Backgrounder

Connected Communities is a network of health advocacy groups from Trail, Castlegar, Nelson, Kaslo, Nakusp, New Denver and the Slocan Valley. Our mandate is to see that the five principles of the Canada Health Act are upheld - that health care in Canada is universally available and accessible, portable, comprehensive and publicly administered. We pursue our mandate regardless of the political party in power.

Connected Communities began to monitor the changes in delivery of health care to area residents following the Minister of Health's overnight firing of the community based health authorities in 2001, an action which removed an important local voice in decision making.

Connected Communities' goal is to inform the public when changes made to health care are contrary to the intent of the Canada Health Act and adversely affect their health and welfare. An example of this is when the BC government added "sustainability" or "affordability" to the five principles of the federal Canada Health Act. This meant that any of the five principles could be ignored if the BC government could prove they were "unsustainable" or "unaffordable".

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"Jeopardizing the well-being of West Kootenay residents who have chronic health issues "
Observations on changes in health care services in the West Kootenays from 2002 to 2010

SUMMARY

Changes to health care services and delivery since 2002 have led to:

1) Centralization and reductions in health care services and options which penalize the patient in a variety of ways.

2) The addition of costly expansions to hospitals while basic health care services are being cut back.

3) The lowering of criteria for standards of health care services.

4) The downloading of costs on to patients and the creeping privatization of services which were previously publicly subsidized.

5) The deliberate ignoring of input from stakeholders (patients, families community groups, nurses, doctors etc) on community health care.

6) Burgeoning costs in IHA's administration as it constantly implements new organizational structures and additional levels of supervision.

We need front line workers not more bureaucrats.

Conclusion

1) Seniors and those with chronic health issues are the most at risk from these trends and changes.

2) The new policy of keeping seniors in their homes for as long as possible will fail as a result of these changes because supports are inadequate.

"Jeopardizing the well-being of our most vulnerable citizens"

Observations on changes in health care services in the West Kootenays from 2002 to 2010

From 2002 to the present, dramatic changes occurred, and are still occurring, in the availability and delivery of health care services in BC, including the West Kootenays. As a result, many problems have been created over the last several years which have still not been addressed by the Ministry of Health Services and the Interior Health Authority. Health advocacy groups have been gathering information on these changes over the last eight years. Although many stakeholders have described them over the years they are worth repeating and show common trends over time.

1) Centralization and reductions in health care services and options.

Where services have been downgraded or removed, adequate supports for patients and their families have not been put in place to ensure residents can still access health care services which have been moved to larger centres.

a) Loss of acute care beds.

In 2002, with the closure of Castlegar, Kaslo , and New Denver hospitals, plus 15 beds cut from KLDH and 10 beds from KBRH, a total of 42% of the West Kootenay's acute care beds disappeared. Former hospitals were reduced to Urgent Care Centres. Castlegar had its emergency room hours cut by 50%. In Nelson the ICU unit was closed and only obstetrics/gynaecology surgery cases were permitted to stay overnight. No emergency surgery was allowed. KBRH could not cope with the extra patients needing to be admitted for treatment. The consequences of these devastating reductions for area residents continue to be felt to this day.

b) Transportation difficulties

Attempts by Interior Health Authority to plan, organize and implement a proper transportation system to enable West Kootenay patients to get to a variety of health care appointments have been woefully inadequate. IHA must hire people to specifically help patients navigate their way through out of town medical appointment, transport

schedules, and options for accommodation, and to routinely provide information for accessing financial assistance where necessary. Too many people arrive at appointments to find they have been cancelled or changed without prior notification. It is also not good enough that IHA relies mainly on the goodwill of volunteer drivers, transportation companies and hotels to subsidize health care costs. How many of the recommendations from the 2009 transportation report on the Health Connections bus network, commissioned by IHA, have been implemented?[1]

c) Inadequate funding and commitment to new health care delivery models.

Kaslo Primary Health Centre, which replaced the Kaslo hospital, was originally seen as a model of integrated health care for rural health care delivery but cuts to services have affected it so severely that it can no longer be considered a success. During 2010 the Primary Health Nurse position was cut from 1.5 FTEs to 0.5, the Public Health Nurse position was reduced from 1.0 to 0, and the site manager position was reduced from full time to a few hours a week. A public outcry led to more hours being assigned but the level of service has not been restored to its previous premium operating level.

d) Community nursing care hours and services reduced

Trail, Castlegar, Kaslo, New Denver, Nakusp, Nelson, Slocan/Arrow Lakes have all had cut backs in Home and Community Care. Community care nurses are being asked to "defer" clients because they cannot see patients in a timely fashion. Quick Response Nurse positions for Trail, Nelson and Castlegar are no longer funded. These nurses were on call to patients for the first 24 hours after their hospital discharge back into the community and prior to them accessing community nursing care which is not available around the clock anyway.

e) Cancellation of counseling and support services for patients and families.

In June, 2010, the palliative care social worker position was eliminated at KBRH. She was an invaluable source of specialized information, education and training for patients and their families and hospice volunteers on death and dying. The Cardiac Rehabilitation program was cancelled at KBRH and area patients now travel to KLDH for this service.

[1] "Health Connections Evaluation Report, February, 2009". C. Ronning, Enrg Research.

f) Cutbacks in long term care beds

Closure of long term care facilities (Kiro Manor, Mount St Francis, Mater Miseracordia, Alpha House, Willow Haven) resulted in 356 LTC beds being cut by 2005. Numbers have still not been restored as in the intervening years the population of the frail and elderly has increased, and will continue to increase, as people age and even more beds are needed. Disorganization and lack of planning still leads to couples being separated and moved to separate facilities, sometimes out of town, where it is hard for family and friends to visit. More and more people now in assisted living places need a higher level of care because of their frail health needs but wait lists are long for publicly funded beds in LTC facilities.

2) The addition of expensive resources in urban areas whilst cutting basic services in rural areas

Multi-million dollar capital projects are under way in Kelowna to build cancer and heart treatment centres. The purchase of high tech equipment, computer programs, and video technology to improve patient and doctor access to highly specialized care is appreciated and necessary for rural and urban patients alike. However it is hard for West Kootenay residents to see these very expensive projects being funded while at the same time the most basic medical services in their own communities are being severely cut (e.g. public health, home care and community nursing, and home support.) One should not be done at the expense of the other.

3) Lowering the criteria for standards of care

IHA has lowered the standard of care with its new policy of “equalization, re-alignment and standardization of health care services across the region.” If one facility has a higher level of care than another, then regardless of why that might be (better management, more dedicated staff, higher quality resources funded through careful management of budgets) staff and/or resources will be reduced to meet the lower benchmark. There is no incentive for managing a more efficient system if services are taken away as a result. Standards existing prior to this new policy ought to be maintained and sub-standard levels of service should be raised to meet them. Because KBRH’s wait list was shorter for knee and hip surgery, IHA wanted to reduce surgical time in the Operating Room to match other hospitals in IHA which had longer wait lists.(At the same time wait lists for patients needing shoulder surgery at KBRH have increased.)

4) Downloading of costs on to the patient and creeping privatization of services.

There is an expectation now that patients will pay user fees, and they are also expected to go to the private sector for services which used to be provided by the Ministry of Health. Rising inflation means that people have less money to pay for their health care costs. Most retirement plans for public servants have eliminated coverage for extra health benefit insurance plans. With the rising cost of prescriptions people with low or fixed incomes are electing to go to the emergency room where medication is handed out at no cost. This is an unintended, inappropriate and expensive use of emergency room services.

a) User fees for convalescent and palliative patients

Convalescent and palliative patients who are moved from acute care hospitals to short stay beds at long term care facilities are now being charged a daily fee of $29.40. This type of care is considered medical care under the Canada Health Act and should be provided without charge, but Health Authorities have bypassed this by placing these patients in non-acute care settings.

b) Cuts to publicly subsidized home support services

People do not want to go into care. They want to stay in their own homes for as long as possible. Comprehensive home support services are an integral part of a person's wellness status, and therefore it is the responsibility of the Ministry of Health Services to provide them. Unfortunately the following previously subsidized home support services are no longer provided by the government: assistance with shopping, housekeeping, laundry, driving to appointments, and meal preparation. Those requiring these services in order to live at home are referred to private service providers if they can afford to pay. Otherwise clients can pay a subsidized rate of $29.40 a day for someone to heat up meals, provide personal care (including a bath once a week), and laundry service if the client is incontinent. Studies show that it is much cheaper to properly support and maintain people in their own homes than to place them in acute care hospital beds or residential care when inadequate home support leads to hospital admissions. For every dollar spent in home support services the health care system saves a further eight.

c) Patients paying for their own CT scans and MRIs

People who are on long wait lists for assessment for specialist services are purchasing their own CT scans and MRIs privately. Then they can move more quickly up the waiting list in the public system, displacing someone who cannot afford to pay privately. People feel guilty but are desperate when they are in severe pain or need to get back to work.

d) User fees for physiotherapy

Post-surgery or accident victims may be allowed three publicly funded visits to a physiotherapist but after that must pay a fee. People with chronic issues due to deteriorating health such as strokes or previous injuries are now expected to pay privately or do without physiotherapy.

e) User fees for routine eye care

Since Nov 2001 the M.S.P. no longer pays for routine eye exams for patients 16 – 65 years of age. Over 65years, people get a 50% reduction in the fee. People are expected to monitor themselves for the onset of serious eye diseases (some of them symptomless) such as glaucoma, macular degeneration, detached retina, corneal disease and cataracts. The Ministry of Health Services now permits eye glasses to be dispensed without an eye exam. Some symptoms can be corrected with lenses but the underlying disease remains untreated. Early treatment of such diseases can be crucial for retaining vision for as long as possible. The Ministry ignored input from a number of professional bodies when implementing this policy.[2]

5) IHA continues to exclude the community from having input into the delivery of health care locally.

IHA has not communicated with local communities or planned for transitions before making changes to health care services or delivery. This results in chaos in the workplace, and resentment, anger and frustration on the part of staff and patients as they try to make these changes work. Staff who report complaints and problems are viewed as troublemakers and intimidated. Rapidly changing organizational structures including name changes and personnel transfers, both within and between communities, make it impossible for the average citizen to keep track of who is responsible for a particular aspect of their health care.

[2] World Council of Optometry, CNIB, Canadian Diabetes Association, Canadian & American OptometricAssociations

Community Advisory Committees are not functioning.

Community advisory committees appear to have been quietly disbanded. Kaslo had no resident consultative committee to liaise with IHA although IHA's website stated that it did. Castlegar's consultative committee (CHAT) did not meet for almost two years and minutes of its meetings were never made available to the public. In February, 2011, the West Kootenay-Boundary Regional Hospital District Board passed a resolution "That the Executive Committee request the IHA to grant the public greater access to its policies and processes" , complaining that the Board had experienced some difficulty in obtaining policies and processes of IHA and questioning why public documents would not be readily available.

IHA ignores feedback from the community

Local stakeholders have put considerable effort into researching health care issues and proposing solutions.[3] [4] [5] In meetings, presentations, and written proposals, these ideas have been communicated to IHA. The same proposals have been made by different stakeholders over and over again for several years and none of the proposals is ever given serious consideration, nor are recommendations accepted. A high degree of cynicism now prevails amongst health care stakeholders. How will IHA convince such stakeholders that any new initiative to involve them will be taken seriously?

The Ministry of Health Services ignores recommendations from its own reports

Likewise independent government commissioned reports have come and gone but the same problems remain. Few of the recommendations are implemented and none appear to be subsequently evaluated. [6] [7] In 2007 Minister of Health George Abbott introduced the province wide "Conversation on Health" with the clear but unstated intent of persuading us that our expectations for health care were unrealistically high and unaffordable unless solutions were provided from the private sector. BC residents,

[3] Janice Murphy, *A Community Participatory Study of the care and support needs and issues of seniors living in the areas of Castlegar, Kootenay Lake, Nelson and Trail.* September, 2006.

[4] Robert Jackson, *Seniors in Rural Communities, The West Kootenay Boundary Area,* Presentation to the Premier's Council on Aging and Seniors' Issues, July, 2006.

[5] KBRH Registered Nurses' Submission to IHA Board Members.*Nursing Views, Support, and Recommendations for KBRH. July 2007.*

[6] Penny J. Ballem, MD.,FRCP, Deputy Minister of Health, *Report to the Honourable Minister George Abbott, Minister of Health: Re: Mrs. Frances Albo.* February 2006.

[7] Medical Management Consulting, *Operational Review for IHA.Kootenay Boundary Regional Hospital & Greater Trail, British Columbia.* August 2006

including those from the West Kootenays, disagreed and had many excellent suggestions for how to fix our publicly funded health care system without privatizing it. This resulted in the "Conversation on Health" being shelved and the government proceeded with its unstated agenda which was to start privatizing as much of the health care system as possible so as to reduce costs to the government and pass them on to the consumer.

The inescapable conclusion is that neither the Ministry nor the IHA is interested in receiving community input unless the participants, the agenda, and the outcome can be controlled by them. Furthermore, IHA has received its mandate from the Minister of Health and must carry it out regardless of local community input.

Conclusion : Seniors and the disabled are the most at risk from the changes

Failure to address the problems created when health care service and delivery were changed has led to a crisis in the most vulnerable sectors of our society.

- People on disability or old age pensions are penalized the most when home support, home nursing and community services are cut. Because they are usually on a fixed pension they are least able to afford additional private sector services to keep them living comfortably and safely in their own homes.
- Limited incomes can mean patients cannot afford their prescription drugs.
- Seniors sometimes have to travel out of town to access programs on chronic disease management. Those over 75 years are the least familiar with computers. They may not be able to download information about their health issues. They may not be able to download benefit forms. Vision impaired seniors who are worried about their illness, find it stressful to read about it online. Literacy levels in our immigrant population can also compromise accessing information. Compromised hearing or cognitive problems impair everyone's ability to navigate phone options.
- Patients have problems driving long distances to access medical services. Severe winter weather and hours of darkness are also a factor. Some people do not own a car. Some seniors may not have a license anymore. A round trip for two by bus to Kelowna from Castlegar over two days, including meals and accommodation costs a minimum of $525.00. Some of this is tax deductible but some people may not pay taxes anyway because their income is too low.

- Driving out of town to get to emergency rooms after dark, particularly in winter weather, is not a desirable option and many patients will wait until the next morning rather than call an ambulance at a cost of $80. Also, once patients have left the emergency room after treatment, they are responsible for finding their own way home. Most of our communities do not have a taxi service on a regular basis and they do not operate at night. Nor do most communities have buses which operate at night or at the weekend.

Special problems for Seniors

Self-respect and pride in the senior age group means that they are least likely to ask for help if they cannot afford it, and they will cut costs somewhere else in order to manage. This can compromise their health and safety. Family members trying to fill the gap are burning out with managing their own families, jobs, and other responsibilities as well as helping out their elderly relatives physically and financially. Some seniors have to purchase home support for themselves, as well as pay for their spouse in a Long Term Care residence. “Involuntary separation” is the route seniors must go in order to pay their bills. Seniors worry over money and their health. They fear loss of their independence, and they experience isolation and depression.

The new “Home is Best” policy will not work

It is ironic that after almost a decade of cut backs in services which supported people’s ability to remain at home leading independent lives for as long as possible, that the Ministry of Health’s new mantra is “Home is Best”. Community groups take no pleasure in reminding policy makers that this is precisely what we have been saying since the cutbacks were implemented almost a decade ago. We predicted that it would be more expensive to fund frequent emergency room visits for people without adequate support at home. Now policy makers want to keep people at home – but with a big proviso – that individuals or their families now must pay for almost all of the home support services needed.

What should be done?

1) We ask the BC Ministry of Health Services to accept responsibility for the problems it caused in placing “sustainability” (i.e. affordability) over and above the five principles of the Canada Health Act which are mandated federally. It has been easy for the Ministry to use affordability as an excuse to avoid providing optimum health care.

2) We ask the Minister of Health Services and the Interior Health Authority to act immediately to reverse the trends outlined above. We ask them to address the declining availability of medical and home support services, the difficulty in accessing such services, the increasing financial burden on patients and their families, and, more broadly, the widening gap between the quality of rural and urban health care. Patients need advocates from inside the health care system to help them to access services.

3) We ask IHA to start respecting the input from local stakeholders before changes are made locally in health care services, whether stakeholders are providers or recipients, and to recognize that rural health care is different from urban health care.

Without doubt, properly funded health care is the most critical issue which patients and their families are facing today. Politicians need to recognize that Canadians view taking care of the most vulnerable sectors of our society, the elderly and the disabled, as a fundamental responsibility of all levels of government.