Context

The Canadian Alliance for Sustainable Health Care (CASHC) was first established in early 2011 with the inaugural meeting held in Toronto at the Deloitte offices. With the support of over 30 members, CASHC has conducted relevant research and impactful knowledge translation and exchange activities over the past four years.

CASHC members meet twice each calendar year in the spring and fall to discuss CASHC’s strategic directions. These meetings also serve as opportunities for CASHC members to connect with each other and with the Conference Board researchers. It also allows for the exchange of ideas to enhance CASHC’s contribution to a more sustainable health system.

This year’s spring meeting was, for the first time, preceded by a networking dinner and keynote presentation. The invited keynote speaker was Dr. Danielle Martin of Women’s College Hospital and the University of Toronto. Her speaking notes are included in Appendix A.

The aim of the Canadian Alliance for Sustainable Health Care is to provide Canadian business leaders and policy-makers with insightful, forward-looking, quantitative analysis of the sustainability of the Canadian health care system and all of its facets. CASHC facilitates open dialogue regarding this research and its implications, with a view to improving the Canadian health system as a whole, as well as health care practices within firms and organizations. The work of CASHC helps Canadians to better understand the conditions under which Canada’s health care system can be made sustainable—financially and otherwise.
Meeting Participants and Objectives

Please refer to Appendix B for a list of meeting participants.

The meeting objectives were as follows:

- To briefly review CASHC’s activities for the year 2014-15; and
- To engage in a strategic discussion about the future of the Canadian health system and how this impacts CASHC’s activities going forward.

CASHC Activities Update

Research

Over the last year CASHC has been working predominately on the following research projects, many of which are ongoing:

- Health Care in Canada: An Economic Growth Engine (ongoing)
- Moving Ahead: Taking Steps to Reduce Physical Inactivity and Sedentary Behaviour in Canada (completed)
- Moving Ahead: Workplace Interventions to Reduce Physical Inactivity and Sedentary Behaviour (in review)
- Mapping the Journey – Success and Failure with Lean (in review)
- Feeling at Home? A Survey of Canadians on Senior Care (EKOS Survey) (in review)
- A Base Case Forecast of Demand and Supply of Care for Canada’s Aging Population (in review)
- The Footprint of Mental Health Conditions: Healthy Brains at Work (completed)
- Multiple Sclerosis in the Workplace: Tackling the Burden of Disability (in review)

There are now sufficient projects in the research plan to fill the research pipe going forward into 2016 (5-year milestone). Please consult the Progress Report for a full list of these research projects. Over the coming year and a half we will also be working on writing the milestone compendium report, tentatively titled “A Road Map to Health System Sustainability”.
Activities

The planning of several upcoming conferences and meetings is currently underway, including the fall 2015 regional health conference in Toronto on financial incentives in health (including population health, health care systems, and workplace health and wellness). A few regional workshops in Toronto’s Queen’s Park on the topics of “Future Care for Ontario Seniors”, the “Economic Footprint of Mental Health Conditions in Ontario”, and “Innovation Procurement” are also planned for 2015/16.

In addition to delivering messages to targeted audiences on key report findings, over the past year, CASHC organized a series of knowledge translation and exchange events that have taken a variety of forms (e.g., network meetings, health summits, and webinars). CASHC members attended the

- May 20 – 21 meeting at the CPA Meeting Facility, Harbourfront Rooms, in Toronto, Ontario which focussed on strategic discussions around the future of the Canadian health system and how this impacts CASHC’s activities going forward;
- April 30 – May 1 meeting at The Old Mill Hotel in Toronto, Ontario, on “Transportation and Healthy Aging: Issues and Ideas for an Aging Society”;
- November 28 meeting at Deloitte & Touche LLP in Toronto, Ontario on sustainable health system models and upcoming CASHC priorities; and
- May 6 – 7 meeting at the Brookstreet Hotel in Kanata, Ontario on “‘Nudging’ Toward a Culture of Wellness”.

CASHC also organized two health summits:

- Western Health Summit 2015, “Making Change That Makes a Difference”, which took place on May 11-12 at the Westin in Edmonton, Alberta; and
- Health Summit 2014, “Aging, Chronic Disease, and Wellness”, which took place at the Toronto Marriott Downtown Eaton Centre hotel, in Toronto, Ontario on October 23-24.

This year’s webinars included:

- “Medical Tourism: An Opportunity for Canada?” with Dr. Ronald Labonté, Canada Research Chair in Globalization and Health Equity and Professor, University of Ottawa;
- “Healthy Active Living: Is An Ounce of Prevention Worth a Pound of Cure” with Thy Dinh, Associate Director, Health Economics, The Conference Board of Canada;
Strategic Foresight Exercises on Probable and Possible Health System Scenarios

For the May members meeting, CASHC engaged Jonathan Veale, Director of Strategic Foresight at Alberta Health, and Josina Vink, Regional Implementation Coordinator from the Centre for Addiction and Mental Health, to facilitate a workshop on the strategic foresight process.

Unlike traditional economic forecasting that focuses on the development of a probable or most-likely future, strategic foresight aims to develop a series of plausible futures. Its goal is not to predict the future, or to suggest which direction might be most desirable. Rather, the goal of a strategic foresight exercise is to offer insights to decision-makers in governments, businesses, and other organizations on how best to prepare for all possibilities, what they might do to shift toward a future they prefer, and how to recognize and adapt to events and trends that may point toward a specific future. Strategic foresight helps leaders build cohesive models of the future, view the world more systematically, and challenge deeply held assumptions. It creates a frame through which decision-makers can define policy interventions and become aware of possibilities.

After watching a short video describing how Taiwan implemented dramatic changes in its health care system by selecting the best elements from other systems from around the world (http://www.criticalcommons.org/Members/Ghent/clips/saw_taiwan.mp4/view), CASHC members highlighted the challenges and missing elements in each of four possible scenarios (see Appendix C, D, E, and F): ¹

- A: Untitled
- B: Health Incorporated
- C: New Social Contract

¹ Scenario A was inspired from content borrowed from CASHC’s July 2014 report on Defining Health and Health Care Sustainability. Scenarios B, C, and D were adapted from the World Economic Forum’s 2013 Sustainable Health Systems Visions, Strategies, Critical Uncertainties and Scenarios. These scenarios do not reflect the position of The Conference Board of Canada or the Government of Alberta.
D: Super-empowered Individuals

Through group discussions of the challenges and missing pieces in each scenario, CASHC members identified a number of opportunities for change in our current system. A few examples include increasing the focus on preventative care and healthy active living, targeting the social determinants of health, identifying and shifting fundamental values and beliefs about the current system, generating clear accountability for money invested, more fully integrating community care and multi-disciplinary teams, emphasizing a patient/person focus and health outcomes, incentivizing actions and behaviour, achieving greater action and participation from the federal government, incorporating useful innovations and technologies, and standardizing particular systems (e.g., ensuring records can be shared across different health care systems). Many of these identified opportunities will be incorporated in CASHC’s activities moving forward.

For specific questions regarding the strategic exercise process, please contact Jonathan Veale at jonathan.veale@gov.ab.ca.

CASHC Compendium Report – Milestone Deliverable

A report that integrates CASHC’s research findings and the insights from CASHC members and other experts will serve as the basis of the CASHC 5-year compendium report. The objective of this report is to lay the groundwork for more impactful and action-oriented work for the second generation of the initiative. This report will outline CASHC’s plans on how we will operationalize our mandate going forward.

The final compendium report will include an overview and summary of the CASHC research from 2011-2016. There will be discussion regarding the strengths (including the impact) of the work, but the report will also highlight the remaining gaps and opportunities for CASHC to address in the second generation of the initiative (CASHC 2.0). The work on informing the “Road Map to Health System Sustainability” will be included in the compendium report. We would like to engage a high-profile person to help write and/or launch this report. We would ask CASHC members to serve as advisors for this final report.
Identifying Research Priorities and Increasing CASHC’s Impact

Health systems are incredibly complex and changes are needed to ensure long-term sustainability. At the May meeting, CASHC members were asked to provide strategic recommendations for future CASHC research and activities. The following section summarizes some of their suggestions.

Developing a Holistic Health System Perspective

Members would like to see CASHC continue to promote a more holistic view of health care in Canada by exploring the social determinants of health and broadening the focus beyond primary acute care to measure the impacts of prevention, wellness, end-of-life, community, and senior care. They would like to see a stronger outcome and person/patient-focus in Canada’s current health system which incorporates additional aspects such as community building, income inequality, and other social determinants that affect health and wellness. They would also value additional research on patient-centered navigation, evidence-based care protocols, heavy health system users, health promotion and disease prevention strategies, and chronic conditions that affect work. This more holistic view will help decision-makers develop more effective health and wellness policies that account for relevant factors affecting health care in Canada.

Incentivizing Action

One of CASHC’s core strengths is its ability to make sound, evidence-based fiscal recommendations that incentivize action (e.g., making the business case). CASHC members would welcome additional research on ways to concretely encourage citizens and employers to make wise choices, participate in health initiatives, and become personally empowered. They suggested additional research into incentivizing the right behaviour, aligning incentives across the health system, and exploring profit as an innovation driver. They were particularly interested in the evaluation and modeling of workplace and other wellness initiatives.

Increasing Collaboration

CASHC is uniquely suited to bring government, industry, and community leaders together to discuss issues relating to health system sustainability. CASHC members would like the Conference Board to continue to leverage this capacity and to promote additional collaboration. Identifying additional ways for governments and other stakeholders across jurisdictions to share services and resources could substantially reduce costs. For example, a national pharmaceutical program would increase Canada’s purchasing power and reduce costs for both the system and individual consumers.
Increased collaboration would help decision-makers set clear public safety, efficiency, accountability, and access standards to ensure appropriateness of care across all provinces, territories, and health boards in Canada.

### Implementing Technology and Other Innovations

CASHC members would like to see Canada better leverage existing health care technology. They suggested additional research into big data and the implantation of a central health system data repository, which would enable the use of Electronic Health Records (EHRs) or Health Care Smart Cards (as Taiwan has implemented). Economic modeling which demonstrates the associated costs and savings could help decision-makers not only articulate the health and business case for implementing these technological innovations in Canada, but also identify the most effective standard data sharing points. Members were also interested in exploring other digital health impacts, such as personal monitoring devices, wearable technology, and other affordable technological innovations currently in use in other countries.

### Comparing Health System Models

CASHC members are interested in exploring different health system models. To better understand supply and demand across the health system (along with what does and does not work), they suggested a comparative analysis of current health systems and potential models, with recommendations based on the best aspects of each. A foundational report on different health models could help decision-makers choose the best business, funding, and organizational models for spreadable and scalable innovations. It could also highlight partnership opportunities between the public and private sector, and effective elements of business models that could be applied to the public health system. Health system comparisons could also help highlight opportunities for optimizing efficiencies (e.g., applying good hospital administration practices to homes and communities, and ensuring appropriate work distribution and staff loading) and for analyzing resource allocation from a systems perspective. Further research could explore relevant models for health system management, and make recommendations on how to build management and leadership capacity.

### Increasing CASHC’s Impact

CASHC members would like health to be a central feature of Canada’s political action agenda – a lightening rod around which system stakeholders can take responsible collective action. They
believe CASHC can help generate a tipping point for change around shared opportunities and values through its evidence-based recommendations. To turn the impactful research CASHC is conducting into action, members would like to see CASHC take a greater role in ensuring that its research and recommendations are shared with the right stakeholders, and that key decision-makers are included in CASHC meetings and activities. By conducting, collecting, and disseminating information, members believe CASHC could become a central distributor of good ideas for health system reform – a “clearing house of innovation” which articulates why and how stakeholders can take action. They would like CASHC to employ creative strategies to raise awareness, broaden its influence, and help implement recommendations. This could involve a variety of forms, such as organizing additional deputy minister briefings, designing workshops for targeted high-level decision-makers, acting as an advisory body to the business community, or using social media (e.g., viral videos on YouTube). CASHC provides a strong evidence-base for change and members would like to see its work generate more political action.

Feedback

We received five completed online evaluations relating to the networking dinner and keynote presentation on May 20th and the CASHC strategic meeting on May 21st. The average ratings were 5/5 and 4.2/5 for the dinner/keynote and strategic meeting, respectively. Respondents commented on the quality of the venues, the speaker, and networking opportunity. Suggestions for future meetings included more relevant health examples for the strategic foresight exercise and ensuring the meeting insights are included in a summary report for members.

Notices

New Staff Additions

Jessica Brichta recently joined the CASHC team as a Research Associate II, Northern and Aboriginal Policy, and Health Economics. We are in the process of hiring some additional staff to deliver on the research mandate.

CASHC Fall 2015 Meeting

The fall 2015 CASHC members meeting and regional health conference dates are still to be determined, but we are currently looking at November 30 and December 1. These events will take
place in Toronto. We are currently looking for meeting space. If you are able to host the meeting, please let us know.

Marlena Blasioli will be following up with dates for the CASHC member meeting, dinner with a keynote speaker, a regional conference on “Financial and Fiscal Incentive Models in Health and Health Care”.

**Member Communications**

As always, we appreciate your constructive feedback on how we can do better, and are looking at ways to better inform and engage you. Please feel free to contact us (see below) if you have any questions, comments, and/or suggestions.

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Appendix A – “Scaling Up Successes and Failures in Health Care”

A Keynote Presentation by Dr. Danielle Martin, Vice-President, Medical Affairs and Health System Solutions, Women’s College Hospital

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 rethought 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 a 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 specialties, 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 medicine 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 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 incorporate 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.
Appendix B: List of Dinner and Meeting Attendees

Canadian Alliance for Sustainable Health Care (CASHC) Member Representatives

Andrew Jones
Director, Public Policy and Government Relations
The Arthritis Society

Barb Hambly
Special Advisor, Government Relations
LifeLabs Medical Laboratory Services

Dalai Cote
Intern, Federal Affairs and Health Policy
Janssen Inc. Canada

David Walker
President
West-Can Consultants Ltd

Denise Carpenter
President and CEO
Neighbourhood Pharmacy Association of Canada

Eileen Dooley
Chief Executive Officer
Healthpartners

Eugene Wen
Vice-President and Chief Statistician
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Patti Cochrane
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Ron Vezina
Director, Corporate Reputation and Health Policy
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Sandi Sandiland  
Managing Principal, Health Care  
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Sarah Park  
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Susan Eng  
Vice-President, Advocacy  
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Invited Guests

Danielle Martin  
Vice-President, Medical Affairs, Women’s College Hospital

Jonathan Veale  
Director, Strategic Foresight,  
Alberta Health

Josina Vink  
Regional Implementation Coordinator, Centre for Addiction and Mental Health

The Conference Board of Canada

Louis Thériault  
Vice-President, Public Policy

Thy Dinh  
Associate Director, Health Economics, Public Policy

Greg Sutherland  
Principal Economist, Health Economics, Public Policy

Jessica Brichta  
Research Associate II, Health Economics and Northern and Aboriginal Policy, Public Policy

Marlena Blasioli  
Executive Assistant to the VP Public Policy and Network Coordinator
Appendix C – Strategic Foresight Scenario A: Untitled

In Untitled, increasing health care costs are critically disrupting the health system in Canada and the sustainability of publically funded care. Pressing issues include workforce shortages, patient safety, declining productivity, and declining trust and confidence in the health care system. These steadily mounting issues are challenging the extent to which (social and ?) technological innovation is believed to be able to resolve the magnitude of worsening factors in health care. Investment into research and innovation is being scrutinized by governments as a cost-saving measure. From 2015 to 2030, the ever-increasing health care expenditures on a per-capita and total health care spending have grown faster than the Canadian economy, and this is concerning to citizens and governments alike.

In this world, total Canadian health expenditures have grown from 11% of the national GDP to 16%, and from almost half of provincial budget towards 70%. Health expenditures, and acute care in particular, are showing signs of gradually pushing out other program funding, creating imbalances and conflict as citizens challenge the way government chooses to distribute scarce public dollars. Health promotion, disease prevention, and end of life supports are not treated as priority investment areas, losing out to more urgent, acute care priorities. Primary health care remains a strong investment area, since the ‘front door of health care’ allows people to remain in their community and out of the acute care system.

The rise of expenditures is not amounting to better patient outcomes, yet patient experience is valued more than ever, and is considered a strategic and relatively low dollar investment lever to improve health system value. The belief is that the design of services to improve patient experience is worthwhile, and especially in light of other cost-cutting measures. Governments and providers are seeking better value for money and prompting politicians to regularly call for improved efficiency. Governments are able to contain unit costs associated with labour, health facilities, and pharmaceuticals. This is the result of Ontario, in partnership with Health Canada, taking steps to advance a national purchasing strategy for pharmaceuticals. Most provinces eventually sign-on.

With a smaller piece of the pie, a great deal of regional consolidation is likely, with regions and delivery arms merging to increase efficiency. Large integrated health authorities emerge as provinces try to free up dollars by focusing on systems of scale. Governance of systems becomes more difficult in light of a ‘big’ scale approach. But on the flip side, efficiency is being improved with a consolidated health authority using its platform for procurement of new technologies, information management, and using data to determine appropriateness of care in more frequent intervals. Accountability for results is somewhat diminishing, without effective oversight.
Access to timely and fair care remains a strong principle for citizens. High users (multi-morbid patients) of health care are increasingly challenging the sustainability of the system and stressing other aspects of the economy. Primary care physicians are beginning to be incentivized to improve patient outcomes, and continue to strengthen patient care networks to improve access and to keep people out of the acute care system. New funding models are negotiated between public payers and private delivery actors, with the goal of incentivizing less traffic in acute care.

Funding is increasingly tied to strategic objectives. In this respect, the health innovation system is highly coordinated towards improving the Triple Aim (value for money, population health, and patient experience). Top-down, strategic innovation becomes a buzzword (“Triple-down innovation”). The private sector offers more and more solutions to fill in gaps that the publicly funded system cannot manage – wellness clinics with integrated care teams, minus traditional professions, grow; and regular ‘health’ flights between Canadian cities and lower cost health destinations (Bangkok, Mumbai, Taipei) become more common. Those who have the resources are becoming more active agents in their own care.

Citizens are threatened with the possibility of increasing taxes to maintain the publicly funded care system. Citizens are also demanding more transparency and greater involvement in deciding how public dollars are used, and are eager to monitor their health systems’ performance. With up to 70% of the provincial budget being allocated to health care, citizens are demanding change. But, the longer it takes for changes to happen, the more radical the suggestions become.
Appendix D – Strategic Foresight Scenario B: Health Incorporated

In *Health Incorporated*, the boundaries of the health industry are redefined. Corporations provide new products and services as markets liberalize, governments cut back on public services, and a new sense of conditional solidarity emerges.

To increase economic growth and spur innovation, governments liberalize their markets and enter into various supranational trade agreements. This enables health firms to access the markets of other countries.

As governments rebuild their balance sheets and adjust to ageing populations, they reduce public services to meet only basic needs and require people to contribute more out of their own pockets for health services. To defuse public tension, governments permit the private sector to step in.

Health schemes and insurance markets boom as people seek to cover their health costs. However, individuals are willing to share risks only with others who have similar or better risk profiles. People stratify into pools of varying risk exposures, some of which include benefits (such as lower premiums) for healthy lifestyles and data sharing. These health-financing schemes direct people to live in a certain way based on assessments of their risks, locking them into contracts that guarantee they adhere to these guidelines.

Governments, meanwhile, focus on regulating large integrated health providers in a complex expanding global marketplace. New and diversified business players emerge in the health industry. Large private sector firms operate the majority of health facilities. Also, firms across different industries integrate and lay claim to new international market opportunities. For example, large hospital conglomerates buy or establish joint ventures with agricultural companies to grow a wider range of “healthy” crops and with architectural and engineering firms to offer designs for incorporating healthy living into buildings.

Innovation becomes predominantly motivated by business-to-business (B2B) demands. Organizations compete and collaborate to establish the new rules of the game – standards that accelerate the adoption of technologies and business models to improve health outcomes (including the accessing, storing and disseminating of data).

However, not all people opt into a system that owns their personal data and intrudes into their lifestyle choices; others find the offerings too expensive. Faith and community-based organizations increasingly shoulder the burden of basic treatment and care for the uninsured poor.
Future Signals

- *Employer-based staff certification schemes increase.* Healthcare providers continue to lobby governments and international professional bodies for greater flexibility to certify their own medical staff.

- *Some national health systems are close to bankruptcy.* Fiscal constraints and relative demand for other government services (e.g., education) put severe strain on the provision of universal healthcare.

- *Nearly one-quarter of the population no longer has access to healthcare.* Insurance companies are increasingly selective about who they choose to insure, even excluding people from localities considered to be environmentally disadvantaged.
Appendix E – Strategic Foresight Scenario C: New Social Contract

In New Social Contract, governments are responsible for driving health system efficiency and for regulating organizations and individuals to pursue healthy living.

Against a backdrop of slowing economic growth and rising costs, health services are stretched to a breaking point. As a result, there is a fall in life expectancy for the first time in the modern age. As public funds are squeezed by the swelling cost of ageing populations, less attention is paid to the younger generation’s priorities, such as education and jobs.

Public dissatisfaction with the situation forces reforms that give governments the political mandate to fix health, education, and social care systems, and preserve social solidarity.

In response, governments start to implement strict measures to increase efficiency and temporarily ease the pressure on the health systems. Efficiency targets are set for health services, a public repository of health data is created to understand the most effective treatments, and regulatory control is enhanced so that only cost-efficient innovations are approved. The result? Heightened public support as health costs fall and gains are made in population health for the first time in decades.

However, the fundamental pressures on the health system remain, as the underlying causes of demand for health services are not addressed. Realizing the gravity of the situation, governments start to introduce broad initiatives aimed at influencing demand. These include the incorporation of responsible health into education and social programmes, regulations to ensure the built environment encourages active lifestyles, and taxes on fast food. Despite these plans, concerns remain that a combination of ageing, higher unemployment, unhealthy lifestyles, and environmental challenges will create further problems.

The realization that healthier lifestyles are vital to control demand leads to a resurgence of welfare solidarity. After an extended political debate, the New Social Contract comes into effect. That is, governments maintain publicly funded health systems in exchange for a greater regulation of lifestyles. Healthy living becomes a civic duty, with individuals sharing responsibility for their health as part of being a good citizen, similar to obeying the law. Health also becomes a human right – an expressed obligation of the state to provide. Data allow the measurement of “health footprints” or health impact assessments for organizations, communities, and individuals. Explicit targets are set for healthy lifestyles, with strong incentives for compliance.
Future Signals

- Each government ministry appoints a senior staff member who is dedicated to integrating health outcomes into policy. As a result of a significant social debate, health outcomes are now increasingly seen as best addressed across sectors, leading central government departments to be held accountable for health outcomes in their policies.

- Individual’s health outcomes as a form of civic duty to be enshrined in tax codes. After a long debate about the responsibility of individuals for their health, tax codes are likely to be changed rewarding individuals for proactively managing their health.

- Governments consider establishing fully-funded health prevention sectors. By taking on the role of first investor and major reimbursers, governments hope to create a significant health prevention sector.
Appendix F – Strategic Foresight Scenario D: Super – empowered Individuals

In Super-empowered Individuals, citizens use an array of products and services to manage their own health. Meanwhile, corporations compete for this lucrative market and governments try to address the consequences.

Growing evidence of the health gains and cost savings achieved by individuals using gadgets, apps, and diagnostic equipment to monitor their health sparks an explosion of demand in these technologies. The ease with which people monitor their vital signs in real time is aided by software to diagnose, prescribe treatments, and recommend tailored courses of action. Shifts in culture, public policy, and business models are triggered as individuals become more empowered to manage their health and illnesses on their own.

Collecting and using personal health data becomes cool and fun. People join health-centric social networks to search for new benchmarks and to swap information on the latest tests, treatments, and lifestyle fads. Websites and games enable people to assemble around topics of personal health and well-being. As a result, people become less concerned about privacy and traditional medical taboos. Healthy living becomes a hallmark of success and an aspiration, especially as people become aware of the problems of not managing their ageing well.

This culminates in a turning point, because healthcare is seen not as a right or an entitlement, but as a goal of self-actualization. Intense social pressure means alternative high-risk lifestyles are driven underground – although some fall through the cracks of the digital divide and lack the means to live like most of society.

The market booms for healthy living and wellness as corporations rush to develop products and services targeted at illness prevention and at physical and mental self-improvement. The result? The health market becomes the most dynamic part of the economy.

Governments, whose share of healthcare costs has fallen sharply, are expected to ensure quality and safety in a diverse and thriving market. However, there is growing controversy over the state’s role in paying for those who did not use new technologies or maintain a healthy lifestyle, and over the health system’s vulnerability to cyber-crime (such as data theft and fraud).
Future Signals

- New health reimbursement schemes based on individual preferences proposed. Introduced by individuals’ increased desire to be more active participants in the management of their care, new schemes will enable their wishes to be factored in.

- Major food and beverage company close to collapse. After several years of falling demand for its products as a result of a significant cultural shift towards healthy consumption, the company today announced that it is considering bankruptcy, following the path of many industry incumbents.

- The health data industry soon to become larger than the financial data market. The introduction of financial reimbursements to people to share their health data has unleashed the health data market, now making it almost as large in market capitalization terms as the financial data sector.