

The Future of Alberta Health Services

Background

- Alberta Health Services (AHS), established in 2008, is one of the largest healthcare systems in the world.
- In comparison to other health systems in Canada, AHS performance is in the middle of the pack on most quality dimensions and has the highest cost per inpatient case.
- To improve the performance and sustainability of healthcare in Alberta, change is needed.

Options

There are four ways in which AHS could move forward:

1. Re-establish individual healthcare organizational and governance models
2. Restore a regional governance model
3. Retain the current AHS structure, but with modifications to refresh and expand innovation
4. Introduce a provincial super board with sector-specific sub-boards

Recommendations

There are three cross-cutting recommendations to consider if any of the delivery model options are adopted.

- Restructure Alberta Health to best support AHS by establishing clearer functions, roles and responsibilities.
- Develop a health governance council as an intermediary between government and AHS.
- Support provincial clinical innovation.



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Background

Alberta did not always have a single provincial healthcare delivery system. Stimulated by actions in the United Kingdom and Europe in the late 1980s (1), and with extensive community, organizational and provider consultations, Alberta introduced the Regional Health Authorities Act in 1995, disbanding over 220 hospital delivery organizations, and creating 17 Regional Health Authorities (RHAs). These were consolidated into 9 RHAs and 3 provincial boards in 2003. In May 2008, these RHAs and Boards were disbanded by the provincial government, and a single provincial healthcare governance and service delivery model, known as Alberta Health Services (AHS), was established. In contrast to the 1995 reform, there was no consultation with the public or providers prior to introduction of AHS in 2008. Overnight, AHS became Canada's first single provincial delivery system and one of the largest healthcare systems in the world.

History of AHS

The surprise decision by the government to move to a single provincial delivery system was bold and audacious, and the system was unprepared for such colossal change. The first eight years of AHS would see five CEOs, the creation of zones similar to RHAs but without separate governance, the establishment of Strategic Clinical Networks™(SCNs) (2,3).

The SCNs were charged with the responsibility of driving evidence-informed clinical change and measurement to achieve the Quadruple Aim (4), and a Health Governance Task Force to examine Alberta Health's involvement in daily management functions, and health system governance and performance (5). In 2014, without explanation to the public, the CEO and boards were disestablished, and an Official Administrator appointed to oversee AHS.

In 2016, a new Board was appointed with meaningful community representation and publicly respected Chair and members. The appointed CEO had a tenure from 2016 to 2022, with corresponding stability in governance. This was a period where AHS began to come together as an organization mostly out of the bright lights of the media and public scrutiny. However, this changed in 2019 when the impact of government on the Board, and Alberta Health on management, intensified. In 2022, the CEO was terminated, and the Board once again disestablished and replaced by an Official Administrator—the one who had occupied that position formerly.

A timeline of Alberta's health system from 1995 to present is presented in Figure 1.

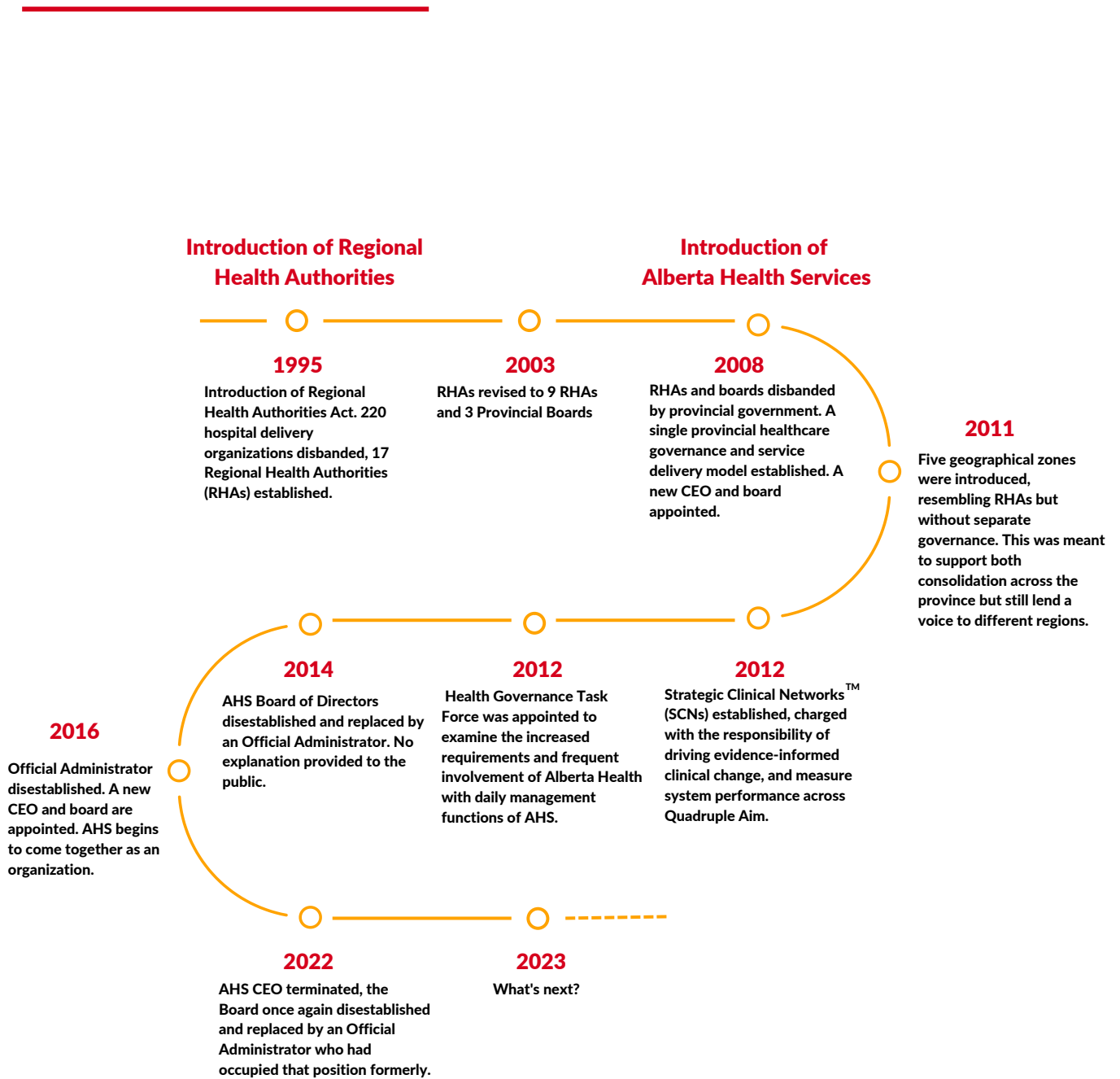


Figure 1. Timeline of Alberta's health system transformation from 1995 to present

Quality of Care

In Canada, measures of quality and safety are systematically collected and analyzed by the Canadian Institute for Health Information (CIHI) (6). This allows for inter-provincial comparisons across an array of standardized measures and assessments of performance. These measures are influenced by numerous factors, notably the health system structures and processes from which they come, and population health in that jurisdiction. The preferred model would be the one that performs highly across all quality indicators. In Canada there are three broad configurations for provincial service delivery: individual institutions (e.g., Ontario), regional authorities (e.g., British Columbia, Manitoba, New Brunswick, Quebec, Newfoundland) and single provincial systems (e.g., Alberta, Nova Scotia, Saskatchewan, PEI). Table 1 displays how Alberta's single provincial system compares to health systems in other Provinces using the latest CIHI data available.

Table 1 shows variation in AHS performance. In some cases, AHS has the best performance in Canada, such as the lowest proportion of administrative costs, overall hospital experience and hip fracture fixation within 48 hours. For most clinical measures, AHS is in the middle of the country. Notably, AHS reports the highest average cost per inpatient case in Canada.

The clinical outcomes data show high level performance in several areas, some of which are not displayed. Highest performance examples include stroke outcomes, select cardiovascular measures and reduced anti-psychotic use in long-term care. Each has been the focus of targeted province-wide clinical improvement initiatives. This suggests that further improvements in performance are possible with focused provincial clinical initiatives aimed at achieving and sustaining them. Operationalizing this is theoretically less complex in a single provincial delivery system than it is in multiple regions or with individual institutional governance and management.

AHS Performance during COVID-19

COVID tested all parts of the Canadian health system, and Canada has come out comparatively well in terms of mortality, hospital outcomes and vaccination rates. While the dynamics between provincial governments, their health systems, and ICUs varied widely across the country, AHS performed well during COVID, albeit cross-provincial data are still emerging at the time of this writing (7). Although Alberta experienced the second highest number of cases of COVID-19 per capita in Canada, AHS had the third lowest reduction in surgeries and the fourth lowest reduction in hospitalizations. The organization's provincial scope may have allowed it to coordinate operations more effectively.

Table 1. Selective measures of quality from CIHI data 2021/2022 (6)

Quality Dimension	Measurement	Provincial Ranking (1 is best)
Efficiency	Corporate Expenses Ratio (Administrative costs)	1
	Cost per inpatient case	10
Effectiveness	Inappropriate use of anti-psychotics in LTC	2
	Postoperative death	2
	Hospital mortality (HSMR)	4
	Low-risk C-sections	6
Safety	In-hospital sepsis	4
	Falls in LTC last 30 days	6
Appropriateness	Readmission to hospital: medical, surgical & obstetrical	5
	Ambulatory sensitive conditions admitted	5
	Potentially inappropriate medication prescribed for senior	6
Patient Centredness	Overall hospital experience	1
	Involvement in decision making & treatment options	3
Access	Hip fracture fixation within 48h	1
	Waiting time to see doctor in ER	4
	Has a regular healthcare provider	5
Population Health Status	Perceived health	2
	Life expectancy at 65	4
	Life expectancy at birth	5

Factors Constraining High Performance

It is beyond the scope of this paper to present methodologically sound research on why AHS is not leading in all areas of health system performance. In reality, and over the fifteen years of AHS, it has been difficult to disentangle performance of the system from external interventions in governance and management. On two occasions the Board and CEO have been replaced by a single person acting in the capacity of an 'Official Administrator'. It is a daunting proposition to consider one person over-seeing 110,000 employees, 10,000 physicians and a budget of over \$16.4 Billion. In the first instance, two Official Administrators in succession persisted for 18 months. At the time of this writing, the second such intervention is in its sixth month. How can such interventions not interfere with system performance?

Options

The promise and potential of a single province-wide delivery system is generally the same as for regionalized governance models introduced in the 1990s: greater agreement in decision-making, higher efficiency, larger economies of scale and scope, and more frequent opportunities for integration in service delivery. In terms of AHS, the reality is that there has been successful consolidation of non-clinical, diagnostic and support services at the provincial level. But, in terms of clinical integration leading to high performance, AHS achieved provincial programs only in diagnostic imaging, lab and pharmacy. Standardized clinical operations are not in place. Moreover, AHS never defined what it means to be a provincial health system and clinical care is organized differently in each Zone. Accordingly, there have been mostly middle-level results and inconsistent, high-level performance compared to other provinces. Where high-level performance occurs, it seems to be explained by focused initiatives.

In terms of service delivery and governance models, what are the options going forward? While there are potentially any number of options, three distinct options emerge from Alberta's experiences as well as a fourth novel option.



1. Re-establish individual healthcare organizational and governance model comparable to pre-1995

2. Restore a regional governance model comparable to 1995-2008

PROS

- Brings decision-making closer to the community served and makes them more sensitive to the community's needs.
- Strengthens the voice of the local public and politicians, hence is likely to be politically popular.

- Familiarity with the model based on prior experience (1995-2008).
- Could align to or arise from existing Zones. Management talent can be readily redistributed.

CONS

- Fragments the delivery system and complicates province-wide decision-making and solutions.
- Complicates achievement of economies in scale and scope.

- While less so than in option 1, complicates provincial clinical and non-clinical integration.
- Creates rural/urban divide in systems.

IMPLICATIONS

The Pre-1995 model of individual organizational governance and management is likely to be popular in rural Alberta where grass-roots community orientation is a cornerstone. That said, the transition from a centralized AHS management model to a decentralized locally based one would not occur easily and could be expensive. At the same time, this could open both opportunities and complexities by broadening municipal government participation and involvement of politicians in their systems. Hospitals and individual institutions have lost some of their identity and differentiation under AHS. This would need to be re-established.

The promises and potential of regionalization were for greater agreement in decision-making, higher efficiency, larger economies of scale and scope, and more frequent opportunities for integration in service delivery. While potentially accomplishable, this would need to be achieved while disestablishing AHS, which has been in place for 15 years. It would be unrealistic to believe there would still be a corporate memory of regionalization and residual expertise which could be readily applied. Accordingly, it can be expected that there would be a great effort required to re-establish the regional model and transition from AHS.

3. Retain current AHS, but with modifications to refresh and expand evidence-informed clinical delivery and provincial innovation.

4. Provincial Super Board with sector-specific sub-boards

PROS

- Least disruptive to the current healthcare system and less politically polarizing.
- Structures and processes are in place.
- Evidence of lowest health system administrative cost in Canada with examples of high performance in select areas.

- An innovative restart, with an attempt to create a more arms-length organization from Government and to offer local input in governance.
- The option offers the opportunity to increase integration within sectors, particularly alignment of physicians and the delivery system.
- Provides governance for parts of the health system such as primary health care that have had limited oversight.

CONS

- Retains the design flaws and complexities inherently within AHS
- Evidence of highest cost per in-patient case in Canada and mid-ranking performance in select areas.

- Intersectoral rivalry and competition for sectoral resources could complicate care integration.
- Some challenges such as mental health and addictions may span sectors and would require consideration.

IMPLICATIONS

This would arguably be the least disruptive option but would carry with it the need for a strong commitment from Government to restore governance and management of AHS and give it the latitude to evolve with a renewed role in concert with Alberta Health.

Offers a potential to readjust budgetary balances at a high level, such as incremental shifts from acute care to community and primary health care.

What would a system with a Super Board and Sub-Boards look like?

Formulate, in new legislation, The Provincial Health Services Board distinct from Government and Alberta Health. Investigate other Western European and Scandinavian systems as to how separation is best achieved. The Provincial Board could be made up of 50% appointed and 50% municipally elected members. The Board could establish four sectoral Provincial Sub-Boards for each of Acute Care, Long-term Care, Primary and Community Care, and Population and Public Health to better integrate all aspects of the health system. Physicians in Alberta would be governed by one or more board and their payment mechanism, which could include support of additional team members, would be administered by that Board.

Recommendations

There are three cross-cutting recommendations to consider if any of the above service delivery models are adopted. First, we need to restructure Alberta Health to best support AHS. Alberta Health needs to establish clearer functions, roles, and responsibilities. Such restructuring of Alberta Health in alignment with AHS was not done in 2008 and has not been done since then. Several areas might warrant attention as potential areas of overlap for provincial consolidation – data management and advanced analytics; health technology assessment and management; health human resources strategic management, to name a few.

Second, we need to reduce government and Alberta Health interference with AHS. Alberta Health interventions have occurred regardless of the government. This has slowed the progress of AHS towards being a high-performing health system. In consideration of all four options, a sound mechanism is needed to reduce government interference in the health system's governance and management.

Examples like the National Health Service (NHS) in the United Kingdom operationalized at the Provincial level might be considered. More expansively, thought might be given to forming a health governance council that is legislatively established as an agency of Government and that might include existing healthcare services, community services, physician, and other professional services, as an intermediary to government, with a broadly based board, made up of members other than political appointees. Alignment of the goals and objectives of the professions and care givers with those of AHS continues to be a work in progress and a necessity to achieving a high-performing health system.

Lastly, we need to support clinical innovation, which seems possible and timely at a provincial level. The promise and potential of provincial clinical programs needs to be expanded, but only after a thorough operational review to determine how best to achieve higher performance system-wide and greater value for money.



Restructure Alberta Health to best support AHS by establishing clearer functions, roles and responsibilities



Reduce government and Alberta Health interference with AHS by developing a health governance council



Support provincial clinical innovation

Figure 2. Recommendations to improve Alberta's healthcare system

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The Centre operates using a partnership model where community organizations and university researchers bring health policy challenges and solutions to the Centre. We broker partnerships between those with public health challenges and those working on solutions. We bring together all the key players - citizens, community groups, researchers, government officials and health system leaders to ensure we have both the necessary expertise at the table and a 360 degree view of the challenge.

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