REGIONALIZATION OF HEALTH SERVICES

IN BRITISH COLUMBIA

A British Columbia Medical Association Position Paper
In Response to Government's "New Directions" Initiative

September 17, 1994

BCMA MISSION STATEMENT

The mission of the British Columbia Medical Association is to promote a social, economic, and political climate in which members can provide the citizens of British Columbia with the highest standard of health care while achieving maximum professional satisfaction and fair economic reward.

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1.0 PURPOSE

This policy position paper summarizes the basic concepts of health reform as proposed by the BC government and examines them in light of the BC Royal Commissions on health conducted in 1973 and 1991. The paper responds to these concepts of reform and builds upon them with specific policy directions of the BCMA.

This paper was presented, for information, to the BCMA Board of Directors at the Annual General Meeting, June 1, 1994, in Victoria, BC. It was reviewed and approved for distribution by the BCMA Council on Health Economics and Policy (CHEP), July 8, 1994, and the BCMA Executive, July 22 and August 14, 1994.

It is important to note that the Canadian Medical Association (CMA) is also developing a policy position paper on regionalization as a continuation of its recently released summary of health reform initiatives in Canada and in Europe, The Language of Health System Reform. Although the policy positions contained within these two papers may not be identical, the BCMA has taken into account current CMA research and policy in the development of this position paper.

2.0 INTRODUCTION

In 1991, the BC Royal Commission on Health Care and Costs stated that British Columbia has one of the finest health care systems in the world. This Closer to Home report went on to state that improvements to the system could be made by re-allocating resources to improve efficiency.

Opinion polls and surveys have demonstrated that the Canadian public is very satisfied with the quality of their current health care system and is also, in a general sense, in favour of regionalization. However, the true definition of regionalization, as applied in BC, or its broader implications upon current health services remains an intangible concept with which no one is comfortable.

REGIONALIZATION, as the term is currently being applied in BC, is a catch phrase used to describe the establishment of health care management bodies based on geographic sub-units and the transfer of decision-making power to these bodies. This process involves both

decentralization of authority from the central organization and centralization of authority from local institutions.

Regionalization of health care is progressing throughout North America and Europe, with many jurisdictions significantly further along than BC. Even with a multitude of individual initiatives, a single workable plan for health care reform has not emerged. Many jurisdictions have encountered difficulties with implementing these initiatives, including, burgeoning bureaucracy and costs. As a result, many of these areas have implemented several different regionalized systems over the years in an attempt to address the problems that have emerged. Examples include the health care reforms in Great Britain, New Zealand, Quebec, Saskatchewan and New Brunswick. The one common thread of these individual efforts is the identification of the need for outcomes measurement and impact analyses. Only in this way will it be possible for the benefits of reform initiatives in different jurisdictions to be shared.

Through the "New Directions" regionalization of health care in British Columbia, government proposes to ultimately delegate decision-making authority (including financial) in specific fields of health care delivery to 21 Regional Health Boards (RHBs) along the same geographic lines as the current 21 BC Health Units (refer to Appendix C). These RHBs will be responsible for the provision of services in their own geographic region. The RHBs will have the authority to delegate to local Community Health Councils (CHCs) of varying numbers (initial estimate of approximately 100 CHCs province-wide) within their region, but will remain accountable to Victoria.

3.0 BC GOVERNMENT'S STATED REASONS FOR REGIONALIZATION

Government has provided the following justification for the regionalization of BC's health care system:

#1 BETTER HEALTH - health promotion, prevention of injury and illness

#2 GREATER PUBLIC PARTICIPATION AND RESPONSIBILITY - increased local input into decision-making, greater lay representation on governance bodies

#3 BRINGING HEALTH CLOSER TO HOME - more services in people's homes, local communities, and regions

#4 RESPECTING THE CARE PROVIDER - pay equity, safe working environment, strengthened support for care providers

#5 EFFECTIVE MANAGEMENT OF THE NEW HEALTH SYSTEM - increased emphasis on accountability, evaluation of outcomes, improved co-ordination of health services within regions, to use health care resources more efficiently and effectively

The preceding statements are general philosophies of health with which the BCMA agrees. They are <u>not</u>, however, clearly stated goals that provide a vision for health care reform in this province. In the absence of such clear and concise goals, the ability for "New Directions" and the regionalization of BC's health care system to achieve the hypothesized benefits of these broader principles is questionable.

4.0 NEW DIRECTIONS TIMETABLE

On February 28, 1994, the Minister of Health announced the following timetable for the regionalization of BC's health care system.

JUNE 1994	Finalization of Health Region boundaries (refer to Appendix D for specific outstanding boundary issues)
OCTOBER 1994	Establishment of interim Regional Health Boards (RHBs) (initial estimate of 21 RHBs province-wide to mirror the existing 21 Health Units, refer to Appendix C)
MARCH 1995	Designation of all Community Health Councils (CHCs) (initial estimate of approximately 100 CHCs province-wide)
NOVEMBER 1996	Major health care services managed at the regional or community level; RHBs operating major tertiary facilities

5.0 THE IMPLICATIONS OF REGIONALIZATION

The BCMA has analyzed the implications of regionalized health care governance and funding, both as proposed in BC and as already implemented in other Canadian provinces, several European countries, Australia and New Zealand. For ease of interpretation, the implications of regionalization have been divided into three broad categories:

QUALITY OF CARE
SYSTEM COSTS
PLANNING

These broad categories are further divided into tangible constructs which have been examined in terms of their current status, the impact of "New Directions", and the appropriateness of such a change and/or if a different direction would be more appropriate.

5.1 QUALITY OF CARE

5.1.1 Defining Health

The World Health Organization (WHO) defines health very broadly as the physical, mental, emotional, and spiritual well-being of the individual. While such a broad definition of health may be appropriate for individuals to strive towards, it is inappropriate to apply such a broad definition as the basis of a publicly funded health care system. Medicare was first introduced in Canada in 1967 to ensure that no Canadian suffered undue financial hardship from either a hospital stay or a required

physician service. Furthermore, the *Canada Health Act* was enacted in 1984 to ensure that public coverage was provided for all "medically necessary" health services, defined very specifically within the Act as essentially in-patient hospital services and services provided by physicians. These national initiatives have resulted in a very comprehensive and effective publicly funded health care system in Canada. However, neither the introduction of Medicare nor the *Canada Health Act* envisioned a publicly funded health care system that would address the multiplicity of health and social issues contemplated by the WHO definition of health.

To the contrary, the BC government's "New Directions" for health care reform specifically identifies the WHO definition of health as the definition upon which reforms shall be based. This "everything for everyone" approach is a potentially costly departure from the earlier, successful models of publicly funded health care in Canada. Professional and public support for such a shift in emphasis for Canada's excellent health care system is questionable. Public opinion polls would suggest that the populace places a much higher priority on traditional health care services.

BCMA Position Statement:

The definition of health care circumscribing reform initiatives in this province is beyond the capacity and expectation of a publicly funded health care program. This definition must be refocussed to ensure a sustainable, publicly funded health care system in BC.

5.1.2 Defining Core Services

The BCMA believes that defining core services and standards is an essential undertaking, especially with the current pressures on limited resources for health care expenditures. Explicit delineation of those services that will be provided through the public program is essential.

BCMA Position Statement:

Core services and standards development is an important subject as it embodies assurance to the public that essential health services will be maintained.

The BCMA has reviewed the Ministry of Health's document, Planning for Core Services and Standards in BC, An Interim Document, November 1993. This document explains that, "core services refer to general categories of health services" and while, "the standards for core services will provide objectives and outcomes for each general category...they will not mandate the type or level of specific services." According to this document, Community Health Councils (CHCs) and Regional Health Boards (RHBs) will be given the latitude to organize the delivery of core services including, "the flexibility to replace existing programs with new and innovative initiatives," without clear provisions for meaningful input from physicians and other health care professionals in these local decisions. In reality, the specific services provided by each region within this broad provincial core services definition may be significantly altered, seriously affecting the health care infrastructure, at significant cost, without the support

of evidence.

Clearly, this is not an acceptable approach to determining publicly sponsored programs. The public must not be given a false sense of security that the new regionally controlled health care system will continue to provide services of the same quantity and quality that it currently does. This concern is shared by the BC Health Association which responded to the Ministry by saying, "... the BCHA feels the definition of standards must be very specific and is concerned that there could otherwise be scope for potential abrogation of responsibility from regions to the province and from communities to the regions." (The BCHA response to the Ministry's core services document appears in its entirety as Appendix F). The BCMA believes that the priority should be to ensure that resources will not be shifted away from current care programs without objective, evidence-based outcome measures demonstrating the benefits of doing so.

BCMA Position Statement:

The Ministry of Health's current definition of core health services is nonspecific and inadequate. Any attempt to regionalize BC's health care system prior to a more thorough definition of core health services is inappropriate and could result in serious discrepancies in the health services available from region to region.

The government's current approach to defining core services blurs the distinction between core "medical" services and core "health" services. A proper core medical services definition should specifically prioritize medical services on the basis of the known course of the disease and the benefits of intervention. One attempt at defining core medical services has recently been accomplished in Oregon. Core health services, on the other hand, must further examine other health services, beyond strictly medical services, and determine priorities for these services through evidence-based outcomes.

Moreover, the current protocol for core services development has consisted of limited consultation with specific groups and, consequently, does <u>not</u> reflect the sentiments of the medical profession nor the general public. The Report of the Royal Commission on Health Care and Costs (1991) cautioned that this approach tends to be unduly influenced by special interest groups and must be balanced with additional input from both the general public and health care professionals.

The current assumption that acute care services are exclusively associated with in-patient hospital stays is a glaring omission of the many diverse patient services provided in doctors offices throughout the province. Such a narrow view of acute care services raises strong concerns that the current approach to development of core service standards may inappropriately reduce patient access to physician services in BC.

BCMA Position Statement:

Input from physicians and other health care professionals is critical in the development of core health services to ensure that acute care services are maintained at acceptable

levels and changes to existing programs are instituted on evidence-based evaluation of the costs and benefits.

The BCMA requests more formal participation in the drafting of core health services and standards for BC.

The BCMA and government must work cooperatively towards defining core medical services for the province.

5.1.3 Meeting Patient Needs

Fundamental to our quality health care system is the practitioner's ability to act as patient advocate. Implicit within this belief is the concept of patient/provider choice. When a patient develops a medical problem, s/he does not care about population health status. S/he needs a caring, understanding professional who can effectively manage the situation, explaining the illness and treatment options, while providing the technical skill and expertise required to deliver the required treatment or to arrange assistance from appropriate specialists and/or other health professionals.

The role of physicians includes diagnosis and treatment, health promotion and disease prevention, rehabilitation and palliative care, counselling and ongoing support with family, advocacy and participation in community intervention where needed. Primary Medical Care consists of a first contact assessment of a patient followed by the provision of continuing care for a wide range of health concerns. It is best provided by physicians who are educated in comprehensive care, who are able to coordinate care in a cost-effective manner and collaborate with consultant medical specialists and other health care providers when appropriate to the best interests of the patient. Physicians are best qualified by training, skills and experience to be the patient's first contact with the health care system (see Appendix H, "Role of the General Practitioner in BC Health Care").

BCMA Position Statement:

The BCMA believes that it is fundamental to a quality health care system that patients continue to have the freedom to receive treatment from the practitioner of their choice.

General Practitioners and Family Physicians should be recognized as a point of entry to the health care system and coordinators of patient care addressing the continuum of care.

The cost-effectiveness of primary care by physicians and other providers should be studied objectively and thoroughly before province-wide changes are made to the present delivery system.

5.1.4 Preventive Care

On a daily basis, the doctors of BC work to improve "wellness". Through patient encounters, physicians communicate the importance of accident prevention, stress reduction, exercise, and diet as they relate to a healthy body and mind. On a provincial scale, the BCMA has initiated numerous public awareness campaigns, including: mandatory use of seat belts, bicycle helmet promotion, alcohol and pregnancy campaign, and the BC Stop Smoking Project. The BCMA Council on Health Promotion has existed since 1957.

Prevention includes not only health promotion, but also includes activities to reduce exacerbations and complications of illness. The distinction between these activities is defined by primary and secondary prevention. Primary prevention consists of activities to decrease the incidence or occurrence of an illness or injury. Secondary prevention consists of activities to prevent exacerbations or complications of illness and injury. Many health care organizations already recognize the importance of secondary prevention and the resulting, measurable cost savings. Unfortunately, regardless of the growing prevention orientation, people still become ill and will continue to do so. Illness is not simply the result of socioeconomic status, environmental factors or controllable risks.

BCMA Position Statement:

The physicians of BC continue to be committed to working towards illness prevention and patient education, to help people avoid problems prior to illness, reduce exacerbations and avoid complications.

Regionalization must not result in the erosion of acute care services in BC because, in spite of the growing wellness orientation, people will continue to become ill and require acute care services.

5.1.5 Medical Input

As is stated in the CMA's global review of regionalization, The Language of Health System Reform, "whatever the objectives, if regionalization strategies are to be effective, there must be an early and ongoing buy-in and support of the principal health care stakeholders". If health care reform is going to be a success in BC, health care providers must be integrally involved in the regionalization process. Consequently, the BCMA continues to strongly support its members' activities at the local planning level. To date, however, the reform process has discriminated against active physician and general public participation. Too often, planning and steering committee meetings are held during the daytime, offering little or no opportunity for practising fee-for-service physicians or working individuals to attend. Consequently, planning decisions are disproportionately influenced by the non-medical community and hinder input from the general public.

BCMA Position Statement:

Local steering committee and planning meetings should be arranged in the evenings or on weekends to enable appropriate provider and public attendance.

5.1.6 Provincial Licensing, Regulatory Requirements, and Standards

Government serves an important role by ensuring practitioners meet necessary licensing and regulatory requirements to protect and safeguard the public during times of illness when they are most vulnerable. Health care professionals and the quality of medical care provision in this province are effectively managed by province-wide licensing and regulatory requirements. These province-wide standards are essential to maintain. In addition, the regionalization process should recognize the existence and jurisdiction of existing provincial licensing bodies. It is unnecessary to establish new regional mechanisms for handling these activities.

BCMA Position Statement:

The role of existing provincial licensing bodies related to the delivery of health care should not be duplicated at the regional level.

Standards of care and patterns of practice, which recognize discretionary variations, must be established at a provincial level in accordance with national goals. The quality of services in each region of the province must be, at minimum, equal to the recognized provincial standards.

5.1.7 Province-Wide Evaluation

Since the early 1970s, the BCMA has proposed the establishment of an objective, arm's length "Provincial Health Council" to provide an annual report card on health in BC. The function of this Council should be to evaluate the effectiveness of health care programs utilizing evaluation mechanisms that are at arms length from government.

BCMA Position Statement:

An independent Provincial Health Council should be established to objectively analyze the health status of BC and provide a yearly "report card".

5.2 SYSTEM COSTS

5.2.1 Funding

The BC government will spend approximately $6.4 billion on health care in this province in 1994/95. Funding for health care services comes from a variety of sources including premiums for health care, general taxation, federal government transfers, local taxation for capital expenditures, lottery funds, and voluntary donations. In addition, individuals contribute through direct payments for the use of some services such as physiotherapy, purchase of prescription medications, etc. This funding is allocated to a multitude of organizations and institutions throughout the province to provide health care services and cover administrative costs. Currently, there is a lack of coordination of

these funding mechanisms.

Regional funding has been proposed to improve this coordination through the provision of funds to regional authorities who are then delegated the decision-making authority for allocating funds for specific services. Regional funding can be applied either globally, for all programs and services delivered in the region, or selectively, where funds are provided to the regional authority to allocate to a specific spectrum of health care programs.

In contrast to the hypothesized benefits of regional funding, the regionalization experience in Europe has repeatedly demonstrated that regional authorities are more susceptible to pressure from individual lobby groups than is a central administration, limiting the regional authority's ability to make objective allocation decisions. It has also been shown that where local authorities are responsible for the provision of services, the resources provided to them are frequently insufficient to meet the needs of their region. Consequently, the transfer of responsibility for funding of health care services to local bodies has been closely followed by requests for transfer of taxation authority in these jurisdictions. Although current BC legislation does not allow for regional health taxation, in government's recently released "CHC Proposed Operating Principles: Regulations, Bylaws, Policies", it is stated in principle (43b), *"...the Minister may direct the Council to collect provincial revenue on behalf of the Province, under such terms and conditions as specified by the Minister."* Regional taxation authority too easily becomes a slippery slope whereby provincially elected officials can divest themselves of responsibility for local health care programming.

The BCMA believes that global regional funding would result in unequal levels of care between regions. As previously stated, there is a very real risk that taxation authority would be requested by regional authorities to meet their service needs. This would widen the gap between regions, with better care provided in wealthier regions and requests for subsidization to fill needs in lower income areas.

BCMA Position Statement:

The BCMA does not support global regional funding.

The BCMA supports specific service regional funding provided government addresses important outstanding issues including: clearly defining the spectrum of programs and services to be funded regionally, development of a comprehensive regional funding formula, clearly defining the source of funding and taxation authority where it applies or could apply in the future.

Evidence-based pilot projects which demonstrate the effectiveness of the proposed regional funding system are essential.

It is the experience of the BCMA that many "New Directions" initiatives are being supported without objective, evidence-based outcome measures that prove their benefit. For example, government recently approved the allocation of $42M to the "Closer to Home Fund". These funds have been divided amongst the 21 proposed regions on a population-based formula to support community-based health care initiatives. This

funding protocol contradicts one of government's primary reasons for regionalization, "that there be increased emphasis on accountability and evaluation of outcomes" (refer to p.2).

The BCMA believes that funding for new program initiatives should be allocated on the basis of merit and in amounts commensurate with the proposed initiative, much like it is for health research grants. No funding should be approved until a clear process for outcome measurement is defined.

BCMA Position Statement:

Funding for "New Directions" program initiatives must be based upon merit. No funding should be provided until an evidence-based, objective process for outcome measurement is defined.

A uniform application and screening process for health care programming, open to public scrutiny, must be established.

The acute care system in BC has been pushed to the limit by current budget cuts. The province has already seen bed reductions beyond the Royal Commission's projected requirement of 2.75 acute care beds per 1,000 population by 1996. BC's current bed ratios are significantly lower than the majority of Canadian provinces. Any further reductions to the acute care system will place the health of the BC population in jeopardy.

BCMA Position Statement:

No further reductions in funding to hospital services should occur in BC until alternative services are in place and proven effective through evidence-based pilot projects.

5.2.2 Accountability

The recently enacted Freedom of Information and Protection of Privacy Act (1993), was introduced to foster an environment of full disclosure as to the rationale and costs of government activities. Adhering to the spirit of this Act, the costs of the province's health care system and the New Directions initiative must be open to professional and public scrutiny.

BCMA Position Statement:

Detailed accounting of the costs of new and existing health care programs, provincially and regionally, must be made available to the public on a current quarter basis.

5.2.3 Information Systems

In many European countries with decentralized health care systems, local levels

of governance complain they do not have the information necessary to efficiently conduct effective planning exercises. Detailed and current information is critical to the success of any regionalization effort. BC currently does not have adequate information systems in place to support New Directions initiatives. These systems must be operational prior to regionalization. This will require additional resources and the costs for this should not be taken from patient services.

BCMA Position Statement:

It is imperative that appropriate systems for data collection and evaluation be established prior to regionalization.

5.2.4 Physician Remuneration

Currently, BC physicians are remunerated through various payment mechanisms including fee-for-service, salary, sessional reimbursement, and capitation. The BCMA has always supported a plurality of payment systems, each tailored to the needs of the individual's practice setting and lifestyle choices.

BCMA Position Statement:

The BCMA supports a plurality of payment systems each tailored to the needs of the population and the environment of the individual practice setting. Physicians must be free to choose the mode of remuneration they feel most appropriate based upon their individual practice setting and lifestyle choices.

Fee-for-service (FFS) physician remuneration has become a favourite target of politicians and health care economists as the primary cause of spiralling health care costs. In truth, however, numerous research studies have concluded that the method of physician remuneration is only one of numerous factors affecting practice behaviour and health care expenditures. In addition to mode of reimbursement, other major determinants of practice include: continuing education, physician gender, provider attitude, certification status, knowledge of risk factors, as well as socio-demographic and organizational factors.[vvvvv]

With specific reference to Health Maintenance Organizations (HMOs), evidence from the United States fails to substantiate the claim that this form of health services delivery leads to reduced costs. While HMO members demonstrate some reduction in utilization rates, such as hospital days per enrollee, these favourable results are at least partially attributable to the age-sex mix of the enrolled population. That is, by selection of members with favourable age, sex and/or welfare status, HMOs have memberships with lower than average health care needs. Studies have consistently shown that pre-enrolment utilization rates of HMO enrollees are lower than those of non-HMO enrollees. Consequently, higher need individuals tend to remain in the FFS system, while those whose expected costs are less than the capitated rate become enrolled in alternative delivery systems.

To its credit, the present FFS system in BC promotes a high degree of patient satisfaction. Patients receive high quality, comprehensive care and patients are free to select the physician of their choice and, at any time, may change their selection or seek a second clinical opinion. A shift to care provided by salaried physicians working for CHCs would eliminate these advantages and could result in patient dissatisfaction as the patient's choice of practitioner becomes limited to the salaried employees at a particular CHC. Studies of patients in capitated versus FFS settings tend to show that patients of capitated physicians are less happy with doctor-patient communication and perceive their physician to be less interested in them. Similarly, a survey of American HMOs and Ontario HSOs (Health Service Organizations) found that patients have a relatively low level of satisfaction with the care provided by these organizations. It is important to note that Ontario has recently retreated on its flat rates for HSO physicians because this reimbursement mechanism has proven to be too expensive.

A final issue to be evaluated is whether fee-for-service medicine ensures appropriate care incentives. In terms of incentives to over-service, data collected from several OECD countries indicates that FFS is no more conducive to overconsumption than is a capitation system. This research concludes that the level of consumption is influenced more by whether or not care is provided free of charge to the patient and not by the method of physician remuneration.

Consequently, it is the BCMA's conclusion that fee-for-service allows physicians to appropriately serve patients with <u>all</u> levels of medical needs. Like no other payment scheme FFS allows practitioners to place the needs of the patient above "organizational loyalty" and the stress on cost containment.

BCMA Position Statement:

The BCMA believes that fee-for-service is an efficient and effective form of reimbursement for physicians in a publicly funded health care system which enhances the quality of patient care.

5.3 PLANNING

5.3.1 Objectives

The CMA, in <u>The Language of Health System Reform</u>, identified that an important common thread of successful health care reform is, "first and foremost, the development and implementation of regionalization strategies that begin with a clear statement of objectives."

The BC government has not yet provided clear objectives or a strategic plan for health care reform to the Association's satisfaction. The Ministry of Health's stated reasons for regionalization (refer to p.2) are general philosophies and not concise reform objectives. The New Directions initiative, and its hypothesized benefits, have not been open to meaningful public discussion and debate prior to implementation.

BCMA Position Statement:

Clear objectives for the regionalization of BC's health care system must be provided and must be open to professional and public scrutiny.

5.3.2 Bureaucracy/Administration

The BCMA believes it is inappropriate to redirect scarce health care dollars from patient services to administration. There is a great deal of evidence from Europe and Australia that regionalizing health care services greatly increases the size of the health care bureaucracy. *In times of increasingly scarce health care dollars, such an outcome is entirely inappropriate.*

Adding two more levels of administration to health care delivery in BC, (RHBs and CHCs) will undoubtedly increase the costs of health care. A significant portion of the difference in health care spending between the USA and Canada today is directly due to the much lower costs of health care administration in this country. In 1985, the costs of prepayment and administration in the US were 0.59% of the GNP and in Canada 0.11%, a difference which represents in excess of $200 million annually in BC. The addition of two layers of bureaucracy in each region, together with hiring the administrative expertise which each region will require, may well offset any potential cost savings in health service delivery.

In addition, the potential exists for a lack of appropriate administrative skills and expertise at the local level. This will ultimately compromise the quality and efficiency of the health care system. In Sweden, for example, the lack of qualified personnel at the county level has adversely affected the negotiation process between payers and providers. As the region's range of responsibility broadens, so too do the resources required to enable these units to exercise their authority.

BCMA Position Statement:

The BCMA believes that implementing two levels of regional governance, RHBs and CHCs, is unnecessary and will inappropriately increase the health care bureaucracy.

If regionalization is to be pursued, the number of regional governing bodies should be kept to a minimum.

5.3.3 Regional Governance

The 1991 BC Royal Commission recommended that the Ministry of Health decentralize control for area specific health services planning and resource allocation. The Commission's rationale for recommending this decentralized control for health care included: better response to local needs, improving efficiencies, and reducing or eliminating redundancies.

The BCMA agrees with the Commission that our health care system can become more responsive to better meet the needs of the BC population rather than prescriptive based upon professional perception of need. It is important for local concerns to be better identified and prioritized.

BCMA Position Statement:

The BCMA believes that regional input, in an advisory capacity, has the potential to enhance local involvement and improve health services planning and delivery. Regional input should include the following:

- *setting local health care priorities;*
- *evaluating the need for services within the region;*
- *identifying service gaps and proposing programs to address them;*
- *input into human resources and construction planning;*
- *developing links with other regions for the provision of highly specialized services;*
- *developing community-based programs, and;*
- *acting as a liaison between persons in the health region and the central bureaucracy.*

One of the first tasks that should be undertaken by regional health care bodies is the detailed discovery of services provided within their region with the purpose of identifying methods to improve efficiencies and reduce redundancies.

As previously stated, the BCMA model for health care governance would include regional input <u>in an advisory capacity</u>, however, it is obvious that government's current goal is to institute regional health care governance. Consequently, the BCMA is obligated to comment on some specific issues related to regional health care governance.

The model of decentralized control as envisioned by the BC Royal Commission is <u>not</u> what the BCMA sees developing through the New Directions initiative in BC. The BC government currently proposes two levels of regional governance, RHBs and CHCs, neither with clearly defined roles. In fact, BC is the only Canadian province that has proposed the development of two additional decision-making structures. Other provinces have proposed only one regional governance structure, both for simplicity sake and perceived effectiveness. Saskatchewan, for example, has established 30 District Health Boards while New Brunswick now has eight Regional Hospital Corporations. Meanwhile, BC has proposed 21 RHBs along with approximately 100 CHCs for a province with a population not larger than that of Greater Toronto, Greater Montreal or many American cities. New Zealand, a country with a population roughly equivalent to that of BC, initially attempted regionalization of health care with the establishment of 14 Area Health Boards (AHBs). In July 1993, these 14 AHBs were abolished because of their ineffectiveness and replaced with just 4 Regional Health Authorities (RHAs), each serving a population ranging in size from approximately 650,000 to 1,100,000. Experience has shown that too many levels of governance are counterproductive and extremely costly. The BCMA is concerned that the two regional governance structures, as currently proposed, will be cumbersome, slow to react, and

very costly. Adequate local input can be obtained through proper administrative and committee structures reporting to a single regional authority.

BCMA Position Statement:

The BCMA believes there is no need for two levels of regional health care governance in BC. The Association believes that the CHC level of regional governance should not be pursued.

The BCMA shares the viewpoint of the Union of BC Municipalities that the Minister of Health's October 1994 deadline for establishing RHBs is unrealistic and potentially extremely detrimental to the health of British Columbians.

BCMA Position Statement:

The Minister of Health should reconsider the artificial deadline of October 1994 to have RHBs functioning province-wide.

Regional health care governance will decentralize functions currently performed by the Ministry of Health. Regional governance will also centralize functions currently performed by various institutions and service delivery organizations. This may include the amalgamation or dissolution of existing boards. The resulting centralization of functions within the regions will impact greatly on the various institutions and agencies. Many of these organizations have volunteer boards and extensive networks of individuals who have committed immeasurable hours of time and have developed considerable expertise with respect to the delivery of health care in their region. This proposed shift in governance will disempower many of these individuals.

Greater public participation in and responsibility for health care provision, including enhanced public representation on local governance bodies, is one of this government's primary reasons for regionalizing BC's health care system (refer to p.2). To the contrary, government currently proposes composing the regional governing boards through a system of appointments and elections where as few as one-third of the members will be directly elected.

Considering the importance of health care and the costs involved, it is imperative that authority remain in the hands of individuals that are directly accountable to the public. If regional governance structures are established with the intention of transferring authority to them, these structures should embody the democratic principles of accountability through direct election. Appointments should be kept to a minimum and only to meet specific, clearly identified needs. If government feels compelled to establish local governing boards prior to an election through a process of appointments, it must be clear from the outset that these appointments are for a short, defined period of time. Any more extensive system of appointments will be open to abuse and diminishes the rights of the public to expect direct accountability.

BCMA Position Statement:

If regional governing bodies are eventually implemented, they must embody democratic

principles of accountability through direct election with a minimum of appointments to meet specific, clearly identified needs.

The BCMA believes that physicians should be voting members of local health boards. The Association does not support the BC government's current interpretation of the "Conflict of Interest Guidelines" which prohibits physician membership on these bodies. Our government's view is not shared by their provincial counterparts in Saskatchewan where physicians have been nominated by government as voting members to 3 District Health Boards. Currently in BC, physicians sit as voting members of several hospital boards and as non-voting, ex officio members of numerous other institutional boards.

Conflict of interest guidelines must be clearly spelled out as they are for other elected officials. It is not appropriate to assume that individuals are in a conflict of interest simply based on their profession. All residents of BC should be equally eligible for appointment or election to their local health board.

BCMA Position Statement:

Conflict of interest guidelines must be clearly delineated and ensure that all BC residents are equally eligible to be elected or appointed to regional governing bodies.

Quality and effective governance requires the establishment of proper advisory structures. Boards of local governing bodies, charged with the authority for health care decisions, must have the benefit of recommendations and input from health professionals. These advisory structures must be adequate to meet provincial and federal regulatory requirements for practitioners and such that the local governing boards can clearly distinguish the medical recommendations placed before them. Additional advisory structures are also necessary to address other aspects of patient care and service delivery.

BCMA Position Statement:

There must be a regulatory requirement for Medical Advisory Committees (MACs) to all local governing bodies, composed of physicians elected or appointed by physicians in the community/region. The head of each MAC should have a direct presence on the local health board as a voting member.

The Medical Advisory Committee would also have the mandate of ensuring that the process of credentialling physicians for hospital privileges is not jeopardized by changes in health care governance. Province-wide standards must be ensured.

In addition, local governing bodies will require a medical director as part of their regional administration. The medical director's duties should include day to day monitoring of medical issues, concerns and needs; monitoring of the implementation of decisions made by the regional authority; liaison with the MAC and other advisory committees.

BCMA Position Statement:

Each region must have a medical director as part of its regional administration.

Adhering to the Ministry of Health's current regionalization agenda (refer to p. 3), RHBs are to be functioning province-wide by October 1994. This timeline calls into question the role of existing hospital boards following this deadline. One of the primary responsibilities of these boards is the process of credentialling physicians for hospital privileges. This process must not be jeopardized through the potential transition from facility authorities to regional authorities.

BCMA Position Statement:

Currently existing health care governance structures must not be dismantled prior to regional pilot projects being established and thoroughly examined as to their impact.

The BCMA must be integrally involved in the development of a standardized credentialling process for hospital privileges.

The BCMA should be directly involved with government in the development of regulations, bylaws and advisory structures for regional governance.

5.3.4 Governance of Province-Wide Services

Regional governance is likely to function most effectively in those jurisdictions which have health care facilities and resources which are accessed predominantly by local residents. However, the BCMA is concerned that regional governance is inappropriate for facilities or programs which have a broad-based, provincial mandate. For example, we cannot support a structure which has a Vancouver-based board responsible for provincial programs such as the Cancer Control Agency and many of the tertiary care programs of St. Paul's Hospital, Vancouver Hospital and BC Children's Hospital.

An alternate governance structure with a provincial mandate is essential to ensure that these facilities maintain a focus which extends beyond the boundaries of the Vancouver region and equitably serves all the citizens of British Columbia.

BCMA Position Statement:

The BCMA believes that a provincially focussed governance structure is required for health care programs and facilities which have a provincial mandate.

5.3.5 Defining Regional Boundaries

As the regionalization experience in Europe demonstrates, regional boundaries must reflect the natural, sociopolitical, and geographic divisions of the population, including current health care utilization patterns. *The government of BC has proposed establishing regional boundaries in keeping with the existing 21 Health Units (refer to Appendix C) even though these boundaries do not fit traditional utilization patterns and patient flow. For example, Heath Unit #8, Central Fraser Valley, is bisected by the Fraser River with no bridge to cross. Obviously, patient flow is significantly different*

on either side of the river.

Failure to ensure that boundaries reflect the natural and traditional health care activities of the population will introduce complexities in management and resource allocation. While inappropriate boundaries may not prevent individuals from receiving health care, they may result in those individuals not having adequate input into the decision-making of their health care system. Appendix D of this document details the many, as yet unaddressed, boundary issues resulting from the proposed use of Health Unit boundaries for the new Health Regions.

BCMA Position Statement:

Government must ensure that regional boundaries and administrative structures are appropriately delineated, recognizing the natural geography and traditional patient flow and referral patterns. There must be local public input into determination of boundaries.

Boundaries for health, education and social services should be coterminous wherever possible.

5.3.6 Pilot Projects

The BCMA agrees with government that the potential for regional health care governance to break down existing institutional and professional barriers warrants further examination. To date, however, few regionalization strategies throughout the world have been formally evaluated. Such evaluation is imperative to determine if they actually achieve the hypothesized benefits. It is disappointing that little effort has been made in BC to openly examine the cost-benefit and outcomes of projects previously undertaken, such as the Victoria Health Project. Consequently, there is little or no empirical evidence to support this shift to regional governance and service delivery, especially in times of extreme fiscal constraint.

Effective pilot projects will include: a defined timeframe, an indication at the outset as to objective outcome measures, and clearly drawn conclusions at the end of the pilot project period regarding abandoning the project, extending the project duration, or implementing the project on a broader scale as a result of successful preliminary outcomes.

BCMA Position Statement:

The BCMA is committed to participating in and assisting the Ministry of Health in establishing pilot projects to evaluate health service delivery. Prior to province-wide implementation, these pilot projects must proceed through formal, evidence-based evaluation.

6.0 THE ESSENTIAL UNDERPINNINGS FOR SUCCESS

If the process of regionalization is to be successful and truly invest the public with relevant input into the health care they receive, on an equitable basis, the following conditions must be met:

(i) Establish adequate communications between the regions and the central authority as well as between regions and provide each with all necessary information;

(ii) Build in adequate, evidence-based evaluation mechanisms for all programs (existing and new), in particular when introducing new programs involving alternate methods of health care delivery and\or payment of health care providers;

(iii) Ensure that new programs do not duplicate existing ones in whole or in part;

(iv) Regionalization must not be at the expense of acute care services and the ability to provide effective investigation and treatment, when needed, to those suffering from illness and injury, and;

(v) Make available to all involved, including the public, complete information on the set-up and continuing costs and outcomes of existing and new programs, including the costs of hiring consultants and facilitators to bring about change.

The BCMA embraces a vision towards a better balance between prevention, community-oriented and institutional services. An effective and efficient health care system requires a wide range of services to meet the varying needs of the population.

7.0 BCMA RESPONSE TO NEW DIRECTIONS

The BCMA believes there are significant benefits to enhancing public input into the health care system. Improved local input will help to break down existing institutional barriers and enhance the power base of the consumers of health care. To date, however, health care reform in BC has been clouded by catch-phrases. The government of BC has outlined a program for "New Directions" in health care based upon general philosophies of health which the BCMA does not dispute. However, government has yet to provide specific **objectives** for improving a health care system that is already among the best in the world.

The BCMA <u>cannot</u> endorse the New Directions initiative until government addresses the following issues to the Association's and the public's satisfaction:

Government must provide clear, concise objectives for regionalizing BC's health care system, open to professional and public scrutiny;

The definition of health adopted by New Directions is too broad for the public purse. This definition must be refocussed to ensure a sustainable, publicly funded health care

system for this province;

Current government definitions of core health and medical services and standards need considerable refining which must include direct input from the medical profession;

Government must develop a comprehensive regional funding formula, open to professional and public scrutiny;

The Minister of Health must remove the October 1994 deadline for establishment of RHBs province-wide;

Government should concentrate on developing one level of regional governance and abandon the CHC model;

Government must resolve all outstanding boundary issues before proceeding with the proposed transformation from the 21 Health Units to RHBs (refer to Appendix D for details);

Conflict of interest guidelines must be clearly delineated and ensure that all BC residents are equally eligible to be elected or appointed to regional governing bodies;

The direct accountability of regional governing bodies must be improved by reducing the percentage of appointments to RHBs;

Government must ensure that this shift to regional governance does not result in an increase in the size of the current health care bureaucracy;

Key provincial resources, such as the BCMA, and local resources, such as practising physicians and other health care professionals, must be better utilized in regionalization planning initiatives;

There must be a legislative requirement for Medical Advisory Committees (MACs) to all RHBs, comprised of locally elected physicians. The Chair of the MAC must have a voting presence on the RHB, and;

Government must commit to regional pilot projects which will proceed through objective, evidence-based outcome assessment prior to province-wide implementation of a regional model.

8.0 SPECIFIC POSITION STATEMENTS

Defining Health

BCMA Position Statement:

The definition of health care circumscribing reform initiatives in this province is beyond the

capacity and expectation of a publicly funded health care program. This definition must be refocussed to ensure a sustainable, publicly funded health care system in BC.

Defining Core Services

BCMA Position Statement:

Core services and standards development is an important subject as it embodies assurance to the public that essential health services will be maintained.

The Ministry of Health's current definition of core health services is nonspecific and inadequate. Any attempt to regionalize BC's health care system prior to a more thorough definition of core health services is inappropriate and could result in serious discrepancies in the health services available from region to region.

Input from physicians and other health care professionals is critical in the development of core health services to ensure that acute care services are maintained at acceptable levels and changes to existing programs are instituted on evidence-based evaluation of the costs and benefits.

The BCMA requests more formal participation in the drafting of core health services and standards for BC.

The BCMA and government must work cooperatively towards defining core medical services for the province.

Meeting Patient Needs

BCMA Position Statement:

The BCMA believes that it is fundamental to a quality health care system that patients continue to have the freedom to receive treatment from the practitioner of their choice.

General Practitioners and Family Physicians should be recognized as a point of entry to the health care system and coordinators of patient care addressing the continuum of care.

The cost-effectiveness of primary care by physicians and other providers should be studied objectively and thoroughly before province-wide changes are made to the present delivery system.

Preventive Care

BCMA Position Statement:

The physicians of BC continue to be committed to working towards illness prevention and patient education, to help people avoid problems prior to illness, reduce exacerbations and avoid complications.

Regionalization must not result in the erosion of acute care services in BC because, in spite of the growing wellness orientation, people will continue to become ill and require acute care

services.

Medical Input

BCMA Position Statement:

Local steering committee and planning meetings should be arranged in the evenings or on weekends to enable appropriate provider and public attendance.

Provincial Licensing, Regulatory Requirements, and Standards

BCMA Position Statement:

The role of existing provincial licensing bodies related to the delivery of health care should not be duplicated at the regional level.

Standards of care and patterns of practice, which recognize discretionary variations, must be established at a provincial level in accordance with national goals. The quality of services in each region of the province must be, at minimum, equal to the recognized provincial standards.

Province-Wide Evaluation

An independent Provincial Health Council should be established to objectively analyze the health status of BC and provide a yearly "report card".

Funding

BCMA Position Statement:

The BCMA does not support global regional funding.

The BCMA supports specific service regional funding provided government addresses important outstanding issues including: clearly defining the spectrum of programs and services to be funded regionally, development of a comprehensive regional funding formula, clearly defining the source of funding and taxation authority where it applies or could apply in the future.

Evidence-based pilot projects which demonstrate the effectiveness of the proposed regional funding system are essential.

Funding for "New Directions" program initiatives must be based upon merit. No funding should be provided until an evidence-based, objective process for outcome measurement is defined.

A uniform application and screening process for health care programming, open to public scrutiny, must be established.

No further reductions in funding to hospital services should occur in BC until alternative services are proven effective and in place through evidence-based pilot projects.

Accountability

BCMA Position Statement:

Detailed accounting of the costs of new and existing health care programs, provincially and regionally, must be made available to the public on a current quarter basis.

Information Systems

BCMA Position Statement:

It is imperative that appropriate systems for data collection and evaluation be established prior to regionalization.

Physician Remuneration

BCMA Position Statement:

The BCMA supports a plurality of payment systems each tailored to the needs of the population and the environment of the individual practice setting. Physicians must be free to choose the mode of remuneration they feel most appropriate based upon their individual practice setting and lifestyle choices.

The BCMA believes that fee-for-service is an efficient and effective form of reimbursement for physicians in a publicly funded health care system which enhances the quality of patient care.

Objectives

BCMA Position Statement:

Clear objectives for the regionalization of BC's health care system must be provided and must be open to professional and public scrutiny.

Bureaucracy/Administration

BCMA Position Statement:

The BCMA believes that implementing two levels of regional governance, RHBs and CHCs, is unnecessary and will inappropriately increase the health care bureaucracy.

If regionalization is to be pursued, the number of regional governing bodies should be kept to a minimum.

Regional Governance

BCMA Position Statement:

The BCMA believes that regional input, in an advisory capacity, has the potential to enhance local involvement and improve health services planning and delivery. Regional input should include the following:

- •setting local health care priorities;
- •evaluating the need for services within the region;
- •identifying service gaps and proposing programs to address them;
- •input into human resources and construction planning;
- •developing links with other regions for the provision of highly specialized services;
- •developing community-based programs, and;
- •acting as a liaison between persons in the health region and the central bureaucracy.

One of the first tasks that should be undertaken by regional health care bodies is the detailed discovery of services provided within their region with the purpose of identifying methods to improve efficiencies and reduce redundancies.

The BCMA believes there is no need for two levels of regional health care governance in BC. The Association believes that the CHC level of regional governance should not be pursued.

The Minister of Health should reconsider the artificial deadline of October 1994 to have RHBs functioning province-wide.

If regional governing bodies are eventually implemented, they must embody democratic principles of accountability through direct election with a minimum of appointments to meet specific, clearly identified needs.

Conflict of interest guidelines must be clearly delineated and ensure that all BC residents are equally eligible to be elected or appointed to regional governing bodies.

There must be a regulatory requirement for Medical Advisory Committees (MACs) to all local governing bodies, composed of physicians elected or appointed by physicians in the community/region. The head of each MAC should have a direct presence on the local health board as a voting member.

Each region must have a medical director as part of its regional administration.

Currently existing health care governance structures must not be dismantled prior to regional pilot projects being established and thoroughly examined as to their impact.

The BCMA must be integrally involved in the development of a standardized credentialling process for hospital privileges.

The BCMA should be directly involved with government in the development of regulations, bylaws and advisory structures for regional governance.

Governance of Province-Wide Services

The BCMA believes that a provincially focussed governance structure is required for health care programs and facilities which have a provincial mandate.

Defining Regional Boundaries

BCMA Position Statement:

Government must ensure that regional boundaries and administrative structures are appropriately delineated, recognizing the natural geography and traditional patient flow and referral patterns. There must be local public input into determination of boundaries.

Boundaries for health, education and social services should be coterminous wherever possible.

Pilot Projects

BCMA Position Statement:

The BCMA is committed to participating in and assisting the Ministry of Health in establishing pilot projects to evaluate health service delivery. Prior to province-wide implementation, these pilot projects must proceed through formal, evidence-based evaluation.

ENDNOTES