

Alberta doing more cataract surgeries

Alberta Health Services is ramping up the number of cataract surgeries again, with a particular focus on Calgary where wait times for the procedure are the longest.

An Expression of Interest document was distributed to cataract service providers last Thursday to perform 1,400 cataract surgeries over the next four months, and up to 120 more corneal transplants this year.

Of these, 1,000 will be performed by private clinics in Calgary, 300 by private clinics in Edmonton and the remaining 100 at Edmonton's Royal Alexandra Hospital.

The new procedures are on top of contracts for 2,140 additional cataract surgeries awarded in March. This competitive bidding process created considerable backlash from ophthalmologists who were forced to book operating room time at one of the four centres that had winning bids.

The government said it was saving \$1.4 million by getting a lower price per procedure. The new surgeries, worth an estimated \$2 million, give clinics another crack at the AHS ophthalmology business.

Cataract surgeries are one of the government's priorities for reducing wait times.

In February, AHS launched a broad first surgical blitz that tackled urgent cancer surgery as well as orthopedic and gynecological procedures, neurosurgery and heart surgery, in addition to cataract removals. More than 3,600 additional MRI and CT scans were also completed.

A second broad surgical blitz is being developed and will be launched soon. **HE**

Big disparities in heart attack rates across the country

Canadians living in the poorest neighbourhoods are 37 per cent more likely to have a heart attack than those in the richest areas. But everyone appears to receive the same treatment and quality of care once they are in hospital – an encouraging sign that universal health care is working.

In This Issue:

- ◆ *Wait times for MRIs in B.C. raised in legislature (Hansard).....2*

Ontario called on to make "urgent" health reforms

The TD Bank's economics group is proposing 10 efficiency and revenue-generating measures to put Ontario health care on a sustainable track. The 35-page report released Thursday is designed to spur a needed debate about what it says is the most pressing public policy challenge facing the province.

"If the fiscal challenge continues to fester, the (health) system will weaken further, even falter. Access and quality care are at risk. Treatment cannot be put off any longer. Urgent reform is required," the report says.

TD projects that under status quo conditions health care expenditures will increase by 6.5 per cent a year on average "well into the future" while revenue growth will lag at four per cent. At this rate, health care will consume 80 per cent of total program spending by 2030.

(See "Ontario" on page 2)

In their 11th annual *Health Indicators* report on the health of Canadians and health system performance, Statistics Canada and the Canadian Institute for Health Information (CIHI) looked at geographic and socio-economic variations for two common reasons for hospitalization – heart attacks and hysterectomies.

While heart attack rates differed substantially for people living in neighbourhoods at opposite ends of the affluence scale, there were even bigger differences between health regions (over a threefold variation) and provinces (a twofold difference).

In 2008–09, heart attack rates ranged from 347 per 100,000 people in Newfoundland and Labrador to 169 in British Columbia, after population age differences across provinces were taken into account.

"While a person's socio-economic status affects the risk of having a heart attack, it appears that where you live in Canada makes a bigger difference," Eugene Wen, CIHI's manager of Health Indicators, said in a news release.

The highest recorded rate was found in the Central region of Newfoundland and Labrador (413) while the lowest was in the Richmond health service delivery area, outside Vancouver in British Columbia (115).

Regions with higher heart attack rates also tend to have higher rates of hypertension, diabetes and other cardiac risk factors.

(See "Health Indicators" on page 2)

(*"Health Indicators" from page 1*)

The news release said that if all provinces had the same heart hospitalization rate as B.C., the national rate of 217 per 100,000 would have been lowered by 22 per cent and there would have been about 15,500 fewer hospitalizations.

This represents a potential saving of about \$150 million in hospital costs, not including physician fees, according to CIHI.

Heart attack 30-day in-hospital mortality and readmission rates continued to decline in the two most recent three-year periods (2003-04 to 2005-06 and 2006-07 to 2008-09).

Again, there were considerable differences between provinces. Alberta had the lowest rates at 7.3 and 3.7 per cent respectively. This compared to the national average of 8.9 and 4.7 per cent. Quebec data were not available.

The risk of dying in hospital from a heart attack was about the same for all socio-economic groups, and unplanned admissions were only slightly higher for patients from the least-affluent neighbourhoods.

The report did not find any great discrepancies between hysterectomy rates between neighbourhoods, but provincial differences remained. These ranged from 512 per 100,000 population in PEI to 311 in B.C. after population age differences were taken into account.

The variations between urban and rural areas were more pronounced. In 2008-09, the hysterectomy rate was 46 per cent higher for women from rural settings than urban ones. This may have more to do with differences in clinical practice than in the health of the respective populations, Dr. Vyta Senikas, associate executive vice-president of the Society of Obstetricians and Gynecologists of Canada, said in the news release.

The *Health Indicators 2010* report can be found at www.cihi.ca. **HE**

Hansard Highlights

Debates in provincial legislatures and House of Commons

In the **British Columbia** legislature last Thursday, NDP Health Critic Adrian Dix raised the issue of wait times for MRIs. He cited a number of examples of 18-month waits for medical necessary scans. Health Services Minister Kevin Falcon denied there is any problem getting urgent scans, but admitted there is an issue with elective, non-urgent ones. He pointed out that the number of MRI machines in the province has gone up from nine in 2001 to 24 currently, and the number of diagnostics performed has grown by 170 per cent. "Even in spite of those increases, there is still a challenge," he said. "So we are looking at the non-urgent MRIs and making sure that we do everything we can — looking at how the system is delivering it, the appropriateness of the referrals —

to deal with the virtually unlimited demand for MRIs."

The **Saskatchewan** legislature adjourned last Thursday but not before the NDP Opposition had another crack at the government about an agreement with the Catholic Health Ministry to build a new long-term care facility in Saskatoon. NDP MLA Pat Atkinson said the government initially claimed the cost per resident will be \$185 a day, but it is now saying this figure has still not been finalized. She suggested it could be higher given that a \$27 million mortgage for the new property will have to be serviced. In his response, Health Minister Don McMorris said the agreement to build the state-of-the-art facility "is a good deal for Saskatchewan. It's even a better deal for seniors."

(*"Ontario" from page 1*)

The report makes 10 recommendations which, taken together, will close this gap.

The first three involve improving information use to improve efficiency:

1. Promote healthier lifestyles
2. Expand information technology use in the system
3. Establish Commission on Quality and Value for Health Care

Ontario is urged to follow British Columbia's example in promoting healthy lifestyles. This includes adopting some aggressive goals such as ensuring 73 per cent of Ontarians are physically active by 2015.

Second, it says Ontario needs to catch up to other provinces, and countries, in the use of information technology to monitor and reward performance in the health system.

Third, it suggests existing organizational structures be brought together in a new Commission on Quality and Value for Health Care that

would be patterned after the National Institute for Clinical Excellence (NICE) in the U.K.

These organizations include the Ontario Health Quality Council which the report says has a "purely advisory and persuasive role" with no executive power in contrast to NICE. The U.S. is setting up a similar body to NICE as part of its recent sweeping health reforms.

The next five recommendations involving incentives to improving efficiency:

4. Alter the way doctors are compensated
5. Change approach of funding hospitals
6. Re-allocate functions among health-care providers
7. Scale back Ontario's Drug Benefit for higher-income seniors
8. Increase bulk purchases of drugs to lower costs

The report supports a shift from

(See "TD" on page 4)

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

Twenty-two new sites in 18 hospital wards and four community hospitals are joining Saskatchewan's "Releasing Time to Care" program. It is the start of a provincial rollout that will see all hospitals implementing the program by 2012. It gives health care staff strategies for improving processes, so they spend less time doing paperwork or searching for supplies and more time on direct patient care. Various sites have been testing the program since the fall of 2008 with promising results. For example, the oncology unit at Regina's Pasqua Hospital increased the amount of time nurses spend on direct patient care during a shift from 26 per cent to 41 per cent. News release and background at www.health.gov.sk.ca under What's New.

A Kitchener, Ontario hospital is getting \$530,000 in performance funding for sharing its best practices with other hospitals in cutting ER wait times. St. Mary's General Hospital has reduced wait times for admitted patients by 43 per cent since April 2008. It achieved this by creating a real-time picture of patient flow in the ER and streamlining existing processes. Also, nurse practitioners now assess and treat patients with less-serious conditions. More information at www.health.gov.on.ca/en/ under Top News Stories ... **Quebec plans to build two new community hospitals in Montreal in the next 5-7 years to ease ER overcrowding** which is a chronic problem in the city, and elsewhere. A survey by *La Presse* has found that the average length of time a Quebec patient has to wait in an ER before getting admitted has climbed to 17 hours, 36 minutes which is a half-hour longer than last year and exceeds the government's target of 12 hours. In Montreal the wait is over 20 hours. (*La Presse*, May 27)

Quebec health care facilities have been ordered to cut their training, publicity and travel budgets by 25 per cent. The direction is given in the budget allocations provided by the province's 18 regional health agencies. The move has been called "irresponsible" by the Quebec Order of Nurses which is already concerned that only-in-four nurses undertook any additional training last year. The association representing hospitals, long-term care and community health centres also sees the budget cuts as misguided. (*Le Devoir*, May 27) ... **Quebec labour unions representing nurses and other health-care workers have been presented with another contract proposal** from the government that offers more flexibility in hours worked, and is designed to reduce reliance on private agency workers to fill vacant shifts. It includes shift premiums of 4-6 per cent for those who work evenings and nights as well as in critical care. Nurses can also arrange their work week in three 12-hour days or four nine-hour days. However, it does not address the unions' wage demands and they have dismissed the proposal as inadequate. (*La Presse*, May 27)

Wait times for cancer radiation treatment in Ontario are continuing to decline despite a more than 10 per cent increase in the number of patients. The *2010 Cancer System Quality Index* report this week said 96 per cent of patients receive radiation within the benchmark of 28 days from being ready to treat. The report says wait times are now at an acceptable level and the province should turn its attention to increasing utilization of radiation therapy. The provincial target is 48 per cent but utilization currently stands at 36 per cent. The report can be found at www.cancercare.on.ca ... **Eighty per cent of Canadian women**

diagnosed with breast cancer experience significant financial burdens during treatment, a report from the Canadian Breast Cancer Network says. On average, the patient household experiences a 10 per cent drop in annual income. The report is based on a 2009 national survey of 446 patients with a recent diagnosis of breast. Fully 44 per cent of respondents depleted their savings and retirement funds, while 27 per cent took on debt to cover treatment costs. The report can be found at www.cbcn.ca.

Some 44 per cent of Canadian seniors living in residential care homes are diagnosed with or have symptoms of depression, according to the Canadian Institute for Health Information. The study is based on data collected from Nova Scotia, Ontario, Manitoba, Saskatchewan and the Yukon. It found seniors with symptoms of depression experienced significant medical, social, functional and quality-of-life challenges, regardless of whether they were diagnosed with the mental disorder. (News release at www.cihi.ca)

The Health Council of Canada has published a report of the McMaster Health Forum on primary care reform held last January. Recommendations from the session include: re-affirming primary health care as the foundation of Canada's health system; ensuring appropriate management structures are in place between health ministries and primary health care providers; linking funding agreements with physicians and others to public policy goals for primary health care; and, finally, paying attention to change management so that physicians and primary health care teams are supported in their efforts to strengthen primary health care across Canada. The report can be found at www.healthcouncilcanada.ca.

(“TD” from page 2)

paying doctors on a fee-for-service basis to some form of compensation per patient. It also endorses a move the Ontario government is already planning to fund hospitals for services actually delivered. Both of these models feature a patient-based approach.

The sixth recommendation deals with changes to who-does-what in health care, maximizing scope of practice.

The last two recommendations in this group deal with drug spending. The report suggests scaling back drug plan entitlements for seniors with the financial means to pay for their drugs or to acquire private insurance coverage. It also supports the government taking advantage of its purchasing power to secure lower prices for both brand-name and generic drugs.

The authors admit that it is not possible to predict what savings these eight recommendations will bring. In fact, a number actually involve increased spending, at least in the short run until benefits are accrued. This includes ramped up spending on promoting healthy lifestyles, and investments in information technology, as well as incentives payments for doctors.

The final two recommendations are ways of bring in additional revenue:

9. Establish pre-funding for drug coverage
10. Incorporate a health-care benefit tax into the income-tax structure

The report suggests the government pre-fund future spending requirements by getting taxpayers to put money aside in their paycheques as they are now doing for the Canada Pension Plan. The “best candidate” for this approach is drug benefits, the authors say, although long-term care could be considered.

It also advocates a benefit tax based on usage of the health system.



Editorials & Commentary

Nursing roles

The *Charlottetown Guardian* (May 27) comments on the controversy surrounding Prince Edward Island's new model of care which, among other things, will see licensed practical nurses and patient care workers taking on some duties formerly performed by registered nurses. In a letter-to-the-editor in the *Guardian* (May 21), Linda Silas, the president of the Canadian Federation of Nurses Unions, claimed “The driving force behind these changes is budgets, not improvements to health care.” She said nurses have been shut out of the process of developing the new model which she said “represents a dramatic de-skilling of the health workforce that is both dangerous and wrong-headed.” The *Guardian* editorial says the arguments, for and against the new model, are “confusing and even alarming” to Islanders. Is the government “simply trying to deliver health care on the cheap,” by using lower-cost health care workers, it asks, or “are we simply witnessing a turf war among professionals in our nursing services?” The *Guardian* says what the public is concerned about is whether the new model will deliver better care. “Government claims it will, but the minister of health needs to explain fully how adjusting the roles and

routines of our nursing professionals will accomplish this.”

Health workers getting flu shots

The *Toronto Star* (May 27) is concerned about a report from the city's board of health showing low vaccination rates among health care workers during last winter's H1N1 epidemic. It averaged 59 per cent which the *Star* points out is comparable to that of seasonal flu shots of past years. The rate averaged just 39 per cent for workers in long-term care homes, but ranged from 100 per cent coverage to zero. It was a similar story in hospitals. Provincial guidelines call for 70 per cent of health care workers to be immunized against the flu, and the *Star* notes that there has been a call to make flu shots mandatory if rates do not improve. “This latest data inspire no confidence that workers are getting the message,” it concludes.

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This is what Quebec is already contemplating with its deductible for each medical visit to be tallied up at Income Tax time. The report acknowledges that there are a host of issues to be sorted out with both revenue-generating ideas.

The expansion of the private sector's involvement in the provision of care is supported by the authors, but they say there is little evidence that reducing public health coverage and

getting the private health insurance to pick up the slack would work.

“For sure more private financing and delistings would save money for the public purse. But if all they did was shift the cost from the public sector to the private sector then nothing would be accomplished,” the report says.

“*Charting a Path to Sustainable Health Care in Ontario*” can be found at www.td.com/economics/special/db0510_health_care.pdf. **HE**