

**improving productivity**

**An Alberta perspective on  
health reform**

**October 19, 2004**

# Introduction: Regionalization & Integration

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- First Ministers deal “fixed” funding
- Funding alone will not fix the system: public does not trust dollars are well spent
- Sustainability requires higher productivity
- Integration is the “magic”
- Alberta achieves high output per \$ (even after adjusting for young population)
- Regionalization is one way to integrate
- Ontario must find its own way

# Outline

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- Sustainability
  - Health spending and GDP
  - The 2004 First Ministers' deal
  - Provincial health spending
- The Alberta approach to integration
  - Health Regions
  - Capital Health - Overview
  - Capital Health - Key Integration Initiatives
  - Alberta - Access and Outcomes
  - Connecting the Dots: Productivity
- Why regionalize?

# Health System Sustainability

BY GEOFF OLSON

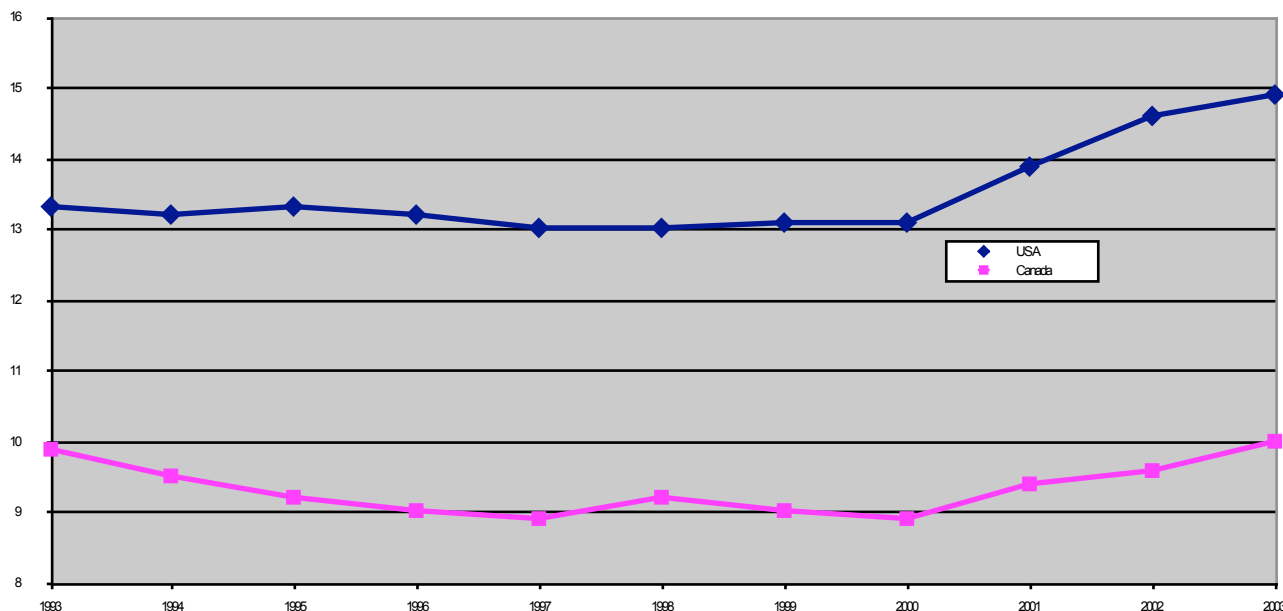
DESPITE MARTIN'S NEW DEAL,  
THERE'S ONLY ONE SURE CURE  
FOR HEALTH CARE...

DON'T GET SICK.



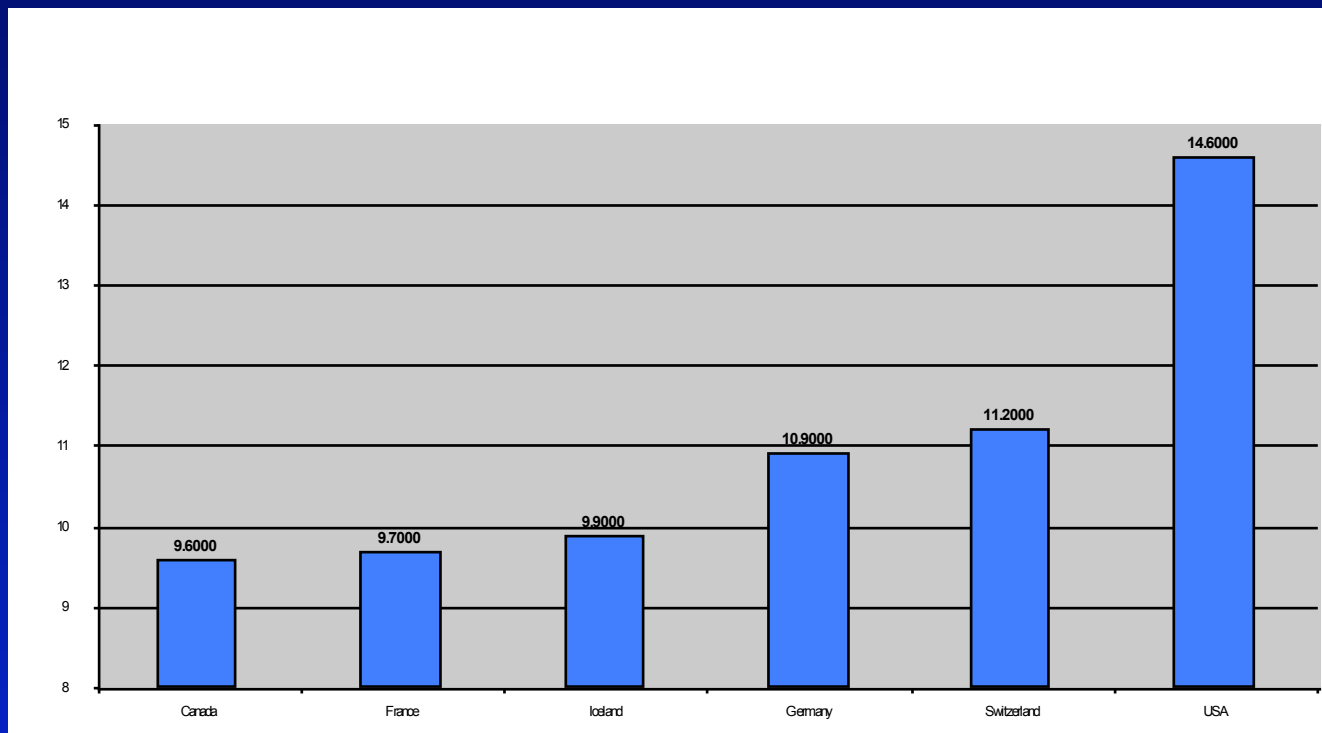
# Health Spending and GDP

- Health is rising as a % of GDP



# Health Spending and GDP (cont.)

- Canada is not alone - this is a global issue



# The 2004 First Ministers' Deal

6% Escalator is a step forward; not a “Fix”

- Escalator: 6%
  - Nominal GDP: 5%
  - Prov. govt. health spending 7%\* (avg., 2003 over 2002)
- Escalator is **higher** than GDP (health will rise as % of GDP)
- Escalator is **lower** than prov. spending (federal % will fall)
- Open-ended funding commitment ignores **productivity**
- Deal does not “fix” sustainability

\* Source: CIHI National Health Expenditures, Dec 03

# The 2004 First Ministers' Deal (cont.)

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The public is willing to spend more; but money alone will not buy confidence.

↑ **Access and Quality** = ↑ **Confidence**

EnviroNics poll, Sept 2004

	<u>Can</u>	<u>US</u>	<u>UK</u>	<u>China</u>
Inefficient management is the main problem (%)	54	55	49	24
Insufficient money is the main problem (%)	32	30	37	72

# Provincial Health Spending

- Alberta RHA funding is 3.5% above avg; ON is 7.5% below
- Alberta RHA funding is 12% higher than ON in total
- **Does Alberta deliver 12% more output?**

<b>Age-adjusted real provincial <u>RHA</u> spending, 2003</b>	<b><u>Alberta</u></b>	<b><u>Can</u></b>	<b><u>Ontario</u></b>
	<b>1,184</b>	<b>1,141</b>	<b>1,059</b>

- “RHA” = hospitals & other institutions (CIHI)

<i>Age-adjusted real provincial spending, 2003</i>	<i><u>Alberta</u></i>	<i><u>Can</u></i>	<i><u>Ontario</u></i>
	<i>2,400</i>	<i>2,140</i>	<i>2,140</i>

# Provincial Health Spending

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- Ontario spending is growing fast - it could catch Alberta in 2-3 yrs
- **Will Ontario output also catch up?**

	<u>Alberta</u>	<u>Can</u>	<u>Ontario</u>
Growth in real prov. health spending, 2003	2.2%	4.2%	7.0%
Growth in real GDP* (forecast, 04 & 05)		3.0%	

Sources: CIHI National Health Expenditures, Dec 03

\* Conference Board of Canada

# Outline

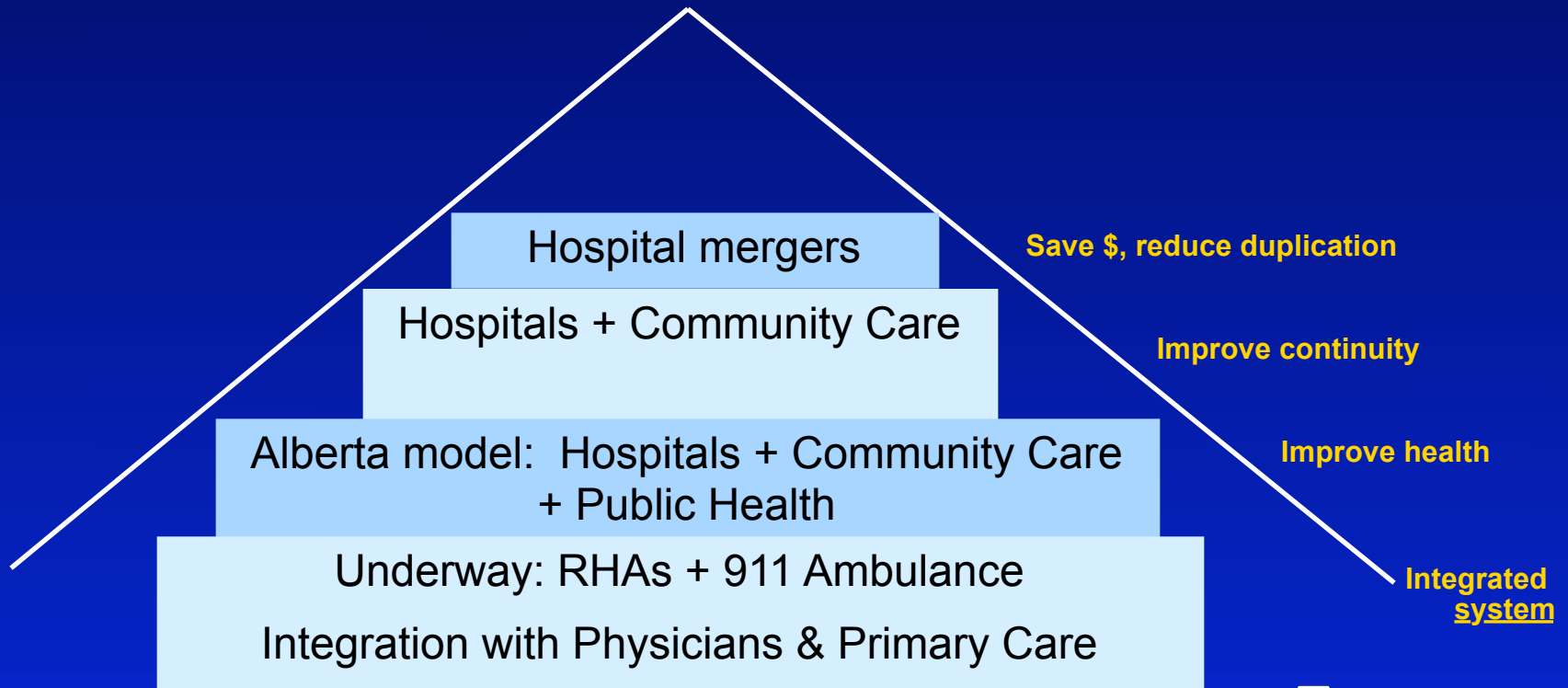
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# The Alberta Model

Productivity rises with scope of integration



# The Alberta Model (cont.)

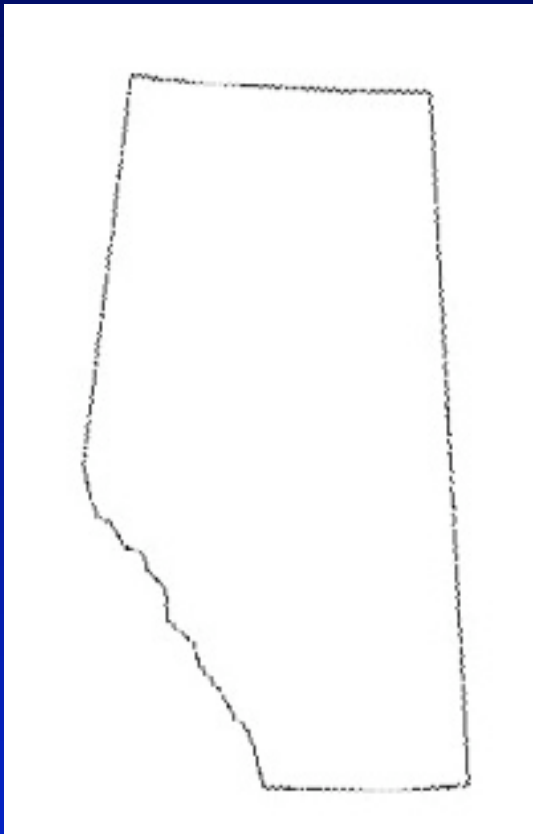
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## History:

- Feb 94 - Alberta Health Business Plan:
  - Restructure, Reduce, Reform
    - Create 17 regional health authorities
    - ↓ hospital beds from 4.3 to 2.4/1,000
    - ↓ \$368M (acute care), ↑ \$110M (community care)
    - Expand community care, integrate health services
    - Two funding plans
      - Population based
      - Specialized tertiary and quaternary based (province wide services)

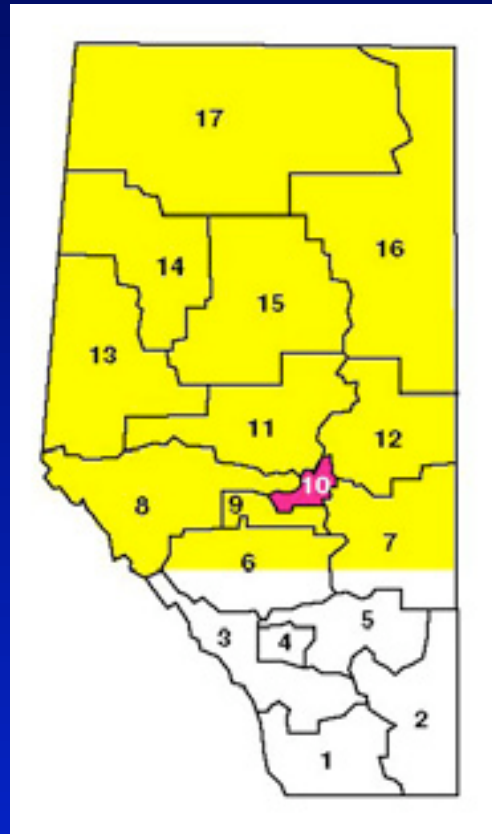
# The Alberta Model: Evolution

Pre-1994



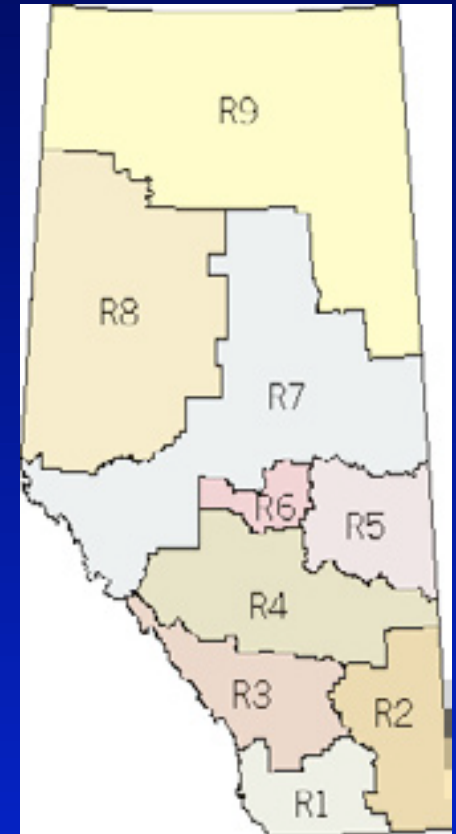
*200 Boards*

1995



*17 Boards*

2003



*9 Boards*

# The Alberta Model (cont.)

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## History (cont.)

- Sep 94 -First Capital Health Business Plan:
  - ↓ budget by 20%+
  - ↓ acute beds from 2,550 to 1,650
  - Re-distribute acute care services
  - Develop subacute care and palliative care
  - Expand Home Care by 80%\*
  - Consolidate support services
  - Create Community Health Councils

*Fully implemented within 9 months!*

\* Current Home Care funding \$81m

# What is Working

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- One voice with governments/universities
- Size matters: purchasing/negotiating power
- Reduced competition between the sites/sectors
- Faster innovation
- Faster/easier movement of resources (e.g. between hospitals, hospitals to community)
- Stronger public health
- Alignment of population health goals with system goal (e.g. obesity)

# What is Working (cont.)

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## The Facts:

- Administration/duplication reduced
  - Admin costs ↓ (maintained) from 7.5% to 2.3%
- Human Resources Plan advanced
  - Nurse vacancy rate ↓ from 8% to 3.7%
- Efficiency/effectiveness increased
  - ↓ patients waiting placement by 64%
  - ↓ ALOS from 7.1 days (94) to 6.4 (03)
  - AMI readmit rate 2.2% (Capital Health) c/w 6.7% (Canada)
- Community care increased
  - May not require hospitalization rates down from 5.7% to 4.6%
- *Clinical training seats* ↑ 10%

# What is Working (cont.)

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## Productivity Gains - 3 Examples:

- Palliative care
  - ↑ in hospital days saved from 1,300 (97/98) to 19,000 (03/04)
- Subacute care
  - ↑ in hospital days saved from 300 (97/98) to 52,000 (03/04)
- Early postpartum discharge program
  - LOS - ↓ from 3-4 days to 30 hrs
  - Low re-admission rates (0.3% of moms, 2-3% of babies)

# Outline

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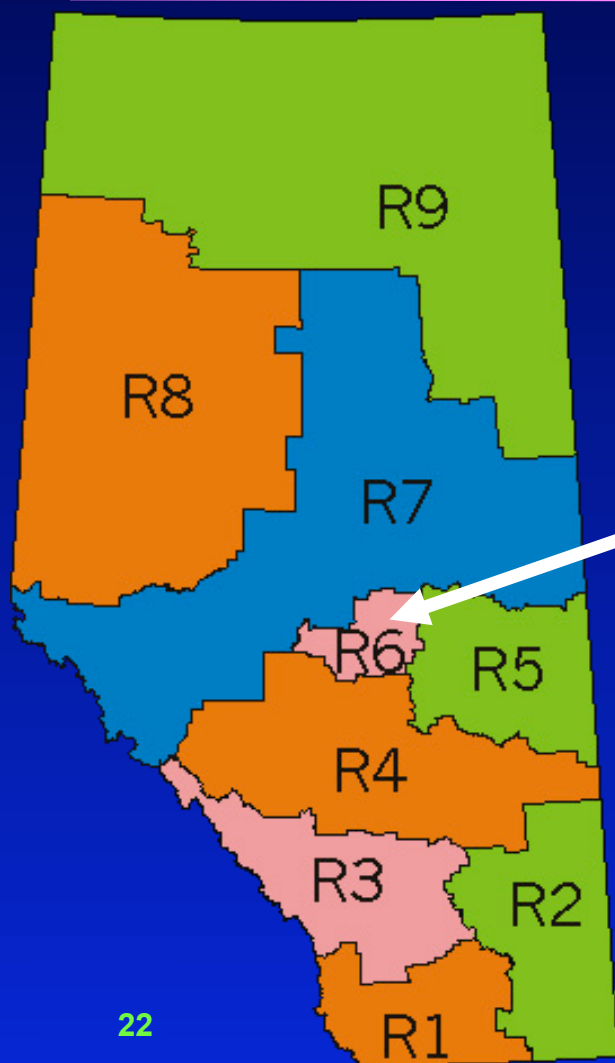
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# Capital Health

*Canada's largest integrated academic health region*



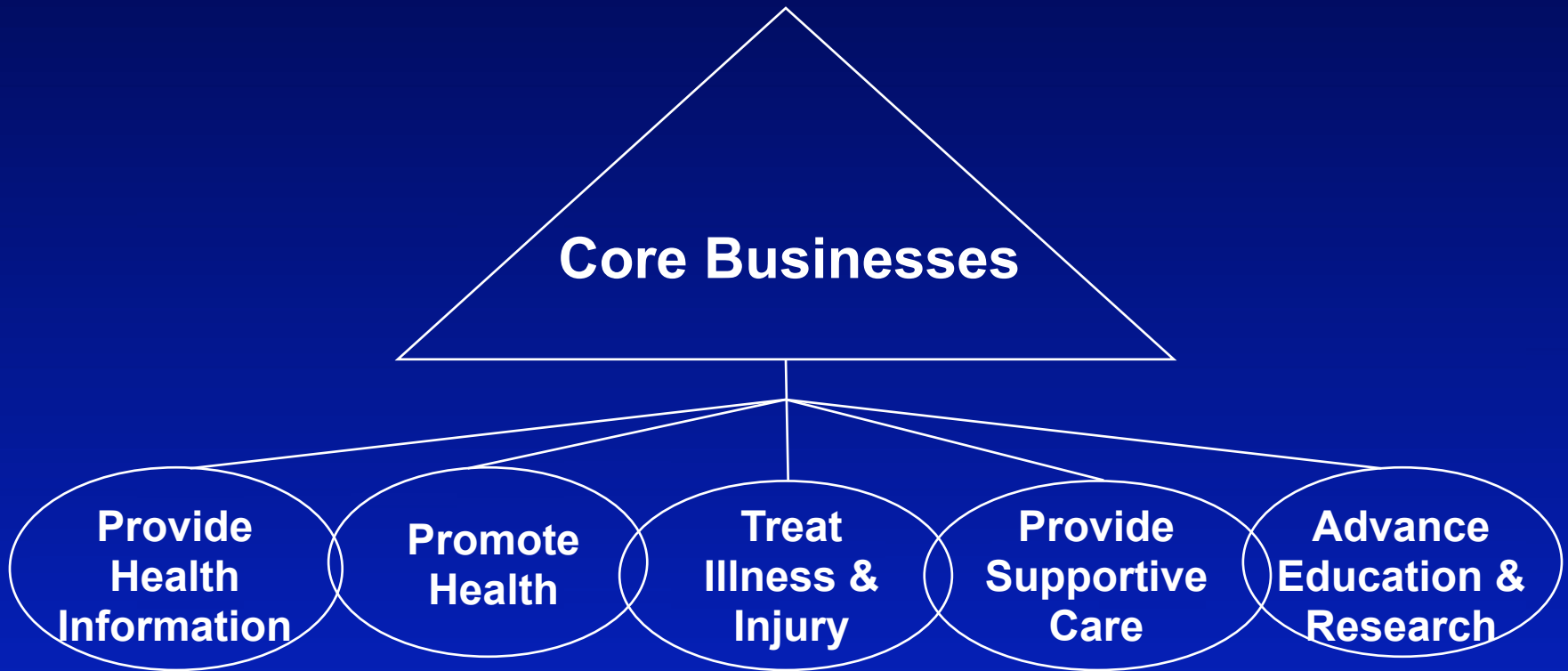
# Capital Health



Capital Health  
1 million population  
(Alberta: 3.2 million)

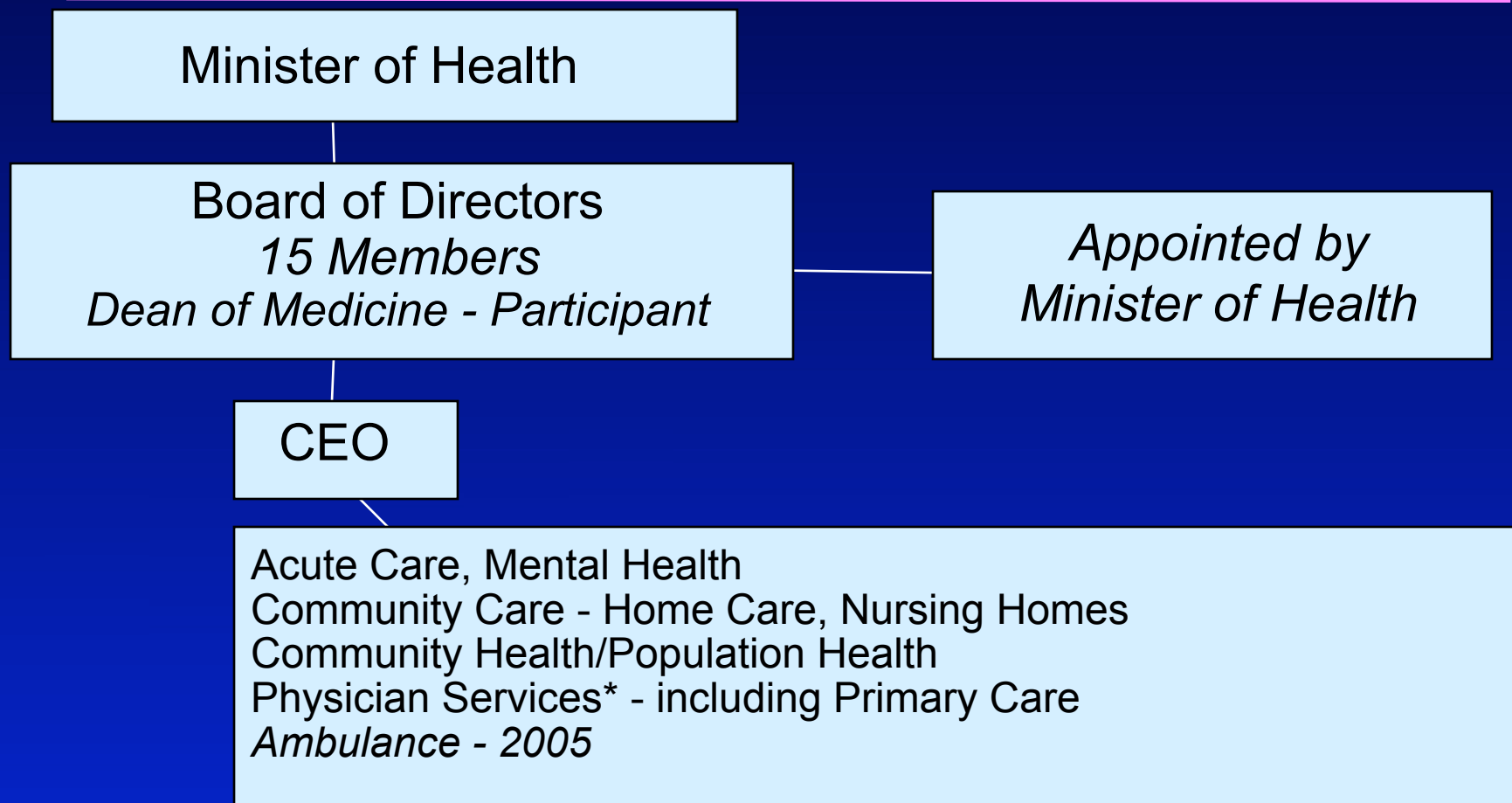
# Capital Health - Core Businesses

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*“All decisions - from selecting landfill sites to financing islet cell transplantation”*

# Capital Health - Governance



*\*Physicians now covered in a Tripartite Agreement*

# Capital Health - Quick Facts

- Referral pop. - 1.6 M
- \$2.2 B budget
- 29,000 staff
- 2,300 physicians
- 9 m sq ft of space
- 2,700 acute beds (1.6/1,000 residents\*)
  - 13 Hospitals
- Highest Alberta acuity



\* excludes psych beds

# Capital Health - Academic

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## Integrated Academic Health Region

- Functionally integrated with Faculty of Medicine
- Full range of health sciences faculties:
  - 520 medical residents/fellows
  - 6,000+ health sciences students
- \$120 M in research funding (grant/industry)

# Capital Health

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## Community:

- Medical Officer of Health
- 23 public health centres
- 5,700 long term care beds (under contract or through wholly owned subsidiaries)
- Community care services (e.g. home care)

# Capital Health - Metrics

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## Annual service volumes:

- 520,000 calls to Capital Health Link
- 435,000 ER visits
- 109,000 admissions
- 13,000 births
- 86,000 surgeries
- 1.25M ambulatory visits
- 10,000 home care clients (month)
- 410,000 immunizations
- 48,000 environmental health service requests

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# Advancing Integration: 3 Capital Health Initiatives

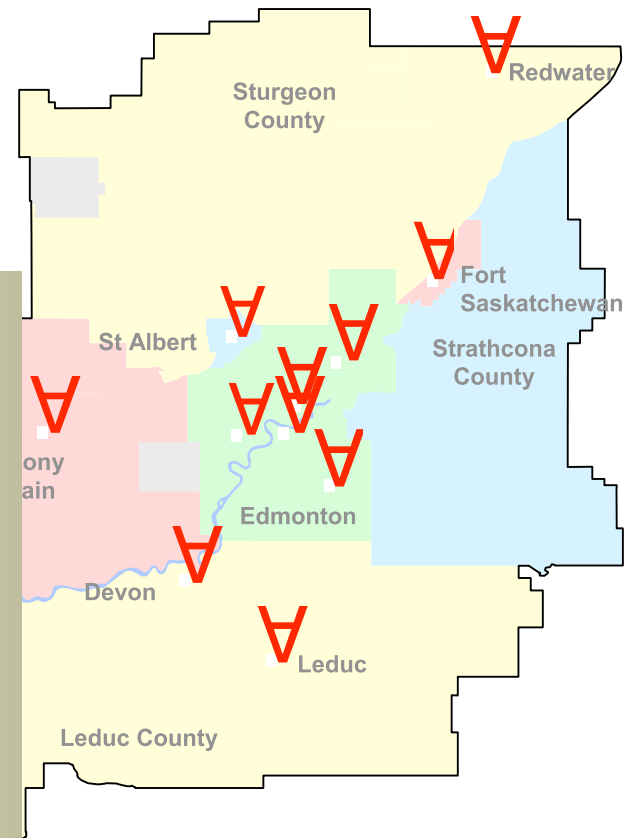
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- netCARE
- Capital Health Link
- Consolidated Diabetes Service



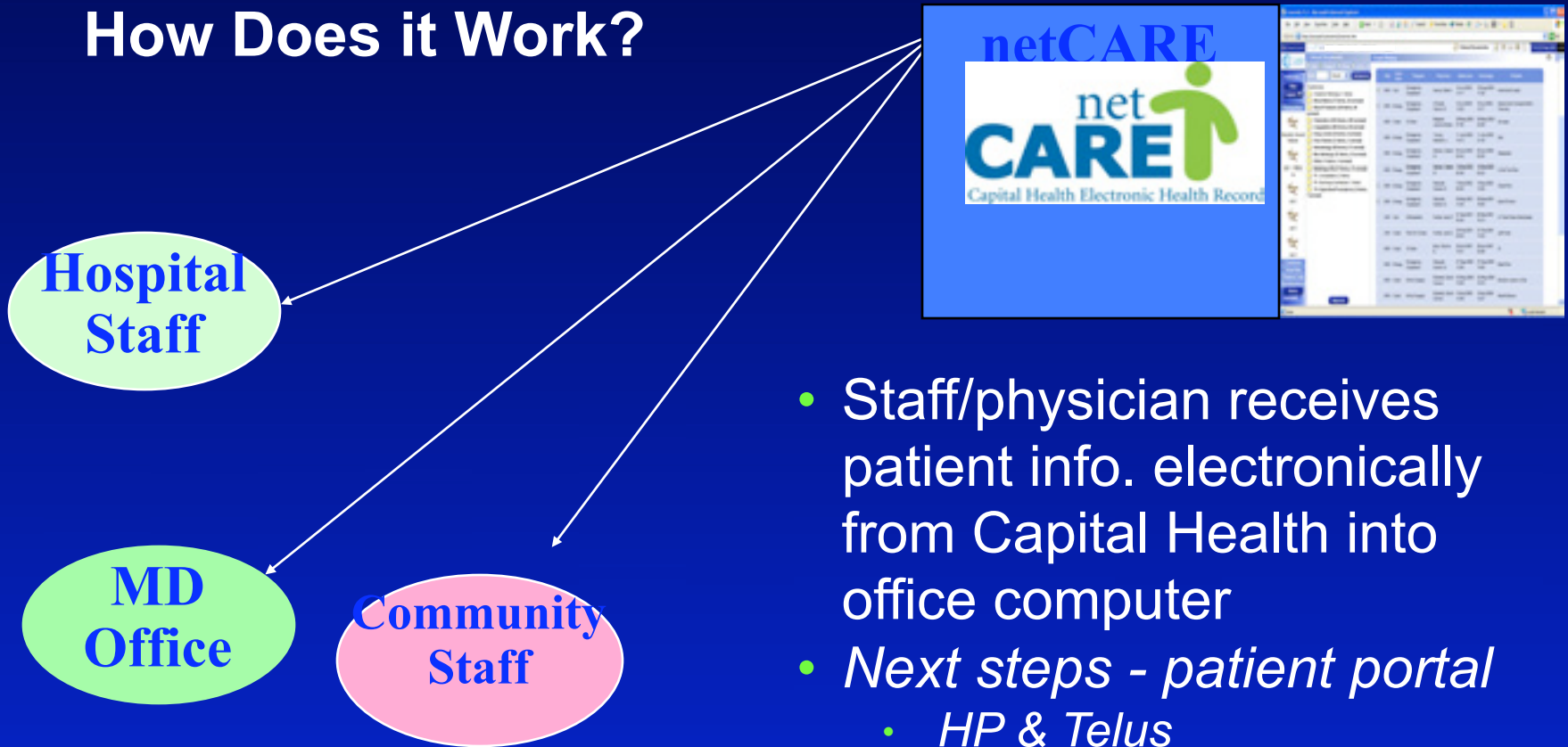
**Canada's first regional,  
fully inter-operable  
Electronic Health record**

- ✓ Launched Apr 2004
- ✓ 4000 users as of Sept 2004
- ✓ Patient Lists and Demographics
- ✓ History of Hospital Visits (Capital Health) – 6+ yrs - including ER visits
- ✓ Reports – Discharge Summaries, CTs, MRIs, x-rays
- ✓ Lab Test Results – 3+ yrs history
- ✓ Medication and allergy summary



# netCARE: Current Status Capital Health & Physician Offices

## How Does it Work?



# Capital Health Link

- 24/7 nurse call centre linked to netCARE
- Launched Sept. 2000
- Province-wide - May 2003
- Call volumes
  - 2003/04 total calls - 520,000
  - 2001/02 total calls - 277,000

**88% increase**



**408-LINK (5465)**

***“Capital Health Link nurse gave me advice about my surgical incision that resulted in my seeking prompt treatment and preventing complications”***

# Capital Health Link - Benefits

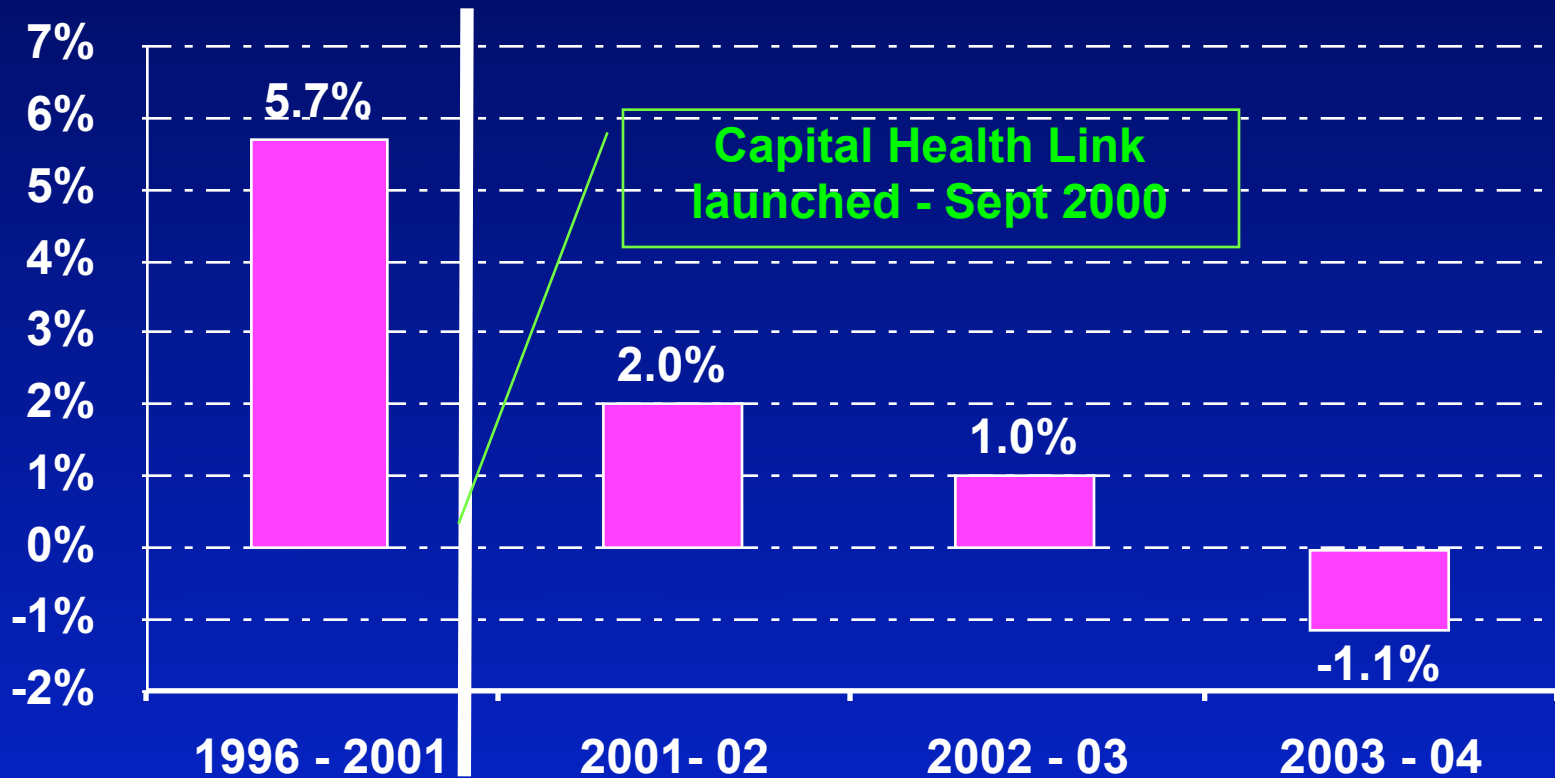
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## Productivity Gains:

- 20,000+ ER visits avoided
- annual growth in ER visits reduced from 5% in the late 1990s to 0.5% in 2003
- 30,000+ physician office visits avoided
- 200,000+ practiced self-care at home

# Capital Health Link - Benefits (cont.)

## Average Annual Growth in Non-Urgent ER visits



# Regional Diabetes Program

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## Key Elements:

- Single point of referral (Capital Health Link), regional triage
  - Interdisciplinary assessment clinics & specialty clinics
- Standardized education modules - all sites
- Linked to netCARE (electronic health record)
- Comprehensive follow-up

## Productivity Gains:

- **New referrals tripled with no new resources**
- **Waitlist decreased from 6 - 8 mos. to 4 - 6 wks**



# Access and Outcomes

	<u>Capital</u>	<u>Alberta</u>	<u>Can</u>	<u>Ontario</u>
Heart attack 30-day mortality*, %	9.1	9.6	11.8	12.0
Stroke 30-day mortality*, %	13.7	15.5	18.7	18.5
Stroke/death from carotid endarterectomy**, %	n/a	2.7	4.1	4.0
Cardiac arrest survival***, %	9.0	n/a	n/a	5.0

Sources: \*CIHI

\*\* Feasby, Cdn J or Neurological Sciences nov 2002

\*\*\*Ottawa Health Research Institute, sept 04

# Access and Outcomes (cont.)

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## Average wait times

Q1 (2004/05)

- Hip/knee replacement 142 days
  - 4.7 months - target is 4 months
- Cataract removal 59 days
  - 25% contracted out
  - 87 days at private clinics, 53 days public
- Long term care placement 40 days
  - Average (250 waiting, 200 placed/month)

# Access and Outcomes (cont.)

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## Nurse Supply:

- Train » Recruit » Retain
  - 60% increase (seats) - 2001-05
  - Accelerated 16 month training
  - Grad Nurse Program (75% of grads recruited)
  - **Alberta pay (total compensation) = Ontario pay**
- Results (1998-2002):
  - Alberta: 6% net gain; Ontario: 0
- Capital Health:
  - **Vacancy rate, Jun 04: 3.7% (Jun 02 - 8%)**

# Access and Outcomes (cont.)

## Physician Supply:

- **Train** » Retain

	<u>Alberta</u>	<u>Can</u>	<u>Ontario</u>
Med school intake, 2003	231	2,118	629
↑ in intake, 1998 » 2003	60%	35%	34%

- Training our own:

	<u>Alberta</u>	<u>Ontario</u>
% of Cdn population	10%	39%
% of total med school intake	11%	31%

- **Alberta trains more than its share, Ontario less**

# Access and Outcomes (cont.)

## Physician Supply (cont.):

- Train » **Retain**

	<u>Alberta</u>	<u>Can</u>	<u>Ontario</u>
Net gain 2003	160	42	3
Net gain ( <u>other provinces</u> )	14	--	61
Net loss to US & other countries, 2002 & 2003	4	289	102

**Alberta is not “poaching” from other provinces!**

**Alberta has stopped the “brain drain” - 2 yrs in a row**

Source: CIHI Southern Medical Database, 2004

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# Connecting the Dots: Productivity

## Inputs:

	Alberta	Ontario	AB vs. ON
Age-adj. prov health region \$/capita	\$1,184	\$1,059	12%* more
RNs per 100,000	750	650	15% more
Physicians per 100,000	183	177	3% more

\* Health region/authority differs by only 3.5%, compared to Cdn avg

# Productivity (cont.)

## Outputs:

	Alberta	Ontario	AB vs. ON
Age-adj. hosp. days/1,000 (2001)	678	534	27% more
MRI scanners/million (2003)	7.3	4.1	78% more
CT scanners/million (2003)	9.6	7.8	23% more
Revascularization post-AMI* (2000)	34%	15%	2+ times more
Solid organ transplants/million (2002)	87	58	50% more
<b>Funding</b>			<b>12% * ↑</b>

Sources: CIHI, \*CCORT

\* Health region/authority differs by only 3.5%, compared to Cdn avg

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# Alberta Goals for Regionalization

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## Goals:

- Slow health spending - help close the cost-revenue gap
  - Reduce administration
  - Consolidate support services, specialty programs
- Improve quality
  - Increase coordination/continuity
  - Increase focus on population health
- Restore confidence
  - Improve transparency/accountability
  - Increase productivity
  - Increase access

# Sustainability and the Cost Gap

## Mazankowski's Plan on Health Financing

Westbury  
Expert Advisory  
Panel

Graydon  
Funding and  
Revenue Generation  
Committee

Government  
Funding  
5%

+

Cost  
Gap  
4%

=

Health  
System  
Costs  
9%

# Sustainability (cont'd)

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## Pressures on the system will increase

- Population growth + Aging\* + Obesity
- Labor costs
- New technologies/drugs
- Public expectations (consumer culture)
- Pressure on govt. revenues (tax cuts, Education)
- System-wide IT to support evidence-based practice, patient safety, etc.

\*Over the current decade, 2001-11 in Alberta:

- Pop. 80+ will grow by 50%
- School-age pop. (5-24) will shrink by 6%

*(Stats Canada, 2004)*

# Common Questions

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- Is there evidence that a regional model improves health and health system performance?
  - We need better data - eg, staff hours worked vs. head counts
- Does the regional model:
  - Support the academic mission?
  - Improve continuity - hospital to community?
  - Support integration of community physicians?
- Is a regional system worth it?
  - Will Ontario match Alberta's output when it matches our spending?

# Conclusion

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## Would the Alberta model work in Ontario?

- Medicare is built on provincial approaches to national goals; only Ontario can decide what will work for Ontario
- Integration is the “magic” that drives productivity; Alberta’s approach is one way to achieve it
- To keep public confidence, we must commit to measuring and improving value for money

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# Thank you!