INTRODUCTION

Thank you for the opportunity to speak with you today.

My name is Dr Alan Ruddiman. I am a rural generalist physician practicing in Oliver BC for the past twenty years.

I am here as the President of Doctors of BC, the organization that represents 14,000 physicians around the province. I also co-chair the provincial Joint Standing Committee on Rural Issues - usually referred to simply as the JSC.

Doctors of BC remains committed to making a meaningful difference in improving health care for all British Columbians by working alongside our physician members and provincial partners to achieve quality patient care through engagement, collaboration, and by promoting and supporting physician leadership in our health care system.

For our organization, "Better – Together" is not just a tagline, it represents the fundamental approach we take as leaders and physicians of influence in advocating for positive change in BC's health care system.

Through the Joint Collaborative Programs, funded by the Physician Master Agreement, Doctors of BC partners with BC Government and Health Authorities to co-create and co-manage a wide range of initiatives that are benefitting patients, clinical care, and service access every day.

Today I hope to have a very open and frank conversation with you on two key areas of interest to this committee – Primary Care and Rural Care – both areas within my own expertise.

First, I would like to start by looking at the big picture- the really big picture at the international level.

Quite simply, our health care system is not what it used to be.

In 2014, the Commonwealth Fund looked at 11 developed nations' health care systems and found that Canada is second to the bottom when measured across all dimensions of our health care system. Only the United States scored lower than we did – and they at twice the per capita cost to us here in Canada.

The study focussed on four key co-ordinates in quality of care:

- effective care,
- safe care,
- coordinated care, and
- patient-centered care.

In assigning the rankings, the other key measures were – Access\ Efficiency \ Equity \ Healthy Lives \ and Per Capita Health Expenditures.

I bring this up not to be demoralizing, but to highlight that simple tweaks or finessing of a healthcare system in duress does not, and will not, bring lasting results.

We are faced with a unique opportunity to update and redesign our provincial and national publically-funded health care system.

The point I want to make is that it is important that we look at the provincial health care challenges we face from a systems-perspective – with a deep and appreciative enquiry of the 'big picture' perspective, particularly here in our own province.

And, we need to stop picking away at the small pieces as we have in past years. Rather we need to consider strategically how to work toward adaptations and improvements in the broader system.

We also need to stop thinking in 4-year election cycles, both in planning and implementing for the needs of our health care system for the next 15 to 25 years – not at some later date, but soon!

PRIMARY CARE

All of which brings us to the cornerstone of good health, and the first big issue to engage you on, - Primary Care….

We are pleased to see that in the policy papers produced by the Ministry of Health there is a real attempt to deal with the broad health care challenges in a strategic and holistic way.

It is a big job, and physicians have been and want to continue to be active partners and managers in helping to move our system forward.

<u>Our interest, first and foremost, is quality patient care and to build a better health care system</u>.

The challenges in our health care system have been discussed often, so I will quickly summarize:

> we are seeing an aging population that requires more care and more complex care,
> our population numbers continue grow,
> we are now appreciating and are on the cusp of a significant number of doctors retiring, and,
> our younger doctors are less willing to put in the grueling, all-encompassing workload taken on by doctors from previous generations. (A smart move really, as they want to remain healthy and be there for their patients, communities, and their own families).

So how do we meet these challenges?

Let's consider physicians as team players and leaders.

A key component of the government's primary care strategy focusses on expansion of interdisciplinary, team-based care.

The thinking is that by combining physician practices with 'networks' of other health providers such as nurses \ Nurse Practitioners \ and others, more patients will be able to get continuous primary care – maybe not from the doctor all the time, but depending on the complexity and severity of their condition.

At the same time, through data and co-ordinated electronic medical records and a team approach, we co-ordinate care and physicians can monitor the patients' progress.

Should something serious be taking place, the patient is referred to the physician (in the same practice) in timely way.

In this way, we are making the best use of the time and expertise of all our health professionals.

Doctors of BC is generally supportive of this direction.

In a visioning consultation conducted by the GPSC with more than 3,000 doctors, the majority viewed the concept in a favourable light, particularly our younger doctors who see this as a way to continue to provide quality patient care while also providing for a more balanced working career.

I should note the foundation for this model really found its foothold during the implementation of the "A GP for Me" program (another government/Doctors of BC partnership along with Health Authorities and local Divisions). We saw a number of successful new team-based practices emerge from this work. For instance:

In the Sunshine Coast and Kootenay communities, GPs are working together with **patient navigators and social workers** to help marginalized patients get community supports that provide daily living needs like housing, medications and transportation. Having these supports greatly improves their ability to manage their health.

At a new Wellness Centre at **Nanaimo's John Barsby Community School**, students in grades 8 through 12 can access primary care without leaving the school grounds. Doctors, public health nurses, social workers and community supports together help young people manage and prevent physical and mental issues early in life.

And in the **New Canadian Clinic** and the **Global Family Care Clinic** in Burnaby, government sponsored refugees whose medical needs may be complicated by language, cultural, and knowledge barriers are cared for by a Nurse Practitioner who works collaboratively with physicians in the community and with interpreters who speak more than 150 languages.

The Burnaby Division of Family Practice then partners with the Health Authority to take unattached patients when they are discharged from the clinic.

So we know these models can work. That said, there are key areas that we believe need attention if these kinds of approaches are to be successful:

1 - Role of the physician within the team

Physicians respect the role all team members play, with collaboration taking place every step of the way.

That said, I think we can agree that when things get medically complicated and when a patient's life is at risk, all eyes generally turn to the doctor – the medical expert – for their skill, expertise, and resourcefulness.

Within all organized teams, there is always a member considered to be the leader. In a team-based health care system, the physician continues to be the medical expert leader.

Doctors take their role in health care very seriously, yet don't have to see every patient, every time – sometimes patients will receive equitable or more focussed care from another health provider within the team.

Collaboration is important. Yet research continues to demonstrate that the fundamental doctor-patient relationship remains the foundation for cost effective and efficient primary care. And we simply must protect that, within the team-based model.

2 – Data/Electronic Medical Records/ Electronic Health Records

How do we effectively and efficiently do this?

A comprehensive, integrated approach to electronic health records is essential.

EMRs are critically important to coordinated care. We need a universally accessible IT system that allows for seamless sharing and access to critical patient information when and where it's needed. Not just in BC, but across the country.

Doctors and other health care professionals need to be a key part of developing these systems in a way that ensures EMRs work within the clinical care system, and that they work to provide the best care for our patients.

Systems designed with little or no legitimate input from physicians and other health care providers are destined to fail.

As tools they should be adaptive to how health care providers think and function, to adapt to the workflow of the health care team. EHRs and EMRs as a utility should be servants to the providers of patient care - not the other way round.

3 - Flexibility

There is no such thing as a 'one-size fits all' model for team-based care. Different solutions work for different communities. What works in a small community in the north, may not work or be

relevant in a larger urban centre.

On a broad scale GPSC, with its membership from Doctors of BC, Ministry of Health, and Health Authorities, is well positioned to provincially co-design the Patient Medical Home and Primary Care Home – while supporting Divisions as they work with their Health Authority at the local level.

Similarly, government and doctors need to be open to new compensation models, including some non-traditional models.

No one model can be imposed and we are pleased that the Ministry appears open to developing local solutions to local challenges, with some Health Authorities working collaboratively with their Divisions to co-create a model.

4 - Health Authorities

This brings me to the last point in this section, and it is a sensitive one. It has to do with how Health Authorities relate to physicians (and vice versa).

We recently surveyed our physician members and included a section on the degree to which physicians perceive their relationship with Health Authorities.

In short, the results are not reassuring and are in fact, quite disappointing.

Many physicians – especially specialists and facilities-based physicians including many GPs (a large number of whom are rural) – feel they get no respect from Health Authorities nor are their professional voices heard and valued. Less than 40% of physicians said they effectively engage with health authorities.

The physician voice deserves greater authority, representation, and influence.

We are working with physicians to be recognized leaders – to be physicians of influence within the HA's. The new Medical Staff Associations funded through the Physician Master Agreement will offer the conduit for this influence and the opportunities for meaningful change.

But we do need this scenario to change in order to move forward effectively and we call on both physicians and Health Authorities to work together to resolve this.

I will conclude the section on primary care with one last thought. Change is hard, especially change of this scope.

It is important that the Ministry provides funding to support change management – including education and supports for physicians and other health care providers – as we navigate this new road. And to ensure that new systems – such as patient data and EHRs – are in place and work effectively.

Physicians look forward to embarking on this adventure. Let's do it together, so that we can embrace positive change. Our patients need it, and they deserve it.

RURAL CARE

Rural medicine is a topic very close to my heart. As I said, I am a practicing rural generalist physician and have been so for the past 25 years in Canada.

I am also the Doctors of BC co-chair on the Joint Standing Committee on Rural Issues – the JSC. This is the longest serving and most enduring of the Joint Collaborative Committees with negotiated government funding through the Physician Master Agreement.

In BC, the number of physicians practicing in rural and remote communities is said to be increasing. But we still have a great deal of work to do.

Twenty-five per cent of patients in BC live and work in rural communities, yet only 14 per cent of doctors are located there. Rural proofing our most vulnerable communities is of paramount importance.

I would like to read to you a brief quote from Dr Peter Newbery of Hazelton, BC, recipient of the Order of Canada, who said as recently as last week:

> *For rural, remote, isolated communities, the presence of a family doctor who makes a commitment to the community contributes not only to individual patient care but – just as importantly – to how the community thinks and feels about itself.*

To move forward, we need to again think "big picture" – to work across Ministries, Health Authorities, and communities.

We need to support the growth of vibrant communities that provide recreational, educational, and work opportunities that will attract physicians, other health professionals, and their families.

Delivering rural health care is way more challenging, and the rewards are equally way more satisfying for so many of our doctors and allied health care professionals.

Health Human Resources

I'd like to go back to my premise that within the team-based care system, the relationship between doctor and patient is of core importance.

In this respect, if we truly are to pay attention to the alert of the Commonwealth Fund, the area we need to focus on, invest in, and heavily promote and advocate for is - <u>generalism</u> in medicine.

Generalism refers to physicians who practice to the depth and breadth of their foundational training, and embrace its tenets.

Generalists are rational risk-takers who are comfortable addressing and dealing with patients with undifferentiated illness and need.

For instance, a GP in a small community may have an office based practice, but they also make hospital rounds, do house calls, participate in the ER call roster, and they may even have enhanced training in obstetrical care or anesthesia, so that they can contribute to the core community surgical programs and deliver babies locally.

Generalism in family medicine and in the core specialities is where we need to be moving in Health Human Resources Planning especially in our rural areas. That's where most of the health care 'encounters' actually happen across our province.

So how do we do this?

It will take a renewed commitment across all levels of society to embrace and promote this, and to ensure the funds and resources are appropriate to enable this to occur.

Access in our own province and country to adequately train our physicians of the future, to encourage our university to embrace generalist education and training as the core of the social contract.

To select entrants to medical school who have the attributes to be our next generation of rational risk takers, not just those with excellent entry grades.

CONCLUSION

Thank you for your time today. Physicians believe that partnership and collaboration are key to moving forward and making a positive difference for patients.

BC's physicians want to do this working with Government, the Health Authorities, and other partners to provide the best quality patient care.

I have provided my thoughts in the two key areas of Primary Care and Rural Care. I look forward to responding to your questions.