



Quarterly Letters

Leaders Up Front, Please!

The changes that must be made to secure the future of healthcare in Canada are not happening – or at best at glacial pace. I fear for healthcare unless the leaders in acute care, primarily in hospital care, are emboldened to seize the lead in making changes in how their services are provided to Canadians. We need to improve dramatically two vital processes in the so-called system.

1. Productivity: the rate of return on the system's use of labour and capital
2. Accountability to the public in its two capacities as users of acute care services and as taxpayers who pay for them

I can almost hear the mental groans of Canada's leaders in acute care at the suggestion they need to be energized. Let me be clear: I *don't* think you are sitting on your duffs as ER waiting rooms overflow, elective surgery lists are cancelled for want of OR time and ICU beds and nursing staff morale plummets – there are many such problems to keep you up at night. But as necessary and hard to deal with as they are, those problems are managerial. What needs to be energized is the issue of governance. Bluntly put, it is the issue of *leadership* – finding answers to two important questions.

1. Are there better ways of organizing ourselves to provide the people of Canada with improved acute care services?
2. How can the transitional changes be made from the way we do business now to those better ways?

The Health Services Restructuring Commission was created 7.5 years ago by a government in Ontario that realized that it had neither answers to these questions nor even the capacity to ask and consider them. Although the power it gave to the Commission was focused on restructuring public hospitals, the real challenge was to identify better, more efficient and effective ways of doing things in healthcare generally, including in acute care – in other words, creating a contemporary vision of healthcare. The second step was to develop credible strategies to convert that vision into reality.

In addition to its task of restructuring Ontario's public hospitals, the Commission kept its eye firmly on the more fundamental question: If we had a real system of health and healthcare services in Ontario, what would it look like and do?

The strategies that were needed to realize our vision included developing a capacity for health information management. I believe this was the most important thing the Commission did.

It is ludicrous to think that we can run an enterprise as big and complex as healthcare effectively and efficiently (one that consumes about 40% of the 13 provincial/territorial budgets and well over 9% of the country's GDP) with only fragmentary information about the myriad interactions between providers and consumers and virtually none about the volume or quality of its products or, most important, or the outcomes of those interactions.

Recall question 1 posed earlier, "Are there better ways of organizing ourselves to provide the people of Canada with improved acute care services?" It's hard to test an alternative when you don't have the data to know what you are doing now, much less how well or poorly you are doing it!

A second key Commission strategy was of ways and means to renew primary healthcare – to make the provision of this fundamental service available to people 24/7; to make it genuinely comprehensive in scope, including primary obstetrics as well as mental health and chronic condition care; to make it a truly interprofessional, shared, group activity; and to make it as available in rural and northern Ontario as to the worried-well 9 to 5 in Toronto's suburban malls. Is this related to acute care? It certainly is!

Consider a recent editorial (Fisher 2003) and article (Ashton et al. 2003), both published in the *New England Journal of Medicine*. Ashton's group in the US Veterans Administration studied the effect on patients with serious chronic disease (those most dependent on hospital-based acute care services) of the VA's policy decision a decade ago to close 55% of its hospital beds and focus its energies on providing high-quality primary care through 22 regional, integrated service-delivery networks. Over four years, (1994–1998), hospital use decreased by 50%, medical clinic visits increased by 10%, visits for urgent care decreased and in five of nine cohorts (six with medical and three with psychiatric conditions) one-year survival rates increased significantly and were unchanged in the others. The authors cautiously concluded that the reduction in hospital capacity had no adverse consequence, an astounding conclusion but one well supported by the evidence.

Fisher's editorial, which comments on the work by Ashton's group, refers to related research using Medicare data showing that patients in areas with high-intensity practice patterns (such as Manhattan, with spending of \$10,550 per capita) have less access to care, receive lower-quality care and are less or at best equally satisfied with their care than those in regions with more conservative practice patterns that use far fewer hospital resources (such as Portland, Oregon where comparable spending is \$4,823 per capita). Fisher comments wryly, "hospitals are dangerous places, especially if you do not need to be there."

At Grand River Hospital, which serves 450,000 people in the Waterloo Region of Ontario, care team members know McKesson's in the room — at the bedside, in the pharmacy, in the physician's office and home — supporting their ability to provide patient-focused care.

Chief Executive Officer Dennis Egan : “Our care team's use of information technology — from McKesson's automated pharmacy robotics system to the clinical documentation and guidelines system shared across encounters, facilities and clinicians — improves the safety, efficiency and quality of how we deliver patient care.

Vice President, Chief Nursing Officer Gloria Whitson-Shea:

“McKesson's electronic documentation system enables clinicians to chart patient data faster and more accurately. It allows staff members to think about how they are doing assessments. And, it improves communication among care team members — not only nurses and physicians, but others such as respiratory and physiotherapists — as we collect, review and share data necessary to coordinate patient care.”

Chief Information Officer Glen Kearns: “McKesson's clinical systems give Grand River's clinicians and physicians easier access to information, and that improves clinical outcomes. Providing comprehensive, consistent patient data enables them to make faster and more effective decisions about patient care and helps Grand River fulfill its mission of having greater capacity to serve the patient population.”

With McKesson in the room, hospitals like Grand River are able to better focus on their patients — providing the right care at the right time. Today, more than 3,000 hospitals in North America rely on McKesson's comprehensive solutions to solve their business and clinical problems.

For more information about McKesson's Horizon Clinicals™, please call 1-800-981-8601 or visit us on the Web at <http://infosolutions.mckesson.ca>.

“McKesson's clinical solutions support Grand River in providing patient-focused care.”



Left to right: Grand River's Dennis Egan, Chief Executive Officer; Gloria Whitson-Shea, Vice President, Chief Nursing Officer; Glen Kearns, Chief Information Officer; and McKesson's Tammy Williams, Manager, Product Development

**MCKESSON DELIVERS ON
CARE TEAM EFFICIENCY**

MCKESSON
Canada
Empowering Healthcare

1-800-981-8601

Fisher points out that if the changes made by the VA were applied throughout the US, Medicare spending (and perhaps healthcare spending in total) would fall by about 30% – and *patients would be better, or at least no worse off!* But, to paraphrase Fisher, it isn't going to happen – about one-third of the healthcare workforce would have to find new jobs. And if such large and rapid productivity changes are practically and politically impossible in the United States, what chance would they have in Canada?

We can't continue spending more money than we can afford on a non-system that is generating anxiety in an aging population facing the certainty of their increasing need for its services. Even if more money were levered out of taxpayers, spending more on healthcare works like a shot of Demerol – it relieves the pain only for a little while; *it is not a cure!*

It is still early days, but I will share my (post-Commission) perspectives on acute care restructuring in Ontario.

First, from the practical perspective of a long-time resident of this cautious, conservative country, I believe the restructuring of urban hospitals directed by the Health Services Restructuring Commission has been as successful and beneficial for the provision of acute care in Ontario as we could have expected. Our work will facilitate building a genuine healthcare system over the long term. Converting the provincial psychiatric hospitals to public hospitals was a good thing. The relatively massive expansion of nursing home capacity that is now coming online and the increased funding for the expansion of home care are good things that came out of the Commission. Some important things are still in the works: possible action on the recommendations of regional task forces on mental health services and primary care renewal that, while still more rhetorical than real, appears to be something whose time is coming.

Overall, I am proud of what the Health Services Restructuring Commission accomplished in Ontario and its demonstration to the rest of Canada that, “Yes, Virginia, change for the better in healthcare is possible, and in your lifetime.”

As a Canadian grandfather, however, I am a much less happy camper. The pace of change of the status quo in healthcare is far too slow. I fear that healthcare will not be “there for them” when my son and daughter-in-law need it, much less my three grandsons. There is frustration in this country with the increasing unevenness of access to primary care services, with long and lengthening waits for hospital-based and specialists' services, and with relatively high levels of taxation and user fees for educational and other services that used to be tax-supported. I fear this will translate into legally irresistible demands, by those who can afford it, for private health insurance coverage to safeguard their access to a preferential “second tier” of hospital and doctors' services.

Senator Kirby and his colleagues (2001) were explicit in their prediction of the effect such demands would have on the

principle of solidarity that underpins the single-payer, collective insurance concept at the foundation of Medicare. We need only to look south to 44 million uninsured lives and the opportunity costs of 13.5% of GDP going into healthcare to see what happens in the absence of support for solidarity by members of the upper and upper-middle class. If Canadians' frustration at not being able to find a primary care provider and long waiting lists grows faster than the system can change to reduce those irritants, we will have a problem that will make the present ones look like child's play. We have to do a very un-Canadian thing and pick up the pace of change smartly – and we don't have much time left to talk about it.

To quote from the Conference Board of Canada's report, *Performance and Potential, 2003-04*, “while Canada is in a position where it can make policy choices, there is ... a critical need to do so.” In other words, we have to get on with it! When discussing the impact of the aging population on healthcare, the report says, with typical Canadian restraint, “demographics are therefore quite significant in terms of the sustainability of the healthcare system [and these are the important words to remember] as it is *currently structured and financed*.” In other words, the status quo won't do; it is not sustainable! Finally, the report says, “the fundamental issue is one of leadership.” I could not agree more!

Where will leadership come from? Canada's first instinct is to look to its elected government. Our elected representatives are not stupid: they have seen the political futures of those who try to lead rather than follow public opinion. Short of an acute and prolonged exigency of gargantuan proportions leadership that will make the quick changes that are needed in acute care – in healthcare generally – is not going to come from governments, provincial or federal. Even if bold leadership were conceived politically, I fear that our entrenched bureaucracies would smother it at birth.

From our several perches at the head of Canada's acute care hospitals, health professional associations, teaching and research institutions and health and disease advocacy groups, we do have, collectively, the resources and freedom to conspire. We must put self-interest aside and act together. The power of this beneficial conspiracy would be sufficient both to make fundamental changes in healthcare and to recruit public opinion to the point where politicians and even bureaucrats would have to support the changes we conspire to make. Politics is a timid sport, referred to as “the art of the possible,” which, these days, means politicians will do what polls indicate people want done.

If Canada's leaders in acute care were to be energized to conspire together, out of that conspiracy could come the leadership urgently needed now to make dramatic changes in how acute care services are organized and provided in Canada. We all have a good idea of what needs be done. What remains is to do it.