



INSTITUTE OF
HEALTH ECONOMICS
ALBERTA CANADA



UNIVERSITY OF CALGARY
O'Brien Institute for Public Health

INSTITUTE OF HEALTH ECONOMICS/ O'BRIEN INSTITUTE FOR PUBLIC HEALTH POLICY FORUM

Physicians as Stewards of Resources Roles, Responsibilities, and Remuneration

SUMMARY REPORT

May 2016

This forum was supported, financially and/or in-kind, by Alberta Health and the Alberta Medical Association. Please note that the views expressed herein are not necessarily representative of any particular organization involved.

Preface

The Institute of Health Economics (IHE; www.ihe.ca) together with the O'Brien Institute for Public Health (O'Brien Institute; www.obrieniph.ucalgary.ca) held a policy forum on February 8th, 2016, entitled *Physicians as Stewards of Resources: Roles, Responsibilities, and Remuneration* to inform decision-making regarding the fiscal sustainability of the provincial healthcare system, with a specific focus on physicians as stewards of healthcare resources. This forum was supported, financially and/or in-kind, by Alberta Health and the Alberta Medical Association.

The purpose of this forum was to explore how changes to physician remuneration and the role of physicians as stewards of healthcare resources can meet Alberta's healthcare goals, including sustainable growth in healthcare spending.

Please note that this document represents a summary reflection of issues raised by participants and does not necessarily represent a consensus view of the participants or of the organizations involved.

The presentations and background material for this meeting can be found online: www.ihe.ca/research-programs/knowledge-transfer-dissemination/roundtables/psrpf/about-psrpf. See Appendix A for the full program.

Please direct any inquiries about this report to Jasmine Brown, Senior Manager, Stakeholders Relations and Policy, Institute of Health Economics, at jbrown@ihe.ca.

THE STRUCTURE OF THE FORUM WAS AS FOLLOWS:

Moderator: Dr. William Ghali, Scientific Director, O'Brien Institute for Public Health

Morning Session: Understanding Our Shared Challenges

- Dr. William Ghali, *Setting the Stage: Health Spending, System Performance, and Physician Services*
- Dr. David Naylor, *Some Reflections on Innovation and Professional Remuneration*
- Mr. André Picard, *The Juggling Act: Can innovation satisfy the public, physicians, and government?*
- Dr. Carl Nohr and Mr. Mike Gormley, *Physician's Perspective on Stewardship*
- Panel Discussion, moderated by Mr. André Picard

Lunch Break: Address by the Honourable Sarah Hoffman, Deputy Premier and Minister of Health

Afternoon Session: The Way Toward a Better System

- Dr. Peter Kaboli, *Re-Conceptualizing Access for 21st Century Healthcare*
- Dr. David Price, *Patient Care Groups: Rethinking Primary Care*
- Dr. Sharon Straus, *Strengthening Our Health System: Opportunities for Physicians to Drive Change*
- Panel Discussion, moderated by Mr. André Picard

FORUM PARTICIPANTS:

Dr. William Ghali – Scientific Director, O'Brien Institute for Public Health

Dr. C. David Naylor – President Emeritus and Professor of Medicine, University of Toronto

Mr. André Picard – Health Columnist, *The Globe and Mail*

Dr. Carl Nohr – President, Alberta Medical Association

Mr. Michael A. Gormley – Executive Director, Alberta Medical Association

Honourable Sarah Hoffman – Deputy Premier and Minister of Health

Dr. Peter Kaboli – Hospitalist and Chief of Medicine, Iowa City VA Healthcare System

Dr. David Price – Professor and Chair, Department of Family Medicine, McMaster University

Dr. Sharon Straus – Professor, Department of Medicine, University of Toronto

Executive Summary

Canada is one of the higher healthcare spenders among Organisation for Economic Co-operation and Development (OECD) countries.¹ In Alberta, spending on health care has even risen at a rate above the national average. Between 2000 and 2015, the rate of cumulative spending on physicians specifically in Alberta was double the national average.²

More spending on health and physician services in Alberta and in Canada has not resulted in higher quality care, when rated using metrics such as wait times, rates of hip and knee replacements, cataract surgeries, or how much time doctors spend with patients. Factors such as older and sicker populations also do not appear to be driving growth, as Alberta's population is younger and healthier on average, compared to Canada's largest provinces.

Physicians are key partners in health care, since they are responsible for directing a majority of healthcare expenditures, through ordering tests, prescribing therapies and procedures, and deciding upon hospital admissions. However, in addition to driving these types of healthcare expenditures indirectly, direct spending on physician services has also outpaced other costs since 2007.³ Higher-than-average spending in Alberta can be explained in part through how physicians are paid, being primarily fee-for-service, which is used more often in Alberta compared with other Canadian provinces.

Many recent primary care reforms have focused on alternative payment schemes for physicians, recognizing fee-for-service incentivizes quantity of services over quality. In Alberta, consideration of alternative physician payment schemes is being led through collaborative efforts between the Ministry of Health and the Alberta Medical Association. The purpose of the IHE/O'Brien Institute policy forum, *Physicians as Stewards of Resources: Roles, Responsibilities, and Remuneration*, was to explore how changes to physician remuneration and the role of physicians as stewards of healthcare resources can meet Alberta's healthcare goals, including sustainable growth in healthcare spending.

Some insights from this forum include:

- Effectively managing physician resources requires going beyond simply focusing on physicians – fundamental structural changes to the health system are required, as

¹ K Davis et al., "Mirror, mirror on the wall, 2014 update: How the U.S. health care system compares internationally." (New York, NY: The Commonwealth Fund, June 2014), <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>.

² W Ghali, "Setting the stage: Health spending, system performance, and physician services" (IHE/O'Brien Institute Policy Forum: Physicians as Stewards of Resources, Edmonton, AB, February 8, 2016), http://www.ihe.ca/download/setting_the_stage.pdf, citing KPMG report conducted on behalf of Alberta Health.

³ Canadian Institute for Health Information, *National health expenditure trends, 1975 to 2015* (Ottawa, ON: Canadian Institute for Health Information, 2015), <https://www.cihi.ca/en/spending-and-health-workforce/spending/national-health-expenditure-trends>.

well as effective partnerships with patients and payers and the necessary means to work together.

- Promising initiatives include increasing integrated care combined with changes in payment strategies such as considering salaries, capitation, blended capitation, bundled payments, and revisiting scope of practice.
- There are many examples of alternative payment schemes that look promising but lack the evidence base necessary to support them. In some cases, there is sufficient evidence to suggest some of them may not work as well as hoped. Introduction of any new scheme will require a commitment to testing before widespread adoption and scaling.
- Effective management of physician resources cannot be done in isolation. It requires partnerships with payers and patients, a greater role for physicians as health system leaders, and the necessary information and communication infrastructure to optimize care.

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Background

Worldwide, growth in expenditures on health care continues to rise at a rate beyond that of national wealth. Between 2000 and 2015, cumulative provincial health expenditure in Canada rose 84%, while the gross domestic product (GDP) rose 32% during this same time period. The contribution of factors such as spending on pharmaceuticals and new technology has been widely recognized, and has been met with policy responses that aim to contain spending in these areas. However, for various reasons, health care's human resources, particularly physicians, continue to be a major contributor to accelerated spending. Despite a long-term understanding that policies should "be focused on trying to limit the growth in expenditures per physician,"⁴ there have been few policies developed to manage spending growth in Canada or internationally.

In Alberta during the same time period (2000 to 2015), spending on health care rose at a rate well above the national average, with a cumulative growth in expenditures (adjusting for population growth) of 135%, compared to 84% for Canada as a whole.⁵ Cumulative spending on physicians during this same time period was more than double the average in Alberta, with a 218% increase in spending, compared to 108% nationally (see Figure 1). Possible reasons for this include differences in how physicians are remunerated in Alberta (reliance on fee-for-service models is higher in Alberta versus the rest of Canada), a larger physician supply, and paying higher prices for individual services.

Spending more on health and physician services has not resulted in higher quality care in either Alberta or Canada, when rated using metrics such as wait times, rates of hip and knee replacements, cataract surgeries, or how much time doctors spend with patients.⁶ Furthermore, it does not appear that Alberta spends more because of higher rates of chronic illness or elderly populations, important factors that can often explain above-average spending. In fact, Canada as a whole, and not just Alberta, continue to rank low on quality metrics when compared to other health systems, despite being a top-ranked spender.

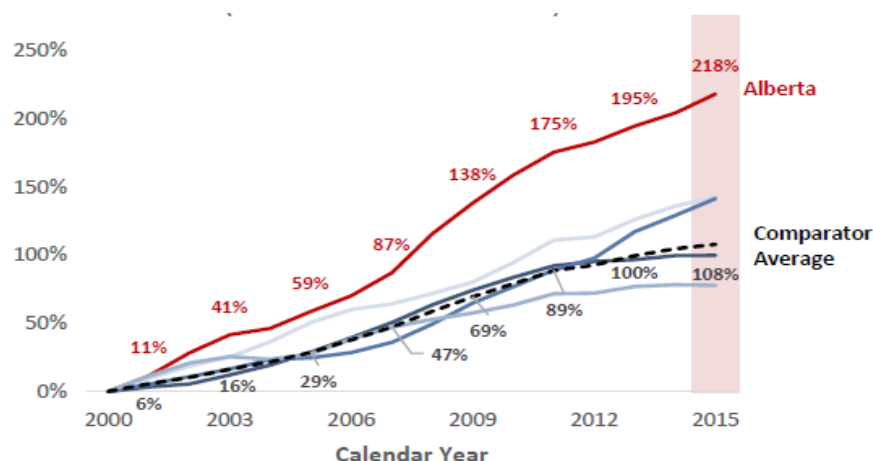
Figure 1: Cumulative Provincial Physician Expenditure Per Capita Growth (2000

⁴ RG Evans, "The Sorcerer's Apprentices," *Healthcare Policy* 7, no. 2 (November 2011): 14-22.

⁵ Ghali, "Setting the stage," citing KPMG report conducted on behalf of Alberta Health.

⁶ Davis et al., "Mirror, mirror on the wall, 2014 update."

to 2015)



Provincial Physician Expenditure (\$ per capita)			
	2000	2015	% Growth
Alta.	\$333	\$1,058	218%
Sask.	\$388	\$942	143%
Ont.	\$474	\$947	99%
Que.	\$353	\$852	142%
B.C.	\$477	\$848	78%
Comparator Average	\$434	\$902	108%

Source: ⁷

While it has been long known that some fee-for-service arrangements can create incentives for service volumes and increase costs, Alberta has not effectively responded to this issue. Yet the Alberta health system is uniquely positioned to take this on. Physicians are also uniquely positioned to influence the demand for health care,⁸ and there are various policy responses that may be positively received by physicians while being able to also meet Alberta's goals of the Triple Aim for health care – improved patient experiences, improved population health, and reduced costs.

A recent call for innovative approaches to health care began in June 2014, with a panel of experts commissioned by Canada's Federal Health Minister (Advisory Panel on Healthcare Innovation, or the "Naylor Panel") to address pan-Canadian concerns regarding health and health care sustainability.⁹ Recommendations from the Institute of Health Economics (IHE)/O'Brien Institute for Public Health (O'Brien Institute) policy forum, as summarized in this report, suggest several innovations that address these concerns, including some that

⁷ Ghali, "Setting the stage," citing KPMG report conducted on behalf of Alberta Health.

⁸ RG Evans et al., "Medical productivity, scale effects, and demand generation," *Canadian Journal of Economics-Revue Canadienne D Economie* 6, no. 3 (1973): 376-93, doi:10.2307/133969.

⁹ Health Canada and the Public Health Agency of Canada Government of Canada, "Unleashing innovation: Excellent healthcare for Canada - Report of the Advisory Panel on Healthcare Innovation - Executive summary," July 2015, <http://www.healthycanadians.gc.ca/publications/health-system-systeme-sante/summary-innovation-sommaire/index-eng.php>.

would truly change the role of physicians as resource stewards. These include health system workforce modernization (highly integrated care and changes to physician payment), as well as more strategic reimbursement and purchasing.

IHE/O'Brien Institute Policy Forum: Physicians as Stewards of Resources

The IHE/O'Brien Institute policy forum, *Physicians as Stewards of Resources: Roles, Responsibilities, and Remuneration*, was held in Edmonton, Alberta on February 8th, 2016. It aimed to inform decision-making regarding the fiscal sustainability of the provincial healthcare system, with a specific focus on physicians as stewards of resources. The forum explored how changes to physician remuneration and the role of physicians can meet Alberta's healthcare goals.

The forum, which was attended by Health Minister Sarah Hoffman as the lunch keynote speaker, intended to mine ideas and dissect information to help Alberta's healthcare system adjust to the new economic realities currently shaping the province.

Purpose of This Report

This report is a synthesis of the themes that emerged from the policy forum discussion. The presentations and background material for this meeting can be found online (www.ihe.ca/research-programs/knowledge-transfer-dissemination/roundtables/psrpf/about-psrpf).

Participants at the forum reflected on these guiding questions:

1. What is Alberta doing well?
2. What opportunities exist for change in Alberta?
3. What proven models of physician remuneration and stewardship might best work for Alberta?
4. What issues need to be addressed first?
5. What are next steps?

This document represents a summary reflection of issues raised by participants, and does not necessarily represent a consensus view of the participants or of the organizations involved.

Findings

Policy Responses – Promising Initiatives

The opportunity for better management and stewardship of resources related to expenditure on physician services may have benefits beyond improving sustainability. It may also create new opportunities for leadership, improving quality of care, and reducing work burden on individual physicians.

Policy forum participants supported the notion that the first step to change is to consider policy options that are evidence-based. Those that appear to have been proven in concept can then be further considered as to whether they offer a “made for Alberta” solution. Several evidence-based policy options were discussed in detail. These include:

- **Integrated care** – Highly integrated systems of care are characterized by collaboration across healthcare professionals as a means of better care coordination. Integrated care models not only allow for better continuity and quality of care, but also better allow for new models of payment including capitation or bundled payments, away from fee-for-service models. A longstanding example of integrated care is from Denmark, where a movement to integrated care led to single organizations caring for elderly and disabled people in a district rather than separate administrative structures. These changes led to significant reductions in expenditure growth; between 1985 and 1995, total long-term care expenditures as a percentage of GDP dropped from 2.4% to 2.2% (in comparison, in the same time period, the United States saw increases from 1.03% to 1.59%).¹⁰

Another excellent example of integrated care is the use of home visits by health professionals with the aim to improve the health and well-being of community-based patients with chronic heart failure. A recent systematic review identified six randomized trials suggesting care in the home for heart failure patients could lead to savings of up to USD \$10,000 per patient.¹¹

- **Alternative payment schemes** – Alternative mechanisms of physician payment may work best when tied to integrated care approaches, but can also exist on their own (see Box 1). In the context of integrated care, alternative payment approaches create similar incentives to achieve health system goals for all those providing care. Approaches that use integrated care with bundled payments for primary care groups were cited as a key needed innovation in the recent Naylor Panel report, as they also provide unique opportunities to optimize scope of practice and better use of information technology to promote patient-centered care. Changing from a fee-for-service model to salaries also has advantages, including improving access to care by encouraging physicians to interact with patients by phone, email, or other

“If you are in a fee-for-service model where you only get paid for seeing your patient, you are not going to do a lot of phone calls or e-mails or anything else.”

- Meeting participant

¹⁰ M Stuart and M Weinrich, “Home- and community-based long-term care: Lessons from Denmark,” *The Gerontologist* 41, no. 4 (August 2001): 474-80.

¹¹ J Fergenbaum et al., “Care in the home for the management of chronic heart failure: Systematic review and cost-effectiveness analysis,” *Journal of Cardiovascular Nursing* (February 2015), doi:10.1097/JCN.0000000000000235.

preferred means that can take place over distances.

BOX 1: DEFINITIONS OF ALTERNATIVE PAYMENT SCHEMES

Bundled payment – Pays for a set of services rather than a specific service for a particular condition or care episode.

Capitation – Provides fixed payments based on rostered patients, regardless of quantity of service performed. Payments may vary by patient complexity.

Fee-for-service (FFS) – Physicians are paid for services individually.

Fee-for-service, enhanced – Regular FFS with bonuses for complex/chronic disease management, or additional funding to work in multidisciplinary groups or to compensate for complex populations (geographically or demographically).

Fundholding – Similar to capitation, except additional budget is provided for consumables, prescription drugs, and other non-service expenses. Fundholding is similar to block funding for acute care hospitals. Physicians are in charge of the budget.

Gainsharing – Or group-based profit sharing, is similar to fundholding, except physicians receive additional bonuses if savings are made, typically based on costs related to drugs, devices, or other physician-directed consumables.

Pay for performance – Physicians are paid according to pre-determined quality metrics, care pathways, health outcomes, or other activities that typically represent system goals.

Salary – Or time-based payment, provide payments based on time spent providing service. A variant of this is sessional fees, which provide payments based on time for specific activities, such as attending in emergency departments.

- **Intelligent workforce planning** – Given Alberta's unique demographic and opportunities for models of care, better workforce planning could anticipate key factors that affect demand for physician services: 1) future demographic trends; 2) alternative models of care; 3) innovations that may reduce intensity or volume of resources (that is, labor-reducing innovations); and 4) trends in workflow and choice among Alberta and Canadian physicians. Whatever decisions are made regarding changes to the role and responsibilities of physicians, they cannot be expected to happen overnight, and will require better workforce planning as a means of improving their implementation.
- **Scope of practice changes** – Scope of practice changes are organizational innovations focused on sharing or assuming roles conventionally or historically played by others. More recently, scope of practice has focused on providing better community-based care for persons with chronic conditions. An example of scope of practice change is educating lay health workers or nurses on various aspects of primary and community health care. High-quality systematic reviews of the substitution of doctors by nurses in primary care, for example, show little impact on

differences in outcomes or quality of care.¹² However, there is still no clear evidence of an impact on costs. In Canada, a recent well-conducted pragmatic trial of a community-based education program showed a reduction in cardiovascular disease-related costs, but not in overall costs.¹³

- **Quality improvement interventions** – Some health system interventions intended to improve measures of quality of care may have a positive impact on the use and value of resources associated with physicians. For example, a high-quality systematic review of quality improvement (QI) initiatives in diabetes care revealed team changes and promotion of self-management had the highest impact on quality measures associated with diabetes care.¹⁴ This review illustrates the need for examining QI initiatives by medical specialty, as not all areas will be amenable to changing physician roles.

Experiment, Adapt, and Scale

A recurring theme throughout the forum discussion was the need to test new innovations in managing physician resources in real time. The Naylor Panel report on healthcare innovation put special emphasis on the need to experiment, adapt, and scale examples of integrated care models, in part because empirical evidence of the best approach to care integration and its true impact on expenditures is still limited.¹⁵

In many cases, there have been innovations in delivery intended to improve the use of physician resources that lacked evidence of proof of concept. Initiatives such as these have since been shown to not work, have had unforeseen or adverse consequences, or seem reasonable with limited evidence but have yet to have good evidence supporting their scaling and widespread uptake.

¹² E Cheema et al., "The impact of interventions by pharmacists in community pharmacies on control of hypertension: A systematic review and meta-analysis of randomized controlled trials," *British Journal of Clinical Pharmacology* 78, no. 6 (December 2014): 1238-47, doi:10.1111/bcp.12452; M Laurant et al., "Substitution of doctors by nurses in primary care," *The Cochrane Database of Systematic Reviews*, no. 2 (2005): CD001271, doi:10.1002/14651858.CD001271.pub2; P Tappenden et al., "The clinical effectiveness and cost-effectiveness of home-based, nurse-led health promotion for older people: A systematic review," *Health Technology Assessment (Winchester, England)* 16, no. 20 (2012): 1-72, doi:10.3310/hta16200; LA Bero et al., "Expanding the roles of outpatient pharmacists: Effects on health services utilisation, costs, and patient outcomes," *The Cochrane Database of Systematic Reviews*, no. 2 (2000): CD000336, doi:10.1002/14651858.CD000336.

¹³ R Goeree et al., "Economic appraisal of a community-wide cardiovascular health awareness program," *Value in Health: The Journal of the International Society for Pharmacoeconomics and Outcomes Research* 16, no. 1 (February 2013): 39-45, doi:10.1016/j.jval.2012.09.002.

¹⁴ Tricco, A. C. et al. Effectiveness of quality improvement strategies on the management of diabetes: a systematic review and meta-analysis. *Lancet* 379, 2252–2261 (2012).

¹⁵ M Ouwers et al., "Integrated care programmes for chronically ill patients: A review of systematic reviews," *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care* 17, no. 2 (April 2005): 141-46, doi:10.1093/intqhc/mzi016; NA Martínez-González et al., "Integrated care programmes for adults with chronic conditions: A meta-review," *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care* 26, no. 5 (October 2014): 561-70, doi:10.1093/intqhc/mzu071.

Some examples of interventions that still may not work or require further evaluation include:

- **Paying for performance** – Evidence regarding the effect of pay for performance is too limited to support widespread implementation, and efficiency has not consistently been demonstrated.¹⁶ One review identified 10 studies of paying for preventive care/screening and found modest improvements in immunization rates.¹⁷ Similarly, in 20 studies of chronic conditions, little benefit was demonstrated.¹⁸
- **Low value lists** – Despite their increasing popularity and intuitive appeal, low value lists such as those produced by Choosing Wisely® have shown little evidence to change behavior and little evidence of impact.¹⁹ Another significant shortcoming of proposals to identify and discourage the use of wasteful services^{20,21} is that they do not guarantee a reduction of expenditure growth. This is mainly due to the fact that healthcare expenditure is driven by growth in the volume and intensity of care, not “disproportionate growth in wasteful care.”²²

Understanding Our Shared Challenges

Health system financing and delivery in Canada has been called a “historical accident” by some, borne of the need to have insurance for acute care and physician services in an era where needs for these services were great.

This has had the unintended consequence of making change difficult. Policymakers are challenged when attempting to

“Yet despite micro-cultures that are focused on innovation and excellent patient care, the big picture is not coming together right. That is not a failing of the people, of the individuals in the system. It is a failing of how the whole system is incentivized and how things are structured.”

- Meeting participant

¹⁶ M Emmert et al., “Economic evaluation of pay-for-performance in health care: A systematic review,” *The European Journal of Health Economics: HEPAC: Health Economics in Prevention and Care* 13, no. 6 (December 2012): 755-67, doi:10.1007/s10198-011-0329-8.

¹⁷ SK Houle et al., “Does performance-based remuneration for individual health care practitioners affect patient care? A systematic review,” *Annals of Internal Medicine* 157, no. 12 (December 2012): 889-99, doi:10.7326/0003-4819-157-12-201212180-00009.

¹⁸ SK Houle et al., “Does performance-based remuneration for individual health care practitioners affect patient care?”

¹⁹ A Rosenberg et al., “Early trends among seven recommendations from the Choosing Wisely campaign,” *JAMA Internal Medicine* 175, no. 12 (2015): 1913-20, doi: doi:10.1001/jamainternmed.2015.5441..

²⁰ Choosing Wisely Canada [Internet], accessed February 2, 2015, <http://www.choosingwiselycanada.org/>.

²¹ Or what Archie Cochrane described as “inefficiency in health care” - interventions shown to be ineffective, or effective interventions incorrectly used. This should not be confused with economic inefficiency, where effective interventions correctly used may still be considered ‘inefficient’.

²² AM Garber, “Cost-effectiveness and evidence evaluation as criteria for coverage policy,” *Health Affairs (Project Hope)* Suppl Web Exclusives (June 2004): W4-284-96, doi:10.1377/hlthaff.w4.284.

move away from the “status quo” of physician service delivery and remuneration, despite its potential for unmanaged expenditure growth. When solutions are proposed, they too often become politicized rather than constructive. This historical accident has also led to a too-singular focus on physician payment during times of austerity, rather than approaches to making fundamental structural changes to the wider health system. Without these changes, it has become impossible to create reforms that adequately align incentives for physicians, patients, and payers.

Resource stewardship requires physician leadership, but must also involve all key stakeholders; patients, payers, and physicians all have a role in creating efficient, high-quality care. However, adequate stewardship among these stakeholders cannot be accomplished without a means for clear communication for shared learning and the provision of sufficient information required for this task. Investments in information and communication technology will clearly be needed to connect these stakeholders. Just what solutions are best will require a thoughtful approach; Alberta must be prepared to experiment and learn from the lessons of others (see Box 2).

**BOX 2: LESSONS ABOUT TELEMEDICINE AND ACCESS FROM THE UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS²³**

“What we are finding is that the e-consults where I consult, say, the neurologist, do not necessarily replace the face-to-face visit. But what they allow to happen is the neurologist can see what the reason for the consult is, and then recommend any tests or other things that need to be done prior to the visit and then take care of it.”

“As we re-conceptualize access, measurement of access is going to be really important for both actual and perceived. And what patients perceive as their access to care may be more important at times. More is not always better.”

On the telephone

“...if you can take care of something over the phone, do it. And so we capture now every phone visit to be able to give what we call ‘workload credit’ for it, and goes into their [relative value] model.”

On video

“We have been doing this for years. And within the U.S. healthcare system, 26 states now require equal payment or comparable payment for telehealth visits. So there is this rapid growth now of telehealth services to be able to link patients to their providers through video. They do not pay for it for phone, but they pay for video.”

Physicians, patients, and payers must also be given adequate responsibility and a clear definition of role if they are to effectively steward Alberta’s scarce healthcare resources going forward. Most importantly, they must also be given a shared goal (see Box 3). A significant challenge in health care has been a lack of explicit goals, making it difficult for healthcare actors to align towards anything; in the absence of a unified vision, physicians, patients, and payers may view the goals of the system differently and work toward slightly different goals.

BOX 3: GOALS FOR HEALTH CARE? (Based on: ²⁴)

In Canada, the stated goal of healthcare policy in the *Canada Health Act* is to protect, promote, and restore the physical and mental well-being of residents of Canada, and to facilitate reasonable access to health services without financial or other barriers.

Other goals include the following:

From Health Canada: Health Canada is committed to improving the lives of all of Canada’s people and to making this country’s population among the healthiest in the world as measured by longevity, lifestyle, and effective use of the public healthcare system.²⁵

²³ Quotes extracted from Dr. Peter Kaboli’s presentation, “Re-Conceptualizing Access for 21st Century Healthcare” <https://vimeo.com/album/3800131/video/155338371>

²⁴ A Picard, “The path to healthcare reform: Policy and politics” (Conference Board of Canada, 2012), <http://www.conferenceboard.ca/e-library/abstract.aspx?did=5863>.

²⁵ Health Canada, “About” <http://www.hc-sc.gc.ca/ahc-asc/activit/about-apropos/index-eng.php>

From 2005 Health Ministers' Consensus: "As a nation, we aspire to a Canada in which every person is as healthy as they can be – physically, mentally, emotionally, and spiritually."²⁶

The Way Toward a Better System

Strong healthcare systems are characterized by strong physician participation and leadership. One key lesson from Alberta is that using more resources does not equate with better care. In order for Alberta to move forward, partnerships across institutional silos will need to be created, along with a commitment that may take years to see meaningful change. This will require political resolve. Commitment to action in other provinces, for example payment reform using a capitation-based model in Ontario, has taken a decade to realize improvements in access and quality-based outcomes such as re-hospitalizations.

Alberta has begun creating the necessary partnerships and networks that will ultimately facilitate the changes required for better management of its resources through physician leadership and stewardship. The province also has considerable strength in human capital, with leaders in research and health system delivery who are needed to test the organizational innovations required to more sustainably manage spending growth.

There are still two hurdles to overcome. These include defining a shared vision with physicians regarding professional roles in an era of resource management, and more broadly defining healthcare goals so that patients and payers are able to effectively contribute. Alberta must also continue to develop the information and communication technology required for effective stewardship. It has already begun this with electronic medical records and patient portals, but there is considerably more work to be done. Innovation can only result through planning, measurement, evaluation, and scaling mechanisms. Beyond facilitating communication between key stakeholders, information and communications technology is a prerequisite for the measurement and valuation of healthcare resources. Using information technology efficiently also requires investment in human capital; healthcare workers need knowledge they can use, solve problems with, and innovate, based on a firm commitment to and understanding of information technology in health care.

"Physicians cannot be doing this in isolation; we have to think of it working in partnership across the system."

- Meeting participant

Concluding Remarks

Changes to physician roles and a shared understanding requires continued and ongoing dialogue. Patients, payers, and physicians must be empowered to determine what works and what does not to effectively manage

²⁶ Public Health Agency of Canada, "Creating a Healthier Canada: Making Prevention a Priority" <http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/declaration/index-eng.php>

scarce healthcare resources in Alberta. Multi-stakeholder dialogue that uses evidence to inform discussion is a good step, but much more is required. A good first step is to acknowledge what works and what does not to give physicians, patients, and payers the necessary means to work toward a shared vision that necessitates the effective stewardship of healthcare resources.

Appendix A: Policy Forum Program

The following is the full program for the IHE/O'Brien Institute policy forum, *Physicians as Stewards of Resources: Roles, Responsibilities, and Remuneration*.



INSTITUTE OF
HEALTH ECONOMICS
ALBERTA CANADA



UNIVERSITY OF CALGARY
O'Brien Institute for Public Health

IHE/O'Brien Policy Forum

Physicians as Stewards of Public Resources

Roles, Responsibilities and Remuneration

Monday, February 8th, 2016

Westin Hotel
10135-100th Street
Edmonton, Alberta

- 8:30 - 9:00 a.m. Light Breakfast
- 9:00 - 9:10 a.m. Welcome and Opening Remarks from IHE and O'Brien Institute Leadership

MORNING SESSION

THEME: UNDERSTANDING OUR SHARED CHALLENGES

- 9:10 - 9:25 a.m. *Setting the Stage: An Overview of Health Spending, Physician Services, and System Performance in Alberta* – Dr. William Ghali
- 9:25 - 9:50 a.m. *Some Reflections on Innovation and Professional Remuneration* – Dr. David Naylor
- 9:50 - 10:15 a.m. *The Juggling Act: Can innovation satisfy the public, physicians and government?* – Mr. André Picard
- 10:15 - 10:30 a.m. Break
- 10:30 - 11:00 a.m. *Physician's Perspective on Stewardship* – Dr. Carl Nohr and Mr. Mike Gormley
- 11:00 - 11:30 a.m. Panel Discussion moderated by Mr. André Picard

LUNCH BREAK

- 11:30 - 12:30 p.m. Lunch Break with Address by the Honourable Sarah Hoffman, Deputy Premier and Minister of Health

AFTERNOON SESSION

THEME: THE WAY TOWARD A BETTER SYSTEM

- 12:30 - 12:55 p.m. *Re-Conceptualizing Access for 21st Century Healthcare* – Dr. Peter Kaboli
- 12:55 - 1:20 p.m. *Patient Care Groups: Rethinking Primary Care* – Dr. David Price
- 1:20 - 1:45 p.m. *Strengthening Our Health System: Opportunities for Physicians to Drive Change* – Dr. Sharon Straus
- 1:45 - 2:00 p.m. Break
- 2:00 - 3:00 p.m. Panel Discussion moderated by Mr. André Picard



Dr. William Ghali

Scientific Director, O'Brien Institute for Public Health

Dr. Ghali is the Scientific Director of the O'Brien Institute for Public Health at the University of Calgary. He is also a Professor in the Departments of Medicine and Community Health Sciences at the University of Calgary, and a practicing physician specialized in Internal Medicine. He recently completed two terms as a Canada Research Chair in Health Services Research, and has also been funded as a Senior Health Scholar by Alberta Innovates Health Solutions. Clinically, he is trained as a General Internist (MD [1990] - University of Calgary, FRCP(C) [1994] - Queen's University, Kingston, Ontario), and completed methodological training in health services research and epidemiology at the Boston University School of Public Health (MPH [1995]).



Dr. Ghali's research program is in the general area of health services research, and his work focuses on interdisciplinary approaches to evaluating and improving health system performance to produce better patient outcomes and improved system efficiency. He leads or co-leads three inter-related research and innovation initiatives: the Alberta Provincial Project for Outcome Assessment in Coronary Heart Disease (APPROACH, www.approach.org); the Ward of the 21st Century initiative (W21C, www.w21c.org); and the International Methodology Consortium for Coded Health Information (IMECCHI, www.imecchi.org), with strong linkages to the World Health Organization. These three initiatives share the overriding goal of enhancing the use of health information to produce applicable knowledge on system performance and patient outcomes, and through knowledge translation, tangible health system improvements.

Dr. Ghali has held millions of dollars of peer-reviewed research funding from various agencies, and has published over 350 papers in peer-reviewed journals. He has received numerous awards, including a Canadian Top 40 Under 40 Award from the Caldwell Group (2006), the David Sackett Senior Investigator Award from the Canadian Society of Internal Medicine, and Distinguished Alumni Awards from both the University of Calgary's Faculty of Medicine (2009) and the Boston University School of Public Health (2001). He was featured recently by *The Globe and Mail* (April 2012) as the Canadian public health researcher with the highest publication H-index, and is also named in the Thomson-Reuters listing of the top 1% of most highly cited researchers by discipline.

Dr. C. David Naylor

President Emeritus and Professor of Medicine, University of Toronto

Dr. Naylor is President Emeritus and Professor of Medicine at the University of Toronto. He served as President from 2005 to 2013. Earlier, Dr. Naylor was Dean of Medicine (1999-2005), founding Director of Clinical Epidemiology (1990-1996) at Sunnybrook Health Science Centre, and founding Chief Executive Officer of the Institute for Clinical Evaluative Sciences (1991-1998).



Dr. Naylor is the co-author of approximately 300 scholarly publications, spanning social history, public policy, epidemiology and biostatistics, and health economics, as well as clinical and health services research in most fields of medicine. He has been active as an advisor to governments, institutions, and enterprises in Canada and abroad over the course of more than 25 years. Dr. Naylor was involved in the initiation and early governance of the Canadian Institutes of Health Research. In 2003, he chaired Canada's National Advisory Committee on SARS and Public Health; the Committee's report sparked the creation of the Public Health Agency of Canada. In 2009-2010, he participated in the Global Commission on the Education of Health Professionals for the 21st Century, and in 2014-2015 chaired Canada's federal Advisory Panel on Healthcare Innovation.

Among other awards and honours, Dr. Naylor is a Fellow of the Royal Society of Canada and the Canadian Academy of Health Sciences, a Foreign Associate Fellow of the US Institute of Medicine, and an Officer of the Order of Canada.

Mr. André Picard

Health Columnist, *The Globe and Mail*

Mr. Picard is a health reporter and columnist at *The Globe and Mail*, where he has been a staff writer since 1987. He is also the author of three bestselling books.

Mr. Picard has received much acclaim for his writing. He is an eight-time nominee for the National Newspaper Awards, Canada's top journalism prize, and past winner of prestigious Michener Award for Meritorious Public Service Journalism.

Mr. Picard has also been honoured for his dedication to improving health care. He was named Canada's first "Public Health Hero" by the Canadian Public Health Association and as a "Champion of Mental Health" by the Canadian Alliance on Mental Illness and Mental Health. His work has been recognized by a number of other consumer groups, including the Alzheimer Society of Canada, the Canadian Hearing Society, Safe Kids Canada, and the Campaign to Control Cancer.

Mr. Picard lives in Montréal.



Dr. Carl Nohr

President, Alberta Medical Association

Dr. Nohr is the President of the Alberta Medical Association (AMA) for 2015-2016. He has served the profession and public as a practicing academic and community general surgeon, a member of the Council of the College of Physicians and Surgeons of Alberta, and in the AMA. He has an abiding interest in all matters that affect the medical profession, which he loves dearly.



Mr. Michael A. Gormley

Executive Director, Alberta Medical Association

Mr. Gormley joined the AMA in 1994 as assistant executive director (Health Policy and Economics). Eight years later, in 2002 he took the helm as executive director. Mr. Gormley is the AMA's fourth executive director and the first non-physician to hold the position.

As executive director, Mr. Gormley has built a solid reputation for his vision, leadership and innovation. His contributions to negotiations between the AMA, Alberta government, and Alberta Health Services (formerly the nine regional health authorities) have resulted in innovative solutions to challenges in the healthcare system – the eight-year trilateral agreement between the parties is a good example.

Before joining the AMA, Mr. Gormley was executive director of economics for the British Columbia Medical Association, a senior health economist for Saskatchewan Health, and an economist for the Ontario Medical Association.

Mr. Gormley received his Bachelor of Arts in Economics from the University of Alberta in 1977. Continuing in his studies, he obtained his Master of Arts in Economics five years later after researching the migration decisions of physicians in rural Saskatchewan.



Dr. Peter Kaboli

Hospitalist and Chief of Medicine, Iowa City VA Healthcare System

Dr. Kaboli is a Hospitalist and Chief of Medicine at the Iowa City VA Healthcare System and Professor in the Department of Internal Medicine, University of Iowa Carver College of



Medicine. He earned his BS in Biology, MS in Epidemiology, and his MD all from the University of Iowa. He completed his residency at LDS Hospital in Salt Lake City, UT in 1998 and General Medicine Fellowship and VA Quality Scholars Fellowship at the University of Iowa/Iowa City VAMC in 2000. Dr. Kaboli's research interests include healthcare access, rural health, inpatient medical care quality, development of valid methods for measuring medication appropriateness, and interventions to optimize medication delivery to vulnerable Veteran populations.

Dr. David Price

Professor and Chair, Department of Family Medicine, McMaster University

Dr. Price is Professor and Chair of the Department of Family Medicine at McMaster University, and has been Chief of Family Medicine at Hamilton Health Sciences since 2004. He has been a physician for over 25 years, practicing comprehensive family medicine.

Dr. Price is currently the Provincial Primary Care Lead and was Chair of the Provincial Expert Advisory Panel on Primary Care (2013-2014). He has considerable interest and experience in primary care reform and healthcare policy development not only through his leadership roles at the University and Hospital, but also through his involvement with local, regional and provincial government bodies where he acts as a consultant and advisor.

Locally, he was the founding director of the Maternity Centre of Hamilton; a multidisciplinary centre that cares for prenatal and intrapartum patients. Dr. Price was also instrumental in helping to create the academic Family Health Team at McMaster University, an interprofessional team, currently serving over 35,000 patients in the Hamilton area.

Dr. Price is a co-investigator on TAPESTRY, a \$6.5 million project funded by Health Canada, which combines volunteers and technology to improve the care provided to seniors by primary care teams. Since 2006, he has also been the administrative lead for OSCAR (Open Source Clinical Application Resource), an Electronic Medical Record. OSCAR was developed at McMaster and is now utilized across Canada by more than 2,500 family physicians and is the fastest growing EMR in Ontario.



Dr. Sharon Straus

Professor, Department of Medicine, University of Toronto

Dr. Straus is a Professor in the Department of Medicine at the University of Toronto. She holds a Tier 1 Canada Research Chair in Knowledge Translation and Quality of Care and more than \$30 million in peer-reviewed research grants as a principal investigator. She has over 300 publications, and has supervised over 25 graduate students from different disciplines including clinical epidemiology, health informatics, and human factors engineering. She is co-Principal Investigator of KT Canada, a CIHR and CFI funded national, Clinical Research Initiative, Principal Investigator of KT Canada's CIHR-funded Strategic Training Initiative in Health Research, and Principal Investigator of a network meta-analysis team grant for the Drug Safety and Effectiveness Network. She is Division Director of Geriatric Medicine at the University of Toronto and Director of the KT Program at the Li Ka Shing Knowledge Institute of St. Michael's.

Dr. Straus has authored three books: *Evidence-Based Medicine: How to Practice and Teach It*, now in its fourth edition and published in nine languages; *Knowledge Translation in Health Care*, now in its second edition; and *Mentorship in Academic Medicine*.



About the Institute of Health Economics

The Institute of Health Economics (IHE) is a non-profit Alberta-based research organization committed to producing, gathering, and dissemination evidence-based findings from health economics, health policy analyses, health technology assessment and comparative effectiveness research to support health policy and practice. Established in 1995, it is a unique collaborative arrangement among government, academia, and industry.

The IHE has a staff of 27 that includes health economists, health technology assessors, research methodologists and policy analysts, information specialists, and project and administrative personnel. The Institute is a member of the International Network of Agencies for Health Technology Assessment (INAHTA) and the World Health Organization's Health Evidence Network (WHO HEN) and is the secretariat for Health Technology Assessment International (HTAi) (www.htai.org).

The IHE regularly designs and conducts consensus development conferences and policy dialogues for provincial and national public and private sector organizations on a wide range of issues. More detailed information on the IHE is available on our website (www.ihe.ca).

About the O'Brien Institute for Public Health

The O'Brien Institute for Public Health at the University of Calgary supports excellence in population health and health services research. To help realize the benefits of such research in local, national, and global communities, the Institute strives to facilitate information exchange with policy and practice stakeholders.

More than 400 members include multidisciplinary researchers from 13 Faculty of Medicine departments and nine other relevant Faculties; health professionals in various departments and portfolios of Alberta Health Services; and research users and policy makers from various municipal and provincial institutions. The shared vision of these dedicated members is "Better health and health care", and is realized through the Institute's three priority areas: Improved Population Health, Enhanced Health Systems Performance, and Innovative Tools and Methods for Public Health.

The O'Brien Institute works to encourage the research and knowledge-mobilization ambitions of its broad membership. Programs for internal peer-review, grantsmanship, and mentorship contribute to academic excellence. Various communication instruments, activities, and special events serve to link knowledge generators and knowledge end-users within the membership and locally. The Institute is also successful in brokering broader external relationships, with provincial and national interest groups, policy makers, research agencies, the media, philanthropists, and community stakeholders. More detailed information on the O'Brien Institute is available on our website (www.obrieniph.ucalgary.ca), and on Twitter (@Obrien_IPH).

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