

“Scaling Up Successes and Failures in Health Care”

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Danielle Martin Remarks – 30 minutes

Thank you Mr. Thériault and thanks to the Conference Board of Canada for inviting me to join you this evening.

Whether you are a clinician, a leader in the health sector, an employer concerned about the economics of health care, or just a concerned citizen, the imperative for innovation in health care should matter to you.

Without a doubt, Canadians feel complex emotions about our health care system – our pride in the principles it represents, our fears about its sustainability, our hopes for its future. It is not an exaggeration to say that for many people across this country, Medicare *is* what it means to be Canadian. It is seen, as Canadian Doctors for Medicare have said, as the highest expression of Canadians caring for one another. It strengthens our economy; it improves our social stability; and it gives us an example we can point to of what our nation stands for.

But each of us has also seen its failures and limitations. In my own practice I see patients every day waiting too long for specialty care, and others who struggle to afford needed prescriptions. I also see money wasted on inefficient processes and on inappropriate and useless tests and procedures. And each of you, both in your day jobs and in your work through CASH-C, are well aware of the large-scale aspects of our system that call out for improvement as well, from funding models that are misaligned with system goals to persistent shortages and maldistribution of health human resources.

Amidst all these challenges, we must contend with the added pressure of fiscal limitations as well. But as you all know, the fiscal challenge, while important, is only one piece of the sustainability puzzle. I want to commend CASH-C for recognizing the broader imperative for system sustainability: care that is fiscally sound while at the same time improves quality, fairness and appropriateness.

How can we go about seeking this comprehensive version of sustainability? My message this evening is twofold. First, as we work to improve our health care system in Canada, we are lucky to have the necessary elements available to us already. If we build on what I call the Medicare Advantage – the basic principles of fairness and simplicity that underpin our system – we can meet the challenges we face. The solutions are not fancy, expensive, or magical, and many are already well underway.

And that brings me to my second message: that the fundamental challenge we face in Canadian healthcare is not an innovation challenge. There are many examples of innovators who are working within our public systems to improve all aspects of sustainability. Rather, the challenge is one of spread and scale. In a federalist system, with powers decentralized to the provinces and local needs driving important decision-making, the biggest challenge that groups like CASH-C need to help us think through is how to spread innovation, how to bring it to scale, and how to help the whole country learn from the successes and failures of each of our local health care ecosystems.

To begin, what exactly is the Medicare Advantage? In Canada we have created a system where each province has a single insurance plan that covers everyone for medically necessary physician and hospital services. There are two reasons for this design.

First, equity. Canadians believe overwhelmingly that people with more money don't deserve faster or better care than people who are sicker. Having a single insurance plan means we all get access based on need rather than ability to pay.

Second, cost. Our system is very administratively simple. As a doctor I send one bill once a month to one insurance company – OHIP - and I get paid on time. I don't have to ask my patients if they have blue cross, red cross, green cross or any other brand of insurance – and they don't have to worry whether their insurance will pay for the particular test or specialist I want to refer them for.

This simplicity keeps administrative costs impressively low. Whereas administration accounts for 31 percent of health care expenditures in the United States for example, that number is only 1.3 percent in our public insurance plans in Canada.

So as we seek to improve and innovate, which we must do, we should do so within our public system, because the Medicare Advantage of equity along with simplicity and administrative efficiency will allow us to reap maximum benefits from the improvements we seek to make.

CASH-C has spent much of its first few years exploring the available solutions to improve system sustainability. From lean process management to interprofessional primary care teams, you have documented and evaluated approaches that, if implemented across the board, could really move the needle on system sustainability, all within the structure of Medicare. Now the question is how to move beyond pilots to system-wide change.

Canada has often been accused of being a nation of pilot projects when it comes to health system innovation. There are pockets all over the country where committed teams have come together and re-thought the way they do things to bring down wait times, or improve care quality, or prevent emergency department visits, to name a few. But we somehow haven't found the magic bullet to spread out and scale up those successful innovations.

We need CASH-C to help us reflect on the art and science of spread and scale. What lessons can be conferred from successful industries, sectors, and other health systems about how to do spread and scale well? And what are the tools we need in the system at various levels in order to accomplish this?

The first step will be to parse the difference between spread and scale. My colleagues at Health Quality Ontario have developed a useful starting point that can inform how we think about the two and how they relate. First, they define spread as horizontal diffusion, whether within an organization or across a health system. But although that sounds like it could be an organic process, spread does not simply “happen” because an innovation is shown to be successful. It requires scholarly evaluation of the sort conducted by CASH-C, a means to disseminate those evaluations out to potential receptors, and sustained leadership to push the whole process forward.

In contrast, scale is all about reach: aligned changes at many vertical levels, stimulated in a complete geographic area. This sort of change requires organizational acuity, which in turn requires the political will and proper stakeholder buy-in to accomplish large-scale action.

Spread is about learning from each other and sharing best practices. Scale is about looking for those opportunities to implement a single solution across the whole system. And depending on the innovation in question, scale, spread, or a combination of the two may be necessary to disseminate success.

Tonight I am going to share with you three concrete examples of innovations for sustainability that require our attention for spread and scale. I use these examples both as prototypes to illustrate my larger point, but I have also chosen each of them for a reason – because I believe that each represents a very high-value opportunity to improve system sustainability by applying the Medicare Advantage and is therefore deserving of the attention and advocacy of system leaders like you.

One is a program that needs to be spread across the country; the second will require a combination of spread and scale, and the third is an example of the kind of sustainability initiative that requires centralized, large scale implementation. Knowing how to implement spread and scale, and recognizing the difference between the two, is the primary challenge in Canadian healthcare and what thinkers like us need to apply our minds to.

So let's get specific. I would like to explore an innovation that has been conclusively shown to improve access to health care services but has not yet spread across the system: **centralized intake for specialty services.**

When I first started practice a decade ago, if I had a patient who needed a knee replacement, I would refer them to the orthopaedic surgeon whose name I knew. That surgeon kept his wait list in the top drawer of his secretary's desk. If he went on vacation for the month of August, the wait list just grew.

Since that time, part of the successful effort to reduce wait times in Ontario has included the introduction of Centralized Intake and Assessment centres across the province. Now when I refer a patient with late stage osteoarthritis of the knee, that person is seen within a week or two, usually by an advance practice nurse and a physiotherapist.

These highly trained professionals educate that patient about the nature of their disease, teach them exercises to improve their pre-operative strength, counsel them on the importance of weight loss, and apply an evidence-based checklist to determine whether the patient is a surgical candidate. If they are, they are given the choice to either wait for the surgeon of their choosing, or see the next available surgeon.

By instituting Centralized Intake and using interprofessional teams, two impressive innovations, we have dramatically reduced wait times and increased the appropriateness of those patients who are awaiting surgical consultation.

The obvious question now becomes, how do we expand this approach so that it becomes the way we do things across the system in Ontario and across Canada, as opposed to an approach that is specific to particular procedure?

My initial sense is that centralized intake would be best spread at the grassroots level so that as it is adopted in different locations and among different specialities, it can be tailored to the local environment. So from hips, knees, cataracts and cancer care we will need to spread to outpatient medical specialist appointments, to mental health services and beyond.

It is my hope that while spread may be slow and specialty-specific, with regional nuances everywhere, at a certain moment we will hit a tipping point where it simply becomes the way we do business in health care. Perhaps from looking at other industries where queuing theory has been applied, CASH-C could help us to understand how to get to that tipping point as quickly as possible.

A **second innovation** for which that tipping point may be not be far off is already well underway across Canada, and in this case pushing forward to achieve broad impact will require a careful mix of both spread and scale. I'm referring to a culture shift away from the presumption that the answer to our challenges in health care is always more – more money in the system, more doctors, more tests and procedures, an approach that has plagued the health care system for too long.

As a group concerned about sustainability, I know that overinvestigation and inappropriate interventions are of great concern to you. So it is promising that at hospitals like my own and across the system we are looking at inappropriate and unnecessary testing that represents harm to patients and a waste of resources.

To illustrate this principle, I want to tell you about a patient we will call Sam who came under the care of a cardiologist colleague of mine. Sam was a perfectly healthy man in his sixties. He didn't smoke or drink, didn't take any medications, and in fact he was a world ranked athlete in a competitive sport. As part of his compensation package at a fancy firm in downtown Toronto he went every year for an executive physical at a private clinic.

One year, in spite of the fact that he felt perfectly well, he was subjected to an exercise stress test, "just in case". Some potential abnormalities were identified. So he was sent for an angiogram, which is an invasive test to see if there is significant blockage of the vessels that bring blood to the heart. Happily, the angiogram confirmed that Sam did not have heart disease. But not before he suffered a stroke on the table, a known complication of the procedure that occurs in 1 in every 1,000 cases. This healthy athlete will never play his sport again because he is paralyzed on one side of his body *as a direct result of a completely unnecessary and inappropriate test.*

Millions of Canadians are harmed every year by inappropriate, wasteful and harmful tests and interventions.

Mammography for young women, PSA testing for men not at risk, colonoscopies after 5 years instead of ten – we need as a profession to acknowledge that even good tests, when used on the wrong people or at the wrong interval, really harm people. The Choosing Wisely Canada campaign is a physician-led initiative about things that physicians and patients need to question, together. It's a culture change that is long overdue. And it will have the added benefit of making resources more available to patients who will truly benefit from them. In a public system where health care is seen as a right rather than a commodity, we have an interest in ensuring that resources are directed to areas of need, as opposed to demand.

Choosing Wisely is a great example of a culture shift that will have maximum impact through a careful combination of both spread *and* scale. In some instances, concepts will spread from one institution to another, as in the example of Women's College Hospital stopping all routine pre-operative bloodwork in our department of anesthesia. In other cases, we will move to scale by making decisions to delist particular tests or interventions from our public programs based on the evidence, as we did in Ontario with serum vitamin D testing. But we will need to be intentional about when to spread, when to scale, and how to know which path to pursue.

This brings me to my third and final example of a health system innovation for sustainability within Medicare: one which is best brought to scale by a centralized effort in order to achieve maximum impact. I'm talking here about **prescription drug coverage in Canada**, which will require courage and a central push to put in place a large-scale solution to a large and thus far fairly intractable system challenge.

Canadians are rightfully proud that our universal, public health care system bases care on need rather than ability to pay. But I'm sad to say that when it comes to one essential area of health care, medically necessary prescription drugs, we are quite simply failing to live up to our principles. Canada is the only developed country with universal health insurance that doesn't include prescription medicines. The result is that 1 in 10 Canadians does not fill a prescription or take their medication as prescribed because they simply can't afford to.

I see the effects of this in my practice all the time. A longstanding patient in my practice, who we'll call Ahmed, is one such person. Ahmed is a taxi driver whose South Asian heritage and sedentary job have predisposed him to his current medical problems of diabetes, high cholesterol and high blood pressure. Although he and his wife are careful in their spending, he simply cannot support his family and pay for his medically necessary medications, which cost hundreds of dollars a month.

I worry, as he does, about the complications he may experience in the coming decades, some of which could be devastating, such as heart attacks, strokes, and blindness, because he cannot both feed his family and buy his needed medicine.

The need to expand our public insurance plans to include coverage of medically necessary prescription medicine, just as we have done for doctors and hospitals, is absolutely clear. And, in keeping with the Medicare Advantage of fairness achieved through simplicity, we actually stand to save money in the process.

It seems counterintuitive to think that covering more people would cost us less. But in fact, the economies of scale indicate that if we bargained more effectively, purchased our medications in bulk, and designed our prescription drug formulary based on evidence, the prices we pay for those drugs we already buy publicly – like for all seniors in Ontario – would go way down, freeing up a lot of money to expand public coverage.

In the absence of collective purchasing and price negotiations for prescription medicines, Canadians currently pay 30% more than the average among 30 peer comparator countries for prescription drugs. Drug prices in Canada are among the highest in the world, mostly because our myriad of private drug plans dilutes Canada's potential purchasing power on the world market for pharmaceuticals. That's why when it comes to Pharmacare, only centralized scale will enable the cost savings that would make it possible.

A recent study published in the Canadian Medical Association Journal that I co-authored found that implementing universal public drug coverage would save the private sector a whopping \$8.2 billion annually, without requiring a corresponding tax increase in the public sector. That's a 32% overall reduction in spending under a single-payer, universal drug plan.

Cost savings wouldn't be the only benefit to adopting Pharmacare. CASH-C's commitment to exploring solutions that promote sustainability of quality and appropriateness also apply here. With medicines left "outside" our Medicare system, no government has been held to responsible for ensuring appropriate prescribing and medicine use in Canada. The result is that this critical element of patient safety and quality is left to private insurance companies or pharmaceutical companies who are not accountable to the public.

If implemented correctly, a universal, public pharmacare system would improve incentives for policy makers to encourage appropriate use of medicines. It could facilitate evidence-based prescribing through a national formulary, mandate adoption of error-reducing electronic prescribing tools, and generate vast amounts of data to be incorporated into life-saving prescription drug monitoring.

It doesn't happen very often in the world of public policy that the right thing to do is also the less expensive thing to do. The economic and quality case for Pharmacare is clear. But the moral argument is just as clear: if access to health care in Canada is to be based on need, not ability to pay, there is no justifiable reason to exclude prescription medications from our public plans. We need to leverage the Medicare Advantage by bringing needed pharmaceuticals under our universal, public system, and we need the foresight and leadership of our national politicians to scale it across the country.

As I move toward the end of my remarks this evening, I want to pause by pointing out that if we focus solely on the spread and scale of successful projects in Canadian health care we will have missed a tremendous opportunity when it comes to the spread and scale of failures.

The converging currents of an aging population, a rise in complex chronic illness, a desire to move care out of hospitals and into the community, and pressure to stem the growth in health care costs all mean that we are standing on a burning platform for change. That means we have to try new things, and if we're being sufficiently innovative, a lot of them won't work.

Publicly accountable institutions can be very risk averse, probably rightly so in some ways. But as we tackle new ways of delivering health care, we need to think about how we can learn from failure rather than running from it. In that, we have

much to learn from our colleagues in the private sector. If we only scale up successful projects, we are missing half the story. Those of us in health care also need to learn how to scale up failure so that we can learn from our mistakes and improve care, and to accept that failure is the flip side of innovation. In order to build the high-quality, responsive, sustainable public health care system we all want to see in Canada, the same principles that we apply to the spread and scale of successful projects need to be applied to those that have failed.

So the next phase of work on system sustainability in Canada lies in exploring questions of spreading and scaling both our successes and our failures, in order to leverage the Medicare Advantage and deliver equitable access to high-quality care to all Canadians across the country.

My colleague Steven Lewis of Saskatchewan said it best when he pointed out that “the single biggest problem in Canadian healthcare is the failure to apply ingenuity on a grand scale.” That is the central challenge before us as we work to foster a sustainable health system: to move beyond looking at particular innovations and solutions that have been more or less successful, and instead think about the road to spreading and scaling those solutions across our country.

As the leaders of CASH-C, I know that tomorrow you are heading into a strategic meeting, and that you will soon be releasing your compendium report that will set the stage for your next 5-year mandate. As you look back on the work you have done, I know that you are struggling, as we all do, with the question of how a group of powerful thinkers and leaders like you can increase your impact, and really change systems for the better.

The work at hand is complex, and it won't happen as the result of one single intervention. But we do know that spread and scale require not only sustained, specific resources but also the political will to commit to those resources. CASH-C can play an essential role in creating the foundation for that will. Our system needs your insights, and your economic and policy expertise, to show us the way forward. CASH-C's contributions to system sustainability have thus far been remarkable. I have no doubt that that coming years hold even more promise, for your group, for our Medicare system, and for patients across this country. Thank you.