

Policy Options for Progressive Health Care Reform in BC

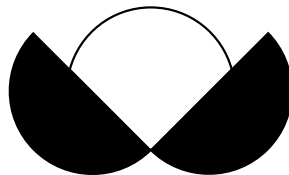
Proceedings of a CCPA–BC Workshop on the Future of Health Care

Edited by Marc Lee and Seth Klein

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Canadian Centre for Policy Alternatives—BC Office

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PREFACE

In June of 1999, the CCPA held an invitational workshop on the future of health care, with a look towards progressive health care reform. Participants in the workshop represented a diverse range of communities, both inside and outside the health care system. They offered different perspectives on the existing system, and the type of reforms that would be beneficial.

In recent years, the CCPA has published a number of pieces on health care financing and privatization, including Colleen Fuller's book *Caring for Profit*, on the intrusion of transnational corporations into the health care system, and more recently, Monica Townson's *Health and Wealth: How Social and Economic Factors Affect our Well-Being*. The BC office has published on health care spending by the provinces. And recent Alternative Federal Budgets have focused on increased spending for health, unemployment, poverty, and measures to stem the privatization of home and community care.

We recognize, however, that we need to do more research and publishing on health care issues. We need to move beyond the issue of dollars, and tackle more substantive issues about the kind of care we are delivering, where we are delivering it, who is delivering it, and how we can really make a difference to the health of the population.

Too often, progressive groups are forced onto the defensive in these neo-conservative times. Amid numerous cutbacks, we get trapped, understandably, defending the status quo, even though our ideal may well

be something quite different. But it is not enough to simply defend the Canada Health Act and its principles. We need to think about how to bring the CHA into the 21st century, outside the walls of hospitals and doctors' offices, and about issues such as how we remunerate doctors.

The ideas outlined in the short papers that follow will captivate and excite all who are interested and concerned about the future of our health care system. We felt that the information contained in those presentations was of high value to policy makers and the general public alike, as a collection of perspectives on the future of health care.

The presenters were:

- Seth Klein, Canadian Centre for Policy Alternatives
- Marcy Cohen, Hospital Employees' Union
- Margaret McGregor, University of British Columbia
- Sheila Roswell, Hospital Employees' Union
- Joan Meister
- Cathy Ferguson, BC Nurses Union
- Colleen Fuller, Independent Researcher
- Pam Bush, Health Sciences Association
- Ian Scott, Canadian Health Coalition
- Robert Reid, University of British Columbia
- Clyde Hertzman, University of British Columbia

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.

INTRODUCTION

Ten Vital Measures for Health Care Reform

Seth Klein

Canadians are hearing mixed messages. They know the health care system is under stress. The provinces say the feds must pay more. The federal government says the provinces need to discuss health care reform. Who is right? They all are. We need more funding and substantial reform. The following recommendations for saving public health care summarize the key directions suggested in the workshop, bolstered by ideas from CCPA publications on health care.

1) Increase health care funding.

Perhaps stating the obvious: this is required from both federal and provincial governments. While it is true that more money alone will not fix our health care system, lack of funding guarantees a deepening crisis. The federal government needs to fully restore and enhance health funding transfers to the provinces. This should take the form of a specific and targeted health transfer (separate from other social and educational transfers), so that the provinces cannot redirect these funds for other purposes.

BC is in a better situation than most other provinces. It is the only province that continued to increase spending through the 1990s. However, these increases have not kept pace with the combination of population growth and inflation (hence the increased stress on the system). In particular, BC needs more nurses (we have fewer nurses per capita than all provinces but Ontario). As the health care system is deprived of funds across the country, care is increasingly falling to family and friends (particularly women),

and people are paying more out-of-pocket.

2) Keep the health care system public. Stop the slow growth in private delivery.

There is now clear and indisputable evidence, from Canada and internationally, that public health care delivery is more efficient, as well as more equitable, than private delivery. Private delivery of publicly-funded health care means vital health dollars are lost to the profits investors demand (as much as 15%), higher executive salaries, higher marketing/advertising costs, and lost economies of scale. That means fewer public dollars going into direct services, and thus longer waiting lists.

Alberta's move towards private over-night hospitals must be stopped. If it is allowed to proceed, the terms of the North American Free Trade Agreement may make it impossible to ever bring these services back into the public sector. We need public institutions accountable to citizens, not shareholders, capable of integrating and coordinating our health care needs.

3) Bring in a Community and Home Care Act (CHCA).

As health care delivery moves increasingly into the community and people's homes (which is, by and large, a good thing), it is escaping the Canada Health Act, and that means privatization trouble (see point 2). The Canada Health Act only applies within the walls of our hospitals and doctors offices. BC should lead

the way in bringing forward a CHCA, which would bring the principles of the Canada Health Act into force in community and home care, and ensure continued public delivery and universal accessibility.

4) Build new public long-term care facilities.

There is a clear shortage, and that shortage is increasing quickly (about 7,000 seniors are currently waiting for one of BC's 24,707 publicly-funded long-term care beds). Without adequate investment in new facilities, long-term care patients will increasingly take up acute care hospital beds and our emergency rooms, in turn, will remain clogged.

These facilities should be built directly by provincial governments, not contracted to the private sector. Private long-term care facilities hamper regional and provincial coordination. Private facilities have higher administration costs, poorer pay and training, lower standards, and higher borrowing costs (public building means access to lower financing costs).

5) Move away from paying doctors primarily on a fee-for-service basis.

This is critical for controlling costs, as doctors working on a fee-for-service basis have an incentive to see too many patients for an inadequate period of time, too frequently, and to order unnecessary procedures. (This is particularly true in BC, which spends a larger share of its health care budget on doctors than any other province.) Doctors on salary can take the time needed for each patient, and do not face the same incentive to "over-doctor". Every major federal and provincial inquiry into our health care system and its financing has identified fee-for-service as a major barrier to improving medicare's efficiency. This is not to say there is no place for fee-for-service. It may make sense for some services (births, for example) to be remunerated on a fee basis (we need to compensate

people for getting out of bed in the middle of the night). The point here is to get the right mix. And contrary to popular perception, many doctors would prefer being on salary (better income security and enhanced personal lives).

6) Move towards multidisciplinary, community-based, primary health care centres.

Our health care system needs teams of professionals working together (on salary) serving their local communities (Vancouver's Reach Community Health Centre on Commercial Drive is a good model). Such centres can provide total care to a given population, and the centre's team can focus on the task of providing ongoing care, without worrying about their personal incomes. Many health care problems do not require the ongoing services of a doctor; they can be looked after by other (less highly-paid) professionals (nurses, physiotherapists, psychologists, counselors, nutritionists, etc.).

We need to encourage everyone to establish long-term relationships with a family doctor/general practitioner, ideally based out of community centres (such as Quebec's CLSCs). We need people's first line of contact to be local health centres or general practitioners (GPs), not expensive emergency rooms or "doc-in-a-box" clinics that do not provide ongoing primary/family care. There is strong research showing that jurisdictions with multidisciplinary primary health care teams have healthier populations and lower costs. Professionals working with teams can also spell each other off and live more reasonable personal lives.

7) Bring in a public National Drug Plan and control drug costs.

Drug costs are escalating more than any other component of the health care system, increasing health costs borne by individuals, employers, and the public

system. This requires repealing federal drug patent legislation (even if it means fighting off a WTO/NAFTA challenge). BC's referenced-based pricing is a good model. If prescription drugs (clearly a medical necessity) are bought under public health care for everyone (not just seniors), governments will find the will to lower drug costs.

8) Provide adequate resources for the Provincial Mental Health Plan.

De-institutionalization has left too many mental health patients out in the cold. These patients still need adequate housing, incomes and support, and the ongoing care of mental health practitioners. The Provincial Mental Health Plan talks about integrating acute and community mental health services, to create a continuum of care. That takes money.

9) Give health care workers and patients a greater say within the health care system.

Working in the health care system is stressful, and too often, encountering it as a patient is even worse. Less hierarchical workplaces would be a good start. There is a growing literature indicating front-line workers with more autonomy and support functioning in more democratic workplaces experience decreased injury rates, take less sick-leave, and deliver better

patient care. We need reform, and both workers and the public will be more willing to go along for the ride if they are included in the policy-making and governance process.

10) Last, but certainly not least: Tackle the determinants of health and adopt a comprehensive anti-poverty strategy.

The research on the determinants of health is clear. The empirical evidence connecting poverty and inequality with poorer population health and increased health costs is unequivocal. That means rethinking tax cuts for those who need it least, and budget cuts for the programs low-income people depend on. If our governments declare war on poverty, child poverty, homelessness, and unemployment, health care costs will come down. More supportive non-profit housing for poor seniors and people with physical and mental disabilities is the most pressing need.

Tied to this recommendation, we need to put more money into prevention and wellness, not just illness. That means tackling the causes of cancer and heart disease, not just the acute emergencies. It means dealing with environmental and food safety issues. It means better working conditions, and fostering healthier lifestyles.

Bringing The Canada Health Act Into The Twenty-First Century

Marcy Cohen

This presentation provides an overview of BC's health care reform agenda over the past 10 years—where we are now, and how we might influence that agenda for the future. It is based largely on a discussion paper, *Blended Care*, that was endorsed by three of the major health care unions in BC: Hospital Employees' Union, BC Nurses' Union, and BC Government and Service Employees Union.

Blended Care presents a vision and strategy for progressive health care reform that builds on the combined knowledge and experience of our front-line care givers and the research and policy work of Dr. Michael Rachlis. Michael co-authored two popular books on community health (*The Second Opinion* and *Strong Medicine*) and is a fierce advocate for primary care reform. Many of our members work in institutional settings like hospitals and long-term care facilities. The main ideas for *Blended Care* emerged in the dialogue between our front-line care givers and Michael Rachlis on the troubled relationship between institutional and community care, and the need for more innovative approaches to health service delivery.

There are four points I would like to raise to set the context for today's discussion. The first is an explanation of why and how it is that the health care unions in BC have the capacity and freedom to go beyond the more common defensive stance of unions and to propose a strategy for progressive change and innovation in health service delivery contained in the *Blended Care* paper.

The reasons are relatively straight-forward and fundamental. They relate to the framework for bargaining in health care established when the NDP first came to power in the early 1990s. The employment security agreement, first negotiated in 1993, protects

unionized health care workers from layoffs due to downsizing or restructuring, and gives them a limited say in the employer's restructuring plans. This agreement created the obligation for the unions to do more than simply resist the changes proposed by government and implemented by management. It created an obligation for health care unions to support the broader goals of health care reform and to engage in discussions with management on the merits of a particular strategy for change. This obligation was further extended with the decision by the provincial government in 1996 to include a representative of the health care unions on each of the newly created Regional Health Boards and Community Health Councils.

The other aspect of the negotiations process, supported by Victoria, has been a commitment to raise the wages and working conditions of community health care workers to the level already in place for health care workers employed in hospitals and long-term care facilities. Although this goal has not as yet been fully achieved, steps in this direction make it easier for our members to support the integration of services between the hospital and community, and the potential reallocation of staff from hospital to community.

This is in stark contrast to the situation in Ontario, where the growth of community health care services has been based almost entirely on a private sector low-wage model, and as a consequence, has been opposed by unionized workers in the hospital and long-term care sector.

The second point I want to raise also relates to NDP policy—the commitment of the NDP to maintain, and even increase, the level of health care spending, despite reductions in federal transfer payments—and the public's view of that policy. It is

difficult to reconcile the NDP's commitment to funding health care with the fact that people in BC, like elsewhere across Canada, have less confidence in our health care system, and are experiencing more problems in caring for themselves and their families.

One gets a sense of this decline in confidence in polls conducted by McIntyre and Mustel Research Associates Ltd. for HEU in early 1994 and 1998. The percentage of British Columbians who considered the quality of health care in BC as "excellent" or "good" declined from 57% to 36%.

In order to understand why it is that British Columbians have less faith in our health care system, despite the NDP commitment to maintain health care spending, it is useful to compare health care expenditures in Alberta, Ontario and BC overtime.

Tables 1, 2 and 3 show that, in comparison to Alberta and Ontario, BC has invested considerably more of government revenues in health care, in terms of the percentage increase in health care expenditures over time, health care expenditures as a percentage of GDP, and the proportion of health expenditures in the public versus private sector.

However, as Table 4 indicates, in terms of constant per capita spending (i.e. factoring in population increases and inflation), BC did not do so well either over time or in relation to the other provinces. When the NDP came to power, spending in health in BC was less than in Alberta and Ontario, and from 1992 to 1996 BC's population grew more quickly than either Alberta's or Ontario's.

Moreover, if you look at how the

increases were applied in BC since 1992, physicians and drug companies received a disproportionately high percentage of the increase, and hospitals a disproportionately low percentage of the increase. And although funding for community services increased substantially over that period, expenditures on community health services are still relatively small (i.e. less than one-fifth of total spending). Moreover, new expenditures

Table 1: Percentage Change in Public Health Care Expenditures, Ontario, Alberta and BC, 1992-98

	Ontario	Alberta	BC
1992-96	-0.4	-5.9	19.3
1997-98	5.5	8.6	6.8
1992-98	5.1	2.7	26.1

Note: Calculations based on current dollar estimates
Source: Canadian Institute for Health Information

Table 2: Total Health Expenditures as a Percent of GDP, 1998

Ontario	Alberta	BC
8.7	7.0	10.4

Note: Calculations based on current dollar estimates
Source: Canadian Institute for Health Information

Table 3: Public Expenditures as a Proportion of Total Health Care Expenditures, Ontario, Alberta and BC, 1992-98

	Ontario	Alberta	BC
1992	72.7	75.5	73.7
1998	66.9	69.4	73.0
Change, 1992-98	-5.8	-6.1	-0.7

Note: Calculations based on current dollar estimates
Source: Canadian Institute for Health Information

Table 4: Per Capita Health Care Expenditures, Ontario, Alberta and BC, 1992-96

	Ontario		Alberta		BC	
	Expenditures	Percent Change	Expenditures	Percent Change	Expenditures	Percent Change
1992	\$1,509		\$1,527		\$1,376	
1993	\$1,447	-4.1	\$1,454	-4.8	\$1,383	0.5
1994	\$1,486	2.7	\$1,347	-7.4	\$1,326	-4.1
1995	\$1,484	-0.2	\$1,279	-5.0	\$1,301	-1.9
1996	\$1,515	2.1	\$1,321	3.3	\$1,308	0.6
1992-96		0.5		-13.9		-4.9

Note: Numbers are in constant 1986 dollars
Source: Canadian Institute for Health Information

Table 5: Public Sector Expenditures by Use of Funds, 1992-98

	Hospitals	Other Institutions	Physicians	Other Professionals	Drugs	Capital	Other Health Spending (ie Community Care)
1992-98 percent change	16.0	25.0	35.4	25.5	40.4	-21.5	56.0
Percent of total budget 1998	36.2	13.2	22.6	2.5	5.6	2.0	18.0

Note: Numbers are in current dollars
Source: Canadian Institute for Health Information

on buildings, equipment and technology actually declined by 21%.

While these figures do not tell the whole story, they do give a sense of the ongoing financial pressures in the system: the disproportionate growth in spending on physician care and pharmaceuticals; the tug-of-war between acute and community care for scarce resources; and, the total absence of public dollars to fund new equipment and buildings.

This brings me to my third point, and that is the need for governments to be more innovative—to find new more effective ways of delivering care and supporting people. Simply adding more and more money

without changing the system makes less and less sense. And yet innovations in the public sector are very difficult in the context of changes that have occurred in the broader economy over the last fifteen to twenty years. With the massive shift in power, in Canada as elsewhere in the world, away from governments and in favour of large transnational corporations, there has been a growing acceptance by governments and large segments of the population that only the private sector has the capacity to innovate.

This creates a huge problem for us in Canada, because Medicare, our best loved social program, is not comprehensive or well suited to meet today's health

care problems. Medicare, as defined in the Canada Health Act (CHA), covers physicians' services and hospitals. It does not cover community services, long-term care, home care, medical equipment, pharmaceuticals, and eye glasses. And so while it is effective in handling acute, episodic and crisis interventions, it is less effective in responding to chronic conditions (i.e. heart disease, asthma, diabetes, etc.) that over the last forty years have become increasingly significant as a percentage of total health care expenditures.

A bit of history here is useful. The origins of Medicare date back to the 1940s and 1950s when acute injuries and infectious disease were the most significant health problems, and a family could be bankrupted by a significant hospitalization. It made sense in that context that the first priority was hospital insurance and then physician care. It makes less sense today when the problems are primarily chronic, and when more and more care is provided in the community.

In this regard it is interesting to note that Tommy Douglas did envision a second stage of Medicare when health service would be available, without charge, through multi-disciplinary teams working in community health clinics with doctors paid on salary. This was derailed primarily because of opposition of the medical profession and insurance companies.

Forty years later, it is more important than ever to move to a second stage of Medicare reform, in order to support innovations in care delivery for people with chronic ailments that cut across the current divide between community and hospital care. A strong endorsement of this position came from the National Forum on Health—a blue ribbon panel of highly respected business and community leaders from across the country—set up by the Prime Minister in 1991. They recommended modernizing Medicare and extending it to include home care and pharmaceuticals.

To date these changes have not been introduced.

If anything, the over-riding emphasis on cost containment in the 1990s has resulted in an increase, rather than a decrease, in the crisis orientation of the system—and Medicare coverage has become more, rather than less restrictive.

This brings me to my fourth point: despite some backward momentum, there is still some reason for optimism. Medicare is our best loved social program—a key part of our identity as Canadians.

International comparisons show that our tax-based single payer Medicare system is less costly than either the social insurance system found in many European countries or the privately-financed US system. In recent years, Canadian employers have benefited directly from the low costs of Medicare—employer health benefits premiums in Canada have not skyrocketed as they have in the US, where private insurers dominate the market.

As a result, even our corporate business leaders recognize the “competitive” advantages created by Medicare. As Charles Baillie, Chairman and Chief Executive Officer of the Toronto Dominion Bank stated in a presentation to the Vancouver Board of Trade the Spring of 1999: “It’s high time that we in the private sector went on the record to make the case that Canada’s health care system is an economic asset, not a burden, one that today, more than ever, our country dare not lose.”

Medicare is the one area of social policy where there is still significant support from the business community and where, as a consequence, increased funding for new government programs and innovative initiatives should be possible.

After Eight Years Of Health Reform: Taking Stock Of Where We Are Today

Health care reform in BC dates back to the Royal Commission on Health Care and Costs report, *Closer*

to Home (commonly known as the Seaton Commission), in 1991. The key recommendations from that report set the framework for health care reform in BC. In reviewing these recommendations, it is very interesting to note what has and what has not been achieved in the ensuing decade.

The most notable change has been the creation of new governance structures in health care. The proposal of the Seaton Commission—to establish regional and local structures to encompass the full range of health care services from hospitals to community care—has been achieved in every area of the province outside of Vancouver (in Vancouver the major hospitals still have their own boards and governing structure). In addition, some progress has been made in reducing the number of both employer and union bargaining agents, and in increasing the participation of health care unions in decision-making and human resource planning.

However, implementation of the recommendations related to changes in the actual delivery of care have been less successful. Little progress has been made in developing non fee-for-service delivery models for primary care, such as community health centres where physicians are paid on salary or by capitation (i.e. by population), and other health care practitioners and the community have a voice in decision-making.

Support of the Seaton Commission for community health centres and alternate methods of payment for physicians reflect the findings of numerous studies on perverse incentives in the fee-for-service system. Fee-for-service payments reward physicians for multiple, discreet and episodic interventions. The research suggests community health centres have been more successful than fee-for-service physician practices in providing ongoing preventative care and monitoring and support for specific populations with chronic ailments.¹

Opposition from physicians' organizations (such as the BC Medical Association) has hampered progress in moving away from a fee-for-service environment in primary care. This is as true today as it was at the beginning of Medicare, although today there is certainly more interest in alternative payment and delivery models, particularly among younger women physicians.²

A second area where the implementation of the Seaton Commission has been less than successful relates to the idea of moving services "closer to home." The goal was to shift services from the hospital to the community, and fund new community services out of savings in hospital care. While acute care has been significantly downsized (the number of acute care days per 1000 population has declined by 40 percent from 1991 to 1997), the anticipated savings have not materialized (because of population increases, increased use of expensive technology and expensive drugs, and the higher acuity of the patients who are in hospital).³ As a consequence, new community services could not be financed out of savings from acute care.

Moreover, because community and home care services are not covered under the Canada Health Act, universal access to these services is not guaranteed. With the pressure on health care budgets over the last several years, the provincial government and health authorities have restricted access to home support, home nursing and physiotherapy programs (by limiting the number of hours and scope of services covered under these programs), instituted larger and larger user fees (i.e. for long-term care and pharmacare) and denied coverage for particular services (i.e. some medical equipment, drugs and supplies that are available if you need them in the hospital are not covered when you go home).

As a consequence there are less rather than more resources available for preventive care and early

interventions. As an example, many regions have eliminated funding for people at home who require only personal supports (i.e. assistance with cooking and laundry). This policy change makes it much more difficult for many, particularly poor and single elderly women, to remain in their own homes. It also makes it harder for health professionals to monitor this population and avoid more expensive and serious crisis interventions later on.

While there has, in the last decade, been some increase in funding for community health services, it has been woefully inadequate. There is no new funding for building long-term facilities, little care is available in the community on a 24-hour basis and few services integrate home nursing, home care and physician care. As a result, there is an increased dependence on informal care givers and private care providers.

The overall effect then of the “closer to home” approach is to increase differential access to needed health resources for lower and higher income earners. This trend will likely accelerate in the future unless there is a Community and Home Care Act, similar to the Canada Health Act, to cover services in the community and at home.

Looking To The Future

The paper *Blended Care* is an attempt by the unions in BC to influence the discussion about the next stages of health care reform in a more progressive direction. *Blended Care* represents a cultural critique of the current health care system and its division into two organizational solitudes: acute care and community care. It builds on the best features of both; that means bringing 24-hour care and universal coverage from the hospitals to the community, and the more democratic, holistic and multidisciplinary approaches of the community to the hospital. It includes examples of innovative services where these features already exist,

challenges hospitals to rethink their role in the health care system, and urges the provincial government and health authorities to lobby Ottawa for a new Community and Home Care Act.

There are three specific points from the *Blended Care* paper I will explore very briefly that suggest what a framework for a progressive agenda for health care reform might look like. The first is the importance of the broader determinants of health. These ideas have had considerable influence on the thinking of people working at all levels of the health system. They have resulted in an increased awareness that changes in the health care system alone will not improve the health status of the population, and that increases in health care expenditures at the expense of other social programs, such as affordable housing and welfare, are counterproductive.

A related point is the importance of focusing on broader social and work determinants of health within the health care sector itself. There is considerable literature to show that when front-line care givers do not have sufficient autonomy and support at work, it not only effects their health and well-being (in terms of both increased injury rates and illness) but the outcomes for patients.⁴ Hospitals are notoriously autocratic. The research evidence is clear: less hierarchical, more democratic forms of decision-making, and more support for front-line care givers in hospitals, will not only reduce injury and illness costs for individual workers and for the health care system as a whole, it will improve the quality of care that patients receive.

The second point is the importance of posing positive alternatives to the idea that innovations in health care—whether it is developing a new automated patient information system, building a new long-term care facility, or developing a care plan for people with a chronic ailment—can only be accomplished through

public/private partnerships. In each of the above cases, it is possible to show how “social partnerships” that link communities, health care services, governments, and academic policy institutes could represent less expensive and more effective alternatives than public/private partnerships.

The fourth and last point is the value of developing new approaches to chronic care management that cut across the divide between the hospital and community, and are delivered by skilled personnel working in

multi-disciplinary teams. There are mountains of research evidence to show that these approaches can significantly improve health status and constrain costs. They require a new incentive structure, however: one that favours integrated, multi-disciplinary care, as opposed to physician-led, primary care.

These points suggest some of the directions that would be useful in moving health care reform in a more progressive direction. I hope that they are helpful additions to our discussions.

HEALTH CARE REFORM AND REGIONALIZATION FROM DIFFERENT PERSPECTIVES

A Doctor’s Perspective

Margaret McGregor

Regionalization was proposed in 1991 by the BC Royal Commission’s document *Closer To Home*, as a vehicle for integration of services through the delegation of power to a regional level. It is interesting to note that the section devoted to decentralization in this document represented no more than one page of a 200 page report. And yet it has been this section perhaps more than any other that to date has been taken up, with huge effort given to devolving power to the regions.

There are now 11 Regional Health Boards in urban areas and 34 Community Health Councils overseeing the budgets of hospitals, continuing care (that is, home-based care to the frail, elderly and disabled)

and preventive programs (such as immunizations).

Despite the fact that these structures are appointed, there is a recognition of the need for representation from health care unions, labour and community constituencies. So for the first time, people such as Sheila Roswell (from the HEU) and Jim Sinclair (from the UFAWU and the BC Federation of Labour) can have direct input into health policy issues facing our region. In spite of criticisms that population advisory committees and other forums set up for grassroots input are tokenism, the general direction of these changes in governance, I believe, is positive.

However, the establishment of community health centres—which was supposed to be the “bread and

butter” of the governance changes—has moved at a snail’s pace. In the Vancouver-Richmond area, one physician and another half-time physician have been recruited to one community health centre in the Kerrisdale area. At this site, a number of services are co-housed, but the level of multi-disciplinary collaboration is relatively primitive. That physician has to contract out much of her on-call duties (to an outfit called Physicians Replacement Services), meaning that continuity of care on a 24-hour basis is often not available. I am told that negotiations for the formation of the Mount Pleasant Community Health Centre are underway, but the evolution of CHCs remains slow, and little effort has been made to nurture or develop the existing community health centres.

Another huge weakness of the regionalization effort is the fact that physician payment and pharmaceutical remuneration continues to reside outside regional control, thereby limiting the ability of this devolved system to develop truly integrated services. This is a crucial issue that must be solved if we are to get anywhere with health reform.

The walk-in clinic phenomenon continues to flourish. These represent the fast-food equivalent of medical care, and they are killing GPs who try to provide more comprehensive care. The user can access these clinics, some of which are US-owned, on a first-come first-serve basis, usually for quick, discrete problems. The walk-in clinic physician can bill MSP for a regular office visit. The result is that patients will often save up their list of complicated problems for their usual GP, putting an increased burden on the community family physicians to manage complex issues with no resultant fee adjustment. As long as these clinics continue to exist, capitated models of spending will be difficult to implement. They clearly fulfill a need, which is provision of urgent care after hours, but it

should be the CHCs, with salaried providers, physicians and nurses, who take on this role.

As patients are being discharged earlier, there is also an increased burden on community physicians to provide care. This is often done poorly, because the fee-for-service system allows the community GP to see multiple ambulatory patients in the hour that it would take her to do a house call. Due to the same type of financial disincentive to do hospital work, community GPs are giving this type of work up, making provision of care even more fractured.

The Vancouver Richmond Health Board prefaces most of its statement of principles with an acknowledgment that social determinants play a key role in our communities’ health. In spite of this, we continue to witness increased funding to reduce waitlists for bypass surgeries, while budget cuts of \$72.9 million are made to the Ministry for Children and Families, the jobs of Youth and Family workers for high risk children in the schools system are being deleted, and early intervention services for children with neurological or developmental delay are cut by 1.5%. Ironically, it appears these latter cuts were because this area now has the misfortune of falling under the Ministry of Children and Families, whereas it used to fall under the Ministry of Health.

The problems of children and youth remain underserved, and services that do exist are poorly co-ordinated in comparison to the other end of the age spectrum. Until a child at risk is seen as a far greater “medical” emergency than an individual with heart disease, we will continue to pour resources into the wrong end of the wellness continuum.

Our boards have a role to play in popularizing this concept. The level of inter-ministerial, inter-sectoral cooperation required to truly put determinants on the agenda of decision-making is a long way off.

A Health Board/Union Perspective

Sheila Roswell

I thought I would start this section of this morning's panel by reviewing health workers' and unions' hopes and fears when the BC government introduced regional governance and responsibilities in 1994/95.

Hopes:

- Unions would have a window of opportunity for greater participation and real influence over current delivery methods and planning for new models;
- Our members hoped that this locally-based community approach and new people in power would mean better quality, more responsive, respectful care for those in their communities and for themselves as workers. There could be less hierarchy and day-to-day oppression—especially of workers near the “bottom of the hierarchy”.

This is true not just in hospitals, but in extended and long-term care facilities where employers have run small fiefdoms for years.

Fears:

- Regionalization would mean a way to cut budgets and off-load provincial responsibility;
- It would mean opening doors to private companies and large corporations anxious to make profits in health care services;
- It would erode equality and access, and increase fragmentation of services between the 52 different regional areas (in 1997, the government revised the configuration to 11 regional health boards, 34 community health councils and 7 community health service societies);

- We would no longer have the certainty of those four walls of our particular facility around us—now there would be regional seniority, posting and bumping;
- This greater rate of change would mean a larger number of us workers would get displaced, face demoralizing increases in workload and injury, and lose even more control over our work day.

After two years of regionalized governance, real progressive health care change seems to be just in the beginning stages. The forces of inertia in health care are very powerful indeed, whatever the sector. I feel a certain urgency and need for labour and progressive people to push as hard as we can now, because we may not have this window of opportunity for much longer.

With regional governance, the CEOs and managers have been reshuffling from hospital to CHC, or have been traveling from one region to another—but very few have changed their approach.

It would be so amazing to run into CEOs and managers who would not just listen to union and workers' ideas and strategies, but actually tell us that yes, even those of us who are dietary workers, care aides, and clerical workers are experts in health care too, and that yes, we will work with you to enact some of your ideas. This is way beyond the “consultation” language that many health workers are now so jaded about.

Is it possible in a capitalist workplace culture? Well, we are still pushing for it, using all the smarts we have as unions and workers. For HEU, there have been some victories: stopping the “public-private partnership” idea for a new residential care facility in Nelson; bringing contracted out work back into public

hospitals; derailing large central food production/stores projects; using well-rounded nursing care teams; taking on places like VGH where they bulldoze ahead with a \$60 million plus patient care information system and re-engineering approaches that are doomed to fail.

Personally, I have been able to plot with co-workers to see some little victories, but lately, I feel like I am on a very large merchant ship in the Vancouver harbour. We are still burning ourselves out to keep everything running. The flag symbolizing who owns the boat has changed—but it is just another flag of convenience. There may be a new captain and navigator but we never see them, so it is not too clear. Worse, they seem to be going down a dead end channel, maybe into the rocks. And that lighthouse that used to be personned by the Ministry of Health—well, it is throwing out random beams of light all over the place, and it is scheduled for closure.

Those of you who followed the 1998 large table bargaining in health care would know that the union had several main issues:

- Workload and intensity of work. There are several causes: shorter lengths of stay, increased acuity, more serious and chronically ill patients in acute care; increase in acuity, demential sorts of diseases in residential care; and, lack of adequate services to address the needs of people with mental illness.
- Expansion of public delivery in all existing and new models of health care. Most threatened are existing food services, purchasing, stores, labs, and direct care—long-term care facilities, supported housing, or congregate care, rehab, home care/support.
- Outrageously high rate of injury and level of disease among health care workers. Health

care has the highest rate of injury—most of it musculoskeletal—in any BC industry. BC’s health/social service sector has the second highest rate of days lost to sickness and injury of all the provinces.

While the new collective agreements made significant gains to address each of these areas, it is still too early for most workers to see concrete results. And these issues are still very big challenges for us.

But then once you head East, you realize that we are in a unique situation in BC.

Here we have provincial standardized collective agreements and main table bargaining. The acute/residential care sector was joined this year by standard agreements in the community health and community social service sectors. For nurses and paramedical professionals, there is one standard collective agreement no matter what kind of facility or community service you work in.

For support workers, the dividing line in collective agreements and mobility between “facility” and “community” remains a very large block—both for workers and for health care reform as a whole.

Second, we did not have to go through months of jurisdictional run-off votes, division and draining of resources as the unions did in other provinces when regional governance was enacted. Here, there are a few glitches, but overall the health care unions are able to work together on our vision and strategy for positive reform.

And third, all workers in health care have at least 12 months of employment security and adequately funded labour adjustment programs, such as matching displaced members to comparable jobs, training/upgrading programs, early retirement, etc.

These three things have enabled BC health care unions to be less defensive and reactive. They give us the ability and room to move beyond analyzing and

criticizing trends. We have some room and time to develop our vision of where public medicare and health care delivery systems should be in 10 to 20 years. The paper described by Marcy Cohen earlier comes out of that window of opportunity. Having the same terms and working conditions no matter where in health care you work, having employment security, having language to prevent privatization, seek worker input, prevent injuries—all of these are not just about protecting workers and maintaining quality services. They are about enabling workers—health care experts in many fields—to participate in and change our system for the better. They must remain in place in BC.

So where could we steer that ship? What are the things we need?

1. National and/or provincial Home and Community Care Acts that provide a free, universal, accessible, portable, comprehensive, publicly-delivered range of services that sit outside a hospital or doctor's office (examples include residential care, rehabilitation, home care and home support, medical equipment and supplies). In publicly funded residential care the government provides an average of \$60/day per person. The individual or family spends from \$25.50 to \$50 per day. A person in totally private supported housing will spend from \$100 to \$200 per day. It is poorer people who stay longer in hospitals, take up many of the "ALC" beds. Having a Home and Community Care Act to provide the same financial access as the Canada Health Act does would help this situation.

2. A national Pharmacare program

3. Publicly-funded and operated (or non-profit operated), affordable, supported housing and congregate care attached to long-term care facilities to provide a continuum of support and care as we age. We have to convince this government to drop their existing policy of only building new residential care through

"public/private partnerships".

4. Well-staffed convalescent units or transition/sub-acute units with a range of nursing care and therapy services to fill the gap between hospital and home, more resources, and a broad team of staff to provide home care/home support, including basic cleaning and homemaking services. Women are quickly burning themselves out trying to deal with convalescing or chronically ill family members.

5. Our version of Community Health Centres

6. Federal and provincial resources and projects to address the determinants of health. BC must stop the short-sighted cuts to funds and policies which undermine environmental protection. All levels of government must stop waging a war on the poor, stop ignoring drug and alcohol treatment, and stop criminalizing people who are forced to live on the margins.

7. Adequate resources to see many of the good ideas in the recent Provincial Mental Health Plan put into place.

8. Secure, full time, full year jobs with good wages and benefits.

9. Resources and creative approaches to improve childhood development.

10. Recognition that control in one's work life is a legitimate and proven health care determinant. HEU is now working on an exciting project to gain collective control, and work to combat workplace stress. (Workplace control and workload have been found to be directly linked to injury rate at a major Vancouver hospital.)

11. A change in the dominant hierarchical structure in hospitals and long-term care homes—not just to a flattened program management model where clinical staff are expected to treat patients and make all the management decisions in the same number of hours and for the same pay. But a radical change that treats workers in health care at every level as thinking

people who have real improvements to suggest and ideas to implement dollars more wisely.

12. Creative ways to talk about the “health care crisis” in the public system and to spark interest in our progressive suggestions and ways to spend health care dollars more wisely.

I have not touched on the fact that every CHC and RHB now must have a labour rep (as well as physician rep) on it. The struggles that union reps face—marginalization, conflict of interest arguments, as well as the inherent contradictions found when one is a worker’s rep who is now, for a time, on the “other side”—this is another presentation in itself. Being on these boards is, however, another way that unions are having some influence and realizing some small victories in health care reform.

A Personal Perspective

Joan Meister

I am not a health care reform expert, so I am going to tell you a story—the story of my recent, personal experience with health care in BC. Over the past 15 months, I have been up close and personal with the health care system in BC, and it was a very scary place to go. I use a wheelchair because I have multiple sclerosis, and last year my energy level required that I switch from a manual chair to a power chair. That was when things started getting scary.

The problem was simple really. I had this brand new \$7,000 toy that I did not know how to get in and out of. And I did not know how to access that information. I did see the people at the seating clinic at GF Strong, and I spoke to the physio at the health unit. Either I was not communicating my needs well enough or they were not understanding me. In hindsight, I do not think that I knew what my needs were or how to

This past weekend, I attended a labour history conference and was reminded of the fact that it has always been workers and their unions who are in the lead for public medicare and progress in health care. By 1900-02, workers in Steveston and in Sandon, for example, had built their own hospital, hired doctors and nurses and started health care insurance funds to cover workers and their families.

Workers and their unions do have a lot to say, and the creativity and organizational structure to make progress happen. We still have a vital role to play. And for all our fears and dashed hopes, long work days and meeting nights—any and all progress in health care reform is worth the effort. Thanks to CCPA for organizing this day. I see it as another spark to help make it all happen.

get more clear. I felt like I was falling between the cracks.

As it turned out, I was falling between the cracks. I feared for my own health and well-being. I thought lots about how if this could happen to me (a very well resourced person), how are other people making out who do not have such good resources, or maybe have English as a second language, or who are elderly and unsure of themselves, or . . .

I knew that this kind of change was fraught with potential hazards in the skin breakdown area. Pressure sores can develop and one must be constantly vigilant. I had my mirror out every evening and thought I was taking good care. It turned out that I not only had never laid eyes on a pressure sore before, but I did not know where to look. I was looking in the wrong place and did not know I had one (two, actually) until I smelled

this awful smell. After the public health nurse came to investigate, she announced, “You are going to hospital, by ambulance.” I had an hour to organize my life.

That is how my year-long acquaintance with many aspects of the BC health care system began. It is also what gives me an up-to-date, intimate view of various parts of the health care system on both an acute care and community care level.

For two and a half weeks, I was at the UBC Hospital. For the first while, I was quite sick and getting IV antibiotics, dehydrated and derided. The wound was resolving itself and ended up being quite big and to the bone. I stayed in bed and everything that happened to me, happened there, and was done by nurses who work twelve hour shifts and who seemed constantly hurried and tired. I was glad I was not on complicated medications. It was my first hint that BC’s health care system really was in big trouble.

The process that led me from acute care back to the community was greatly facilitated by me changing rooms and having access to a telephone. Having access to a telephone was a surprisingly big issue since I cannot walk, could not sit in my wheelchair, and had no means of communicating with the outside world. I have extended health benefits, and due to my supportive doctor got a private room with a phone. I made most of the arrangements for my discharge and return home after being provided with phone numbers by various staff. It all went fairly smoothly, and off I went to my rented hospital bed with a wound that was 4 x 3 x 7 cm big that I could not sit on.

Being home was clearly more cost effective for the hospital and more hazardous for me. Home care, through the poorly coordinated auspices of Drake Medox, took care of the physical needs of a bed-ridden client. Just. There were many, many problems that were, I thought, a direct result of a large corporate entity’s sloppy, unprofessional and uncoordinated

management of my situation. For instance:

- although I was designated “complex care”, most of the workers had little or no training to equip them to deal with most of my needs;
- there seemed to be no accreditation process which applies to worker training;
- confidentiality was an issue;
- language skills were often inadequate and caused concerns, particularly around taking medications; and,
- there was no consistency in the scheduling of workers so that I often received care from as many as 10-12 different workers in a seven day period—a very precarious situation for my wound.

The nurses from the health unit proved to be the dressing that bound my healing together. These women came twice a day for months to dress the wound that would not heal. For this reason, I had confidence that there was some “quality control” and even accountability about my homecare service. Even so, there were also many different nurses and being treated by many different practitioners took its toll. The reason my wound would not heal was that it was too big and needed plastic surgery. I did not know this during the three and a half months that I lay in bed, but I did reach the top of a plastic surgery waiting list. Three months after returning home, I entered VGH Burn and Plastic Surgery Unit.

VGH was just another hospital, with worse food and nurses who seemed even more overworked than UBC. I had the plastic surgery and was completely flat, and I even needed help eating for two weeks. I was on a gel mattress and I needed to be turned every four hours. I developed tendonitis in both shoulders and got very crabby indeed. I returned home as an “early discharge”. Once again, it was more cost effective to release me as soon as possible, but my inability

to be anything but completely horizontal made my home care that much more “complex” than before.

At home again, I experienced the same kinds of problems with home care, but a few of the wrinkles had been ironed out. The biggest difference was that I started out flat in bed, then was allowed to be upright to 30 degrees for a week, then 60 degrees and finally 90 degrees. The skin of the wound healed. I saw a health unit physiotherapist during this time. After getting to an upright sitting position in bed, I began my “mobilization schedule”, where I was allowed to get into my wheelchair for 10 minutes once a day, then twice a day, then 15 minutes once, twice a day all the way up to one, two, three hours once, twice a day until finally I was able to go to GF Strong Rehabilitation Centre for upper body strengthening in the hopes of achieving independent transfers. And freedom from the presence in my life of three people per day to assist with my transfers.

A sidebar to my second experience with Drake Medox was the implementation of new scheduling, as a result of a BCGEU contract for the newly unionized workers. It seemed to goad Medox into behaving in the same way that bosses have done everywhere through the centuries: berating, belittling, intimidating and otherwise abusing the workers. It allowed me an opportunity to shake the dust off my trade union knowledge. My home care workers have read their contract and two want to be shop stewards!

My ability to start as an out-patient at GF Strong marked what I felt was a real milestone in my progress back to a normal life. There, I met with a team that was charged with my rehabilitation. There is a doctor who belongs to this team but I have not seen him. The team seems to be a bit of a rudderless ship, and my rehab has been very much self-directed. It is a good thing I am self-motivated and very familiar with the GF Strong rehab system, or my progress would have

been very limited. The most beneficial thing that happened there was a suggestion that I see a trainer at my local community centre.

I did this and I am now strong enough to start learning a new transfer technique, which is really what I should have done about 15 months ago.

All of this happened to me without my foreknowledge or permission. I am a white, middle class (more-or-less), university educated, English speaking, assertive homeowner on Long-term Disability Insurance coverage and Extended Health Benefits. If this can happen to me, it can happen to anyone.

What happens if you are disabled and not all of the above? What happens to all of those people who, for instance, live in the Downtown Eastside and who do not have any resources? Or elderly people who have strokes and heart attacks and find themselves cast up on the rocky shores of home care services without any assertiveness skills? What happens to people who use English as a second language and cannot understand what is going on when they experience an accident that changes their lives?

A reformed health care system must be able to deal better with all of us.

Health care workers have unions to represent them and their interests in this health care reform process. Doctors have professional associations and the accrued power of privilege and history. Consumers/clients/users of the system have no voice or representation. *Blended Care* makes occasional (dare I say token?!) reference to participation by consumers of health care services, but does not ever specify how this participation will be achieved.

A joint committee of health care workers, professionals and consumers should be struck to suggest specific ways to enable consumer participation in the kinds of health care reforms that are being proposed in *Blended Care*.

RN First Call Project

Cathy Ferguson and Morrie Steele¹

In 1997, registered nurses (RNs) at Ashcroft District General Hospital became British Columbia's first "First Call" nurses on a trial basis. First Call provides an opportunity for RNs to work to their full scope of practice and meet the health care needs of their community. The program, a joint effort of the Registered Nurses Association of BC and the BC Nurses Union, proved so successful that the Ministry of Health agreed to provide funding to expand First Call to a minimum of ten more sites in 1998. There is now a waiting list of health agencies to be involved in the project. To date, 225 nurses from 14 sites have participated in the five-day education program.

The First Call model is a system whereby, based on an initial assessment, the RN triages patients to one of three levels of care: non-urgent; urgent; or, emergent. Patients receiving non-urgent care are experiencing common uncomplicated, low-risk health problems, such as: scrapes, bruises, bites, nosebleeds, urinary tract infections, colds, minor lacerations, or minor burns. In many rural hospitals, up to half of all emergency visits account for these non-urgent health care conditions.

Care in the non-urgent category can be provided by a registered nurse or a physician. Nurses involved in the First Call program receive direction from standard protocols. For continuity, local physicians are notified of any care provided by nurses through a copy of the case record. Nurses consult with the physician if concerned about a patient's status, if the patient specifically requests to see a physician, or if the volume of patients at any point warrants more help.

In the urgent category are patients with more complex health problems requiring care beyond the scope of nurses to manage independently under protocol. In these situations, the nurse conducts an assessment, and also phones the physician regarding patient manage-

ment. The physician decides, based on the information, to either come in to provide treatment or provide further direction over the phone.

While these first two levels reflect collaborative care between the nurse and physician, emergent care is physician-directed. Patients in this category require immediate attention and the unique skills of a medical doctor. Pending the physician's arrival, the nurse provides nursing care and other interventions based on protocols or telephone orders.

Currently, ten protocols have been developed and are under review by an expert panel. The evaluation component has been built into the project to monitor patient and provider satisfaction, impact on existing roles, health outcomes for patients, and cost effectiveness.

Goals and Objectives

The goal of the First Call project is to develop and implement a program to use registered nurses in selected emergency units to manage minor uncomplicated health problems and injuries.

The project has a number of objectives:

- Assist a minimum of ten organizations to develop the necessary collaboration and support for First Call within their respective health authorities, communities and among provider groups;
- Identify and/or develop protocols to support nurses involved in implementing First Call in emergency units;
- Develop and provide education programs to ensure that all nurses involved in First Call have the necessary competencies to provide safe and appropriate care;

- Develop and implement an evaluation of First Call including: patient and provider satisfaction, impact on existing roles and workload, health outcomes for patients and cost-effectiveness of this mode of care delivery; and
- Advise the Ministry of Health regarding legislative and other barriers encountered in the process to facilitate legislative review.

Key Players & Events Shaping the RN First Call Project

June 1996—A registered nurse from Ashcroft District General Hospital called her BCNU regional chairperson and stated that no doctor would be available for three weekends in July & August. She inquired as to her duty to provide care in the event that patients requiring medical treatment presented themselves at the hospital. BCNU legal counsel suggested contacting the RNABC for advice.

RNABC Practice Consultant Heather Mass responded and suggested setting up a meeting with RNs at Ashcroft District General Hospital (ADGH).

July 1996—The BCNU regional chair plus two ADGH nurses met with the hospital administrator to outline concerns.

September 1996 to March 1997—Several meetings occurred. Heather Mass met with RNs and discussed the possibility of utilizing First Call protocols. Once nurses became comfortable with the idea they completely shaped the vision for First Call. Heather Mass and the BCNU regional chairperson acted as advisors and facilitators during the entire process.

During the fall and winter, the participation at meetings expanded to include ADGH and regional management, local doctors, unionized employees, community health care professionals, and local

citizens. Implications of First Call, such as interdisciplinary and union jurisdiction, legislative barriers, patient care and community concerns, were dealt with through careful consideration of everyone's point of view. As the project evolved, all participants had ample opportunity to critique and provide input.

The Ministry of Health accepted a joint BCNU and RNABC proposal for funding for Ashcroft and ten additional sites around the province.

The Thompson Regional Health Board approved a policy on RN First Call.

Fall 1997—An educator was hired, and a training program for RNs was devised and initiated. The education occurred on site.

Spring 1998—First Call at Ashcroft was in full swing. RNs were using five protocols. Other communities, particularly in northern BC, were implementing First Call as well.

August 1998—The BCNU regional chair and the Thompson regional medical director devised an evaluation tool for the ADGH First Call project.

September 1998—To date, the First Call project is currently being implemented at 14 sites in British Columbia. A core committee meets regularly at RNABC or by conference call to monitor and track progress of the project. Committee members include: representatives from the Ministry of Health, College of Physicians and Surgeons, the BC Medical Association, RNABC and BCNU.

Conclusion

First Call represents a positive model for health care reform. The development of the project was inclusive and gradual. The project allows nurses to practice to the full extent of their skills, better serves the needs of their communities, and likely saves the health care system money.

STEMMING THE TIDE OF PRIVATIZATION

Ending the Public Payer/Private Provider Split

Colleen Fuller

Integration of health care service providers is a goal of federal and provincial governments across the country. For example, the Health Transition Fund established in 1997 by the federal government provides \$30 million to national level projects, and \$120 million to provincial and territorial projects for pilot projects relating to practices and services in the areas of home care, primary care and health services integration. Its stated aim is to generate information on the organization, funding and delivery of health services in four priority areas: home care, pharmacare, primary health care and integrated service delivery. BC has received \$15.7 million so far in HTF funding for 14 pilot projects in this province.

Health care integration is a concept that has received its primary support from the corporate sector, as well as hospitals and governments. It is not a “bad” idea, but the aims of the private sector are at odds with those of the public.

Integration promises to remove some of the barriers to easy movement throughout the health system. Canadian health care services, many proponents say, are too fragmented and disjointed, making it difficult to provide what is called a “continuum of care”.

This year, the Ontario Hospital Association published a paper that sums up what is referred to as “systemic barriers” to integration. It said there were at least eight barriers to integration, including:

- the lack of coordination among government departments and ministries;
- the fact that funds are not “tied to the pa-

tient”, but rather to institutions like hospitals;

- the lack of integrated information and data storage systems that would make patient medical records available to public or private providers in an integrated system;
- a so-called silo structure that creates ineffective use of human resources and inhibits the movement of staff between silos; and,
- the unwillingness of health care organizations to let go of some of their power, and of health care workers to “reflect the needs of the consumer, not the provider” in their work.

There is no doubt that our health care system needs to become better integrated, but not along the lines being pushed by hospital associations, doctors and the corporate sector. They, in fact, have failed to identify the biggest barrier to integration: private sector dominance of the provider system.

Our health system is becoming both more fragmented and more “integrated” or consolidated. How can both these things be happening at the same time?

Fragmented: public policies, including regionalization and underfunding, is fragmenting public authority and control over health care decision-making. The Ministry of Health used to be responsible for ensuring the appropriate allocation of funds, but this responsibility now has been turned over to Regional Health Authorities. The number of RHA’s who are in debt is increasing, and many are vigorously lobbying Victoria for funds to pay off their debts, instead of funds to improve or increase services in their com-

munities. The Ministry has rejected attempts to see progressive policies implemented province-wide, referring activists to the appropriate regional health board. So instead of lobbying one body for changes, activists must now lobby 26 bodies spread throughout the province.

Consolidated: the goal of Industry Canada, and of the federal government generally, is to assist in the export of health care goods and services into the global market. To do this, a number of obstacles have to be overcome, including:

- Small and medium-sized companies that characterize the private sector have to “consolidate” through mergers and acquisitions by larger corporations who have “global experience” and access to larger pools of capital not available in this country;
- The public sector has to make room for the private sector so it can acquire the experience it needs to successfully sell Canadian health goods and services in the global marketplace.

As health services move from large institutions like hospitals to the community, they are increasingly moving, as well, into the for-profit sector. As corporations become more involved in health care, the goals of integration for providing an accessible continuum of care will become more and more elusive. You cannot force private companies that compete with one another to “integrate”—only the market can do that. You cannot force private companies to locate in areas of low population density, where gaps in service provision are growing.

That does not mean there is not integration taking place in the private sector, there is. Managed care,

for example, began integrating payers and providers in the United States, such as Liberty Mutual, the world’s largest workers’ compensation insurer, and owner of what used to be called Ontario Blue Cross. In 1995, Liberty Mutual began integrating its insurance operations with newly-acquired rehab facilities so it could control both ends of the market—payer and providers.

Merck Frosst is pushing projects in Canada that link “the private and public sector, government and industry, academia, family doctors, nurses, pharmacists and others to track patients through each stage of their disease”. That is what is meant by “integration” when the corporate sector is talking about it.

I believe that we need to take some guidance from the corporate sector on the issue of integration. If we want to achieve all the goals touted by groups like the OHA and the federal and BC governments, we will have to bring about the integration of the public payer and private provider systems in Canada—that is, we will have to bring the private providers directly into the public sector.

Is this possible? Yes, anything is possible, but not necessarily within our current economic system. I believe there is very little hope for our ability to protect or expand medicare if we confine ourselves to thinking “in the box” we live in and fail to imagine something that may not yet exist.

Nonetheless, even if we despair of capitalism’s ability to meet our fundamental needs, as health care activists we should be proposing achievable and workable alternatives to the direction things are going in now. Integration of our payer and provider systems may be such an alternative, especially given the continuing strong support among Canadians for medicare.

Laboratory Services: The Tip of the Iceberg

Pam Bush

Although BC has been bucking the trend towards privatization in health care, laboratory services in the private sector are an example of existing for-profit providers in our current health care system. They demonstrate the danger to the system if we do not protect and expand the provisions of the Canada Health Act as services shift to the community.

For-profit provision of services has created barriers to the integration of laboratory services. If BC's per capita expenditures for laboratory services were the same as Manitoba's (a province in the middle of the pack), we could save over \$100 million dollars a year, through the integration of services.

Some Basics:

Laboratory services in BC are funded in two ways:

- Services provided to inpatients in hospitals are funded out of hospital global budgets; and,
- Outpatient services are funded by the Medical Services Commission on a fee-for-service basis, with this funding outside the control of regional health authorities.

The MSC (a tripartite commission made up of doctors, government representatives, and members representing the “public interest” who must be mutually agreed upon by the other members/interests) determines the fee schedule for outpatient services.

Both hospitals and for-profit laboratory companies provide outpatient laboratory services. The two main for-profit laboratory companies in BC are BC Bio, a relatively small, BC based company founded by doctors, and Ontario-based MDS Inc., Canada's largest and most aggressive health and life sciences

corporation. MDS did not have a presence in the lab sector in BC until a few years ago, when they bought out Metro-McNair (another doctor-founded BC company) and Island Medical Laboratories (the same, but on Vancouver Island).

There is “competition” for revenues between hospital and for-profit laboratories in the provision of outpatient testing.

Some Strategies Pursued By Health Care Unions

1) *Compete with the for-profit sector*

This approach attempts to:

- Prevent further privatization of laboratory services;
- Promote the expansion of “satellite” laboratories run by hospitals, and make these services more accessible to patients;
- Create a more “client-centred” approach by hospitals;

The goals are to increase services, revenues, and jobs in the public sector. Some funding is provided by the Healthcare Labour Adjustment Agency, because of the loss of jobs in laboratories due to changes in technology.

This response is driven by money—employment security created an incentive to protect jobs in the public sector. The problem with this strategy is that it does not promote integration of services and savings to the system overall.

2) *The Public Sector Accord on Strengthening BC's Public Health Care Services*

The impact of the Accord was greatly overstated by the media in many sensationalist headlines. Strangely enough, none of them suggested there would be a negative impact on patient care. The Accord

established a joint union/Ministry of Health policy committee to advise the government on measures to strengthen the public health care system, including the provision of laboratory services. The committee was to seriously examine the introduction of a new block funding system for laboratory services.

The Accord was, however, viewed by the for-profit laboratories and the doctors as a serious threat. MDS and BC Bio saw this as an attack on their business (and profits).

The BCMA played a key role in the public opposition to the Accord for several reasons:

- It was seen as a threat to fee-for-service funding;
- The strong role within the BCMA of doctors with personal financial interests in for-profit laboratories; and,
- The BCMA's dispute with the provincial government over funding for doctors' services.

The BCMA and the private laboratories proved to be formidable opponents. Between October and March 1999, they gathered 165,000 signatures on a petition opposed to the Accord. This raises the issue of the role of doctors in the decision-making process in health care: to what extent should they have a role, when their personal financial interests are at stake?

3) Organizing

We need to recognize the significant victories of health care unions in creating barriers to privatization over the last several years, and I hope, incentives for de-privatization over the next several years. Laboratory services are not the only publicly-funded health care services provided by for-profit providers—a significant number of long-term care facilities and home support agencies are also run by private corporations.

Over the last two sets of negotiations, health care unions have worked hard to obtain (and have largely

achieved) provincial consistency in wages and working conditions for health care workers. The creation of this (almost) level playing field, should make it more difficult for for-profit providers to “compete” with non-profit providers.

Until recently, the private laboratories have been the largest group of publicly-funded health care employees who were unorganized. Health care unions are now organizing workers at MDS—there is now a BCGEU certification for a group of MDS employees in the Lower Mainland, and there have been applications for certifications in Victoria.

With luck, as unions increase the wages and benefits of these workers, the private laboratories “competitive advantage” and ability to generate profits will be eroded. Over time, we will see if this creates an incentive for the for-profit companies to move out of this sector and seek their profits elsewhere. We also need to look at other initiatives that can support the progress that has been made here in leveling the playing field in terms of wages and working conditions.

And the Bad News Is...

While for-profit companies are losing the “advantage” of paying their workers lower wages, the government is moving in the opposite direction with respect to capital funding. It is now government policy that all new long-term care facilities must be built as public/private partnerships. This policy is a direct reaction to right wing and media attacks on the debt load of the government—they just want to get the debt “off the books”.

While the CCPA is working hard to reveal the deficit craze and the new tax cut craze for what they are, it is clear that there is still a way to go. We must also try to see if there are other sources of capital that we should be looking at to fund construction of health care facilities.

The Privatization of Health Information

Ian Scott

Health information refers to data that describes the health status of individuals and populations. Health information technology refers to both the content of, and the process of, collecting, assembling and collating, analyzing, and disseminating health data that describes the health status of individuals and populations. Descriptions of the health status of individuals and populations can be used to improve clinical care, to inform policy, to allow better administration of the health care system, and to inform the public.

To date, a number of federal initiatives have examined the issues surrounding health information, and have recommended the establishment of a comprehensive, national health information system.

The 1994 National Forum on Health recommended that "...the Ministers of Justice and Industry, in preparing proposals for the protection of personal data in the private sector, recognize that the interest of commercial bodies in data may differ significantly from the public interest in research" and that "...Legislation must: (i) Distinguish between the administrative use of data which identifies individuals and statistical use of data which does not refer to the identity of specific individuals; and, (ii) Distinguish between use of the data to advance the public interest and its use in pursuit of a private or commercial interest."

With the exception of the National Forum on Health, however, government reports on health information have paid little attention to the public good. This is problematic because the rapid development of technological processes has allowed more health data to be collected, analyzed and disseminated. This expansion of health information capacity has the potential to improve or harm the health of Canadians

depending on how the technology is implemented, regulated and owned.

An Expanded National Data Set

Currently, our national health information systems suffer from incomplete and fragmented data that cannot be easily shared. What data we do have that is complete is not analyzed to its fullest extent. In 1994, an amalgamation of a number of governmental organizations and parts of Statistics Canada resulted in the Canadian Institute for Health Information (CIHI). This private, non-profit organization collects and manages data on health services and health expenditures based on the regulatory requirements of the Canada Health Act.

CIHI's current budget is \$13 million per year, but its role as a national health information body is currently being expanded. The 1999 Federal Budget allocated \$95 million over the next three to four years to lay the ground work and report regularly on both the health of Canadians and the health care system.

Such a national organization that is able to collect health data (both inputs and outcomes) and share them with the regions would allow comparability among regions. Such observed heterogeneities could result in improved care and improved health.

For such a national organization to be representative of the needs and desires of Canadians, individuals who represent the entire spectrum of health care provision and utilization in Canada must govern it. CIHI's current board is composed of a small set of representatives from: Statistics Canada, Health Canada, regional health authorities, a provincial research institute, provincial information officers, provincial ministries of health, a hospital, and a community health centre.

In addition, the CIHI partnerships do not appear to represent the cross-section of those who will produce and utilize health information. The partnership for health informatics/telematics, established by CIHI to advise it on the development of health information management and information technology standards, is made up of public and private sector representatives who pay to sit in these positions.

CIHI should evolve into an organization with expanded capacity to accurately measure the performance of the entire health care system (acute care and community, home and long-term care) through expanded data collection that would allow for comparisons among Canada's regions. To do this, CIHI must garner support from the provinces, territories and regions, providers and public and improve its ability to represent all stakeholders involved in the health care system, as well as be accountable to these stakeholders.

Information Technology Development For Planning And Managing The Health Care System

Canada spends 9.8% of its GDP to provide health care to its entire population, while the United States spends 14.3% of its GDP to provide health care to a segment of its population with the remaining 45 million of its citizens being underinsured or having no health insurance. Canada's mainly not-for-profit, single payer health care system has many advantages. Care is provided to all citizens, landed immigrants and many refugees.

The cost of administration is much less in managing the Canadian system, with Canadian hospitals spending 10% on administration, compared to 25% being spent by US not-for-profit hospitals, and 34% being spent by US for-profit hospitals. Outcome measures of care are also better in Canada with, for example, cancer patients of lower socioeconomic status doing better in the Canadian health care system than

the US health care system.

The advantages of the public administration of Canada's health care system are numerous, and as such, public administration has been entrenched in the Canada Health Act as one of the five guiding principles for the maintenance of Canada's national health care system.

The potential benefits to the private sector in the creation and expansion of health information technology systems are many. The most direct of these is to firms that sell information management systems (software, hardware and maintenance). Others who can benefit are companies that can use health information to create and sell disease management packages, or can market health care products either to consumers or providers. The Canadian information technology and telecommunications sector was worth \$70 billion in 1996 and grew at a compound annual growth rate of 8.7% per year.

Partnerships between publicly administered and funded health care organizations and private information companies are occurring across the country:

- The Vancouver General Hospital is developing an electronic patient record in partnership with BC Tel and Phamis Inc. BC Tel will have proprietary rights to the software that is the outcome of this partnership.
- Alberta awarded IBM a \$2 million contract to develop software for a province-wide health network, WellNet.
- Saskatchewan Health and the Saskatchewan Association of Health Organizations have partnered with Science Applications International Corporation and will invest \$40 million toward creating the Saskatchewan Health Information Network (SHIN).
- Manitoba awarded a \$100 million contract to SmartHealth, a subsidiary of the Royal Bank

of Canada, to develop a computerized health information network. MediSolution (formerly known as FoxMeyer and Evans Health Group Limited) is providing services to Quebec's health care industry focused primarily on practice management.

- New Brunswick has partnered with Meditech to develop an integrated data system between the province's eight health regions.

These partnerships between the public and private sector have raised a number of concerns related to the cost, accountability and integrity of single-payer systems. The cost of public-private partnerships can escalate when the private partner may not have expertise in health matters, and must also satisfy an audience other than the public good (a board of directors, shareholders etc.).

For example, in 1995 the BC Tel/Phamis partnership to create a Patient Care Information System (PCIS) with the Vancouver Hospital was projected to result in sufficient operating savings and was supposed to cover all costs related to development. In 1997, the Vancouver Hospital received approval to borrow up to \$27 million from private financial institutions to cover the shortfall during the implementation of the PCIS. In 1999, an audit was ordered by the provincial government due to its concerns surrounding cost overruns, missed deadlines and deteriorating standards of quality surrounding the implementation of PCIS at this public institution.

Agency costs must also be considered when these partnerships are formed. These costs entail the transfer of decision-making from the public partner to the private partner. Fragmentation costs must also be examined. Numerous private companies providing health information services to numerous organizations will invariably lead to fragmentation and a reduction in economies of scale and coordination. There is currently

no accepted Canadian standard for interconnectivity between health information systems. Fragmentation of the health information system may not only weaken coordination but may also create inefficiencies.

A final cost that must be considered is the cost attached to the loss of accountability to the public sector in these public-private partnerships. As health information systems become more integral to the Canadian health care system, the concept of transparent public administration (one of the five core principles of the Canada Health Act) may be threatened by the increasing role of private partners in health information systems. In the process, decisions about how the health care system will be managed and organized will effectively shift from the public to the private sector. As one example, international companies are interested in generic software solutions that can be marketed internationally. They are less interested in creating specific software solutions that would build and support the unique character of the Canadian system due to our relatively small population base and the specific nature of our health system.

Symposiums that deal with health information technology attest to the profitability of this sector and the barriers to public sector providers remaining current in this rapidly changing area. The second annual Canadian Forum on Health Care Information and Integrated Delivery Systems, a multi-national consulting company, cost nearly \$1,500 for the two-day conference held in 1998. There are no similar symposiums for the not-for-profit sector at the national level that are priced to be accessible to public sector health managers, planners, and providers.

We are currently at a health information crossroads: health care expenditures are escalating; health care delivery is being reorganized across the country; computer and telecommunications technologies are advancing at a rapid rate; and, the Federal Government

announced in 1999 a \$328 million investment over four years to further develop health information systems in Canada. At this time, more than any other, coordination of Canada's health information technological systems is needed.

The Ownership Of Health Information

Centralization and interconnectivity of health information has the capacity to improve the health of Canadians through linking patient files held by providers, hospitals, pharmacies and other agencies. Access by providers to a patient's complete health information data set could improve care through a provider's understanding of the complete medical history of a patient, reduced repeat invasive procedures, and improved prescribing practices by reducing duplication and dangerous interactions.

Cost savings may also be realized through reduced duplication of tests, reduced unnecessary prescriptions, reduced fraud by patients and providers, and creating diagnostic and treatment efficiencies by improving care.

Corporations currently access and utilize health information for profit in a number of ways. Pharmaceutical manufacturers, biotechnology firms, insurance organizations, management firms, and organizations that provide health care use health information to design marketing strategies, to direct pharmaceutical detailing, to inform policy advocacy, to create and inform management packages and strategies, to create patient profiles to improve the profitability of health care insurers, and to direct research and development.

Expanded private corporate access to an expanded and interconnected patient health record is a threat, not only to patient privacy, but also to maintaining Canada's single payer, universal health care system. Currently, the federal government's health information strategy appears to be skewed in industry's fa-

vor. In the 1997 federal budget, \$50 million was dedicated over three years to develop a national strategy for a Canadian Health Information System. The subsequent Advisory Council on Health Info-Structure had members from policy institutes, universities, health associations, and private industry, including the Royal Bank's SmartHealth, IBM's Sierra Systems, Bell Canada, and TecKnowledge Health Care Systems Inc.

Private industry can benefit from health information initiatives in a number of ways. Currently, the largest beneficiary of government spending on health information is the information technology and telecommunications industry through the creation of health information infrastructure. In the future, health information itself is expected to be the most lucrative component of the system. In 1997, Intercontinental Medical Statistics (IMS) announced that they want spend \$40 million to build Canada's first warehouse of health information.

Employee extended health benefit plans and disability plans are another sector of the health care system that can benefit from increased access to health information that in turn may compromise the privacy and well-being of Canadians. By utilizing health records, these plans can create profiles of workers who are at "an increased risk of injury or disease". Bayer sells a health promotion and disability prevention program based on evidence from over 2 million confidential health questionnaires that has been "proved to reduce health risks and improve lifestyle habits."

A related area is the activity by American HMOs that provide their patient utilization and demographic data to firms that create patient profiles of individual patient characteristics to assist HMOs in selecting patients that will result in lower health care costs should they be enrolled by the HMO. Private profit-making corporations should not have access to Canadian health data generated in the public system in order for them

to generate profit from this data.

The insurance industry is another sector that will be able to benefit from access to health information and is perhaps one of the greatest threats to individual privacy. Disability insurance and life insurance all require plan applicants to sign a release of medical information. With a comprehensive linked electronic record, these corporations will have access to an applicant's entire record. An STD clinic visit in Whitehorse, a therapeutic abortion at the Everywoman's clinic, a single visit to a counselor ten years ago for difficulty adjusting to the death of a parent, individual pharmaceuticals prescribed, the exact date and duration of chiropractic visits, and all other health care utilization may be available to the insurer.

If one signs a release of medical information, what limits will be placed on it? This threat to individual privacy, as well as the ability of these organizations to share this information with other industry members,

is a significant threat to individual privacy. Links between banks and insurance companies typify this threat as demonstrated by the example when a Maryland banker was able to cross-reference a list of patients with cancer against a list of people who had outstanding loans at his bank and then call in the loans of those people.

The above examples show that the improvements in health information and the growth of health information technology system have the potential to both improve the health of Canadians, as well as harm the health of Canadians. It appears that the largest threat is in how this information will be used and how the health information technology system will be managed. Governments must take a larger role in formulating policy and directing the management of both health information and health information technology. If not, the private sector will, and the health of Canadians and the Canadian health system will suffer.

WHAT DOES POPULATION HEALTH HAVE TO SAY ABOUT A PROGRESSIVE HEALTH POLICY AGENDA?

Primary Care Reform and Population Health

Robert Reid

My talk is meant to discuss a how a critical facet of our medical care system, primary care, intersects with population health.

The rapid change that is occurring within Canada's medical care system creates opportunities to reassess the orientation of health service delivery in Canada. In 1997, the National Forum on Health recommended that a main thrust of Canadian health reform for the coming years be primary care reform.¹ Since this report, a variety of primary care reforms and demonstrations have been initiated throughout the country, including the Primary Care Demonstration Project (PCDP) undertaken by the BC Ministry of Health. What is meant by improved primary care? Can primary care reform really be expected to influence the health of Canadians? Are these reforms appropriate for improving the population's health? These are some of the questions I intend to address in this talk.

The health and well-being of individuals is influenced by a variety of determinants, only one of which is the attainment of quality medical care. Other factors critical to the development of disease and disability, and to the achievement and maintenance of well-being, include an individual's genetic profile, the physical and social environment they inhabit, and the behaviours they exhibit.

While some of these determinants operate at the individual level, many operate at the level of populations. As Dr. Hertzman points out, socioeconomic

status is a powerful predictor of health; as one moves from more to less advantaged across the socioeconomic spectrum, there is a clear and consistent association with reduced life expectancy and the development of the majority of illnesses. To improve and maintain population health, therefore, it is clear that a variety of strategies are necessary, directed both at individuals and the communities in which they live.

Within this framework, the medical care system has several roles to play. It operates generally at the level of the individual patient, and provides services directed at diagnosis and management of problems for which patients seek help. These services are not only directed at preventing the onset of new illness, but are also oriented towards limiting the duration of illness, reducing symptoms, improving function, and preventing illness progression.

This is in contrast to public health systems that generally operate at the level of populations and employ a variety of environmental interventions to limit the development of disease, such as the maintenance of safe food and water supplies. The provision of clinical preventive services, such as screening and immunization, is often divided between medical and public health systems, due largely to a combination of circumstances, not by design.

Despite the connections between the medical care system and the health of populations, the overall spending on medical care is not uniformly associated with

better levels of health. One has to look no further than the United States which, despite spending on health care that exceeds all other industrialized nations, has a relatively poor track record on health outcomes.

It is logical, therefore, that the effect of medical care on health is a result of specific attributes around which health services are oriented. It is also logical that, for a medical care system to influence a population's health, it must address health issues amid the backdrop of other powerful health determinants. It follows that in responding to health concerns, medical care should also act to help mitigate negative and enhance positive physical and social circumstances of patients.

There is considerable evidence from several areas of inquiry to suggest that enhancing primary care can improve the health of populations. International comparison studies have generally found that countries or states with better primary care have improved health outcomes. Starfield (1994), in a study of 11 Western industrialized nations, found that a strong primary care infrastructure was associated with the achievement of better health statistics, including mortality rates, productive years of life lost (PYLL), incidence and prevalence of selected conditions, and provision of preventive health care.² Furthermore, it appears that this effect is concentrated largely in younger populations; the relationship gradually disappears with age, and disappears entirely for the elderly.

It is clear that Canada is intermediate both in the attainment of primary care and in the ranking of health outcomes, suggesting that there is considerable room for improvement in both. One problem with these types of studies is that countries with better primary care also tend to be those with more equitable distributions of incomes. It is difficult, therefore, to disentangle the effects of primary care from the effects of income

disparity on the achievement of good health outcomes. Shi (1994) attempted to account for this problem in his analysis of health outcomes, income distribution, and accessibility to primary care providers among the 50 US states.³ He found that there was an important effect of primary care on health independent of income disparity.

In addition to cross-national or cross-state comparisons, a variety of clinical studies also suggest that primary care can have an important effect on improving population health status. Shea et al. used a case-control study to examine the effect of having a primary care physician on outcomes in hypertension patients.⁴ This study found that men presenting to emergency departments with complications due to poor blood pressure control were less likely to report visiting a regular primary care provider. This effect persisted even after adjusting for a variety of confounding influences, including risky behaviors and socioeconomic status.

If primary care is related to population health, what are its main features and how can it be enhanced? There have been many attempts to define primary care, usually by way of listing a range of tasks provided in primary care or specifying the types of providers who perform them. These definitions have generally been unsatisfactory because services may be delivered in various locales and by various providers.

Recent definitions of primary care by authoritative bodies in Canada⁵ and elsewhere⁶ characterize it by four normative features that are unique to primary care:

- *First contact* refers to the fact that primary care is the entry point of individuals into the health system when they encounter new health problems. Strong first contact implies that patients are able to easily access care when faced with a health concern.

- *Comprehensiveness* refers to the ability of primary care systems to respond to all common problems for which patients seek care.
- The third feature of primary care, *longitudinality*, refers to the personal relationship that develops between patients and their primary care provider over time, extending across all the patient's problems and episodes of illness.
- The final attribute, *coordination*, refers to the integration of the other aspects of the patients care across programs, facilities, and health care personnel. In other words, primary care serves as the principal conduit to other types of care and the locus of coordination.

In addition to these four attributes, primary care also encompasses two derivative features: family centredness and community orientation. These additional features call on primary care providers to consider their patients' problems in the context of the family and community. Primary care is differentiated from specialty care in that it is patient- not problem-focused. Whereas specialty care is oriented around the diagnosis and management of specific problems or organ systems, such as heart disease and diabetes, primary care addresses the full range of problems encountered by patients. *[Editors' note: Primary care can also be contrasted with emergency or walk-in care, which may be a patient's first contact, but which lacks the features of longitudinality and coordination.]*

Given the attributes of first contact and longitudinality, primary care providers are better equipped to understand and respond to the patients' physical and social environment. From this theoretical vantage point, it is not difficult to appreciate why health systems grounded with strong primary care systems are more likely to achieve better population health

outcomes.

In spite of the evidence supporting a strong primary care orientation for our health system, there is a major countervailing trend that threatens to weaken it. Recent advances in medical care have led to an explosion of new diagnostic tools, surgical techniques, and pharmaceuticals. With the limits of medicine expanding, there has been a trend for physicians to specialize and concentrate on providing care for a narrower range of diseases or patient populations. Accompanying this specialization has been the fragmentation of care among an increasing range of disconnected providers and programs, challenging the ability of primary care providers to establish long-term relationships with their patients and coordinate the spectrum of their care.

For the remainder of my time, I am going to discuss two policy options relevant to the strengthening of our primary care system. First, shifting primary care payment from fee-for-service to capitation systems is often touted as a major initiative to promote primary care. The major advantage is the encouragement of long-term patient/provider relationships. Some research has shown longitudinality to be poorly attained in Canada.⁷ Since provider populations are defined, capitation also encourages a population-orientation to the delivery of care.

However, with capitation-funded primary care, comprehensiveness can be threatened as the financial incentives shift from providing more services than are required to providing too few. Evidence for skimping on service delivery in capitated systems is contradictory, and no firm conclusions can be drawn as the certainty of this hazard. The establishment of capitation payment systems (with the notable exception of the primary care demonstration project and their system of 'virtual' rostering) generally means enrolling patients with primary care providers. Even though

mechanisms can be established to ensure the patient's ability to change providers at will, this feature has been criticized as an intolerable restriction on patient choice.

A second policy option often considered in primary care reform is shifting care from individual providers to primary care teams. The main reasoning behind this is that accessibility to, and comprehensiveness of, services can be expanded. Whereas a single physician is limited in his or her ability to provide 24-hour access to care, primary care teams can ensure that care is available when needed. The establishment of primary care teams, however, brings with it challenges for longitudinality and coordination. Mechanisms must be implemented to ensure that the long-term relationship with a physician the patient considers his or her

'own' is not threatened, but enhanced. Similarly, improved mechanisms to transfer information among team members, and to define roles and responsibilities, are needed. As teams increase in size and scope, these challenges become larger.

It is clear that a strong primary care system is needed for our health system to be most sensitive to the health needs of Canadians. To date, health reform in Canada has concentrated in the regionalization and integration of institutional and specialty services. As reform efforts increasingly stretch across the continuum of care to reach primary care, a careful blend of policies is needed to ensure access to primary care services, and foster relationships between the providers and their patients.

What the Policy World Should Know about Population Health

Clyde Hertzman & Dafna Kohen

Why are some populations healthier than others? Since 1987, an interdisciplinary network of anthropologists, political scientists, epidemiologists, and health economists has been studying this central question, under the auspices of the Program in Population Health of the Canadian Institute for Advanced Research. Emerging from this work are ten key observations that are relevant to policy-makers in health, health-care, and broader aspects of human development.

1) Increased life expectancy in wealthy societies is not primarily due to the provision of individual health care services.

Thomas McKeown showed that the precipitous decline in mortality from infectious diseases, such as tuberculosis, during the past century was not due to

clinically effective vaccinations and antibiotic treatments. These diseases had been the major causes of mortality for centuries, yet effective clinical prevention and treatment interventions were developed and implemented after approximately 90 per cent of the historical decline in mortality had already occurred. Thus, in direct contradiction to received wisdom, the vaccine and antibiotic revolution played a rather minor role in lengthening human life expectancies in Western Europe, North America, Japan, and other wealthy countries.

Instead, the principal factors responsible for increasing life expectancy—from less than 50 years to more than 70 years in wealthy countries—are to be found outside the health care system as traditionally defined, and instead, in the broader socioeconomic

environment. Socioeconomic factors that could be related to improved health include improvements in housing, water supply, pollution control, nutrition, child spacing, working conditions, education, and a wide range of psychosocial factors which are thought to improve in prosperous, tolerant, democratic societies. Some of these are improvements that were made in a conscious effort to improve the health of the population, and others not. The unanswered question is: “how important has conscious human agency been in translating socioeconomic progress into health?” In other words, what is the relative contribution of public health measures, compared to other correlated factors that emerge among societies as they become wealthier, more democratic, and more tolerant over time?

2) There are substantial differences in health status among wealthy countries today.

The average life expectancy difference between the “healthiest” of the world’s wealthy countries and the least healthy of this group is approximately five years. This five-year life expectancy difference (between 74 and 79 years) is generated by an approximate two-fold difference in age-specific mortality during the early adult years (age 25-64). It is not primarily due to national differences in the provision of effective health care services, barriers to access to effective care, or the level of health spending at the national level.

3) Historically and internationally, increasing wealth has been a strong correlate of improved health status. This is much less the case among the world’s wealthiest countries today.

Differences in wealth in terms of GDP amongst the wealthiest countries in the world are no longer strongly associated with health status differences

among these countries. In the early part of the century, there was a strong correlation between increasing per capita gross domestic product (GDP) and increased life expectancy for all countries in the world.

As the century progressed and wealthy countries became wealthier, a “flat of the curve” gradually developed wherein variations in health status were only weakly associated with differences in national income. By 1990, the flat of the curve included those countries with GDPs per capita greater than US\$11,000. Furthermore, over the period 1970-1990 differences in rates of increase in GDP among these countries were not associated with differences in gains in health status.

4) Differences in health status within and among wealthy societies are associated with differences in equity of income distribution.

Differences in health status within and among wealthy societies are associated with the equity of income distribution within those societies. International, and Canada/US, comparisons show that low levels of income inequality is associated with relatively low mortality. For instance, comparison of the ten Canadian provinces with the fifty US states shows that the range of income inequality between the states is very large, whereas in Canada the range is quite narrow, and all provinces fall at the level of lowest income inequality for the American states (see Figure 1, facing page). Similarly, all Canadian provinces fall at the lowest level of mortality among the states; whereas the states with the highest level of income inequality have mortality rates, after adjustment for age, which are 30-60% higher than the Canadian provinces.

5) A complex interplay exists between factors associated with the psychosocial environment and with the material living conditions that act

such as England and Wales show the gradient effect for the major causes of disease and death of the time (infectious diseases). Over the next 3-5 decades those diseases tended to disappear and were replaced by chronic diseases such as heart disease. At first, these new disease tended to show unique epidemiological patterns, but over time the socioeconomic gradient asserted itself. In the case of heart disease this had occurred by the 1950s. A similar pattern has been emerging over the last 15 years in the case of HIV/AIDS.

These characteristics point to the existence of fundamental biological processes connecting social circumstances to human resilience and vulnerability to disease, and strongly suggest a role for early child development in the process.

8) The gradient exerts its effects over the entire life span.

There has been much debate about the emergence of gradients over the life span. Gradient effects are apparent early in life in relation to infant mortality and low birth weight, but health gradients tend to disappear in teenage years and re-emerge in mid-life. In fact, the gradients early in life are found in cognitive and behavioral development, and have been measured in Canada as (modifiable) socioeconomic inequalities in

readiness for school. During early adulthood, gradients emerge for mental health status, obesity, and a series of limiting long-standing illnesses. In late adulthood, this translates into more traditionally defined diseases.

9) Gradients appear to “flatten up” .

The principal significance of the gradient for policy is simply that gradients appear to “flatten up.” In other words, those societies which produce the least inequality in health and human development across the socioeconomic spectrum have the highest average levels of health and development. International comparisons have shown this for the development of literacy and numeracy skills across OECD countries and for health status across the European Community.

These investigations have shown that “raising the bottom” of the socioeconomic spectrum does not “lower the top”. This is a fundamental challenge to the folk wisdom surrounding economic models currently in vogue that predict that reductions in societal inequalities for those at the low end of the socioeconomic spectrum can only occur at the expense of those at the upper end. In other words, population health reminds us, first and foremost, that we are a social species, and our health and development depend upon the quality of the social environments where we grow up, live, and work.

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