Complete Solutions

How communities can work within & around the established health system

By Curt Smecher

In 2002 the government of British Columbia amalgamated the province's 52 regional health boards into five large health authorities. The smallest serves over 300,000 people living in the north of the province, the largest over 1.5 million people in its Lower Mainland. These authorities have used their power to contract out some services, cut many others, and generally serve as the government's major instrument in the reduction of provincial health costs. In B.C., "efficiency" means "centralization."

Yet the larger, more centralized the health system, the less likely it is to be responsive to local needs. Competing demands tend to lead to incomplete solutions, "good enough" for a large health authority that needs to move on to its next crisis.

Where local priorities differ from those of the health care authority, it is up to the local community to resolve the differences. No-one else will or can. To do that, community members have to look upon problems or gaps in their health services also as opportunities. They need to identify the resources available to them, to tap into those opportunities, and to create an organization to co-ordinate their actions. Lastly, they have to be ready to learn as they go, and go as they learn, and reflect on both their wins and their losses so they can do even better next time.

This article explains how that is happening in two small towns in B.C., Port Alberni and Nelson.

Port Alberni's Problem: Recruitment of Medical Specialists

Since 2002 many small communities in B.C. have lost vital services. Port Alberni lost its hospital laundry services and a quarter of its acute care beds; we saw registered nurses replaced with practical nurses and care aides. There were budget cuts throughout the system. Medical leaders, both in the hospital and in private clinics, saw their ability to care for patients seriously eroded. Community members organized a coalition, Save Our Services, to protect local health care services.

Then, in the winter of 2005, we learned that our last two internal medicine specialists would be leaving, one for health reasons and the other because of the onerous working conditions that faced a solo internist. This spelled disaster for Port Alberni and its hospital. The Intensive Care Unit depended on those specialists, as did the Emergency Room and family physicians. There could be no local specialist follow-up for complex medical patients.

This was not a problem that a large, distant bureaucracy could address. Nor could it perceive or grasp the opportunity this also presented to Port Alberni. In 2006, the municipal government, the Save Our Services coalition, and local doctors came together to do something about it.

The Opportunity

Our opportunity lay in identifying and removing local barriers to recruitment with the resources available to us.

The larger, more centralized the health system, the less likely it is to be responsive to local needs. Competing demands tend to lead to incomplete solutions, "good enough" for a large health authority that needs to move on to its next crisis.

Small towns like Port Alberni often lack employment opportunities for spouses. Candidates may be discouraged by start-up costs and logistics, onerous call responsibilities, and lack of locums (i.e., temporary medical professionals) to provide time off. Then there is the need for homes, schools, and facilities – like recreation centres or libraries – important to family members, apart from any number of issues peculiar to the individual professional or community.

Each community has resources that may be brought to bear on many of these obstacles. Some of these resources (like public enthusiasm, local employment opportunities, and knowing who's who in medical, educational, business, and government circles) may be invisible to outsiders. Only those of us who live in small towns can use these resources to "sell" the community and compete effectively for the short supply of doctors.

Money is crucial. The Canadian health care system, with government the only billable party for all services deemed

medically-necessary, has many advantages. But it does mean that trying to establish competing alternatives can be financially difficult. There are four main sources of funds for community-driven initiatives in health care:

- *Government programs* that pay private sector agencies (nonprofit or for-profit) to provide services, for the long-term care of seniors, for example. Sometimes government grants are also available when the government is promoting specific initiatives, such as primary health care reform, nurse practitioners, or electronic medical records.
- *Health Care Providers* who pay rent and facilities management fees (e.g., maintenance, cleaning, garbage collection, ordering supplies, capital equipment, receivables, staff hiring and supervision) or who contract to supply services paid for by the provincial medical health insurance plan.
- *Patients and their families* who choose to pay for medical services that are not insured under the medical health insurance plan. Services such as insurance forms, third party medical exams, and pre-employment exams are examples of services that are billed separately.
- *Third parties* like credit unions, charitable foundations, economic development organizations, or non-governmental organizations may supply grants or loans to cover costs of planning and start-up. Longer term funding may be possible through special interest groups. They assist a wide variety of community-based projects well beyond the narrower definition of health care.

The Initiative

As a member of the coalition and a concerned physician, I drew up a strategy to shore up the town's immediate need for an internal medicine specialist and create a environment more attractive to medical professionals. We would open an internal medicine clinic on hospital premises, with locums to cover services while we sought out permanent staff. This would keep the Intensive Care Unit open, and support the Emergency Room and family physicians. Once we hired an internist, s/he would have the locums as support and as a means to share on-call responsibilities and as back-up resources.

The Regional Health Authority agreed to locate the clinic in the hospital and cover the costs of renovating the space, as well as equipment from the hospital's supply and even some additional purchases, where necessary. It was not clear exactly what the Health Authority would provide or for how long, so there was no clear financial plan, but it seemed reasonable to proceed.

Although two internists and then a third moved to town to work in the clinic, no one came forward to manage it. It offered a relatively low return, given the difficulty that a specialist clinic could involve. It was also unlike any other local business and depended on the co-operation of the Health Authority. It finally fell to me to run the clinic "off the side of my desk" – manager, accountant, and supervisor rolled into one.

As a result, management was haphazard and burdensome.

Results & Lessons

Port Alberni now has a well-functioning Internal Medicine Clinic, owned and operated by the three internal medicine specialists themselves. They continue to operate in the hospital, sharing the expenses between them.

A business plan, a clear financial plan, and an adequate management plan may not be exciting, but they are necessary. The next attempt to create a clinic was different. I was one of six residents who first formed the board of the Pacific Rim Health Services Cooperative so we could address the challenge with a properly resourced team.

If a community initiative is worth doing, it deserves the attention that any business would. Without adequate support, the service looks haphazard to physicians, & this may make it more difficult to hire & keep them happy.

The 2nd Problem: Recruitment of General Practitioners

Many communities across Canada are finding it difficult to recruit and retain doctors, nurses and other medical professionals. In 2003, more than 1.2 million Canadians were unable to find a regular physician. The Canadian Nurses Association predicts that the country will be 113,000 (31%) nurses short of the estimated demand for 2016.*

In the spring of 2006, Port Alberni had a large number of citizens who were unable to find a family physician. One family practice was about to close, leaving thousands more people without a doctor. Local family doctors were all operating as solo practices. Each doctor had to do all the management, carry all the costs of overhead, and bear all the responsibility for finding relief while away. Any physician new to town would have to find office space, renovate for a clinic, hire staff, buy telephones, office supplies, medical supplies, and perform many more tasks before treating a single patient.

* Statistics Canada, "The Daily, June 15, 2004." 25 July 2007 <http://www.statcan.ca/Daily/English/040615/d040615b.htm>; E. Ryten, "Planning for the Future: Nursing Human Resource Projections" (Ottawa: Canadian Nurses Association, 2002). 25 July 2007 <http://www.cna-nurses.ca/CNA/documents/pdf/publications/Planning_for_the_future_June_2002_e.pdf>.

The Opportunity & Initiative

Going by the experience of other towns, Port Alberni would likely have been much more attractive to doctors if group practices were available. It was up to the co-op to create the confluence of opportunity and resources necessary to make an initiative happen with a budget that, at first, was exactly zero.

After an extensive search, we located a suitable building for a group clinic. It was owned by the City, which agreed to lease the building to us for $1 for two years. The Health Authority agreed to finance the few renovations that the space required. A departing doctor even agreed to leave the clinic his office furniture.

Twenty or more co-op members and other volunteers cleaned, painted, and moved furniture and supplies into the new building. A local group supplied a short-term loan for operating funds. The facility management fees were expected to cover the clinic's expenses, and the doctors' rent payments would provide operating funds for expansion. The local Women's Resources Group provided management of the facilities and accounting services in return for office space.

As a result, we faced essentially no expenses until we had found doctors and the clinic was operating.

Results & Lessons

By the time the building was ready, the first physician was all set to move into what we had named the Alberni Family Practice Clinic. Within three months, a second had joined her. Anyone looking for a family physician in Port Alberni could now find one.

The clinic is owned and operated by the co-op. It owns the assets and hires the staff. A wide range of skills is represented on the board – management, financial, legal, and medical. With the community behind it, the co-op has easy access to additional skills as needed.

We have just added a general surgeon to begin broadening the service base. Co-location of family physicians and specialists should make it easier for the doctors to discuss cases and co-ordinate treatments. We are looking at purchasing the clinic building and expanding services to include both physician and non-physician based health services.

Clearly, it is not advisable to "bolt" small-scale, no-budget projects onto the job description of a fully-employed person, as was the case with our Internal Medicine Clinic. If a community initiative is worth doing, it deserves the attention that any business would. Clarity of roles, expectations, and time-lines are difficult when working with volunteers, but vital to the health of the organization and therefore its ability to reach its goals. Without adequate support, the service looks fragmented and haphazard to the physicians, and this may make it more difficult to hire and keep them happy. This is their livelihood and it affects the health of their patients.

Nelson's Problem: Extended Care for Seniors

Nelson was another community deeply disturbed by health care restructuring in 2002. Adding to the sting in Nelson's case was the fact that local organizations used to control many of the facilities being terminated. For many years, a nonprofit society had run over two dozen publicly-funded programs for seniors, disabled people, teen mothers, children, and mental health patients out of buildings it owned. The society turned over these assets to the government in the early 1990s when the province drove to reduce costs through service amalgamation. Mount St. Francis, an extended care facility owned by a religious order, was also appropriated.

The Interior Health Authority's (IHA) subsequent elimination of Nelson's acute care services and many of its "non-health related" seniors programs in 2002 caused an uproar. Nelson has a high proportion of seniors, especially single women living below the poverty line. The community is well organized around the needs of seniors, with a Seniors Coordinating Society and Seniors Committee that report to City Council.

Like Port Alberni, Nelson organized a Save Our Services coalition and then in February 2003 the Community First

(above) The reception area for the Acupuncture and Natural Health Clinic in the Nelson and Area Wellness Centre. The Centre has brought an entirely new look to a building (inset) left vacant by the Ministry of Forests. Credit: Community First Credit Union.

Health Co-op to find a "workable, positive, and proactive community based approach to health care." Over 1400 people joined.

The Opportunity & the Initiative

The IHA was accepting proposals for an extended care facility to replace the aging Mount St. Francis. Community First's first project was to submit a proposal to build and operate a complex care and assisted living facility.

Co-op members believed that Nelson was ready to take on the challenge of building and operating such a facility. They also wanted the facility to reflect community values and to ensure that residents were treated with due respect and dignity. The many co-op members offered a wealth of resources and contacts, providing direct knowledge of running, staffing, and operating such a facility, as well as general business and health care expertise.

For complete solutions of health care issues community control is essential. Only local people can fully perceive community needs, the opportunities latent within those needs, & the unique local resources available to grasp those opportunities.

The facility was to be operated under contract from the IHA, like most of the region's extended care facilities. These funds would cover the mortgage as well as the operating costs. As a nonprofit co-operative, additional funds would be available beyond the IHA contract, such as grants in aid of business start-up.

The plan was to hire a manager for the facility and use the existing staff to run it. The co-op board would provide oversight. The Good Samaritan Society, which currently operates in over 230 communities, would provide "back up," if additional help was needed.

Results & Lessons

The IHA rejected Community First's proposal because of the co-operative's lack of a corporate track record in the provision of services. In fact, IHA had drafted the Request for Proposal with a for-profit model in mind, since this was the usual mode of operating. Community-owned co-operatives were (and remain) a novel approach that is outside the model and experience of the large health care authorities.

The need to invest more in presentation and marketing to the IHA was now apparent. What seemed self-evident to the community still needed to be sold to the large agencies in their own terms of reference and within their own business understanding. *The IHA was looking for an answer to its Request for Proposal, not to local needs as the community perceived them.*

Internally, however, this disappointment reinforced the community's determination to exercise authority in health care services and affirmed the appropriateness of the co-operative as a mechanism for doing so.

A Second Problem: Lack of Service Co-ordination

Nelson has a wide range of alternative health providers, including the Academy of Classical Oriental Sciences, a training facility offering 3-5 year programs in traditional Chinese medicine. It also has a good complement of traditional western medicine resources in the community.

Nelson residents found the co-ordination between alternative and traditional medical practitioners difficult, each having a limited understanding of the strengths and weaknesses of the other. The location of social services, early childhood services, and other community resources in different places around town impaired co-ordination of these services as well.

The Opportunity & the Initiative

Once again, outside health authorities could perceive neither unique community needs nor unique community resources. Co-op members recognized both. The community wanted a co-ordinated approach to health care and a vacant government forestry building would make suitable premises for a common service outlet: The Nelson and Area Wellness Centre.

Community First secured a grant from the local credit union and a 25-year mortgage from a commercial lender to purchase the building and do the required renovations. The plan, for the present, is to operate at cost, and pay off the mortgage. Agencies and practitioners are to pay a rent based somewhat on ability to pay, with different rates for nonprofit and for-profit services. They are also to share the costs of maintenance and utilities. Once the mortgage is paid off, funds will flow back into the co-operative and channel back into local health and well-being projects and activities.

The building is run by a volunteer manager with the support of a volunteer building committee and an in-house committee made up of tenant representatives.

Results & Lessons

The building is now up and running. It houses practitioners of traditional Chinese medicine, general practitioners, social

services, and early childhood services. The building provides a locus for growth of services within the community.

In the meantime, Community First has other projects on the go. It has received funding from Canada Mortgage and Housing Corporation to begin the conversion of one-time community college dormitories into housing units. The co-op is looking for funding to support the renovation of multi-generational affordable residential apartments. A 60-unit retirement centre and a rehabilitation centre are also under discussion.

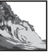
Relieving a System Under Stress

Within the centralized health system we currently have in B.C., everyone is under stress. Physicians are frustrated at not being able to give the care that they feel is required. They are often blamed for the inadequacies of the system, yet cannot get it to respond to their advice or requests. Nurses are burnt out by overtime and workload. They get angry at doctors for not discharging patients earlier and relieving pressure on the part of the system to which they are closest.

Each group lashes out at the nearest target – each other. The only local priority big enough to warrant the attention of the Regional Health Authority is crisis. This tempts people to engage in "crisis creation" to get local issues dealt with, and perpetuates stress, mutual mistrust, and short-term, incomplete solutions.

For complete solutions of health care issues community control is essential. Only local people can fully perceive community needs, the opportunities latent within those needs, and the unique local resources available to grasp those opportunities. A great many business and management skills are required to carry out these responsibilities, it is true. But communities often have access to the necessary skills within the vast array of abilities present (and often hidden) locally. Residents can also learn new skills and expand on existing strengths. They are not doing this for "clients" or "constituents," after all, but for themselves and for their neighbours.

Pacific Rim Health Services Cooperative and Community First Health Co-op demonstrate how it is possible to grow a community-owned and -operated health service. It is time to make our health system tap this resource.



CURT SMECHER is the former Chief of Staff at West Coast General Hospital in Port Alberni, Tofino General Hospital, and Chief of Primary Care for the west coast of Vancouver Island. He practices as a specialist anesthesiologist at West Coast General Hospital and is the President of the Pacific Rim Health Services Cooperative. Contact him at curt@smecher.bc.ca.

enrichingyourlife

Since we began our Community Investment Program we have contributed close to $300,000 to help support various groups, projects and initiatives involved with health care! It's one more way we can get behind those who work so hard to make our communities in the Kootenays healthy places to live.

Nelson & District

Nelson 352-7207 Rossland 362-7393 East Shore 227-9221

enrichingyourlife@nelsoncu.com

CUSO

SUSTAINABLE INTERNATIONAL DEVELOPMENT SINCE 1961

Photo: CUSO Archives

Open your eyes. Share your skills. Test your limits.

VOLUNTEER OVERSEAS

CUSO is seeking Canadians who have experience in community based natural resource management, land planning, economic development, agriculture, and project management. Together, CUSO volunteers and international partners are working to make change happen around the world. For more information on our volunteer placements benefits and to apply online, visit:

CUSO.org