House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 006 • 1st SESSION • 39th PARLIAMENT

EVIDENCE

Thursday, June 1, 2006

Chair

Mr. Rob Merrifield

Also available on the Parliament of Canada Web Site at the following address:

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● (1110)

[*English*]

The Chair (Mr. Rob Merrifield (Yellowhead, CPC)): I will call the meeting to order.

First of all, welcome everyone. This is the sixth meeting of the Standing Committee on Health of the 39th Parliament.

I will start first of all with an announcement to the committee members to let you know we will need to deal with one motion concerning some finances of the committee, which we will do after we're done with the witness portion and questioning portion of our meeting. We will have this later on in the meeting; I just wanted to give you that information.

We have a great selection of witnesses with us today to talk about wait times and success stories right across Canada. We're looking forward to what they have to present to committee and, by doing so, to Canadians. I first of all want to introduce them.

With us today is Mr. Cyril Frank, who is vice-chair of the Alberta Bone and Joint Health Institute. Thank you for being here.

Also, from the Cardiac Care Network of Ontario we have Kevin Glasgow. Thank you for coming.

The Canadian Association of Radiologists is represented by Dr. Martin Reed. Thank you for being here.

And with us also today from Capital Health is Richard Lewanczuk. Thank you for coming, as well as Angela Estey, also from Capital Health. Thank you for being here.

We are looking forward to what you have to share with us, and we'll start right off the bat with Mr. Frank. Would you please start us with your presentation?

Dr. Cyril Frank (Co Vice-Chair, Alberta Bone and Joint Health Institute): Mr. Chair, it's a great honour to be here. Thank you for the invitation.

I'm here not to rehash all the problems in health care but to propose some potential solutions, with some preliminary evidence that it is possible. I brought copies of my presentation in both English and French, to be distributed to you.

I would like to start by telling you a little bit about the Alberta Bone and Joint Health Institute, what it is, what we've done with our pilot project and what we're planning to do with our next steps, and tell you where the institute is going in the future.

The institute is a not-for-profit entity, which is a registered charity created by philanthropy in the province of Alberta. It has two key roles. It attempts to be the catalyst for positive change in our health system and to become the objective evaluator of the success of the changed system.

The central operating theme of the institute is to create cooperation between the key players in health that have been operating in relative silos—the health regions; the universities; members of the public; the bone and joint health practitioners, in our case; government; and industry.

The institute was created by Mr. Bud McCaig, a philanthropist in our community who engaged a number of community leaders to serve on a board of directors. Their names are listed for you, including Peter Lougheed, who is a special adviser to our board of directors. We also have an international advisory board of prominent people from the United States and internationally who are advising us on whether we're doing the right things to promote change in our health system and not reinvent the wheel.

The goal of the institute is to create a sustainable system of patient-centred care that efficiently provides the best quality care to all Albertans equally. It meets people's needs as the top priority. It isn't organized for doctors, it's organized for patients and the public.

The problem, as we see it in the institute, is that there are these long waiting times for various elective procedures such as hip and knee replacement, as one example, and the reasons for those long lists are not totally clear. We would propose that we need to be clear on what the problems are in order to solve them, and a systematic solution is possible if we understand what the problems are.

Central to solving the problems, we believe, is that a partnership is required between these various entities that have been operating in silos, and that's the role of the institute—to bring them back together where they're no longer adversarial but cooperate to achieve the right balance of access, quality, and cost control.

The hip and knee project that the institute championed is an example of that. The institute analyzed the problems and began implementing solutions by communicating with all those partners and securing buy-in of all the health regions in Alberta, Alberta Health and Wellness, primary care physicians, and all the orthopedic surgeons in the province. About 100 orthopedic surgeons are behind this project. The institute then worked with those partners to clean up the poor information that existed in the system, starting with the waiting lists. I'll give you some examples in a few minutes of how poor the information is.

The institute analyzed the existing way of doing business and designed a new way of doing business, called a continuum approach, which is not totally unique. There are other examples that we're going to hear about today of reorganizing the system to make it more efficient and effective.

The institute did secure the buy-in of Alberta Health with the commitment of new dollars to be able to do this, and I will talk about that in a few minutes, too. But there was $20 million allocated by the Province of Alberta to make this happen, which was obviously very important for change management, as well as doing the new joint replacements.

● (1115)

We then went on to test this new way of doing things, the ideal continuum. The top of the next page shows the partners involved in the project: the universities, the health regions, and all the doctors.

I want to again quickly highlight what we believe the problems are.

The system is very confusing; patients are left on their own to try to navigate this complicated system. There is a lot of redundancy, inefficiency, and waste when people are trying to navigate the system on their own, seeking care from multiple providers, recycling through diagnostic testing in a very inefficient manner, and consuming unnecessary resources and time.

There was also a critical lack of good information to fix this problem. The administrative databases do not contain the real information needed to solve this in terms of access, quality, and cost. There is a schematic here of a spaghetti-like system that has been organized around departments and doctors and hospitals. It looks very confusing to people.

Central in our whole argument is that we need accurate information to solve this. A couple of examples of cleaning up the so-called queue or the waiting times occurred when we analyzed 20 surgeons' practices. We discovered that about 15.5% of people who had already signed consent forms to have surgery by those surgeons were not really waiting for surgery at all. Many of them had already had surgery; some of them were dead, had moved away, or didn't want surgery, despite the fact that they had signed a consent form. They had done so just to have their names on the list in hopes of having surgery in the future.

A separate list of people who had been referred to these surgeons was even worse. Fully one-third of them were not really waiting to see that surgeon. Unknown to the surgeon, they had already seen others and had had their surgery. They had actually been working their way through a separate path in the system entirely, consuming unnecessary resources. These surgeons were waiting in good faith for patients to show up in their practice, whereas they had already been treated. That's just an example of poor information driving unnecessary cost, waste, and inefficiency of people's time and effort.

What the institute did was create a continuum approach with some hard guidelines around when the clock starts and stops on different parts of the continuum of care. The system was reorganized from a patient's perspective from beginning to end, from hip pain all the way through to a happy, healthy, educated patient back home again. I'm not going to go through the details of that unless you want to in the questions, but the way the system was re-engineered was through creating focused facilities with central triage clinics, multidisciplinary teams with case managers assigned to every patient and armed with standards and benchmarks of time of access, and appropriate testing. These were implemented in every patient's case.

Central to this was the creation of an accurate database of access quality, which meant satisfaction as well as patient outcomes were being measured in every case—and cost, both direct and indirect, with a costing system that has been agreed to by all three participating health regions. We were able, for the first time, to define accurate case costing of hip and knee replacements with some agreement on what that means, and have the ability, most importantly, to track it prospectively for all cases. We have a benchmark of figuring out cost.

We set this up as a randomized control trial, which is a research design in which the same surgeons send patients either into this new path or into the existing path. Then we measured access, quality, and cost.

● (1120)

A preliminary report released in December talked about their improved access times. Times were dramatically reduced: the waiting time to see a surgeon went down from 35 weeks to 6 weeks, and the waiting time for surgery went from 47 weeks to 4.7 weeks. Again, this was 1,200 patients in a specialized system, just to show proof of the concept that it can be done. This is a kind of best-case scenario, with new resources, new teams, and adequate pathways. It shows what can be done.

The most important part of that is the information being generated for all patients going through the system. There'll be another report coming out from the institute within the next couple of months, with more quality and cost information. That will be more revealing about the cost-benefit ratio of doing it this way.

Patients were very satisfied with this new way of doing things. They said it was better. They felt as if they knew what was required. Somebody was always looking after them in the system. They loved their case managers. So proof of concept shows this new way is better in terms of satisfaction and can provide better access.

However, you might say, “So what? This was done with new money that could have been directed to doing new hips and knees”, which is the solution in some other jurisdictions we're aware of. Well, not only did this provide better access and higher satisfaction, we think there will be better outcomes. There will be a system in place for measuring access, quality, and cost for all the patients in the province, because we're now actually spinning out this model to the entire province. We've engaged all of the orthopedic surgeons doing hip and knee replacements. Using what we've learned from this project, it's now being used for all the doctors in those three regions, and we're educating the others in the other health regions.

This also gives us the chance to now identify how much it really costs to provide care across the continuum, and for the first time ask the providers, “Can we save money and provide better care?”, which I think is critical to creating a sustainable system. They've never been asked before, “Can you imagine saving money, as co-owners of this business?” In hallway discussions I've had, every one of them believes they can.

I don't want to over-promise and under-deliver, but I'm thinking that a minimum of 10% in costs could be saved in every case, which could be reinvested in doing 10% more. It could probably be more than that with a little bit of pushing.

So the bottom line is that this gives us better information to drive change. We can drive this out with evidence-based decision-making on access, quality, and—I emphasize—cost, and create a new business model with incentives for providers, for the first time, to participate in fixing the system.

We've set up a case rate for funding hip and knee replacements that is flowing into physician groups to manage the continuum of care. I believe that will change how the physicians are actually incented to help fix access, quality, and cost with real information, knowing that somebody is paying attention and getting the right information that's going to improve their quality of care, but also incenting them to be more efficient and cost-effective.

This will allow us to project what's really needed in the future, so there will be no more hysteria about how many patients require care and how much it is going to cost. We will know accurately within the next few months what it will cost to fix this problem, for all time and eternity, for the province.

Our stepwise approach to solving this is to optimize what we have and make it as cost-effective as we possibly can by asking the providers to participate in the solution. We believe that if we don't do that as the first step, it'll never happen. We believe people will continue to order unnecessary tests and drive unnecessary cost, unless they're incented to fix it first.

Then we can transparently define what we need, discuss the options on how to fix it by stopping to do things of marginal benefit that are evidence-based—diagnostic tests, rehabilitation, and whatever is unnecessary—and reinvest that value. That's the bottom line. We propose that as a tactic going forward.

Thank you.

● (1125)

The Chair: Thank you very much for your presentation.

Just before we go on to the next presentation, I would ask that you send the committee the results of the report that is coming. I'm sure there are going to be some questions on where the $20 million was spent, how many extra physicians it took, and so on. Nonetheless, we'll wait for the questioning part to get into that.

We'll go to our next presenter right now, Mr. Glasgow.

Dr. Kevin Glasgow (Chief Executive Officer, Cardiac Care Network of Ontario): Standing committee members, *mesdames et messieurs*, thank you for this opportunity to discuss monitoring, management, and reduction of wait times for cardiac procedures.

My name is Kevin Glasgow. I am chief executive officer of the Cardiac Care Network of Ontario.

By way of background, CCN is funded by the Ontario Ministry of Health. We operate North America's largest population-based cardiac registry and integrated wait list monitoring and management system. Our pioneering wait time registry work has been adapted by several other provinces, including the Saskatchewan surgical wait list system and the Quebec cardiac surgery registry. We are also an advisory body to the Ontario ministry on cardiac matters, and are well known in our field for expert consensus panel reports on cardiac issues. These are publicly available on our website.

CCN is a national and international leader in facilitating timely and equitable access to quality cardiac care. We do this on a province-wide basis for selected cardiac procedures—specifically cardiac surgery; coronary artery bypass graft and valve surgery; coronary angioplasty, or balloon stents to open up blockages in the arteries of the heart; and cardiac catheterization, also known as coronary angiogram, dye injected to take a look at the blockages of the arteries of the heart.

In conjunction with our 18 member hospitals—every hospital in Ontario that has a cardiac catheterization, or “cath”, lab—and our regionally based cardiac care coordinators, more than 85,000 patients a year benefit from the following from CCN: clinical urgency rankings, urgent, semi-urgent, and elective, based on standardized clinical criteria; maximum wait time guidelines; monitoring while on the wait list; and patient management, to ensure that the most urgent patients receive priority access to care.

We have achieved 100% participation in the provincial cardiac registry with cardiac surgeons, interventional cardiologists, and cathing cardiologists. Essentially, we have taken wait lists out of the desk drawers of doctors, consolidated them on a hospital basis, and then consolidated them on a pan-provincial basis. One of our key success factors has been the engagement of multidisciplinary stakeholders in CCN's committee structure, where clinicians are actively engaged—with nurses, hospital officials, and ministry officials—to continually improve the cardiac system. Accountability agreements are also signed between CCN and each of our member institutions.

In your information packages, I have included background literature on how CCN works and what our procedural monitoring shows over time. Additional materials have been left with the clerk for translation.

CCN has standardized wait time definitions between hospitals and between clinicians, thereby permitting apples-to-apples comparisons. In our recent data definition review process, our expert panel included representatives from the provinces of Nova Scotia, Quebec, and Alberta, in addition to representatives from the Canadian Cardiovascular Society. Thus, a significant step was taken toward achieving common data definitions to facilitate interprovincial comparisons. CCN also has close ties with the Winnipeg Regional Health Authority and the B.C. cardiac registries.

For over a decade, CCN has publicly reported wait times by cardiac hospital. We provide, on a monthly basis, very detailed reports that go back to clinicians, hospitals, and ministry officials. Through our collective efforts, and with the support of successive governments since 1990, cardiac procedure wait times have been substantially reduced and equity in access improved. But translation of wait time data into useful information and associated monitoring of wait times can only improve patient access so far. Active system management is required to achieve the next level of wait time reductions and the next level of improvement in equity to access.

I am pleased to report that a year ago, CCN was given an enhanced mandate from the Ontario Ministry of Health to further reduce regional variations in wait times through active system management. We are achieving success in altering referral patterns and reducing waiting list bottlenecks to increase the percentage of patients receiving their procedures within recommended maximum wait times. I wish to acknowledge the conceptual and financial support of the Ontario wait time and access to care strategy in this regard.

The key action items in CCN's 10-point plan for action in reducing regional disparities are included in your package, on these two sheets, in both official languages. Our detailed 10-point plan for action is available on our website at www.ccn.on.ca.

● (1130)

I also wish to thank both the provincial and federal governments for their financial support for improved information technology. By the end of 2006, CCN will have a modern web-based real-time information system that will much improve the timeliness of information availability for active system management.

Now I wish to highlight some of the positive trends that have occurred in Ontario over the past year in cardiac wait times. Please refer to the handout entitled, "10 Point Plan for Action in Reducing Regional Disparities to Care".

The first slide in this handout, which is a very important slide, shows substantial improvements in the percentage of patients receiving their procedure within the recommended maximum wait time. For example, if we look at CABG, coronary artery bypass graph elective—and this is where the federal-provincial benchmark was set at six months—we've seen an improvement from fiscal year 2004-05, with 86% of patients in Ontario receiving the procedure within the recommended maximum wait time, to the fourth quarter of the 2005-06 fiscal year—so very recently—when it's up to 98%. Similar improvements are seen across other urgency categories for cardiac surgery and cardiac catheterization.

The remaining slides in this particular handout show marked reductions in wait time disparities between high and low wait time hospitals.

On slide 2, I'll draw your attention to the schematic for elective catheterization. In the colour version, the blue top line represents a high wait time hospital, and the pink line stands for a low wait time hospital. Over the past year, they've essentially converged, which means that the percentage of patients getting the procedure within the recommended maximum wait time has improved. It's less important where you live in the province of Ontario, in terms of where you're receiving your procedure within the recommended maximum wait time.

So why has Ontario succeeded in reducing cardiac wait times and improving equity? Success has been built on several things: first, monitoring and anticipating demand; second, investing in capacity; third, coordinating and facilitating access across the system, with specific addressing of wait-time hot spots; and fourth, ensuring that physicians, surgeons, administrators, and ministry officials participate in planning for the common good.

In my invitation to meet with the standing committee, I was asked to comment on ways of dealing with wait times to the satisfaction of patients, within an environment of limited human and financial resources. I will do so by making reference to listening to patients, assisting patients, increasing throughput, utilizing capacity, planning ahead, and linking utilization to quality outcomes.

First, one must listen to patients and the public. Last year, CCN surveyed more than 2,000 patients waiting at home for elective or semi-urgent procedures, plus providers and members of the public. Some highlights of our survey—the details of which will soon be posted to our website—were as follows:

First, wait time was not then a major consideration in most physicians' decision about where to refer patients.

Second, only a minority of patients and providers were discussing wait times and options of care.

Third, we posed a theoretical question to patients and said, if you had been provided with full information on your options, would you be prepared to travel a farther distance to get your care in a shorter period of time? Twenty percent of non-urgent patients said yes, they would consider this. It is important that patients be fully informed.

As a result of this survey and other data and information, and the liaison we've done, we're in the process of further improving access to care in Ontario. We have strengthened our partnership with the Heart and Stroke Foundation of Ontario to make sure that what we do is patient focused.

A second key point is that one must assist patients and the public. So our hospital-based regional cardiac care coordinators serve as patient navigators to navigate that confusing pathway. Wait time information is also available on our website, and in our package you have examples of patient information brochures, which are given to 85,000 patients a year in the province of Ontario.

Third, one must increase throughput. CCN is currently engaged in operational efficiency benchmarking and sharing of best practices across our 18 member institutions. We're also reaching out to community hospitals that refer into the specialty hospitals. The Ontario provincial wait time strategy has also initiated improvements to surgical throughput across therapeutic areas.

● (1135)

Fourth, one must utilize present capacity to benefit the maximum number of patients—hence CCN's 10-point plan for action, which essentially equates to better use of current health care resources.

Fifth, one must plan for the future. CCN engages in procedural volume target-setting, looking into the future, to assist the Ontario ministry in making decisions regarding future capacity investment. We are also currently engaged in scenario planning for cardiac surgery—the volume is essentially stable—given rapid changes in that field associated with the growth of angioplasty.

Sixth—and I'll reinforce Dr. Frank's comments—one must link wait time information, utilization, to outcomes and quality. CCN and the Institute of Clinical Evaluative Sciences have collaborated on cardiac surgery report cards for a number of years. They are publicly reported on our website, and reports compare patient results by hospital. By the end of this calendar year we'll be producing an angioplasty report card, which we believe will be a Canadian first.

This brings me to my final point. A truly patient-focused wait time reduction strategy needs to address both upstream and downstream waits, in addition to wait times once the patient has been accepted to specialists' procedure lists. This means addressing the wait time to see a family physician; the wait time from the family physician referral to the specialist; and then after one's procedure, the referral time for cardiac rehabilitation. It also means reducing the need for procedures in the first place—primary prevention, and the need for repeat procedures and re-entry into the acute care system—secondary and tertiary prevention.

The recent federal and provincial initiatives directed at reducing wait times are a great start. In Ontario, we have seen substantial reductions in wait times and improvements in equity in cardiac care. This momentum needs to be sustained and applied more broadly.

I thank you for your attention and look forward to addressing your questions.

The Chair: Thank you, Dr. Glasgow.

We'll now hear from the radiologist, Dr. Martin Reed, for 10 minutes.

[*Translation*]

Dr. Martin Reed (Executive Member, Canadian Association of Radiologists): Good morning.

[*English*]

Thank you very much for inviting me to this meeting.

Diagnostic imaging plays a very important role in the diagnosis of clinical conditions in many clinical areas, and we know that you cannot treat patients properly without having an accurate diagnosis. Therefore, wait times in diagnostic imaging create major bottlenecks in many other areas of clinical care.

I just want to share a few figures with you to give you some idea of the problem. In 2003, there were 35 million diagnostic imaging studies performed in Canada. That's 17,000 exams per radiologist, about 2,000 more than we feel are optimum, and more than one diagnostic imaging exam per Canadian.

In 2004, there were approximately 2,000 radiologists in Canada. This was, we feel, about 500 short of the number of radiologists we actually needed, and that situation has not changed substantially a year or two later.

If current trends continue, we expect that diagnostic imaging volumes will increase by 30% over the next six years, whereas the net supply of radiologists will increase by less than 5%. So the situation is not going to get better; it's going to get worse unless we can do something about it.

In the past we have advocated for more diagnostic imaging equipment, and we certainly appreciate the response of the federal and provincial governments in providing money for more equipment. But we also know that the solution does not lie just in providing more equipment. We have to become more efficient and more productive.

The Canadian Association of Radiologists is working on four projects that we feel will increase our efficiency and productivity. The first of these is advocating for more PACS and RIS systems in Canada. PACS are picture archiving and communications systems. RIS refers to radiology information management systems. These are electronic systems, and you can view these as the diagnostic imaging part of an electronic health record. These will increase our efficiency, and we appreciate the support of Infoway in helping to fund PACS and RIS systems across Canada.

We're also working with the Canadian Association of Medical Radiation Technologists on developing physician extenders. This means training technologists to do some of the procedures that radiologists do, under the radiologist's supervision, thus freeing radiologists to do other things and to become more efficient in other areas.

We're also advocating with the Canadian Interventional Radiology Association the increased use of interventional radiology. These techniques, we believe, can move patients out of operating rooms into interventional radiology suites, where procedures can be done in less costly and invasive fashions, and free operating room time for more complicated procedures.

The fourth project is the guidelines project, and that's a project I want to spend a little time on. I'm the chair of the guidelines committee, and we believe that guidelines have the potential to make a substantial impact on diagnostic imaging wait times.

Just to give you a little background and to share a few more figures, based on a pilot project we did in New Brunswick and based on studies and the literature, we believe that at least 10% of diagnostic imaging studies performed in Canada are unnecessary. That equates, this year, to about four million examinations. That's the workload of 250 radiologists, half our shortfall. It's also the workload of about 200 average-sized hospitals. So it's a substantial number of exams, and if we could stop doing those we feel it could make a significant difference to wait lists in radiology.

● (1140)

So you may ask, why are all these unnecessary exams done?There are three basic reasons. One is that exams are repeated because the original study is unavailable or inaccessible, and PACS will go a long way to ameliorating this problem. There are two other reasons, though.

You have to understand that the amount of information that is being provided to physicians daily, weekly, and yearly is overwhelming, and no physician can keep up completely. So physicians often are not sure what is the most appropriate diagnostic imaging study to do. They are not always sure whether diagnostic imaging will help their patient, but they do the best they can and they order a diagnostic imaging study.

In some cases those diagnostic imaging studies are not the most appropriate studies to answer the clinical question the physician has. What happens is they then have to go on and do another study that is more appropriate.

In other situations they order studies believing that they can help them, when in fact the diagnostic imaging study will not help them in their clinical situation, or at that time.

Guidelines are designed to prevent as much as possible these inappropriate examination orders. Because of this, the CAR decided that we should develop guidelines for imaging procedures. We looked at what was available and we decided that those of the Royal College of Radiologists in England, which had developed an excellent set of evidence-based guidelines, were the most suitable for our purposes. With their permission we adopted these guidelines. We modified them slightly for the Canadian situation, and we published them in booklet form at the end of last year. The first printing has already been distributed and we're now into a second printing. I may add that they were published in both English and French.

However, we also believe that printed guidelines are not the most effective way of implementing guidelines. Busy physicians don't often have time to look things up when they're seeing patients. We believe the best way to implement guidelines and have them be effective is to provide them at the point of care.

The CAR is partnering with Medicalis, which is a Canadian medical software company based in Waterloo. They have developed an electronic diagnostic imaging order entry software called Percipio, and they have integrated the CAR guidelines into this software. When a physician orders a diagnostic imaging study, he provides clinical information. If the study does not meet with the guidelines, he immediately gets an electronic prompt suggesting to him what would be a more appropriate study or suggesting that diagnostic imaging would not help him.

We are currently about to start a demonstration project of this software at my hospital, the Children's Hospital of Winnipeg. This project has been jointly funded by Health Canada and Manitoba Health, and has the support of the Winnipeg Regional Health Authority. I may add that it also has the enthusiastic support of our pediatricians.

We're going to have an independent research team assessing the effectiveness of this software, using both quantitative and qualitative methods.

We believe it will be important to do other demonstration projects in other clinical settings, such as testing it with family practitioners in rural and remote areas and testing it in busy emergency departments, and we would very much like the support of the committee in getting funding for these demonstration projects.

In conclusion, as an association we believe that ongoing cooperation and communication between all parties—governments, physicians, and patients—is essential to initiating and sustaining change. We are committed, as a national organization of radiologists, to working cooperatively with all parties to create positive change.

● (1145)

[*Translation*]

Thank you for your attention.

[*English*]

Thank you for your interest.

The Chair: Thank you very much for your presentation, Dr. Reed.

Now we'll move to our last presenter, from Capital Health in Alberta, Dr. Richard Lewanczuk.

Dr. Richard Lewanczuk (Regional Medical Director, Chronic Disease Management, Capital Health): Thank you very much for this opportunity to present this morning. We had a couple of days' notice, but we'll be happy to forward some written materials to the committee.

We come from the non-procedural end of the spectrum, from the chronic disease area, and we'll highlight one of our experiences and how we're applying that in other areas in Capital Health.

Chronic diseases are responsible for about 60% to 80% of our health care costs, they are responsible for about 60% of our hospitalizations, and we all know about waiting lists for hospitals. They are the most common cause of a visit to an emergency department, and we hear daily in the media about emergency department backlogs. Chronic diseases are also the most common reason for a visit to a family physician, and again, we hear daily about difficulties in access to family physicians and waits to get into see the family physician.

Chronic diseases are conditions like diabetes. One in four of us in this room will develop diabetes in our lifetime. High blood pressure is another chronic condition. If we live to 80, all of us will develop high blood pressure. Osteoporosis, the entire population by age 70 of women will have osteoporosis and so on and so forth. Chronic diseases are very common and they're a major driver in our health care system.

To put it in perspective, in our region of Capital Health in Edmonton there's about 0.2% of our population waiting for joint replacement surgery, but there's about 80% to 90% of our population who need access to chronic disease services. Internationally, within our region and within Canada, diabetes tends to be the prototype of chronic disease because it tends to be one of the major drivers behind costs for cardiac care, amputations, kidney dialysis, and a number of other high-cost areas.

In Capital Health, like many areas around the country, we had a six-month waiting list to access diabetes services, to access education, or a specialist. Some of my colleagues around the country tell me that in some parts of the country it's now a one-year wait to access diabetes services. You can imagine, if you were told today that you had diabetes and you were wondering what is diabetes, what do I have to do? Am I going to go blind from diabetes? Am I going to lose my leg? You'd have to wait one year to get the answers to those questions.

Similarly, in our region we had five centres that provided diabetes services, and all of them were at acute care hospitals. There was no coordination amongst the centres, there was no prioritization. It was on a first come, first served basis, no matter what the urgency, and despite this we were only serving, we estimate, about 6% of the population with diabetes. We knew this system really wasn't sustainable, it wasn't appropriate for the patients, and it wasn't providing good care to the public, so we had to change the system.

Beginning about three years ago we did change our diabetes system to a unified regional system using principles of chronic disease, and in doing so we were able to take that six-month waiting list and reduce it down to two weeks. We were able to catch up on about a 1,000-patient backlog from that list. We were able to triple the number of people we were seeing in our system and we were able to do it at no additional cost. It was for the same cost; we just redistributed our resources. More importantly, we also did it in a sustainable manner. In other words, we took existing resources and we just redeployed them. It wasn't pilot money, it wasn't extra money that was going to run out; it was money that was there and that would always be there. So it was a sustainable model.

How did we go about doing this? We're now applying exactly the same model to a whole host of chronic diseases in Capital Health. We did it by a principle, and I'll use an analogy. You can imagine what would happen if your 18-year-old was heading off to school in the morning and he asked you to tie his shoes for him. You'd say, that's ridiculous, my 18-year-old wanting me to tie his shoes. But that is what was happening in medical care. What we did was say, you know what, son, we're not going to tie your shoes for you any more, you're going to have to do it yourself; but we're going to teach you and help you tie your shoes.

That's what we did with our system. We changed the focus of our system from an acute care specialist based system back to the community, based on the patient, the family, the family physician, and the resources in the community. We used those resources to start providing care. That was one of the principles we shifted to.

● (1150)

We also took on another major principle, which was that we in the health region were responsible or had some accountability for every single person in our region who had the particular chronic disease. In this case it was diabetes. We weren't responsible only for the nice, compliant patients who showed up for their appointments and did what we told them; we were responsible for the people who didn't, couldn't, or wouldn't show up to appointments, because those are the ones who end up in trouble. Those are the ones who end up in the emergency department in kidney failure, or with major eye problems, or needing amputations. So we took on the responsibility for the entire population, and as you have heard from some of my predecessors, it's important to know who our population is, who the people are that we're treating.

The other principle we used to design our system, and it was also mentioned by Dr. Glasgow, was to go as far upstream as we could in the care continuum. In other words, we wanted to treat the disease and the risk in the community before it impacted our acute care facilities. In other words, we wanted to treat the high blood pressure before we needed to treat the coronary artery disease.

Today, each one of us in this room is going to develop 20 new plaques in our arteries. Wouldn't it be better to treat ourselves today, rather than wait until we need the coronary artery bypass or the angioplasty? That is the principle upon which we operated, trying to operate as far upstream in the continuum as possible, as you heard.

How did we do this? One of the ways has already been mentioned. We used a central point of access so all of our requests for services come in through one central point. That allows us to know where the patient population is, but more importantly, it allows us to triage the patients to appropriate levels of service.

Under the old system, it was presumed that everybody needed to see a specialist. We sort of denigrated the role of the family doctor and thought that they couldn't possibly look after diabetes. In fact, we know that family physicians can look after 70% to 80% of people's chronic disease, that's what they do for a living. Most of their day is spent managing chronic disease. So we shifted the focus there.

Now we've redeployed our resources so that the family physician sees the majority of the simple, straightforward cases. The specialists now see the more complicated cases, so we're better utilizing our specialist resources. The most complicated, the most sophisticated teams, now look after the most complicated patients. That's what centralized access has allowed us to do.

We've put heavy emphasis on information exchange, because again, as you have heard, not having appropriate information leads to duplication of services and a whole host of issues. Now we've put a lot of emphasis on electronic medical records so we can efficiently obtain information from family physicians, transmit it back to family physicians, allow patients access to their own records to give patients information and methods to manage their own disease.

I don't know if any of you have ever had the experience of going to an emergency department or a hospital, but if you have, probably the nurse comes and asks you questions, then a medical student comes and asks you the same questions, then the emergency doctor asks you the same questions. You think, my God, don't these people talk to each other? How come I'm asked the same questions over and over again? Having electronic records helps us to eliminate that need, because we have the information available.

We know there is in Canada a shortage of medical specialists, cardiologists, pediatricians, general internists. If I could offer you a way of doubling that number in a few months, I think we'd all be very interested. We wouldn't have to go through this whole immigration and credentialing or eight years of training business. One way in which we can do that is through the use of electronic records.

Right now, as a specialist, for example, if I see a new patient, it takes me about 45 minutes to do a consultation on a patient. But if the family physician has an electronic record and sends me electronically that patient's history, or even a printout, saying this is the medications they are on, this is the past history they have, the operations they have had, this is the family history, it eliminates the majority of my encounter. I can now do my 45-minute consultation in 15 minutes. In other words, in that 45 minutes I can see two or three times the number of patients, with no more additional specialists. That's some of the power behind electronic records and that's what we've used in our diabetes system.

We certainly support patients, so we engage our patients in managing their own diseases. We provide them with information, tools, self-empowerment tools, so that when they go to the doctor they ask why they are on this medication, or shouldn't they be on this medication, or can the doctor check their blood pressure, or their feet. In fact, we had to start giving our patients sheets of paper to give to their doctors to say the patient had been through a training program and may be a little bit more demanding than they had been, a little bit more interested in their own health.

● (1155)

A lot of change management, as you might imagine, is involved in changing a system like this. But we support our family physicians. We don't just dump the responsibility onto them; we provide our family physicians with the materials, education, and tools, the algorithms, the electronic methods in which to handle these patients.

As you've heard as well, we have software that embeds guidelines right at the point of care. So when a family physician calls up the patient on the electronic record, it says this is Mr. Smith or Mrs. Tremblay and they're diabetic and are overdue for their kidney test. Right at the point of care, we know what's necessary. So we use methods such as this.

We use data that we collect. We heard about the need for data, and we're thankful to Canada Infoway, for example, for supporting some of our data collection. In our region we know where the demand is coming. Every two weeks we look geographically at where the demand for diabetes services may be coming from. We may see that it might be coming in that month or in two months from the northeast part of our region, and we will actually take our health care workers and move them physically to the northeast part of the region in order to provide care. But we can only do that by having access to the data.

We've recently discovered, for example, with patients who have diabetes, that their care seems to improve for about 12 to 18 months and then it plateaus and in fact starts to deteriorate. That tells us we have to start doing something at 12 to 18 months; something different is happening. We're doing the right thing at the beginning, but we have to start doing something at 12 to 18 months. We didn't know this nationally or even internationally up until this point.

These sorts of data collection help us drive our system and provide better care to the patients and prevent them queueing up for the acute care services.

We take a very proactive stance in treating our patients as well. We contact them by telephone to see how they are doing, whether they have any problems, whether they have made behaviour changes. We will admit patients to hospital proactively if something is going wrong. For example, if a patient with heart failure is getting into trouble, rather than waiting until they're *in extremis* and have to show up in the emergency department, we admit them to hospital. We know what we want to do, we do what we need to do, and they're back to their primary health care provider in less than half the time they would take for a normal acute care hospitalization. We're using proactive methods like this; we're using the hospital as a tool in the whole health care system.

So these are some of the techniques we've used in our diabetes system, but we're not a one-trick pony. We've used a similar sort of system, for example, in endocrinology. That's my specialty. Endocrinology takes into account diabetes or such things as osteoporosis or thyroid disease. We've also taken the practice of having one central point of access now for endocrinology services. It's no longer the family physician phoning 11 different physicians trying to find who has the shortest waiting list—we also had six-month waiting lists.

Through having a central point of access, every day the endocrinologist goes through the requests for services and picks out the urgent cases. Most patients are seen sometimes the same day, sometimes the next day, but within a day or two. The only limiting factor is the patient's availability. Patients who are less urgent we will see in a few days. Patients who are routine can wait a month.

One of the things we learned from our diabetes system is that you can actually have too short a waiting list. We found that when we shortened our waiting list to two weeks, patients didn't have time to arrange time off work or to arrange child care. We found that the optimal waiting list for routine types of care was about three to four weeks. We use this sort of technique in endocrinology. By doing it, we've taken our six-month waiting list and.... In fact, waiting list really doesn't mean much to us anymore, because we see the urgent patients when they need to be seen, the semi-urgent ones when they need to be seen, and the routine ones on a routine basis. We're also able to handle about 25% of our cases over the phone, so we don't necessarily even need to see patients.

So there are a number of innovations we're able to apply in this whole area.

In conclusion, then, there are a number of recommendations we would suggest. Some of them are that rather than focusing strictly on things such as wait lists, we focus on the whole access to appropriate care at the appropriate time—as we say, the right provider, the right place, and the right time—things such as centralized registries in order to know who our denominator is and who the patients are, investing in electronic health records, system redesign to support primary care providers and the patients, taking into account the community providers as well, and continuous monitoring.

We thank you for this opportunity. We're optimistic that we will be able to change our system. It is starting to happen. It does seem to be starting to work, and we really need your help to drive this system.

Thank you very much.

● (1200)

The Chair: Thank you to all of the witnesses and the presenters. You're all very passionate about some of the success stories you have to share, and we want to thank you for coming.

I now will open it up to the questioning part of the meeting. We'll start with Mrs. Brown, please.

Ms. Bonnie Brown (Oakville, Lib.): Their presentations were so helpful and so clear I don't really have a question, other than some things I'd like to ask the endocrinologist. I'm going to pass to Mr. Steckle, who has questions.

Mr. Paul Steckle (Huron—Bruce, Lib.): Thank you.

The Chair: Absolutely. Mr. Steckle.

That seldom happens, by the way. I've never heard of that happening before.

Mr. Paul Steckle: I have many questions and many comments, but having just come from the agricultural committee you would wonder.... I'm subbing this morning. But I do thank you for coming. I feel privileged to be able to be at the table and listen to your presentation. It was very interesting.

You people are making a lot of progress. In the past we've always believed money was the answer to our problems: if we had more money, we could resolve our problems.

Do you believe the money that was committed to the 10-year accord is adequate? I'll put the question to Dr. Frank. I want to get into some of the things you have done; I know you haven't done it by yourself. I want to know this. Do you feel the 10-year commitment that was made to money by the provinces a year or so ago is adequate, going forward?

Dr. Cyril Frank: I don't know yet. I would like to have better information before giving you a solid answer.

It's a lot more predictable than we think, because we know the population demographics better than ever before. If we knew the costs of care and of the infrastructure required—that would be acute care and human resources—we could answer that more clearly.

But I would like to have that discussion with real information, through central data registries and real population demographics and real cost information, to be able to give you a solid answer. I think we're heading in that direction, and I've heard the same thing from everyone here.

● (1205)

Mr. Paul Steckle: Information sharing with the institute and the work you're doing there, the early prognosis, and the early results you seem to be indicating, what interest and what sharing of that information is there among other provinces, among other hospitals?

Dr. Cyril Frank: We've been giving our information to similar groups in other provinces from the time of our announcement to the present day. We believe it should be shared and best practices should be emulated, and knowledge transmission is one of our key themes.

Mr. Paul Steckle: Dr. Lewanczuk, you mentioned that if you could, with a flick of the finger, if you could move quickly, we would have more doctors. Is the system able to sustain more doctors?

We have doctors who were trained in other countries who are driving taxis today and who would like to get back into the practice of medicine. We're a little slow on the draw to get these people back in again. We're graduating young doctors who are, in many cases, immigrating to the United States.

Do we, as government, have some obligation to put measures in place to keep those doctors here at least for five years? Would that be a positive, from your standpoint, to have these young doctors spend five years here, or perhaps three years in northern Canada or in some remote place, so they don't simply run off from grad school into the medical system in the United States, or elsewhere for that matter?

Dr. Richard Lewanczuk: To address the first part of the question, there are other techniques we can use to extend our physician abilities, and using other health care professionals will certainly extend the capabilities of the existing physicians that we have. As you can probably tell, I could go on for hours and hours in this area.

Across the country, there are various forms of primary care reform that are now introducing nurse practitioners, nurses, pharmacists, and mental health navigators into the health care system. That certainly extends the capabilities of our existing physicians. Having nurse practitioners work with specialists extends what they're able to do. So by using other health care professionals and other techniques—for example, the electronic medical records—we can expand our capacity. Certainly we can still use more physicians, and as you point out, particularly in rural and remote areas.

I guess many medical organizations wrestle with this question. It's always difficult to compel someone. But I think the way we're heading in Canada is that we can develop systems where we become so attractive that people really don't want to move. I know some of my colleagues have moved to the United States. They find that they're only allowed to keep the person in hospital for three days. It doesn't matter that the person is 90 years old and has every complication, the administrator says, "No, the book says three days. Why are you keeping them in longer?"

All of the difficulties and challenges in other countries actually make our system look appealing. I think that having these other professionals, the electronic records, and a really well-integrated system actually attracts, or at least keeps, people. I think it's always difficult to compel people.

Personally, I would hope that people realize it's we the taxpayers who fund a lot of the education for these people and that there would be some obligation.

Mr. Paul Steckle: I know sometimes we get down on ourselves. We think our system has many shortcomings, and it does, but when we compare what is happening in the U.S.—the costs, the amount of people they're seeing, and the results—we have a fairly favourable response in this country.

But I want to point out something that I think is very important. I think if you're going to be honest with us this morning, you're probably going to have to agree that this is happening. Do we not have too much infection in our hospitals today?

I say that with a great deal of authority. I come from the London region. I have a family member who is still on antibiotics one year after surgery. I can point to three or four places where we can eliminate it. I'm not a doctor, and I don't want to take your position, but I think in terms of infection that occurs with the migration of people into areas they shouldn't be, is it not time that we start looking at that as a high cost to the system?

I'd like a comment, quickly, on that.

● (1210)

Dr. Cyril Frank: Sure. I'd like to comment on that.

I agree that safety and prevention is a key strategy with infection, because we know a large number of them would be preventable. Again, I believe that with the right information, a lot more of that is predictable, to risk manage patients more appropriately, to make sure their diabetes is controlled, that they're taking the correct medication and they've done whatever can be done to try to prevent that. There are other measures that could be used to probably decrease infection rates within the acute care settings.

There's obviously a lot of work going on in that area, but I agree that it needs to be a focus, because it is driving an enormous use of resources.

Mr. Paul Steckle: Who should drive that? I don't want to take away from your time, but who should drive that? Should the public be driving that? When nurses ask us to do something about this, there's a serious problem.

Dr. Cyril Frank: I think it requires a team effort to solve it. It's the teams that need to solve it, including administrators, with people watching from the public.

Dr. Richard Lewanczuk: May I respond as well, Mr. Chairman?

I agree with you. There's a whole host of things we can do. I'll give you one example of a patient across town in our region who had this methicillin-resistant staphylococcus, one of the most problematic causes of infection. It showed up at my hospital, the university hospital, because we couldn't exchange information and we had no idea that this person had this infection. So what happens is that the infection spreads. That's a matter of information exchange.

We know that one of the difficulties is the over-prescription of very powerful and potent antibiotics. But as we also heard, if we can embed some of these guidelines right at the point of care for the family doctors, saying that when a patient comes in with a cold you shouldn't be prescribing this antibiotic, that will also help us.

There's a whole multi-faceted approach that we could take.

The Chair: Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): Good morning and thank you.

Your solutions are mainly patient-centred, and you have had quite a bit of success with this. I would like to put some questions to Dr. Cyril Frank.

Following the plan that you have implemented, you found some ways to solve urgent problems. Among other things, you said that you identify urgent cases sooner, and that in order to help patients after surgery, you have changed some practices and offer certain kinds of support. Besides, when the need arises, you often rely on other health care networks, for instance physiotherapists in order to strengthen the muscles before an operation. You also offer support to some patients who need help after surgery. Basically, you have taken measures to help patients recover more quickly.

You said that the costs had been cut by 10%. There are many phases of health care that come before and after surgery. With regard to home care, did you have to transfer funds to certain sectors or did you keep more or less the same budget for the hospitalization procedure?

[*English*]

Dr. Cyril Frank: Thank you for the question.

We actually saved money in acute care by decreasing lengths of stay, and some of the in-hospital costs and spending more money at the front end in terms of optimizing patients, educating them, and preparing them for surgery. The case costs were about the same per case across the continuum, from time of presenting with hip and knee replacement all the way through, including rehabilitation and home care costs. That's what we call the case cost. I said that I think we could, over the next year, save 10% per case with a focus on saving costs.

We were trying to optimize the experience—improve the efficiency and quality of care—as our top priority. We believe it is still the top priority. If we carefully look at saving money, where across the continuum could we save and then invest in maintaining a high-quality experience? We believe that the saving could then drive increased volume for the same envelope of funding.

● (1215)

[*Translation*]

Ms. Christiane Gagnon: I also want to know whether any patients had been pressured in any way to assume costs that would normally have been paid by the health network. Some patients even had to assume costs in order to become more eligible for surgery or to qualify for follow-up after surgery.

Now you said that you are in charge of all the steps preceding surgery.

[*English*]

Dr. Cyril Frank: This was entirely publicly funded. There were no incremental costs beyond the normal system of care; there were no incremental costs. This was entirely covered by the new funding I mentioned.

I believe there is some limit on the number of physiotherapy visits that people get post-operatively; they may have to pay a small amount, but I actually don't think it's an issue for these people, who recover quite quickly.

[*Translation*]

Ms. Christiane Gagnon: For example, there are vulnerable persons who cannot necessarily afford a follow-up on top of a preparation process and who could find it difficult to follow your program. Some kinds of health care may not be provided for by drug coverage or, in Quebec, by the Régie de l'assurance-maladie. In any case, I was talking about the prevailing situation in your province.

[*English*]

Dr. Cyril Frank: In Alberta, everything was covered. There were no incremental costs beyond the normal health care system. And patients were randomized into the system, so that in fact two-thirds of the people we treated were in the low socio-economic group, and their cost of care was entirely covered.

The Chair: Thank you very much for the questions, Madame Gagnon. Your time has expired.

Mr. Fletcher has a quick statement, and then we'll have the rest of the time for Ms. Davidson.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Mr. Chair.

I just want to say to the panel, thank you very much for your presentation today. The Government of Canada is looking at each of your activities closely, and we look forward to using your ideas and innovations to help us meet our wait time guarantee.

I'm yielding the rest of my time to Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you.

First of all, thank you to our panel.

It's difficult to understand how we can have a problem with our health care system after listening to you four gentlemen. I think there are some very innovative solutions out there, and each of you in your own area has worked towards making them successful.

My first question is to Dr. Reed. I found it alarming to hear your statistics on the number of radiologists we have today. I think you said in 2004 we were 500 radiologists short, and over the next six years our number of tests is going to be increasing 30%, but our number of radiologists is only going to be increasing 5%. Is that correct?

Dr. Martin Reed: Less than 5%.

Mrs. Patricia Davidson: So those figures are certainly very alarming, and I think we all, in our own communities, have seen that trend building over the last few years.

I found this guideline project that you chair extremely interesting, to listen to you speak of that.

The 10% of unnecessary procedures could even be low, I would think.

● (1220)

Dr. Martin Reed: Yes.

Mrs. Patricia Davidson: Many years ago I was an X-ray technician, and I would say that at that time over 10% were unnecessary, and I think that trend has only increased.

These guidelines that you have embraced are certainly intriguing. Did they go to each family physician, or to each physician? How did you distribute those, and are they only guidelines? I guess guidelines are guidelines and don't carry a whole lot of weight. So that's one question.

Second, could you talk a little bit more about your pilot project?

Third and last, is there a parallel education program for the public? I firmly believe a huge part of our problem is public expectation and what they feel they are entitled to.

Could you answer those questions for me?

Dr. Martin Reed: On your first question, I would agree with you. We feel that 10% is a low estimate of the number of unnecessary examinations that are done, so we're certainly hoping there will be an even greater reduction in the number of diagnostic imaging studies when the guidelines are widely circulated.

The CAR itself has distributed electronic versions of these guidelines to all the medical schools, all provincial radiology societies, and I believe all provincial colleges of physicians and surgeons.

We've also, through the national specialty societies, distributed versions to all the specialty societies in Canada. We feel this is very important, because these guidelines will only work if we have the support of the specialty societies.

We've also provided them to the College of Family Physicians of Canada and have their support. We've distributed them at some meetings—a national internal medicine meeting, for instance.

We have made them available for sale, so various people have purchased them for distribution. I have to say, we're not sure where they have all gone, but those are the methods we've used to distribute them currently.

You were asking about the demonstration project. I'm assuming you're talking about the project in my hospital.

Mrs. Patricia Davidson: Yes, it was at the Winnipeg Children's Hospital.

Dr. Martin Reed: We are initially starting with four sites in Children's Hospital where there are physicians or pediatricians who are very keen on using these guidelines. We'll implement them there. We will make sure that all the bugs are out of the system, that the software is working the way it should, and that the clinicians are happy with using the software. Then we hope to spread it throughout the hospital, so that by this fall, all the diagnostic imaging studies ordered in the hospital will be ordered through Percipio. In that way, we can collect quantitative data on who is using the guidelines. If physicians get a guideline, get a suggestion, do they follow it? That kind of data will let us know how we need to change the guidelines or change physicians' behaviour.

It is the same situation everybody has been talking about. We need hard data.

There is also a clinic of pediatricians, the biggest pediatric private group in Winnipeg, that wants to use this software, and we hope to implement it there too in the fall. This project will last about a year. We hope to collect about a year's data, then analyze it and report on it.

The Chair: Our time is gone, actually. We may get back to that subject as well, but thank you.

Ms. Keeper, you have five minutes.

Ms. Tina Keeper (Churchill, Lib.): Thank you very much.

I would like to ask Dr. Lewanczuk a question.

I was really interested in this restructuring you're talking about. I represent a riding with a large aboriginal population, and I have 33 first nations in my riding. We actually have a backgrounder here from AFN on the health crisis. Of course, diabetes is a chronic issue in our community.

One of the interesting comments you made was that you're responsible for patients who are not showing up for appointments, that you need to treat disease and risk in the community. Can you share with us how you approach that? How do you work with those patients or doctors, and what is the impact?

● (1225)

Dr. Richard Lewanczuk: We do it in a number of ways. Would you like me to comment on some first nations issues while we are on that? We have some specific strategies there as well, and we have done considerable work.

One way we do that is by knowing all the people in our jurisdiction who have diabetes or a particular chronic disease. We do this in the capital region. We basically, electronically, know who everyone is, and all their information is accessible. If we do that, and by interacting with the family physicians' electronic records, and by using strategies.... For example, we know that people who have diabetes must have a high blood sugar record somewhere in the laboratory that would be available electronically. So if we search through the laboratory, we can pick out all the people with diabetes. In fact, that is what we have been doing through the Canada Health Infoway project.

Because we have this integrated electronic system, we can then see that these people have diabetes. Have they visited a physician in the last year? Have they had the yearly urine test? If they haven't, we can remind them. We find that it is most beneficial and works best if we remind patients. We remind them by letter. If they don't respond after three letters, we can give them a phone call. And we have a community team that will even go knock on the door.

We use other strategies. Some of our community health nurses go to seniors' centres—there are about 47 of them in our region. They are there ostensibly to measure blood pressure and check blood glucose, but what they are really there for is to ask, while they're doing that, if there is anybody in the building or the centre who might be ill and who has not seen a doctor. We actually try to ferret out the patients.

We use community resources as well. Particularly with first nations, we rely, in the case of diabetes, for example, on people with diabetes serving as mentors to newly diagnosed patients. I have gone out on many trips. They will say that so-and-so is at home and has a problem with his foot. He has an ulcer on his foot. We will actually go out to the home and see him.

We really use the community and try to develop community spirit. We have various programs that develop patient empowerment, that get the communities empowered to look after each other. So there is a host of strategies we use to engage the public to pick out the people who don't go to physicians regularly.

In the inner city, we offer free lunch. Patients come in for the free lunch, and we capture them there for health care reasons.

Ms. Tina Keeper: Are there any problems with jurisdictional issues or privacy issues related to jurisdiction?

Dr. Richard Lewanczuk: That question commonly comes up, and we ask it ourselves. But when the providers get together and we ask the question of each other, we haven't been running across any.

One of the strategies and techniques we use is we point out to the patient that this information is available, but here's the benefit. It means that if you're hit by a bus and you show up in emergency, we know everything about you. We know your allergies. We know what medication you're on. We can be a bit proactive; we can help you.

So we work with the patient. We tell them right up front what we're doing. They have the option of opting out of some of these systems, and amazingly, when they realize the benefits, patients are very engaged.

The Chair: Thank you very much.

Mr. Batters.

Mr. Dave Batters (Palliser, CPC): Thank you very much to each of you for coming before this committee. I think I join the other members in saying that it's clear you've done some great work on this in your respective fields and hospitals and areas of influence. You're to be commended for that, and certainly this committee and this Parliament can learn a lot from you.

First of all, we know this issue is extremely important to Canadians. It's extremely important to the Government of Canada. As all of us in this room and most of the Canadian public know, it's one of the five priorities identified by the government to have this health care wait time guarantee for patients.

I come from Saskatchewan, where under the provincial NDP government we have the longest wait times in the country for diagnostic and surgical procedures. My time doesn't permit me to get into examples of that. I want to talk a little about general practitioners and the shortage of GPs in this country.

Dr. Lewanczuk, you talked about one of the strategies that you've employed being to empower general practitioners. I wonder if you could comment quickly—and it's certainly not just limited to Dr. Lewanczuk—on the shortage of GPs, how best to address that problem.

Many GPs in this country are not taking new patients. At least that's the case in my home city of Regina, where it can be difficult to find a general practitioner taking new patients. Often you have to go to medi-centres and seek care in those venues. How best can we address this problem?

And this is one I'm sure you'll want to comment on. Is there a problem with how we pay doctors in Canada? There's clearly an incentive for the quantity of patients that our GPs can see. It's obvious, when you go to the doctor's office. I have the utmost respect for our general practitioners, but the reality is that there are significant incentives to see 60 patients a day as opposed to 35. You see the signs up in the doctor's office: “One complaint only”. Hence, our wait times. It's no surprise that the same patient is back a week from then, because they've got only one complaint out and they had six.

I wonder if you could talk a little bit about the shortage of GPs, the difficulty getting in to see your GP. You're talking about empowering them. You talked about GPs doing diabetes education, for example. That probably takes an hour a patient.

How do you complete that circle?

● (1230)

Dr. Richard Lewanczuk: I will give you a short answer to a long problem.

One of the difficulties, as mentioned, is that we provide no resources to our family doctors. We like to beat up on them, and often as specialists we tell them, you're doing a poor job, look at the poor levels of blood pressure control, the poor levels of diabetes control, and yet we do nothing to help them.

Some of the primary care reform strategies...for example, now in Alberta the primary care reform strategy is having family physicians get together in groups in what are known as primary care networks, and they're provided with extra funding to hire nurses, pharmacists, and other health care professionals to help them, and so now they don't have to personally deliver the diabetes education. A nurse may help them. A nurse may get the height, weight, the blood pressure, do the initial screening for the family physician.

We've done a tour around the world to see how it's done in other countries. New Zealand uses this model very effectively, for example. Over time we've put our resources into the acute care hospital specialist-based system, and so now the patients, as has been mentioned earlier, expect that they need to see the specialist and at the cocktail party it's, I see an internist for my thyroid, or, I see an endocrinologist. But what about the family doctor?

So we provide this expectation, and in fact the family doctors can do a lot with help from the specialists. In fact, the specialist is somebody the family doctor should use as a tool. We should be there to support the family doctors with advice and in multiple other ways. So we have to elevate the status of the family physician.

The remuneration model, you're right, is not aligned with the behaviour that we want. It does force high volumes of patients through. If we get another health care worker and they do some of the work, the family physician under the current funding models across Canada usually doesn't get paid for that. So alternate funding mechanisms are another mechanism.

In terms of this emphasis on the acute care system, in one university of Canada that I'm aware of, in the last two years not one family medicine graduate has set up a family medicine practice, because they can get paid more money by working as a hospitalist, with no overhead, and at 5 o'clock they're done. And so again it's not only the method but the magnitude of the remuneration for family physicians. We've put them at the bottom of the heap in terms of respect and resources, and we need to turn the pyramid upside down.

The Chair: Maybe we'll get another round.

Madame Demers.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): Thank you, Mr. Chairman.

I would like to congratulate you, ladies and gentlemen, for all the work you have done up to now.

Dr. Reed, I appreciated your straightforwardness when you mentioned that we did not have enough radiologists. You are right.

Dr. Frank, at the outset, when you began to describe your success, I thought that you had found another use for petroleum. I thought that knee and hip replacements were perhaps made from oil, because you and your team have done some outstanding work. I thank you for it.

However, with good ideas like those, if you can accomplish the feat of reducing wait times from 47 weeks to 4.7 weeks, has anyone thought of sharing this information with our colleagues in the other provinces? Has anyone thought of sending this information out so that it can be used by other physicians in other places? This is very important.

● (1235)

[*English*]

Dr. Cyril Frank: Yes. I believe this method is transferable, but I want to emphasize that we haven't even transferred it to all the surgeons in the province of Alberta yet. It was a pilot that started with 13 surgeons that achieved those results, and there are a number more who we're engaging now. We would like to meet that standard for all of them over the next 12 to 18 months.

And we are talking about this with our colleagues across the country. At the Canadian Orthopaedic Association meeting starting on Friday, there is a working group talking about best practices in hip and knee replacement access, so we are discussing this with all of our colleagues.

[*Translation*]

Ms. Nicole Demers: Thank you very much, Dr. Frank.

Dr. Reed, I have one specific concern. There are many women who received silicon gel breast implants and who have to have them removed. However, they must undergo an MRI scan in order to detect the problem. I know that there is not much equipment in Canada and in Quebec for detecting leaks, breaks, and other problems with breast implants. I also know that very few radiologists have been trained in this kind of diagnosis.

Could you tell me how many there are? Could you tell me how many pieces of specialized apparatus and equipment have been designed specifically for this kind of diagnosis? I think that in English they call this core MRI equipment.

[*English*]

Dr. Martin Reed: I'm sorry. I'm a pediatric radiologist, and you're going out of my area of expertise, so I'm afraid I can't answer that question. I'm sure that we could answer it through the CAR, but I can't answer it personally at this time.

[*Translation*]

Ms. Nicole Demers: Could you get the information and send it to the health committee through the Canadian Association of Radiologists?

Dr. Martin Reed: Yes, I can try.

Ms. Nicole Demers: Thank you very much, Dr. Reed.

[*English*]

The Chair: Thank you, Madame Demers.

Madame Demers is quite passionate about this issue. We have another session—I think it's next week—on this, so that will be valuable information for us.

Mr. Epp, go ahead, please.

Mr. Ken Epp (Edmonton—Sherwood Park, CPC): Thank you very much.

Thank you so much for coming here and telling us of your successes. If we could just spread that across the country, the problem would be solved, right? Everybody smiles.

I would like to ask a question of Ms. Estey. She's the director of the regional diabetes program in Edmonton. She's come all the way to Ottawa from there, and I'd like to give her the opportunity to tell us briefly what her group is doing in order to give timely and rapid access to people who are suffering from diabetes.

Go ahead.

Ms. Angela Estey (Director, Regional Diabetes Program, Capital Health): Thank you for the opportunity, and thank you to the larger committee for the opportunity to be here.

Dr. Lewanczuk has highlighted a number of different types of initiatives that we've put in place that deal with, first of all, understanding what the problems and the needs of people are, and then with trying to make sure there is timely access to care, whether that be a simple call from a nurse or a dietician to ask people how they're making out, or whether it be attending a formal group education program.

There are a number of things. One is a central access system. There's a phone line that patients can call. It's widely advertised. People know how to access our team at any time. We have leveraged off some of the successes of Health Link Alberta, which is a provincial nurse call centre where our diabetes educators have spent some time training some of the nurses who are available 24/7 to help patients.

We know that people get into trouble at all times of the day and night. Quite often diabetes centres work eight to four, typically, Monday to Friday. So having this available 24/7, 365 days of the year, as somewhere people can get that kind of personal contact, is great. We have information available on websites that people can go into. We're actually now exploring some e-health technology as a way to customize information and have more virtual contacts and connections with people. Giving people lots of different options as opposed to the old traditional approach of, “Here's your brochure, and here's your program to take”, certainly, I think, has helped with access.

As Dr. Lewanczuk mentioned, we monitor all the time. As soon as we see pressure starting to build, we learn about the population, what works with them, and what's been successful, not just for diabetes but for other jurisdictions, and we see how they've dealt with the needs of these patients. One of the examples is the Northeast Community Health Centre, into which we've gone and provided free lunch. What a great way to get to know not only the people who attend but their friends who might have diabetes. We link with running rooms. We link with community agencies to deliver lots of lifestyle education programs. Partnerships have also been really important and have helped us to identify other people in need.

There are lots of different innovations. We're trying to not be static. We want to be responsive, so our people are out in the communities trying to learn how best to meet the needs of our patients.

● (1240)

Mr. Ken Epp: It's my understanding, from what little I know of diabetes, that down the road diabetes will put great pressure on our health care system. In other words, the consequences of having an untreated situation will escalate the demand on our health care system.

Is it your experience and your view that one of the things you are doing to reduce the pressure on our health care system and thereby, in general, reduce wait times is to give earlier diagnosis and better care?

Ms. Angela Estey: Yes. We really believe that the healthier people are and the more that's done upfront for them, the less strain there will be on our system. We need to find the people, connect with them, and then monitor them on an ongoing basis. We don't just provide one-time intervention. We want to hang on to them. We want to see how they're doing. We send the reminder letters. We look at their labs, virtually; and if we start to see trends of blood sugars creeping up, we don't wait until they show up in crisis. We're on the phone with them, and again we are providing the support to the primary care teams that are seeing them on an ongoing basis.

So yes, we're doing a lot more upstream.

Mr. Ken Epp: Obviously you are on the cutting edge here of a new approach, which is very encouraging, and I'm glad it comes from Alberta and from the city that I represent.

What I would like to know now is whether you are working together with other provinces, with other areas, in order to help get this system out there, so that there are more people involved and so that we get a national result from the work you're doing.

Ms. Angela Estey: Yes, definitely.

I'm not sure you are familiar with the chronic care model, and we could certainly provide some background on it, but most jurisdictions in Canada are now using this model. There are some common themes through this model around community partnerships, decision support tools—IT, things like that—so when we start attending conferences we're all talking the same language. There are great opportunities to share when we're all seeing things the same way. So yes, that is happening.

We are working very closely with the other health regions in our provinces, and as Richard mentioned, we have been doing a lot of touring around to try to share our learning and to learn from other experts.

The Chair: Thank you very much.

Before we start into the second round, perhaps the committee will allow me to get a little bit of clarification from Dr. Frank's presentation.

There was $20 million in a pilot project. Can you tell us where that money was spent? I understand there were no new doctors and no new nurses, so can you tell the committee where that money actually went?

Dr. Cyril Frank: Sure.

The money was divided between the three health regions that participated in the project: Edmonton, Calgary, and Red Deer. Each received a proportionate amount to deliver 1,200 new joint replacements. They were to be delivered in the way that the region and its physicians thought was best for the resources and infrastructure they had.

Calgary contracted out with a private facility to provide the care in a private facility, with people who were hired by that facility to provide the care. Edmonton and Red Deer seconded staff who were dedicated to this purpose and seconded operating rooms for the purpose of delivering their portion of the 1,200, which was 500 in Edmonton, 500 in Calgary and 200 in Red Deer. The funding went to the case costs through the local cooperative between the region and the physicians in that region, to provide the care across the continuum. The funding went into a case cost per patient that the region managed and gave to the collective.

● (1245)

The Chair: Is it accurate to say that the case costs would have been there anyway and this was just accelerated? The case costs would have been there at any rate. I'm just trying to get a handle on it. Was it an extra $20 million provided or would the system have been tabbed with the $20 million, even if the time had been extended?

That is the nuts and bolts of my question.

Dr. Cyril Frank: This was $20 million new money that the province dedicated for this purpose, over and above the existing health region budget.

The Chair: You said it went into each specific case, probably for the knees and the hips and so on. Would that money have been spent, regardless of whether the project had been in place or not?

Dr. Cyril Frank: It could have been done without the incremental funding, but to be honest, receiving the incremental funding provided an incentive to the regions to commit time and resources to make this happen.

The Chair: There were no new doctors.

Dr. Cyril Frank: No, these were the same doctors and the same nurses.

The Chair: Fair enough. I think that clears it up.

We will have one quick question from Ken, then we'll go to Mr. Batters for the second round.

Mr. Ken Epp: This is just a short intervention.

The major part of that cost was the cost of the prosthesis itself, wasn't it?

Dr. Cyril Frank: Well, we're collecting accurate case costs, actually, and the prosthesis cost is about one-quarter of the case cost.

The Chair: That will come in your report that we'll be waiting for.

Mr. Batters, you have a few minutes.

Mr. Dave Batters: Yes, unless Ms. Brown has something first.

The Chair: Do you want to go ahead? It doesn't matter. We're going to get you both in anyway, so it doesn't make any difference.

Ms. Brown, then.

Ms. Bonnie Brown: I'm impressed with how much has happened around cleaning up the queue. Eliminating 15% of the wait list in one case and 33% of the referral list is pretty impressive, I would think, even from the point of view of the morale of the surgeon receiving the referral, to know that not all those people were waiting.

I was wondering who did all this phoning to find out if these people were still at the phone numbers and addresses, etc. Did you hire some people to reorganize the wait list by phoning and contacting people?

Dr. Cyril Frank: The institute did the entire evaluation of this whole process, and the institute is a separate philanthropic body that writes grants to get the money to do this work.

Ms. Bonnie Brown: Did you hire nurses? Would they have nurses, or could it have been almost anybody? I mean, surely anybody could have found out that patient X doesn't live at that address or answer that phone anymore.

Dr. Cyril Frank: One of the keys was that we had to become an affiliate of all the custodians of the information in order to give the institute permission to contact people on behalf of the physicians. Not just anybody can call. These are designates of the physicians calling patients, and they work for the institute at the discretion of the physician.

Ms. Bonnie Brown: Yes. But are you saying that the physicians suggested the person who would work for the institute, or did the institute hire its own staff?

Dr. Cyril Frank: Yes, the institute has its own staff of research associates, some of whom are nurses and physiotherapists who were doing this calling.

Ms. Bonnie Brown: Some of whom are not.

Dr. Cyril Frank: Yes.

Ms. Bonnie Brown: Yes. It would seem to me that it be would another way to save money if we could get people who weren't particularly medically qualified to simply track some of this stuff.

● (1250)

Dr. Cyril Frank: Absolutely. This was the recurring theme that we heard in all the presentations. I think Dr. Lewanczuk emphasized teams to better help and support resource physicians, in both primary care and speciality care, with lower-cost people doing a lot of the work.

Ms. Bonnie Brown: Exactly. Something that should be tracked is exactly how highly priced the help was for each task and whether they were able to sufficiently accomplish it.

There's another thing that I was wondering about. With the incentive of $20 million, it was probably fairly easy to recruit these surgeons. They would know that they'd have all this support and this goal. Any kind of project often gets better results because people are motivated.

Has anybody tracked the impact on the salaries of those participating surgeons? In other words, were they able to perform more surgeries because some of the preliminary work had been done by somebody else and their salaries therefore went up? Did it go down because they were so involved with the patients or something?

Dr. Cyril Frank: I don't have accurate numbers, but anecdotally, yes, they made more money. They had an incentive to do this, because they certainly had the time available to do it.

We're also tracking to see what impact it's had on the rest of their practice to make sure that no one else is at a disadvantage in the process of focusing on hips and knees.

I have to say that they've all become advocates of this, not only because they had more volume, but because it's better. They're now selling it to their colleagues and in fact saying that they've got to do this central triage approach with the teams because it's better for the patients. They become the advocates for others, who admittedly see that they can make more money with the current compensation system, which still has a volume incentive. But the case rate actually gives us the ability to give them an incentive across the continuum for access, quality, and cost-effectiveness, as opposed to only volume.

Ms. Bonnie Brown: I understand. I think Dr. Lewanczuk probably had the same experience. In fact, if he's only going to take 15 minutes to see a patient as opposed to the 45 minutes he used to take, he could see three patients in those 45 minutes.

Have you been tracking the impact on salaries?

Dr. Richard Lewanczuk: Absolutely. One of my other roles was chairing our alternate funding planning committee at the University of Alberta.

It's worked in a number of ways. If we had methods such as electronic medical records, as you point out, then we wouldn't put the specialists at a disadvantage. Organizing who we saw was one of the difficulties in the diabetes area. The specialists were now seeing more complicated patients who took longer to see, but the remuneration was exactly the same. Their incomes went down by about 25%, until we started to bring in other ways to boost that.

Ms. Bonnie Brown: I understand.

The Chair: Mr. Batters, you have one last round. We'll then have five minutes for some final business of the committee.

Mr. Dave Batters: Thank you very much, Mr. Chair.

Everyone has talked a lot about the importance of primary prevention, and I'm certainly a believer in it. You refer to it as “upstream patients”. I've never heard that expression; I like it.

Clearly it's very important to have good patient education. Also, in keeping with treatment guidelines, the role of pharmacology is extremely important in primary prevention. I'd ask Dr. Lewanczuk, Dr. Glasgow, and Ms. Estey to comment, please. I'd like your opinion on three different questions.

To the gentlemen, I address you because I'd like you to comment on the effect on wait lists that pharmaceuticals can have. Specifically, I'm thinking of surgical wait lists, dialysis, and drugs like statins or ACE inhibitors. I'd like to know your opinion on the effect of wait lists and the effect pharmaceuticals can have on a patient's quality of life. Third—and this gets to a broader question—we're always looking at finite resources and infinite demand in health care. I'd like your opinion on whether these drug classes I've mentioned, or similar drugs, represent a net cost or a net savings to our health care system when you consider what the impact may be on dialysis, or surgery, or time in hospital.

I'd like to get you to comment on these. They're pretty big questions; I recognize that.

Dr. Richard Lewanczuk: Our various professional bodies go through the evidence, and that's how we come up with the guidelines on the use of pharmaceutical agents. Obviously, if they've been recommended, they must have benefit. Other people—the health economists—will then come to do the various cost utility and cost-effectiveness studies.

I did a similar presentation to your provincial government not that long ago. We have good data from Saskatchewan, and we know that for many of the chronic conditions we could prevent through the use of effective pharmaceutical therapy, patients have difficulty in adherence. Of course, some of it may be cost-related, but some of it's just behavioural issues.

For example, we know that 60% to 70% stop taking their cholesterol-lowering medication. We might as well not have prescribed it; it's wasted money to our system. If it hasn't done anything, or if they stopped taking it, they then represent wasted lives or wasted opportunity to our system. If we had ways, through all the various strategies, to ensure and facilitate adherence, it would certainly translate into a benefit from a medical perspective.

● (1255)

The Chair: I'll ask Dr. Glasgow to comment as well.

Dr. Kevin Glasgow: Thank you.

I welcome that question, as a former medical officer of health and a public health physician and family physician by background. I'll comment briefly on the drugs. I want to get back to the concept of primary prevention.

Yes, it is important—I'll echo those comments—for care pathways that the appropriate patients be put on the appropriate medications to prevent disease from happening, and then after disease. There are care protocols. The Institute for Clinical Evaluative Sciences in Ontario has put forward on their website a number of care pathways in the cardiology field.

Let me get back to the concept of primary prevention—the upstream. It is very important to decrease intake, because once we have a wait list for a procedure, it's too late. Some of these things clearly could have been prevented. What I'm talking about is healthy public policy. I'm talking about federal and provincial anti-smoking legislation; that is going to decrease intake. Over time you'll have seen tremendous changes in the incidence of certain diseases, with healthy public policy such as this.

Cardiovascular disease—heart problems, head problems, strokes—still remains the number one cause of morbidity and mortality in our society. One third of us are going to die from a heart problem, a stroke problem, or cardiovascular disease. What we're seeing is the fall-out of some bad eating practices, lack of activity, and smoking practices. As we decrease that, people will live longer. The whole concept of primary prevention is very important.

In Ontario, CCN is partnered with the Heart and Stroke Foundation of Ontario. Last week we had a cardiovascular summit, and it really is to connect primary prevention to treatment, to secondary prevention, rehabilitation, palliation; to look at the continuum of care approach that's been here. Addressing things in isolation is still a silo approach; you need to look at the full spectrum.

In Ontario we have a cancer strategy and we have a stroke strategy, but we do not yet have a cardiac or cardiovascular strategy. We will be making recommendations to the two Ontario ministries of health—Ministry of Health Promotion, and Ministry of Health and Long-Term Care—and to the 14 local health integration networks in the near future.

Primary prevention cannot be neglected. Like family physicians... and I'm one. I still see patients every second Friday; I cover for my family doctors. I see the patients who can't get in to other family doctors and who rely on just a cookie-cutter approach. The reality is that prevention has to be raised in profile and in emphasis as well—a comprehensive solution.

That was my concluding comment: don't look at acute care in isolation; it needs to be connected for a comprehensive solution.

Thank you.

The Chair: Thank you very much.

That takes us to the end, but I'll add one last thing about Dr. Frank's study and pilot project. I have a very close friend who was diagnosed with a hip problem just before Christmas. This young man's doctor got him in for surgery on January 31, but he couldn't make it because he couldn't clear his schedule in time to make the surgery. He had to put it back a couple of weeks. That's how successful it is.

I applaud all of you for your examples. You've given us a lot of hope for our system, because really it's not sustainable the way it's going. We need this kind of innovative thought process to be able to sustain our system.

We want to thank you for coming and for sharing with the committee today.

Just before we clear out, we have one quick motion so that we can pay these gentlemen.

Madam Brown.

Ms. Bonnie Brown: This is to allow the money we need to run the committee. A series of these motions will come forward.

I move, Mr. Chairman, that the proposed budget in the amount of $11,900 for the study on health care wait times be adopted.

(Motion agreed to)

The Chair: Boy, they're feeling better already.

Thank you very much. This meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

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