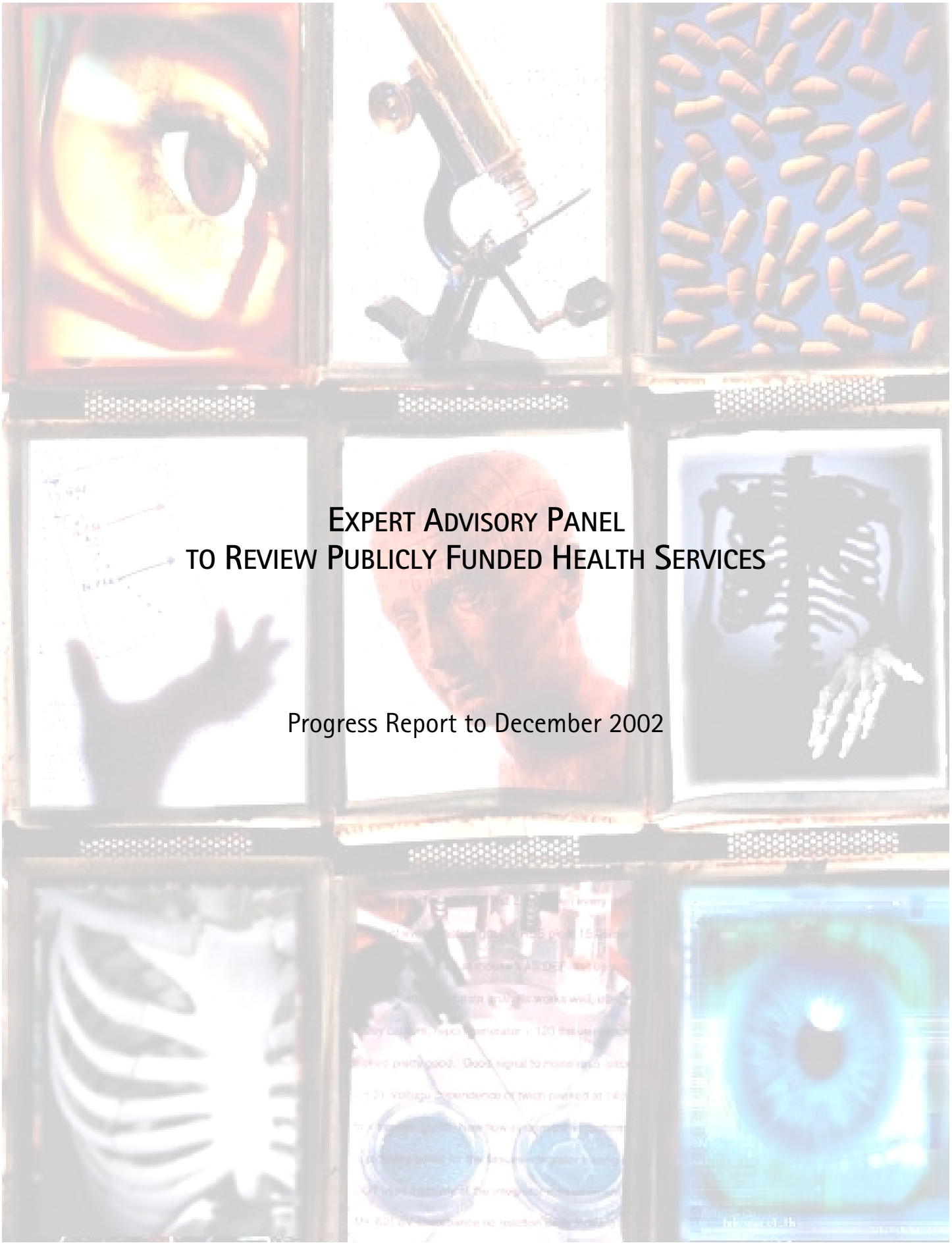

EXPERT ADVISORY PANEL TO REVIEW PUBLICLY FUNDED HEALTH SERVICES

Progress Report to December 2002

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INTRODUCTION

The Expert Advisory Panel to review publicly funded health services was established by Alberta's Minister of Health and Wellness, Gary Mar, in May 2002. The purpose of the Panel is to review the current basket of publicly funded health services and, on an ongoing basis, to review new health services to ensure that Alberta's publicly funded health services remain comprehensive and sustainable for the future, and provide the best value.

The Expert Advisory Panel arose out of recommendations in the report of the Premier's Advisory Council on Health. The Council recommended that an expert panel should be established to review and make decisions on which health services and treatments should be publicly funded. In their words, "If we want to make sure there is access to the best treatments available, we are going to have to make some choices about which services are covered and which are not." To make these choices in an open and objective way, the Council recommended that the Panel should establish criteria for determining whether each new diagnostic treatment, services or drug should be covered.

Since the Expert Advisory Panel was established, it has reviewed current processes for publicly funding health services, considered approaches used in other countries, and sought the input of various organizations and experts. The Panel's first priority was to establish clear principles, set criteria for evaluating services, and develop a process for making decisions on which categories of health services should be funded as part of the health care "basket" in Alberta.

Since the Panel was established, its work has focused on five main tasks:

- Reviewing models and approaches in other jurisdictions and receiving submissions and presentations from health organizations in the province
- Laying the foundation for the Panel's review by establishing goals, principles and criteria
- Developing a process for reviewing health services and treatments and establishing a research group to assist with the process
- Reviewing and developing recommendations on future funding for four areas referred to the Panel for review – optometry, podiatry, chiropractic services, and community physical therapy
- Reviewing broad categories of currently funded health services.

This report provides an overview of the work done to date on all five of those tasks. It also highlights the important work to come in the new year – namely setting up a process and structure for a more detailed and thorough review of currently funded and new services, setting priorities, and proceeding with reviews of specific services.

A number of important points should be made at the outset.

- First, like all Canadians, Albertans care deeply about protecting, promoting and preserving public health care. The Panel's mandate is to make recommendations and to ensure that health care services in Alberta continue to be consistent with the principles of the Canada Health Act.

- Second, the objective of the Expert Advisory Panel is to ensure that publicly funded health services in Alberta are up to date and the most effective in meeting the health needs of Albertans. The current list of services has been added to over the last 40 years. During this time, medical advances and practices have changed dramatically and, as a result, more procedures, tests and treatments can be done for more people.

- Third, while much of the discussion and debate about the Panel's work has focused on the review of current services, the Panel believes its most important contribution to the sustainability of the health system and the health of Albertans lies in developing an open and rigorous approach for making decisions about public funding of new services in the future. The criteria and review process developed by the Panel will guide future decisions and ensure that those decisions are made through a consistent and transparent process based on the best available evidence.

- Fourth, the process developed by the Panel to date is a flexible one that can be adapted to address new information and research over time. The next phase of the Panel's work will involve developing a comprehensive process and structure to ensure that both new and currently funded services are thoroughly reviewed and appropriate decisions are made on the basket of services to be funded in Alberta.

- Finally, the principles, criteria and process for reviewing health services can and should apply not only to existing services but also to proposed new treatments, cures and technologies. As noted above, this is where the most significant benefits are likely to come in terms of sustaining Alberta's health care system and ensuring that Albertans continue to have access to the best and most effective basket of health services.

Like all Albertans, the Panel is deeply concerned about the sustainability of Alberta's health care system. Sustaining the health system will require difficult choices not only in how much we pay but what mix of health services we are prepared to pay for, now and in the future. The initial stages of the Panel's work has identified areas where some savings can be achieved, however, it is not a "quick fix" and the result will not be substantial savings to the health system at this time. However, we are confident that, over the longer term, the work of the Expert Panel will contribute directly to the future sustainability of the health system by ensuring that appropriate decisions are made on how best to spend available dollars on the range of available health services. The Panel believes that, as we review services and treatments and make decisions about whether or not they should be publicly funded, the key question isn't "is this service worth funding?" but rather "is this the best use of the resources we have in order to provide the best health outcomes for Albertans?" That question is at the heart of the Panel's work.

THE CURRENT SITUATION IN ALBERTA

Publicly funded health services

It is important to begin by setting the context in terms of publicly funded health care services in Alberta. Health care services fall into four main categories:

1. *Services that are covered by the Canada Health Act and insured under Alberta's Health Care Insurance Act and Hospitals Act*

This includes medically necessary hospital, physician and dental surgery services. The province spends 60% of its health care budget or $4.1 billion on Canada Health Act insured services (2001/02).

2. *Other services that are covered under Alberta's health care insurance plan*

In addition to services covered under the Canada Health Act, the Alberta Health Care Insurance Plan provides coverage for other health care services such as chiropractic care, optometry, and podiatry. The provincial insurance plan also covers government-funded Blue Cross coverage for drugs, ambulance and some hospital services, and other out-of-province care. In 2001/02, the province spent 7% of its health care budget or $455 million on these services.

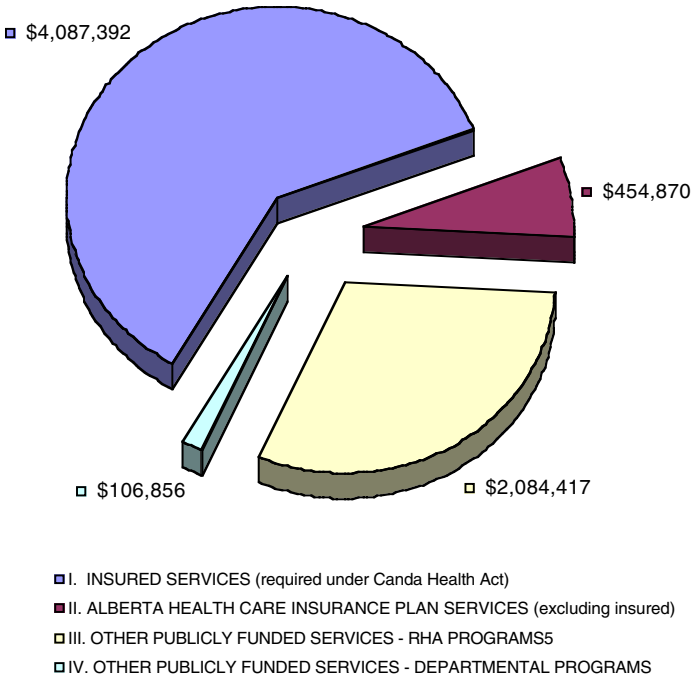
3. *Other publicly funded services provided by regional health authorities*

This includes services such as continuing care services in nursing homes and long term care facilities, home care, promotion of health and prevention of diseases and injuries, immunization, environmental health, mental health services, and community rehabilitation services (e.g. audiology, occupational therapy, physical therapy, respiratory therapy, speech and language therapy). The province spent 31% of its health care budget on these services for a total of $2.1billion.

4. *Other Publicly Funded Services provided by Alberta Health and Wellness*

Alberta Health and Wellness directly supports and administers a number of programs including Alberta Aids to Daily Living, oral maxillofacial devices, air ambulance services, and provincial promotion, prevention and protection services including communicable disease control expertise. These programs accounted for 2% of health spending for a total of $107 million.

Expenditures on Publicly Funded Health Services In Alberta
By Health Authorities And Alberta Health & Wellness
(in millions)



**Graph provided by Alberta Health and Wellness.*

The Panel's mandate

In terms of the Expert Advisory Panel's mandate, the Panel was asked to look at categories of health services that are publicly funded. The Panel was also specifically asked to review and provide recommendations on future coverage for chiropractic care, podiatry, optometry, and community physical therapy. In reviewing the various categories of services, the Panel is expected to consider the principles of the Canada Health Act, medical need, patient benefit, appropriateness, and fairness to Albertans who cover the costs through their taxes and health care premiums.

Current processes for deciding on publicly funded services

The range of publicly funded health services has evolved over time. As new drugs, technologies, and procedures have been developed, many have been added to the benefits and health services that are publicly funded in Alberta. Decisions about adding new treatments or services are made by the provincial government. The general processes for making these decisions typically include the following steps:

- Health technology assessment including a review of the scientific literature on the safety, effectiveness, benefits and risks associated with the services and consultation with experts and practitioners

- Policy analysis and development including assessing consistency with government policy as well as financial, program, workforce, statutory and regulatory, and other implications, including the development of options for providing the services
- Stakeholder consultation on issues and the options for the services
- Government review of the feedback from consultations and consideration of the proposed policy options
- Development of legislation if necessary
- Review and approval by the Legislative Assembly or by government
- Implementation

In the case of prescription drugs, a separate provincial committee was established to review and make recommendations regarding the addition of new drugs to the Alberta Drug Benefit List. The Expert Advisory Panel's mandate does *not* include prescription drugs. A process is also in place for making decisions about province-wide services – services that are often life-saving, highly complex and offered only in the Capital and Calgary Health Regions. In terms of medical services, the Schedule of Medical Benefits is determined through an agreement between the Alberta Medical Association and Alberta Health and Wellness.

Ultimately, the decision about whether a health program, specific service, drug or procedure is funded in Alberta rests with the Minister of Health and Wellness or with the government.

Current challenges

The purpose of the Panel is to provide an objective and transparent process, guided by sound and consistent principles and criteria, for making these decisions on an ongoing basis. In beginning its task, the Panel has identified the following important challenges:

- Finite resources
- Growing demand for services
- Emerging technologies
- Lack of evidence-based data for evaluating services and treatments
- Increasing public expectations
- Escalating health care costs
- Balancing individual and societal interests
- Population growth and demographic change.

REVIEWING APPROACHES AND IDEAS

Models and approaches in other jurisdictions

The Panel reviewed summaries of approaches in place in other countries including the United States (Oregon), New Zealand, Sweden, Norway, the Netherlands, Denmark, the United Kingdom, and Germany. These summaries vary in scope from comprehensive reviews of an entire health care system to reviews that focused on setting priorities and reviewing benefit structures. A variety of different approaches are used in different countries and jurisdictions to make decisions on the package of health care services covered in their health care systems. The factors that are considered typically include assessments of whether treatments are effective, whether they prevent certain illnesses, their costs and benefits, the consequences of approving or not approving the new treatment or service, who the service is intended to benefit and whether the service or treatment is consistent with community or societal values. Many of the approaches involve setting priorities based on pre-determined criteria and some have established principles to guide their decisions. A summary of the various approaches is included in Appendix 1.

Submissions and presentations

The Expert Advisory Panel requested input and advice from a wide range of organizations in the health care sectors. A complete list of submissions is included in Appendix 2. The Appendix also includes a list of groups the panel met with as part of its initial work.

A number of organizations made suggestions for principles and criteria that should be used to guide decisions on publicly funding health care services. Suggestions included:

- Funding should go only to those services that respond to a health need and demonstrate a benefit
- Decisions should be based on the best available evidence
- Criteria should be reliable, standardized and based on comprehensive health information
- Decisions on what is medically necessary should address four questions: Does it work? Is it needed? Is it wanted? Should the public pay?
- Funding should be based on the service that is provided, not on where it is provided or what type of practitioner provides the service
- Services should not only treat illnesses but help prevent illnesses and chronic conditions, provide adequate rehabilitation, and encourage individual accountability for health
- Criteria should address population health issues and risk factors
- Decisions on publicly funded services should reflect underlying values including the dignity of the person, the right to health care, collective responsibility, compassion and caring, good stewardship, and social and ethical justice
- Patients' need and medical appropriateness should be the overriding factors in determining whether services are insured

- No medical service currently covered should be removed from the list of insured services unless it can be demonstrated that the service is not medically beneficial
- Because evidence changes over time, decisions should be subject to ongoing review and periodic evaluation
- Evaluations of services should be conducted at arms length from government or from agencies with a private, for-profit interest in the outcomes
- Consideration should be given to field testing a new service or technology before a decision is made on whether it should be fully or partially funded
- Consideration should be given to alignment with neighbouring provinces
- The service should be provided by a regulated professional, appropriately qualified and authorized
- The potential harmful effects of not providing coverage for a service should be considered
- Criteria should consider safety, access, sustainability and the availability of other funding options (e.g. supplementary insurance coverage)
- The process for making decisions should reflect the following values: transparency, accountability, evidence-based, inclusiveness and procedural fairness
- Defining core health services should not only be about cost containment; it should also be about making appropriate investments in core health services so that the basket of services is kept current.

GOALS, PRINCIPLES AND CRITERIA

As the foundation for its work, the Expert Advisory Panel identified the following social goals for publicly funded health care services:

Human Worth

All people are equal in worth and dignity and have a right to a healthy life.

Social solidarity

Albertans view medicare as a trust and believe those who are ill or injured must always be cared for, particularly those who are most vulnerable in our society.

Fairness and Equity

All Albertans will be assured of the universality and accessibility of appropriate health services regardless of their individual characteristics or circumstances.

One of the essential first steps for the Expert Advisory Panel was the development of principles to guide decisions about publicly funded health care services. Consistent with the above social goals, the Panel has established a set of seven principles.

Principles for Publicly Funding Health Care Services

1. The Government of Alberta is committed to the principles of the Canada Health Act: comprehensiveness, universality, portability, public administration, accessibility.
2. Publicly funded health care services must be sustainable now and in the future.
3. The cost of treating illness and injury must not create undue financial hardship for individual Albertans.
4. Saving lives and significantly improving quality of life are priorities within our health system.
5. Alberta's health system supports innovative models of care.
6. A sustainable health system requires a responsible user and a provider that supports responsible use.
7. Services that promote wellness, protect health and prevent disease and injury are necessary to support a healthy population.

Within the context of those principles, decisions about public funding for health care services should be based on clear and consistent criteria. The Expert Advisory Panel has developed the following criteria that will be used throughout the review process. These criteria should provide an ongoing basis for making decisions about providing public funding for specific health services. At the same time, the Panel believes that criteria should be flexible and should be adapted over time to respond to emerging issues and changing practices in the health care system. The Panel also decided that it would not deal with issues that have jurisdictional or Charter of Rights implications and therefore, are more properly dealt with by the federal and provincial governments.

Criteria for Reviewing and Recommending Public Funding for Health Care Services

Safety

- Do the expected benefits outweigh the potential risks?

Demonstrated Benefits or Effectiveness

- What is the available evidence of benefit or effectiveness?
- What is the impact of benefit relative to cost?
- Can the equivalent service and benefit be delivered at lower cost through different delivery models?
- Does the service significantly improve quality of life?
- Does the health service support early detection/health promotion?
- Does the health service support independent living and/or optimal quality of life given an individual's circumstances, e.g., physical, psychological, social, spiritual?

Impact of Decisions on Individuals and the Health System

- What is the impact on the health system and other services?
- What is the impact on individuals who require the service?
- What other options are available for individuals to receive the service?
- Are co-payments or private insurance appropriate options?
- What are the implications relative to alignment with other provinces?

Consistency With Health Reforms

- Is the decision consistent with directions and priorities set for Alberta's health system?

Sustainability/Financial Implications

- Does the service represent an appropriate use of resources?
- What are the limits on available resources?

Framework for Reviewing Health Services

Decisions about providing public funding for new and existing health services must be consistent with the principles and criteria noted above. They also must be made through a rigorous process involving a thorough consideration of a number of essential factors.

A Three Screen Process

The Expert Advisory Panel has adopted what we have called a "three screen process." Through the proposed process, three levels of screening would occur for existing categories of services and for proposed new services, technologies and treatments.

The **technical screen** looks at whether the service or treatment is safe (i.e. the benefits outweigh the risks), has demonstrated benefits, is effective in treating or preventing particular health problems, and is well-integrated with other health services. It considers the following criteria established by the Panel:

- Do the expected benefits outweigh the potential risks?
- What is the available evidence of benefit or effectiveness?
- What is the impact of benefit relative to cost?
- Can the equivalent service and benefit be delivered at lower cost through different delivery models?
- Does the service significantly improve quality of life?
- Does the health service support early detection of health-related problems/health promotion?
- Does the health service support independent living and/or optimal quality of life given an individual's circumstances, e.g. physical, psychological, social, spiritual?

The **social and economic screen** assesses the impact of decisions to provide or not provide public funding for the service or treatment on individuals' access to the services, possible ethical issues affecting groups of individuals, the impact on the health system, the availability of other options, and the consistency with health reforms. This screen considers the following criteria:

- What is the impact on the health system and other services?
- What is the impact on individuals who require the service?
- What other options are available for individuals to receive the service?
- Are co-payments or private insurance appropriate options?
- What are the implications relative to alignment with other provinces or territories?
- Is the decision consistent with directions and priorities set for Alberta's health system, including directions for health reform and improved integration of the health system?

The **fiscal screen** looks at the financial costs and the implications of continuing to fund existing services or providing funding for new services or treatments on the sustainability of the health care system and deciding whether a service or treatment should be publicly funded in whole or in part. This screen considers two financial criteria:

- Does the service represent an appropriate use of resources?
- What are the limits on available resources?

Appendix 3 provides an overview of the three screen process.

It is important to note what the Panel has determined the **"burden of proof"** for currently funded versus new treatments and services. In the case of services that are currently publicly funded, a service, treatment or program would have to **fail** one of the first two screens in order to recommended that it would no longer be publicly funded. In effect, evidence would have to be provided indicating that the service, treatment or program was unsafe, did not provide demonstrated benefits or that it did not have a positive impact on individuals or the health system, could be provided in other ways, or was inconsistent with approaches in other provinces or health reform directions and priorities in Alberta. In addition, currently funded services would not fail the first screen if the available evidence on effectiveness was inconclusive.

In the case of new services, a new service would have to **pass** the first two screens in order to be considered for public funding in Alberta's health care system. In the case of the technical screen, conclusive evidence on the effectiveness of new services would have to be provided in order for a new service or treatment to be approved for public funding.

The Research Group

To implement the three screen review process, the Panel established a Research Group to consider available research evidence and provide findings and conclusions to the Panel. The Research Group combines clinical researchers, health and public finance economists, and a health ethicist. The Health Technology Assessment Unit of the Alberta Heritage Foundation for Medical Research provided assistance to the Research Group.

Reviewing Four Referred Services

The Minister of Health and Wellness specifically requested that the Panel review three allied health services – optometry, podiatry, and chiropractic services – as well as the community physical therapy program, and provide recommendations on continued funding.

The Panel used the three screen process in order to review these four areas. The Research Group considered available research evidence and provided their findings and conclusions to the Panel. The Health Technology Assessment Unit of the Alberta Heritage Foundation for Medical Research provided synopses of abstracts from selected systematic research reviews in each of the four areas. It is important to note that, give the limitations of time, the Research Group looked only at available research and evidence. A copy of the report of the Research Group is included in Appendix 3.

In addition to the report of the Research Group, the Panel also considered various submissions, information from Alberta Health and Wellness, and experience and advice from individual Panel members in making its own assessments, particularly in relation to the second and third screens.

Overall Observations

In reviewing the findings of the Research Group and developing its recommendations, the Panel noted a number of overall observations.

- *More research and analysis is needed on the effectiveness, and especially the cost effectiveness, of treatments and procedures.*

  The Panel's approach was to review existing research rather than to undertake any new or primary research. The Panel was struck by the lack of comprehensive research evidence on the effectiveness of existing services and particularly on the cost effectiveness of services where there is very little evidence to indicate whether existing services are, or are not, cost effective in comparison with other services. The provincial government provides extensive support for research and the Panel suggests that more of this funding should be targeted at research that addresses the effectiveness and cost effectiveness of treatments and services. This may involve expanding primary research in ways that are not inordinately expensive but provide sound research evidence over the longer term.

- *Overall, a publicly funded program should be targeted at treatments that have been proven effective and are delivered in an integrated manner.*

  This statement captures the objective we should be trying to achieve in providing public funding for health services. Funding should go only to services or treatments that are proven effective and, to the extent possible, delivered in an integrated manner. Directions for health reform in Alberta clearly point to the importance of integrating health care services to reduce overlap and duplication, streamline services, and make the best use of the range and skills of health care providers. The concept of integration should be considered as a continuum ranging from effective referrals among health care providers, to effective sharing of patient health information, or truly sharing care within multi-disciplinary teams. From an individual patient's perspective, integration means that services are well coordinated to meet their needs, that transfer of care occurs seamlessly among different providers, and that they participate actively in their health care with a variety of health care providers.

  There is no single approach that would fit all the various situations across the province. Integration is more of an approach to care, a mindset, and a way of doing business than a model or a location where services are provided. Many things will have an impact on how services are integrated including the needs of the patient, the availability and skills of care givers in the community or in a region, the distance to care, and the presence of other barriers that may prevent effective integration. The Panel recognizes the complexity of improving integration of services because it affects so many different aspects of the health system—from the scope of practice of health providers to the roles and mandates of health authorities, sharing of information on patient records, and funding models. However, the Panel suggests that the province should continue to report to Albertans on progress that is made in improving integration of health services across the health care system. Because of the importance of integrating health services to improve the health and health care of Albertans, the Panel's review of health services for future funding will continue to take the extent of integration into account as one of the factors in its decisions about continuing funding.

- *Broad categories of services are difficult to assess because specific services or treatments within a category may pass the three screen process while others may not.*

  The Panel's mandate is to review **categories** of services rather than conduct an in-depth analysis of each service or treatment provided within the category. In the case of community physical therapy, chiropractic care, and podiatry, for example, the Panel's task was to determine whether or not public funding should be continued for these categories of services. But there is a wide range of services provided in each of these categories. Research showed that certain treatments were effective for certain conditions while, in other cases, sufficient evidence was not available to assess their effectiveness. This made it difficult for the Panel to make "all or nothing" recommendations. It also means that individual services or treatments within these broad categories could be brought to the Panel in future to be considered for public funding.

- *Fee code methodology could be improved to allow better information and analysis.*

  The current way in which fee codes are applied makes it difficult to track information and assess services. This is particularly the case for chiropractic services where only a few codes are assigned and the result is limited information on the types of chiropractic services provided.

- *Ongoing research is needed to evaluate the impact of any changes in public funding made as a result of the Panel's recommendations.*

  The Panel understands that decisions to discontinue public funding for existing services or to introduce public funding for new services will have an impact on access to services, on how those services are delivered, on the number and practice of certain health care practitioners, and on the sustainability of the health care system. Analysis of such impacts will be an important part of an ongoing research plan in order to provide comprehensive information to the Expert Advisory Panel.

- *The Expert Panel sees its role as providing recommendations to government on "where" they should be going in terms of services/treatments that are funded, not to recommend "how" they should get there or how programs should be designed.*

  The Panel recognizes that a number of issues and concerns raised through its three screen review process could be addressed by re-designing the program or changing how services are delivered. This, however, is beyond the mandate of the Panel. The Panel's role is to review categories of programs or services and to determine whether or not they are consistent with the Panel's criteria and the three screen process. It is up to the Minister and government to decide whether to accept or reject the Panel's recommendations and whether or not to re-design programs or continue to fund all or a part of existing programs and services.

Review and recommendations

Optometry

Current situation

Currently, Alberta residents who are under the age of 19 or 65 and over are entitled to receive one complete and one partial eye exam plus one diagnostic service per year. Just under 300,000 clients were served in 2000-01 and 372,000 services were provided. The total cost to the Alberta Health Care Insurance Plan was $13.2 million in 2000-01. Over the past three years, the number of services provided per year has increased by 7.9% a year and the costs have increased by 9% a year.

Research Group Findings

- *Optometry services do not fail the technical screen.*
    - No safety concerns were noted.
    - Based on limited evidence, services appear to be effective in diagnosing certain diseases of the eye and vision defects and in treating vision defects with corrective lenses.
    - Clinical practice guidelines in the United States do not recommend annual examinations for children who are not at risk for eye problems.
    - Services may or may not be well integrated with other health services – for some treatments (e.g. management of glaucoma),services are integrated while in other cases, they may not be.
    - Insufficient evidence is available to draw conclusions on cost effectiveness.

- *Optometry services do not fail the social and economic screen.*

    - If public funding was not provided, the Research Group concluded that access may be an issue for low income children and seniors. Catastrophic coverage is not relevant to eye examinations.
    - Information suggests that eye examinations to screen for vision and eye problems are important ways of maintaining independence for seniors. Unlike some of the conditions considered in the other three areas under review, eye problems are not likely to resolve themselves without treatment and the eventual outcome of a failure to diagnose and treat eye problems could be very serious, including blindness. Treatment is essential to address eye problems and maintain safety and independence, especially for seniors. For children, failure to detect and treat eye problems can have a serious impact in a number of areas beyond their health including their ability to function effectively and learn in school.
    - Similar procedures are funded for physicians but billed infrequently.
    - Eye exams may be covered by employer or individual supplementary health plans.
    - Optometry is not covered under the Canada Health Act but many jurisdictions cover these services for children and seniors.
    - In terms of consistency with health reform, the issue of optometry services was not specifically addressed as part of the health reform initiatives underway within government. However, eye examinations are primarily screening tests that are used to detect and address eye problems and, in this sense, they are consistent with the overall emphasis on prevention and promoting wellness.

- *Optometry services may not pass the financial screen.*
    - Costs are growing at a rate of 9% a year and are not sustainable given provincial revenue growth that averages about 4% per year.

Assessment by the Expert Advisory Panel

The Expert Panel reviewed the findings of the Research Group and concurs with their overall conclusions.

Recommendations

Public funding for complete and partial eye exams and certain diagnostic procedures for children 18 years of age and under and for people 65 and over should be continued.

Funding should not be continued for optometry services provided outside the province or outside Canada.

The provincial government should review the current policy of providing funding for annual eye examinations for children who are not at risk for eye problems and develop an Alberta guideline within the next six months.

Advice to the Minister

- Clinical practice guidelines in the United States recommend eye examinations every two years or at certain ages for children who are not at risk for eye problems. The current policy of funding annual eye examinations for children should be reviewed and an Alberta guideline developed. The Panel suggests that a review of the appropriateness of annual eye examinations for seniors should also be considered.
- The Panel notes that there currently is no extra billing allowed for eye examinations for children and seniors. The Panel suggests that this practice should continue since the objective of public funding is to ensure that there are no financial barriers that would prevent access to these services for children and seniors.
- The Panel also notes that neither the Panel's Research Group nor the Panel reviewed optometric services to people who are between the ages of 19 and 64. Research would be required if, at any time in the future, consideration was given to including public coverage for services provided to a broader range of Albertans.
- The government should consider alternative ways of capping the increasing costs of these services either by putting an overall cap on the overall amount of money to be spent on optometry services or by adjusting the fee paid for each service. As noted above, the Panel does not support co-payments or extra billing for these services.

Podiatry

Current situation

Currently, partial coverage is provided for various foot care and treatment services, including some surgical services, to a maximum of $250 per eligible Alberta resident. 83,000 clients were served in 2000-01 and about half of the clients are seniors. About 257,000 services were provided in 2000-01 at a total cost of $6.1 million. Podiatrists are also allowed to charge a co-payment over and above what is paid by the Alberta Health Care Insurance Plan. The average growth in costs since 1998-99 has been 10% per year.

Research Group Findings

- *Podiatry services do not fail the technical screen.*
    - There is no evidence of significant concerns associated with podiatry services.
    - Surgical treatments for injuries or congenital defects are effective and services are effective in the prevention and treatment of diabetic and other foot ulcers. Treatments are also effective for skin and nail infections and other disorders.
    - There are examples where podiatry services are integrated with other health care services. There is some overlap with services provided by physicians, nurses and physical therapists.
    - There is insufficient research evidence to assess cost effectiveness.

- *Podiatry services, with the exception of surgical services, may not pass the social and economic screen.*
    - The existing, substantial co-payment does not appear to have significantly limited access to podiatry services. Catastrophic coverage is not relevant.
    - The Research Group found that discontinuing public funding for surgical procedures could have a negative effect on the independence of some clients. There are no minority ethical considerations involved.
    - Similar surgical services can be provided by physicians and foot care is provided by other health care providers. However, in the case of surgical services provided by podiatrists, the Research Group's view was that it was unlikely that orthopedic surgeons would be able to fill in the gap in services if public funding was not provided for medically necessary surgical services.
    - Services may be covered by employer or individual supplementary health insurance plans.
    - Podiatry services are not covered by the Canada Health Act and are not funded in 10 of 13 jurisdictions in Canada.
    - In terms of consistency with health reform, there are no specific issues related to podiatry although it can be argued that the emphasis on prevention of further problems as a result of adequate foot care and treatment for conditions such as diabetes is consistent with the overall emphasis on prevention.

- *Podiatry services may not pass the fiscal screen.*
    - Growth in services and costs are in the range of 10% a year and are not sustainable given provincial revenue growth.

Assessment by the Expert Advisory Panel

The Expert Panel concurs with the Research Group findings for the technical and fiscal screens. In terms of the second screen, the Panel understands that access to adequate foot care is a problem in rural communities, especially in northern Alberta. Physicians and other providers may be able to provide some of these services, but access to these providers is a problem and, as a result, seniors, in particular, have a difficult time accessing necessary foot care. The Panel also feels that foot care is a valuable service for seniors and plays an important role in maintaining their independence and preventing further health-related problems, particularly in the case of people with diabetes or other circulatory problems. Treatment of diabetic and other ischemic foot conditions is also important in order to prevent further deterioration and effective treatment of foot lesions. In terms of medically necessary surgical services, the Panel believes that these services should be covered regardless of whether they are provided by podiatrists or physicians.

Recommendations

Public funding for podiatry services should be limited to the following three services:

- **Full funding should be provided for medically necessary surgical services with no co-payment included**
- **Full funding should be provided for diabetic and ischemic foot care provided as part of an integrated approach with no co-payment included**
- **Funding for general foot care should be provided for seniors 65 years of age and older with a co-payment included and an annual cap on the funding to be provided per person per year.**

Funding should not be continued for podiatry services provided outside the province or outside Canada.

Advice to Minister

- Fees paid to podiatrists for surgical services should be negotiated between the podiatrists and the Minister.
- Given concerns about sustainability and increasing costs, the government should consider different options for limiting the increases in costs for podiatry services including introducing an overall cap on the amount of money allocated to podiatry services, adjusting the annual cap on services for each individual served, adjusting the fees paid for each service, or other alternatives that may be appropriate.

Chiropractic care

Current situation

Chiropractic services are not covered under the *Canada Health Act*. Currently, the Alberta Health Care Insurance Plan provides coverage for chiropractic services up to a maximum of $200 per person per year. 418,000 clients were served in 2000-01 and close to three million services were provided. 85% of the clients are 19 years of age and older. Since 1997, chiropractic services have grown by 5.7% per year. In 2000-01, the Alberta Health Care Insurance Plan paid $36.5 million for chiropractic services. Chiropractors are allowed to charge patients a co-payment over and above the rate paid by the Alberta Health Care Insurance Plan.

Research Group Findings

- *Chiropractic services do not fail the technical screen.*
    - Evidence suggests that the risks of cervical manipulation are small and within an acceptable range.
    - Based on limited evidence, chiropractic care appears to be as effective as other treatments for acute and chronic back pain. Patients also report high levels of satisfaction with chiropractic treatments. There is insufficient evidence to judge whether treatments for other conditions are effective.
    - Most chiropractic services are not well integrated with other health services.
    - There is insufficient evidence to draw conclusions about cost effectiveness.

- *Chiropractic services may not pass the social and economic screen.*
    - The existing significant co-payment does not appear to have limited access. However, without public funding, access may be an issue for premium-subsidy clients. Catastrophic coverage is not an issue.
    - Chiropractic services do not affect independence, however, the evidence suggests that chiropractic care does provide short-term relief from back pain. Minority ethical views are not an issue.
    - There is considerable overlap in services with physical therapy and some overlap with physician services.
    - Chiropractic services may be covered by employer or individual supplementary health insurance plans.
    - Chiropractic care is not covered by the Canada Health Act and it is not funded in the majority of Canadian jurisdictions.
    - In terms of consistency with health reform, the Research Group notes that there are no issues related to chiropractic services.

- *Chiropractic services may not pass the fiscal screen.*
    - Although costs are not increasing as fast as some other allied health services, costs are increasing by 5.6% a year and are not sustainable given provincial revenue growth.

Assessment by the Expert Advisory Panel

The Panel reviewed the findings of the Research Group and, based on the evidence available and the burden of proof for currently funded services, concluded that chiropractic services did not fail the first screen. In terms of the second screen, opinion was divided and the majority of Panel members did not support continued public funding for **all** chiropractic services.

The Panel was concerned primarily with continuing access to treatment for back pain. Both chiropractic services and physical therapy can be used to treat back pain. Research reviewed by the Research Group indicates that there is no evidence to suggest that one type of treatment is preferable than the other. Both can be effective for specific individuals and under certain conditions. Consequently, the Panel's view is that funding for chiropractic treatments and physical therapy treatments for back pain should be handled in a consistent way. If public funding is not provided for either chiropractic care or community physical therapy, there would be a significant gap in access to treatment for back pain. The Panel therefore concluded that continued public funding was important to ensure access to treatment in the community.

The Panel also considered whether or not public funding for the treatment of back pain (provided by either chiropractors or physical therapists) should be restricted to adults only. Because 85% of the clients are 18 years of age and older, limiting the services to adults would ensure that funding is targeted to those who use the services the most. However, there are cases where adolescents, in particular, may have back pain as a result of sports injuries, falls, or other causes. Therefore, an argument was made that they should have access to publicly funded treatment for back pain on the same conditions as adults. On the other hand, back pain is not common in young children and can be a result of serious medical conditions. Chiropractors who see children with health-related back pain would typically refer them to physicians. While there is no evidence to suggest that the treatment of back pain in young children by either chiropractors or physical therapists is unsafe, an argument was made that, because of the potentially serious health conditions involved, public funding should not be provided for treatment of back pain in children by either chiropractors or physiotherapists. Children could continue to access these services, but no public funding would be available.

Recommendations

Public funding for chiropractic services should be limited to treatment for pain related to the muscles and joints of the spine and pelvis.

A co-payment should be allowed and an annual cap should be set on the funding to be provided per person per year. A single, annual shared cap should apply to both chiropractic and community physical therapy treatments for pain related to the muscles and joints of the spine and pelvis.

Funding should not be continued for chiropractic services provided outside the province or outside Canada.

The Panel supports public funding for these treatments for adults but was unable to reach a consensus on whether or not public funding should be provided for treatment of back pain in children by either chiropractors or physiotherapists.

Advice to Minister

- The Panel did not review each of the services provided within the category of chiropractic services. Individual services could be reviewed in future for possible public funding provided that they meet the requirements of the three screen process.
- The Panel could not come to a consensus on the question of whether public funding for treatments of back pain should be limited to adults. There is insufficient evidence for the Panel to assess the effectiveness of these treatments and, given the timelines involved, the Panel was not in a position to do any further research on the question. This relates directly to an overall concern by the Panel that there frequently is insufficient evidence on a number of treatments and services to assess their effectiveness in treating certain health problems. The Panel suggests that further research should be done on the effectiveness of these treatments in children. The Panel would be prepared to reconsider the issue when additional research evidence is available.
- In the case of community physical therapy, there is evidence to suggest that services are more effective if they are integrated with other types of care. While comparable evidence is not available for chiropractic care, given the similarity in services, the Panel believes a good case can be made for improving the integration of chiropractic care with other types of health services and treatments.
- The Panel also notes that there are inconsistencies across the province in terms of chiropractors' access to x-ray services. In the major centres, chiropractors can refer patients to x-ray services in clinics and, in some cases, in hospitals. In smaller centres, x-ray services are only available in hospitals and a referral from a physician is required. The Panel suggests that regional health authorities should consider entering into agreements with chiropractors to allow access to x-ray services without a physician referral.

- In order to contain increasing costs, the Panel suggests that the government may want to consider alternative ways of capping the amount of funding provided for these services including an overall cap on the amount allocated to these treatments or adjustments to the annual cap on services per individual.

Community physical therapy

Current situation

Physical therapy provided in hospitals to both inpatients and outpatients is covered under the *Canada Health Act* but physical therapy services provided outside of hospitals are not. Currently, community physical therapy is provided by regional health authorities. Access to services is determined by a common "Determination of needs" assessment. Regional health authorities determine what specific community physical therapy services they will deliver either directly or through contracts with private providers. In 2000-01, 147,000 clients were served and just over 750,000 services were provided in non-hospital settings. There is considerable variation in access and in the services provided across the province. In 2000-01, $20.9 million was spent on community physical therapy services.

Research Group Findings

- *The program does not fail on the technical screen.*
    - Physical therapy is a safe practice.
    - The program covers a wide range of services. Evidence suggests that a number of physical therapies are effective (e.g. post-operative rehabilitation and management of some chronic illnesses). For other treatments, evidence is insufficient to assess effectiveness or indicates that treatments may not be effective.
    - Integration with other health services improves its effectiveness; however, the program currently is not well integrated with other health services although there are good examples of integrated approaches (e.g. post-operative rehabilitation and treatment of chronic conditions such as COPD and cystic fibrosis).
    - Evidence on cost effectiveness is sparse and makes it impossible to conclude whether physical therapy in its entirety is cost-effective, although therapy for certain conditions and for certain populations is probably very cost-effective.

- *The program may not pass the social and economic screen.*
    - Access to publicly funded community physical therapy varies widely and private insurance is widely used. Information suggests that access may be limited in some parts of the province because the program is funded through regional health authorities and may be a lower budget priority than other services in some regions. Catastrophic protection is not a relevant consideration.

- Information suggests that the current process for assessing clients based on need may not be effective. It is applied inconsistently across the province. Since the program is administered by regional health authorities with little overall direction, there are also inconsistencies in access and services covered.
- The availability of community rehabilitation services may affect the independence of people with certain chronic illnesses such as cystic fibrosis or COPD. There are no minority ethical issues involved.
- Other service options are available and there is significant overlap with hospital physical therapy and chiropractic care especially in the treatment of lower back pain.
- Other insurance options are available and physical therapy may be covered in employer or individual supplementary health plans.
- Community physical therapy services are not covered by the Canada Health Act; however, services in hospital are covered. Non-hospital physical therapy is not funded in the majority of jurisdictions in Canada.
- In terms of consistency with health reform, the Research Group suggests that if community physical therapy services were delivered in a more integrated way, they would be consistent with the overall direction of health reform. Community physical therapy services delivered as part of an integrated, disease management approach, as in the case of people with chronic illnesses, are consistent with the direction of health reform.

- In terms of the fiscal screen, there are no data on the growth of demand for the services. Funding for the program is included in RHA budgets and they determine annual allocations. RHAs have contained their expenditures on community physical therapy services.

Assessment by the Expert Advisory Panel

As noted by the Research Group, the primary concern is with the overall community physical therapy program rather than with the effectiveness of specific services. The Panel does not question the effectiveness of specific community physical therapy services particularly in areas such as post-operative care or care for certain chronic conditions; however, the current program does not pass the three screen process.

As noted in the discussion under chiropractic care, the Panel is also concerned about access to effective treatment for back pain. Since both community physical therapy and chiropractic care have been shown to be effective in treating pain of the muscles and joints of the spine and pelvis, the Panel concluded that these services should be treated in a similar way in terms of public funding.

Recommendations

Public funding should be provided for community physical therapy treatment for pain related to the muscles and joints of the spine and pelvis. As noted in the recommendations on chiropractic services, the Panel was unable to reach a consensus on whether these treatments should be limited to adults.

A co-payment should be allowed and an annual cap should be set on the funding to be provided per person per year. A single, annual shared cap should apply to both chiropractic and community physical therapy treatments.

Public funding for certain community physical therapy services such as post-operative physical therapy and community physical therapy for chronic diseases should be continued. The annual cap should not apply to post-operative physical therapy or treatments for chronic diseases.

The community physical therapy program should be redesigned, services should be provided in an integrated way with other health care services, and the program should be monitored on an ongoing basis.

Advice to the Minister

- The primary concern is with the way in which the current program of community physical therapy is organized and delivered and the inconsistencies in access across the province.
- The Panel supports continued public funding for community physical therapy services for post-operative conditions and for chronic diseases. Regional health authorities should ensure that these services continue to be available in communities.
- The program should be redesigned, broken up into individual services, and certain services could be considered for full public funding provided they meet the three screen process. If they meet the criteria, public funding could be provided for community physical therapy services that are proven to be effective and are delivered in an integrated manner with other health services.
- The Panel also notes that the intent of redesigning the program should not be to move more physical therapy services into hospitals so they would continue to be publicly funded. This direction would be contrary to health care reform which envisions more services delivered outside of hospitals and in communities closer to people's homes.
- As in the case of the other three areas reviewed, the government should consider alternative ways of addressing increasing costs of these services.

Review of Broad Categories of Currently Funded Services

A key task for the Panel was to review broad categories of currently funded services. Public funding is provided for the following broad categories of health services: (Note: The figures used for percentage increases in each of the categories are based on a comparison of 2000-01 to 2001-02 spending. While actual figures are not yet available, the percentage increases between 2001-02 and the current budget for 2002-03 are smaller.)

- Insured services including:
    - Medical services – medically necessary services provided by physicians and services. These services cost about $1.1 billion and the costs grew by 10.6% in 2001-02.
    - Oral surgery – medically necessary oral and maxillofacial surgery provided by oral surgeons. The cost of these services is close to $2.2 million and the costs declined by 5.2% in 2001-02.
    - Acute care hospital services – inpatient, outpatient (including emergency services) and province-wide services. This is the largest component of publicly funded health services. These services cost just under $3 billion and grew by 15.4% in 2001-02.
    - Out-of-province health care – medical, hospital and oral surgery provided in other provinces and limited coverage for services provided out of country. The cost of providing medical, acute, and oral surgery outside Alberta was $40.5 million and increased by 7.5% in 2001-02.

- Other services funded by the Alberta Health Care Insurance Plan:
    - Chiropractic services, optometry and podiatry – addressed in the previous section of this report
    - Extended health benefits – currently includes only selected dental and optical benefits for widows. This is a small program that cost $37,000 in 2001-02. The Widows Benefit program currently is being redesigned by Alberta Human Resources and Employment.
    - Government funded Blue Cross Health Benefits – for drugs, ambulance services and extended health benefits. The total cost of this program is close to $371 million and costs grew by 18.5% in 2001-02.
    - Accommodation and subsistence for out-of-province medical care – to cover travel and subsistence costs for people who receive approved medical treatment out of the country. The costs of this program were $97,000 and costs declined by 43% in 2001-02.
    - Out-of province/country allied health services – to cover chiropractic services, optometry and podiatry provided in other provinces and outside Alberta. It cost $272,000 to cover these services and costs grew by 42% in 2001-02. (As noted in the previous section, the Panel recommends that this coverage not be continued.)

- Other publicly funded services – provided through regional health authorities:
    - Continuing care services – to support long term care and home and community care. Regional health authorities spend close to $1.1 billion and spending increased by 7.3% in 2001-02.
    - Promotion, prevention and protection – to promote health, prevent injury and disease, and address health-related factors in the environment. Over $190 million was spent on these services and costs increased by 26.7% in 2001-02.
    - Mental health – to cover mental health hospital, community and outpatient services provided by the Alberta Mental Health Board. Close to $251 million was spent on these services and costs increased by 14% in 2001-02.
    - Community rehabilitation services – to support physical therapy, audiology, speech therapy, occupational therapy, and respiratory therapy. The total cost of this category of services was just under $30 million. Information on spending increases in 2001-02 is not available.

- Other publicly funded services – provided through Alberta Health and Wellness:
    - Aids to Daily Living – provides support for medical equipment and supplies for chronically ill and disabled people. This program costs close to $70 million and costs increased by 4.8% in 2001-02.
    - Air ambulance services – to support emergency and transfer of critical care patients to higher levels of care. These services cost about $22 million and declined by 13.2% in 2001-02.
    - Other departmental services – provides grants for special initiatives and contract funding for federal nursing stations in remote areas. These services cost just over $15 million and declined by 9.7% in 2001-02.

Findings of the Research Group

Overall, the Research Group found that the categories were too broad to allow a useful analysis, particularly in terms of the technical and social/economic screens. In terms of the fiscal screen, the Research Group found that most broad categories fail the fiscal screen and that current growth rates threaten the viability of the publicly-funded services.

While the Research Group was not able to usefully apply the three screen process to the broad categories of currently funded services, a sample of sub-categories was identified for more detailed review. The Research Group reviewed the fastest growing services and identified four sub-categories for further review:

- Joint replacements
- Low birthweight babies
- Diagnostic imaging
- Hemodialysis.

The full report of the Research Group on these four sub-categories is included in Appendix 4. Highlights of their findings are as follows:

- **Joint replacements**

  Joint replacements cost a total of $44 million in 2001-02 and costs have increased by 23% a year since 1998-99. Over 4700 joint replacements were done in 2001-02 at an average cost per operation of between $8,500 and $12,400. The number of joint replacements has grown by 21% a year since 1998-99. Despite substantial increases in funding to reduce waiting times for joint replacements, the median waiting times have increased from 3 to 3.6 months in Calgary and from 3.4 to 4.5 months in Edmonton.

  Joint replacements are used to treat osteoarthritis, traumatic arthritis, rheumatoid arthritis, avascular necrosis and trauma. Joint replacements can sometimes be prevented through injury prevention, reducing obesity, improving fitness, and early detection and treatment of arthritis.

  A number of factors will affect increasing demand in the future including population growth, aging and fitness. Technological advances mean there is an increasing capacity to treat both older and younger patients. Improved trauma life support and the treatment of trauma patients also increases the possibility of providing joint replacements in patients who may otherwise have died.

  In terms of curbing costs in the future, prevention may help mitigate growth. Standardization of care and provincial purchasing of prostheses may also slow the growth in costs. However, continuing to ration services may be the only way of containing costs under the current system. Adoption of new treatments and changes in practice should be based on evidence and evaluated.

- **Low birthweight babies**

  The total cost of providing medical services for babies born with low birthweights was $13.4 million in 2001-02, an increase of 11% a year since 1998-99. The average cost of treatments for each low birthweight newborn is $37,600 and there were 357 cases in 2001-02.

  The incidence of low birthweight babies is increasing. Risk factors include: smoking and substance abuse during pregnancy, poverty, age of the mother (either under 20 years or over 35 years), multiple births, poor maternal education, and poor prenatal care. With improvements in technology, more babies are able to survive at very low birthweights. While the survival rate has improved, the rate of long-term disability has not. Low birthweight is associated with increased hospitalization until at least the age of six. There are significant ethical issues involved. While a recent Canadian study showed that the majority of parents believe babies should be treated regardless of their birthweight, only a small percentage of health professionals agreed.

Improving technology will increase the survival of low birthweight babies but also increase the costs of treatment. Prevention is the most effective way of containing costs and education for parents on ethical issues is also important before babies are born. Interventions for low birthweight babies should be based on evidence and their effectiveness should be evaluated.

- **Diagnostic imaging**

The total cost of MRIs, nuclear imaging, and CAT scans was just under $77 million in 2001-02 and costs have increased by 43% a year since 1998-99. The average cost per service is between $315 and $717 and the number of services has grown by 63% a year since 1998-99. About 176,000 diagnostic imaging services were provided in 2001-02.

Advances in technology have markedly improved the effectiveness of diagnostic imaging and MR scans have become routine in orthopedic surgery and other areas. The growing demand may come from pressures from the public as well as increasing reliance on scans by physicians. Although there may be significant benefits in diagnostic imaging, there appears to be very little research evaluating the overall cost effectiveness of these changes in practice.

Given the explosive growth in some areas of diagnostic imaging, further investigation is urgently required in the following areas:

- alignment of incentives for diagnostic imaging stemming from payment schemes
- guidelines on who can order diagnostic imaging scans and on what criteria
- evidence to support new uses of diagnostic imaging
- evaluation of the cost effectiveness of current and new practices.

- **Hemodialysis**

The total cost of providing hemodialysis services was $38 million in 2001-02 and costs have increased by 20% a year since 1998-99. The average cost per treatment is $295 and over 130,300 patients were served in 2001-02. The number of patients on dialysis has been increasing by 18% a year since 1998-99.

Dialysis is required for people who have end-stage renal disease and the only alternatives to this treatment are transplantation or death. The two most common causes of chronic renal failure are hypertension and diabetes, both of which are preventable and treatable. The burden of diabetes is expected to double in the next 15 years. Half of patients aged 35 – 64 survive about six years after starting dialysis while half of the people 65 and over survive two years on dialysis. There are serious ethical issues involved in providing and withdrawing dialysis treatments. Appropriate education and information should be provided for patients.

The key to managing the growth in dialysis lies in preventing the causes of end-stage renal disease. Interventions should be based on evidence and should be evaluated.

In addition to those overall comments, the Research Group identified the following overall findings based on their review of these four sub-categories:

- The sustainability of the public health care system is threatened if the growth in currently funded services in recent years continues
- There is no single answer to managing the growth in costs and action will be required on many fronts
- Existing services should be subjected to a rigorous systematic review by the Expert Advisory Panel
- Assessments of existing and new services should include an investigation of:
    - Ways of preventing and managing the disease
    - The explicit conditions under which treatment and funding should be provided
    - The alignment of funding incentives
    - The alignment of new technology and practice patterns with the three screen process
    - A rigorous ongoing evaluation of services that are funded.

Observations and recommendations from the Expert Panel

As noted in the Research Group's findings, the categories of services are too broad to allow a useful analysis of whether or not funding should be continued for each category of services. Therefore, the Panel concludes that, aside from some minor changes, funding should be continued for the broad categories currently in place. That does not mean, however, that all services within those broad categories should continue to be funded. It simply means that categories like "medical services" or "acute care hospital services" are too broad to review.

Given the timeframes involved, the Panel was not able to "drill down" within these broad categories to identify which services should be reviewed in greater detail. However, initial work by the Research Group on four of the fastest growing services indicates a number of serious questions and concerns that should be addressed through a more complete review and analysis. The work done to date also confirms that the review process will be very effective in identifying areas where important decisions and changes could be made – not necessarily in terms of whether or not to fund the services, but in setting some necessary conditions aroundpublic funding.

The Panel believes that the next step of identifying specific services and doing a complete review in those areas is critical. The Panel has learned that once a service or treatment is funded, it simply continues to be funded without further evaluation. As new services and treatments come on stream, the Panel feels that other currently funded services and treatments should also be evaluated on an ongoing basis. While the Panel's mandate was to focus on reviewing broad categories of services, the Panel believes that the only way to make decisions about continued funding for currently-funded services is to set criteria for deciding which of these services warrant review, to establish priorities, then review specific services that match the criteria. This process would allow the Panel to determine whether or not funding should be continued and, perhaps more importantly, under what conditions funding should be

provided. As a result, the Panel will proceed to develop criteria to identify high priority, currently funded health services that should be reviewed on an ongoing basis, using the process and structure developed during its next task.

Impact of the Panel's recommendations

The Panel is concerned about the future sustainability of Alberta's health care system, but that extends beyond immediate cost savings. The Panel believes that its recommendations will support evolutionary change in the health care system. However, the Panel acknowledges that its recommendations will not result in substantial savings in currently funded health services in the short term. A number of the Panel's recommendations should curb longer-term growth in costs to the health system. The Panel's continuing emphasis on the importance of integration will support new approaches for delivering health care services. The proposed combined cap for both chiropractic services and physical therapy is a new approach that would provide choice for Albertans and may influence how services are delivered in the future.

The Panel believes that further savings will be generated when the process developed during the next phase of the Panel's mandate is activated. The extent of potential savings depends very much on a more detailed review, not of broad categories of services, but of specific areas such as diagnostic imaging where demands and costs are growing rapidly. The Panel also intends to combine its recommendations on whether or not to provide public funding with advice on how best to deliver services, under what conditions and for what groups of Albertans. In specific cases, our advice will highlight the importance of prevention as the best way of reducing future reliance on treatments and services.

The Panel was not in a position to do a full assessment of the impact of its recommendations, nor is it appropriate for the Panel to undertake that detailed work. As the Minister and government review these recommendations and make their decisions, they would undoubtedly consider the impact of the recommendations along with other considerations. As noted earlier, the Panel believes that ongoing research should be conducted to assess the impact of the Panel's recommendations on access to, and utilization of, services and on other specific areas such as the substitution of one service or one type of health care provider for another.

NEXT STEPS

The Panel's work to date has highlighted the effectiveness of a three screen approach to review currently-funded services. However, the need to "drill down" into specific services rather than simply looking at broad categories is essential and should be undertaken on a priority basis. There also may be other areas such as current policies for public funding of pharmaceuticals where the Panel could play a role, including providing policy advice to the Minister. The mandate of the Panel will need to be clarified before this work can proceed.

The next step in the Panel's work is to develop a comprehensive framework for reviewing new and currently funded services, establishing criteria for determining which services should be reviewed, setting priorities, and identifying specific services that should be reviewed on a more detailed basis as the first priority. This work will also include developing a process and structure for reviewing new and currently funded services on an ongoing basis. The objective is to build on the three screen process developed by the Panel and the initial work of the Research Group – and use that as the foundation for a comprehensive process and structure for the longer term.

The Panel is currently in the process of consulting with experts and reviewing approaches used in other countries such as the United Kingdom and Australia. Further consultations with health stakeholders are planned to seek their input on the most effective process and structure for reviewing and making decisions about publicly funded services and treatments in Alberta.

This next step should be complete by Spring 2003 and will provide a blueprint for the ongoing work of Alberta's Expert Advisory Panel.

APPENDIX 1

HIGHLIGHTS OF REVIEW PROCESSES IN OTHER COUNTRIES

Oregon

An 11-member Health Services Commission was established to make recommendations on how Medicaid coverage could be expanded to groups of people that previously had been excluded and how priorities should be set. They adopted a cost-benefit methodology that ranked conditions and treatments according to four factors: their cost; the net duration of the benefit; physician estimates of the clinical benefits; citizen views and values on the seriousness of the symptoms and their impact on limiting people's ability to function. The result is 17 categories of service ranked from most important to least important. The services in the first nine categories are deemed essential components to a health plan and are funded by the Oregon Legislature. The next four categories are considered "very important" and are funded to the greatest extent possible. The last four categories are deemed to be important to certain individuals, but less important to society as a whole. The list is updated every two years.

New Zealand

A National Health Committee was appointed in 1992 to advise on the basic health care package to be funded in their health care system. Instead of drawing up a list of services, the Committee made recommendations on services it felt should receive higher priority. A series of consensus conferences was held to draw up guidelines on particular treatments and conditions. The Committee developed the following four criteria for making decisions about a basic package of health care services to be made available to all citizens:

- Is the treatment or service beneficial
- Is the treatment or service cost-effective
- Does the treatment or service represent a fair use of resources
- Is the treatment or service consistent with community values.

The Committee consults on an ongoing basis with the medical profession to consider the desirability of particular treatments and involves the public in debates for deciding treatment priorities.

Sweden

The Swedish Priorities Commission was established to control costs, reduce waiting times, and distribute resources more fairly. The Commission established an ethical framework for health care rationing based on three basic principles: human worth, need and solidarity (resources should go to those who would benefit the most), and efficiency. The Commission separated administrative priorities from clinical priorities. The priorities range from treatment for life-threatening acute diseases to care for reasons other than disease or injury. The process resulted in the establishment of national priorities to guide local decision making in planning and delivering health services.

Norway

A review of the health system was undertaken in 1987 in response to growing waiting lists and patient demands and expectations for service. In 1996 the Lonning Committee reconvened to provide additional guidance on priority setting. The committee identified three criteria for priority setting: severity of the condition, effect of the intervention, and cost-effectiveness of the intervention. Professional groups will apply these criteria to classify interventions and conditions into four priority groups: basic health services, supplementary health services, health services of low priority and services that do not belong within government-funded health services. The establishment of a permanent national priority board is recommended, to ensure that thresholds for deciding whether a treatment is high, medium or low priority are as consistent as possible between service areas and among disciplines.

Netherlands

The Dunning Committee was established by the Dutch government in 1991 to provide advice on priorities for a reformed social insurance system. The Committee proposed a system of four "filters" to determine which services should belong in a basic package of health care - necessity, effectiveness, efficiency, and individual responsibility. Necessary services fell into three groups in order of priority:

- Those that benefit every member of society by ensuring the restoration of normal functioning or protecting that person's life
- Those that could benefit every member of society by focusing more on health restoration, i.e. emergency care
- Those determined by the severity of disease and the number of people with the disease, i.e. cancer.

Denmark

Reviews were conducted in two counties. In the County of Funen, four priorities were established for treatments:

- Possibly fatal and acute illnesses
- Illnesses that may have serious consequences if not treated
- Treatment of diseases with documented applicability, and which may have serious consequences later if not treated
- Diseases where treatment improves the quality of life, but the consequences for not treating them are less grave than for treatments with a higher priority.

The County of Storstrom established seven criteria for hospital care based on patient need:

- Acute patients
- Subacute patients
- The patient's life and mobility is in danger
- Patients whose quality of life has been impaired considerably
- Patients with a reduced quality of life
- Patients whose quality of life has been reduced to some extent
- Treatments that are not efficacious.

United Kingdom

The National Institute for Clinical Excellence (NICE) was established in 1999 to provide patients, health professionals, and the public with authoritative, comprehensive and reliable guidelines on current best practices. NICE appraises new technologies, develops clinical guidelines for managing specific conditions, and promotes clinical audit methods. Its guidelines and recommendations are intended to help health professionals to provide the most effective treatments and to protect patients from care that is not effective. It provides advice on the clinical and cost effectiveness of new and existing health technologies including pharmaceuticals, devices, diagnostic tests, surgical procedures, and other interventions. The role of NICE is primarily focused on new and expensive technologies and treatments.

Germany

A Federal Committee of Physicians and Sickness funds is responsible for determining regulations for defining the catalogue of curative, diagnostic and therapeutic services that are covered through the national insurance sickness funds. Different criteria are applied to prescription drugs, medical aids, therapeutic procedures, and diagnostic procedures. Based on its review, the Committee determines whether a procedure or treatment will be included or retained on the benefit catalogue, not provided in the statutory health insurance program, or excluded from the standard package. Guidelines are used to guide physicians' decisions, but they do not apply to the hospital sector.

APPENDIX 2
LIST OF SUBMISSIONS AND PRESENTATIONS

List of Organizations Invited to Comment

COLLEGES & PROFESSIONAL ASSOCIATIONS

Acupuncture-Traditional Chinese Medicine Association of Alberta
Alberta Association of Midwives
Alberta Association of Naturopathic Practitioners
Alberta Association of Optometrists
Alberta Association of Registered Nurses
Alberta Association of Registered Occupational Therapists
Alberta College of Paramedics
Alberta College of Social Workers
Alberta College of Speech-Language Pathologists and Audiologists
Alberta Dental Association
Alberta Medical Association
Alberta Physiotherapy Association
Alberta Podiatry Association
College & Association of Respiratory Therapists of Alberta
College of Chiropractors of Alberta
College of Licensed Practical Nurses of Alberta
Dietitians of Canada, Alberta and Northwest Territories Region
Pharmacists Association of Alberta
Psychologists Association of Alberta
Registered Psychiatric Nurses Association of Alberta

PROVIDER ORGANIZATIONS

Alberta Catholic Health Corporation
Alberta Long Term Care Association
Calgary Health Region
Capital Health Authority
Council of Chairs, Regional Health Authorities and Provincial Boards
Home Care and Support Association, Alberta

List of Professional Organizations and Service Providers Which Provided Submissions

Acupuncture-Traditional Chinese Medicine Association of Alberta
Alberta Association of Midwives
Alberta Association of Naturopathic Practitioners
Alberta Association of Optometrists
Alberta Association of Registered Nurses
Alberta Association of Registered Occupational Therapists
Alberta Catholic Health Corporation
Alberta College of Speech-Language Pathologists and Audiologists
Alberta Dental Association
Alberta Long Term Care Association
Alberta Medical Association
Alberta Physiotherapy Association
Alberta Podiatry Association
College & Association of Respiratory Therapists of Alberta
College of Chiropractors of Alberta
Council of Chairs – Provincial Health Authorities of Alberta
Dietitians of Canada, Alberta and Northwest Territories Region
Pharmacists Association of Alberta
Psychologists Association of Alberta

Presentations to the Expert Advisory Panel

Drew Hutton, MLA Edmonton Glenora, Chair, Collaboration and Innovation Committee
Dr. Larry Ohlhauser, Chair, Health Reform Implementation Team
Dr. Glenn Griener, Ethicist, University of Alberta
Dr. Norm Campbell, Expert Committee on Drug Evaluation and Therapeutics
Alberta Association of Optometrists
Alberta Association of Registered Nurses
Alberta Employer Committee on Health Care
Alberta Long Term Care Association
Alberta Medical Association
Alberta Physiotherapy Association
Alberta Podiatry Association
Capital Health Authority
College of Chiropractors of Alberta
Council of Chairs, Regional Health Authorities and Provincial Boards
Pharmacists Association of Alberta