

Fire, Aim... Ready? Alberta's Big Bang Approach to Healthcare Disintegration

Feu, en joue... présentez arme? Big bang de l'approche albertaine pour la désintégration des services de santé



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Abstract

Alberta's abolition in 2008 of its health regions and the creation of Alberta Health Services (AHS) was a bold move, but the reasons for the change remain hazy. The stated goals were to "help make Alberta's ... system more effective and efficient" and to "provide equitable access to health services and long-term sustainability." Data show, however, that Alberta's health regions were already performing well on these goals relative to other provinces, and where changes have since occurred, they cannot necessarily be attributed to AHS.

Résumé

En 2008, l'Alberta effectuait un changement audacieux en abolissant ses régions sanitaires et en créant les Services de santé de l'Alberta (Alberta Health Services, AHS). Cependant, les raisons derrière ce changement demeurent vagues. Les objectifs énoncés visaient à « aider le système albertain à être plus efficace et plus efficient, à donner un accès équitable aux services de santé et à favoriser la durabilité à long terme ». Toutefois, les données montrent que le rendement des régions sanitaires de l'Alberta quant à ces objectifs était déjà bon, comparé aux autres provinces. Les données montrent également que les changements qui ont eu lieu depuis cette réforme ne sont pas nécessairement attribuables aux AHS.

TWELVE YEARS AGO, ON TAKING UP THE SVARE CHAIR IN HEALTH Economics at the University of Calgary, I arrived to witness the controlled implosion of the Calgary General Hospital. This seemed like the ultimate in recognizing the new dawn of a regionalized, integrated healthcare system in Alberta (Martin and Rushforth 1998). Having spent some of 2009 on sabbatical back in Calgary, I once again witnessed Alberta's "big bang" approach to healthcare reform: the sudden abolition of the health regions and the creation of Alberta Health Services (AHS).

This was a bold move. Many advanced economies of the world operate regionalized systems, at least to some degree (Saltman and Figueras 1997; Petretto 2000). Regionalization basically involves the allocation of resources from either the provincial or the national level of government to a geographically defined entity. Health regions are said to bring leadership closer to populations served and, thus, are more readily able to assess health needs, decide how best to deliver services within budget to meet as many of these needs as possible, and be more accountable for their actions. There has never been much hard evidence on the extent to which regionalization improves health for resources invested. Indeed, doubts over its ability to deliver such an outcome have been expressed (Church and Barker 1998). However, a counter-claim would be that regionalization has been challenged by issues of instability and government interference rather than anything inherent in the model itself (Lewis and Kouri 2004).

The real questions, though, are: Why did Alberta make such a move? How did the province intend to achieve its stated aims? Did it in fact achieve these? After addressing these questions, I turn, finally, to potential ways forward in the future. The main messages I hope to convey:

- Many healthcare reforms fail to streamline costs in the ways initially portrayed; the case of AHS and its associated initiatives are no exception.

- Based on limited comparative data from other provinces, the need for the Alberta reforms is unclear.
- Given the limited data and the fuzzy need for reform, the potential for significant gains (e.g., in reduced waiting times) is limited.
- Cost increases in AHS were inevitable as a result of flagship waiting list initiatives that focused on increasing activity in the costly acute sector and the introduction of financial incentives to further encourage such activity.

The Alberta Reform and Its Objectives

For readers who have not been following the events in Alberta, the health regions were abolished in 2008, and the publicly funded system is now being administered by AHS. A new body, the AHS Board, is charged with organizing the delivery of health services across the province and is accountable to the Minister of Health and Wellness. Several objectives for the reform have been stated. At the time the changes were announced, now-former Health Minister Ron Liepert stated on the AHS website that “moving to one provincial governance board will ensure a more streamlined system for patients and health professionals across the province” (AHS 2010). Premier Ed Stelmach announced that the changes would “help make Alberta’s publicly funded health care system more effective and efficient” and “create a high quality and innovative system that provides equitable access to health services and long-term sustainability” (Government of Alberta 2008).

The return to a provincial-level system initially gave the appearance of saving management costs, based on statements from the premier and health minister along the lines of wanting to “clarify roles and responsibilities” and “improve the way health care is administered” (Government of Alberta 2008). Most healthcare reforms are indeed sold on such bases. However, it has long been known that promised savings are never realized as the previously unforeseen costs of management and monitoring of the newly reformed system mount up (Brown 1979). Any sensible analyst would have predicted that the same would happen in Alberta because the system would have to plug the informational gaps left by abolishing the health regions. If health regions were thought to be unresponsive, it is difficult to imagine how requests or complaints from various parts of the province would be more swiftly dealt with by Edmonton, where the top tier of management is now based. Indications that such a prediction would likely be borne out were given by the need to create such entities as the “Calgary Health Zone” (to administer sites and services previously administered by the Calgary Health Region) and the “Alberta Cancer Corridor” (to administer sites and services previously administered by Alberta Cancer Services). These involved the (re-) creation of necessary management and administrative posts in order to make the system function efficiently.

Furthermore, as illustrated in Table 1, data from the Canadian Institute of Health Information (CIHI) show that spending on health administration in Alberta was not out of line with that in other provinces, either in absolute terms or as a percentage of total health expenditures. In terms of trying to achieve low spending on administration, Alberta ranks second on percentage of the total spent on administration and seventh in terms of absolute spending per capita. If one were to look at public dollars only (not shown in the table), Alberta comes out fifth in terms of achieving the lowest absolute spending; the two big provinces of Ontario and Quebec are ahead because of the economies of scale they can achieve relative to the others. The puzzle here is: Given how well Alberta was doing in terms of administrative costs, what exactly was expected to be achieved in terms of “streamlining” and “improving administration”?

TABLE 1. Administrative costs of healthcare by province, 2008

Province	Total health expenditures (public and private) per capita, current \$	Percentage of total (public plus private) health expenditures
Alberta	192.94	3.3
British Columbia	183.83	3.7
Manitoba	184.50	3.3
New Brunswick	178.84	3.4
Newfoundland and Labrador	175.04	3.2
Nova Scotia	222.20	4.0
Ontario	179.60	3.4
Prince Edward Island	369.59	7.1
Quebec	152.22	3.3
Saskatchewan	210.74	3.8

Source: CIHI 2009.

More formally, the stated objectives of AHS have now appeared in a strategic plan. The objectives are threefold, covering quality (i.e., healthcare services are safe, effective and patient-focused), access (appropriate healthcare services are available) and sustainability (healthcare services are available both now and into the future) (AHS 2009). These objectives seem to be carefully worded. For example, they do not specify desired trajectories over time, although presumably improvements in quality and access are required. Likewise, the third objective implies that all should be achieved within budget, although again, this is not explicit in the sense that “available resources” could also be taken to mean that deficits will be met if the province can afford it.

Activities and Outcomes

Eventually, a year after the announced creation of AHS, we began to hear some noises about what would be done to arrest the growing deficit across the province. This gives the impression that, like the war in Iraq, where the decision to invade was taken without a plan for how to win the peace, the decision to abolish the regions was more of a political gut reaction to the unruly behaviour of health region executives but with no plan for what to do once the axe had fallen. However, it seems that after the decision to *fire* and having taken a belated *aim*, the province was now *ready* to proceed on its plan for achieving greater efficiency in health services.

Waiting Targets

In 2009, we saw reports of the proposals in the AHS draft strategic plan to cut waiting times and emergency room delays. Such targets are not new and have been implemented in other countries without abolishing their health regions. What is more, in the United Kingdom, these targets have been achieved in conjunction with the largest ever (planned) real increases in funding in the history of the National Health Service, and also on the back of slim evidence about how long people are actually willing to wait (given that the money could be spent on other health-generating activities). Some of the increased funding in the United Kingdom was required to increase capacity in order for the targets to be met, giving a strong indication as to what might happen as a result of a focus on waiting lists in Alberta.

Thus, the question arises as to how AHS, aiming to shave hundreds of millions of dollars, could achieve such ambitions on wait times and delays given that it was already having to spend some of the planned savings to localize the management needed to make the system work, as well as to collect information on wait times in order to audit the stated objectives.

To begin with, in 2008, and according to data published on the AHS website, when benchmarked against the rest of the country, Alberta was performing at about the Canadian average on wait times for common procedures such as hip fracture surgery and knee replacement. This finding raises two further questions: (1) Why was such an initiative required; and (2) Could much improvement really be expected?

It is difficult to assess trends in wait times over the period 2008–2010 owing to changes in reporting and variations in data availability across the provinces. Furthermore, as indicated above, it is ambitious to expect impacts on waiting times from such reforms in such a short space of time. Nevertheless, for some common procedures, the CIHI has been able to calculate trends from December 2006 through December 2009 (Table 2):

- For hip replacements, there has been no change in Alberta, while times have dropped in three other provinces.
- Although the waiting time trend for knee replacements in Alberta is downward, this is also the case in at least three other provinces.
- On another indicator, the rate of coronary artery bypass grafts conducted within the recommended benchmark for the most serious of cases (i.e., level I) are high (at 96%) for Alberta, along with similarly high rates for five other provinces (CIHI 2010).

Thus, it would seem that little change might have been expected or has been achieved, and where they have occurred, changes cannot be attributed to the creation of AHS.

TABLE 2. Access to healthcare in Alberta relative to other provinces

Procedure	Waiting times in Alberta	Waiting times in other provinces
Hip replacement	Dec 2006: 97 days Dec 2009: 92 days	Dec 2006 (BC, SK, ON): 114 to 281 days Dec 2009 (BC, SK, ON): 70 to 163 days
Knee replacement	Dec 2006: 134 days Dec 2009: 110 days	Dec 2006 (BC, MB, ON): 139 to 353 days Dec 2009 (BC, SK, ON): 96 to 177 days
Percentage within benchmark of 14 days:		
	Alberta	Other provinces
Level I Coronary artery bypass graft	96%	81%–100%

Source: CIHI 2010.

Case-Based Costing

At the leadership level, there is obviously great expertise in this area (Duckett 1995). There is known variation in the costs of treating equivalent cases across the province, as will be the case in other provinces too. What is not clear is that abolishing regions is the solution to this variation. If regions were not addressing such issues prior to abolition, then they are culpable, as perhaps was Alberta Health and Wellness. But maybe regions were indeed auditing this situation and found that such variation is, to an extent, justified. Rural hospitals are likely to be less able to achieve economies of scale, and thus will have more capacity (and associated longer lengths of stay) and greater fixed costs of maintaining minimum required levels of beds and staff (Asthana et al. 2003). Case-based costing will not eliminate such costs. Also, it has always seemed to me that costing everything based on the average is not necessarily optimal. Consequently, when we strip out cases from some institutions, we will strip them out at full average cost, which

may be too much; or, if we put more cases through some institutions, they will be funded at full average cost, which again may constitute overfunding.

How the actual mechanics of case-based costing will work is not clear. The international evidence regarding its impact on the efficiency of various healthcare systems, summarized by Donaldson and Gerard (2005), is conflicting, to say the least. Recent research on payment by results – the UK version of case-based costing – confirms that even if unit costs are reduced, volume of activity tends to go up (Farrar et al. 2009). Increased volume is then likely to lead to overall cost increases, given that the acute sector is the most resource-intensive part of the system.

However, if the predictions of those who propound case-based costing are to be believed, presumably one would see cost savings, or at least some element of stability in costs. Although once again there are caveats about attribution and drawing conclusions too soon, we seem to have gone from a situation where the collective deficit of the former health regions (in May 2008) was \$97 million to one where the deficit for the whole system was reported as \$1.1 billion in June 2009 (CBC News 2009) and now seems to require an injection of over \$2 billion (CBC News 2010).

Alberta Service Models

“Alberta service models” gather evidence on best practice and ensure that, where such evidence exists, then such practice is implemented systematically across the province. Such models, however, are simply guidelines or care pathways by another name, and thus do not represent any kind of innovation at all. It would appear that by simply using the “Alberta” prefix, they will appeal to Albertans’ sense of distinctiveness and originality in having models that are “made for us.” This is window dressing. In Alberta, clinicians in the big-ticket areas, like cancer and cardiology, have already worked out detailed and evidence-based protocols that serve Albertans well (Graham et al. 2006; Ross et al. 2006). Likewise, the Alberta Hip and Knee Replacement Project has already worked out a pathway that has even been evaluated in a randomized trial (Gooch et al. 2009). The added value from engaging several health professionals around the province in further activity to compose the models would appear to be doubtful, at best.

Where Now?

Based on the comparative data available, it is unclear why Alberta had to take the radical steps it undertook in forming AHS. It may well be that the health regions in Alberta were culpable for not coming to grips with how to manage their fixed funding envelopes in order to best meet population need. However, the limited evidence described above would indicate that there is no prospect that AHS will do so to any

greater degree. Indeed, the waiting list initiatives undertaken have focused on the most expensive part of the healthcare system, the acute sector, almost guaranteeing that more money will have to be pumped in, as has indeed been the result. My prediction is that other elements of the reforms will add little because the value has already been realized. Much variation in cost is likely to be justified, and approaches such as case-based costing focus on the average and not “best” – i.e., most efficient – practice, adding further to cost pressures as increased activity in the acute sector actually becomes incentivised.

To manage scarce resources, we need to be able to squeeze more efficiency out of the system – which, on the face of it, is what case-based costing is about. However, beyond that, we need to compare the relative value of what is currently done with prospective service developments so that we can think about scaling back some current services in order to fund those that will better meet the needs of the population. Calgary Health Region was an international leader in the development of frameworks for doing this (Mitton et al. 2003), allowing it to service a \$42-million deficit in 2000, not only by balancing the budget but also by cutting back more than the deficit to allow some reinvestment. This initiative involved substantial engagement of local managers and front-line physicians (Ruta et al. 2005), but after two years of success, the activity was not taken seriously enough at senior levels and was not sustained.

This example indicates the source of the problem in Alberta: strong leadership is required in healthcare, whether at the regional, provincial or political level. De-listing the “easy hits” will not be enough, and neither will pumping in more resources. All the latter does is encourage a culture of contentment, one that existed in the run-up to abolition of regions. It would seem, therefore, that rather than a failure of the regional structures that were in place, what Alberta experienced was a failure of leadership, not only of the regions but also at the political level – and this was a failure that had to be dealt with. It has not, however, resulting in even greater costs to the taxpayer and, no doubt, more pain down the road.

Then what? Regionalization?

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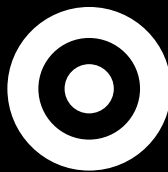
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