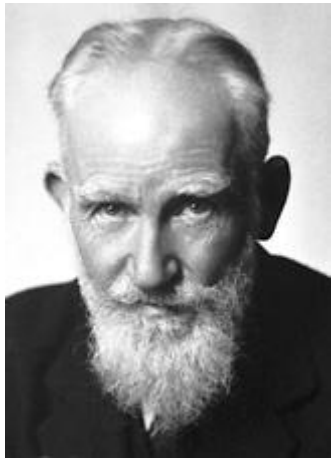
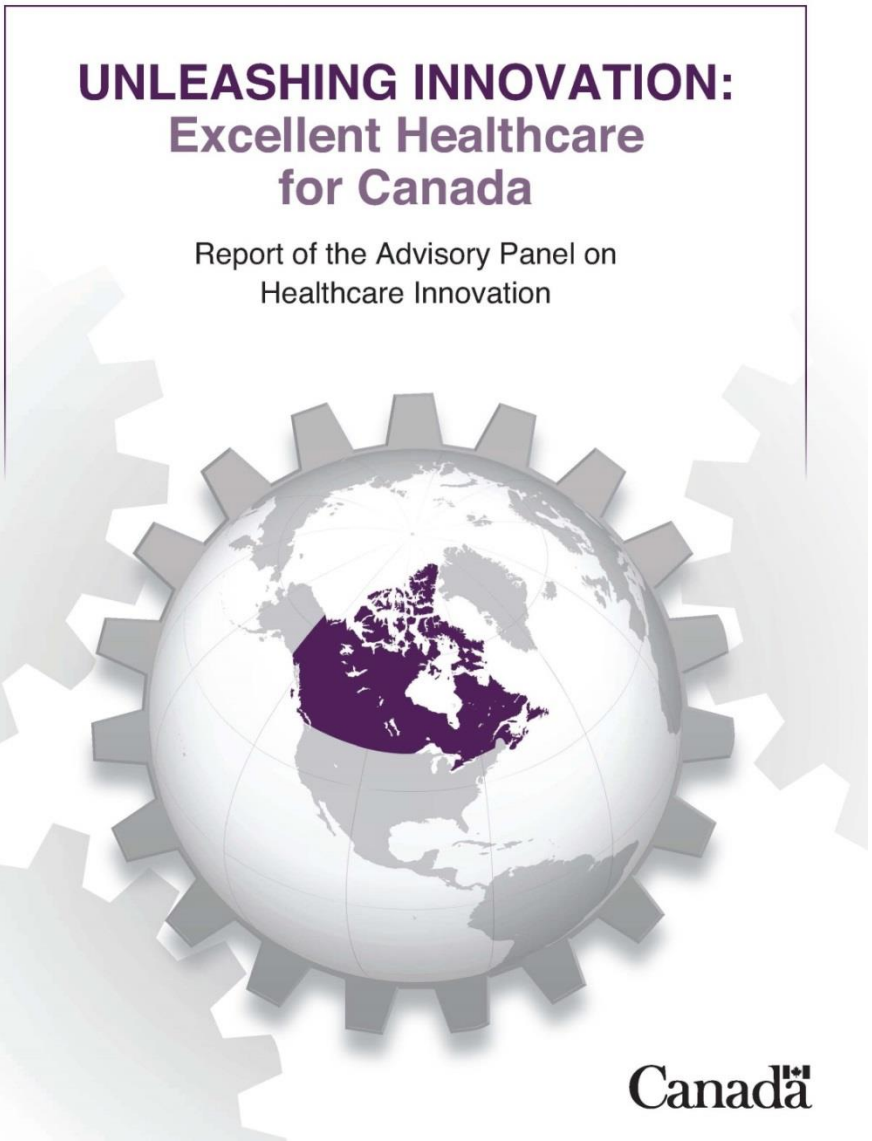
Some Reflections on Innovation and Professional Remuneration

UNIVERSITY OF TORONTO

George Bernard Shaw on Fee-for-Service Payment of Physicians, 1906 (from the Preface to The Doctor's Dilemma),

" That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg is enough to make one despair of political humanity."





Neil Fraser. President, Medtronic Canada

Francine Girard. (Dep. Chair) Dean of Nursing. U de Montréal (to 01/06/15)

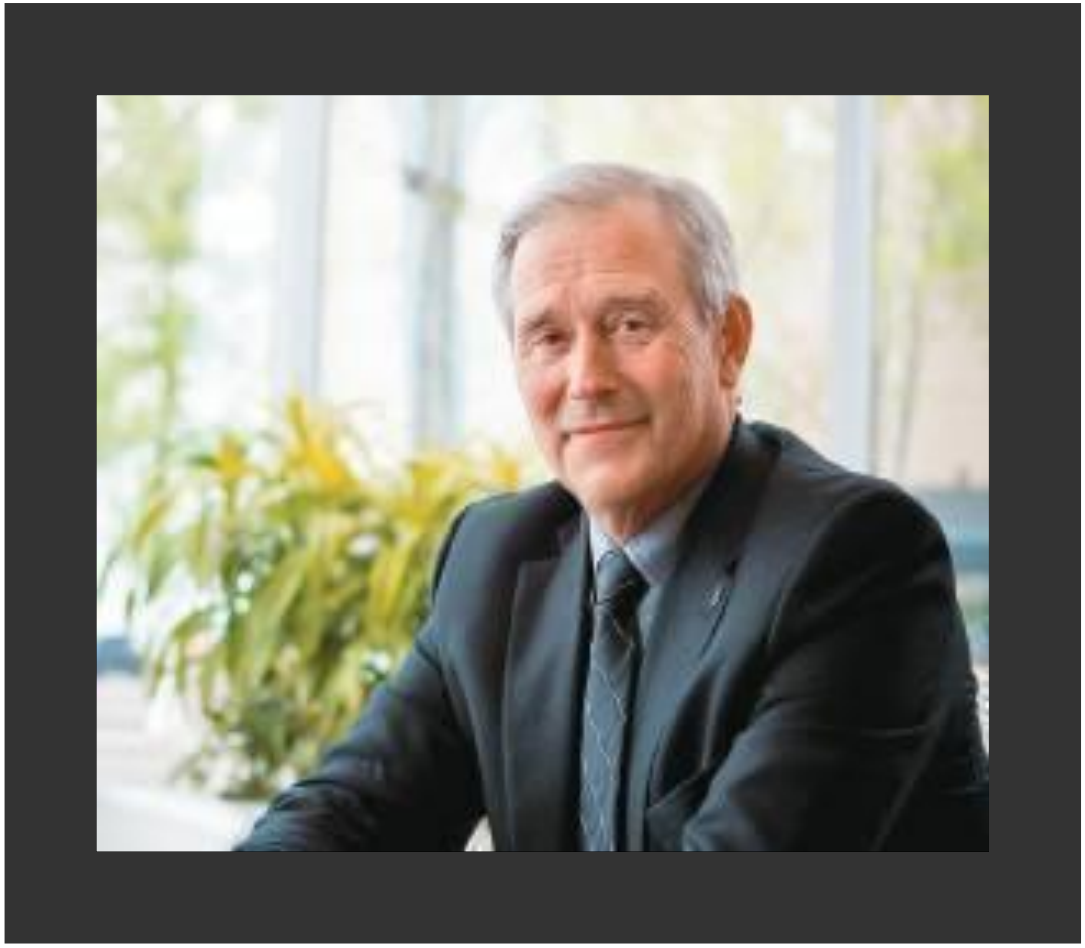
Toby Jenkins. Executive Fellow, School of Public Policy, U of Calgary

Jack Mintz. Director, School of Public Policy, U of Calgary (to 30/06/15)

Christine Power. CEO, Can. Patient Safety Inst. (eff. 01/03/15). Past CEO, Capital Health, Nova Scotia.

Dedicated to Panelist Cy Frank (1949-2015), former CEO, Alberta Health Innovates.

Dr. Cyril B. Frank



Overview of Panel Mandate and Activity

- The federal Minister of Health, the Honourable Rona Ambrose, launched the Advisory Panel on Healthcare Innovation on June 24, 2014.
  - Mandate:
    - Identify the 5 most promising areas of innovation in Canada and internationally that have the potential to reduce growth in health spending while leading to improvements in care.
    - Recommend 5 ways the federal government could support innovation in these areas.

- Panel work included:
  - Consultations with stakeholders and public (with over 400 written submissions)
  - Literature review and commissioned research
  - Engagement with international and domestic experts

- Report released on July 17, 2015

What was our view of Canadian Healthcare from 35,000 Feet?

Forces of Change

- Demographics
- Information Technology Revolution
- Biotechnology Revolution
- Patients: Autonomy, Transparency, Engagement
- Spending Fatigue and Limits

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

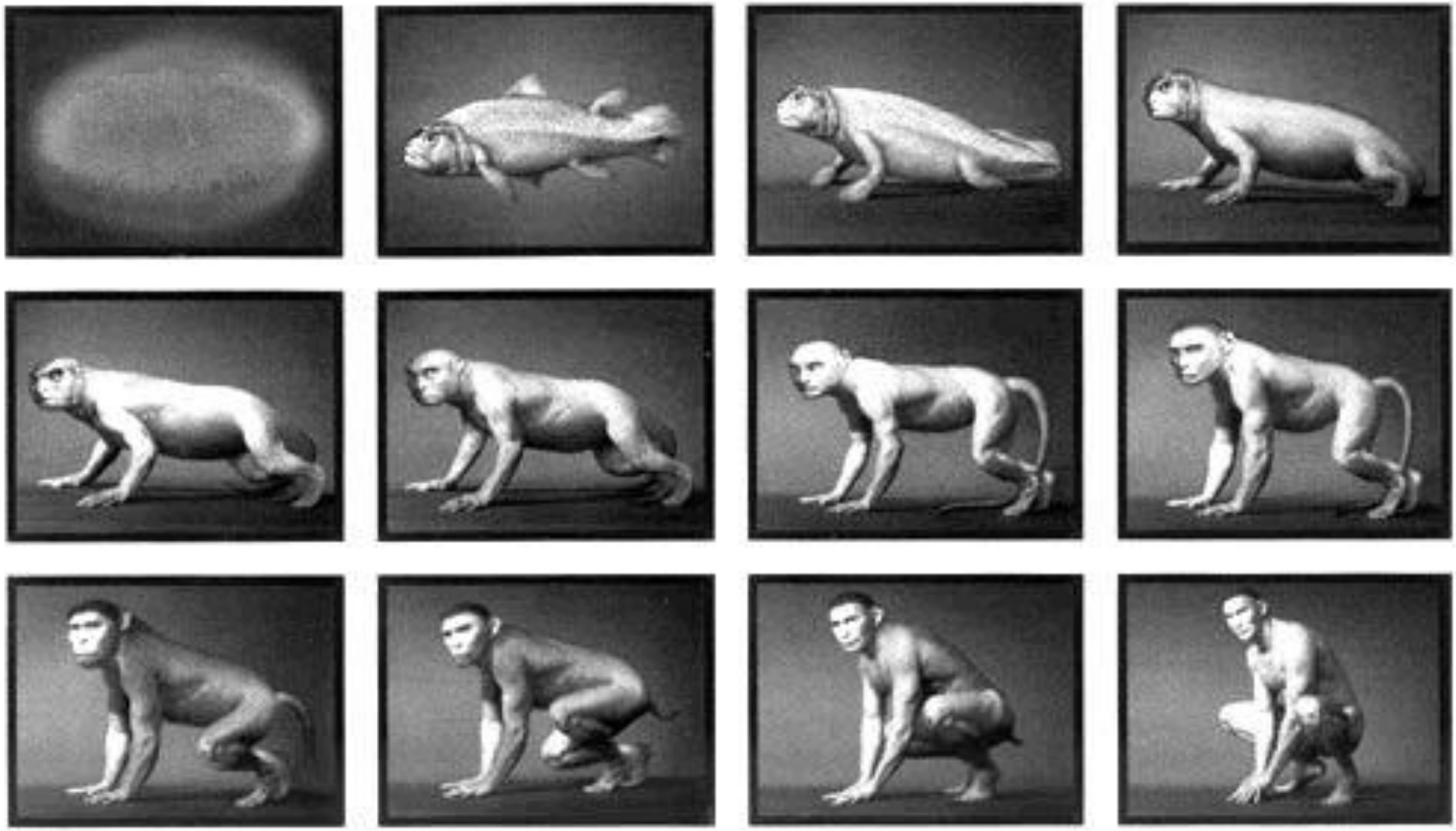
Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Canadian Medicare: Evolution or Arrested Development?



The Five Key Fronts for Innovation

- Patient engagement and empowerment
- Health systems integration with workforce modernization
- Technological transformation via digital health and precision medicine
- Better value from procurement, reimbursement and regulation
- Industry as an economic driver and innovation catalyst

2a. Health Systems Integration with Workforce Modernization

Findings

- More integrated care is critical to improving quality of care and health outcomes, and optimizing scopes of professional practice
- Highly integrated systems (e.g., Kaiser Permanente) rely on:
  - Inter-professional teams of providers
  - Seamless collaboration across organizations and sectors
  - Information technologies to link providers, patients, and settings
  - Integrating payment models and provider accountabilities
  - Emphasis on outreach and prevention/wellness
- Steps towards integration:
  - US experimentation, not least bundled payment models
- In Canada, integration of care largely unrealized
  - Fragmentation of care a particular issue for First Nations

2b. Health Systems Integration with Workforce Modernization

Set of Recommendations

•Support provinces/ territories and regional health authorities in implementing highly integrated delivery systems that test new forms of payment, where care is organized and financed around the needs of the patient.

- Ensure integrated delivery arrangements address social needs and determinants of health, protect and promote health, and prevent disease

•Support the adaptation and scaling-up of partial integration models, viz. Bundled Payments.

•Support implementation of the Canadian Academy of Health Sciences 2014 report *Optimizing Scopes of Practice.*

4. Better Value from Procurement, Reimbursement & Regulation

Findings

- Canada does not have a strong value-for-money orientation in healthcare.
- Changes to healthcare finance, purchasing and regulation needed.

Among the Recommendations, e.g.

- National Pay Commission/HHR analyses of scopes of practice in relation to value


CALIFORNIA
OUTATIME

SPECIAL ARTICLE

The Burlington Randomized Trial of the Nurse Practitioner

Spitzer WO, Sackett DL, Sibley JC et al. *N Engl J Med* 1974: 290:251–256

From July, 1971, to July, 1972, in a large suburban Ontario practice of two family physicians, a randomized controlled trial was conducted to assess the effects of substituting nurse practitioners for physicians in primary-care practice. Before and after the trial, the health status of patients who received conventional care from family physicians was compared with the status of those who received care mainly from nurse practitioners. Both groups of patients had a similar mortality experience, and no differences were found in physical functional capacity, social function or emotional function. The quality of care rendered to the two groups seemed similar, as assessed by a quantitative "indicator-condition" approach. Satisfaction was high among both patients and professional personnel. ***Although cost effective from society's point of view, the new method of primary care was not financially profitable to doctors because of current restrictions on reimbursement for the nurse-practitioner services.***

A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services.

Manning WG, Leibowitz, A,. Goldberg GA, Rogers WH. and Newhouse JP. N Engl J Med 1984; 310:1505-10.

Abstract

Does a prepaid group practice deliver less care than the fee-for-service system when both serve comparable populations with comparable benefits? To answer this question, we randomly assigned a group of 1580 persons to receive care free of charge from either a fee-for-service physician of their choice (431 persons) or the Group Health Cooperative of Puget Sound (1149 persons). In addition, 733 prior enrollees of the Cooperative were studied as a control group. The rate of hospital admissions in both groups at the Cooperative was about 40 per cent less than in the fee-for-service group ($P<0.01$), although ambulatory-visit rates were similar. The calculated expenditure rate for all services was about 25 per cent less in the two Cooperative groups ($P<0.01$ for the experimental group, $P<0.05$ for the control group). The number of preventive visits was higher in the prepaid groups, but this difference does not explain the reduced hospitalization. The similarity of use between the two prepaid groups suggests that the mix of health risks at the Cooperative was similar to that in the fee-for-service system. The lower rate of use that we observed, along with comparable reductions found in non-controlled studies by others, suggests that the style of medicine at prepaid group practices is markedly less "hospital-intensive" and, consequently, less expensive.

Allocation of health care resources: a challenge for the medical profession

David Naylor, MD, DPhil
Adam L. Linton, MB, ChB, FRCP, FRCPC

If current limitations on health care funding continue, medical practitioners will face increasing pressure to conserve scarce resources and to participate in the allocation of funds. This article discusses the ethical and economic aspects of the physician's role and briefly reviews some efficiency measures that might mitigate the effects of rationing of health care services.

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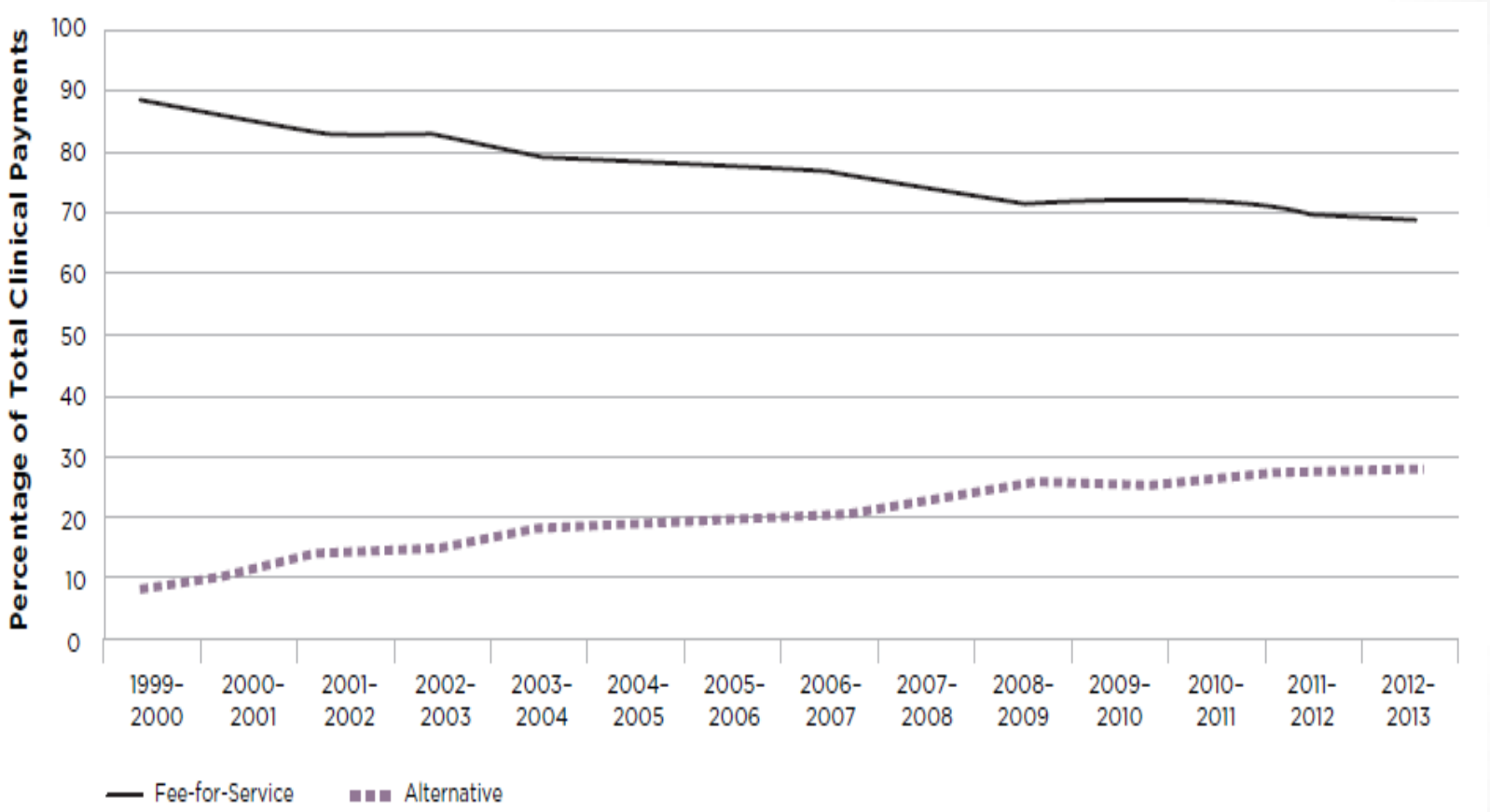
CANADA DOES NOT HAVE INTEGRATED HEALTHCARE. Canada has a series of disconnected parts, a hodge-podge patchwork, healthcare industry comprising hospitals, doctors' offices, group practices, community agencies, private sector organizations, public health departments and so on. Each Canadian province is experimenting with different types of organizational structures and processes with the intent of improving the coordination of services, facilitating better collaboration among providers and providing better healthcare to the population. However, regional health authorities and their variants in Canada do not possess most of the basic characteristics of integrated healthcare such as physician integration and a rostered population (Hospital Management Research Unit 1996,1997).

In contrast, most developed countries are currently emphasizing integration of the components of healthcare as a

* At the time of writing this paper Prof. Leatt was on secondment as CEO, Ontario Health Services Restructuring Commission, Toronto, Ontario

Fee-for-Service vs. Alternative Payment



Source: Adapted from: Canadian Institute for Health Information (CIHI). Approaches for Calculating Average Clinical Payments per Physician Using Detailed Alternative Payment Data. Ottawa: CIHI; 2015 March 12. Available from: https://secure.cihi.ca/free_products/PhysicianMetrics-mar2014_EN.pdf. P.12

Over-reliance on Fee for Service as a Remuneration mode

- Misaligned incentives – rewarding volume, not quality or stewardship
- Limits motivation to engage and lead in the system more broadly
- Longstanding challenges with relativity and complexity
- Slump and boom cycles erode morale and collaboration
- Contradictory: Private contractors + closed market + collective bargaining + overhead payments?

Lots to learn from the US, lots of creative energy under the US Affordable Care Act

Selected 2014-15 Reports from CMS-I

(limited to au:Conway PH)

- **Accountable Health Communities--Addressing Social Needs through Medicare and Medicaid. N Engl J Med. 2016 Jan 7;374(1):8-11.**
- **Medicare's New Bundled Payments: Design, Strategy, and Evolution. JAMA. 2016 Jan 12;315(2):131-2.**
- **Medicare's Vision for Delivery-System Reform--The Role of ACOs. N Engl J Med. 2015 Sep 10;373(11):987-90.**
- **Behavioral economics and physician compensation--promise and challenges. N Engl J Med. 2015 Jun 11;372(24):2281-3.**
- **Paying for Prevention: A Novel Test of Medicare Value-Based Payment for Cardiovascular Risk Reduction. JAMA. 2015 Jul 14;314(2):123-4.**
- **Screening for lung cancer with low-dose CT--translating science into Medicare coverage policy. N Engl J Med. 2015 May 28;372(22):2083-5.**
- **The CMS Innovation Center--a five-year self-assessment. N Engl J Med. 2015 May 21;372(21):1981-3.**
- **Association of Pioneer Accountable Care Organizations vs traditional Medicare fee for service with spending, utilization, and patient experience. JAMA. 2015 Jun 2;313(21):2152-61.**
- **Guiding Principles for Center for Medicare & Medicaid Innovation Model Evaluations. JAMA. 2015 Jun 16;313(23):2317-8.**
- **State innovation model initiative: a state-led approach to accelerating health care system transformation. JAMA. 2015 Apr 7;313(13):1317-8.**
- **Beyond a traditional payer--CMS's role in improving population health. N Engl J Med. 2015 Jan 8;372(2):109-11.**
- **Getting more performance from performance measurement. N Engl J Med. 2014 Dec 4;371(23):2145-7.**
- **Opportunities for quality measurement to improve the value of care for patients with multiple chronic conditions. Ann Intern Med. 2014 Nov 18;161(10 Suppl):S76-80.**
- **The Pioneer accountable care organization model: improving quality and lowering costs. JAMA. 2014 Oct 22-29;312(16):1635-6.**
- **The Patient Protection and Affordable Care Act: opportunities for prevention and public health. Lancet. 2014 Jul 5;384(9937):75-82.**
- **The Medicare physician-data release--context and rationale. N Engl J Med. 2014 Jul 10;371(2):99-101.**
- **CMS--engaging multiple payers in payment reform. JAMA. 2014 May 21;311(19):1967-8.**
- **Quality improvement of care transitions and the trend of composite hospital care. JAMA. 2014 Mar 12;311(10):1013-4.**

Can Albertans lead Canada by creating a more sustainable version of Canadian Medicare?

a) **Yes, they can, but they won't**. Take a look at pan-Canadian experience over the last 40 years. Alberta will wait for oil prices to rise and the usual cycle will recur.

b) **Yes, they can and they will.** The economic shock will galvanize major changes in the organization and financing of health services.

c) **Yes, in theory, they can.** But the jury is out. Much depends on public awareness, expertise and leadership.