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B.C. introducing primary care innovations

Every British Columbian who wants one will have a family doctor by 2015, Health Services Minister Kevin Falcon promised June 24 in announcing a $137 million overhaul of the primary health care system. Currently there are at least 250,000 people in this predicament.

"Ensuring that British Columbians have access to their own family doctor – a health professional who is familiar with their medical history – can drastically improve health outcomes for patients and in doing so, can help ensure the sustainability of our health system." Mr. Falcon said.

High needs patients, frail seniors and patients with chronic diseases will also be provided with enhanced care planning and support with an individualized and coordinated personal medical health-care plan linking together various health professionals to provide better quality care.

Patients with higher needs will have access to innovative models of care. This will include faster access to medical consultations with specialists following the introduction of a new payment mechanism in April. It allows family physicians to get immediate telephone access to a medical specialist for a telephone consultation.

But the central idea to the primary

*(See "**B.C.**" on page 4)*

We're back

Due to Canada Day falling on a Thursday, we only posted an abbreviated version of the newsletter on our website June 30. This issue covers all the news from June 25 to July 8 inclusive.

Canadian health care fares poorly in international survey

Canada has come out second last in an international comparison of health system performance by the Commonwealth Fund in New York. Only the U.S. did worse in the survey of seven countries that also included Australia, New Zealand, the UK, Germany and top-ranked Netherlands.

This perhaps comes as no big surprise since Canada had the same dismal showing in all previous surveys done by the Commonwealth Fund dating back to 2004. The organization uses 74 performance measures which draw heavily on annual international surveys it has sponsored.

Of the seven countries, Canada was dead last on quality of care, sixth on efficiency, and fifth on access and equity. Only in terms of citizens having "Long, Healthy and Productive Lives" did Canada get ranked second (and after Australia).

The low uptake of electronic record systems by Canadian physicians had a significant bearing on the country's scores in a number of categories. Under quality of care, for example, Canada ranked last on six measures that pertain to physicians having ready information in computerized form such as a printable list of patients due for tests or preventative care, or electronic alerts about potential problems with drugs they are prescribing.

Canadian physicians were also much less likely than their colleagues in other countries to say they receive the information they need from hospitals within two weeks of their patients being discharged – yet another area where electronic health records would be beneficial.

Access to care was another area where Canada fell down compared to other countries, ranking last in wait

*(See "**Study**" on page 2)*

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Quebec cuts generic drug prices

Quebec has followed Ontario's lead in reducing the price of generic drugs to 25 per cent of the brand. Health and Social Services Minister Yves Bolduc made the announcement June 25. Currently, generics in the province are about 54 per cent of the brand.

By Quebec law, its health insurance plan does not pay more than the lowest price in the country for any drug so the policy change is automatic. However, it will still take four to eight weeks to implement.

Dr. Bolduc said Quebec will save about $164 million a year from the price cut or about 22 per cent of the $750 million a year the government spends on generics. This could balloon to as much as $300 million as new high-volume generics come on the market.

Last week, generic drug manufacturers warned that Quebec's decision could damage its investment and employment in the province. *HE*

("**Study**" from page 1)
times for appointments, emergency care and ability of patients to get in to see their regular physicians on a same- or next-day basis.

The Commonwealth Fund has typically used its international comparison reports on health care to point out the need for substantive reforms in the U.S. With the changes introduced by President Obama, it says the performance of the U.S. should improve relative to other countries. However, it says no country is performing at an "ideal" level and all "could improve performance by looking for best practices within and outside their borders."

The report — *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally* — can be found at www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx. *HE*

Hansard Highlights

Debates in provincial legislatures and House of Commons

The spring session of **Newfoundland and Labrador** legislature closed June 24, the last to do so.

Health Minister Jerome Kennedy was questioned about the status of the government's long-term care strategy which has been in development since February 2008. He said consultations could start as soon as this summer, and that there would be a background document "hopefully" containing the government's "vision, the mission and the principles." He said the government has spent $110 million in recent years on long-term care infrastructure, but he wants to consider other options for helping seniors stay independent in the community. "We are looking at how we can utilize all the resources we have at our disposal, and that will include community care homes, independent living, how we can work with seniors' groups. All of these things will decrease the need for long-term care facilities," he said. As things stand, there are 2,500 long-term care beds in the system and the minister said there may be a need for another 900 as the population ages. By 2021, 22 per cent of Newfoundlanders and Labradorians will be over the age of 65. NDP Leader Lorraine Michael pointed out that a patient flow study released in March by the Eastern Health authority in St. John's concluded "that a lack of community-based resources to provide home care services are affecting the organization's ability to discharge patients."

Ontario is scheduled to be the first legislature back in the fall, opening September 13. *Hansard Highlights* will be back then.

Alberta Health Services tables $11 billion good-news budget

Alberta Health Services released its $11.2 billion 2010-11 budget on June 29, a far different one from last year when the agency was warning about severe measures to get rid of its $1 billion-plus deficit.

This year's provincial budget erased that deficit, and gave AHS a five-year funding plan that includes six per cent increases for three years followed by a 4.5 per cent rise in each of the last two years.

AHS is targeting two priority areas in its new budget – improved access to continuing care, and reduced wait times in emergency departments.

At least 1,000 new continuing care beds will be added each year over the next three years, increasing overall capacity by over eight per cent. It will include options like assisted living to allow seniors to live independently in their own homes or in the community, but no breakdown of how the beds will be allocated has been announced.

This will relieve pressure on hospitals. In his internal blog, Stephen Duckett, the CEO of Alberta Health Services, said that although the number of acute care beds went up marginally over the past year – from 7,719 to 7,802 – it was not enough to keep pace with demand.

"The consequence is there for all to see: waiting times for elective procedures are still too long and our emergency departments are overcrowded with too many people waiting too long for care."

The new continuing care beds will help. There are some 700 Albertans waiting in acute care or sub-acute care setting for a placement in continuing care. Medical assessment units are also being opened in two hospitals to improve ER flow. Patients waiting for an inpatient bed are transferred to this unit where physicians and nurses initiate consultations, treatment and diagnostics.

With the financial pressure lessened, Dr. Duckett said AHS has lifted its vacancy management program meaning managers can staff jobs in existing positions without getting approval "up the line."

However, he told a CBC editorial board recently that AHS will be after a temporary wage freeze for all health workers, including physicians, in new contracts coming up for negotiation. Alberta nurses were the first to have a zero per cent increase in the first two years of a new four-year contract ratified June 30.

More information on the AHS budget at www.albertahealthservices.ca/2127.asp. *HE*

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

Health PEI is now running the Island's health system. A ministerial directive was signed by Health Minister Carolyn Bertram at the agency's inaugural board meeting this Tuesday. A report by a consulting firm for the government in November 2008 was critical of the fact that the government was running most health care operations directly and decisions were getting caught up in red tape. The creation of Health PEI was a recommendation of the province's Health Governance Advisory Council last November and an 11-member board was announced in April. (*Charlottetown Guardian*, July 8) … **A single group-purchasing organization is being set up in Nova Scotia**. It would act on behalf of the province's nine health district health authorities and the IWK Health Centre in Halifax which is a separate entity. The move was signalled in the April budget and the Speech from the Throne in March said the government wanted to reduce the amount of money spent on administration, now accounting for 6.3 per cent of total costs. The objective is to reduce this to the national average of 5.3 per cent. British Columbia has a shared service organization and Saskatchewan is looking into doing the same thing. (*Halifax Chronicle-Herald*, July 8)

Alberta nurses have ratified a new 3-year deal recommended by a mediator that contains no salary increase this year, a two per cent increase in 2011 and a four per cent boost in 2012. United Nurses of Alberta was pleased that the contract begins to address adequate and safe nurse staffing, including a commitment to hire at least 70 per cent of the province's nursing graduates each year which could work out to 1,300 new nurses a year. The union and Alberta Health Services have also agreed to study overtime pay and wages for casual positions to identify areas which could benefit from full-time work. (*Calgary Herald*, July 2; News release) … **Members of Quebec's largest nurses' union have rejected the government's call for them to return to the bargaining table**. The Fédération interprofessionnelle de la santé du Québec (FIQ), representing 80 per cent of the province's nurses, has turned down the deal the government recently reached with public sector unions representing 475,000 employees including 20,000 nurses. It provided a seven per cent wage increase over five years. The main issues for the FIQ are working conditions and the use of private agency nurses to fill vacant shifts. "Why is the government ready to pay $100 an hour for an agency nurse when those in the public sector earn $30," FIQ VP Michele Bouclair asked at the union's news conference July 2. (*La Presse*, June 26, July 3)

Manitoba's e-Health program will take longer and cost more to implement than planned, the *Winnipeg Free Press* reported June 29. Government documents obtained through a freedom of information request revealed that the cost could run to as much as $600 million and development of the various systems could take 10 to 20 years. The government earmarked $150 million for e-Health when the project was launched in 2007. The documents raised concerns about breakdowns in existing systems due to outdated technology, but replacing these systems is more expensive and time-consuming than initially thought, Manitoba eHealth Chief Information Officer Roger Girard told the *Free Press*. Some 30 per cent of eHealth applications are outdated, the reports revealed. (*Winnipeg Free Press*, June 29)

Fourteen per cent of rural physicians in Canada plan to move from their communities within the next two years, a study published this week in the *Canadian Journal of Rural Medicine* reveals. Given that there are already physician supply problems in rural Canada, this "risks making a bad situation worse," the Society of Rural Physicians (SRPC) says. It submitted a number of recommendations to the Commons Health Committee in June including scholarships for rural students to study medicine, and a Rural Medicine Skill Enhancement Program to increase rural medicine procedural and other skills training in current medical school training programs and to allow rural physicians to upgrade their skills and competencies. This week, the Saskatchewan government announced that four medical residency positions are being established at a new clinic in Swift Current, the latest step in a plan by Saskatchewan's College of Medicine to expand medical education beyond Saskatoon. More information at www.srpc.ca

In the past year, the number of new physicians registered in British Columbia has more than doubled, from 216 to 488. Dr. Heidi Oetter, registrar of the College of Physicians and Surgeons, says it is the biggest one-year increase ever. The government has taken a number of steps to increase physician supply including doubling medical school enrolment. The number of physicians in the province has grown 17 per cent between 201 and 2009. (*Victoria Times-Colonist*, July 7) … **Saskatchewan hopes to have a system for assessing international medical graduates by next year**, the College of Physicians and Surgeons says. It would allow them to get licenses to practice in underserviced areas under certain conditions. (*Saskatoon Star-Phoenix*, June 30)

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care overhaul is the aggressive expansion of Divisions of Family Practice announced in January 2009. These are the brainchild of the General Practice Services Committee – a joint government, B.C. Medical Association (BCMA) group.

There are currently three such divisions involving 250 family physicians (membership is open) with each one set up as a society. Members work with the local health authority and community agencies through a collaborative services committee to develop and implement solutions for region-specific issues affecting the delivery of health services at the community level – including access to a family physician.

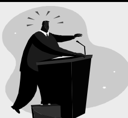
New approaches to building capacity are going to be tried as well. This could involve offering group consultations for patients with chronic diseases instead of the traditional one-on-one sessions.

Mr. Falcon hopes there will be broader use of the province's 190 nurse practitioners in integrated primary and community care. A government and BCMA working group is being established to explore this further.

The government is also considering the use of patient-focused funding to support primary care beginning next year. This model was introduced at 23 of the province's largest hospitals in April and offers incentives for services to be delivered at a competitive set price.

The government plans to add five more Divisions of Family Practice soon and perhaps as many as 20 by the fall. By next March, the program is expected to spread to more than 40 communities and regions, and provincewide by 2015.

There is more information on this announcement at www.gov.bc.ca/health/index.html under News. The Divisions of Family Practice website is www.divisionsbc.ca. *HE*



Editorials & Commentary

Reducing, reporting wait times

The *Halifax Chronicle-Herald* took two editorials to air its views on the recent report from the Wait Time Alliance (WTA) on how the provinces are doing in reducing and reporting wait times. On June 25, the *Chronicle-Herald* said Nova Scotia got "terrible grades" on its wait times, and that "If this were a university, an F, a C and three Incompletes would get you kicked out of the program. But the sick aren't in a position to expel the Health Department." The June 27 editorial noted that the WTA report did acknowledge that Nova Scotia is doing better than other provinces in its wait-time reporting and the ease-of-use of its website, even if the data are somewhat dated. "A system that's slow on service but good on telling you about it is not the order of priorities that patients would ever chose," the *Chronicle-Herald* commented, even if it is "at least a tiny step forward." The editorial said it is time to raise the bar and improve wait-time performance.

Benefits of fewer health regions

In a letter-to-the-editor of the *Moncton Times-Transcript* (June 28), New Brunswick Health Minister Mary Schryer pointed to the "remarkable" achievement of the province's two health regions posting a combined surplus in 2009-10. She said this is the first time it has happened "in more than a decade." The government amalgamated eight health regions into two new entities in 2008. In their final full year in operation, the previous regions posted a deficit totalling $44 million. "Transforming the regional health authority structure into one provincial system, delivered through two networks, has resulted in a more efficient, sustainable and integrated health system," she said. While the two new regions had a combined surplus, one was slightly in the red. Horizon Health Network posted a $900,000 deficit. The former RHA "A" (now called the Vitalité Health Network) in the northern part of the province, and which also handles French-language care in the Moncton area, had a $4.9 million surplus. Ms. Schryer said the surplus funds would be reinvested in the health system "to fund one-time expenditures."

Focus on primary care

In an opinion-editorial published in the *Toronto Star* (July 4), health policy analyst Dr. Michael Rachlis says it is not surprising that a recent international comparison of health systems by the Commonwealth Fund had Canada beating the U.S. Almost all other developed countries' health systems can do the same thing, he says. He also observes that there are 18 instances in the report where Canada is compared with other countries, 16 of which are unfavourable. "The main determinant of overall health-care system performance is the quality of primary health care. Unfortunately, Canada's system of family doctors and a few community health centres just isn't built to carry the load that it must if Canada is to beat anyone but the U.S. in the health-care Olympics," he says.

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