Submission to

Regionalization Assessment Team

from
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We thank the Honourable Joy MacPhail, Minister of Health, for applying the brakes to health care regionalization to allow for an assessment. The BC Coalition of People with Disabilities (BCCPD) has been among those in the community who have voiced serious concerns about how regionalization was proceeding and, although we welcome this opportunity to respond to some specific questions, we continue to believe that the regionalization process is fundamentally off course.

The Ministry's Consultation Questionnaire speaks directly to one of the main problems thus far–an almost exclusive emphasis on governance issues. The original motivation for regionalization of health care–to move services "closer to home" to make them more responsive and accessible to the public–has become almost totally obscured by governance. To be blunt, people who advocate around and receive health care in this province don't really care about governance. They want to know how they can work toward having the best possible health care for all people within their community.

If the Minister's assessment is to have any genuine impact on the direction that regionalization will take from here on, the basic assumptions have to be reexamined. The Seaton report did not recommend merely rearranging the health care pieces differently–it envisioned old and new pieces arranged together in a new creative whole to involve and better serve people wherever they live. To the extent that the BCCPD bought into regionalization at all, it was with the hope that it offered the potential for locally-defined heath priorities, alternative approaches to health care and delivery, new and effective partnerships, and consumer choice.

However, no work has thus far been done to determine if regionalization has or will improve actual delivery of services. If better care and service delivery are not the primary goal vs. governance or saving dollars, we fear that regionalization will give us nothing but a more unwieldy and less accountable

bureaucracy. We sincerely hope that this assessment will convince the Ministry of the need to revisit its commitment to a "new direction" in health care.

Following are our responses to questions in the Consultation Questionnaire.

Questions 2,3 and 4 • Roles of/Relationships between RHBs and CHCs

Since most of the RHBs and CHCs are not yet managing the funds allocated to their regions, it is not possible to fully assess their performance. However, we've come to see that these bodies will likely not create a new, more responsive level of health care delivery, but rather another level of bureaucracy.

Membership on the RHBs and CHCs is weighted in favour of Ministry of Health employees and administrators, and health professionals. The BC Nurses Union, for example, did a recent phone survey of the 82 CHCs and found that 49 CHCs have senior administrators or CEOs at this time. In 40 of these 49 CHCs, the same person is administrator for the CHC and the local hospital. The Ministry of Health hierarchy has simply transferred its people, power and philosophy to the regional and community levels–where is the "new vision"? When advocates and community participants see these kinds of patterns, they can be forgiven for feeling that the die is already cast.

The CHCs and RHBs need to be truly representative of their communities in order to reflect the health needs in their area, and they cannot be if they are dominated by health professionals who may well be in a conflict of interest around service delivery. These bodies could be effective if they have legitimate authority to make decisions and disperse funds in consultation with their communities.

Community health advocates want–and can fulfill–a legitimate role in defining regional needs and developing innovative programs to meet them. At this time, three groups–service providers, unions and management, and physicians–have mandated committees within the advisory structure. However,

the citizens' advisory committees are not mandated and therefore community concerns and expertise continue to be marginalized in favour of established and vested interests in the health system.

Question 10 • Amalgamation of Facilities

BC Rehabilitation Society

In 1995, the "Lovelace Report" stunned disability advocates who had been taking part in province-wide hearings on rehabilitation held by the Ministry of Health. Before the report from these hearings was completed, the Lovelace Report, an internal Ministry of Health document, made the recommendation to "cluster" BC Rehabilitation Society with the Arthritis Society and Vancouver Hospital. At the time, advocates from BCCPD had been involved in the hearings and on a consumer steering committee; they felt blindsided by this report that undermined the months of work they had undertaken in good faith.

BCCPD has since been working with BC Rehab and several other provincial disability groups to stop the amalgamation of BC Rehab. When demographics show that the number of people with disabilities is increasing, and the expectations of society and people with disabilities around their rights and quality of life are expanding, rehabilitation will need to be more anchored than ever in a distinct mission. Rehabilitation fills a unique and complex role in the independence and ongoing quality of life for people with disabilities, and this role will be severely compromised by blending rehabilitation with acute care services.

We believe that the amalgamation of rehabilitation with acute care signifies a continued misunderstanding about disability–that people with disabilities are sick. People with disabilities need to learn ways to adjust to and live with disability, they need different supports in their communities and they may need different accommodations to find their way back into a full life in their communities, but they are not sick. The amalgamation with acute care is a step back toward the sickness model of disability and takes us away from the

progressive, coordinated solutions that are needed for an effective rehabilitation network.

One of the most pressing rehabilitation issues over the past years, particularly with the downsizing of hospitals, has been a lack of transition planning. The transition that people face when moving from a rehabilitation setting to the community is a very sensitive one; in many cases, clients are discharged only to find that the services they need are not available or are overloaded in their community. Coordinated regional responses are needed for people who use transition rehabilitation services.

BC Rehab has been developing a "continuum of rehabilitation services" approach which the BCCPD supports. Specifically, we support BC Rehab's recommendation to form a regional rehabilitation/transition network to pilot an integrated, community-based approach to rehabilitation. We urge the Ministry to stop the amalgamation of BC Rehab with Vancouver Hospital and to support BC Rehab's initiative.

Question 11 • Role of the Ministry

The BCCPD and other community advocates are very concerned that regionalization has come to mean downloading of responsibility. The Ministry must maintain its role as the point of accountability for the health system–regionalized or otherwise. This includes development of core services, legislation to ensure equal access to health care, monitoring delivery of services, shifting the emphasis from treatment to prevention and health promotion, and fiscal management.

Perhaps most importantly, the Ministry needs to be the ideological force that keeps service delivery true to the Seaton report "closer to home" recommendations and builds a responsive flexible health system. We also need to see mechanisms to ensure accountability to taxpayers and health care consumers.

Question 13 • Challenges of Regionalization

Bottom-Up Process

By far the greatest challenge will be to shift the momentum from a top-down model to one that is bottom-up and truly community based, i.e. the Ministry needs to facilitate health care processes that are responsive to community needs rather than "managing" them. There are well-established ways of doing things within the health care professions and bureaucracies, and there is resistance to look at different ways–out of self-interest, out of the belief that nothing else will really work, or out of a lack of information.

However, some of the most progressive and effective health movements, such as the HIV/AIDS communities, women's health, and deinstitutionalization of people with disabilities, have shown us the possibilities that grassroots movements hold for leading community and social development. The Ministry of Health can and should take advantage of the rich resource of community experience and commitment, and direct its efforts to creating the infrastructure to support these kinds of initiatives.

The James Bay Community Health Centre is an excellent local model for how a community health centre can become a focal point for community expertise, participation and coordination. Ideally, it is this kind of initiative that regionalization could encourage and support. The centre works so well because the citizens involved in the James Bay Centre are experts on the needs of their area and they are working on issues that are important to them. We recommend that the Ministry encourage the development of community health centres by removing barriers, establishing incentives and providing resources.

For regionalized health care to fulfill its potential, the Ministry of Health must make a real ideological commitment to a health care system that supports community-defined needs.

Core Services

The fact that regionalization has proceeded this far without implementation of clear core services and ensured access to them is difficult to fathom. The Ministry's 1994 Core Services Report is written in such a way that there is no guarantee that citizens in different areas of the province have the right to equal access to service. The Report is also replete with terms like "should" and "might" in regard to provision of services. Because the delivery of core services is in turn tied to standards of care that vary from region to region, "core services" begins to look like a misnomer. Provincial health advocates are worried that advances they have fought for over the years are in danger of being undermined by a flawed core services process.

Legislation has been put in place for CHCs and RHBs, and governance, but people in BC have no legislation ensuring our right to equity of access around the province. Citizens' groups need to have input into core services and legislation must be designed to entrench province-wide access to them. It would be irresponsible to leave it to small under-resourced groups of people with disabilities, family members and advocacy organizations in the regions to lobby for their own essential services.

Comprehensive and clear definitions of core services and delivery must be an immediate priority for the Ministry of Health. We support the recommendation made by the BC Coalition for Health Care Reform, that a:

> "Core Services Task Force be established that will include provincial advocacy groups, health care providers, Ministry representatives and a personal representative of the Minister of Health. The Task Force should be mandated to:
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> - develop a blueprint for core services in each region which defines each service and outlines targets and timelines for their achievement
> - recommend what new or amended legislation is needed in order to guarantee equity and access to core health services (for example, the

Continuing Care Act must be replaced by more comprehensive rights-based legislation)

- establish a framework that will allow for an accountable, public process for monitoring regional compliance."