

Private clinic bankruptcy threatens contracted surgeries

The Health Resource Centre, a Calgary private clinic embroiled in the health-care privatization debate in Alberta 10 years ago, is back in the news.

An ongoing legal dispute between the owners and one of their creditors threatens to push the clinic into bankruptcy. This could lead to the cancellation of surgeries Alberta Health Services has contracted to the clinic.

Since 2006, HRC has provided publicly-funded hip, knee, foot and ankle surgeries. In 2009-10, it did some 1,000 surgeries including about one-third of all hip and knee surgeries in Calgary.

Alberta Health Services wants HRC to stay open until at least this winter. That is when it will be opening eight additional operating rooms at a new health facility in Calgary and can take over the caseload.

It applied to the courts last Friday to stay the bankruptcy application against HRC, and to appoint PricewaterhouseCoopers Inc. as the interim receiver for the company that owns the clinic. On Monday, a Court of Queen's Bench justice appointed the management firm as interim receiver until May 11 when a full hearing will be held.

In 2002, HRC was the first private clinic to get approval to perform certain orthopedic procedures requiring overnight stays. This followed rancorous public debate over Bill 11 which established the rules for the operation of private surgical facilities in the province.

For some, the bankruptcy case
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Ontario moves to tighten health-care accountability

The Ontario government has introduced the *Excellent Care for All Act* laying the groundwork for a fundamental culture shift in health care.

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BC, AB and SK may bulk purchase health supplies

The three westernmost provinces have agreed to an arrangement that could see them form a common procurement system for health supplies, including pharmaceuticals.

The New West Partnership, signed by the premiers of British Columbia, Alberta and Saskatchewan in Regina last Friday, creates what they say is "Canada's largest interprovincial barrier-free trade and investment market."

The partnership covers agreements on trade, international cooperation, innovation and procurement. On the latter, they will work together to jointly purchase goods and services in order to achieve efficiencies and cost-savings. This could include health supplies such as pharmaceuticals.

An agreement to develop a joint purchasing plan for pharmaceuticals was reached by the premiers of all four western provinces and three territories at the Western Premiers' Conference last June. However, Manitoba and the territories are not part of the New West Partnership. **HE**

Bill 46 is part of a broader strategy to improve quality, value and promote evidence-based health care. It is founded on four core principles which Bas Balkissoon, the parliamentary assistant to the health minister, outlined in his speech introducing Second Reading of the Bill in the legislature Tuesday.

"Care must be organized around the patient to support his or her health; continuous quality improvement is a critical goal; payment, policy and planning must support both quality and the efficient use of our resources; and quality care must be supported by the very best evidence and standards of care."

Bill 46 strengthens the accountability of hospitals — measures which could be extended to other health care organizations.

Each hospital will have to set up a quality committee and produce an annual quality improvement plan. Executive compensation would be linked to achieving improvements set out in the plan.

Furthermore, hospitals will have to set up a process to address patient, client and caregiver relations including annual surveys to assess satisfaction with services.

Improving quality at a time when hospitals have to live with a 1.5 per cent increase in base funding is a way of squeezing better value-for-money out of the province's \$43 billion-plus investment in health care.

"We need to do a better job of get-

(See "Accountability" on page 2)

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ting value-for-money in our health care system. Quality and value: if you’re not getting both, you’re not getting either,” Mr. Balkissoon said.

He cited a number of examples of how resources are not being used efficiently. Some 40,000 patients last year were admitted to hospital with conditions that could have been managed better and cheaper in the community, and 140,000 patients had unplanned readmissions to hospital within 30 days of their original discharge.

More than 5,000 x-rays and 49,000 cardiograms were performed on patients about to have cataract surgery even though there is no clinical benefit for these patients having the tests.

Meanwhile, many Ontarians with diabetes and other chronic diseases are still not receiving all the care they should according to clinical guidelines, Mr. Balkissoon said.

Bill 46 expands the mandate of the Ontario Health Quality Council to provide recommendations on clinical practice guidelines and protocols. It will also be making recommendations, in consultation with the public, “on possible changes to the way health care is provided and paid for,” he said.

“This would help ensure that future investments in health care get results and improve patient health,” he added.

Another element in the government’s plan to reform health care, although not included in Bill 46, is to switch the method of funding larger hospitals to a patient-based approach. They will be funded based on the types and volumes of patients they treat.

This will be implemented on April 1, 2011 after consultations with hospitals, Local Health Integration Networks and other stakeholders have been conducted.

Hansard Highlights

Debates in provincial legislatures and House of Commons

In **Quebec’s** National Assembly Tuesday, Parti Quebecois Health Critic Bernard Drainville questioned Health Minister Yves Bolduc about the use of private agency personnel to fill vacant hospital shifts. He said that despite Dr. Bolduc’s assertions a year ago about wanting to reduce reliance on the agencies, new figures show that hospitals are spending even more money on this kind of help. Fully \$366 million was spent last year, up from \$324 million the year before. The number approaches \$200 million for private agency nurses despite them costing 15-30 per cent more than regular personnel, he said. Dr. Bolduc replied that at present “we do not have a choice.” and to cut out the use of agency workers would result in service disruptions. But, the health critic pointed out that one hospital has been able to cut its expenditures on agency personnel by more than half by offering more full-time work to nurses.

In **Saskatchewan’s** legislature, Health Minister Don McMorris has remained under fire over the government’s recent regulatory change allowing patient names and addresses to be used in hospital foundation fundraising efforts. On Monday, he admitted that he “did misspeak” in claiming that the privacy commissioner had

been consulted on the measure. He clarified that three formal consultations had taken place with the commissioner when the previous NDP government had attempted to make a similar change. Mr. McMorris said the government is aware of where the commissioner stands on the issue, and the latter’s preference for allowing patients to opt-in to having their names on a fundraising list rather than having the right to opt-out.

In the **Newfoundland and Labrador** legislature this week, there has been continued debate over the government’s recent controversial decision to move the air ambulance service from St. Anthony’s, at the tip of the Great Northern Peninsula, to Happy Valley-Goose Bay in Labrador. The decision was based on heavier traffic for air ambulance transfers in Labrador. However, the residents of St. Anthony’s are fighting the change and say it will add to wait times at the regional hospital. On Monday, protesters in the Public Gallery of the legislature caused a brief disruption in proceedings. Health Minister Jerome Kennedy has said the air ambulance decision is “final” and on Tuesday pointed out that the regional hospital is “very well staffed” compared to other facilities.

Among the issues to be considered is how to account for hospitals with unique roles, such as academic health science centres and facilities serving small and rural communities.

This latter point is a concern for the Progressive Conservative opposition in Ontario. Although Health Critic Christine Elliot said the PCs support the objectives of Bill 46 in principle, they question how patient-based funding will work for small hospitals which will not be able to achieve service vol-

umes entitling them to additional funding.

She is also not sure that hospital boards will have all the necessary information and data to be able to tie executive compensation to success with quality improvement plans. “That’s a pretty tall order,” she said in her remarks during Second Reading debate Tuesday.

More information on Bill 46 can be found at www.health.gov.on.ca/en/legislation/excellent_care. **HE**

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

Patients for Patient Safety Canada has been launched, an advocacy organization that is working with the Canadian Patient Safety Institute to make "Every Patient Safe." One of its activities is a national campaign to get health providers to wash their hands before seeing patients. It says 40 per cent fail to do so. In Ontario, there has been an over 10 per cent improvement in hand hygiene over the past year. The proportion of health care workers washing their hands when entering a patient's room has gone up from 53 per cent to 67.5 per cent. (Toronto *Sun*, May 1; www.patientsforpatientsafety.ca)

Ontario's Health Care Connect program has found 22,108 people a family doctor since it was launched in March 2009. This represents a success rate of 48 per cent of the 46,016 so-called "orphan" patients who have registered with the program, even if this is far less than the estimated 400,000 to one million people who are without the services of a regular doctor. The program has been particularly successful in matching 78 per cent of patients who have chronic conditions with a doctor. Ontario Medical Association President Mark MacLeod says Health Care Connect is just one tool in helping patients find a doctor, and that since 2004 Ontario doctors have taken on one million new patients. (Toronto *Star*, May 3,5) ... **Patient care at Nurse Practitioner-led clinics is expensive** according to information compiled by the Ontario Medical Association. It says the NP-led clinic in Sudbury, the first one in Canada, costs an average of \$182 per patient visit compared to \$49 at a family physician's office. In 2007, the government pledged to create 25 more NP-led clinics and has announced sites for 11 of them since February 2009 although none of them are so far opera-

tional. The OMA would prefer the government to invest in physician-led Family Health Teams (FHTs) and was pleased this week that the government has called for applications to create 30 new FHTs (Toronto *Sun*, Apr. 30; news release)

Newfoundland and Labrador physicians and the government are meeting Friday in an attempt to restart stalled contract negotiations. On Monday, the province's medical association rejected the government's offer of a 24 per cent wage increase over four years and a plan to achieve 98 per cent parity with physicians in the other Atlantic provinces. This week the government announced that it would start a public awareness campaign to counter what it says is misinformation being spread by the physicians' association. This includes claims about a lack of psychiatrists in the province. The government says it has recruited 23 more since it came into power in 2003. "Even though we may not have as many psychiatrists as we need, it's very unfair to be out there saying that the government is not doing enough," Health Minister Jerome Kennedy told the *St. John's Telegram*. (May 6)

There is momentum building for a national strategy on the pricing of generic drugs, following Ontario's recent decision to lower the price to 25 per cent of the brand. The *Globe and Mail* reported Thursday that other provinces are interested in following suit. It said Manitoba's health minister sees "a lot of merit" in the idea, and British Columbia has given pharmacy chains until the end of June to come up with a plan to reduce prices or the government will take unilateral action. The director of pharmacy services in Prince Edward Island also told the *Globe* that Atlantic provinces have had initial discussions about working to-

gether to get better prices on generics. Meanwhile, the Loblaw grocery chain says it will try to drive up its market share of the pharmacy business to mitigate the effects of Ontario's policy decision. About 500 or half of its stores have pharmacies, and it is piloting a pharmacy model that would work in smaller outlets. It also wants to increase the number of its in-store medical clinics from 84 to 200 in the next two years. (*Globe and Mail*, May 5,6) ... **Prince Edward Island is adding 10 new medications to the provincial formulary effective July 1, 2010.** Six of them will be provided through the High Cost Drug Program for people who meet established clinical criteria and complete an income assessment to determine how much they should contribute to the costs. The PEI Cancer Society welcomes the additions, which include colorectal cancer drug Avastin, but says the government should be creating a catastrophic drug program so that Islanders are not left with high drug bills. (*Charlottetown Guardian*, May 1)

British Columbia is being urged to create more emergency physician positions. The B.C. Medical Association is concerned that there has not been any real progress in negotiations that started in 2007 and after the government created 16 new full-time equivalent positions. The BCMA estimates that 35 more ER physicians are needed, particularly in high-growth areas. Patient traffic at hospital ERs is increasing by about two per cent a year, but some areas such as Kamloops in the B.C. interior are experiencing growth at twice this rate. B.C. Health Services Minister Kevin Falcon has pleaded for patience in negotiating a solution, but the BCMA says there have been no talks since December. (*Kamloops Daily News*, May 6)

Quebec forum discusses doctor-nurse collaboration

Bureaucracy is getting in the way of collaboration between physicians and nurses in Quebec, leaders of both sectors said at a keynote forum at the annual meeting of Quebec Order of Nurses Wednesday.

Legislation was passed eight years ago to expand nurses' scope of practice, but physicians and nurses condemned the slow progress the government has made in bringing this to fruition in the workplace.

The panelists, who included the heads of the College of Physicians and the federation representing medical specialists, said the health ministry and regional agencies are reticent about encouraging collaboration between nurses and physicians. They said to achieve anything the rules often have to be circumvented.

They called for more involvement by both professions in planning activities and organization of work.

A survey conducted by the Order of Nurses found only 40 per cent of nurses reported that collaboration between physicians and nurses is standard practice where they work.

One exception to the rule is the Jewish General Hospital in Montreal where nurse-physician teams are prevalent. The head of nursing services at the hospital told the forum that the result has been lowered mortality and complication rates, patients recover more quickly and are satisfied with the care they receive. **HE**

(**"HRC"** from page 1)

demonstrates the pitfalls of relying on the private sector for health care services, and NDP Leader Brian Mason said the government should simply take over HRC.

"Albertans want a publicly funded and publicly delivered health-care system so they can avoid this exact scenario," he said in a news release.

HE



Editorials & Commentary

24-hour shifts

The Montreal *Gazette* (Apr. 30) comments on arbitration hearings into the practice of Quebec medical residents having to work 24-hour on-call shifts, something that is part of their collective agreement with the health ministry. "We're all for economies in health care, but exhausted doctors are not a solution to any problem," the *Gazette* says. "We have strict rules limiting shift time for pilots and bus drivers; why are we so relaxed about the alertness of medical residents?"

One complaint per visit

Some physicians in New Brunswick are limiting patients to one complaint per visit, a practice which has been judged "unacceptable" by the College of Physicians and Surgeons as well as the government. However, the Medical Society says this is the result of physicians with high caseloads trying to manage their time effectively. An editorial in the *New Brunswick Telegraph-Journal* newspaper (May 1) traces the problem to the government's use of billing numbers which controls the number of physi-

cians in practice and therefore the costs that are generated by the health system. However, the editorial says the number of active billing numbers no longer represents the number of active physicians since many are reluctant to give up their billing privileges even though they are not working full-time. This has shifted the burden to others who are handling as many as 5,000 patients in their practices. "By restricting the pool of doctors and increasing the patient load, the billing cap has encouraged physicians to adopt a one-complaint-per-visit policy or turn patients away." It says it is time to scrap the billing cap, recruit more physicians "and insist that each patient be fully heard."

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Quebec EHR pilot gets back on track

Last week, Quebec Health Minister Yves Bolduc announced that five clinical sites and 10 pharmacies in the Quebec City area are testing a drug information system that is part of the government's plans for an electronic health record (EHR) for the province.

The Quebec City pilot has been plagued with operational problems that caused some participating pharmacies to pull out of the project. They only agreed to give it another try in March.

However, Dr. Bolduc says it is now full steam ahead, and a provincewide

EHR will be in place by the end of 2011.

He said other aspects of the EHR are virtually complete: lab tests are already computerized, as are 98 per cent of medical imageries. He also said work on an electronic prescribing program should be available to physicians and pharmacists soon.

In a report last May, Quebec's auditor general raised serious doubts about whether the EHR project would be finished in 2011. He also warned that it would cost much more than the initial \$563 million estimate. **HE**