Alberta

Unleashing Innovation Daily Report

Unleashing Innovation in Health Systems
ALBERTA'S SYMPOSIUM ON HEALTH

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Wednesday, May 4, 2005

Day 2 - The symposium continues ...

Day 2 begins bright and early. Over 400 people. Returning for Day Two of *Unleashing Innovation in Health - Alberta's Healthcare Symposium*. And the day turns into an amazing - and sometimes mind-numbing - mix of ideas, advice and information from around the world.

Dr. Matt Spence focused the room on the attributes of a high performing health system:

- Outperforming comparable systems while delivering valued products and services
- Proactively adapting and responding innovatively to environmental changes, and
- Delivering an enhanced performance while offering providers a rich quality of work life.

Day One dealt with the first of the three elements of a high performing system - People and Culture. Day Two focused on the other two elements: Financing and Decision-Making, then Technology - Innovation and Cost Escalation and Technology - e-health.

Session 1 - Quality and safety

Sir Michael Rawlins

from the National Institute for Health and Clinical Excellence in the United Kingdom provided the perspective that designing quality in health care is as much a political issue as it is a technical issue. It is also imperfect and inevitably leads to contradictions. However, we must try, test and revise; not letting the best be the enemy of the good. Designing quality is also a human resource issue - health professionals need clear standards of care and quality requires the dedication and commitment of the people delivering the care.

John Cowell

of the Health Quality Council of Alberta talked about the strong link between quality and sustainability - a system that delivers quality care translates into fewer adverse events, for example, which are very costly to the system and society. Therefore, attention to the details of quality will lead to improvements and sustainability. We need to come to a common agreement on how we define quality and how we measure quality. Let's measure the impact of what we do in health on outcomes, not transactions. We need an effective electronic health record and we need to act.

John Perry

of the National Quality Institute of Canada stressed that leaders of an organization need to be involved in the drive for quality - this isn't something you can delegate. Other key principles include an integrated

approach by management; a primary focus on internal community, patients/clients, and teams; continuous improvement and innovation; and an obligation to society at large. Perry echoed the need to make quality a human resource issue - providers need to feel involved and valued in the quality journey.

Dr. Ben Chan

of the Health Quality Council of Saskatchewan put the focus of the quality journey on measurement and quality. There's a real need to pick indicators you can do something about, and when you're putting out information, make sure that you give people tools to work with the information. Otherwise, it will just sit on a shelf. Chan issued a challenge to the Canadian health system to stop spending so much of its time on the debate between public or private health care. If you're looking for a third way, Chan said, it's all about quality.

Peter Davis

of the University of Auckland looked at the impact of the legal system in the drive for quality. New Zealand has used mechanisms outside the tort system to resolve issues around quality and complaints about practitioners. As a result, most complaints are satisfactorily resolved without moving to a disciplinary hearing - only ten out of the 500 formal complaints in the previous year went to a disciplinary process. Tort law was replaced with a code of patient rights. Injured patients can seek remedies through an Accident Compensation Corporation or through the Health Commissioner. Along with a high level of satisfactorily resolved complaints without resorting to formal hearings, New Zealand physicians are faced with very low malpractice insurance rates.

Summary Points

- Need to design for quality - it doesn't just happen. And it's not just an add-on and we can learn from other industries.
- Designing for quality should be based on best available evidence.
- Need to develop a common understanding and common definitions of quality, plus common measures, then get on with it.
- Measure what's important and what can make a difference, what you can do something about.
- Not enough to just measure and make information public. Need to get recommendations off the shelf onto the floor.
- Taking away legal blame can allow people to focus on what went wrong and how it can be fixed and prevented in future.
- Alberta's "third way" has to make quality the focus.

Session 2 - Funding and making decisions

Janice MacKinnon,

Professor, University of Saskatchewan pointed out that increased spending on health care is crowding out spending on other areas like education, poverty reduction and environment - areas that have a direct impact on determinants of health. The second problem is the structure of the health system and incentives for health providers. As a solution, McKinnon proposed tying increases in health care spending at the rate of increases to general revenue - that would pay for essential hospital and medical services. The rest of the necessary funding for health care would come from making health care a taxable benefit. Relating health care funding to the use of the tax system is common in other OECD countries - e.g. Sweden - where people pay part of the costs and these systems achieve better health outcomes at a lower cost than in Canada.

Dr. Ted Marmor,

Professor, Yale School of Management, talked about what the U.S. and Canada can learn from each other and the problems that arise from the misunderstandings and myths that travel fast across the border. Marmor challenged people to be wary of projections and easy explanations. He also pointed out that the primary value in international comparisons lies not in the ability to adopt other solutions, but to look at your own system through an international lens - to see yourself from a different perspective and walk away with a deeper understanding of your own issues and journey.

Richard Saltman,

Professor of Health Policy and Management at the Emory University School of Public Health, talked about the Western European experience with market influenced health reform. He talked about two approaches: one focused on tax-funded systems and one addressing social health insurance systems. Tax funded systems tend to expand policy-making options in the public sector, melt the boundaries between public and private systems, and expand patient choice of providers. Social health insurance systems expand policy-making options in the private sector, increase individual's financial risk, and expand patient choice of insurers. The future challenge is to harmonize health reform with cultural and social imperatives in a time of aging populations, advancing technologies, and global economies.

Dr. Martin Pfaff

gave participants a snapshot of the German system with its mix of both state managed and market-driven systems. New plans and options are being considered in Germany and will be the subject of future political debates. In his view, if competition and market reforms do not violate social values, there is no reason not to pursue them. However, his caution was that private funding is no guarantee of increased efficiency. He has not seen the efficiency of market reforms and it's important to make sure that individual reforms make a positive difference in the health system.

Dr. Rudolf Klein

from the United Kingdom talked about the public/private mix of health care finance: solutions and delusions. His starting point was the need to be clear on what problem governments are trying to solve. Are we worried about health care spending, raising taxes to pay for it, or paying for rising costs? Or, as a society, are we worried that ever increasing health care spending will reduce our ability to consume other things? He outlined the impact of different approaches to complementary insurance and supplementary insurance. And his conclusion was that sustainability is a political, not an economic, conception. Governments need to seek a social consensus on what should and should not be covered in a public health system and what level of taxation their citizens will tolerate to pay for health care costs.

Summary points

- Costs are increasing and crowding out spending on other areas that, in fact, have a tremendous impact on health outcomes.
- We need to look at new ways of funding health care and there are different models around the world.
- There are good reasons for looking at experiences in other countries - not necessarily to transplant their ideas, but to look at our own system through a different lens.
- Be clear on what you're trying to achieve. Is it just about reducing expenditures on health care or do we need to look at other factors including personal responsibility?
- Remember, there are good and bad incentives no matter what approach you use. Think about the impact of your incentives on consumer and provider behaviour.
- It's important to understand the impact of different types of supplementary insurance. First, what does it cover? What it covers can impact issues of social equity and access to care.

Session 3 - Innovation and escalating costs in health care

Dr. Egon Jonsson,

began the session with an overview of health technology assessment in Sweden. While many countries undertake comprehensive assessments of new drugs and have appropriate legislation in place, there is no such legislation to cover the assessment of other new technologies and treatments. Given the increasing costs of new technologies, it's important not only to assess new technologies before they are introduced but also to assess existing ones to determine if they continue to be effective and more effective than new approaches. The Swedish approach focused on a wide range of topics such as back pain, alcohol and drug abuse, home care, smoking cessation, asthma, hypertension, stroke, and prostate cancer. They assessed all treatments used in those areas to determine which ones are most effective. In terms of back pain, for example, they found that only one of the common treatments was proven to be effective. The challenge,

then, is to use evidence to guide and change practice.

Dr. Steven Morgan

from the University of British Columbia reviewed the economics of innovation in Canada. His key point was that there need to be optimal incentives for innovation, and they include: monopoly rewards proportional to the relative value of the end product; competition between old and new approaches; and the reward for innovation should bear no relationship to the cost of R&D. In comparison with innovative industries, performance has improved and typically, prices for new products like new cell phones or plasma televisions have come down. In health care, the opposite occurs. Over 90% of the new patented products in health care cost four times the cost of older drugs and create no substantial improvement. He encouraged Alberta and Canada to invest more in trials, in assessment, appraisal, pricing and monitoring.

Dr. Wayne McNee

described the operation and impact of the Pharmaceutical Management Agency of New Zealand. He described how the Agency has been effective not only in managing costs but also in determining which drugs will be covered and which ones will not. A variety of tools can be used to reduce prices of existing technologies and drugs, including a tendering process used in New Zealand. The Agency has also used a variety of approaches to manage demand including public campaigns for citizens and physicians. He conceded that one of the difficult challenges is saying no to certain drugs - but the key is to look at risks and benefits and to understand that some drugs simply aren't worth funding.

Summary points

- We need to collect evidence on the effectiveness of all technologies, not just pharmaceuticals.
- But the tough challenge is to move beyond compiling the evidence. It must be put to use to change treatments and practices.
- Finding better ways to introduce new and more effective technologies and also reduce prices is also important.
- Trends in health care are the opposite of innovation elsewhere - new patents in health care increase costs. And "new" isn't necessarily better.
- We also heard that we need to invest in basic science and assessment of new technologies - everything from clinical trials to monitoring.
- We also heard about comprehensive models for analyzing the cost and benefit of new drugs and technologies.
- Serious and difficult decisions have to be made when new technologies and drugs are highly effective but have extremely high costs. It's a balancing act and a challenge for all countries.

Session 4 - Technology and e-health

Dr. Richard Wootten

provided a postcard from down under and described how technology and especially telemedicine are being used to bring health services to Australians in more remote or under-served communities. Roy the Robot is a self-contained video unit that does virtual rounds and provides specialized services to pediatric patients. He also described approaches that make use of less expensive technology like e-mail to extend health services to people in under-developed countries. His message was that you can do a lot with the technology you've already got. It requires continual training and professional development to get the best results. Rather than invest in computers and software, the best investment is in telecommunications. And his overall conclusion was that e-health isn't the solution, but it certainly might be part of it.

Richard Alvarez

from Canada's Infoway declared that e-health is definitely a critical component of the future for Canada's health systems. The search for the best approaches to electronic health records and telehealth is going on around the world. The goal for Canada Health Infoway is to have an interoperable electronic health record in place for 50% of Canadians by the end of 2009. His message is that provinces can't go it alone. Alberta currently is leading the pack and has one of the most articulated plans in place for achieving the goal of

providing Albertans with electronic health records by January 2008. But to make it work, it requires strong leadership and a well planned deployment strategy. We need to keep the pressure up and don't let the best be the enemy of the good.

Dr. Ricky Richardson

pulled no punches. In his words, e-health is disruptive. It's a transformational process that has nothing to do with technology. It's painful, it's difficult. But if it's not done, the UK National Health System will be bankrupt by 2020. The current approaches are simply not sustainable and they're not in the best interests of patients. In his view of the future for health care, electronic health records will combine comprehensive information about health services and treatments with genetic information, information about travel and exposure to health risks to provide a profile of individuals and of populations. In the UK, this is the single biggest IT project on the planet and the end of the journey is by no means in sight. The future of health care is call centres providing access to the full range of care. In his view, the challenges have nothing to do with technology - they are about people.

Archie Galbraith

began with a quote from Florence Nightingale and her plea for better hospital records to show how money is being spent and what amount of good is being achieved. He quoted a headline from The Economist saying that the inability of physicians to effectively use technology is killing people. His message is that the key isn't to force physicians to use it. We have to expect and anticipate opposition and convince physicians and others in the health system that the information is more important than their opposition to change. The key is to decide what kind of health care we want in Alberta, then determine the kind of technology that's necessary to achieve it. Technology shouldn't drive decisions. Just because the tools and toys are there, doesn't mean we should use them. Technology is not a nirvana. The tough part is to get everyone to agree first on what you're trying to achieve, decide on the direction and the architecture, then choose the right technology and stick to it.

Summary points:

- Watch out, doctors, you could be replaced by a robot! However, some of you may be very happy to hand off on-call duties to people Down Under.
- We need to make use of new technologies, especially telecommunications, but there is also more that we can do with existing technologies.
- The drive towards electronic health records is international, but Alberta is the leader in the electronic health record. You have to keep the pressure on.
- E-health may or may not be the solution, but it's certainly a critical part of the future.
- E-health is about patients and they like the results.
- Decide what kind of health system you want and then use technology to help you get there.

Some words to remember

"In policy making, you can't get it right. But you can make damn sure you put it right as soon as you discover what you've done wrong."

"Too often employees in health systems say: we're in the dark. The focus is on cost not quality. Areas battle with each other. And it's only because people care that things are getting done. It doesn't have to be that way. There is a better way. And that's by nurturing a culture of quality."

"Let's stop spending so much of our time on public vs. private health care. If you're looking for the third way, it's all about quality."

"It may come to pass that the most effective remedies for the ills of the tort reparation system will be disclosed by demonstration in an attractive, usually tranquil, and very civilized little country half a world away ..."

"In Canada, we tend to believe that we can't improve quality until we get costs under control. Are

Canadians ideologically blocked from seeing quality as the true path to sustainability?"

"Preserving the essential values of Canada's health care system means we need to change."

"We need to remind Canadians where we are today. We're the third biggest spenders. We have among the longest waiting lists. Out of 24 countries, we're only 13th in outcomes. We can do better."

"Myths travel fast across the border between the US and Canada."

"The technique of trial and error is flourishing in health care. And there are too many errors."

"Investments in health care shouldn't be viewed as investments that are lost. They are investments in the economy."

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