

## 'Surge' in surgical volumes in Alberta

Alberta Health Services is ramping up the number of surgeries being performed. As part of an "initial surge" of activity, 2,230 more procedures having long wait lists will be done by the end of March. As more surgical capacity becomes available, there will be further increases in April, May and June.

This is a dramatic reversal from a year ago when there was a cap on the number of some procedures in order to hold the line on spending.

At the time, Alberta Health Services was staring down the barrel of a \$1 billion-plus deficit. But this has all changed.

In last week's budget, the government absorbed the AHS deficit, bumped up its base funding, and provided it with a five-year funding plan that includes six per cent spending increases for the next three years.

The additional surgeries, costing an estimated \$8 million, will include urgent cancer surgery, orthopedic procedures like hip and knee replacements, gynecology, neurosurgery, heart surgery and cataract removals. In addition, there will be 3,500 more MRI and CT scans performed. Most will be done after-hours.

However, Opposition leaders jumped on the fact that some of the extra procedures will be done in private clinics. Liberal Leader David Swann said 83 per cent of additional hip and knee replacements will be done privately.

Private clinics are also getting 750 cataract procedures whereas 175 are being done in a public hospital, the Royal Alexandra in Edmonton. **HE**

# Challenges remain for B.C. electronic health records

British Columbia has made progress in developing an electronic health record system, but there is a long way to go before the system is fully in place, the province's Auditor General said in a report this week.

"We found that the Ministry of Health Services now has most of the mechanisms in place, or in development, to provide effective management of EHR (electronic health record) implementation," Auditor General John Doyle said in a news release Wednesday. But he added that "it will still need to be fully integrated across the health sector and regularly used by health professionals in treating their patients."

The report said the government's spending on EHR development could amount to \$222 million once the system is finished. This does not include the substantial sums that health authorities have spent on their own systems, or ongoing operating costs which are estimated at over \$27 million a year.

There is no doubting the appeal of EHRs. They are a secure computerized file of a patient's medical history and, as Mr. Doyle pointed out, can facilitate faster, safer and more effective care.

Every province and territory is developing such systems, subsidized in part by \$1.6 billion in federal funding through Canada Health Infoway. It has a goal of ensuring 50 per cent of Canadians have EHRs available to their health care professionals by this year.

The EHR effort in B.C. got underway in 2005, but progress has been hampered by the lack of a "well-formulated strategic plan or effective planning processes" to

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## Sask. health spending to go up 3 per cent in budget

The Saskatchewan government is hoping to freeze spending in next month's budget, but some ministries will see a reduction in order to provide health care with a three per cent increase.

Even a three per cent increase would be substantially less than what the health sector has been getting in recent years. In the 2009-10 fiscal year, for example, spending went up 8.8 per cent.

Premier Brad Wall outlined the government's budget goals to reporters Wednesday and admitted the limit on health expenditures will be a challenge. "I've had officials say it would be a minor miracle if we can hold health to three per cent," he said.

Among other things, health-care employers are locked in a bargaining standoff with the union representing hospital workers, and the *Regina Leader-Post* reported that four other unions as well as the Saskatchewan Medi-

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bring all the elements together, Mr. Doyle observed. He also said health professionals were not involved in the original planning and health authorities embarked on their own EHR activities creating duplication of effort.

A new approach was adopted by the government in 2008 bringing planning and management of individual projects under one roof. A comprehensive five-year Health Sector Information Management/Information Technology Strategy was also released this past December.

These activities have largely addressed the planning concerns raised by Mr. Doyle when the field work of his audit was completed last May.

In his report, he said most of the core EHR components are already developed or close to it. These include registries with basic information about patients and providers, systems containing patients' laboratory and diagnostic test results, and a method for authorized professionals to view patient information and for systems to inter-connect.

The sixth component is an electronic drug information system (eDrug) which will be finished in 2012.

But this is not the end of it. Work to integrate and support the adoption of these components by health authorities and providers is still a work in progress. This includes encouraging physicians to set up electronic medical records in their offices to replace paper files.

The Ministry of Health Services says 20 per cent of physicians had electronic medical record systems in 2008-09. It wants to get this up to 60 per cent in 2010-11.

Because there is so much uncertainty about how EHRs will be deployed, and what benefits will be accrued, Mr. Doyle has decided to keep close tabs on future

## Hansard Highlights

### Debates in provincial legislatures/House of Commons

The **Ontario** legislature resumed this week. It is expected to soon be prorogued and a new session to begin with a Speech from the Throne. The lead-off questions from the Opposition have been about Local Health Integration Networks (LHINs) and whether they are subject to new rules banning sole-source contracting. Opposition Leader Tim Hudak mentioned an \$80,000 contract awarded by the Toronto Central LHIN to a consulting company that last year was linked with the eHealth Ontario contracting-out issue which precipitated the rule change.

In the **Alberta** legislature Tuesday, NDP Leader Brian Mason asked about the announcement from Alberta Health Ser-

professionals. He will be doing a follow-up every six months until the EHR system is fully implemented.

He is not alone in being diligent. Another five provincial auditors have also published reports on EHR activities in their jurisdictions, and the federal auditor general released a report on Canada Health Infoway last November.

The kind of planning problems which Mr. Doyle initially noticed in B.C. have cropped up in other places.

In October 2009, the Auditor General in Alberta said the government does not have an integrated delivery plan that connects all the many EHR initiatives. In December, Saskatchewan's auditor said a strategic and operational plan for the overall EHR system is missing. And the Auditor General in Nova Scotia made the same point about work on that province's EHR system in a report earlier this month.

Auditors have also voiced the same opinion as Mr. Doyle about the need to ensure EHR systems are actually used by health pro-

gresses this week that \$8 million is being spent to do over 2,000 more high-priority surgeries in the next six weeks. Mr. Mason said, "It's fine to fund something for six weeks, but that's a miniscule amount of time, and it won't solve the basic problem" of wait times. He asked if there is a long-term plan to deal with the issue. Health Minister Gene Zwozdesky replied that "there are a few plans that are being finalized right now" and should be available in early April. He said this includes a long-term capital plan for health facilities which will be out before March 31. "We'll also have more details on the five-year funding plan (for health care in the recent budget), and there will be additional plans on a per area basis ..."

professionals. As well, EHRs need to mesh with electronic medical record systems at the physician level, but this does not appear to be something that will be available when various provincial EHR systems are launched.

The timetable for implementing EHRs is an issue in Ontario and Quebec. Ontario's efforts have been sideswiped by project oversight issues at eHealth Ontario. Its goal of delivering an EHR system by 2015 is in doubt.

Quebec had hoped to have its EHR system in place this year, but is now planning for June 2011. In his report last May, the province's Auditor General expressed serious doubt that this new date would be met.

The Auditor General of Canada, Sheila Fraser, tabled a generally positive report about Canada Health Infoway, and her office has collaborated with other provincial auditors on their reports. Ms. Fraser will be releasing a summary of the findings in the federal and provincial audits this spring. **HE**

## .. Briefly .. News Shorts .. Briefly .. News Shorts .. Briefly

**Elective surgeries at the hospital in Kamloops, British Columbia have been cancelled** for the time being at the request of medical staff who are concerned about contaminated surgical equipment. They demanded an independent audit as well as an internal review after several incidents came to light. This included finding bone fragments on a surgical drill. The Chief of Surgery at Royal Inland Hospital, Dr. Simon Treissman, suggests the problem is linked to aging equipment, staffing, supervision and perhaps underfunding of the facility. (*Kamloops Daily News*, Feb. 17)

**A \$17.5 million court settlement over botched breast cancer tests in St. John's has been approved** by a Justice of the Supreme Court of Newfoundland and Labrador. At least 425 patients received the wrong results from hormone receptor tests conducted between 1997 and 2005. In addition to the monetary compensation, the settlement obliges Eastern Health region to issue a public apology, and conduct an external review in three years of progress made in fulfilling 60 recommendations by a Commission of Inquiry into the incident. The region is also required to erect a memorial to victims, and meet with people involved in the class action suit. (*St. John's Telegram*, Feb. 17)

**Ontario and Quebec will allow foreign companies, including those in Europe, to bid on hospital and school construction projects**, public sector unions claim. They say this agreement is in the works as a by-product of the recent *Buy American* deal that gives Canadian firms the chance to bid on projects in the massive \$787 billion infrastructure program in the U.S. The *Globe and Mail* reports that only Ontario and Quebec will allow for-

eign firms to bid on hospital and school projects. All other provinces have excluded them from the list of what is eligible. (*Globe and Mail*, Feb. 12) ... **Nova Scotia has increased its funding support for a new regional hospital in Truro**. The local community had said 'enough is enough' when it was asked to cover an additional \$25 million construction expense on top of its current contributions. Civic leaders demanded an explanation of why the cost of building the new Colchester Regional Hospital had soared from \$104 million to \$180 million in four years. On Thursday, the government said it would invest an additional \$25 million and bring its share of the total cost to \$154 million or 85 per cent. It pointed out that hospital projects are typically cost-shared with communities on a 75-25 per cent basis. (News release; *Truro Daily News*, Feb. 13)

**Alberta Health Services will be introducing activity-based funding on April 1**, at the beginning of the 2010-11 fiscal year, for services to seniors. "It ensures hospitals and nursing homes and seniors' care homes get paid for the services they provide, as opposed to what their budget was last year," Ken Hughes, the chairperson of AHS, told the Calgary Chamber of Commerce in a speech this week. He said the funding model will be applied to all acute-care patients by April 2011. (*Calgary Herald*, Feb. 18)

**The Manitoba government is after a two-year public sector wage freeze** to help it with a \$600 million budget deficit. Finance Minister Rosann Wowchuk says health sector wages were about \$3 billion in 2009 and civil service salaries were around \$770 million. "If we can contain those costs, maintain them where we are without having increases, then we can

look at ensuring that we don't lay off people and maintain services." The Manitoba Council of Health Care Unions, representing 25,000 health-care workers, calls the proposal "irresponsible, simplistic and short-sighted." (*Winnipeg Free Press*, Feb. 17,18)

**A Quebec legislative committee has begun hearings into the legalization of euthanasia**. Physicians making presentations asked the committee to tackle the issue of dying with dignity head-on and not be distracted by issues of palliative care. The committee expects to hear 30 expert witnesses and prepare a report as a basis for public consultations in the fall. (*Le Devoir*, Feb. 16)

**Francophone New Brunswickers are entitled to their own health care institutions**, the board of governors of the University of Moncton said this week. In a unanimously passed resolution, the board also called on the government to designate the Georges-L. Dumont Hospital in Moncton a French-language university hospital. This is the first public comment by the university into the issue of equal access to health care services for French-speaking New Brunswickers. It is currently the subject of a legal challenge following the government's amalgamation of health regions and the elimination of the only one (in Moncton) that was designated French-language. (*New Brunswick Telegraph-Journal*, Feb. 18)

**One-in-five Canadians have hypertension**, a study by Statistics Canada has revealed. Of the 4.6 million Canadians with high blood pressure, 80 per cent are being treated with medication and it is successful for two-thirds of them. But for 30 per cent of all those with hypertension, the problem remains uncontrolled. (Canwest News, Feb. 17)

## Paper challenges ban on private insurance

A University of Calgary economics professor says there is no justification for continuing to prohibit the availability of private insurance for medically necessary procedures.

In a paper for the School of Public Policy at the university released Thursday, Dr. J. Herbert Emery says this would not have any impact on the level of public health insurance coverage.

However, it might address the unsustainable status quo where Canadians are not paying the full resource costs of the tax-based health system.

An aging population is just going to make matters worse with future generations paying more and getting less from medicare. This could trigger a serious political crisis as taxes rise.

The paper, *Understanding the Political Economy of the Evolution and Future of Single-Payer Public Health Insurance in Canada*, is available at [www.policyschool.ucalgary.ca/publications](http://www.policyschool.ucalgary.ca/publications). **HE**

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cal Association are working under expired contracts.

Mr. Wall suggested that efficiencies may be found in the budgets of the 12 health regions. As part of last year’s Patient First review of the health system, a consulting company looked at administrative spending and recommended the creation of a single Shared Services Organization for supply chain, human resources and finance functions, as well as a consolidation of some regional management functions.

The report also said there is a need to reconsider the current regional structure, but Mr. Wall said the government is not entertaining the idea of moving to a single organization like Alberta has done. **HE**



# Miscellany

## Standards for clinics

The *Montreal Gazette* (Feb. 15) comments on the case of a 25-year-old woman who died two years ago in the recovery room of a private clinic after having cosmetic surgery. Her family has recently announced that it will sue the clinic after the coroner concluded it did not have proper treatment standards. The *Gazette* notes that the government will be implementing new accreditation standards on April 1 for private clinics to perform some 50 designated procedures. The start date had been put off, as the *Gazette* observes, “on the regrettable grounds that too few of the province’s 60 private clinics were ready to put the rules into effect.” It says no further delay should be permitted. “Medical clinics, whether they’re publicly funded or run privately, should all adhere to the same high standards of professionalism. Those standards must be spelled out – and enforced – by government.”

## Having a children’s hospital

The *Saskatoon Star-Phoenix* (Feb. 12) discusses the recent decision by the Saskatoon Health Region to revisit the decision of where to locate a long-promised children’s hospital. The editorial says the opportunity should be taken to review whether the province indeed needs to have a children’s hospital. “For nearly 18 years, the debate over building a children’s hospital in Saskatchewan has been distorted by politics, emotions and contradictory evidence.” It said all of this has “helped muddy the waters on where and if the facility should be built.” The health region is now undertaking the necessary due diligence on the site selection which has been the subject of vo-

ciferous debate, and the *Star-Phoenix* says “The process needs to be free of vested interests, open to the public, and done with the long-term interests of the province in mind. Rather than looking at how to spend the \$200 million committed for a children’s hospital, the study needs to focus on what Saskatchewan actually needs to provide the best care for its children and how much that will cost. It’s after that the decision should be made on whether and when we can afford it.”

## Speeding up surgeries

The *Edmonton Journal* (Feb. 18) is pleased with the announcement by Alberta Health Services to spend \$8 million to crank up the number of surgeries performed and deal with wait lists. The *Journal* says there are two important observations to make. First, by its involvement in the announcement, “the government has reduced its ability in future to pretend that AHS is an arm’s length body whose actions are not something elected officials are directly responsible for.” Second, and in reference to the relatively small price tag for the surgical surge, the *Journal* says unless there is an ulterior motive for the government to tolerate long wait lists, “there is no reason why a six-week waiting list costs a dime more to maintain than one twice as long.”

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