hfma briefing

Contributing to the debate on NHS finance
December 2011

Study tour: Canada

The HFMA and ACCA have joined forces again to learn best practice lessons from healthcare systems abroad – this time in Canada

Foreword

The NHS is confronted with a period of unprecedented financial and clinical challenges, but it is not alone. Over the developed world, healthcare systems face similar issues, such as ageing populations and technological developments. The HFMA recognises this and is keen to understand how other systems are tackling common issues.

With groups having already visited the United States and Australia, this briefing focuses on Canada. The Canadian health service is often likened to our own NHS – it is largely publicly funded, provides care on the basis of need and is free at the point of delivery. And just as we have four national systems in the UK, in Canada there are 13 – 10 provincial and three territorial governments responsible for administering and delivering healthcare.

While the health service in England gained substantial growth in resources in the early years of this century, in 2004 the Canadian federal government agreed to raise its healthcare funding by 6% for 10 years (federal funding makes up about 25% of local funding, though this varies across the provinces/ territories).

In the 1990s it introduced cost-cutting measures – made famous by the demolition of Calgary General Hospital in 1998, which was covered around the world (and can still be seen on YouTube).

There are also key differences between Canada's Medicare and the NHS, particularly in England. Canadian hospitals are paid by block contract, though some local governments are starting activity-based funding in a limited way. In contrast to the UK, most doctors, including those based in hospitals, are in private practice and paid on a fee-for-service basis.

Spending on healthcare is higher in Canada, due in part to the higher levels of co-payment and private health insurance. Canada is largely insulated from the global economic crisis as it did not deregulate its financial institutions, but its health service continues to seek out cost savings. The detailed challenges and the need for cost savings are the same.

Many programmes, such as virtual wards, reflect the QIPP (quality, innovation, productivity and prevention) initiatives in England's NHS that seek to improve the patient experience and find efficiencies.

The HFMA has a track record in looking to learn from global experience and this briefing contributes to the debate on the future of our own services.

Phil Taylor is the HFMA's international officer

ACCA

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Overview: Commonwealth gains

While Canada's health service appears similar to the NHS, there are significant differences, says Sharon Cannaby

It is often said that, of all the health systems around the world, it is the Canadian health system – known as Medicare – that most resembles the NHS. In some respects this is true: the Canadian health system is predominantly publicly funded, provides universal coverage for medically necessary care provided on the basis of need, and is free at the point of delivery. It is also hugely political and, like the NHS, also dynamic. Over the past 40 years, it has been through several reforms and reorganisations.

But scratch the surface and significant differences emerge. Perhaps the most noticeable is that Canada is not one health system but 13 different systems. Responsibility for the administration and delivery of all aspects of healthcare delivery does not rest with the federal government but with the 10 provincial and three territorial governments. This is a relic of the 1867 British North American Act, which assigned responsibility for establishing, managing and maintaining hospitals to the territories and provinces.

Each 'local' government has over time developed its unique organisational structure, operational processes and health strategy. So the Canadian health service is best described as 13 disparate, although interlocking, health systems.

The federal government's role in health is limited to three main areas:

- Setting priorities under the Canada Health Act, which details how the system is financed.
- Partial funding of health services
- Providing direct delivery of healthcare to specific groups of people, including serving members of the Canadian Forces, First Nations (Canada's non-Inuit or Métis indigenous population) and eligible veterans.

In contrast to this, the provincial and territorial governments' role is much broader and includes:

- Administering the health insurance plan
- Strategic planning
- Providing all physician, hospital and allied care
- Negotiating nurse salaries and physician fees
- Overseeing payments to hospitals
- Dealing with pharmacy companies
- Providing financial support to those on low incomes for health services not covered under Canada Health Act (such as prescription drugs)
- Public health.

Funding

Like the NHS, the Canadian health system is funded mostly through taxation. However, only about 25% of total public funding for the health service comes from the federal government. The balance is made up from taxes collected locally by the provincial and territorial governments. Health spending is further boosted by private spending (see figures 1 and 2).

The amount of funding to be transferred from the federal government to the provinces and territories was set out in the 2004 Health Care Accord. This was a 10-year agreement, so it injected some stability into the health system and helped support long-term planning. With the accord due to expire in 2014, there is much interest among policy makers on what will happen next.

The federal government allocates funding to each province and territory, subject to their health insurance plans meeting five criteria set out in the Canada Health Act:

- Comprehensiveness
- Universality
- Portability
- Accessibility
- Public administration.

For example, it sets out what has to be covered under 'insured services' and ensures residents moving from one territory to another remain covered for healthcare.

Mandatory financial penalties (dollar for dollar deductions) are levied for non-compliance in respect of extra-billing or user charges as these

FIGURE 1: HOW THE CANADIAN HEALTH SYSTEM IS FUNDED

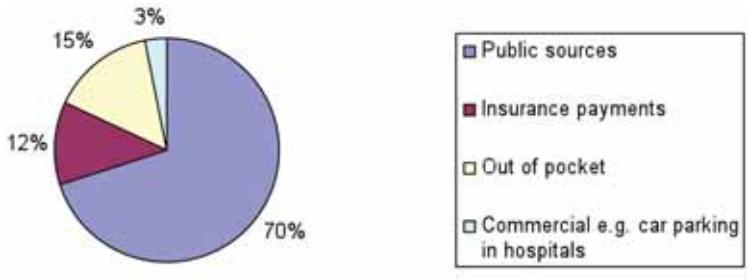


FIGURE 2: SPENDING BREAKDOWN

	Total spending on health (as % of gross domestic product)	General government spending on health (as % of total health spending)	Private insurance (as % of total health spending)	Out-of-pocket spending (as % of total health spending)	Other (as % of total health spending)
2006	10.0	69.8	12.4	15.0	2.8
2007	10.0	70.2	12.6	14.7	2.4
2008	10.3	70.5	12.7	14.6	2.2
2009	11.4	70.6	12.7	14.6	2.1

source: OECD

are seen as practices related to queue jumping and a two-tier health system. Discretionary penalties are applied for non-compliance in other cases, though in practice these are used only as a last resort.

Federal funding may be given conditionally or non-conditionally. Conditional funding is provided for the delivery of specific initiatives, such as the reduction of waiting times, while unconditional funding or equalisation payments are given to provinces with lower fiscal capacity – those below the national average in terms of ability to fund public programmes.

Despite the federal government having limited powers, healthcare remains a hugely political issue – gaining a particular prominence at election times. Responsibility for negotiating the federal funding agreement therefore rests with the first minister, not the health minister.

The Canada Health Act specifies the services that provinces and territories must provide free of charge in respect of hospital and physician care as part of their local health insurance plan. But funding of other services, such as prescription charges, ambulance and patient transport services, and cosmetic surgery, is left to local discretion.

The services provided will depend on local priorities, demographics and the remoteness of the population. Any services not covered must be paid for out of pocket or through private or employer-funded insurance schemes. This has resulted in significant variation as the amount invested in health is not consistent across the country. For example, Alberta invests more than C$1,000 more in health per head of population than British Columbia.

Hospital payments

There is no purchaser/provider split in Canada. Hospitals and other healthcare providers receive an annual budget that is negotiated locally. A small portion of this may be targeted at bringing down waiting lists, but the vast majority is paid as a block contract based on the previous year's budget.

The federal government has concerns that block contract payment systems encourage hospitals to focus on low-cost procedures to the detriment of waiting lists. To address this, some local governments are introducing snippets of activity-based funding.

In comparison to England, however, this is only on a limited scale. British Columbia, for example, has set itself a goal to pay just 20% of its budget through activity-based funding by 2012/13, with the intention of increasing overall volumes of activity in targeted areas.

Overall, there appears to be little appetite in Canada to move towards more detailed costing models. One health official told the study group: 'We have looked at patient-focused funding, but are not willing to go through such a high level of disruption as the UK has in moving to payments by results.'

Staff

The health industry is the third largest employer in Canada. With the exception of doctors or physicians, most health service staff are employees of an organisation and receive an annual salary.

Physicians generally work in private practice and are paid on a fee-per-service basis, a method sometimes thought to cause dysfunctional behaviour as it can encourage physicians to focus on high-volume work. Specialist physicians (equivalent to English hospital consultants) generally earn C$200,000-C$300,000 (£120,000-£180,000) per annum.

Family practitioners are also paid on a fee per service basis, but with earnings ranging from C$150,000 to

C$180,000 (£90,000-£110,000) their remuneration is less than specialist physicians. This pay discrepancy has tended to discourage doctors from specialising as family practitioners and has led to a shortage of these doctors in some of the more rural areas of the country.

Neither staff salaries nor physician fees are standardised across Canada. The fees are negotiated locally between the medical associations and the provincial and territorial governments. This can cause problems when clinical staff in one province receive higher payments than those in a neighbouring region. It also restricts the mobility of physicians who work in provinces, such as Alberta, that offer better rates of pay.

Salaries are higher in the United States and in the past this has resulted in a drain of Canadian physicians. However, interest in crossing the border appears to have declined in recent years.

Access to services

As in the UK, access to health services in Canada is through primary care. This is either through a family practitioner or, for anyone not registered with a practitioner, through a walk-in centre. Estimates on the number of Canadians registered with a family practitioner fluctuate widely, but official figures suggest that nearly 85% of the population have a regular doctor. Some provinces are considering an attachment scheme that would encourage or require residents to register with a family practitioner. But this does not appear to be a top priority and it seems unlikely to have any impact on accessibility of either hospital or specialist services.

Challenges

While UK and Canadian structures are different, it is not surprising that both countries face similar challenges in healthcare. Like the UK (and other health systems), Canada is looking to meet the rising costs associated with caring for an ageing population, to cope with increasing levels of chronic disease and to deliver new drugs and technology within tight resources. It must do this while maintaining and improving safety, quality and access levels. Both countries are tackling these challenges in similar ways, looking to move work from secondary to primary care settings, reducing lengths of stay, focusing on outcomes rather than throughput and, where politics allow it, reconfiguring services.

One challenge still facing Canada is reducing waiting times. While this appears to have been addressed in the UK, at least in recent years, in Canada it is not unusual for patients with non-life-threatening conditions to wait nine or more hours for treatment at a walk-in centre or emergency department. This is an issue of concern for policy makers and one they are trying to address through the introduction of targets. Alberta, for example, is working towards a target of 90% of accident and emergency patients to be seen within four hours by 2014. Waiting lists for treatment can also be very long.

PROVINCIAL THINKING

Ontario

Since 2007 Ontario, the largest province by population (13 million), has managed its health services through a series of 14 local health integration networks (LHINs), *writes Mark Millar*. These are not-for-profit crown agencies that report to the provincial minister of health and long-term care. LHINs have accountability agreements with healthcare providers, each of which has its own board to ensure local accountability.

Among their responsibilities, LHINs must 'facilitate effective and efficient integration of healthcare services in Ontario, making it a system that is patient focused, results driven, integrated and sustainable'. Despite this mandate, the Toronto Central LHIN continues to spend more than 75% of its budget on hospital services. Funding is based on an historical global allocation for a basket of services to be delivered to patients. This allocation shifts each year due to:

- Inflation adjustments
- Agreed increased volumes for priority services
- Required efficiency savings
- Extraordinary pressures
- Specialised programmes (such as First Nations).

Delivery is through a mixture of public and private providers.

Alberta

A smaller concern than Ontario, with a population of 3.7 million, Alberta has moved from a system of 19 health boards in 1995, to 11 in 2004, and then to the formation of a single agency – Alberta Health Services (AHS) – in 2008. Recently AHS has organised its delivery mechanisms into five zones. A matrix management system works at executive director level, with individuals having responsibility for both corporate and local services.

Alberta operates a centrally controlled, fundamentally public delivery system with only some private sector community and long-term care, in contrast to the more mixed model found in

Although Canadian health authorities are responsible for managing waiting lists, it is the physicians who decide who to put on the list and when to put them on. The authorities cannot say with certainty how many patients are waiting for a particular procedure and how long they have been waiting, which can make service planning difficult.

Overall satisfaction with the Canadian system, however, is high. In a survey of 2,300 Canadian healthcare consumers, part of a study by Deloitte, 50% of respondents described their health system as excellent or very good and only 14% as poor (22% and 37% in US). And 41% thought Canada's system worked better than other countries' (24% in US).

More than a quarter of respondents cited issues with accessing services (28%) and more than half (57%) highlighted long waits. As in the UK, respondents expressed concern about the amount of waste in the system. But unlike the UK, this was not targeted at health service managers but at 'individuals not taking responsibility for their own health' (54%).

While the public funding of the UK's and Canada's systems inevitably draws comparisons, there are also key differences – Canadian provinces' and territories' lead role makes it one of the most decentralised countries in the OECD in terms of health policy and there are big differences in funding models. However, common challenges mean there are plenty of opportunities for both countries to import best practice solutions from across the Atlantic.

STUDY TOUR PARTICIPANTS

The joint HFMA/ACCA study tour was set up to enable UK delegates to explore how Canada's health service handles its financial challenges. Taking part in the tour were (pictured above, left to right):

- Mark Millar, Milton Keynes Hospital NHS Foundation Trust interim chief executive
- Paul Cummings, Northern Ireland Health and Social Care Board finance director
- Sharon Cannaby, ACCA head of health sector policy
- Phil Taylor, consultant, Phil Taylor Associates, and HFMA international officer.

This and other HFMA briefings, including reports from study tours to the USA and Australia, can be downloaded at www.hfma.org.uk/publications-and-guidance – follow links for HFMA briefings.

Ontario. Funding to individual providers is not dissimilar to Ontario, but perhaps less transparent. The economic conditions are easier in Alberta due to the significant oil and gas revenues the province receives, although to some extent this is taken into account in the level of federal support received.

British Columbia

With a population of 4.5 million, this province has one programme-based and five geographic health authorities (the former includes the cancer programme). These authorities are funded primarily through block contracts.

As with health services across Canada, British Columbia has been enjoying significant cash growth of 6% per annum over recent years, but recognises the need to 'bend the cost curve' (a widely used Canadian term meaning to trim spending to expected funding levels). While the authorities are following a number of initiatives familiar to NHS colleagues – moving care from secondary to community settings and reducing length of stay, for example – they are wary of the introduction of a tariff system, feeling it would be disruptive at this point.

Variation

The Canada Health Act, while enshrining universal pre-paid coverage, represents a minimum level of what has been agreed between provinces. There is a surprising level of freedom for each province/territory to act. One example is that the physician fee for service schedule is negotiated at province level, giving rise to a competitive tension between provinces, especially when training places were cut in some parts of Canada as part of the health economies in the 1990s. A further example would be the way that generic drug prices are negotiated at province level. It is easy to forget that despite their impressive geographical size, provinces are in most cases smaller than the 10 English strategic health authorities.

Funding focus

Phil Taylor examines the differences in the funding and performance of health services in Canada and the UK

The 2009 HFMA/ACCA study tour to Australia highlighted the use of co-payments. At the time, OECD figures showed the UK and Australia were spending similar amounts on healthcare – 8.4% of gross domestic product (GDP) in the UK compared with 8.7% in Australia. The big difference between the two countries was the proportion of healthcare spending funded by government – 87.3% in the UK as against 67.7% in Australia.

In Canada, a higher level of co-payment and private health cover support a higher overall level of spending on healthcare than in the UK. Figure 3 below shows health spending levels as a percentage of GDP for a selection of OECD countries and how they have changed over the past 10 years. The per capita spending figures are only illustrative as they are based on exchange rates at a point in time.

The statistics show a big change in the UK. In 2006 it spent 8.4% of GDP on healthcare. By 2009, this had increased to 9.8%. Over the past 10 years the UK has overtaken Spain, Australia and Italy in terms of the proportion of GDP devoted to healthcare. We now spend more than the OECD average.

The big change in these statistics was between 2008 and 2009. Most countries on the table increased the proportion of GDP on healthcare by 0.5%-1% from 2008 to 2009, with particularly big increases in the US (16.4% to 17.4%), Germany (10.7% to 11.6%) and Canada (10.3% to 11.4%). The UK also increased significantly from 8.8% to 9.8%. A large part of these increases is the result of low GDP growth rather than increases in healthcare spending. The recession has led to these increases in GDP share, as health spending continued to rise strongly but GDP began to fall in 2008 and 2009. The effect was particularly marked in the countries hit hardest by the global recession – in the Republic of Ireland, for example, the percentage of GDP devoted to healthcare rose from 7.7% in 2007 to 9.5% in 2009.

Looking at the comparison between the UK and Canada, it seems the period of unprecedented growth in healthcare funding in the UK in the early years of this century had some effect. Over this 10-year period, UK spending rose from 6.9% of GDP to 9.8%, an increase of 2.9%, and Canada's increased from 8.9% to 11.4%. While the gap is smaller, Canada ranks as sixth highest spender on healthcare in the OECD table of 34 countries, while the UK is 13th. It will be interesting to see how this changes given that Canada is not facing the same recessionary pressures as the UK and Eurozone. Increasing healthcare spend in Canada could also become a smaller percentage of an increasing GDP, while potentially level spend in the UK may become a higher percentage of a decreasing GDP.

The relatively good prospects for the Canadian economy compared with the UK are reflected in the financial outlook of the respective health services. But in all the areas we visited, there is concern about increasing levels of healthcare spending and concerted action to contain it. The requirement for efficiency gains is not at the levels we face in the UK. Annual absolute growth levels of funding in Canada are reducing from an average of around 6% over the past 10 years to 4.5% in some provinces. Annual efficiency programmes vary, but we did not hear of any above 1.5%.

Examining funding levels is interesting, but the important issue is how they affect the resources available to the two systems and their performance.

First, as was the case with Australia, the UK has more doctors and nurses – 2.7 practising physicians per 1,000 population, compared with 2.4 in Canada. While both well below the OECD average of 3.1, the number has been increasing rapidly in recent years. Possibly linked to the low numbers of physicians is the number of nurses per 1,000 population, which is higher than the OECD average of 8.4 in both countries – 9.7 in the UK and 9.4 in Canada.

In terms of hospital beds, both countries are way below the OECD average of 3.5 beds per 1,000 population. The UK has 2.7 and Canada only 1.8. In

FIGURE 3: HEALTH SPENDING AS % OF GDP

	1999	2004	2009	
	% health/GDP	% health/GDP	% health/GDP	£ per head
US	13.6	15.7	17.4	5,068
France	10.1	11.0	11.8	2,532
Germany	10.3	10.6	11.6	2,686
Canada	**8.9**	**9.8**	**11.4**	**2,778**
New Zealand	7.5	8.3	10.3	1,899
UK	**6.9**	**8.0**	**9.8**	**2,220**
ROI	6.1	7.6	9.5	2,407
Italy	7.8	8.7	9.5	1,997
Spain	7.3	8.2	9.5	1,953
Australia	7.8	8.5	8.7	2,193
OECD weighted average			*9.5*	*2,052*

source: OECD

both countries, the number of hospital beds per capita has fallen over recent years, in line with reducing length of stay and rises in day surgery rates.

Both countries are well below OECD averages in the availability of diagnostic technologies. The number of MRIs in the UK was 5.6 per million population, compared with 8 per million in Canada and an OECD average of 12. The number of CT scanners was 7.4 per million population in the UK compared with 14 in Canada and an OECD average of 22.

Canada also has a waiting time challenge. In December 2005, health ministers across Canada issued the following waiting time benchmarks:

- Hip and knee replacements: 26 weeks
- Surgical repair of hip fracture: 48 hours
- Cataract removal for high-risk patients: 16 weeks
- Cardiac bypass: 2-26 weeks depending on urgency
- Radiation therapy for cancer: 4 weeks

Achievement of the benchmarks averages around 80%, except for cardiac bypass and radiation therapy, which are 99% and 98% respectively.

Canadians' life expectancy is above the UK and the OECD average. In 2009, life expectancy at birth in the UK was 80.4 years and 80.7 years in Canada – higher than the OECD average of 79.5 years. These statistics paint a remarkably similar position across the two countries. Given that we both have systems where access is generally through primary care and is mostly free at the point of access for medically necessary treatments, this should not be a surprise.

Given current pressures on government spending in the UK, what can we learn from Canada on the contribution of non-government funding? Figure 4 (above) compares total spend with government spend on healthcare. The UK position stands out with around average levels of overall spend but the second highest proportion funded by government. The overall percentage of GDP spent on healthcare is 16% higher (1.6 percentage points) in Canada than in the UK, but the proportion of that funded by government is only 70.6% compared with 84.1% in the UK. So Canada can sustain higher levels of spending on healthcare while calling less on the public purse, by drawing more on alternative sources of funding.

The healthcare Canadians have to pay for varies across the provinces and territories, but usually includes prescription drugs, dental and optical care, medical equipment and appliances, independent

FIGURE 4: COMPARISON OF TOTAL SPEND WITH GOVERNMENT SPEND

	2009 total health spend		2009 govt health spend		
	GDP %	OECD rank	GDP %	% govt of total	% govt OECD rank
US	17.4	1	8.3	47.7	32
France	11.8	3	9.2	77.9	9
Germany	11.6	4	8.9	76.9	12
Canada	**11.4**	**6**	**8.0**	**70.6**	**19**
NZ	10.3	10	8.3	80.5	6
UK	**9.8**	**13**	**8.2**	**84.1**	**2**
ROI	9.5	17	7.1	75.0	14
Italy	9.5	19	7.4	77.9	9
Spain	9.5	18	7.0	73.6	15
Australia	8.7	23	5.9	68.0	21
OECD average	*9.5*				

source: OECD

FIGURE 5: CANADA – USE OF FUNDS

	% total health spending 2008	% public/ private	% private health ins	% out of pocket
Prescription drugs	13.6	46.2/53.8	67	33
Dental care	6.9	5.1/94.9	53.6	46.4
Vision care	2.3	7.5/92.5	20.5	79.5
Other health professionals	1.6	18.5/81.5	38.3	61.7
Nursing home services	9.9	73/27	na	100

source: OECD

living and the services of professionals such as podiatrists and chiropractors. The young, elderly and those on social assistance don't pay and many have private health insurance to cover the charges, either personally or through employment. The main items funded are set out in figure 5 (above).

In total about 30% of healthcare is privately funded, including 15% out of pocket and 12% from private health insurance. In the UK, 10.5% is out of pocket and the balance of 5.4% is private health cover and other minor sources. The question for us in the UK is whether extra investment in healthcare could be generated from non-government sources.

Canada and most of our European neighbour governments fund 70%-78% of healthcare spending, so UK government funding at 84% is clearly an outlier. Reducing the proportion of government funding from 84% to, say, 75% by increasing charges and co-payments, would generate in excess of £10bn. That would make a very big hole in the £20bn efficiency challenge.

To increase charges and co-payments clearly would be a bold move by any government. But to an extent it is already happening – from 2006 to 2009 the proportion of funding from government fell from 87.3% to 84.1%. Perhaps the real question is: 'How quickly will charges and co-payments increase?' rather than 'Will it happen at all?'.

The overall percentage of GDP spent on healthcare is 16% higher in Canada than in the UK

Controlling costs: bend in the road

Paul Cummings looks at the recent history of cost cutting in the Canadian health service – and its consequences

'Bending the cost curve' is a term you hear across Canada from members of the finance profession as they seek to curtail costs within expected funding levels. They, like us, have recognised that costs are likely to rise over the next three to five years at a rate they cannot afford. And that means they need to do something to bend the future expected cost curve to prevent a repeat of the deficits they experienced in the early 1990s.

But the size of their challenge is of a totally different magnitude. Canada has escaped the economic downturn largely because it did not de-regulate its banking sector. As a result the country still expects to see total income levels rise by 4% per annum over the next four years. The problem is that for the past four years it has averaged more than 6%, so, for Canada, bending the cost curve means living within that 4% growth level.

The Canadian system also has much longer funding plans in place. In 2004 the federal government agreed to increase its funding by 6% per annum for 10 years. That is two and a half parliamentary terms, regardless of which party wins. Federal funding is in the region of 25% of the state funding, dependent on the individual province (see figure 6).

Although we are starting from a different place and the size of the challenge is different, the agenda for Canada is the same as in the UK. Canada's plans read like any project developed under the QIPP (quality, innovation, productivity and prevention)programme. This is illustrated by British Columbia's masterplan, which seeks to:

- Reduce chronic disease
- Integrate primary and community care
- Improve quality and safety
- Implement Lean techniques
- Reduce drug costs
- Maximise e-health
- Consolidate administration services.

The focus of the work currently lies in controlling future labour costs; controlling the cost of pharma care; reviewing the medical service fee schedule; and consolidating diagnostic and laboratory services.

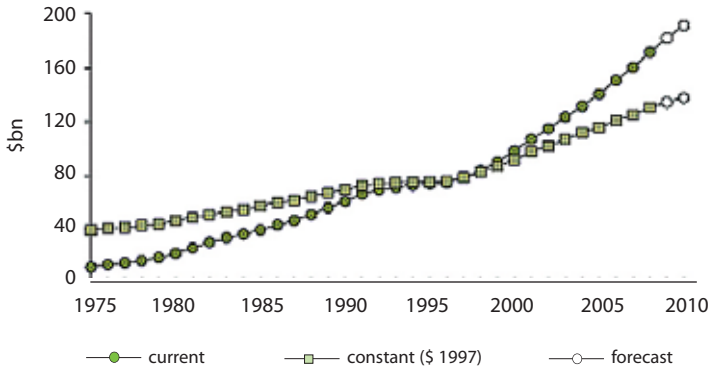
The figures contained in *Ideas and opportunities for bending the cost curve – advice to the Ontario government* (above) read just like the UK's benchmarking exercises. However, its targets are set at the Canadian average – it says Ontario could save C$2.2bn (£1.37bn) if it paid physicians at the Canadian average, while C$390m (£240m) could be saved from prescribing at the Canadian average.

The challenge they face is how to get there – and quickly. Reducing doctors' salaries in the past resulted in many doctors leaving to their near neighbour, the United States. So, while it is clear that a reduced physician cost base is needed, the task is not approached with confidence.

One of the main reasons we looked at the Canadian system was its reported success in cutting costs in the mid-1990s. The infamous demolition of the Calgary General in 1998, part of the cost-cutting exercise, received extensive coverage here in the UK.

Looking across the expenditure trends over the 1990s in each of the 13 health systems, it is clear there is a marked variation. Some show no change to the previous spending levels, yet others, such as Alberta and Quebec, show a marked downturn in expenditure over a three-year period. The difference is due to each province having a different budget deficit and a varying plan to tackle it. In Alberta the cuts were dramatic and drastic, including a 5% cut in the salaries of all staff. Staffing levels were reduced to

FIGURE 6: TOTAL HEALTH SPENDING, CANADA FROM 1975 TO 2010



Source: Canadian Institute for Health Information

PHOTO: PRESS ASSOCIATION

Calgary General 's demolition in 1998 was part of the province's plans to stem rising healthcare costs

such a level that in 2001 the World Health Organisation singled out Alberta in its document on international working conditions, stating: 'Lay-offs have resulted in heavier workload for the remaining staff and the quality is reported to have reached crisis levels.'

In total a staff reduction of just under 15,000 whole time equivalents (WTEs) was achieved in Alberta. The Calgary Regional Health Authority closed three downtown hospitals and concentrated on more modern facilities. Mergers of hospital and laboratories were common.

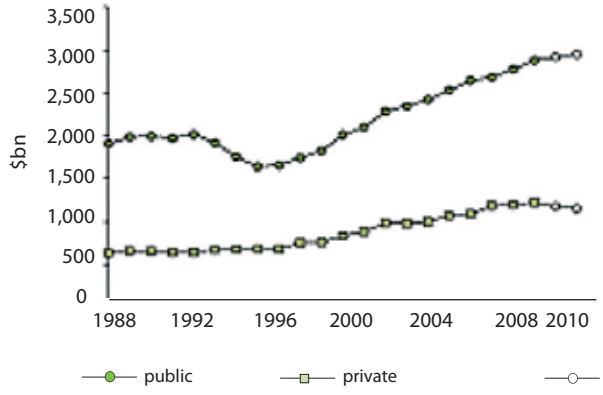
In the short term, the measures worked, but the long-term effects are clear. From 2001 to 2010 the cost curve in those provinces that cut most, such as Alberta, rises more steeply (see right). Many Albertans feel they have suffered for it ever since. Their wage settlements have been higher and the area has suffered big staff shortages, especially of doctors and nurses. Many feel that decade of under-investment in training can never be replaced.

There are clear lessons for the UK, particularly the importance of not losing sight of long-term issues when dealing with a short-term funding crisis.

The other factor that is evident looking back is that political support for the cuts was clear and united. The burning platform that was created by budget deficits gave the politicians the cover to make difficult decisions, even though many Albertans feel they made the wrong decisions.

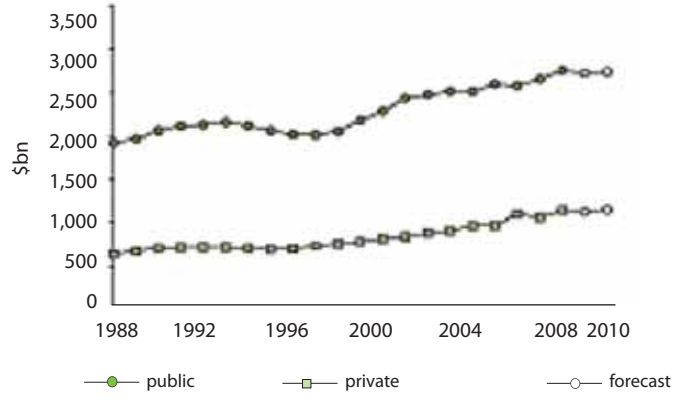
The parallels with the UK are clear. We may not be cutting gross pay, but with an increase in superannuation contributions, the effect on net pay will be just the same. The Canadian system coped with short-term pain but followed it with sustained growth. Without that 6% growth over 10 years, who knows where their health system would be now? We can only hope that the economic climate for the UK allows us a similar bend in the cost curve.

FIGURE: 7 PUBLIC AND PRIVATE SECTOR HEALTH SPENDING PER CAPITA IN ALBERTA (CONSTANT 1997 C$)



Source: Canadian Institute for Health Information

FIGURE 8: PUBLIC AND PRIVATE SECTOR HEALTH SPENDING PER CAPITA IN BRITISH COLUMBIA (CONSTANT 1997 C$)



Source: Canadian Institute for Health Information

Public support: a positive view

Paul Cummings examines a survey that shows Canadians are largely happy with their health service

What do Canadian people think of their health service? Well, the answer is they are more positive about it than we are about ours here in the UK.

A recent wellbeing survey (separate to the Deloitte study, page 5) shows that more than 80% of those who use the Canadian health service rate it as either good or very good. That's despite waiting considerably longer for their treatment than we would in the UK or having to go to a walk-in centre rather than a primary care physician.

Be it an older person who had just had eye surgery or a young businessman needing a check-up, the survey respondents were very supportive of the service they received.

That support is more noticeable in some areas. When Georgetown Hospital, Toronto, raised money for a CT scanner for its community facility, the local supermarket donated C$10,000 (about £6,250) to the project. Similarly, St Michael's Hospital in the same city has just opened a C$100m-plus research facility, which was funded by donations. While not quite on the scale of the United States, this is a long way from the UK's low level of charitable giving.

The survey also showed that Canadians appreciate the value of their health service – possibly because the costs of the services are clearer.

Not everything is covered by the state, so the public must pay or have the relevant insurance in place to cover these costs. Drugs, for example, are not covered – every prescription filled out has a cost attached, even when the recipient does not pay, as is the case for older people.

Insurers have limits on aspects of their cover for some elements of care – such as physiotherapy and behaviour therapists – so patients are aware of the cost of each consultation.

The one exception is payment to doctors. How they are paid seemed to be a mystery to the survey respondents, some of whom were unable even to guess their salary. This confusion could have been caused by the way doctors are paid – they are reimbursed on a fee per service basis by their provincial government.

There appear to be few concerns among respondents about closures or mergers, rising costs or poor care for the elderly. If anything, the standard of care for older people seems well respected by those in the over-65 age group.

There is a noticeable difference between the UK and the Canadian approach to old age. A huge percentage of Canadians move south in the winter to US states such as Alabama and Florida – so much so that the number of cataract operations falls in the first quarter of the year. No last-minute waiting list initiatives here. In addition, older people seem to welcome moving into care or supported communities, making community care much easier to deliver.

Those who work for the institutions we visited are equally positive, many having worked for the same institution for 20 or 30 years.

Part of the reason there is such widespread support for the health system is the fact that Canadian people are relieved they do not have the same arrangements as their neighbours in the USA.

Despite its weaknesses, people are generally supportive of their country's social system. Canada's population includes many immigrants and there are some issues of homelessness. But they are all given equal access to the care they need. Although Quebec has increased taxes and co-payments, in general it seems there is little willingness to expand this approach.

The challenge the Canadians set us here in the UK is a tough one: how do we get the same sense of ownership for our own health service?

Study tour participants visit St Michael's Hospital

Calgary's city skyline takes in iconic 1960s observation platform the Calgary Tower

In perspective: payment systems

Mark Millar examines the pros and cons of the fee-for-service payments system used in Canada

Canada, along with the United States, operates a fee-for-service system for doctors, including hospital consultants. In Canada, unlike much of the US, these payments are made from the public purse.

This contrasts sharply with the UK model of hospital consultants paid a salary on a time-based contract. UK hospitals are increasingly equating time, expressed as a number of programmed activities (PAs) to an anticipated level of output, either patient volumes for direct clinical care (DCC) PAs or supporting professional activity (SPA) PAs.

In a situation where – in both countries – economies in healthcare delivery are required, does one system have significant benefit over the other in promoting or inspiring changes in behaviour of senior clinicians?

Those working in the NHS may wonder why consultants agreed to the current contract. It is interesting that a strong professional group agreed to accept a 'tradesman's' contract that measures time as an input rather than direct outputs. Much of the discussion in annual job planning therefore centres on what relationship between time and patient volumes might be reasonably expected.

It is only through those discussions that a reasonable link can be made between the volume of work to be done and the number of DCC PAs required to undertake it. There is no explicit link to quality or outcomes. Overlaid on this is the professional overhead of SPAs, where it can be even more problematic to agree what the employer is getting in return.

The fee-for-service system on the other hand clearly incentivises volumes. In the US it is argued that fee for service includes an implicit long-term allowance for quality – which is expressed in patient choice – and therefore continued referrals. This may be true where an individual is making the payment, either directly or indirectly. But without a system of choice, can it justified where the payment is out of the public purse?

Fee-for-service is an incentive for hospitalisation – if a patient is admitted, the higher the fee. It is interesting that the Canadian system allows each

Canada operates a fee-for-service system for doctors and these payments are made from the public purse

province/territory to negotiate the fee for service tariff with its own medical association.

In the provinces we visited, this negotiation was on the basis of all doctors in the province, including primary care. The medical association settles the split between hospital and community (GP) doctors.

The North American system does appear to favour remuneration of specialists at a significantly higher level than community physicians (GPs) who, in both Canada and the US appear to be somewhat second class citizens and more likely to take up a salaried position. In remuneration terms, this contrasts sharply with the NHS where it is GPs who have retained an element of fee for service within their contracts. In the Canadian negotiations, it is the specialists who wield the power and have the influence. Primary care services appear less attractive and consequently harder to recruit to.

The Canadian agenda for healthcare change is no different to the UK or the rest of the developed world. It is looking to concentrate on supporting people in their own homes through integrated care pathways, remote monitoring and admission avoidance. These initiatives have a direct impact on the incomes of a key influential group, the hospital doctors, which can be seen as challenges to change.

Fee-for-service schedules reductions are also notoriously difficult to negotiate as technology changes reduce doctor input on a particular procedure.

Within the UK, the system of PAs allows some flexibility, both in the short and long term, to adjust the remuneration of consultants above the standard 10 PAs. This can recognise changes in circumstances, for example workload or for undertaking other duties that add value to the employing trust. Sometimes these discussions can be difficult, but there are opportunities if managed well.

SPAs within the NHS contract also ensure doctors can make adequate time for keeping up to date and move the profession forward. Again, there can be challenging discussions around the extent and use of that time, but a perceived danger in a purely fee-for-service system is that it is these activities that get squeezed out in the pursuit of income maximisation.

Most patients accepted on the virtual ward programme require significant support

Virtual ward: 'Whatever it takes'

The virtual ward is not a new concept to UK providers, but as part of the study tour Sharon Cannaby found out about a scheme in Toronto to prevent readmissions

Reducing the number of readmissions to hospitals is a key challenge for policy makers and health providers worldwide. One innovative model of care being piloted to address this issue – adapting a model pioneered in England in 2008 by Dr Geraint Lewis, now a senior fellow at the Nuffield Trust – is the Toronto virtual ward.

Launched in March 2010, the virtual ward is being run as a randomised controlled trial that will enrol more than 1,000 patients. The goal is to reduce readmissions by providing transitional care to about 350 patients a year who have been identified as being at high risk of hospital readmission following discharge. The project is being run collaboratively by Toronto Central Community Care Access Centre, St Michael's Hospital, the Women's College Hospital, the University Health Network and the Sunnybrook Health Sciences Centre.

Potential patients for the virtual ward are identified and invited to participate in the programme before they are discharged from hospital. They are assessed to ensure they meet the rigid eligibility criteria and then, because this is a controlled trial, either placed on the virtual ward or within the control group.

Once accepted on the programme, virtual ward patients are assigned a care co-ordinator. An interdisciplinary team – a physician, a pharmacist, two care co-ordinators and a community nurse practitioner – ensures the patient's discharge plan is carried out.

The majority of the patients accepted on the programme require significant support. In addition to complex medical problems, they may have

mental health and social problems; they will often be housebound and may also be suffering from addiction problems. Some patients do not have a family physician, so the virtual ward team helps them locate one and register with them.

Once home, the patient's care continues as if they were still in hospital. Nursing staff, physiotherapists and clinicians visit and treat the patient in their home setting as necessary and a pharmacist visits to check that the patient understands how and when to take their drugs.

The patient is also provided with a telephone number to call if they have a problem at any time of the day or night.

The majority of patients stay on the virtual ward programme for between two and six weeks, but if they need support for slightly longer it will be provided. The virtual ward team's motto – 'Whatever it takes' – means they do everything possible to minimise the risk of a patient being readmitted.

Improved collaboration between secondary and primary care teams has proved particularly beneficial. The virtual ward team call in community services where necessary and ensure that the family physician is briefed on the patient's condition and is involved in their post-discharge care.

Any staff who are not physicians are employed as salaried employees of the community partner, Toronto Central Community Care Access Centre. Physicians are paid a stipend (effectively a salary) and are not reimbursed on a fee-per-service basis.

On the virtual ward, physicians are required to work in three-week blocks and during that period they are expected to be available 24/7. Remuneration on the basis of fee per service would not have worked in these circumstances.

A critical success factor for establishing the project, therefore, has been the agreement reached with the Ontario Ministry of Health and Long Term Care to permit stipend payments for physicians working on the virtual ward. Funding has been allocated until the end of the evaluation, but this will need to be revisited in the long term.

Despite the long hours and the remuneration being slightly lower than that paid to hospital-based physicians, there has been little difficulty in recruiting physicians to the project. In addition to answering their pagers out of office hours, physicians visit patients in their home to provide direct care and prescribe treatment plans. These home visits have helped them understand the challenging domestic conditions of some of their patients and has shown how impractical discharge plans may be in real life.

Physicians have welcomed the opportunity to get involved in a more innovative model of care and have found it to be a valuable learning experience.

It is too soon to say whether the project has delivered its goal to reduce readmissions. The virtual ward project is being undertaken as a formal three-year study that will compare hospital readmission rates of patients on the virtual ward with those in a control group. The results are not expected to be published until early 2013.

The staff and organisations taking part in the project are positive about it and have already identified a number of benefits:

- Increased collaboration between secondary, community and primary care organisations
- Increased awareness of issues arising around the discharge process
- Identifying systemic barriers while finding solutions to fill gaps in the system.

This article gives only a brief overview of the project. For more details on how the project developed, the governance structure and to learn more about how it is operated please visit www.virtualward.ca

Physicians have welcomed the opportunity to get involved in a more innovative model of care

St Michael's Hospital

Integrated thinking

Phil Taylor provides a tour of an innovative community-based health centre in Calgary

The desire to move health services into community health settings is just as strong in Canada as it is in the UK. Following a restructuring of healthcare services in Calgary, Alberta, there was an opportunity to relocate services into the community in a very bold and innovative way.

The result is the Sheldon M Chumir Health Centre (SMCHC), the largest integrated, community-based healthcare centre in Canada. This Alberta Health Services (AHS) state-of-the-art facility provides services close to the centre of Calgary on the site of a former veterans' hospital. It offers a wide range of healthcare services for those who live and work in the inner city.

The centre also has programmes that serve the broader city of Calgary and southern Alberta. Located in the beltline of the city's downtown core, the client population served by the centre is diverse, ranging from business professionals to homeless people.

One of the primary programmes at the Chumir is an urgent care centre (UCC). There are six UCCs in Alberta, five of which are in Calgary. The Chumir's UCC is the only 24-hour facility and provides same-day treatment for anyone with unexpected but non-life-threatening health concerns. The centre has about 60,000 visitors per year.

It has a vast waiting area featuring three separate zones for patient treatment supported by on-site lab services and diagnostic imaging providing general radiography and CT scans. Each zone is staffed by a physician, usually from primary care, and three nurses. One zone is reserved for musculoskeletal problems.

One particularly effective feature is that the UCC is co-located with an urgent mental health programme that offers mental health intervention and short-term follow up and referral for adults experiencing a mental health crisis.

To further complement the urgent care services there is a sexual assault response team. Medical attention, supportive counselling and access to justice services are all provided in-house. The police are also involved through the police and crisis team (PACT). This partnership between AHS and police aims to provide a response to incidents involving individuals and families experiencing mental health, addiction or psychosocial crisis when a danger to the public is evident.

The urgent care centre is co-located with a mental health programme that offers intervention and short-term follow up

Sheldon M Chumir Health Centre

Other services complement the UCC, so that overall a comprehensive, innovative and patient-focused service is provided in the community.

Urgent care occupies only one floor of the building. Other major services provided include:

- Southern Alberta Renal Program – 24 haemodialysis stations operating 12 hours a day, six days a week, supported by a multidisciplinary team providing education and training for home-based treatment programmes. Peritoneal and home dialysis services are also provided, along with an extensive research agenda.

- Mental health services – a wide range of support services for 10 community mental health programmes are run from the centre. This includes assertive community treatment, an active treatment team, a mobile response team, geriatric mental health and outpatient services.

- Family physician services – the top floor is devoted to a teaching centre for family physicians in a clinical setting. Services are provided to the local population in this educational environment.

- Elbow River Healing Lodge – adult mental health and comprehensive primary health services are provided for First Nations, Métis and Inuit (Aboriginal) people. The mental health service provides culturally relevant interventions and some traditional healing services. Primary health services provide prenatal, diabetes, wound care, street outreach, social resource advocacy and health promotion services.

In total, 1,100 people work in the building providing community care in more than 40 programmes.

Surprisingly, when the centre opened some programmes experienced a drop-off in general service numbers. The new building was an unknown facility and it took some time for people to adjust and transfer from many previous sites in the surrounding areas. However, it soon picked up and by the end of the first year overall numbers began to creep up.

Urgent care has perhaps been too successful and there have been some long waiting times. On busy days, waits can extend to several hours at the start of the night shift. Bids are in place to secure additional staffing to cover the existing workload and in the longer term there is the potential increase to 100,000 attendances.

The facility provides a wide spectrum of innovative, patient-focused community services that are being accessed by a growing number of people. Providing so many services in one place is a bold initiative that seems to prove that it is possible to draw people away from the traditional acute settings. ■

FROM THE ARCHIVE

In 2010 a joint HFMA/ACCA study tour visited the US. In part, the study tour was arranged to enable UK delegates to contribute to a workshop looking at improving healthcare value and to hear about US moves to introduce fee-for-value payments. Delegates also visited local health systems to look at innovative work using telemedicine in intensive care and how US hospitals were using electronic records to gain a competitive edge.

An earlier study tour to Australia provided insight into the idea of running hospitals under franchise arrangements – an approach now being used to run the Hinchingbrooke Health Care NHS Trust. The study tour, which visited a number of facilities in 2009, looked at the experience of Joondalup Health Campus, a comparable facility to Hinchingbrooke in the North Metropolitan Areas Health Service in Western Australia.

● Both study tour briefings and other HFMA briefings can be downloaded at www.hfma.org.uk/publications-and-guidance – follow links for HFMA briefings.

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