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ALBERTA CANADA

VALUE FOR MONEY IN THE HEALTH SYSTEM

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Event Proceedings

IHE Innovation Series
Forum VIII

About the IHE

The Institute of Health Economics (IHE) is a not-for-profit organization committed to producing, gathering, and disseminating health research findings relating to health economics, health policy, health technology assessment, and comparative effectiveness. This work supports and informs efforts to improve public health and develop sustainable health systems. Founded in 1995, the IHE provides services for a range of health-sector stakeholders, and is governed by a Board* that includes representatives from government, academia, health-service delivery organizations, and industry:

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Preface

In December 2008, the Institute of Health Economics launched a series of semi-annual Innovation Forums whose goal is to bring together senior public and private sector decision-makers to address policy issues of importance in the health care system, not just in Alberta, but to all of Canada and the international community, as well.

"Value for Money in the Health System" was the eighth in the series of Innovation Forums. The keynote speaker, Mr. Don Drummond, Matthews Fellow and Distinguished Visiting Scholar in the School of Policy Studies at Queens University, and a former Associate Deputy Minister of Finance in the Government of Canada, as well as a former Senior Vice President and Chief Economics at TD Financial Group, presented on *The Imperative of Greater Value for Money from Health Care.* Mr. Drummond most recently served as Chair of the Commission on the Reform of Ontario Public Services, which released a major report earlier this year on ensuring the sustainability of health care and other public services.

Mr. Drummond's presentation can be found on the IHE website at http://www.ihe.ca/research/innovation-forums/---value for money in the health system/.

IHE Innovation Forums

Forum I: Paying for What Works. Comparative Effectiveness of Health Technologies and Programs – December 2, 2008

Forum II: Making Difficult Decisions – May 25, 2009

Forum III: Maximizing Health System Performance. Cost Containment and Improved Efficiency – December 1, 2009

Forum IV: Innovation and Economics. Investing in the Future Health System – April 22, 2010

Forum V: Innovation and Sustainability in Health Systems – October 14, 2010

Forum VI: Maximizing Health System Performance – Assisted by Evidence, Science, and Information Systems
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Forum VII: Social Determinants of Health – May 31, 2012

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VALUE FOR MONEY IN THE HEALTH SYSTEM

Welcome and Opening Remarks

Master of Ceremonies: Dr. Lorne Tyrrell, Chair, Institute of Health Economics

My name is Lorne Tyrrell, and I have the honour of serving as the chair of the board of the Institute of Health Economics. On behalf of all of the members of the board, our CEO, Egon Jonsson, and the whole IHE team, it gives me great pleasure to welcome you to the eighth IHE Innovation Forum.

Since December 2008 we have held these forums in conjunction with our semi-annual board meetings. I am very pleased that we have been able to do this so successfully, as I think it has become an important fixture on the healthcare landscape in Alberta. These forums provide a great opportunity for Alberta health system leaders to learn from international thought leaders and experts. They also provide a chance for all of us in Alberta's health system to discuss informally how those lessons might be applied in this province. Good things happen when people get together, and we at the IHE are pleased to provide a forum for that.

Before moving into the program, I would like to take a moment to thank a few people. First, I want to recognize the board of the IHE. I don't know how many are here, but I know that the most faithful board member ever, Terry McCool, is here from Toronto. He has just stepped down from the board, but he never missed a board meeting except on one occasion when we changed the date. This man had has had a tremendous amount to do with the success of the IHE.

I also want to give special thanks to Egon Jonsson, our CEO. Egon and his team have built the Institute into a thriving organization that is recognized nationally and internationally. It is a unique organization because it brings together academia, government, healthcare system leaders, and the private sector. We have always believed that industry should be at the table. The problems we face in improving the health of Albertans are so challenging and complex that they can be solved only through partnerships, and I am pleased to lead an organization that puts partnership at the forefront. Thank you, Egon, and everyone at the Institute.

I want also to acknowledge the board and the management of Alberta Health Services. They have supported these Innovation Forums, as well as many other IHE events. And, finally, I would like to thank the Government of Alberta. We are delighted to be joined today by the Honourable Fred Horne, Minister of Health. A friend and a colleague of the Institute for many years, he was a leader in the health system long before he became a minister and he continues to serve the system with great distinction. Another key governmental partner is Alberta Enterprise and Advanced Education, and we are honoured to have the deputy minister here today.

The theme today is value for money in the healthcare system, an area that clearly needs more concentrated effort and attention. We have an aging population. We have new technologies and more effective drug treatments, but often they are far more expensive than the technologies and treatments of the past. Our keynote speaker, Mr. Don Drummond, has pointed out in his report to the Government of Ontario that health care is, in technical economic terms, a luxury good. That does not mean that it is a mere luxury, of course. It means that we spend more on it as we become wealthier and, of course, as we get older. The question is whether we are going to have more to spend, and, if not, how we can control the rate of spending and maintain the system. This means maximizing the value we get for our money. The IHE plays a key role in this field, of course, but it is our partners that make it possible. The strength of that partnership is reflected in the program today, one which, I think, really is extraordinary.

If you look at the people who have taken time to participate today and consider the demands they have on their time, I think today's event is a new benchmark of our Innovation Forums. Alberta is a place where people put aside the sign on the office and get together and learn from each other.

We are honoured to be joined today by Minister Fred Horne, a long time friend and colleague. As you know, Fred was elected first in 2008 and again in 2012, and was appointed Minister of Health and Wellness in 2011.We have been fortunate over the years to have him participate in many of our events, and all of us in the health system are fortunate to have him serving and representing us in the cabinet.

Honourable Fred Horne, Minister of Health, Government of Alberta

I have had the pleasure and the privilege of attending a number of these Innovation Forums, beginning long before I was appointed Minister of Health. One of the greatest challenges of being involved in health care is that things change rapidly and it is often difficult to find the time and space to do what I call the thinking work. The Innovation Forums provide that time and that space. I have participated and I have talked to other participants, and I know that the discussions and learning that come from these events have a very marked influence on how we conduct ourselves in our respective roles in Alberta.

I want to take the opportunity to welcome Mr. Don Drummond to Alberta. It is a pleasure to have you here, as I have followed your work in Ontario very closely, and before that as well. I am looking forward to hearing your address.

I come from a health policy background of about 30 years. I started as a health planner in the old District Health Council program in Ontario, and probably 99 percent of the reason that I entered public life is because I became very interested in the question of change. In the policy domain, we have many opportunities to talk about new ideas, to read about new ideas, and to hear politicians and other leaders talk about big changes. Unfortunately, very few of those game-changing strategies seem to be brought to bear. That is not a reflection on anyone in particular or on the quality of the ideas, but change is what we must have in health care. So I want to talk about today's theme of value in health care in the context of change. I'll start with a bit of perspective.

Traditionally, elected officials have talked about the sustainability of health care by talking about health care as a proportion of the total provincial budget. Some choose to talk about it as a percentage of gross domestic product. No matter how you cut it, that is a woefully inadequate description of the problem that we face. The fact that we spend 41 percent of the provincial budget on health care, or the fact that Ontario

and Québec are spending closer to 50 percent, is not in and of itself a call to action. There is no greater way to learn that lesson than to enter elected life and to attempt to discuss with a constituent an issue that involves millions, if not billions, of dollars. It tends to be a very short discussion, because of course people don't look at things from that point of view. Their value proposition for the healthcare system has absolutely nothing to do with how many taxpayers' dollars are devoted to a particular program, and that is probably as it should be. I am going to talk about some alternatives to our perspective on value a little later.

What worries me about this closed perspective on sustainability is that nobody talks about what happens when we hit 50 percent. As someone who makes some pretty significant financial decisions, what concerns me is not so much whether that is too little or too much to spend on health care. It is the fact that the day that one of the provinces in this country hits 50 percent is the day that health care becomes an opportunity cost for advanced education, for infrastructure, for the environment, for human services, for all of those other very important public policy priorities that people hold dear. If you carry that thought a little further, you quickly come to the realization that all of the things for which health care may become an opportunity cost are, in fact, the social determinants of health, things like housing and income and education. That is a reason to be concerned. I think we have a responsibility as ministers not to allow health care to become an opportunity cost for public policy in other critical areas.

We should not be talking about cost. We should be talking about the value derived from the expenditure of resources. That involves a little bit of bravery, particularly when you are in a leadership role, because in this country we have tended to look at health care as an important public good, but not as a commodity. In fact, when it comes to talking about health care, we ignore many of the criteria that we might apply if we were talking about a good or service in the private sector. As IHE has helped to remind us, we do not talk enough about the role of evidence in making good decisions about drugs, devices, clinical protocols, and other inputs to the system. We have done some good work in health technology assessment, and we are beginning to acknowledge that evidence must play a role in the decisions that we make. But we have not yet arrived psychologically where we need to be, which is where evidence drives decisions about resource allocation in the healthcare system. That is something that we have to confront.

I think that one of the reasons we do not want to confront our application of evidence is that acknowledging the direct link between evidence and the value proposition for health care would force a discussion about standardization within our system. We would be faced with reconciling what we know to be supported by the evidence with what we actually do and what we actually pay for.

It goes back to the question of value. As Canadians, we have chosen to view the healthcare system as a value. Mr. Romanow's report of a few years ago made it very clear that he was examining these questions largely through the lens of health care as a value of citizenship in Canada. Similarly, many people like to think of the formation of medicare in 1962 as recognition that we should have strong universal publicly funded health care as a value of being Canadian. That is a noble idea, and I think the people who pioneered medicare had that in mind to a certain extent, but it was not their first frame of reference. In fact, it was on the principles of insurance that public health care was founded in this country. It was based on the very clear principle that no citizen should have to suffer undue financial hardship as a result of illness or injury. Even in Alberta's early legislation and health policy, we can see that personal responsibility — the responsibility of individuals, families, and communities to try to mitigate the risk of incurring illness or injury — was quite openly discussed in a way that we don't engage in today in public discourse about health care. If we are going to discuss value, we need to be very clear about what we mean. There is certainly room

for the sentiment, if you will, that we attach to our healthcare system, but we also have to be prepared to look at value from an economic standpoint.

Once we agree on the question of value, how do we measure whether or not we are getting value? If you ask a group of people what they think is wrong in the health system, they will cite a perception that there is a lot of waste in the system. Sometimes that waste takes the form of people going to an emergency department for services that they should be accessing at the primary health care level. Sometimes people talk about administrative waste. When you dig a little deeper and ask what proportion of the total health budget they think is wasted in this way, nearly every time people will say 30 percent or about a third. It is very consistent. They are not questioning the amount of resources that we are putting into the system. They are questioning whether those resources are utilized appropriately from a consumer standpoint.

I like to look at the value proposition a little differently. Universal publicly funded health care certainly involves people being looked after when they are sick, but its ultimate purpose, in my view, should be to improve the health status of people over time. That means paying attention to some of the very startling statistics that we are faced with in Canada today despite the tremendous resources we put into our system. In recent months, the statistic I have been thinking about the most is the fact that this is the first generation of Canadian children to have a lower life expectancy than the generation that preceded it. This country is, I think, the fourth highest per capita spender on health care in the OECD and yet it has some of the lowest population health performance indicators. In fact, at best, we are in the middle of the pack.

This question of value must therefore go beyond our ability to keep up with the demand for resources and it must look beyond how we can simply continue to do things in the same manner as in the past. A recent study from the University of Calgary talked about chronicity in the population and the burden on future generations. Those sorts of economic projections are useful to a point, but most of them are based on the assumption that we will continue to do things the way we have always done them in the past. We cannot move forward with that assumption if we truly want to address this question.

I have the privilege of being in a province with arguably the best healthcare system in the country. We also have one of the highest rates of acute-care utilization in Canada and very high rates of diagnostic imaging. The reason for that is fairly easy to determine. We have been fortunate in Alberta to have the financial resources to invest in our health system, and we have chosen to invest a great deal of those resources, arguably appropriately, in the acute-care sector, in areas like technology, in the traditional bricks and mortar that we associate with tertiary care. At the same time, our health status indicators are not what we would like. Again, if I go back to my early roots as a health planner, what we considered the building blocks of a strong healthcare system in those days were things like primary health care, continuing care, and mental health care. Not the sexiest things to be out there talking about when you are a health minister. Talking about primary health care does not give you many opportunities to cut ribbons on new facilities or to unveil the newest and best high technology, but I think that is where our discussion of value has to go. It has to look at the quality of the job that we are doing at the foundational level in our healthcare system.

I will take just a couple of minutes to talk about what I think that might mean. I am sure that all of you are aware of our current focus in Alberta on primary health care. We have made a commitment to give every Albertan a home within the healthcare system. We have talked with Albertans over the last couple of years, and, as many of you know, if you ask people their impression of the care they receive, they will tell you readily that when they were in the hospital the care was excellent. If they had surgery or cancer treatment,

they will call it second to none, and they will rave about it. But they will inevitably end the description with a qualifier: "Everything was wonderful once I got in the door."

We have chosen as a government to focus on opening that door, but it is more than the sentiment of having a home in the healthcare system. We believe that the value we are seeking for the dollars we are spending is largely going to be found in strengthening the relationship — the attachment, if you will — between citizens and the team of healthcare providers that is serving them. That is not something that we have seen a great deal of in this country. We have seen attempts at capitation models, but we have never approached it by asking what incentives would lead citizens to want to form this attachment, to recognize the team of providers as their home, and to be receptive to being supported by that team of providers to mitigate their risk of developing chronic disease or of suffering an injury.

That brings me to the second part of the equation. We can talk about giving people a home in their healthcare system, but we cannot do it by simply paying for the same services two and three times over in the hope that at some point in the future strong primary health care will be of benefit to our citizens. We need to think about what factors would attract citizens, our families and communities of today and tomorrow, to cement this relationship with primary healthcare providers.

We have invested a great deal in technology, and in Alberta we have some very good surveillance. We do not do a great job of sharing the data that we are collecting, and we are working on that. We have six research ethics boards in a population of 3.8 million, and we need to do something about that. We don't necessarily do as well as we could in partnering with industry, but we do have the processes and collection methods in place to know what some of the health challenges are at a community level. As a simple example, we have for years been tracking the A1c levels of people who have blood tests. As a result, we know who has diabetes and we have the ability to discern who among our population is most likely to develop type II diabetes five years from now. And yet we have not organized our systems or aligned resource allocation decisions to support those people in mitigating their own risk. This goes back to the principles of insurance that I talked about earlier.

Again, to go back to my early experience, people regarded health promotion largely as a question of marketing. They believed that if you put up enough signs that said smoking is bad for you it would influence behaviour. Of course, we know that not to be the case. What we do know is that patients and families today are much better informed about health. Many are motivated to achieve the best possible health status they can for themselves, for their children, and in many cases for aging parents that they are helping to support. They are very receptive to the provision of information and to the coaching and mentoring that a strong primary healthcare team can provide.

Arriving at the true value proposition for Canadian health care — and, if you accept the sustainability frame as the problem, dealing with that problem as well — is largely tied up in our determination as a society to return to those fundamental building blocks of a high-performing healthcare system: primary care, continuing care, and mental health care. That will mean making some tough decisions, because we do not have enough resources, even in Alberta, to throw additional money into those three areas, nor should we. What this demands from us is the determination to re-allocate existing resources based on evidence and, with the support of healthcare providers who are involved fully in the discussion, to refocus our system on those building blocks, to stop doing things in hospitals that we can and should be doing in the community, and to ensure that we are making resource allocation decisions that reflect that attitude. There are many opportunities to manage our spending better. We have to stop being afraid to regard ourselves as anything

other than very discerning purchasers of goods and services. On a national level, we certainly need to do more to improve efficiency in areas such as long-term care and drugs — as a population, to pool our risk and our resources and to find innovative ways to fund those services. And, finally, we have to have the courage and the determination to bridge the gap between what we know and what we are doing by applying evidence in a very direct way to decisions that ultimately have long-term impact.

I have said this before, but it can't be said often enough: we have had a great deal of change in health care in this province, particularly over the last three years. It has been a tradition to reinvent the system and to develop new plans and new frameworks. We are not afraid in Alberta to try new things, and that is one of the reasons that I came here. But we are not going to achieve value unless we are prepared to build a sustainable platform for healthcare service delivery. That is why we established Alberta Health Services. We now have a single platform across the province. We are seeing newly developed clinical pathways rolled out uniformly across the province, we are seeing tremendous efficiencies in administrative costs, and we are beginning to see a real focus on primary health care. You will continue to have my pledge as your minister, and the premier's pledge, not to reorganize or restructure or otherwise disrupt what you are doing currently. We very much support what you are doing, and will continue to provide that stable platform.

Thank you again for the opportunity to share a few thoughts with you. And thank you for the leadership that you are providing in moving us toward a value-driven healthcare system.

Lorne Tyrrell: Thank you very much, Fred. I would like to call on Deborah Marshall to introduce our keynote speaker. Deborah is an associate professor in the Faculty of Medicine at the University of Calgary. She holds a Canada Research Chair in health services and systems research, and she is Director of Health Technology Assessment at the Alberta Bone and Joint Health Institute. Deborah is also a colleague at the IHE, and we always look forward to working with her because she brings tremendous enthusiasm and value to any project. We are delighted and grateful that she made time to join us today. Deborah Marshall.

Keynote Presentation
The Imperative of Greater Value for Money from Health Care

Introduction: Dr. Deborah Marshall, University of Calgary

Thank you very much, Dr. Tyrrell, and thank you, Minister Horne. As a health economist, the way you talk warms my heart.

I have the big privilege of introducing our keynote speaker, Mr. Don Drummond. IHE, as all of you know, has a great history of bringing phenomenal speakers in for these events. But I have to say that Egon [Jonsson] has really outdone himself this time. I do not know how he figured out that Mr. Drummond was going to be a candidate for the governor of the Bank of Canada, but, clearly, you are catching on to a new way of forecasting that works. For those of you who question forecasting models developed by economists, take note: Dr. Jonsson has the formula.

When I was asked to do this introduction, I was very intimidated and I had to look up Mr Drummond's official biography. It said that he is "frequently quoted by the media on economic and policy issues." I'm an economist, and I thought, what does 'frequently' mean? I checked on this, and it turns out that Don Drummond's name has appeared in the Canadian media just about 1800 times this year alone, and the year

is not finished yet. In my health economics notebook, that is more than frequently. It is about four-and-a-half times a day. So Mr. Drummond is both a media star and a serious economist. He says what the data say, whether people like it or not; but on the other hand, he is always clear that economics is just a tool for helping us do a job. What do we want our province or our country to look like, and how do we get there? It is not about defining our goals. It is not about imposing preconceived ideas. It is about how we get to where we want to be.

People like Don Drummond are why our Canadian banking system is the envy of the world, and that alone would certainly be good enough to make us want to be here to hear him talk; but he also, as you know, has had multiple careers, three major ones. He was the Chief Economist at the TD Bank and the federal Associate Deputy Minister of Finance. And then he retired, and we all know that people like this don't retire. He is currently the Matthews Fellow in Global Public Policy at Queen's University where he teaches. And since he had a lot of time on his hands — you know, being an academic is only a part-time job — he also decided that he would fix the finances of the Ontario government. He was appointed chair of the Commission on the Reform of Ontario's Public Services in 2011 and released his final report in February of this year. It is a very long report, over 600 pages, but the chapter on health care should be required reading for everyone who works in health policy and health economics. Obviously the recommendations are for Ontario, but I think the general recommendations and the directions and the guidance in this report apply everywhere, including Alberta. There is a huge amount that all of us can learn from this report.

Of course, there is nothing like hearing it straight from its creator, which we are about to do. There is no one in public life that we would be more keen on hearing from than today's keynote speaker. As I was sitting here, I saw a quote from Gary Mason in The Globe and Mail, which I think summarized it all: "The Drummond effect is felt across the land."

Thank you, IHE, for bringing Mr. Drummond here, and welcome, Mr. Drummond. We are very excited and looking forward to feeling your effect.

Keynote Speaker:
Mr. Don Drummond, Former Senior Vice President and Chief Economist, TD Bank Financial Group

Thank you very much, and good afternoon to everybody. Just to come clean, I don't know an awful lot about the Alberta health system. (Close the door so people don't race out of here!) The little bit of research that I did in Alberta, though, made me regret that I wasn't asked to look after Alberta's health system instead of Ontario's. I think that would have been even more fun, because while it seemed that everything I looked at in Ontario's system was bad, yours is maybe terrible compared to their bad. Keep in mind that people like me don't have to bother fixing things. That's over to the minister and his bureaucrats when we make our recommendations. It's just fun to look at how something works.

It has been interesting for me to have that third career. It has added a dimension to my observations of public policy that I had not anticipated. It is an opportunity to step back and look at things without being saddled with implementing and defending them. You can look at the commonalties of programs and at where something went well and something went wrong. My observation is that it almost always starts with the very first step. What was the motivation? What was the objective? Almost every program that goes off

the rails does so because the motivation and the objectives have not been set out very carefully. You end up with a mess because you started off with a mess.

That was, in fact, my difficulty when I started the Ontario commission. The motivation was all wrong. My mandate just said to make sure that the Ontario deficit goes away. I could have done that in about two or three days, because all governments in Canada, including Alberta's, accomplished that feat in the 1990s. And in many cases, they didn't have to be particularly smart or strategic. They just starved funding for a number of years. That caused a lot of problems, but fortunately their budgets balanced before the problems brought down their economies, or their governments.

I think there are a couple of lessons to learn from that. It did not prove to be durable. If you look at the fiscal results of the mid 1990s, every jurisdiction had extraordinarily strong spending in the first two years after the restraint. In Ontario's case, there were three consecutive years of 1 percent increases and then increases of 11.4 and 10.2 percent. If they had never implemented the restraint, they probably would have had the same level of spending by the end of the five years. No government in Canada — and I would include Alberta — did the bare-knuckles reform that they needed to do. For the most part, they just starved the system of money; and there was a perception, if not a reality, of that creating undue pressure, particularly on wait times, and people were getting irritable about that.

Fortunately, the economy started to grow fairly rapidly towards the end of the 1990s. Of course, the dollar was tanking — remember, it hit 62 cents — so we had that competitive boost. The US economy was growing relatively strongly. The revenues were coming in the front doors, and governments heaved a sigh of relief.

I thought, if that's all you want to do, that's really simple. I can just say, "Here's the mathematics. You're in a deficit. You want a balanced budget. Here's the amount of money you've got to cut. Just pull out the playbook from the 1990s." However, I don't think that would work again in Ontario, and I don't think that would be a valid approach in Alberta either.

First of all, my bet was that this time Ontario is not going to get the economic and fiscal reprieve that it got in the 1990s. The Canadian dollar is still hovering around parity, not at 62 cents, and economic growth in the US and the rest of the world is in a real funk and cannot give support. We have got quite a pronounced slowdown in labour force growth in Canada, and it has been about 30 years since Canada had decent productivity. Hopefully, that will change, but if you haven't had something in 30 years, you have to wonder how likely it is that it will be coming next year.

Looking at that historical record, I thought that the motivation for what I was being asked to do was completely wrong. What I should have been asked to do was improve the value for the money that is being spent, not just on health care, but on everything. Even if your objective is to have a nice balanced fiscal position, in the long run that can come only if you are delivering public services of a certain quality, not just cheap public services. Delivering cheap public services will buy you votes in the short term, but I don't think it will in the longer term. It is just not sustainable from that perspective.

I approached absolutely everything in this commission from the question of how to derive better value for the money, and within that context, at least in the short term, how to take some money out of it. I was much more focussed on the period well beyond the government's end point of 2017 than on the period up until 2017.

Now, what motivated the Ontario government to ask me to lead this commission? It was clear in the mandate that they had only a single motivation, and that was to get rid of their deficit. If they cared about the quality of health care or the public perception of health care, they certainly didn't convey that in anything that was passed to me or in any of the public messaging. It was singularly a fiscal objective, and I think that is quite substantially off the mark. The objective should have been twofold: to increase the quality of the system and to get money out of the system. That is obviously a much more difficult task.

I feel sorry for the Alberta health authorities because you do not have the convenience of an Ontario-style fiscal crisis. If I were the Alberta Deputy Minister of Finance and my sole objective was efficiency reform of the healthcare system, I would be wishing for a fiscal crisis, because it is very rare for a government or even an individual minister to wake up one day and, out of the blue and without a context, say, "I have an idea to make the world better." Whenever we have efficiency gains and greater value for money it is because of a fiscal squeeze. Ontario's got it. Quebec's got it. Virtually everybody else has got it. Does Alberta have it? You are probably going to dip back into deficit this year, maybe around $3 billion, but that does not seem to be that big. And, of course, you have an ace that Ontario and the others (other than Saskatchewan) do not have, in that you do not have a huge debt. So you don't have a fiscal crisis.

One thing that has been bugging me in the last couple of years is the notion that because things have recently been pretty good here economically they are going to be good forever. Whether you go back to the 1940s or the 1890s, you see the same thing over and over again. You have a good run for a few years, and people think it is going to be like that forever. And, of course, it never is. Does what's going on in the rest of the country have any relevance? I would say that it absolutely does.

The recent natural gas scenario is a reminder of how things can go. I suspect that if this were 2005 or 2006, we would have a tough time finding anybody to bet against the prediction that gas would be over $10 per billion cubic feet. It was thought to be the fuel of the future. It was clean. It was going to replace all the coal generation. It was going to be up, up, and away. Yet the price of gas only recently came up from the bottom basement, and it is still hovering down at about a third of what anybody would have bet it was going to be. Who knew that shale gas was going to be economical at such low pricing? Who knew there would be reports from the International Energy Agency that the United States may well be a net exporter of gas within 10 years? Now they are saying that within 10 years their import requirements for oil might be 10 percent of their former requirements. They might have more reserves than anybody in the Middle East. That all happened in a short period of time. That's got to make you think. So I am not sure that Alberta should think it is different from Ontario.

Here is the part that interests me. I said I would go back to the topic of value for money spent. Alberta spends about 10 percent more per capita on health care than do other provinces. On an age-adjusted basis, given that Alberta has a young population relative to the other provinces, you are closer to spending 20 percent more on health care than everybody else. And you are the wealthiest province. If you look at individual incomes and at GDP per capita, you are way above the rest of Canada and well above the average. Alberta has gone from approximately Ontario's level to dramatically over Ontario's level in a fairly short period of time.

As the health minister indicated, health care is a positive good as opposed to a luxury good. Luxury goods are ones that people buy more of when the price goes up. What does a Gucci handbag cost? Maybe $2000? And if you raise the price from $2000 to $3000, people buy more of them. That's a luxury good. Health care is a positive good, in the sense that you want to spend more on it as your income goes up. In Alberta, it

would be a perfectly legitimate decision as a society to consume more health care because you are wealthier than everybody else. I think that beneath that is a proposition that you want to consume better health care, not just more expensive health care. But, of course, what you actually have consumed is more expensive health care and not better health care.

I lament that we do not have more objective measures of the quality of a healthcare system. We have only smatterings here and there. From measures provided by the Canadian Institute for Health Information, we can tell that for three of the four types of cancer the survival rates in Alberta are lower than the average. Waiting time seems to be around the average; but another source, the Frontier Centre for Public Policy, has Alberta in the bottom tier. It is interesting that the three provinces that are the worst performers for waiting times are the three provinces that spend the most on health care. The ones that have the shortest waiting times tend to spend less. So, obviously, what you get does not necessarily reflect what you spend for it. In the crudest measure of healthcare quality, longevity, Alberta is a little bit below the national average.

I would have to go back to my statistics course, which was somewhere around 1973, to decide if any of these differences are statistically significant. I suspect that they are not, that the quality of the healthcare system in Alberta is probably about the Canadian average. But when it is age-adjusted, you are spending about 20 percent more. And as an economist, I would love to get my hands into that and figure out where all that money is going, because it does not seem to be going where you want it to go.

One thing I have learned at the national level is that in many cases the process is more important than the substance of the policy, and probably this is never truer than in health care. There is emerging a quite firm consensus across the country about what we need to do to get better value, but it is a very, very tricky thing to move into the front. In most policy domains the politicians lead, but this is one in which politicians are typically hesitant to lead. All of us have probably heard the statement attributed to Joey Smallwood that goes along the lines of, "I've never said anything about health care without losing votes."

I think that we have to understand the context. The healthcare field is the best example of an area in which we are dealing with a completely misinformed Canadian public. That makes things very difficult. Canadians, for whatever reason, think we have a very good healthcare system, and they think it is not very expensive. Of course, they are wrong on both accounts. If I were a politician, I would be a little bit nervous about telling them that, particularly if I had been in power for any length of time, because somebody might think that was my responsibility.

In 2010 when the CBC conducted a poll on what defines us as a nation, people named our public healthcare system. I thought it was fascinating, first of all, that people regard it as a public system, because next to the United States we have the least public healthcare system of any of the developed countries. We do not really have a public healthcare system. Thirty percent of all healthcare spending in Canada is by the private sector. In the United States, 54 percent of spending is by the private sector. In almost every other developed country private-sector spending is somewhere between 15 and 25 percent, and most of that 15 to 25 percent is a mix of private and public. Where, for example, is there a public insurance program for pharmaceuticals in Canada? If you are not being treated in a hospital, you are on your own. So right off the bat, we are dealing with an animal that is quite different from other public healthcare systems.

Why do Canadians think we don't spend very much on health care? Again, it is because we are singularly trained since birth to compare ourselves to the United States, and we have finally, at long last, found one thing that we beat them on hands down, and we gloat about it endlessly. But you have to keep in mind that

beating the United States in health care is the equivalent of winning a 100-meter race when all the other contestants are going backwards. It is not that impressive. The US spends 17.5 percent of their gross domestic product (GDP) on health care. Canada is in a small group of the second-highest-spending countries in the developed world, and we would be closer to the US if we compared per capita expenditures rather than looking at health care as a percentage of our much higher gross domestic product.

If we were a more sensible nation and compared our system to best practices around the world, we would look terribly different. We would find healthcare systems that have much better outcomes and higher patient satisfaction and that spend quite a bit less of their GDP. And, of course, people would say that Europe has a more compact population. And I would counter with, yes, but it is also an older population. So, tit for tat, that part balances out. There are other aspirational models around here, but we don't tend to look at them. On the political policy side there is probably a reluctance to tell people that we have a big problem and that we should look at it.

In the last year there was a finding from two independent surveys on pharmaceuticals that had a bit of an impact on Canadians, but less than I anticipated. One survey found that 13 percent of Canadians had not been able to fill a prescription in the past 12 months due to financial restrictions; the other had the figure at 15 percent. I suspect that if you could get the attention of all Canadians on that particular question, they would say, "There is a mistake. That is the United States or some other country. That's obviously not Canada, because we have a public healthcare system." But the public aspect of the Canadian health system is almost 100 percent in primary care. Public health care covers only 46 percent of all pharmaceuticals and less than 10 percent of everything else, including — unless you are in the hospital — care for mental illness, which is the fastest growing disability. So we do not have a public healthcare system.

We have now made it even more complicated. There is the question of how much we spend and how fast that expenditure is going up. There is the question of why we do not seem to get particularly good results. And now we have the question of the appropriate balance between public and private. We are overlaying this in the public policy area that is, bar none, the most sensitive to the public. I have never seen a poll in Canada that does not show health care to be the number one concern. We all know that when we are not feeling well, there is not much else that matters. It is a very sensitive area.

The few forums that measure quality, such as The Commonwealth Fund, rate Canada right smack in the middle of the developed countries on most health-quality indicators. In value for money, we are second from the bottom next to the United States among major countries. It is not a pretty picture. A particular vulnerability is our wait times for general physicians, and we are off the scale compared to everyone else in wait times for specialists.

If we cut back to the very core of it, we realize that we actually have the wrong system. This is a classic problem in life: the times have changed, but you are saddled with your own history. If we did not have a healthcare system in Canada and we were going to build one today, we would build it around chronic care. That is what the current population and the future generation need. But we built our system in the 1950s and 1960s when the population called for acute care. We have morphed away from that, but slowly, and our system has ended up in a middle-of-the-road position where it would never be if we were starting it again. We have to move that in a more aggressive fashion.

We also have in health care, as in every aspect of public policy, an approach of waiting until something goes wrong and then intervening to try to fix the problem. We do very little on the prevention side, and in fact

we don't really know what to do. We see, as the minister spoke about, some of the huge problems we are going to have. We see test results indicating that young people are suffering from obesity and are going to have older people's maladies in a very short period of time. We see the connection between Alzheimer's disease and lifestyle. And we don't know what to do with that information. We are not doing very much about it.

History tells us that it is incredibly difficult to do anything about it. That is one of the great lessons of the tobacco experience. We threw everything at that. We put the skull and crossbones on the package. We priced it and taxed it to death, and none of that did anything. We saw a reduction in tobacco consumption only when we finally made it illegal to smoke almost everywhere. That got it down, although interestingly, not across the population. Young females have an increased propensity to smoke, so that message has not penetrated to everybody. It just shows you how difficult it is.

Also interesting — and this is one of the things that I love about public policy — is the phenomenon of unintended consequences. It seems like a no-brainer that if you want young people to eat better food you should put better food in school cafeterias. However, it has been unambiguously demonstrated that unless students have no choice but to eat in the school cafeteria, that policy will leave them eating poorer quality food because, instead of eating the mediocre food in the cafeteria, they will go to the nearest fast-food joint. The policy works only where there is a captive audience, and that occurs primarily in the younger grades where students are not allowed to leave the school grounds. It shows you again that you have to be very smart in how you do this.

I hope that I have demonstrated that the catalysts we are looking at in Ontario do apply to you. In fact, I would argue that they apply to you twofold, in that Ontario spends a lot on health care with mediocre results, and you spend a lot more on health care with still mediocre results, certainly no better than Ontario's. The Frontier Centre for Public Policy actually rates Alberta's healthcare results below Ontario's.

So what kind of things are we looking at? I think we are building a consensus to move more aggressively away from acute care to chronic care, and toward prevention instead of patching them up afterwards. There is a very strong consensus to move hospitals to an activity-based funding model as opposed to base funding. Consider what happens in the base-plus-inflation model. We have two hospitals side by side, both with $100 million budgets, but one is extremely efficient and the other is extremely inefficient. The annual inflation factor is three percent, so they both get a three-percent increase; and next year they both do exactly what they did this year. The inefficient hospital continues to be inefficient because it has no incentive to be efficient.

I would like a budget that is based on the episode of care. For hip replacements, for instance, you don't want to budget a certain amount for the procedure because that might encourage the hospital to boot patients out before they are ready, resulting in a higher bill for physiotherapy. Budgeting around episodes of care would drive efficiency forward. It would drive more specialization in the hospitals as well: a hospital that is having difficulty achieving the state of the art in hip replacement might decide to do cardiac cases instead because they are good at that.

With an episode-of-care model we would also see a more aggressive effort to move health care out of the hospital environment. Hospitals are by far the most expensive places to be. They expose people to infection. They give the least satisfaction to patients. But here again there are lessons to be learned. Ontario made a massive effort to move patients into family health clinics, but they forgot one little component:

accountability. They never told the physicians what they had to do and how they had to report it. So, for example, if you are setting up a family health team in a certain geographical region, you do not have to take everybody in that region. You can take whomever you want. If somebody comes in the door and doesn't look very healthy, you can just send them on to somebody else. Aggressive claims would often be made that family health teams saved money relative to individual practice. Then the next day somebody would say they cost more, and then somebody else would say that the cost was about the same. And, of course, the answer is none of the above or all of the above, because we don't know. We don't know what they are doing or even what hours they are working. We don't have data on that. Often a number of physicians are working in one place and providing a wide range of services and thereby reducing the number of referrals. That needs to be accounted for, and we just do not have comparable data to do that.

It always happens that one piece of data grabs my attention and I just can't let go of it. For me, in Ontario, it was the statistic that 1 percent of the population accounts for 49 percent of all hospital spending. I asked ICES [Institute for Clinical Evaluative Sciences] what proportion of the healthcare budget that represents, and it is 34 percent of all healthcare spending in Ontario. Ontario is a big province, but 1 percent is only 130,000 people. A population equivalent to one moderate-sized city is driving half of the hospital spending and over a third of the total healthcare spending. The flipside is that the rest of the population is not very expensive to look after. You have to be a little cautious, however, because everything in life is skewed like this: only a small percentage of people get in trouble with the law, for example. We are never going to get that 1 percent down to 1 percent of healthcare spending or anything even remotely close to it. But I was interested in the substance of this statistic, as well as in the process by which it came to light.

The process first — and this was very disconcerting. How did I become aware of this? It was mentioned to me by people at the Ontario Health Association (OHA), who said that it appeared on a slide presented by an official from the Ontario Ministry of Health. The OHA members in the audience thought the slide said 49 percent, but it was up and gone in 30 seconds and the official refused to answer questions on it. The next time this official gave a presentation, the OHA had five people in the room, all assigned to write down the number the moment it flashed on the screen. All of them wrote down 49 percent, so I had a reasonably high degree of confidence that the number was 49 percent. But the ministry refused to give the study to the OHA. This flabbergasted me, because, as far as I could determine, the OHA wanted it only in order to research what they could do to make the situation better. In a moment of great bravado, I told the OHA, "Don't worry about it. I've got connections all over the Ontario government. I'll get it for you." But I couldn't even get it for myself. I did eventually succeed, but it was months later. It turned out to be a rather disappointing study, in the sense that, as an economist, my instinct is to want to know the socioeconomic status of this one percent, but the study didn't have that information. The one percent were categorized only by type of morbidity, and, as you can imagine, if they were that sick they suffered from multiple morbidities.

But again one thing grabbed my attention. It was that the most common condition among that one percent was congenital heart failure. I wondered why that was so high. It is expensive to treat, but why would it get somebody in the one-percent frequent-flyer category? Well, here is what happens. Most of the hospitals in Ontario did not have electronic discharge records, so the practicing physician did not know the patient was out of the hospital. And perhaps even more important than that, the community association did not know the person was out. I have seen independent pilot projects that have demonstrated fairly robustly that with congestive heart failure your probability of being re-admitted to hospital is reduced by over a third if you are visited by a community nurse within 48 hours after you go home. But that didn't happen, because the community association was not informed within that 48 hours. If the patients, or their families, thought

there was anything untoward, they called 911. And you know what happened: they went by ambulance to emergency and then back through the system again.

This pattern kept repeating itself, and while it was obviously a tragedy, it was in some sense also music to my ears because it reflected a refrain that runs through the system about the synchronicity between wasting money and reducing the quality of life for patients. These people are absorbing more healthcare resources than they should, but whipping back and forth between home and hospitals is not giving them or their families the time of their lives either. Health care does not need to be a competition between saving money and providing quality. In many cases they can work together.

In Ontario, the number of hospital patients requiring an alternate level of care (ALC) was at 13 percent when I was working on my report. I think today it is at 16 percent. In other words, one-sixth of Ontario hospital beds are occupied by people who should not be in the hospital. I don't think Alberta is considerably different. The percentage of ALC patients will always be some non-negligible number because at the end of care it takes a little time to place people in appropriate facilities. But what was fascinating was that people needing ALC had, on average, much longer stays in the hospitals than people who were supposed to be in the hospitals. In fact, an astonishing number of them, about five percent, had been in that state for as long as a year. Another statistic that flabbergasted me is that, on average, people over 80 years of age lose 80 percent of their physical capacity within five days if they are not moving. That is a fairly typical situation for an alternate level care person who comes by ambulance to emergency. If they are lucky they are put in a room, but they are probably put on a gurney in a hallway somewhere. In terms of going back home, that chance is gone within five days. It shows, once again, the interaction between quality of life and quality of care.

In public policy the instinctive first-line response is usually not the best one. The high percentage of ALC patients offers a classic example of that, because the knee-jerk reaction is to say that we need more long-term-care beds. When I was preparing my report in Ontario, David Walker at Queen's University was conducting a study on alternative long-term care. His report starts with a calculation that given the current needs and demographics, within 11 years Ontario will have to build 200,000 more long-term-care beds. I looked at who is considered to have the best care of the elderly, and everything points to Denmark. Here is a fascinating thing about Denmark: Denmark has not built a single long-term-care bed since 1987, and just to discipline themselves they passed legislation making it illegal to build a long-term-care bed. They have actually closed down about 30 percent of the beds they had in 1987. This was to force themselves to make a community homecare system work. There is that quality of life again. In every survey, people say overwhelmingly that if they feel physically capable of staying in their home and looking after themselves, that is where they want to be. And you know what? That is much cheaper than the alternatives. We see that with the Veterans Independence Program. They will send somebody to plough the driveway; they'll put a ramp up to the front door; they'll send meals. You can do an awful lot of that kind of thing before institutionalizing somebody.

In the area of physician costs, the name of the game right now is to ensure that compensation levels do not go up at all. Physicians are a big part of the total cost of health care, and the total is not going to grow at a modest rate if there are appreciable increases in their compensation. So controlling that has to be part of the game, but it is a small part overall. We often hear that we have a shortage of physicians in Canada, and that is true if you compare Canada to Europe. Most European countries have somewhere between 35 and 39 physicians per 10,000 population, and in Canada we are at 22. But the important question is what are

physicians asked to do? We ask doctors to do all kinds of things they don't need to do. Nurses and others could do some of those things. If we just opened up the scope of practice, we would achieve much more savings.

The form of the compensation is also a factor. In Ontario — and Alberta is probably the same — we have been extraordinarily slow to adjust the fee schedule to reflect technological changes. The two examples that leap out are radiology and cataract surgery. The time per transaction is probably one-third to one-quarter what it was 10 or 15 years ago, and the compensations have not aligned with that whatsoever. There are all kinds of things you can do. The first is to create the right micro-incentives for the hospitals, and I think that requires a strong emphasis on activity-based funding. In compensating physicians, I think we need to continue to move away from fee for service. What is the microeconomic incentive of fee for service? Obviously, you maximize your income by maximizing your services, and indeed we have seen a phenomenal increase in the average number of transactions per physician. I am sure that most of them are legitimate; but we all react to economic incentives, and that is an incentive.

Again, you have to be careful, because instinctively everybody leaps to the conclusion that the alternative to fee for service has to be capitation or complete salary. Think for a second about the economic incentive of that. The incentive is to treat very few people and make darned sure that you don't take anybody into your practice that looks like they might be sick. You would see creaming like crazy if that were the only form of compensation, so obviously there has to be a hybrid of the two systems. For example, the Ontario Health Association, with no particular science behind it that I could determine, thought they would be most comfortable with a compensation formula of 70 percent capitation salary and 30 percent fee for service. They said that a large number of their practitioners actually do like to work long hours, and why would you want to curb that? If people want the services and the physicians are providing them, go for that. So the form of compensation can be changed.

Another challenge is to ensure that physicians have clear clinical guidelines. It is daunting to be a physician: there are changes all the time and you are working incredibly long hours seeing people. How in the world are you supposed to keep abreast of the best practices? I noted an interesting example in the 2010 CIHI report: over 3000 arthroscopic knee surgeries had been performed for osteoarthritis, although there is overwhelming evidence that, at best, the procedure postpones the inevitable knee replacement for only one year. Why would you bother to do that very expensive and very invasive procedure?

In Ontario we are building the ground work for improved clinical guidelines. We have had, for quite some time, the Institute for Clinical Evaluative Studies. A flaw in their model, however, is that they have looked almost exclusively at effectiveness, not efficiency. Their guiding principle is whether something is better than what we had before, not whether it delivers value for money. They are slowly beginning to change that. Six provinces have these types of institutes right now, and you would think that one of them would stand up to facilitate this work. As I understand it, at least they talk to each other and have sorted out who is going to specialize in what. But there is a great deal of overlap.

The model that we are probably grasping for is the United Kingdom's NICE [National Institute for Health and Care Excellence], which does cost-effectiveness studies and actually has teeth. In the case of osteoarthritis, if they felt that it was wasteful, they would delist it. They would not send the report to the government for the government's decision. They would just delist it. We don't have enough of a track record to do that, but I can see the day coming when we will.

The statistic that I find second-most flabbergasting is the number of prescriptions per person in Ontario. I questioned the drug companies about this, and the number that came back was so high that I was quite convinced they were counting refills. They finally just said, "Go away. That's primary prescriptions. That's the number. It's solid." The average was 10. Given the age profile for drug prescriptions, that means unambiguously that somebody who is over 65 likely has well over 15 primary prescriptions. I have read studies showing that regardless of what medications you take, if you take more than 8 you have more than a 90-percent chance of experiencing adverse reactions. If you go into the medical cabinet of a person with 15 prescriptions, you will find that prescription 15 was prescribed to offset the side effects of prescription 1, prescription 14 was clearly prescribed to counter side effects from 2, prescription 13 matches 3, and so on. There are perhaps only three drugs that are needed. How did that happen? Well, first of all, there is no disincentive for an individual to go to multiple physicians. We are only beginning to develop electronic records that can track that. A person can go to different pharmacies as well, so a single pharmacy cannot track a person's prescriptions. That is an information-flow problem that is wrecking the quality of people's lives and wasting an awful lot of money. And, of course, in Ontario's case, we aid and abet that with a stupid system that essentially gives free drugs to anybody over 65 or anybody on welfare. If you are the working poor, tough luck to you. You are among that 15 percent that cannot afford to fill prescriptions. Better to get on welfare. That's the clear message from that distorted system.

I think the situation in Ontario is depressing, and you should be even more depressed. But across Canada we should all be depressed. We have built a system that is not giving particularly good results and yet is one of the most expensive systems in the world. We should do better than that. The good thing is that there are so many things that are so obviously done poorly that there is scope to fix them, and that comes back to policy. Even if we and other practitioners as a group come to a fairly ironclad consensus on what to do, that does not mean it is going to be implemented the next day, because you have a very sensitive public that you have to deal with.

A first approach, to borrow a term from the medical world, is triage. Some of the things I spoke about can be done within isolated constituencies. If you want to change the funding formula for a hospital, you don't need a national referendum. You don't have to give endless public speeches. You don't have to risk riling up the public. Quite frankly, they don't even need to know about it. That is inside the beltway. It certainly would incite the hospitals, who would not like it, but they are one particular group. On the other extreme, if you want to introduce a provincial or national pharmaceutical plan, that is a big public deal and you are going to have the much more difficult job of explaining value-added taxes. People will see that their taxes are going up, and you have to explain that they won't need that private plan any more, and they won't have to worry about the 15 percent who cannot pay.

This is where politicians need the help of the stakeholders in the healthcare field. We will get meaningful healthcare reform only if and when the stakeholders come to a rough and ready agreement on the general nature of it. That does not mean that every single stakeholder has to agree with every single thing, but they cannot be fighting among themselves. We had a classic example of that just a month ago when the nurses' association said that the community association should be disbanded. That is not the way to move forward. For politicians who want to lead policy reform, the last thing they want to hear is that some constituencies say this is going to risk lives or is not going to work. They want the turbulence cleared. When they peek out from the bunker and see that it is relatively calm they will move forward, but they will probably not lead as much as in other fields.

I think we are closer to reform than we have ever been. We have an unprecedented interest among the various stakeholders in looking at reform. I am most familiar with what is happening in Ontario, but much has happened on a national level as well. We have had some very interesting documents from the Canadian Medical Association, not self-serving at all, presenting their perspective on overall systems change. The nurses' association at both the national and the provincial levels have put out many suggestions. We have had phenomenal ideas in Ontario from the Ontario Hospital Association (OHA). My first contact with them followed from an interesting incident. In the 2011 budget, which just preceded my starting the report, the Ontario government had given only a total for health care. They had not given any of the components of it. In Ontario, when you call an election you have to have the Auditor General examine not only the actual books but your forecast, and the Auditor General published the internal, previously confidential, disaggregation of the total. The disaggregated internal numbers showed the hospital budget growing faster than the community-care budget. The then head of the Ontario Hospital Association, Tom Klassen, called me up and said, "I can't believe these numbers in the Auditor General's report. The government is actually planning on giving the hospitals more money than the community associations? That makes no sense whatsoever."

And I said, "Okay, I'm having a little trouble here. You're suggesting to me that your association shouldn't get as much money as the government is planning on giving you?"

He said, "Absolutely. We should not get that kind of increase. The hospitals at best should be flat-lined. We have to move people out of the hospitals. We should be moving more toward community coordination of people through the healthcare system. This doesn't make any sense." He came back to me numerous times with suggestions of things they could do without increasing their budgets in the least bit.

I have had a number of dealings with pharmacists who have wonderful ideas about how they could participate. One of those ideas got picked up recently. In Ontario, a physician gets $31 for giving a vaccination. The pharmacists said, "Why shouldn't we do it? Why should somebody have to go to the doctor's office or hospital when there's a pharmacy on almost every corner?" Pharmacists have wonderful ideas about their scope of practice, too. We have, for example, therapeutic substitution in British Columbia, which I think is quite intriguing. Until Viagra came along, Lipitor was the number one selling drug in Canada in terms of value. Every year that it was on patent protection the sales totalled over a billion dollars. Yet it does not cure high cholesterol. It manages cholesterol. Why, when presented with a patient with a cholesterol problem, did physicians so quickly reach for their prescription pads, knowing they were not doing anything to cure it? Why did they not review the patient's lifestyle and see what they could do about it? I think this goes back to the medical schools and the need for codes of practice. Why are we so trigger happy on prescriptions? Is that really leading to a better quality of life?

The drug companies have put out a number of policy papers about reducing cost. I want to dispel one myth. Everything you hear about the Canada-EU trade agreement suggests that drug prices will go up because there is extended patent protection on brand-name drugs in Europe, and they are insisting that we incorporate their patent protection. But generic drugs cost 10 percent of brand-name drugs in Europe, and they cost 25 to 30 percent here — in fact, more than that in some provinces. So it is not quite as bad as we said.

I have ended up hopeful, simply because things are so inefficient now that they can go in only one direction. We have a coalition of the willing and the smart. We just need to bring them one step closer together. We have an industrious group of stakeholders who are thinking all the right stuff. It is a fascinating experience to

go to their retreats and blue-sky sessions. They are not thinking about how to maximize their own incomes or build their empires. They are thinking about what they can do to improve the quality of the healthcare system. They are complete neophytes in public communication, and that presents a difficulty because they will not only have to communicate their ideas before the politicians, or at least simultaneous with the politicians, they are going to have to condition the public as well. They have never done that before, and everybody is going to have to leap out of their stand. The various stakeholders are also complete neophytes in dealing with their counterparts, and there is danger in that. So, for example, the medical and the nurses' associations have an agreement to work together, and the agreement states in the first line that scope of practice is off the table and never to be discussed.

I think reform is going to come about, and I think it will happen because of the fiscal imperative. So I end up where I started off. If you could say to me with a degree of confidence that this latest fiscal dilemma in Canada is going to have the same outcome as in the 1990s, I would say that reform initiatives will fall apart. We will not be having any meetings like this in three or four years. We will just go back to spreading money all over the place and be quite happy and smug to run an inefficient system. But I don't think that is going to happen, not even in Alberta. My bet is that we are going to struggle for two or three years and then level off with a sustained economic growth of about two percent per year in Canada. With two percent inflation, that is four percent growth.

As the minister said, we are getting close to spending 50 percent of our budget on health care. That creates a limit. If we look at healthcare costs based on the status quo, we start with an annual increase of one percent due to population growth. We add one percentage point due to aging of the population, so we are at two percent population-wise. We are running at a two-percent rate of inflation. We are now up to four percent. The long-term average increase in the intensity of health care use has been two percent, and sometimes higher. Now we are at six percent or more. It is going to be very difficult to spend six or seven percent more on health care when we are stuck on that two-percent growth track. So that fiscal imperative is not going to go away, and eventually it will win the day. That is not the way it should be, but that is the way it is going to be. It is going to force people to think very smartly and very strategically on a long-term basis about how to build a better healthcare system.

The win will not necessarily be that we end up spending less money, since spending will go up due to the inevitable pressures. It will go up less rapidly, however, so we will have a fiscal win, but I think we will have a quality win as well. And I think that will be tangible in the satisfaction of people. I will end there. Thank you very much.

Panel Discussion

Moderator: Dr. Annette Trimbee, Deputy Minister, Alberta Treasury Board and Finance

Panel Members: Chris Eagle, Jon Meddings, Anne McFarlane, Don Drummond

Lorne Tyrrell: Let me briefly introduce Annette Trimbee. Dr. Annette Trimbee has had a major role in a number of departments. She was an Assistant Deputy Minister of Health for five years and took on many issues while in that portfolio. She moved over to Advanced Education and Technology, and again was a leader of many of the things that happened in that department. She is now with Alberta Treasury Board and Finance.

Dr. Annette Trimbee, Deputy Minister, Alberta Treasury Board and Finance: Thank you. Good afternoon, everybody. It's a pleasure to be here. I have been in many Treasury Board meetings over the last couple of weeks, in the throes of consultations on the fiscal framework and the budget, and, darn, I wish I had come with my slides because I really need to convince you that there is a crisis. If you look at revenues and spending over the past few years, what do you think happens to spending when revenues go up? Spending goes way up. When revenue growth starts to slow down, what do you think you see with spending? It has a certain momentum, right? If you plot outcomes over that same period of time — and you can look at this through a number of lenses, whether it is health outcomes, education , access, quality — what do you think you see over that same time period? We are treading water. Whether you talk about high-level outcomes, such as the health of Albertans, or about outputs toward those outcomes — access, quality, and choice, for example — we are not doing very well. Therefore, what we are trying to do right now, both in and outside of government, is to have a conversation about the need to connect outcomes to spending. They have become disconnected. We cannot afford to waste the opportunity that we will have in the next couple of years to get serious about transforming the healthcare system. I would not want to make it sound as if we are going to be tough on your budget targets, but, really, economic downturn is an opportunity for innovation.

We talked about what the public thinks of our healthcare system. When I was at Advanced Education and Technology, I went to a celebration of a partnership in dentistry between the University of Alberta and a German state. I sat with the Germans and asked them why they were here. They said they wanted to partner with Alberta because they would get to treat patients with third-world dental problems in a rich province. It really hit home that there is much that we could do better.

I am supposed to introduce the panel members one at a time, but I am going to give you a little flavour for each of them and then leave it to them. First is Dr. Chris Eagle, President and CEO of Alberta Health Services. Chris is a rare breed, a clinician, a leader and a super administrator, and a pleasure to work with from my perspective as a bureaucrat. Next is Jon Meddings who as Dean of Medicine at the University of Calgary is well positioned to take a provincial perspective. Anne McFarlane is Vice President of CIHI. I met Anne a number of years ago when I was an Assistant Deputy Minister at Health and Wellness.

Each of you has five minutes. After that, we will have a Q&A session. Chris, you have the honour of going first.

Dr. Chris Eagle, President and CEO, Alberta Health Services: Thank you, Annette. Alberta Health Services spends a lot of money. The publicly funded part of the healthcare budget in Alberta is roughly 16 billion dollars a year, and currently 11 billion of that is what Alberta Health Services spends. How do we look at value for money? Don and the minister talked about value being what we do to improve the health status of the population. I agree that is the way to look at value.

Now, being a vigorous student of economics — the last economics course I took was somewhere around about 1970 — I went to Wikipedia and looked at

economic topics I could weave into this. And I thought, maybe efficiency. There are three types of efficiency, according to Wikipedia: allocative, technical, and dynamic efficiency. I wondered how those work in the world we live in.

First, allocative efficiency: we touched on that earlier. Our allocation of resources is based in the 1960s. We built a hospital system. We support a hospital system. We have completely underinvested in community care, primary care, and seniors care. We just do not put the money in the services that are needed by this population. So we are in a very backward-looking healthcare system, but that does not mean that the public doesn't like it. This year we looked at the emergency department activity in our seven largest hospitals over the last three years. Emergency department visits increased by 10 percent per year. That is unsustainable, but the public really, really wants to have that access. They are not going to primary care. They are not complaining about lack of access to after-hours primary care. They are complaining about lack of access to emergency departments after hours. The public loves our hospitals in Alberta.

We have a tremendous increase in chronic disease, and we actually are changing the profile of our spending to match the need for chronic-disease management. The percentage of Alberta Health Services' budget spent on acute care went down last year and the year before. The percentage spent on community care is going up. We have the South Health Campus coming on in Calgary this year, so that will probably get warped, but you can see a gradual shifting of the way resources are allocated.

We also had some ministerial directives to respond to this year. One was related to occupancy, and one to the number of ALCs in hospitals. We allocated significant resources, brought on new capacity, all that kind of good stuff, and bent some of the curves. But we also started looking at what we need to do to make this sustainable. We found that 5 percent of the population is costing us 60 percent of the healthcare dollars. We know who they are, we know what they have, we know why they are coming back, and we know what interventions are needed to prevent them from coming back to acute care. Why are we not designing specific services for those identifiable high-risk populations?

This is not an Alberta-specific issue. In the blog called "Healthy Debate," which many of you probably follow, there is an article today about the 1 percent of patients that cost 50 percent of healthcare resources in Ontario. All of a sudden, things that everybody knew for a long time have reached headline status. We are not allocating our resources to the best places.

In terms of technical efficiency, we have a very soiled healthcare system. We do not follow the course of care of patients. We have tons of clinical-practice guidelines, but they are not followed consistently. We have not spent a lot of time looking at clinical appropriateness. So in Alberta we are building strategic clinical networks to force adherence to clinical standards. Stephen Duckett spent a great deal of time talking about how expensive Alberta's health care system is. Our physicians and nurses are highly paid relative to other provinces. We don't use our nurses appropriately. We have too many hospitals, et cetera, et cetera. So we have a real technical efficiency issue, both on the capital and on the operating side.

Dynamic efficiency: As things change, does the system change to keep up? We have many sacred cows, or a path dependency, whatever you want to call it, in health care, and the model of the 1960s is very much in place in the 2010s. New knowledge is not adapted quickly. The old is hard to excise. Speed to act is too slow. Looking at this picture, how do you move forward? One of the guides that we will use increasingly is the Institute of Medicine report "Best Care at Lower Cost," which describes some of the markers of high performance in a health system.

I think that Alberta does have some advantages. Our single structure allows us to shift resources relatively seamlessly from acute care to continuing care and, to some extent, to primary care through the primary-care networks. The structure allows linkages of seniors' care, primary-care networks, and hospitals in order to serve local community needs. This is not a unique thing. Everybody is waking up to this idea. Ontario is doing it. We can do it. We just have to move it faster.

We have data from across the province, which we did not have three or four years ago. We can get data on everything that is happening within subpopulations. Without that kind of data, it was very hard to manage this healthcare system previously. And we can use the data to support internal competition between hospitals, in activity-based funding, in outcomes, in staff safety, in patient safety. There is a great deal we can do to create an internal competitive environment. We need to support best practices better through the strategic clinical networks.

What is missing, other than momentum on these issues, is the next generation of electronic health record, one that will go from stem to stern of the healthcare system — one record per patient, complete with clinical decision support and physician order entry, so that each provider along the chain, whether in a hospital or in a community care setting, can know that they are doing the right thing and are encouraged at the time of decision to do the right thing. It goes back to clinical appropriateness. Without that, we will always be lagging.

Dr. Jon Meddings, Dean, Faculty of Medicine, University of Calgary: Whenever you come to a meeting like this, you have to take with a grain of salt what a speaker says. You have to think about the speaker's qualifications. I am a dean of medicine and a practicing gastroenterologist, and neither of those gives me licence to speak about value in health care. But I will make a couple of comments.

It strikes me that the way in which we have made advances in health care over the years — and I am not talking over the last five years but over decades — has been to transform innovations into practice. That truly is the way we are going to move forward in the future. That means we need to make decisions in health care that are evidence-based. I think that all of us in this room know that we do not do that now. And in order to do that, we need two things.

The first thing we need is data about our healthcare system, as Chris just mentioned. In Alberta it is inordinately difficult to get data. In fact, we do ironic things. We hire people at the University of Alberta and University of Calgary and pay them with wonderful Alberta dollars to buy Saskatchewan healthcare data and solve problems for Saskatchewan. It is an ultimate irony to me. But data by itself does not help. You need to transform data into information that can help you make decisions; and for that, you have to get data into the hands of experts. Data does not speak for itself. It needs somebody to use it. We have tremendous resources in the province who are able to do that. We have Deborah Marshall sitting here who loves working with data, but it is difficult to get the data into the right hands. That is something we have to think about.

The second thing I'll say is that I have heard a great deal today about the need to make best-practice changes, to bring in new things that make a difference and are evidence-based, and I think all of that is absolutely true. What we often do not do, and especially in my field in gastroenterology, is use good evidence to get things that no longer work out of the system. I would love to hear from Don and others some examples of how we can do it better.

Finally, if we are going to make changes — and we have to make changes — it is very important that we do it with a plan. I think that all of us recognize that sometimes we can stumble from one problem to another and make change just for the sake of making change. I hope that all of us would recognize that it would be great to have a plan for it.

Ms. Anne McFarlane, Vice President, Western Canada and Development Initiatives, Canadian Institute for Health Information: I think that it is true that Alberta is not in a crisis situation in the way that many jurisdictions are, but you can always borrow from a crisis. I think the crisis will affect Alberta, and it will affect Alberta because the sheer waste in the international systems will become more evident. That is going on in the National Health Service in England. What is going on in the United States, if they manage to avoid the fiscal cliff, will call attention to bad practice across the West, and that is an opportunity that you can seize to improve the situation.

I agree with the speakers who have said that there is very little new that we hear here. We have all heard about better organization of primary care, better integration at the community level, paying attention to population health, et cetera, et cetera. But as the minister commented, there is tremendous political difficulty in persuading people that they have to improve the healthcare system when 82 percent of Canadians think this is a tremendously good healthcare system. I would suggest that in 20 years when the baby boomers are using services and when you uniquely have a younger population, you are going to have to deal with a question of intergenerational equity. Bringing the planning for those expenditures forward so that you can use that to articulate a crisis might be something that you want to think about.

The second point I want to make is about quality. The Lean initiatives that we go through in the West show that quality is associated with less. We see this in the tremendous overuse of diagnostic imaging. We see it with prescription drugs. We recently reported on atypical antipsychotic use in seniors in nursing homes, and it is pretty shocking the extent to which these drugs are used on people who do not benefit from them. The mastectomy report that we just produced showed that 69 percent of women in Newfoundland have mastectomies and 26 percent of women in Québec have mastectomies. Same stage at diagnosis; same level of outcome. We are doing too many mastectomies. We can see that there is room both to improve quality and to reduce expenditure.

The challenge is that it requires clinical leadership and management. Management in the healthcare system has become a bad word because it is associated with expensive muffins or expensive salaries. I think there has to be a way to articulate that in a very large system like this, queuing theory and the creation of infrastructure that allows you to manage will require some attention and some money, but they are very important. This is not a small system anymore. It is a huge system, and that is required.

The final thing that I want to point out is that there are areas of care that lack organization — end-of-life care, for example, particularly for non-cancer deaths. We lack awareness or lack understanding of how to care for some deaths, such as heart failure deaths, and we could do a much better job. I am sure that some people would say that when their parent was dying, it was a crisis. I think that many people who are trying to deal with alcoholism in their family would say that the care that they are receiving is not great care, and they have been through many crises. Why we have not addressed the needs in some very specific, very evident areas of care and do not regard that as a crisis is something that I think we have to ask ourselves.

Questions and Answers

Unidentified speaker: I'll address this question to Dr. Eagle. I am a medical officer of health here. I asked this question of Mr. Drummond during the break, but I would like to hear from you. What do you think population health and preventive medicine can bring to the table, and where do you see room for improvement in that area?

Chris Eagle: Thinking of the burden that we are going to have from the next generation and the issues of pediatric obesity and so on, I think there is room for leadership to build a partnership with Albertans so that they will start taking care of their own health. Who will lead that? It is not coming from primary care. It is not going to come from people working in hospitals. Where will it come from? I think there is a domain in population health and preventive medicine to start building Albertans' expectation that health care is a partnership with the system. The system is not a parachute. The system is a partnership for them from birth to death, and they have to buy into the fact that they are partners in their own wellness. I don't see that happening. We have our technical inefficiencies, there is no doubt. But unless Albertans start looking after their own health in a much more substantial way than they are at present, we are not going to have the resources to deal with this. I would look to that as a leadership issue that you could deal with.

Jon Meddings: I totally agree with that. I think health is much broader than what happens in physicians' offices, community health centres, and hospitals. We know that the best determinants of health are socioeconomic status and education. We know that things like vaccinations and simple knowledge go a long way. People have to take control of it themselves, and there has to be education. I am shocked sometimes when I look at the rates of vaccination in this province, for instance. We know that it is the one thing that has prevented disease and deaths in many different ways over the years. And we are happy with a vaccination rate of 70 percent? It's absurd.

Chris Eagle: *If* we get 70 percent.

Wendy Armstrong: I am affiliated with the Alberta Consumers' Association, as well as a couple of consumer public interest health-protection groups nationally. You talk about why the public says they love Canadian health care and why they cherish and hold onto the old ways. Our experience across Canada over the last 20 years is that, as we have shifted from one location of care to another, funding has not followed the patient, and the consequences have been quite significant. The reason that most Canadians support medicare, portability, public administration, and all those kinds of things, is actually not to improve the health of the population. It is to have a certain level of personal security if somebody in their family gets ill. People's responses in surveys depend on their experiences with the system, but also on their fears. If you want the public to buy in, you have to ensure that there is a level of personal security and quality and safety in whatever you are building.

The second point that I would like to make is that most people recognize something that health professionals have been slow to recognize, which is that what makes people healthy is economic security, housing, those kinds of things. What we have seen at the practice level is a proliferation of screening tests that often result in drug prescriptions, et cetera. There seems to be compelling evidence that maybe we are overdoing the screening tests and giving false promises to people. I am interested in any comments anybody may have.

Chris Eagle: The point about personal security is very important. It may not be a great healthcare system, but I think everyone who gets into a trauma or gets cancer or a major heart problem knows that this is a

pretty good healthcare system. I have worked in the US, and I have seen people who have not received care that would be routine here. Because of economic factors, they didn't receive the care they required. I think there's a huge fear in the Canadian population of being left like that.

Wendy Armstrong: And we have seen that happen over the last 50 years.

Chris Eagle: Your point about providing assurance and supporting change is very important. And that is a great point about screening and the pursuit of total body scans and so on. I have actually seen people die from having a total body scan that delivered a questionable result that led to an unnecessary surgery that led to a bad outcome that led to death. That happens. I think we oversell the benefit of technology. Everyone thinks that there is something out of Star Wars that is going to cure them. We have not sold the risks of medical technology. Everybody thinks the more technology we have, the better. You see this in everything we do — the gross overuse of MRIs, the tests. People expect the most definitive test. If the answer is, "I'm not going to give you that test," then the response is that you are not a good provider.

Wendy Armstrong: I agree with that, but I think one problem is the marketing done even from within the public healthcare system for regular bone-density testing, regular cholesterol screening, mental health checklists, and what have you. Over the last 20 years both the growing commercial sector and the public sector have really promoted this. I think it is an important thing that you need to consider, that promise that if you do this, you'll be saved.

Jon Meddings: I think that comes back, first of all, to evidence. We should be following evidence, and if screening tests are shown to be valid, we should be doing them. When they are shown no longer to be valid, they need to be removed. We need to set our policies based on evidence. Something that we have to wrestle with in the whole system is the perverse incentives that lead people to do things that are unnecessary. Much of this comes back to the way we fund people in the healthcare system. As gastroenterologist, if I scope somebody, I get paid to do it. If the best thing to do is not to scope someone, I don't get paid to not scope them. We have to think about how we structure funding. Don referred to this. A blended system of some sort is probably where we need to go.

Anne McFarlane: I would add something about the screening issue. Screening is a strategy that works if a disease is a certain type of disease, if treatment is available in a certain kind of way. Screening tests by their nature change over time as treatment changes, as we find other ways to diagnose the disease. Part of the challenge for all of us as we move into a more sophisticated system is to keep the public informed about changes in how health care is delivered. What was a good screening test 20 years ago may not now or in 20 years be a reasonable thing to do. But when people feel that is the standard of care, sometimes it is hard to change their minds. This issue of health literacy is something that I think will continue to be a challenge for us.

Annette Trimbee: Dr. Marshall.

Deborah Marshall: I look at Alberta as an incredibly rich and interesting experiment with a system-wide healthcare system. That means there is lots of good data, and presumably we should be able to have access to that. But even without that, we know many things already. The Drummond report has highlighted — as our panel members have reiterated — many things that we actually know already. I would love to hear what the panel members think is stopping us from just doing it. You know that Nike saying, "Just do it"? We have enough information. What is it that we need to do to make it happen? Can you address that?

Chris Eagle: I have lived in Alberta since 1982, and during that time I have been through two major upheavals of the healthcare system and inherited the results of the last upheaval. I find that we completely underestimate how much energy it takes out of a system to go through that kind of upheaval. I look at the rather moderate changes that have occurred in Ontario and at the results that have been achieved, particularly in their hospital sector, which rival anything that we have done. And I ask myself, why is this?

Since our last upheaval, it has taken three and a half to four years, from 2008 until today, to recover to the point of having a health system that is beginning to move. The regional health authorities were beginning to move in the decade prior to their being eliminated. It is very easy to opt for structural change: You're not getting the outcomes? Change it. I am very reassured by the statement of the minister that there will not be that upheaval as we go forward, because having lived through three different systems I don't think system design matters a great deal. I think system outcomes and the accountability for outcomes matter. Give me some stability, and give me some clear definition of the outcomes that you want from this system and give me the time to get there, and we can get there. But the constant change and the big-bang theory of healthcare reform, which I think we have shown we can do, is very expensive in preserving the quality of the system over time.

Annette Trimbee: I spent five years at Health and Wellness, and even in that short five years, we had a number of waves of big change. I wanted to do health reform by stealth because I thought we spent too much time talking about it. We knew what needed to be done. We just needed to go forward and execute. I think when we talk about structural change, we have to think about something other than organizational change. There are other types of structure.

Don Drummond: I'll just key off the last word. Why don't we just do "it"? Of course, the "it" is no single thing. You can try to make it a single thing with a big-bang upheaval, but I think we have learned that that is very difficult. It is too much, and it is too politically sensitive. I think you always want to keep in mind where you are and what your endpoint is, when all the pieces will come back together. You don't necessarily need to approach them in a time sequence. You approach things separately because there are different stakeholders and different degrees of public and political sensitivity to things. If you had the data you could move on activity-based funding of hospitals without setting off a lot of people outside the hospital community. You could move on some aspects of compensation for physicians just by dealing with the physician community. You could set some of the guidelines that we have talked about, the codes of practice. Some may spill over to public debate, but most of them wouldn't. And you would not implement just one this year and then another one next year. You could approach it on multiple fronts, with different stakeholders, with different degrees of visibility, and hopefully sometime five, six, seven years in the future, the parts will all come back together. And you will have done the big bang, but it was never visible.

Anne McFarlane: I would add one thing. I was very impressed when Ontario rolled back generic drug prices in 2010, and British Columbia has just rolled back as well. I was party to discussions of that in 2000, so it took some time to do it, and the amount of money that was spent in that period of time cannot be recovered. I would say that the leadership to do that was created by crisis. Ontario was in a situation where they could take that step. But there are different ways to reform, not all having to do with clinical practice guidelines, and I think we should be supporting people who take those kinds of courageous decisions. That was a very tough decision to take.

Don Drummond: But it was a coldly calculated risk. They defined the constituency that was going to get upset, and they debated for hours and hours and days and weeks whether that constituency could beat them

up or not. And they tried: the pharmacy groups were passing out pamphlets to everybody. The government was seen as putting health first and they won it on that bet, and the pharmacies and the pharmacists lost big time. But that cannot be generalized to everything. It is almost an example of what I said earlier. You pick the constituencies in which you think you can succeed. The government was successful in that particular case, and to add to it they targeted the seven most common generic drugs and gave them another whack right after the last budget. Sensing this is a constituency they won with one time, they whacked them again.

Chris Eagle: Misery loves repetition.

Don Husereau: Don Husereau, Institute of Health Economics. I have a question following up on these comments. It seems to me that we expect things to change — and there is a lot of change. Is there evidence that too much change displaces opportunities for health? If we are constantly breaking it down and tearing it up, are we creating opportunity costs and reducing quality of care? Has that been observed, or is it something that could happen?

Don Drummond: Oh, absolutely it can happen. I referred to a couple of microeconomic incentives. For example, if you are not careful with activity-based funding, you will give hospitals the incentive to kick people out faster than they are supposed to be kicked out. I mean, if you are going to give me $8,000 for a hip replacement, I won't even bother to finish sewing them up. I got my $8,000. If you switch holus-bolus to capitation or salary, you will get cherry picking of clients. You have to be very careful. I don't think there is any area of public policy where you do not discover unintended consequences. Unlike the chemists, you don't get to mix it up in a test tube. Even in that case, they exploded the atom bomb many times in the test tube before they went to Hiroshima, and they were still shocked at the amount of radioactivity it released. If you cannot even get it right in a scientific lab, imagine what happens in real life with people who are responding to incentives.

That is why I say that you have to proceed incrementally and observe the responses and fallout. It is a matter of balancing. One of the themes that everybody has talked about is a code of practice. A patient presents with certain symptoms. There are certain diagnostic tests and certain pharmaceuticals that are helpful, and certain ones that are not. The doctors are pretty much free to pick any path they want, whether or not it has positive results. I think we would all like to see that clamped down; but on the other hand, you don't want to stifle experimentation completely because that is the only way progress gets made. You have to allow a little bit of loosey-goosey work. Again it's a matter of testing. You change things, but you leave a little bit of fuzziness and then constantly check for those unintended consequences.

Terry McCool: We heard the minister say that making changes in health care is pretty politically difficult, and I think that applies to every province. But in Canada, the private sector in health care seems to be growing in certain provinces. It was not mentioned here today, but I wonder if in your view there is a role for the private sector in alleviating the fiscal crisis we are in?

Don Drummond: We discuss that an awful lot. One of the very few restrictions put on my mandate was not to recommend anything to privatize health care. That is all it said, quote... end of quote, and I interpreted that as meaning not to affect the public-payer model. I did not interpret it to mean that there could not be a private-sector role. I think there are all kinds of private-sector roles within the public-payer model. You wouldn't believe the number of recommendations I got to blow up the public-payer system and put everything in the private domain. Coming back to the importance of the political end, I replied that you are never going to get anywhere with that. It is just going to be a show stopper, stopping any kind of reforms you

want to do. And if you look around the world, we do have a mix of the public-sector and private-sector involvement, and there is no clear delineation of the cost and the quality. If you could point out 50 examples of private-sector models that get better results, then that might be of interest, but we don't have that.

And finally I asked, why would you want to put it into the private domain right now when it is horrifically inefficient? Let's fix it up first, and then consider it again. I think there are many areas where you could have the private-sector delivery, and, of course, the vulnerability there is that you open it up to a fear that it is a race to the bottom or to the cheapest. But I think you can control for that. If you are going to put out for a tender for blood testing, it is not just to find who is going to test the blood for the cheapest possible cost. There are standards you have to meet, and you hold the cards. If the standards are not met, you change it.

We have talked about political sensitivity, but here is an example that shows how that can change. In 2003 in Ontario, a provincial government poll showed an overwhelmingly negative attitude toward having any private-sector involvement in health care, even if it was only to deliver services under the public-payer model. In fact, the government actually bought back the seven private outfits that were offering MRIs at that time, even though they were doing it under public payer. And the government ran an election campaign in 2003 to undertake public-private partnerships on hospitals and got such a bad reaction that they quit it. They have undertaken 29 such partnerships since then. There is private sector all over the place. The last polling that was done said that people don't really care. If they can use their OHIP card, they don't care who provides the service beneath that. The opinion did change an awful lot in only a nine-year period.

Annette Trimbee: Several of you have talked about quality and choice. We give individuals a lot of choice. We give health care providers a lot of choice. There are a lot of technology choices. These choices do not necessarily lead to better quality. You have talked about clamping down. How come it is so difficult to have an honest conversation about health care quality? We don't always have to shoot for the moon.

Jon Meddings: Maybe I'll just take a quick stab at it, and I can guarantee you up front that I don't have the answer. I think there are a couple of things. One is that we can talk about quality, but we actually do not incent quality. What we incent is volume. What we incent is doing things. We do not actually say to providers, We would like you to get best outcomes and we will pay you for those outcomes. So I am not totally surprised that that may not happen.

The second observation that I would make — coming back to the topic of guidelines — is that while there are obviously algorithms for much of what I do, there is a huge amount, especially in very complex care of complex patients, for which there is no clear algorithm to follow. Becoming overly reliant on algorithms will, I think, actually lead to decreased quality of care. I have no evidence for that. That's pure anecdote, but I think we need a healthy balance.

Don Drummond: It comes back to data. Oftentimes we don't know the quality of the data. I like very much what has been happening in education in the last couple years in most provinces. They are going to standardized tests and comparing the results by schools. This is putting enormous pressure on the schools that are not doing well to improve. The spotlight had never been on that before. The outcomes in certain hospitals are completely different from the ones in hospitals right across the street, and some physicians differ from others, but we don't have that kind of information. I think if we do become much more

cognizant we will not necessarily advance the state of the art, but we will at least get the laggards up to the existing state of the art.

Anne McFarlane: It is my perception — and I am interested, Chris, in your perception of this — that although there are people who complain about the quality of their care, most people put up with it and are accepting. It is possibly what you said earlier, that people are afraid that it will be taken away from them. But I think two things. I think people do not complain and are complacent; and I think that is because we do not speak about a vision of what quality looks like. We can speak about a vision if there are clinical practice guidelines. It is strange to use the word vision there, but we can think about a vision of community care or a vision for seniors' care or whatever. There was a discussion on the radio a number of weeks ago of Alzheimer's treatment in Denmark, which was really impressive, and you thought, gee, that does sound like quality care. But creating that vision of quality in heath care, one that we would recognize in ways that are not highly technical is, I think, a challenge. Chris, I would be interested in your perceptions of that.

Chris Eagle: I think what matters to patients is not necessarily what gets reported. In Alberta, we have quarterly reporting of about 60 performance measures, and what those performance measures report on is a skewed cross-section of the system. It is not a balanced scorecard report, and not all of the things that are reported are of interest to the public. I think we have to have a very consistent set of performance measures at the level such that a person on the street can understand why those measures are important in describing the health care system. The data must be completely bulletproof, and you have to look at the same measures consistently from year to year.

Obviously there need to be feeds beneath that so the operators of a system can look at subsets of the data, but the data must be closely linked to an incentive system that is meaningful for both hospitals and physicians. It has to be the same incentive system. You cannot incent half the system for volume and the other half for not delivering volume, which is about where we are at this point in time. It goes back to incremental change, as Don was saying. You build in the things that you can build in. Certainly we can build in activity-based funding for hospitals, and that is one of the things we are working towards. But we also now have a 20-month negotiation uncompleted with the Alberta Medical Association, so trying to build common incentives into the system is incredibly hard. That is where we have always had problems: in trying to build a common purpose with the physicians in this country.

Lorne Tyrrell: There has been nothing said about the education of the next generation of healthcare providers. We talk about value for money, and we are talking about efficiency and activity-based funding. Can you tell me how you are going to look after the teaching of the next generation? There are some inefficiencies when you have to do the teaching, and somehow you have to make sure that we leave a good experience for the teaching.

Chris Eagle: Let me just say that 'activity-based' is, I think, the wrong word. I think it is basically outcome-based funding, and the outcomes that you want to achieve may vary. The outcomes that a community hospital needs to produce are different from those of a teaching hospital where you have to acknowledge the trainee costs — and there are very direct and indirect costs of having trainees — and the research costs that must be built into that. If you don't have a system of activity- or outcome-based funding that represents the complexity out there, it will not be very effective. I think we can deal with those types of things.

Don Drummond: In the Health-Based Allocation Model of Ontario there is an explicit adjustment, and the rates are higher for teaching hospitals than for non-teaching. In fact, it is horrifically complicated. That is probably one of its flaws, but there are adjustments for these sorts of factors.

Jon Meddings: I think the education of medical students is incredibly complex right now, and we could talk for hours about it. But I would make a couple of comments. First, what are we training them to do? How many of them do we need? And where do we want them to go? We don't have that data. For instance, in Alberta — and, I believe, in Ontario — we do not have a physician workforce plan that extends over the next 20 years. I am not sure whether we are training as many as we need or too many. We don't know how many of our trainees are going to stay in Alberta and how many are going to leave. We actually don't know for certain what their scope of practice is going to be. Don brought this up, and it is absolutely true: we need to define the scopes of practice of the professions and also within medicine itself. There is a great deal of turf protection, as you are aware.

So I think we need to have a clear idea of what we want out at the end. If we were going to be smart about this, we would plan that. If we don't need orthopedic surgeons or cardiac surgeons, why in the world do we still have residency programs that train those individuals? We need to make those decisions, but it is difficult to make plans inside the data-free zone that we have now, not knowing what it is we are going to need in ten years' time. I think medical education is like the proverbial supertanker. It takes us ten years to train a specialist, and that's the length of time it takes to change. If we haven't got workforce plans that go out 10 to 20 years, we are going to be making big mistakes.

nother thing I will just point out is that there is a big national move afoot to train more primary care delivers — and even without a plan, we know we need to do more of that — and, secondly, to shorten training periods as much as possible. Outcome- or competency-based education seems to be the mood now. Rather than training for four years, if you do very well and learn everything you need to learn in two years, you're done.

Deborah Marshall: I very much support the idea that quality of care has multiple dimensions. I think we have to keep remembering that it should be about patient outcomes and quality of life. Of course, we also have to measure the performance of the health system in a consistent and repeatable manner. With the province-wide opportunity that we have here in Alberta, and the establishment of the strategic clinical networks, where are we in thinking about care pathways that extend along the continuum of care and cut across the different sectors of our health system — the acute, the chronic, the community care, and primary care — in order to plot out how we can best deliver services? I hear a lot about the transition states in the continuum of care. Most diseases now are complex chronic diseases. How do patients transition through the system? We have to think about the services, the people who deliver the services, what it costs, and when and how they are made available. There are tools from other sectors, such as business, that look at how to supply the demand. Have we thought about using these kinds of tools for long-term system planning across the continuum of care and about taking advantage of the data that we do have and linking it and talking to each other?

Chris Eagle: I think that the desire of our strategic clinical networks is to do just that. They are taking large significant health issues, such as depression, and looking at how that illness is managed across not only the continuum of the system but the continuum of the population, from adolescents with depression to seniors with depression. This entails looking at the entire spectrum and trying to come up with the best clinical pathways and make sure that the appropriate care is delivered in the right place.

We have half a dozen of these networks. They are still in their very early stage, but they are already coming forward with those types of clinical pathways. And we know this stuff works. I think it was around 2005 that we had the arthroplasty pilot in Calgary and Edmonton, which demonstrated very well that you can lay out a prevention-to-rehabilitation pathway. It provides a very clear path for the providers. But most importantly, patients know where they are on that pathway, too, and the level of patient engagement was quite significant, to the point where patients were calling their physiotherapist to say, "Look, I haven't been called. According to the plan, I should have been called yesterday." That's the kind of patient engagement in care that you want. If you want people to be partners in their care, they have to know what the roadmap is.

I have a lot of faith in these clinical networks, not only from a clinical care perspective but also from a health research perspective. They trigger questions about health system research that we might conduct in order to figure out if there are problems in delivery, what the options are, and how we can evaluate the options. I am really kind of high on what these clinical networks can do for us.

Deborah Marshall: Thank you.

Wendy Armstrong: One of the things that struck me in the comments from the panel was the talk about aligning financial incentives. If you look in the political science literature, you see that in the late 1980s and early 1990s many countries, particularly Anglo-Saxon countries, embraced the model of bringing market incentives into public services, whether that be education, health, or any of a number of services, implying that all human endeavours are driven by economic incentives and disincentives. What is very interesting, now that we have had 20 years of playing around with this model around the world, is that both the political science literature and the psychology literature suggest that there may be problems with that, particularly in the area of human services. Certainly as members of the public, when we look to healthcare professionals, we are looking for some kind of motivation other than dollar bills dangling in front of their eyes.

Over the last 20 years there has been demoralization among many health professionals as their sense of commitment to patients and to care in the system has eroded. In fact, there is some interesting research that found that financial incentives actually result in reduced outcomes rather than improved incomes. I encourage you to go to the Internet and look up a fellow by the name of Barry Schwartz. He has some YouTube TED videos that give very good examples of the pushback or unintended consequences of too heavy reliance on financial incentives. I am interested in any comments anybody would make.

Chris Eagle: I think we do have incentives financially in the system. If my friend here wants to do more endoscopies, he is incented for doing those. It is not an appropriateness incentive, but it is there. And I think to the extent that we do have incentives, we should be smart about making sure that we don't have one-half of the health care team being incented to go left while the other half is incented to go right.

I am having problems linking demoralization of the health workforce to incentives, because most of the healthcare workforce is not incented. Whether they do high volume or low volume, or whether they do public health or rehab, they are paid almost exactly the same, so most of the system is free of any incentive whatsoever.

Don Drummond: Let me go back to the point about medical schools and the labour ship. In Ontario, we are training more doctors in looking after children than we are in gerontology. And why is that? Because gerontology is the lowest-paid profession. That comes back to the billing process. Older people tend to take longer, and you don't get the appropriate billing for it. You cannot accept, given where the population is

going, that you don't have people going into gerontology. You have to be smart about what the incentive is, but clearly there is a disincentive in the system right now. That's an example of where you need to change it.

John Meddings: I think the question of why people do what they do is very complex. I have many colleagues who love what they do and are truly remarkable with patients, and they do it for the love of it. But I also think that there is a whole series of things that sit on people, and some of these perverse incentives are truly there. We have to be careful as we design the system. I don't think you need to incent everything. You are absolutely right that in the UK system, people played beautiful games with some of the incentives, and exactly the wrong outcomes resulted. But as Chris says, if you want everybody to go left you should not put all of your incentives into making them go right. That just creates discord.

Annette Trimbee: I think we are past time, but we have had one person standing at the mike for quite a while.

Unidentified speaker: Thank you very much for all of your comments. I was very intrigued at the beginning when we talked about health as being broadly defined, and then curious as to how we got very focussed on medical health. We referenced the importance of context, and there was one reference to the social determinants of health. I bring that all around back to data collection. What data elements are we going to track, and what framework are we going to use? As Alberta has been involved in many community consultations, it is imperative, if this is important to us, that we invest time and money in the process of designing a plan. If you are going to have multiple data points from different domains, you must consult with the right people at the design phase. Ultimately it comes back to bite us if, when we go to do evaluation and outcomes, we are unable to connect the dots and the complexity of being a human being, and we miss the point. And then we do not do a very good job of speaking to preventative factors that have health implications. What do you think we need to do? Is there even a hope that we are willing to go down that kind of an innovative and unpredictable path?

Don Drummond: I think there are two ingredients. The first is that the moment you start to raise the socioeconomic dimensions of health, you need longitudinal data because it is not a contemporaneous cause and effect. It takes time. So, for example, if you wanted to look at the health consequences of having a child brought up in a situation of poverty and disadvantage, that does not necessarily show up for quite a long time. You need to track that person for some time.

The second ingredient is one that I have racked my brain on for decades — and I don't know how you solve it — and that is the time discount in public policy. The timeframe in public policy is, at the municipal level, sometimes two years. At the provincial level, it is maybe three or four years, so the longest is five years. There is no value applied to anything in the public policy field that does not have a payoff in less than five years, which is why we are not particularly interested in changing those societal dimensions. I mean, we can predict with fair accuracy who is going to run into difficulty with the penal system, who is going to run into difficulty with health at a fairly young age, and there are things you can do about it, but they are not going to give you a net-benefit cost ratio in the next three or four years. And hence we tend to turn away from them. I'm not quite sure how you eliminate that obstacle.

Closing Remarks

Annette Trimbee: Before Dr. Tyrrell closes, I would like to thank IHE for putting on this event and allowing some time for us to listen and think and share. And I'd like to thank the panel. Please join me in thanking the panel.

Lorne Tyrrell: Thank you very much, Annette. This has been a great afternoon, simply great, and a lot of fun. I just want to make a few comments. When we made the recommendations from the Association of the Canadian Medical Colleges about increasing the number of physicians in 1999, the second recommendation, which was very important but has never been followed, is that every three years we should work with government to evaluate who we need to train and where. This year, we graduated 22 people in critical care medicine in Canada, and 3 of them found jobs. So that is one of the issues we are facing.

I have spent a whole career with a foot in two camps, one in the healthcare economics we are talking about today, and the other in discovery research. In a day and age when we want everything to be translational research, let me tell you a few things about how important discovery research is. We built hospitals in Calgary and Edmonton, to house polio patients, but it was discovery research that changed it and made them redundant. Enders found out how to culture viruses and sell culture and won a Nobel prize. Not Salk, not Sabin, but Enders, because he eliminated polio and measles.

In 1983, every AIDS patient we diagnosed died in 11 to 14 months. The University Hospital had a ward of 18 beds, 12 of them set aside to treat the symptoms of AIDS patients until they died. Today, we don't have any beds in the hospital for AIDS patients. AIDS patients have virtually a normal life expectancy, and that is directly attributable to, A, finding the virus and, B, finding the ways to treat it.

We heard about tainted blood and the problems it caused in Canada and around the world. Four percent of all blood donations in 1989 contained hepatitis C virus (HCV), a non-A, non-B hepatitis. The virus was discovered by Michael Houghton when he was working at Chiron, and who is, by the way, now a Canada Excellence Research Chair at the University of Alberta. We began screening blood, and the presence of HCV in blood samples that might transmit it has gone from 4 percent to 1 in 10 million. Furthermore, HCV will be the first persistent viral infection that will be cured by 2014. I would say that 100 percent of AIDS/hepatitis C patients who can afford the therapy or whose systems can afford it will be cured.

Just think of somebody with chronic myelogenous leukemia who is traded from the New York Rangers to the Toronto Maple Leafs and never misses a practice while he goes through chemotherapy with the new Gleevec, a highly specific anticancer drug that cures those patients.

I just came back from an outstanding conference on the human genome in Toronto, and I am so optimistic about what we can do in the future. We need to get the delivery systems right, but with the convergence of medicine, mathematics, physics, biology, and chemistry in attacking these problems, we are going to see many more outstanding examples of health care continuing to improve and to be much more specific. The best example may be that all pediatric patients undergoing chemotherapy across Canada are now screened to detect who will have serious side effects and to determine how we use those drugs. It's going to be a very good future, and we need to continue to support discovery research as well as find ways to improve the healthcare system in the ways we have been talking about today.

We heard something about the informed patient today. I treated AIDS patients, and as you remember, the first AIDS epidemic was among often very intelligent individuals who read a lot. They came into the clinic so informed and knowledgeable that I used to wonder if I was going to be able to keep up with them. It was the perfect example of patient engagement. I think the more we can do to educate patients to be part of their care, the better the future will be. There are problems with some of the patient education found on the Internet, but there are also many positives.

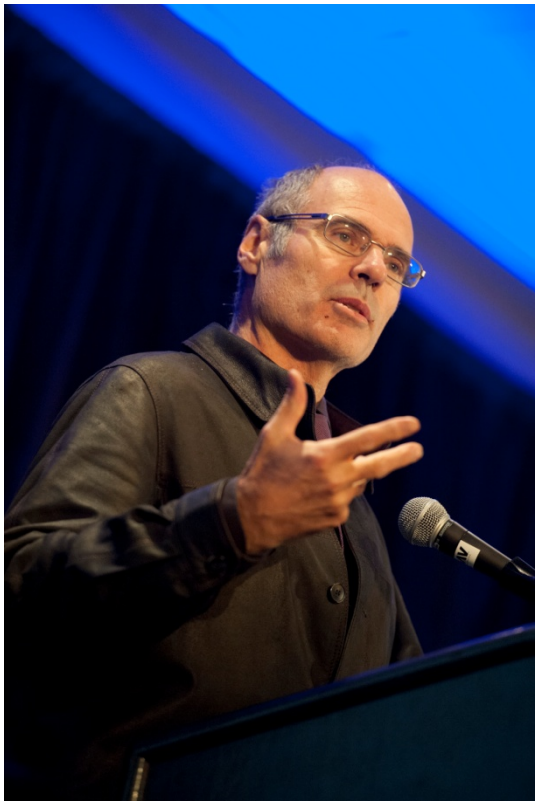
And, finally, my philosophy in this business is that everyone should have the right to live a maximal life until their biological clock runs out. I believe we all have a biological clock. It's set a bit differently in each of us. When we look at end-of-life issues, we should think about the biological clock. If it has run out, then you treat appropriately.

Those are just a few thoughts. I want to thank this committee. I want to thank our guest speaker who came in and antagonized some Albertans and challenged us. I think it was a wonderful opportunity. Thank you very much, Dr. Drummond, and thanks to the whole panel.

Appendix I – Program

INSTITUTE OF HEALTH ECONOMICS
ALBERTA CANADA

IHE INNOVATION FORUM VIII: VALUE FOR MONEY IN THE HEALTH SYSTEM



Keynote Speaker:
Don Drummond, Former Senior Vice President and Chief Economist,
TD Bank Financial Group

December 6, 2012
Edmonton, Alberta, Canada
Westin Hotel

Program

Master of Ceremonies, Dr. Lorne Tyrrell,
Chair, Institute of Health Economics

3:00 Welcome and Opening Remarks

Honourable Fred Horne,
Minister of Health

3:20 Speakers/ Keynote Presentation: The Imperative of Greater Value for Money from Health Care

Deborah Marshall
Associate Professor, University of Calgary

Don Drummond
Former Senior Vice President and Chief Economist
TD Bank Financial Group

4:45 BREAK

5:00 Panel Discussion

Annette Trimbee
Deputy Minister, Alberta Treasury Board and Finance

Chris Eagle
President & CEO, Alberta Health Services

Jon Meddings
Dean of Medicine, University of Calgary

Ann McFarlane
Vice President CIHI

Don Drummond
Former Senior Vice President and Chief Economist
TD Bank Financial Group

6:00 Reception

Mr. Don Drummond
Former Senior Vice President and Chief Economist, TD Bank Financial Group

Don Drummond is the former Senior Vice President and Chief Economist at TD Financial Group. He retired from TD to his current rolw as Matthews Fellow and Distinguished Visiting Scholar in the School of Policy Studies at Queens University. Prior to joining TD Bank, Mr. Drummond had a long career in the Department of Finance, serving most recently as Associate Deputy Minister. He was responsible for economic analysis, fiscal policy, tax policy, social policy and federal-provincial relations, and he coordinated the planning of annual federal budgets. Born and raised in Victoria, BC, Me. Drummond graduated from the University of Victoria and received his MA in Economics from Queen's University. In 2011 he was appointed as the Chair of the Commission on the Reform of Ontario Public Services. The Commission released its final report in February 2012, with a wide range of recommendations to ensure the sustainability of health care and other public services. Mr. Drummond travels widely across Canada and abroad, speaking about the Canadian economy and its prospects, and he is frequently quoted by the media on economic and policy issues.

Dr. Annette Trimbee
Deputy Minister, Alberta Treasury Board and Finance

Dr. Annette Trimbee oversees Alberta's Capital Plan, spending management and planning, tax policy and administration, analysis and forecasting of Alberta's economic and financial trends, internal auditing and accountability, and the regulation of insurance, pensions, financial institutions and Alberta's capital market. She is also leading the implementation of results-based budgeting, a new approach to government budgeting that emphasizes fiscal discipline and effective and efficient programs and services that address Albertans' priorities. She was previously Deputy Minister of Treasury Board and Enterprise, and Advanced Education and Technology. She received her BSc from the University of Winnipeg, MSc from University of Manitoba, and PhD from McMaster Unviersity.

Dr. Chris Eagle
President and CEO, Alberta Health Services

Dr. Eagle is a Professor at both the University of Alberta and the University of Calgary, and holds an adjunct appointment at the University of Victoria. He has had a long career in health-care administration. He served as Executive VP and Chief Clinical Officer, VP and CIO of the former Calgary Health Region, as well as Associate Chief Medical Officer, Executive Director of the Foothills Hospital in Calgary, and Head of the Department of Anesthesia at the University of Calgary. Dr.

Eagle has served as a board member for a number of health organizations. He was on the inaugural board of the Health Quality Council of Alberta and currently served on the Board of the Canadian Institute for Health Information.

Dr. Jon Meddings
Dean of Medicine, University of Calgary

Dr. Jon Meddings has a long and accomplished record with the University of Calgary. He began his first term as Dean of the Faculty of Medicine in July 2012, having served as Vice Dean since 2009, and previously as Interim Vice-President (Research) at the University of Calgary (2010), head of the Division of Gastroenterology, and as a professor in the Department of Medicine, while continuing to be an active member of the medical community. He served as Chair of the Department of Medicine at the University of Alberta from 2004 to 2009.

Ms. Anne McFarlane
Vice President, Western Canada and Development Initiatives, CIHI

Anne McFarlane serves as Vice-President, Western Canada and Development Initiatives. Anne works extensively with the other regional offices and program areas within CIHI to improve our responsiveness to client needs and our ability to plan and promote uptake of new systems and programs. Previously, Anne held the position of Executive Director, Western Canada, for more than five years. During that time, she established the Western office – the organization's first regional bureau. Along with an MSc in community health and epidemiology, Ms. McFarlane has more than 20 years of experience in the health and social service sectors. She has held senior management rules with both the British Columbia Ministry of Health Services and the Health Services Utilization and Research Commission of Saskatchewan, and advisory roles with the Canadian Institute of Health Research's Institute of Health Services and Policy Research and the Canadian Cochrane Centre.