

Appropriate Care for All Act (ACAA)

Proposed Legislative Bill – British Columbia

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BC has a unique opportunity to lead the nation in evidence-based healthcare reform—setting a strong example for other provinces and positioning Canada as a global leader in high-quality, publicly funded healthcare.

Executive Summary

Problem:

Healthcare delivery in British Columbia and across Canada is increasingly misaligned. Patients are receiving long-term care in acute care facilities, primary care in emergency and urgent care settings, convalescent inpatient care in emergency departments, and life-saving treatment on hallway stretchers. This inappropriate care delivery stems from a lack of transparent performance metrics, defined accountability, and independent oversight to proactively address systemic issues. As a result, dysfunction has deepened across our health system. This is reflected in rising costs, long wait times, emergency department closures, provider burnout, workforce attrition, and deteriorating patient outcomes.

Purpose of the Act:

The *Appropriate Care for All Act* (*ACAA*) aims to realign healthcare delivery to ensure timely access, greater system efficiency, and improved patient-centred outcomes. It leverages transparent performance metrics to drive and sustain healthcare reform, while enhancing public trust through a culture of transparency and accountability.

ACAA is grounded in robust evidence and aligns with the policy positions of leading physician advocacy bodies, including the Canadian Medical Association (CMA), Doctors of BC, and the Canadian Association of Emergency Physicians (CAEP). Comparable initiatives in Alberta and Ontario have demonstrated measurable gains in system performance. With no comparable legislation currently in place in BC, *ACAA* addresses a critical gap in the province's healthcare framework.

Key Components:

1. Establish transparent provincial performance targets for emergency and hospital care that align with national standards, allowing both the public and policymakers to track measurable progress
2. Mandate public reporting of specific emergency and hospital metrics, including quarterly region-level performance reports
3. Introduce an accountability framework to embed system-wide accountability and drive innovation
4. Establish independent oversight to audit performance, ensure sustainability, and create opportunities for meaningful engagement with patients and providers

Impact:

BC has a unique opportunity to lead the nation in delivering *Appropriate Care for All*—ensuring every patient receives high-quality care from the right provider, at the right time, and in the right place. Research consistently shows that well-aligned healthcare delivery improves patient-oriented outcomes, including access to care, safety, and satisfaction. It also enhances system efficiency and promotes the efficient use of scarce resources.

The *ACAA* empowers communities, healthcare leaders, and policymakers with actionable, timely data and a comprehensive accountability framework. This will enhance public trust and foster constructive engagement across our system. Addressing the root causes of burnout and fostering meaningful engagement with frontline providers will improve the retention and recruitment of healthcare professionals.

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Background:

BC's emergency departments (EDs) have faced systemic challenges for decades and are now at a breaking point. ED closures, hallway medicine, preventable patient harm, provider burnout and accelerated workforce attrition are now commonplace. Patients are waiting longer than ever for care, and overcrowded hospitals are placing both patients and staff at risk. BC is not alone in facing an access crisis – similar scenes are playing out across Canada, and national health outcomes are declining even as healthcare spending rises.

The absence of a clear accountability framework is a root cause of chronic system dysfunction. Without defined accountability, there is no stressor to drive innovation and accelerate the movement of patients from queues into care. The result is system-wide inefficiency and inappropriate care.

Appropriate care was defined in the CMA's 2014 *Appropriateness in Health Care Policy* as "the right care, provided by the right provider, to the right patient, in the right place, at the right time, resulting in optimal quality care." Research consistently shows that appropriate care improves outcomes and system efficiency, while system-wide capacity is compromised when patients receive care in the wrong setting.

Transparency is a critical first step to achieve both accountability and appropriateness in healthcare, yet it remains limited despite policy commitments. For example, BC Health Authorities have variable compliance with reporting to the National Ambulatory Care Reporting System (NACRS). Without public access to this data, communities and policymakers cannot identify gaps or drive meaningful change. The *ACAA* would mandate transparent reporting, establish clear performance targets, define accountability zones across the system, and ensure independent oversight and evaluation.

Legislative Gap in British Columbia[1]

There is no current legislation in BC that mandates emergency care transparency or ties performance to Health Authority accountability. While some laws touch on related themes, none fulfill the specific objectives of the *ACAA.*

1. The *Health Authorities Act* requires annual reporting but lacks standardized ED/hospital metrics, real-time public-facing dashboards, and accountability mechanisms for missed targets.

2. Quarterly reporting obligations exist (e.g., executive compensation), but these are not tied to system performance or patient-oriented outcomes.

3. Bill 12 – *Public Health Accountability and Cost Recovery Act* (2024) focuses on corporate cost recovery, not health system performance.

4. The *Public Interest Disclosure Act (PIDA)* provides baseline whistleblower protections for some public-sector employees but does not address the unique risks faced by physicians who advocate for systemic change. In two years, there have been just 37 disclosures, 9 investigations, and 1 finding of wrongdoing. Given our Health Authorities employ an estimated 150,000 workers, these results suggest the Act, in its current form, is not achieving its intended effect.

[1] See references 14-17

Comparable Legislation and Policies in Canada (Appendix 1 and 2)

Province	Transparency	Accountability	Independent Oversight	Outcomes
Ontario[2] (*ECFAA*) 2010	Publicly reports ED metrics Data are viewable by hospital, community, or region to enable comparisons Broader data sets along with targets are published regionally to drive accountability Mandatory audits of ED return visits with annual public reporting of findings and QI initiatives	*ECFAA* links hospital executive compensation to quality targets and mandates patient and staff surveys Ontario's Pay-for-Results program linked data submission and hospital performance to funding	Ontario Patient Ombudsman created to address complaints, resolve disputes, identify recurring issues and systemic problems, and offer recommendations for broader healthcare reforms	~15% reduction in LOS[3] 13% reduction of PIA[4] 30% reduction in LWBS[5] rates Ambulance offload delays nearly eliminated in urban centers
Alberta[6] (*HCAP* – Policy) 2022	Publicly reports ED metrics since 2011 Integrated data systems track and compare ED metrics across regions Performance benchmarks published since 2014, with regular weekly updates *HCAP* expanded use of real-time public dashboards and increased reporting of system performance indicators	*HCAP* linked performance to leadership roles	Utilizes third party audits to ensure data accuracy and transparency	Wait times dropped ~17% ED LOS for admitted patients decreased by 26%

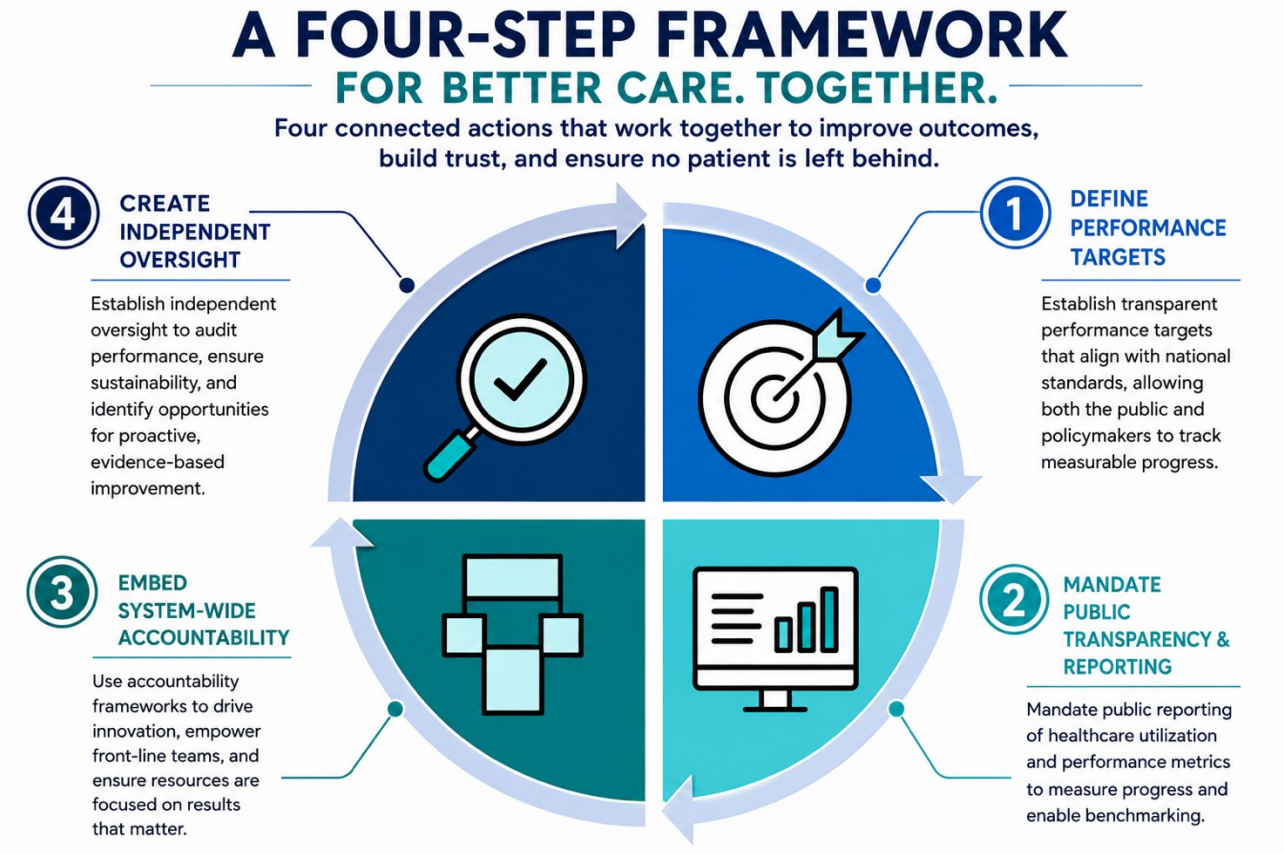
[2] See references 18-24

[3] Length of Stay

[4] Physician Initial Assessment

[5] Left Without Being Seen

[6] See references 25-34



Key Components of the Proposed Bill:

1. Performance Targets & Benchmarking

    - The Ministry of Health will set annual targets for each metric, with province-wide and regional benchmarks available for public review.
    - These targets will be informed by national standards (Appendix 4).
    - Performance expectations apply to Health Authorities and executives through a principle of graded improvement—measured progress over time rather than punitive enforcement.
        - Health Authorities meeting targets (e.g., timely access to care) are eligible for innovation grants or funding bonuses.
        - Persistent under-performance triggers structured Ministry support, audit review, or funding realignment.
    - Executive roles must be explicitly defined with clear lines of responsibility for meeting metrics.

2. Mandatory Public Transparency and Reporting:

    - Each BC Health Authority must comply with NACRS requirements and submit this data to the Canadian Institute for Health Information (CIHI) within a specified time frame.
    - A publicly accessible online portal will provide timely visualization of health system performance, including plain-language summaries and region-by-region comparisons.

- Each BC Health Authority must publicly report current and projected specialist shortages so communities and providers can plan accordingly.
- Each BC Health Authority must publish public-facing quarterly reports on standardized emergency care and hospital performance metrics (Appendix 3).

3. Patient Care Accountability Framework:

   Accountability is the evolutionary stressor required to drive system improvement. It is defined conceptually, as outlined below, and quantitatively based on performance and time targets.

   - Patient care accountability frameworks define care expectations and accountability zones, clarifying that every program has a population (accountability zone) and every patient has an accountable healthcare home (Appendix 5 and 6).
   - They present a clear and different understanding of program accountability, intended to drive the implementation of strategies that will expedite the right care in the right place (appropriate care).
   - Program accountabilities include timely patient assessment and disposition; management of budget, space, and nursing care for program patients; and development of contingency plans for surges and queues.
   - To better achieve accountability metrics, programs must develop service delivery plans that rationally and efficiently allocate resources to care for their target population, including patients in the queue.

4. Independent Oversight and Provider Engagement:

   Health authorities, as direct operators of care delivery, cannot simultaneously act as impartial auditors of their own performance. BC should be the first province to establish an independent Health System Transparency & Accountability (HeSTA) Office.

   HeSTA would provide specialized, data-driven, and proactive oversight of BC's healthcare system, while also addressing complaints currently handled by the BC Ombudsperson. This dual mandate would allow both systemic oversight and individual support, improving public confidence in the system’s fairness and responsiveness.

   <u>Core Functions of HeSTA</u>

   - Audit and Investigate: Monitor key system metrics and investigate critical incidents, system failures or recurring patterns of concern.
   - Whistleblower Protection: Provide a safe channel for healthcare workers to raise concerns without fear of reprisal.
   - Patient Support: Manage patient complaints and mediate concerns (currently done by BC Ombudsperson); conduct and publish annual patient-experience surveys by health authority.
   - Provider Support: Address administrative bullying, mediate disputes, and publish annual surveys on provider well-being, safety, and engagement.
   - Ensure Independence: Maintain stable, protected funding and operate at arm’s length from government and election cycles.

Future Expansion

1. Implement a Comprehensive Appropriate Care Strategy

   Health-system leaders should establish transparent performance targets across all key domains, including primary, specialty, acute, and community care. Legislation should:

   - Mandate independent evaluation and public reporting on wait times, continuity, and access to both primary and specialist care (Appendix 7).
   - Close the “access–accountability loop” by ensuring every program is responsible for its patients until an appropriate handoff occurs.

2. Federal Role in Access Accountability

   - Tie portions of the Canada Health Transfer (CHT) to provincial public reporting of access metrics.
   - Develop national performance standards with incentives for transparency and timely care
   - Support interprovincial comparisons to highlight innovations, identify gaps, and share best practices.

Summary and Conclusions

BC policymakers have an opportunity to realign healthcare delivery by embedding transparency, measurable performance targets, independent evaluation, and defined accountability at every level. The *ACAA* fills a critical gap in BC's legislative framework and leverages existing infrastructure to drive sustainable reform.

While no Canadian province has enacted legislation as comprehensive as the *ACAA*, both Alberta and Ontario have implemented key components that demonstrate its feasibility and impact. By building on these precedents and adapting them to BC's context, this Act positions the province as a leader in modern, data-informed health governance. Future expansions should include a comprehensive *Appropriate Care* model that encompasses other key domains such as primary, specialty, and community care. The federal government should play a leadership role in access accountability by linking funding to public reporting, setting national performance expectations, and fostering interprovincial collaboration.

Adopting these measures would shift the system from reactive crisis management to a proactive *Appropriate Care* model—where patients receive care from the right provider, at the right time, in the right setting. This approach has consistently been shown to improve patient-oriented outcomes, workforce stability, and system efficiency, all of which are essential in our current fiscal and human-resource environment.

Central to this transformation is the implementation of a Patient Care Accountability Framework, where individual programs must develop service delivery plans aligned with the needs of their target population. Lengthening queues and temporary closures must no longer be accepted as inevitable outcomes of demand. Jurisdictions that have embraced transparency demonstrate that transparency drives accountability—and accountability drives innovation.

The creation of the HeSTA Office would provide independent, data-driven oversight. HeSTA would ensure both systemic and individual concerns are addressed in a proactive and collaborative manner.

There is robust evidence that the key components outlined herein can reduce wait times, improve emergency and hospital flow, enhance patient safety, and support the retention of a resilient healthcare workforce. The Act aligns with the policy positions of leading physician advocacy bodies, including the CMA, Doctors of BC, and CAEP. Moreover, it directly addresses several current Ministry of Health mandates.

By equipping patients, communities, healthcare leaders, and frontline providers with transparent data and a clear accountability framework, this legislation lays the foundation for lasting, evidence-based change. Ultimately, BC's healthcare system belongs to all of us—and with bold, collaborative leadership, BC can lead the nation toward *Appropriate Care For All*.

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Appendix 1: Comparable Legislation in Ontario[7]

1. Transparency and public reporting:
    - Ontario publicly reports ED metrics such as time to Physician Initial Assessment (PIA), Length of Stay (LOS) for admitted and discharged patients, stratified by CTAS levels. Data are viewable by hospital, community, or region, with options for comparison and download.
    - Hospitals and regions receive broader datasets including 90th percentile LOS, ambulance offload times, left without being seen (LWBS) rates, and daily bed waitlists. Shared with 160+ hospitals to drive accountability (quasi-public & internal reporting).
    - Mandatory audits of ED return visits with annual public reporting of findings and quality improvement initiatives.
2. Accountability
    - Ontario's *Excellent Care for All Act* (*ECFAA* 2010) links hospital executive compensation to quality targets and mandates patient and staff surveys.
    - Ontario's Pay-for-Results (P4R) program linked data submission and hospital performance to funding. Ontario achieved reductions in LOS (~15%), improved median time to PIA (~13%), and reduced LWBS rates (~30%). Ambulance offload delays were nearly eliminated in urban centers.
3. Independent oversight:
    - *ECFAA* implemented independent oversight through the creation of the Ontario Patient Ombudsman. This offers patients and their families a neutral, independent body to address complaints, resolve disputes, and improve transparency within the healthcare system. The Ombudsman's office also identifies recurring issues and systemic problems, offering recommendations for broader healthcare reforms.

[7] See references 16-22

Appendix 2: Comparable Legislation in Alberta[8]

1. Transparency:

    - Since 2011, Alberta Health Services (AHS) has published real-time ED wait times showing number of patients, triage levels, and estimated physician wait times.
    - Integrated Data Systems: AHS leverages systems like Connect Care to track ED metrics in real time across regions, supporting operations and public communication.

2. Performance Targets & Benchmarking:

    - Facilities receive internal metrics (e.g., LOS, LWBS, bed block) to support continuous quality improvement efforts.
    - Annual and Weekly Reporting: Since 2014, AHS has published performance benchmarks, with regular weekly updates showing time to physician, LOS, and other flow indicators.

3. Accountability & Independent Oversight:

    - In 2022, Alberta launched the Health Care Action Plan (HCAP), which expanded the use of real-time public dashboards, increased reporting of system performance indicators, linked performance to leadership roles, and reinforced the use of third-party audits. Measurable performance improvements include:
        - ED physician wait times dropped ~17% (7.1 h → 5.9 h).
        - ED LOS for admitted patients decreased by 26% (42 h → 31 h).
        - ED performance metrics began to decline again in late 2023. As performance metrics worsened, the level of transparency receded, emphasizing the need for legislation.

[88] See references 25-34

Appendix 3: Suggested metrics for public-facing quarterly health authority reports on standardized emergency care and hospital metrics

1. ED wait times (median and 90th percentile for CTAS 1-5)
2. ED boarding hours for admitted patients
3. ED revisits within 48 hrs
4. Hospital readmission within 30 days after discharge
5. ED visits within 7 days of surgery
6. ED staffing vacancies (physicians, nurses, allied health)
7. Temporary ED closures
8. Ambulance offload delays
9. Ambulance response times
10. Transfer wait times (time from initiation of inter-facility transfer request to departure of transfer team)
11. Length of stay for admitted patients
12. Percentage of hospital beds occupied by Alternate Level of Care (ALC) patients
13. Hospital occupancy rates, with a benchmark target of <85% occupancy to ensure surge capacity

Appendix 4. Recommended Accountability Performance and Time Targets

Program	Target	
ED	Ambulance offload time after ED arrival	30 minutes
ED	Time to triage assessment	10 minutes
ED	Time to ED physician, stratified by CTAS levels 1-5	0-120 min.
ED	ED length of stay (LOS) for discharged patients	4 hours
Inpatient	Consultation interval (referral to disposition decision)	2 hours
Inpatient	Inpatient transfer time (admission order to unit transfer)	2 hours
Inpatient	Mean hospital discharge time (with scheduled departures)	11:00 am
Inpatient	Actual LOS/Expected LOS	96%
LTC	Hospital beds occupied by ALC* patients	<4%
LTC	Time from long-term care referral to transfer (ALC time)	7 days

Reference: Innes G. Accountability frameworks: A critical evolution in healthcare. *Healthcare Manage Forum*. 2025 Mar;38(2):84-90. doi: 10.1177/08404704241290794.

Appendix 5: Accountability Zones

Table 1. High-Level Program Accountability Zones		
Program	**Accountability**	**Program Boundaries**
Primary care	Patients who need primary and preventive care	Encompasses most of the population, although the need is not always immediate
EHS	Patients requiring prehospital care	Begins with 9-1-1 activation and ends at the time of ED arrival
ED	Patients who arrive at an ED (i.e., referrals, walk-ins, EHS arrivals)	Begins with patient arrival and ends with an admission order. Patients on EHS stretchers fall within ED zone.
Inpatient	Medical - Patients referred for inpatient care Surgical - Patients referred to determine the need for a surgical procedure	Begins at the time of referral and ends with referral to community. Admitted patients in the ED fall into the inpatient accountability zone.
Community	Patients do not require hospitalization but cannot function independently in the community	Begins with patient referral from the hospital or community. ALC patients on inpatient units fall within the community accountability zone.

Reference: Innes G. Accountability frameworks: A critical evolution in healthcare. Healthc Manage Forum. 2025 Mar;38(2):84-90. doi: 10.1177/08404704241290794.

Appendix 6: Accountability Framework Reference

Check for updates

ORIGINAL ARTICLE

CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ

Accountability frameworks: A critical evolution in healthcare

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Abstract

Canadians face prolonged waits for primary care, specialist care, hospital care, elective surgery, and advanced imaging relative to peer countries. A root problem is unclear queue management expectations. If programs have no mandate to provide timely care, the intuitive approach to demand challenges is not to innovate and improve, but to block access, create a queue, and force patients elsewhere. Patient care accountability frameworks define program expectations and accountability zones, clarifying that every patient has an accountable healthcare home and every program has a population (accountability zone). Program accountabilities include timely patient assessment and disposition; budget, space, and nursing care for program patients; and contingency plans for surges and queues. Accountability frameworks are an evolutionary stressor that would drive strategies to expedite appropriate care in the right place, to move patients out of queues into care. This article discusses accountability, accountability frameworks, and accountability strategies to improve system-wide access.

Introduction

Canadian healthcare is characterized by waiting. Canadians wait weeks or months for advanced imaging, and months to years to have a joint replaced or get a family doctor. Canada provides poor access to primary care, specialist care, hospital care, elective surgery, and advanced imaging relative to other Organization for Economic Development (OECD) countries.[1,2] Queueing, wait times, and care delays are all manifestations of access block, which is the number one problem for Canadians requiring healthcare.[1,3,4]

Access blocks in any program have a domino effect, compromising other components of an interdependent system.[5] Alternate Level of Care (ALC) patients waiting for Long Term Care (LTC) or rehabilitation lie in hospital beds for days or weeks, often deconditioning or cognitively deteriorating as they do.[6-8] Resulting hospital bed blocks delay medical admissions and cause surgical cancellations.[9] Admitted inpatients unable to access hospital beds are held for hours or days on Emergency Department (ED) stretchers, preventing the inflow of emergency patients with serious illness or injury. This leaves ambulance crews lined up in congested ED hallways, unable to offload acutely ill patients or respond to emergencies in the community.[10] At every level, providers assume that someone else will deal with the waiting patients. Access blocks permeate the system, compromising patient outcomes, system efficiency, and cost.[5,11]

Access block has many causes, including poor system integration, limited bed capacity, staffing shortfalls, care maldistribution, process inefficiency, and an ageing population with rising care needs.[12-14] A critical root cause seldom discussed is the absence of healthcare accountability frameworks and a lack of access and queue management expectations. Logically, all programs should strive to assure timely care for their patients. They should also have surge and queue management contingency plans, but unclear expectations reduce the impetus for programs to address today's growing care gaps.[11] When accountability is vague and no one is accountable to solve specific access blocks, no one solves them.

Accountability frameworks, strangely lacking in Canadian healthcare, would address this lack of clarity by identifying functional units (programs) that are accountable for specific populations and care needs. Although aspects of accountability are widely discussed in business and administration, there are no descriptions in the peer-reviewed literature addressing the need for care accountability frameworks to improve care access.

Alternatives to program accountability

In the face of growing demand and limited capacity, health leaders have choices. They might consider innovative staffing models, efficiency initiatives, or flow improvements. They might modify care allocation, develop surge strategies, and queue management contingencies, or even lobby for new funding and capacity, but these approaches are challenging. In a system where programs are not accountable to provide timely care for their populations, there is an easier solution.

Management by closing doors

When patient demand outstrips apparent care capacity, the intuitive approach is to block inflow and form a queue, leaving patients to seek care elsewhere. Blocking access is a default response and primary coping mechanism for most

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Appendix 7. Recommended Annual Reporting for Primary and Specialty Care

Collecting robust demographic data will aid in incorporating an equity lens into these measures. This will aid in understanding how access, experience, and outcomes may vary across populations, including those who are currently underserved, and to support more equitable planning and decision-making across demographics and communities.

Primary Care

Metric	**Target**
Number of family physicians and nurse practitioner per capita and per community	Informed by national standards
Percentage of the population attached to a family physician or nurse practitioner	100
Percentage of longitudinal clinics who offer same-day appointments for *urgent* issues (can be with any provider, not necessarily the patient's usual provider)	100
Number of longitudinal clinics who offer after-hours/weekend appointments for *urgent* issues (can be with any provider, not necessarily the patient's usual provider)	100
Average wait times for routine primary care appointments	?
Emergency utilization rates of unattached and attached patients	n/a
Urgent Care and walk-in-clinic utilization rates of unattached and attached patients	n/a
Proportion of primary care visits delivered in longitudinal settings	n/a
Proportion of primary care visits delivered in episodic settings (e.g. WIC, UPCC, ED)	n/a
Cost per patient visit in longitudinal family practice, UPCC, WIC, and ED	n/a

Specialty Care

Metric	**Target**
Number of specialists per capita for a community, by specialist type	Informed by national standards
Wait times for each outpatient specialty by urgent, semi-urgent and non-urgent triage categories	Targets with vary by specialty. Reporting should be by specialty/region.
Proportion of specialists who have closed their waitlists to non-urgent referrals	Reported by specialty
Wait times for medical imaging by type, urgency, community	Informed by national standards

Wait times for oncologic care	?
Surgical wait list info	
Number of deaths while on a wait list (any of the above)	

Community Care

Metric	**Target**
Wait times for LTC bed	? informed by national standards
Wait time for publicly funded home supports	?
Number of acute care beds occupied by patients waiting for LTC	?
Wait times for palliative care home supports	?