

Quebec provides nurse practitioner funding

Quebec is investing \$117 million to create 500 positions for nurse practitioners in primary care by 2018. It is the first project financed by revenues flowing from a new health premium which the government started collecting from Quebecers July 1.

The March budget announced a health and social services fund to share the financing load for health care with users of the system. In the short term, this will come from health premiums but may be joined down the line by a controversial deductible charged on each medical visit.

Wednesday's announcement about the nurse practitioners (NPs) is a long-time coming. In fact, the government promised last fall that it would create 500 NP jobs within five years, and the nursing community has complained that Quebec is far behind other provinces in the use of NPs – especially Ontario where there are some 1,250 in practice.

Health Minister Yves Bolduc said there are currently 25 NPs working in Quebec primary care but more practicing in specialized hospital programs like neonatal care. There are another 122 NPs in training, with 40 of them set to graduate in 2010-11. Each year, 60 are expected to enter the health system.

This week's announcement includes \$12 million to support the integration of NPs in medical clinics. They will be able to order drugs and diagnostic tests, and perform certain medical procedures such as suturing wounds and draining abscesses. They can also follow pregnancies up to 32-weeks gestation and monitor

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Alberta looking at broader role for Primary Care Networks

Alberta is considering handing more power to Primary Care Networks, a model of multidisciplinary primary care launched five years ago and which currently serves almost two-thirds of the population. A discussion paper prepared by Alberta

Health Services on primary care reform has been obtained by the *Edmonton Journal* and was the subject of a front-page story Saturday.

There are 35 Primary Care Networks (PCNs) in Alberta with another eight in development. They are the product of the Primary Care Initiative in the 2003 contract agreement between the government, the Alberta Medical Association and the nine former health regions which have since been rolled up into Alberta Health Services (AHS).

This agreement is up for renewal next year and, according to the *Journal*, AHS wants to use this opportunity to move PCNs "to the next level."

These networks bring together teams of health professionals to improve access to care, and enhance treatment for specific groups of patients such as those with chronic diseases.

The discussion paper apparently sees them doing much more than this in the future. The *Journal* says they would also have responsibility for mental health and some public health services and home care as part of an overall goal to reduce use of hospitals and improve preventive care.

The radical change in primary care delivery in Alberta is inspired by the UK's Primary Care Trusts. They provide a range of primary care services to local populations, including purchasing some hospital services on behalf of patients. They are responsible for spending some 80 per cent of

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Executive compensation at AHS criticized

The issue of performance bonuses for executives of Alberta Health Services is again in the news after the organization released financial details of the 2009-10 fiscal year.

Despite racking up an \$885 million deficit and falling short of a number of its performance targets, CEO Stephen Duckett and more than a dozen other executives pocketed \$5.8 million in salary, bonuses and benefits.

Mr. Duckett was eligible to receive \$143,750 in bonus pay on top of his \$595,000 base salary. He was awarded \$76,619 from the AHS board for meeting some of his performance targets.

Forty per cent of his bonus is for improving access and wait times, and he only received 3.3 per cent of this amount. However, he got 20 out of the 30 per cent allocated for improving quality of care and the full 30 per cent for sustainability which includes attaining budget targets.

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the UK's National Health Service budget and have an incentive to manage their financial resources as efficiently as possible.

Coincidentally, British Health Secretary Andrew Lansley released a White Paper Monday in which the government is proposing to replace Primary Care Trusts in three years with another approach which gives general practitioners even more authority. They will be obliged to form consortia to purchase a complete range of services on behalf of patients, including those provided by hospitals and private providers.

It is part of a sweeping reform of the National Health Service that seeks to cut 20-billion pounds from its current 104-billion-pound budget by 2014. Management will be reduced by 45 per cent, and the private sector will be invited to have a larger role including providing administrative support to these new GP-led consortia.

Even if the AHS primary care reforms do not go this far, GPs in Alberta could well be taking on more administrative responsibility. This is something which University of Alberta political scientist John Church says physicians are ill-equipped to handle. He says AHS should be looking at beefing up the use of existing community clinics which involve the public in management decisions.

He told the *Journal* that there should be public discussion of the AHS proposed reforms. **HE**

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There has been a lot of criticism of executive compensation in the health sector, and Premier Ed Stelmach has promised a review of the process.

However, it has also been pointed out that Mr. Duckett's salary is not unreasonable considering that he is in charge of an \$11 billion organization with 90,000 employees. **HE**

Moncton area assessed as best larger health region

A recent study of health region performance has put the Moncton area in New Brunswick at the top of the list of 30 regions with a patient population of over 200,000. The Palliser region in Medicine Hat, Alberta was ranked first among 15 smaller entities serving populations in the 100,000 to 200,000 range.

The study by University of Regina business professor Wallace Lockhart used the latest available information for 19 performance indicators measuring quality, access and patient satisfaction. For each one, the region's score was compared with the overall Canadian average and also benchmarked against two other regions in the country of similar size.

A number of the regions in the study – including Moncton and Palliser – are no longer stand-alone health regions and have been amalgamated into larger organizations. However, Dr. Lockhart says the data remain valid for comparing health-

care performance in those areas.

The purpose of his study was to identify best practices and performances in health care, and he found the aggregate scores of the different regions were reasonably close. Among the larger regions, Moncton's top score was 109 versus 92 for bottom-placed Fraser North in British Columbia. A score of 100 would mean that a region performed overall at the national average.

Palliser's score was 106 among smaller regions while Thompson-Cariboo-Shuswap in BC was in last place with 89. The latter did poorly on access to family physicians, as well as patients' satisfaction with physicians and the care provided at the Kamloops hospital.

Kevin Krueger, who represents the area in the BC legislature, dismissed the study as "fearmongering" and a "misuse" of statistics. It can be found at www.uregina.ca/admin/faculty/Lockhart/download.html. **HE**

Rural physicians more open to accepting new patients

Rural family physicians are almost twice as likely to accept new patients as physicians in urban areas, the Canadian Institute for Health Information says in a report released last week that is based on an analysis of data in the 2007 National Physician Survey.

More than 35 per cent of rural-based physicians reported that they were accepting new patients compared to fewer than 18 per cent of those in urban areas.

Among family doctors working in rural areas, international medical graduates (IMGs) were more likely to say they were accepting new patients than family physicians who obtained their medical degrees in Canada (62 to 27 per cent). While the difference was not as pronounced in urban areas, IMGs were still significantly more likely to be accepting new patients (27

versus 16 per cent).

Age was also a contributing factor to both rural- and urban-based physicians accepting new patients. Those at either end of the age spectrum were more likely to be accepting new patients than their colleagues age 45 to 54. Male physicians were also more likely to have open practices than their female counterparts.

Almost four-in-10 physicians in rural areas working in group or multidisciplinary practices indicated that they were open to new patients, compared to just a quarter of those in solo practices. However, there was no difference between the two groups in urban areas.

The report, *What Do We Know About Family Physicians Who Accept New Patients?* can be found at www.cihi.ca. **HE**

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Prince Edward Island's first new primary care network opened last week at the new O'Leary Health Centre in the western part of the island. The \$3 million facility includes 16 exam rooms and an ambulatory care room, and provides a range of primary care services including walk-in, ambulatory care, diabetes programs and community mental health programs. All will be provided through a coordinated approach using different health professionals. The government has committed to opening five primary care networks to ensure no Islander is more than 30 kilometres away from basic health services. Not everyone in O'Leary is pleased with the new health centre. A community group continues to fight the loss of emergency services at the local hospital to which the new centre is attached. Residents have to go to the hospital in Alberton, about 17 minutes drive away. (News release; *Charlottetown Guardian*, July 10)

A once-vaunted Alberta hip and knee replacement program has not improved wait times. The program had immediate success when it was launched as a pilot in 2005 and subsequently expanded provincewide. But wait times for knee replacements now average 51 weeks and 37 weeks for hips which is well above the 26-week benchmark. The program uses central assessment units to screen out patients not yet ready for surgery, but the funds to increase operating room space for more surgeries has not been forthcoming. It has been suggested that Alberta follow the example of some Toronto hospitals in using specially-trained physiotherapists to screen patients. (*Edmonton Journal*, July 15) ... **Alberta Health Services has awarded contracts for an additional 1,400 additional cataract surgeries** and up to 120 corneal transplants to be performed mostly at pri-

vate clinics in Edmonton and Calgary clinics over the next several months. A previous blitz announced in February added about 900 more cataract surgeries over and above the 35,000 eye-related surgeries funded annually. News release at www.albertahealthservices.ca/2218.asp.

British Columbia emergency physicians have a new contract that will see the government invest \$146 million over the next two years in 19 ERs where physicians are paid by salary versus fee-for-service. The new deal will create 10.6 new full-time equivalent positions at the busiest ERs and increase the total number of hours of service provided to meet demand. Vancouver General received the largest increase — the equivalent of about five extra physicians. In April, ER physicians at the hospital reported that there had been 34 "near misses" over a two-week period where patient safety could have been compromised by waiting too long for care. (*Vancouver Sun*, July 15; News release at www.gov.bc.ca/health under News) ... **A new \$14.7 million emergency department at St. Paul's Hospital in Vancouver opened last week** and is described as one of the most efficient and technologically advanced in the country. It includes real-time electronic tracking boards that show where patients are, who is treating them, what tests they are undergoing and if their treatment time is meeting department guidelines. There is also an electronic patient discharge system which sends a comprehensive health record to each patient's physician by the next business day. (News release at www.gov.bc.ca/health under New)

Colorectal cancer screening is a cost-effective program reducing mortality rates by 55 to 83 per cent depending on the type of test used. An-

nual testing using a high-sensitivity fecal occult blood test or colonoscopy every 10 years offers "good value for money in Canada," the study by researchers at UBC and Dalhousie University concluded. It was published online by the *Canadian Medical Association Journal* this week (www.cmaj.ca) ... **Mortality rates for a number of types of cancer in New Brunswick have declined.** It is the third report on provincial cancer statistics to be issued, and the first from the NB Cancer Network since it was formed in 2005. The report covers the 2002 to 2006 period and records a drop in mortality rates for three of the most common types of cancer: prostate, breast and colorectal. The report also contains a special section documenting the success of the province's breast cancer screening program. It can be found at www.gnb.ca/0051/cancer/pdf/6675e-compressed.pdf.

Quebec nurses say mediation has been a waste of time in trying to settle their contract dispute with the government. They say the mediator's report this week just reports on the nine meetings which have taken place in the last two months. The only subjects which have been reconciled are meal allowances, vacation time, professional training for new nurses and a process for nurses to make complaints about workplace violence. The nurses have rejected a public-sector-wide contract agreement reached last month. (News release) ... **Residents of Charlevoix, Quebec are forming a cooperative to get medical care.** Some three quarters of 1,523 people approached to be part of the program agreed to participate and pay an annual fee of \$90 per adult. It is hoped the coop will help recruit physicians, and relieve administrative pressures on private clinics in the area. (*Le Soleil*, July 13)

B.C. lowers prices of generic drugs

British Columbia has become the fourth province, after Alberta, Ontario and Quebec, to lower the prices of generic drugs. It has taken a middle-of-the-road approach — capping the price to 35 per cent of the brand name versus 25 per cent in both Ontario and Quebec.

Alberta, the first province out of the gate in this policy move, pays 45 per cent of the brand for new generics and 56 per cent for existing products.

Like Alberta and Quebec, B.C. has chosen not to touch professional allowances (rebates for stocking products) which were abolished in Ontario and sparked a firestorm of protest from the pharmacy community. Indeed, B.C. pharmacists were full of praise for the government's "collaborative" approach in reaching a negotiated agreement.

The government expects its new pricing policy, to be phased in over three years, to net \$380 million a year in savings — \$210 million flowing to private drug plans and individual consumers, and \$170 million to the public sector.

Out of its share, the government will be dishing out more in dispensing fees. They are going up by about 50 cents a year from \$8.60 currently to \$10.50 by April 2012. The government is also plowing more money into new clinical pharmacy services.

More information at www.gov.bc.ca/health under News. **HE**

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patients with chronic diseases.

The announcement also contains funding for universities to support NP training programs — a cost they have been carrying for over three years. They had actually threatened to suspend these programs if no funding was forthcoming. **HE**



Editorials & Commentary

Funding fertility treatments

On Tuesday, Quebec Health Minister Yves Bolduc announced that the province would be the first jurisdiction in North America to comprehensively cover the costs of *in vitro* fertilization.

Beginning next month, the government will cover three cycles of treatment at an initial cost of \$25 million. This could grow to \$63 million by 2013-14 when the number of treatments is expected to double.

The launch of the program comes barely a year after passage of legislation (Bill 26) regulating clinical and research activities related to assisted procreation. The haste with which the program has been pulled together has raised a few eyebrows, and there have been a number of comments that the government has not thought it through.

The chief concern is that the government has announced an expensive program at a time when health care costs are being trimmed. There are also fears that the demand for free *in vitro* fertilization will overwhelm the limited resources available. There is a shortage of 60 to 70 obstetricians and gynecologists in the province and pregnant women are already having difficulty getting follow-up care, the head of the association representing these specialists, Dr. Robert Sabbah, says.

Le Soleil editorialist Brigitte Breton (July 14) says the Charest government made a political decision to offer this program, but it is by no means the “logical and rational” choice claimed by Dr. Bolduc. If this were the case, she says, the government would have followed the advice of medical experts. This includes the opinion of the Commission on Ethics in Science and Technology that there is no automatic “right to a child.” She also raises the

questionable logic of investing \$60 million in a program that has a success rate of only 30 per cent. Furthermore, she notes that adoption is another route to parenthood. She wonders if, in the interests of equity, the government will cover costs for all adoptions too.

Le Devoir Editorial Page Editor Marie-Andrée Chouinard (July 15) says the support for assisted procreation is a noble cause “but we doubt that it is necessary to make a priority of it.” In fact, she is not convinced the government made the right choice for a new health-care investment at all. She notes the view of one reader of the newspaper who, in a letter-to-the-editor that day, asks which should take precedence: the right to procreate, whatever the cost, or the right of seniors and the handicapped to live in dignity? Ms. Chouinard points out that the needs at the other spectrum of life are “gigantic.”

Quebec's new program drew the attention of the *Saskatoon Star-Phoenix* too. In an editorial (July 15), the newspaper says it is a “poorly considered move whose impact will reverberate across Canada” because it will put pressure on other provinces to follow suit. It observes that Quebec's program goes much further than the one in Manitoba where there is a 40 per cent tax credit for *in vitro* treatment to a maximum of \$8,000.

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