

OMA rejects report saying physicians are overpaid

Ontario Health Minister Deb Matthews is trying not to be drawn into a debate between the province's medical and hospital associations over whether physicians are being paid too much.

A report last week, co-produced by the Ontario Hospital Association (OHA) along with the Ontario Association of Community Care Access Centres and the Ontario Federation of Community Mental Health and Addiction Programs, presented a number of ways for the government to save money on health care.

Included was the suggestion that Ontario could save \$2.2 billion if it paid the same rate per capita on physician services as other provinces.

The Ontario Medical Association called the figures "misleading" and said they do not account for differing patient volumes and demographics.

"The leadership of the OHA is out of touch with the rest of the province's health care providers, who are all working tirelessly to improve quality care for Ontario's patients," OMS President Suzanne Strasberg told Canadian Press.

Health Minister Deb Matthews would not comment on the report, saying the government is committed to the four-year contract it signed with physicians in 2008.

However, Ms. Matthews opened the door to speculation that the government may take a harder line with physicians in the next round by telling CP that targeting how doctors are paid is "not part of our plan right now."

Ontario Hospital Association
(See "Physicians" on page 4)

EHR coverage target this year will not be met

Canada Health Infoway says it will fall short of the goal of ensuring half the population has an electronic health record by the end of this year. Instead, it will happen by mid-2011. Infoway made the admission in a response to a report this week by the

federal auditor general summarizing the reviews she and six provincial auditors have done on EHR initiatives.

Infoway's response, prepared with the governments of the six provinces, pointed out that it does not count work-in-progress when making its calculation of how far along things are. As such, it says there have been considerable achievements that are not reflected in what stands as a 17 per cent Canadian EHR coverage rate as of the end of last March.

In her report, federal Auditor General Sheila Fraser said there is limited public reporting on progress being made at the provincial level.

"Provinces are hampered by the lack of comprehensive information, including costs, baselines and performance measures for the overall initiative," she said.

Her report synthesizes reviews by provincial auditors in British Columbia, Alberta, Saskatchewan, Ontario, Nova Scotia and Prince Edward Island who collaborated on a common study approach.

These reviews found most provinces have inadequate strategic planning for EHR undertakings which undermines their ability to ensure goals and priorities are attained, and the needs of users are met.

Only Alberta has had a current and comprehensive strategic plan from the get-go. Ontario finalized its plan last year after nearly a decade working on EHRs and spending some

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Drug spending hits \$30 billion in 2009

Total spending on drugs in Canada is estimated to have reached \$30 billion in 2009. While \$1.5 billion more than the year before, and an increase of 5.1 per cent, this is the lowest rate of growth in more than a decade, the Canadian Institute for Health Information says in a report released Thursday.

Prescribed drugs account for 85 per cent of drug expenditures, but the rate of growth has slowed down considerably from the early part of this decade when they were experiencing double-digit yearly increases, CIHI says.

CIHI adds that private sector spending on drugs has outpaced that of the public sector in the last four years, reversing the trend of the last 20 years. In 2009, public sector spending on prescribed drugs is forecast to have gone up four per cent compared to seven per cent in the private sector.

The report can be found at www.cihi.ca. **HE**

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\$1 billion.

With the shifting sands of advancements in information technology, Ms. Fraser also raised the issue of needed upgrades to what is presently in place. These upgrades are also necessary to make systems compatible with Infoway's technical standards and allowing sharing of patient data between jurisdictions. Infoway says strategies are currently being developed to deal with this.

The federal government has bankrolled the EHR effort to the tune of \$1.6 billion, in money either already spent or committed, with another \$500 million on the way. Of this, over \$1.2 billion has supported provincial or territorial initiatives with almost half going to Ontario and Quebec.

Provinces and territories have invested money on top of this, although there is no firm handle on the total given that it also involves spending by regional health authorities, hospitals and others.

The question raised by Ms. Fraser is: what are the benefits? She noted that only a limited number of primary care physicians have switched from paper- to computer-based patient records, and "Unless there is a significant increase in this number, the potential benefits of EHRs will not be fully realized."

Infoway has published a study that puts the theoretical savings at \$6 billion a year, but it admits that it will take time to assess benefits "since systems must be complete and in use before impacts can be evaluated." In the meantime, it has developed a "Benefits Measures Framework" to define indicators for each of its investment programs with respect to access, quality and productivity.

All of these issues aside, Ms. Fraser said Infoway and the provinces and territories have accomplished a great deal in the last eight years. *HE*

Hansard Highlights

Debates in provincial legislatures and House of Commons

In the **Alberta** legislature this past week, the Opposition has criticized the recent decision to consolidate cataract surgeries. As a result of a competitive bidding process, four clinics in Alberta (two each in Edmonton and Calgary) are doing all of these procedures. On Monday, Health Minister Gene Zwozdesky said the province has been able to save \$1.4 million by getting a lower price per procedure and this money is being used to fund more procedures — some 2,100 on top of the more than 30,000 that are done annually. Still, a number of ophthalmologists are angry about the consolidation process and the minister is meeting them this weekend to discuss their issues.

In **Saskatchewan's** legislature, the province's kidney transplant program has been a hot topic. It has not been functioning since last July after one of three vascular surgeons in the transplant team became ill. Health Minister Don McMorris told the legislature last Thursday he wants the program "up and running within the next three to four months." Under continued questioning this week from the NDP health critic, he said the government is seeking a sustainable solution to problems with how the program was structured, and until then his ministry is seeking to have high-risk patients transferred to Edmonton, or even to other centres out of the country if need be.

In the **British Columbia** legislature Tuesday, Opposition Leader Carole James said ER overcrowding conditions at the Vernon Jubilee Hospital have reached unprecedented levels. She said there were over 50 Code Purple alerts (where non-urgent patients are moved from hospital beds to make room for more critical cases) in 2008 alone. "The doctors say

crowding is now the worst level they've seen." Health Minister Kevin Falcon said many ERs experience periodic cases of severe overcrowding, but the Vernon hospital will benefit from a new \$180 million critical care tower due to open a year from now. He said the government has invested over \$400 million in ER improvements at 30 hospitals across the province.

Last Thursday, Myrna Driedger, the health critic for the Progressive Conservatives in **Manitoba**, said 43 heart surgeries were cancelled last December due to a shortage of nurses to staff beds. She added that the number of cancellations in 2009 reached 262, more than twice the 116 in 2006. Health Minister Theresa Oswald said the province's record in cardiac surgery wait times is a good one, but "We know we need to develop even further expertise, not only in health human resources but in technology, in our cardiac program." She noted the building of the new Cardiac Centre of Excellence at St. Boniface Hospital in Winnipeg to be completed by the end of the year.

In the **House of Commons** Wednesday evening, a bill amending the Criminal Code to allow euthanasia and the right to die with dignity was defeated at Second Reading by a vote of 228 to 59. Bill C-384 was sponsored by Bloc Quebecois MP Francine Lalonde. Stephen Fletcher, a junior Cabinet minister who is also a quadriplegic, abstained from the vote. However, he made this statement afterward on a Point of Order. "I believe end of life issues need to be debated more in our country. I believe that life should be the first choice but not the only choice and that we have to ensure that resources and supports are provided to Canadians so that choice is free."

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Leo Steven has been appointed chair of the new Health PEI agency which will oversee the day-to-day delivery of health services on the island. Mr. Steven, who was CEO of Sunnybrook Health Sciences Centre until his retirement and move to the island two years ago, will head an 11-member board. Health PEI was a recommendation of the PEI Health Governance Advisory Council last November. After the province's four health regions were abolished in 2004, the health department ran things directly. However, this approach was criticized in a 2008 consulting report for the government. (News release at www.gov.pe.ca/health/index.php3)

Wait times for patients to see specialists are not just a factor of medical need, they also have a lot to do with who is doing the referring, a report by Statistics Canada this week says. Patients referred by a specialist, or even a non-physician provider, get an appointment quicker than those referred by a family physician. The report, based on an analysis of data taken from the 2007 Canadian Community Health Survey, found 46 per cent of patients waited less than a month for their specialist appointment while another 40 per cent waited no more than three months. Women were significantly less likely than men to see a specialist within a month which the report's authors suggest may be the result of "systemic gender biases in access to health care services." Wait times varied by province too, with Quebec posting the highest proportion of patients (51 per cent) waiting less than a month. Non-physician referrals to specialists were also the highest in the province — fully 20 per cent. The report, *Waiting time for medical specialist consultations in Canada, 2007*, is in the April issue of *Health Reports*. A link can be found at [www.statcan.](http://www.statcan.gc.ca/daily-quotidien/100421/tdq100421-eng.htm)

[gc.ca/daily-quotidien/100421/tdq100421-eng.htm](http://www.statcan.gc.ca/daily-quotidien/100421/tdq100421-eng.htm) ... **Canadians have a much harder time accessing specialist services than those in other countries**, according to a report from PricewaterhouseCoopers this week. The research, involving 3,500 consumers in 11 countries, found almost half of Canadians saying it is difficult to see a specialist compared to 29 per cent of global respondents. The Canadian Compendium of the report, which also contains the views of Canadian health-care leaders and experts, can be found at www.pwc.com/en_CA/ca/healthcare/publications/healthcast-canada-2010-04-20-en.pdf www.pwc.com/ca/healthcast.

British Columbia is expanding paramedics' scope of practice to integrate the ambulance service more closely with the health system. Amendments to the *Emergency and Health Services Act* were introduced Wednesday that pave the way for "treat and release" whereby a paramedic called to a scene could assess a patient, provide appropriate treatment and advise follow-up care instead of having to transport the patient to the emergency department. The government also sees paramedics providing additional support including dealing with people who have chronic diseases in residential care facilities, joining home and community care workers in supporting clients in their homes, and providing care in emergency departments. (News release at www.gov.bc.ca/health/index.html) ... **Ontario is prepared to look at the idea of nurse practitioners admitting and discharging patients**, something the Registered Nurses Association of Ontario has been after for some time. Premier Dalton McGuinty, speaking at the RNAO's annual meeting this past week, said he is committed "to getting to work on

that." (Canadian Press, Apr. 16)

Ontario will be lifting its *de facto* moratorium on competitive bidding for home-care contracts, Health Minister Deb Matthews has acknowledged. But she says quality of care will be a prerequisite in any winning bid. "It's not just about getting the lowest price," she told the *Thunder Bay Chronicle-Journal*, "Seventy-five per cent of the scoring will be based on quality and we want to have an open, transparent process so those organizations applying to deliver services know what it is we're looking for." (*Thunder Bay Chronicle-Journal*, Apr. 21)

Newfoundland and Labrador physicians have been offered 98 per cent wage parity with their colleagues in other Atlantic provinces as part of a four-year contract offer from the government. They have also been offered a two per cent increase in each of the last three years of the deal. Each fee-for-service physician groups stands to receive a minimum 10 per cent increase over the period. The offer was presented as a "total package" which "must be accepted or rejected in its entirety." The province's medical association says this amounts to a "take it, or leave it" ultimatum. It had previously called for binding arbitration to settle stalled contract negotiations. (*St. John's Telegram*, Apr. 21)

Over half the people in Manitoba over 19 live with a chronic condition, a report this week from the Manitoba Centre for Health Policy says. Health spending on Manitobans without one of the chronic conditions studied is about \$4,000 per person over two years, but is twice as much for those with asthma and chronic obstructive pulmonary disease (COPD) and six times more for people who have had a stroke. The report can be found at mchp-appserv.cpe.umanitoba.ca/deliverablesList.html.

No end in sight for war over Ontario drug reforms

The stand-off between the Ontario government and pharmacists over controversial drug reforms continued this week.

Both sides have ratcheted up the public relations battle to win public opinion. Pharmacists started a two-week advertising blitz, and the Ministry of Health has turned to YouTube to get its message across.

Government is saying it is trying to get lower drug prices for Ontarians, while the other side says government is trying to solve with its deficit issues on the back of community pharmacy.

So far no talks have been held to deal with the impasse, but the Independent Pharmacists Association has accused the government of shunning its proposals to save the drug plan \$1.3 billion over the next four years.

These proposals include phasing out of professional allowances which are at the centre of the government's new reforms.

Professional allowances are paid by generic drug companies for pharmacies stocking their products.

Pharmacy says government has to put more money on the tablet to offset the loss in revenues from professional allowances. Dispensing fees, instead of going up a dollar to \$8, would have to double. **HE**

(**"Physicians"** from page 1)

President Tom Closson said physicians need to be subject to the same performance guidelines as hospitals.

"Hospital CEOs are going to be on pay-for-performance. It's really important that we have doctors' accountability and hospitals' accountability aligned," he told CP.

He suggested the new physicians' contract could include expectations on patient volumes per physician and the number of hours they would be available. **HE**



Editorials & Commentary

Disparaging deductibles

The *Calgary Herald* (Apr. 18) says Quebec's idea of possibly charging a deductible for each doctor's visit is "a trial balloon that (Quebec) Premier Jean Charest ought to pop at the earliest opportunity." It says such a fee would not only penalize the sick but discourage people from seeing a doctor which will end up costing the health system more in the long run.

The *Herald* supports Canadian Medical Association President Ann Doig's proposal to raise needed revenue for health care through health premiums and other tax-based means that spread the cost burden equitably amongst all Canadians. "That approach reflects the true spirit of the *Canada Health Act*, and of the collective compassion for one another, which has been a hallmark of Canadians' attitude toward health care."

The *Montreal Gazette* (Apr. 16) agrees that the deductible idea was a trial balloon. But it notes that Quebec Finance Minister Raymond Bachand expects company from other provinces in considering such fees in the next couple of years. The *Gazette* even speculates that the deductible proposal may really be negotiating tactic to prise more money out of Ottawa. "Whatever it is, it is an acknowledgement that the current funding for health care is insufficient, and that something's got to give."

Jean-Robert Sansfacon, editorial writer for *Le Devoir*, notes (Apr. 19) that Mr. Charest has signalled the government's willingness to adjust the amount paid in the deductible by income. But Mr. Sansfacon says this does not make the idea any better, and "it is obvious that old people, pregnant women and the chronically ill will pay the almost \$600 million" the government is expecting to collect. He

also suggests the government has other means of dealing with the health-care revenue issue. First is to raise income taxes, and the other is to slow down the schedule for getting rid of the province's deficit. Since Ontario is prepared to take eight years to balance its books, why is it necessary for Quebec to do the job twice as fast, he asks.

Focusing on outcomes

The *Globe and Mail* (Apr. 17) welcomes the report, published last week by three Ontario health-care organizations, on ways for the province to save money by shifting the focus to paying for improved health outcomes. It notes the example in the report that \$100 million could be saved if best practices were followed in wound care.

The *Globe* asks, rhetorically, why such "common-sense solutions" are not being widely implemented. It says there are no consequences to those who do their jobs inefficiently. "What is missing in health care are quality, accountability and value for money. Medicare needs a champion, a strong arm that can make transformative change, piece by piece." The *Globe* says without this "the system is doomed to become increasingly inefficient, unmanageable" and virtually obsolete.

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