning of this letter, divergent interpretations of the *Canada Health Act* apply to a number of other practices. It is always my preference that matters of interpretation of the Act be resolved by finding a Federal-Provincial/Territorial consensus consistent with its fundamental principles. I have therefore encouraged F/P/T consultations in all cases where there are disagreements. In situations such as out-of-province or out-of-country coverage, I remain committed to following through on these consultative processes as long as they continue to promise a satisfactory conclusion in a reasonable time.

In closing, I would like to quote Mr. Justice Emmett M. Hall. In 1980, he reminded us:

> "*we, as a society, are aware that the trauma of illness, the pain of surgery, the slow decline to death, are burdens enough for the human being to bear without the added burden of medical or hospital bills penalizing the patient at the moment of vulnerability.*"

I trust that, mindful of these words, we will continue to work together to ensure the survival, and renewal, of what is perhaps our finest social project.

As the issues addressed in this letter are of great concern to Canadians, I intend to make this letter publicly available once all provincial Health Ministers have received it.

Yours sincerely,

Diane Marleau
Minister of Health

Annex C

Dispute Avoidance and Resolution Process Under the Canada Health Act

In April 2002, the Honourable A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a *Canada Health Act* Dispute Avoidance and Resolution process, which was agreed to by provinces and territories, except Quebec. The process meets federal and provincial/territorial interests of avoiding disputes related to the interpretation of the principles of the *Canada Health Act* , and when this is not possible, resolving disputes in a fair, transparent and timely manner.

The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues, as they arise; active participation of governments in ad hoc federal/provincial/ territorial committees on *Canada Health Act* issues; and *Canada Health Act* advance assessments, upon request.

Where dispute avoidance activities prove unsuccessful, dispute resolution activities may be initiated, beginning with government-to-government fact-finding and negotiations. If these are unsuccessful, either Minister of Health involved may refer the issues to a third party panel to undertake fact-finding and provide advice and recommendations.

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This is Exhibit....H.....referred to in the affidavit of ...Joyce Jones.... sworn before me, this ....13th.... day of ....AUGUST.....20.09.

.....
A COMMISSIONER, ETC.

Homework required before Falcon tackles health care system

Vancouver SunJuly 3, 2009Be the first to post a comment

Kevin Falcon brings a welcome, impatient energy to his new job as British Columbia's minister of health, but he still needs to do his homework before speaking out.

Falcon jumped head-first last week into the ongoing and generally uninformed and unproductive debate over public versus private health care. In an interview with Sun health reporter Pamela Fayerman, he said he has no philosophical problem with people paying for private surgery with their own money, just as they pay for services when they go to the dentist.

Alas, the Canada Health Act -- as interpreted by the government of which he is a part and his counterpart in Ottawa -- is not so relaxed on that approach and Falcon appeared to be signaling his appointment was a precursor to fundamental change. He also appeared to be waving a red flag under the nose of health care unions.

Although he phoned back later to insist he had not been talking about defying the law, Falcon still left the impression that he won't be bound by convention as he pushes for reforms needed to ensure future generations will be able to count on affordable health care. That attitude should be an asset, as long as Falcon, who came to prominence as a partisan scrapper, can demonstrate that he also is able to keep an open mind.

Falcon was stating the obvious by arguing that innovation is needed to cope with increasing demand and we are too often hung up on silly ideological debates. But he needs to recognize also that while, as Premier Gordon Campbell likes to say, the status quo isn't an option, neither is it his job to rush in and rip up the old system and replace it with something new just

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for the sake of change.

The first step is to understand that the health care problem in B.C. stems not from failure but from success. Our population is growing. We are living longer, healthier lives, extended and enhanced in part by often-costly new medical procedures and drugs.

While we focus on the problems -- the waiting lists for some treatments and crowded hospitals and emergency rooms -- we are also doing a lot of things right. B.C. spends less per capita on health care and for drugs than almost any other province, yet we have the healthiest people by most measures.

And while the portion of the provincial budget consumed by health care costs has been rising at an alarming rate, when compared to the total output of our economy as measured in GDP, the increase, while still a concern, looks more manageable.

Still, Falcon won't have the luxury of spending much time celebrating success. He has the huge task of meeting ever-increasing expectations in the face of rising costs and a growing, aging population. Along with the need for more health care funding, he will be faced with continued pressure to lower taxes, for governments to do more with less.

So we are encouraged to hear that he is prepared to try out new ideas, to discount tired arguments about private versus public care and to bring his energy and activist approach to his new job.

He will need all that plus an unaccustomed does of humility as he faces one of the fundamental challenges of our generation.

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Health minister says private surgery clinics okay, with limits

Patients should have choice for procedures not medically necessary, Kevin Falcon says

BY PAMELA FAYERMAN, VANCOUVER SUN JUNE 25, 2009

New B.C. Health Minister Kevin Falcon says patients should be able to use their own money to buy expedited treatment in private surgery clinics.

"I don't have any philosophical objection to it," Falcon told The Vancouver Sun, adding, "What we have to do is improve the public delivery of services."

In his first major interview since being named health minister June 10, Falcon said: "I don't have an objection to people using their own money to buy private services just as they do with dentists, just as they do with other decisions they make -- you know, sending their kids to private school or what have you.

"I think choice is a good thing, actually -- reducing choice I don't think is a good thing."

However, he called back later to qualify his remarks, saying he was referring only to non-medically necessary procedures such as plastic surgery, since provincial and federal statutes prohibit extra billing for medically necessary procedures.

Falcon said he's not departing from the official government stance or getting into a "fight" with the federal government over the Canada Health Act.

"As long as the medically necessary service is publicly funded, I don't have a problem if it is privately delivered," he said. "If we're talking about medically necessary care, we don't have the right to allow people to [buy it privately].

"Frankly, in my second week in the health portfolio, I haven't yet got my mind wrapped around that," he said, referring to the complex legal issues around a public-private parallel health care system similar to that in European countries.

Falcon said he has never gone to a private clinic and doesn't expect to ever do so.

"I'd insist on being treated like anyone else. People might hear that and say. 'Yeah, right,' but I would, because I wouldn't be looking for special favours and I hope none would be offered," he said.

Reminded that Environment Minister Barry Penner used a private surgery centre in 2004 when he needed a back operation during a Hospital Employees' Union strike, Falcon said: "I have no problem

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with what he did, particularly because it was during the strike."

Penner said at the time he would have preferred to save the money by having surgery in a public hospital, "but that was not an option."

He was one of thousands of patients whose surgeries were cancelled or delayed during the strike. The government contracted out many procedures to private clinics to catch up.

Asked how the public should reconcile his views with a current court case in which private clinics are suing the government for not allowing doctors and clinics to accept private payment from patients, Falcon said he has not been fully briefed on the case.

"It's before the courts, so I have to be careful," he said.

The private clinics are seeking a declaration that preventing patients from paying for expedited care in private clinics is an infringement of their rights. A trial date has not been set.

Despite the law, about 50,000 patients each year use the 50 or so private surgery centres in B.C.

About two dozen patients a year complain to the government after they've used private clinics, in a bid to recover from the so-called user or facility fees they've paid. The Medical Services Commission is obliged to investigate complaints.

The government maintains the private clinics launched the litigation as a result of the MSC's announced intention to audit clinics over extra billing.

The clinics are not, by law, supposed to collect fees for any procedures that are medically necessary and publicly funded by the Medical Services Plan. But the law is routinely flouted.

Dr. Brian Day, the co-owner of the Cambie Surgery Centre and one of the litigants in the court action, said if private clinics are successful, it will "pave the way for a European-like hybrid public-private partnership in the funding and delivery of care, in which access for all is achieved without the extreme rationing and delays that have characterized health care delivery in Canada."

"Patients of centres like ours include many NDP political leaders and many public-sector union leaders," Day said. "While some of those claim to reject freedom of choice for sick patients on wait lists . . . unionized workers comprise the biggest single demographic group in B.C. that benefits from private health care. The biggest growth of private clinics occurred under the tenure of an NDP government."

Judy Darcy, secretary-business manager of the Hospital Employees' Union, said: "It's important for this government to focus on public solutions that will improve care for everyone.

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"That's the clear message that British Columbians articulated during their year-long 'conversation on health' consultation."

pfayerman@vancouversun.com

This is Exhibit.....I.....referred to in the affidavit of ....Joyce Jones.... sworn before me, this ....13th.... day of ....AUGUST....20..09

.....
A COMMISSIONER, ETC.

BC Health Coalition **fact sheet**

Private for-profit surgical clinics in B.C.

Expansion of the private, for-profit surgical and medical clinic industry in Canada is virtually unchecked. Owners of for-profit clinics are waging an aggressive campaign to capture a larger share of the health care "market" from non-profit public hospitals.

In the last five years, the number of for-profit clinics has more than doubled, and many of these are charging patients privately for necessary health services. In B.C. there are 71 medical/surgical clinics, with 22 providing publicly insured general surgeries on a for-profit basis.[1]

Public Dollars to Private Clinics

The for-profit medical business is only financially viable if it is publicly subsidized. The significant growth of private for-profit clinics in B.C. is largely the result of contracts that private operators have received from the province's five health authorities to provide specific, publicly insured surgical services such as orthopedics and ophthalmology, as well as diagnostic services such as MRI, CT and ultrasound scans.

In addition to providing services on contract to public health authorities, for-profit clinic owners are also required by law to protect and promote the interests of their shareholders and provide a satisfactory return to their investors. This has contributed to a rapid increase in costs charged by for-profit clinics. In 1996, for example, an hour of operating room time at a private facility cost $450—the same as the public hospital system. However, ten years later that cost had risen to $1,500—an increase of almost 250 per cent over 10 years. In the public hospital system, on the other hand, the cost had remained relatively stable at $660 an hour—less that half the rate of private facilities.[2]

Unfortunately, while government continues to fund for-profit surgical and diagnostic services, it increasingly ignores or chooses not to enforce Medicare laws that limit for-profit delivery of medically necessary services.

Private Clinics Versus Public Interest

There is a fundamental conflict between the aims of Medicare, centred on patients, and the aims of the market, centred on profits. Private clinic operators are motivated to increase their revenues as much as possible by charging patients user fees, and extra billing for services covered under Medicare. Many of these billing practices are illegal.

Similarly, many physicians who either work at or have invested in a for-profit facility also work in the public system. This can lead to unethical business practices such as providing "kickbacks" or self-referrals that are not in patients' or the public's best interest.

■ user fees and extra billing

Extra billing is the practice of charging an additional fee for physician services that are publicly funded. User fees are additional charges to patients that can take the form of "facility fees" or "membership fees". Both these practices allow "queue jumping" by those who can afford to pay the additional cost, and they are a necessary part of the for-profit medical business. According to the *Vancouver Sun*, an estimated 50,000 patients in B.C. obtained surgery at for-profit clinics in 2004/05 and paid facility fees ranging from $700 to $17,000, depending on the surgery.[3]

■ kickbacks and self-referrals

A kickback is the financial compensation a physician receives for referring patients to a particular clinic. If he or she owns or operates the clinic, it is a self-referral. The potential for this kind of abuse is high because many physicians operate in—and bill—both the public and private systems, something that is illegal under BC's *Medicare Protection Act* and the *Canada Health Act*. Doctors who work in the public hospital system and refer patients to private clinics in which they own shares are in a conflict of interest. Unfortunately, there are no laws governing private surgical clinics that prevent this type of unethical behaviour.

Supporting positive, public solutions to make Medicare stronger in British Columbia!

www.bchealthcoalition.ca

1,2,3 All references for this fact sheet can be found at www.bchealthcoalition.ca/BCHC Resources/Fact Sheets/References

May 2008

Private Problems

Private clinics COST MORE

The international experience with private surgical facilities is that they tend to charge much higher prices than a publicly funded hospital for the same surgery. Hip replacement surgery in a non-profit hospital in Alberta cost a reported $10,000 in 2006, compared to $20,000 in a for-profit clinic. In Canada's public hospital system, knee replacement surgery averages $8,000 compared to between $14,000 and $18,000 in a private surgical facility.[4]

Private clinics "CHERRY PICK"

For–profit clinics make money by choosing less sick patients and those with fewer complications. Cherry picking occurs because for-profit clinics have a material interest in serving patients who require less complex procedures, whose outcomes are more predictable and whose overall costs are lower. It allows them to minimize their risk and maximize their profit, but it increases the average level of severity among patients who remain in the public system. Consequently, the average cost of treating patients in public institutions rises.[5]

Private clinics INCREASE WAIT TIMES

For–profit facilities can provide faster care to those with deeper pockets, but they seriously compromise access for those waiting for care in the public system. Parallel private delivery diverts resources away from the public system and into the private one. Doctors, nurses and other health professionals can't be in two places at once. The more care they provide in the for-profit sector, the less they can do in the public sector because there are shortages of most health professionals. This leads to longer waiting times for patients in the public system.[6]

Private clinics REDUCE SAFETY AND QUALITY

For-profit providers cut corners to ensure owners obtain their expected returns on investment, and the profit motive may adversely affect patient outcomes. Research shows that, overall, patients who use for-profit facilities have significantly higher death rates than those who use non-profit providers. A key reason for poorer quality of care and health outcomes in for-profit facilities is the lower number of skilled personnel employed. It has been estimated that if all Canadian hospitals were converted to for-profits, there would be an additional 2,200 deaths a year.[7]

Public Solution: specialty elective surgery clinics

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Outpatient surgical clinics located in the non-profit public sector achieve the benefits of specialization and innovation normally ascribed exclusively to the private sector, while maintaining the public sector's long-standing advantage of low overall administrative costs.

Most peer-reviewed studies have shown that publicly-funded hospitals are much more efficient and, compared to their for-profit counterparts, provide a higher quality of care at a much lower cost.[8]

Recent successful examples include North Vancouver's "one-stop" joint replacement assessment clinic and Mt. St. Joseph's Hospital cataract and corneal transplant program, both of which have dramatically reduced wait times.

The evidence is clear: private for-profit care is less fair, more costly and poses a greater risk to patients than not-for-profit care.

Take Action!

SPEAK out for the good of your health. Don't allow an internationally proven failure like privatized health care to take root in your community. Add your voice to the thousands of British Columbians who reject this for-profit model and instead, actively support fully funded, public and universally accessible health care for all.

CONNECT with your neighbours and get involved in supporting positive, public solutions to make Medicare stronger in BC. For more information, contact the BCHC or visit the websites below:

www.yourmedicarerights.ca
www.canadiandoctorsformedicare.ca
www.healthcoalition.ca
www.profitisnotthecure.ca

DEMAND that the provincial government enforce the Canada Health Act and prohibit the charging of user-fees and extra billing by any health care provider for insured medical services. Visit the BCHC website to send a message to Health Minister George Abbott and insist that health reform is NOT about selling off the public system to for-profit operators and investors.

BC Health Coalition

4th Floor, 411 Dunsmuir Street, Vancouver, BC V6B 1X4 • info@bchealthcoalition.ca • phone: 604.681.7945 • fax: 604.681.7947

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4, 5, 6, 7, 8 All references for this fact sheet can be found at www.bchealthcoalition.ca/BCHC Resources/Fact Sheets/References

May 2008

This Federal Election...

VOTE

Public Health Care

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Public Solutions for Wait Times!

We all know people who have had to wait a long time to see specialists, get tests done or have surgery. In fact, waiting for health care services is the main reason Canadians are concerned about Medicare *(Future of Health Care in Canada, Romanow Commission, 2002)*. In general, wait times are the only reason people would be willing to pay for treatment outside the public health care system.

Why do we have long wait times for surgery?

Our present health care system is not as good as it could be. This leads to 2 main causes of long waits for surgery.

1. **Each doctor keeps separate waitlists for surgeries.** Individual doctors and their office staff work to organize surgery for just their patients, but no one is managing the whole system. This means that the wait lists for surgery aren't organized efficiently. Delays happen at every step. With separate waitlists, it isn't possible to make sure the sickest people are helped first.

2. **There are not enough doctors, nurses and health science professionals, and their services are not coordinated.** In the 1990's the federal government cut back the money it spent on health care and this reduced the number of doctors and nurses. The government is putting back some of the money now, and that will help. But it will not be enough unless surgeons work as a team with nurses and health science professionals. Their services need to be coordinated to make the best use of them.

What are the solutions?

We don't need a whole new system. The federal government can fix wait time problems by improving the system we have now. Canadians could:

- see their doctor or nurse on the same day they make an appointment
- see a medical specialist within one or two weeks
- have tests and surgeries with almost no waiting

(The 2006 Report of the Federal Advisor on Wait Times)

These improvements can be made by organizing health care more efficiently. We need central waitlists for all patients, and we need "one stop-shopping" public surgery clinics.

- **Central Management of Waitlists**

  Wait lists should be organized centrally instead of each doctor having a separate list. When the information on all patients is kept on one list, it will be possible to make sure the sickest people get treated first. Information can be gathered electronically, and it can be available in one place. Another benefit of managing waitlists centrally is there will be good data for planning and funding.

- **Public Surgical Clinics**

  Public Surgical Clinics can bring services together under one roof. People could get tests done and see different specialists without driving around town for many appointments scheduled over several weeks. Patients would have the benefit of care by specialists, and at the same time the overall costs for offices, staff and equipment would be much less.

Supporting positive, public solutions to make Medicare stronger in British Columbia

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Why don't Wait Time "Guarantees" Work?

Since 2006 the federal government has tried to use wait time "guarantees" with the provinces, but these don't work. Guaranteeing that patients will be sent to other provinces or even the U.S. for some surgeries doesn't deal with the causes of waitlists. It's expensive and takes money away from the real solutions – centrally managed waitlists and public surgical clinics. Using money on "guarantees" ignores the causes of waitlists, so wait times get longer. This makes people think that we need health care centers operated for profit, but they will only take money away from public health care and away from solving the problem.

Private For-Profit Problems

We often hear that the problems in the Canadian health care system can be solved by opening up private, profit-making facilities. Some people argue that if people who can afford for-profit health care use it, there will be fewer people waiting for public care, so everyone will get faster treatment.

But private profit making systems don't cut public wait-times. Countries that have tried this have longer waitlists in the public system. In fact, research shows these countries have the longest wait-times.

The reason is that doctors and nurses can't be in two places at once. The more time they spend giving care for profit, the less time they can spend giving care in the public system. This can lead to even longer wait-times for patients using the public system. The few people who can afford to pay privately get faster treatment. The rest of us, who rely on the public system, have to wait even longer.

Public Solutions

We have good examples of solutions within the public health care sector. Local, regional, provincial and federal levels have had successes that could be adopted across the country. New ways of managing wait lists have been tried and special elective surgery clinics have been set up.

In North Vancouver, a "one-stop" joint replacement assessment clinic has been set up. Five surgeons work together to manage referrals and waitlists better. This has reduced wait times to see a specialist from 50 weeks to between two and four weeks!

The Sault Ste. Marie, Ontario breast health centre reduced the time it took to get a breast-cancer diagnosis by 75%. This was done by bringing all the steps together in one place. If a woman has a mammogram which shows she might have cancer, she often has an ultrasound, and sometimes a biopsy as well, on the same day.

For-profit health care has been a proven failure in other countries. We need fully funded, public health care available for everyone in Canada.

We need the federal and provincial governments to solve the problems by improving the system.

Add your voice to the thousands of people in B.C. who reject the for-profit model. Support public health care and the public solutions for waitlist problems. For more information, contact the BC Health Coalition or visit the websites listed below:

www.yourmedicarerights.ca
www.healthcoalition.ca
www.profitisnotthecure.ca
www.canadiandoctorsformedicare.ca

Questions for Candidates

Download from our website and take to your all candidates' meeting.

"Vote for Public Health Care" Buttons & Pens

Call 604-681-7945 to order.

BC Health Coalition

4th Floor, 411 Dunsmuir Street, Vancouver, BC V6B 1X4 • info@bchealthcoalition.ca • phone: 604.681.7945 • fax: 604.681.7947

Supporting positive, public solutions to make Medicare stronger in British Columbia

www.bchealthcoalition.ca

This Federal Election... VOTE Public Health Care

Enforce the Canada Health Act Now!

What is the Canada Health Act?

The *Canada Health Act* is the federal legislation that aims to make sure that people who live in Canada can get health care services no matter what their income is. The Act makes sure that health costs are covered by insurance, so people don't have to worry about paying at the time they need health care. The purpose of the Act is to make sure we have a health system that will *"protect, promote, and restore the physical and mental well-being of residents of Canada." (Canada Health Act)*

What is the role of the federal government ?

The federal Minister of Health is responsible for making sure that the principles and rules of the *Canada Health Act* are followed by the provinces. The federal government transfers money to the provinces for hospital and doctor services that are covered under the Act.

What is the role of the provincial government ?

The health services that are covered by the *Canada Health Act* are insured and administered by the provincial governments. The services are delivered by organizations like regional health authorities, doctor's offices and health clinics. Provinces must report to the federal Minister of Health to show that they are providing health care as they should be under the *Canada Health Act.*

Is Canada's health care system in danger?

The *Canada Health Act* is under threat. The number of clinics that make a profit off people who need health care is growing quickly. More and more resources and doctors' time are going towards serving patients who are willing and able to pay doctors directly. In the mean time, wait lists grow for those on public lists. The federal government is responsible for making the provinces live up to the *Canada Health Act*. It needs to take this responsibility seriously. The federal government has the power to demand that provinces end private health services.

Some politicians argue that it is not a problem if doctors make a profit off people who need health care. They argue that for-profit clinics do not extra-bill or charge user fees. But these are some of the ways that private surgical clinics extra-bill and have user charges:

- they charge a "facility "or "membership" fee
- they make sure patients who pay extra charges get to see specialists ahead of other patients
- they refer patients from their public practice to their own or other doctors' for-profit practices
- they say a medical procedure is "unnecessary", and so must be paid for even if it really is covered by public insurance,

The federal Health Ministry is not living up to its responsibility, the clinics are not telling about their profit-making practices, and patients are not likely to report the doctors who they depend on for health care. The government is ignoring the problem when it should be stepping in to make sure the *Canada Health Act* is followed by the provinces.

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Principles of the Canada Health Act

To get full federal funding under the Canada Health Transfer program, the provinces must meet certain conditions. The *Canada Health Act* makes it clear that the provinces' health care programs must have:

1. Public Administration

Provincial health care insurance plans must be administered and operated on a non-profit basis by a public authority.

2. Comprehensiveness

Provincial health care insurance plans must cover all insured health services provided by a hospital facility, such as acute, rehabilitative, and chronic care.

3. Universality

Insured health services must be provided to everyone in an equal way.

4. Portability

People moving from one province to another must still be insured for health services by their "home" province during any waiting period they have in the new province.

5. Accessibility

No one who is insured in a province should be charged user fees for health services. Health care must be provided without discrimination on the basis of age, race, health or income.

Questions for Candidates

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Our demands:

■ Enforce the Canada Health Act Now

Canadians expect the Government of Canada to take the law seriously. It isn't enough to make laws about health care; the laws need to be enforced. It has been proven that for-profit health services cost more and deliver worse care. They also make health care less available to Canadians who can't pay extra for it. This undermines two basic principles of the *Canada Health Act* - "universality" and "accessibility."

We must demand that the federal government send a clear message to the provinces that the Canada Health Act will be enforced and that non-profit health care is the most efficient, fair and safe way to deliver health care.

■ Expand the Canada Health Act

Many important kinds of health care are not included in the *Canada Health Act.* The federal government must expand public insurance to include medical services such as dental care, home care and home support, physiotherapy, long-term care, and pharmacare in order to make sure all Canadians are able to have important health care services.

Private, for-profit health care has failed in other countries. Don't allow a proven failure like for-profit health care undermine the Canada Health Act. Add your voice to the thousands of British Columbians who reject the for-profit model and support fully funded, public health care for all.

For more information, contact the BCHC or visit the websites listed below:

www.yourmedicarerights.ca
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Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

CANADIAN INDEPENDENT MEDICAL CLINICS ASSOCIATION ET AL.

PLAINTIFFS

AND:

MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA ET AL.

DEFENDANTS

AND

SPECIALIST REFERRAL CLINIC (VANCOUVER) INC.

DEFENDANT BY COUNTERCLAIM

AFFIDAVIT

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