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Ontario wait times down, but not for long-term care

Progress has been made in reducing wait times for care in Ontario over the past year, the Ontario Health Quality Council says in its fifth annual report released Thursday. However, it warns that roadblocks to patient flow are causing backlogs.

There have been "solid improvements" in cardiovascular care, including declining rates for heart attack mortality and hospital readmissions.

Wait times are also considered "good" for both cardiovascular surgeries and cataract removals, and have improved for hip and knee replacements as well. The Council furthermore sees "cautious signs for improvement in care for diabetes and other chronic diseases."

But it says wait times for long-term care have tripled since 2005 and stand at 105 days overall. Fully 16 per cent of hospital beds are occupied by patients who do not need to be there, but are waiting for a place in community care.

The report points to the success Lethbridge, Alberta has achieved in using assisted living and supportive housing to reduce reliance on long-term care. Wait times there are under a month, yet it uses one-third fewer long-term care beds than Ontario.

The issue with long-term care came as no surprise to the Association of Non-Profit Homes and Services for Seniors in the province. In a news release commenting on the Council's report, it pointed out that there are about 76,000 long-term care beds in the province which are 98 per cent full and there is a wait-list of over 25,000 people.

On other matters, the Council is pleased that the use of electronic medical records in physicians' offices increased from 26 to 43 per cent be-

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Academic Health Sciences Networks proposed

Canada's teaching and research hospitals need to get better organized and leverage their considerable contributions to health care if they are going to effectively address their financial and other challenges.

This is one of the central messages in a report this week from a task force on the future of academic health sciences centres or AHSCs.

There are 57 of these institutions in Canada, associated with faculties of medicine and other programs such as nursing and pharmacy. They have a three-pronged mandate: to train new health professionals, conduct research, and provide leading-edge complex care to patients.

They are a big part of Canadian health care with operating budgets in the range of $24 billion a year and research budgets of $1.8 billion. Each year, AHSCs provide close to 55,000 clinical placement opportunities across multiple health professions. They also handle care for 97 per cent of rare and complex conditions.

AHSCs have not been immune to the mounting financial pressures facing health care. With their teaching and research budgets, and complex patient caseloads, their expenses are generally higher than for community hospitals.

But AHSCs have been struggling with inadequate funding for years, and patient care is subsidizing the teaching and research aspects of their missions. Funding comes from different sources, both federal and provincial governments (as well as the private sector), and a number of different ministries are involved. This

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Ont. interested in changing physician compensation

Ontario's health minister is open to some of the ideas in last week's report from TD Economics calling for "urgent" reforms to health care. The report said rising health care costs are unsustainable.

In an interview with reporters last Thursday, Health and Long-Term Minister Deb Matthews said the report's recommendation of limiting drug plan coverage for wealthier seniors was "something we can look at." She was similarly interested in another recommendation to shift more physicians from fee-for-service to salary-based compensation.

The report said "a healthy and vigorous debate" on the future of health care is needed – again something Ms. Matthews supports.

In fact, this has become a standard refrain from the minister and Premier Dalton McGuinty since the need to engage Ontarians in an "important conversation" about the funding challenges of health care was

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tween 2007 and 2009. But it is perplexed that access to primary care remains a problem despite a steady increase in the supply of health professionals. About seven per cent of Ontarians (some 730,000 people) do not have a family doctor.

Recent legislation in the province aims to expand the mandate of the Council to promote evidence-based care. It will also be given the job to make recommendations to the government on the "provision of funding for health care services and medical devices."

The Council's report can be found at www.ohqc.ca/pdfs/2010_report_-_english.pdf. *HE*

("**Networks**" from page 1)
sometimes creates problems with "competing agendas, conflicting policies and fragmented priorities," the report says.

The report recommends the creation of academic health sciences networks or AHSNs to reflect the regional and even national scope of their responsibilities, as well as to respond to new approaches in patient care, teaching and research.

These networks would involve formal partnerships between academic health care facilities and other provider organizations similar to what exists in some parts of the country.

For example, Quebec has four *Réseaux Universitaires Intégrés de Santé* or RUIS which are constituted around the four medical schools and affiliated academic hospitals. Although they work closely with regional health agencies, they have a direct accountability relationship with the government.

The 19-member task force was co-chaired by Jeffrey Lozon, president and CEO of Revera Living, and Dr. Jean Rouleau, dean of Medicine at l'Université de Montréal. The report can be found at www.ahsc-ntf.org. *HE*

Hansard Highlights

Debates in provincial legislatures and House of Commons

In the **House of Commons**, medical isotopes have again been an issue. On Tuesday, Liberal Health Critic Carolyn Bennett said the supply of isotopes last week was 10 per cent of normal, but Health Canada had turned down a request from a company to bring in isotopes from Israel.

It has been reported that the company, Lantheus, negotiated a deal to bring in isotope "generators" processed in Israel from isotopes produced in South Africa. While South Africa is a Health Canada approved source, the Israeli material has not been evaluated for its safety and effectiveness. It would only be available for import under the Special Access Programme that allows practitioners to apply for permission to get products not yet been approved for sale in Canada. Apparently, the company did not go through the right channels to get the Israeli product and that is why it was stymied by Health Canada.

In the Commons Wednesday, Natural Resources Minister Christian Paradis said the government that day had announced $35 million over two years for research projects to come up with new sources of medical isotopes. The work will focus on linear accelerator and cyclotron technologies to produce technetium-99m (TC99) used in about 80 per cent of all nuclear medicine scans in Canada. Ms. Bennett responded that the research money "will do nothing to help the patients waiting for their cancer and heart tests."

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first mentioned in the March Speech from the Throne.

That Speech promised a period of unrelenting reform in health care, and the government has already taken a number of steps in this direction including radical changes to the drug plan and the abolition of lucrative professional allowances or rebates pharmacists receive from generic drug companies for stocking their products.

Pharmacists are still fighting the initiative which is due to come into effect this month.

The TD report saw distinct advantages in using capitated payment models whereby physicians get paid a certain amount per patient, as well as salary arrangements which have been put in place for new team-based primary care practices.

"Once doctors have moved away from billing for services performed towards a blended per-capita, salary and volume structure, further incentives can be put in place through the payment mechanisms to reward effective practice, increased number of patients, etcetera."

The report's focus on aligning physician compensation with performance is again something that was mooted in the Throne Speech. It promised legislation "to make health care providers and executives accountable for improving patient care." However, the legislation that was tabled in early May (*Excellent Care for All Act*) only tied hospital executive compensation to meeting quality objectives.

There is a certain willingness on the part of Ontario physicians to consider different ways of being remunerated. The 2007 National Physician Survey found half would prefer some form of blended payment.

The three most desired components of this formula were fee-for-service, on-call, and benefits/pension payments. Salary and task-related (sessional) payments were further down the list. *HE*

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

Saskatchewan Health Minister Don McMorris has received a new mandate letter from Premier Brad Wall. All Cabinet ministers received such letters outlining objectives for the next 18 months leading up to a provincial election in late 2011. Most of the items on the list for Mr. McMorris are already part of the government's agenda, and include moving forward in implementing key recommendations in last year's *Patient First* review of the health system. New items include establishing a provincial addictions agency and revitalizing the province's kidney transplant program. The mandate letter can be found at www.gov.sk.ca/cabinet/mcmorris ...**The Regina Qu'Appelle Health Region is looking for a third-party supplier of CT services** to combat growing wait lists. The three scanners at Regina hospitals are operating at maximum capacity seven days a week, and waits for lower-priority cases can be as long as a year. Health Minister Don McMorris says contracted-out services will still be paid for by the public sector. "The only difference would be the deliverer." (*Regina Leader Post*, June 2)

Ontario was lucky the H1N1 pandemic was not worse, the province's Chief Medical Officer of Health says in a report this week on how Ontario fared. Dr. Arlene King says the province had a plan and was prepared, but had more people swarmed emergency departments for longer than they did "that might very well have tipped the system." She says there is a need "to take a hard look at our immunization system" including ways of tracking and managing vaccination programs which were inadequate during the outbreak. Dr. King says there is also a need for strong central oversight and management during an outbreak. This includes giving her office the authority to direct what the province's 36 public health units do "in real time." Her report can be found at www.health.gov.on.ca/en/public/publications/ministry_reports/cmoh_h1n1/cmoh_h1n1_20100602.pdf.

Telus has announced that its "health space" personal health record is now available for licensing. Twelve health organizations are collaborating with Telus in providing educational and other materials. For example, the Canadian Diabetes Association is including interactive educational tools to help people with diabetes manage their conditions. Also in the past week, information technology company Nightingale Infomatix and Canadian Patient Access Inc. announced that their patient portal myPatientAccess.ca will be launched this summer and will later be available to physicians using the Nightingale electronic medical record platform. (News releases)

New Brunswick is being urged to introduce a comprehensive diabetes strategy. The Canadian Diabetes Association has produced a cost model showing that the current cost of diabetes in the province is $347 million annually, and could rise to $427 million by 2020 unless something is done to check the rising prevalence of the disease. It stands at 9.9 per cent of the population compared to the national average of 7.3 per cent. The New Brunswick government promised a diabetes strategy in 2006 but has yet to introduce a comprehensive program. (*Fredericton Daily Gleaner*, June 2; report at www.diabetes.ca/images/news/cost-model-en.pdf)

The sustainability of New Brunswick's health system is under threat from rising demand and cost structures, the New Brunswick Health Council says in a report this week. It projects health expenditures to increase by approximately five per cent a year but a number of cost drivers "have the potential to raise the growth of costs to well in excess of these numbers." Examples include new technologies, pharmaceuticals, and increased incidence of chronic and new diseases. "In order for sustainability to occur there will need to be a balance between a low per capita cost, adequate capacity and resources, quality health care services, and citizen satisfaction with the health system while providing the best health outcomes for the population of New Brunswick," the report says. It can be found at www.nbhc.ca/docs/sustainability_report_en.pdf.

Hospitals have failed to adapt to the needs of seniors even though, as patients, they account for 45 per cent of hospitalizations. A report prepared by geriatric specialists in Quebec, and obtained by *Le Devoir*, found that a third of older patients who are hospitalized experience a functional decline. Of these, 40 per cent will suffer a deterioration in basic activities such as the ability to wash or dress themselves. For half of these patients, the situation will persist for more than three months and risk a progressive and irreversible decline. The report pointed out that patients 75 years of age and older lose five to 10 per cent of their muscle mass per week of confinement in a hospital bed. (*Le Devoir*, May 29)

Manitoba nurses have a tentative new contract. It incorporates the two-year wage freeze announced by the government in the budget, but provides a one-time, lump-sum payment of two per cent followed by a four per cent increase in year three of the deal. It also includes a two per cent wage bonus after 20 years of service, and provides indexed pensions beginning in 2018. A ratification vote is scheduled for June 16. (News release)

Nova Scotia not meeting mental health standards

On Tuesday, Nova Scotia Health Minister Maureen MacDonald named the co-chairs of a committee charged with developing a mental health strategy for the province.

The announcement anticipated a scathing report the day after from Nova Scotia's Auditor General who said there is inadequate oversight of the mental health system and no effective monitoring of compliance with mental health standards by the Department of Health.

"The Department is not fulfilling its legislative requirements under the *Health Authorities Act* to monitor and evaluate the quality of mental health services," Jacques Lapointe said.

In fairness, Nova Scotia is the only jurisdiction with mental health standards; they were developed in 2003. Furthermore, when these standards were released, the Department of Health recognized that there was a funding shortfall of about $20 million that would inhibit the ability of the province's district health authorities (DHAs) to meet them. This shortfall rose to $23.5 million in 2007-08.

Mr. Lapointe said the government should have developed a plan for how the standards would be met over time.

Developing such a plan is one of the recommendations of his report, and, in fact, it will be one of the things the committee developing the mental health strategy will be doing.

The Auditor General's report was based on a review of mental health services in three DHAs as well as the IWK Health Centre in Halifax, a separate entity that provides pediatric and women's health services. He reviewed 358 patient files to see whether they met 15 selected standards.

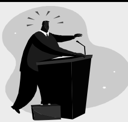
A number of standards had to be excluded from his analysis because of their vague wording, or the varied interpretation of what they mean from organization to organization.

Only 14 per cent of the patient files in the review met all selected standards. In the Capital Health District, the largest in the province, only one file met all the standards.

The testing did not assess whether clinical decisions were appropriate, but Mr. Lapointe commented that failure to comply with the standards "negatively impacts mental health patient care across the province and increases the risk of poor patient outcomes."

Health Minister MacDonald plans to name the remaining members of the mental health strategy committee in the coming weeks.

The Auditor General's report can be found www.oag-ns.ca/June2010/full%20report.pdf. *HE*



Editorials & Commentary

Sustainability of health care

In an opinion-editorial published in the *Toronto Star* (June 1), Robert Evans, a UBC economist with the university's Centre for Health Services and Policy Research, says that while it is true health care is taking a bigger bite out of provincial government revenues this has a lot to do with reductions in their revenue base due to tax cuts they (and Ottawa) have made over the past 15 years.

He says those cuts, between 1997 and 2004, removed some $170.8 billion from public sector coffers. "Total provincial revenues are by now roughly $35 billion per year less, or about half provincial spending on medicare."

With regards to the considerable debate underway about the sustainability of health care, Dr. Evans believes there are two motives behind claims that the system is going broke.

First, higher-income people contribute more to supporting the health system without any preferred access or standard of care. They would benefit from any shift to more private financing.

Second, "every dollar of health-care expenditures is also a dollar of someone's income" and "Privatization is a way to avoid cost containment, reopening greater income opportunities for providers of care (and private insurers) outside public control."

He agrees that it is "long past time" for a debate about these factors and "a clear identification of the winners and losers from eroding or dismantling medicare." He believes this debate should also focus on what is driving cost utilization. Increases in the intensity and costliness of care "is the real issue," he says.

Dr. Evans identifies medical imaging and laboratory testing as the major sources of cost escalation, although he says the benefits of this activity is unknown. As an example, he notes that utilization of ultrasounds for low-risk pregnancies is up 50 per cent in the past decade.

He also says patterns in medical practice and hospital use vary widely across the country without any apparent reason. He says groups such as Ontario's Institute for Clinical Evaluative Sciences have tracked some of these variations "but they are largely ignored."

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