

## In Conversation with David Henry

Ken Tremblay

**Dr.** David Henry, president and chief executive officer of the Institute for Clinical Evaluative Sciences (ICES), assumed the helm in September 2007. Prior to his arrival in Canada, Dr. Henry held several clinical, administrative and leadership roles at the University of Newcastle, Australia. He is an internist, clinical toxicologist and professor of clinical pharmacology and has a wealth of international experience in pharmaco-economics and pharmaco-epidemiology, sponsored in part by the World Health Organization. He was extensively involved in the development and operation of Australia's National Pharmaceutical Benefits Scheme and has pursued a range of research interests, including the evaluation of adverse effects of drugs and (more recently) lay media coverage of new medical treatments. Ken Tremblay caught up with him during his move to Canada.



**HQ:** Congratulations and welcome to Canada. Why ICES?

**DH:** On a professional note, ICES is one of the premier health services research (HSR) institutes in the world [with] genuinely talented researchers and staff, and a great blend of commissioned and investigator-initiated research. I had some connection with individuals who work (or had worked) at ICES and was interested in its strong links to health service planning and delivery. At a personal level, I was very comfortable in my present job but wanted a new challenge. Both Julia and I love Toronto, and it is much closer to family (in Scotland) than Sydney.

**HQ:** What have been your first impressions about Canada's healthcare system?

**DH:** Those within the system will always point to the cracks and complain about access and wait times. But Canada seems to have avoided some of the major structural problems that plague other healthcare systems – for instance, the terrible federal-state split in Australia, the underfunding and growing use of private capital in the United Kingdom and the excesses of

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private healthcare delivery and commodification of healthcare in the United States. One of the major tests for Canada will be whether it can resist the move to privatization as seen in many other countries.

**HQ:** What lessons might be learned from Australia's experiences with a national health strategy?

**DH:** That certain components work quite well, particularly those that are centralized (e.g., Australia's Pharmaceutical Benefits Scheme), might be a lesson for others. But the constant blame shifting between federal and state jurisdictions over healthcare is wasteful and damages morale. There have been several attempts to integrate care, but they seem unable to bridge the gaps between primary care, aged care services (national mandates)

and acute care hospital services (state mandate). Private care can provide very-high-quality, efficient technical services for low-risk individuals but inevitably picks the low-hanging fruit and then sells it at a high price. The private sector provides little real support for management of chronic complex disorders, and the Commonwealth government's subsidy of the private sector (through tax relief on private health insurance) has been wasteful and inequitable.

**HQ: The notion of “evidence-based practice” (EBP) has become popular in Canada. What does that mean to you?**

**DH:** Canada, more than any other country, embraced EBP at an early stage, and many of its leading proponents are in Canada. The effects of this movement worldwide have been huge. EBP is now part of what we do every day in hospitals – at morning report or clinical rounds. The application of EBP principles is harder in primary care. This is not a criticism of primary care practitioners. It reflects the fact that many problems seen in this sector are low risk, unsorted and self-limiting and the evidence base is both different and (sometimes) deficient. EBP is no longer seen as an “alternative” to opinion- and experience-based practice – they are now blended in mainstream clinical care. The idea that we would not base our decisions on the best available evidence would strike the public as bizarre. But the best evidence needs to be interpreted by practitioners who have experience of the disorders being managed.

**HQ: National and provincial governments have made wait time improvements a priority for both investment and accountability. How would ICES gauge whether these investments have made a difference in outcomes?**

**DH:** Wait times are the single metric that is most often seized by politicians to defend a system or to score points. This appears to be the case in most countries, including Australia. It is important to remember that this metric only reflects one aspect of the performance of a complex healthcare system. ICES has been one of the leading HSR institutions internationally in studying wait times. In doing so, ICES has tried to keep the focus on not just waits but rates, appropriateness, unmet need and capacity to benefit from the procedures. I fully expect that ICES will continue to do this and will work with the Ontario Ministry of Health and Long-Term Care to make the best use of the available data.

**HQ: As you know, we are beginning to unravel the issues associated with adverse events in hospitals, including drug use. What are your initial thoughts about the opportunities for ICES?**

**DH:** There is a limit to what can be achieved with existing data sets. My understanding of ICES is that many of the data are too high level to allow sensitive judgments about decisions that are

being made and are potentially modifiable. Drugs are a good example. Some adverse events are intrinsic to the molecules, while others depend crucially on how the drugs are used. One system will not work for both scenarios. Achieving safety depends on the capacity to monitor and (if necessary) modify complex human behaviours; routinely collected data will never give all the needed answers. As ICES continues to mature, we need to capitalize on the efficiency and breadth of data, while supplementing it with more detailed primary data in strategic areas. Most effective safety work needs to be done locally – ICES can and hopes to support this.

**HQ: Most of Canada has embraced some form of “system integration” to improve the performance of providers and the system in general. Any thoughts about how one might measure “integration” and link it to the metrics of system performance?**

**DH:** This is genuinely difficult for me as I don't know the Canadian system well enough and have been in ICES for a very short time. Integration is a very difficult area in healthcare, and Canada has at least one advantage in that primary, secondary and tertiary care are all organized at the provincial level. As with our safety discussion earlier, high-level data can provide only limited information about the success of integration; a broader range of other information, including qualitative data, is needed. But behind all this lies an important question: how much integration is desirable? In my view, totally seamless healthcare is probably unachievable. The key developments are in communication and information technology; in these areas, healthcare and its providers seem to lag behind other sectors, and the public themselves.

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**HQ: ICES has enjoyed a relatively high media profile, releasing data and study results to providers, policy makers and the public. How do you see ICES improving the health of Canadians?**

**DH:** By providing information on which decisions can be made at a policy and at a clinical level; by engaging with policy makers in an effective way; by being responsive to the needs of the various parties; by tailoring the data to fit the evolving healthcare processes; by continuing to do high-quality investigator-initiated research; and by communicating the results of the research in the most effective way to the media, to professions and the public. I certainly intend that ICES continues to have

a high media profile and that it explore new ways of communicating the results of HSR to people who need (or want) to know or hear about what we can achieve.

**HQ: Computerized physician order entry (CPOE) is heralded as a major innovation to improve safety, quality of care and the communication and coordination of care among providers. How might ICES assist in the assessment of these claims?**

**DH:** As with some other topics, ICES information systems are at a rather high level; evaluation of various forms of electronic decision support needs to be made initially at the local level, although major beneficial (or adverse) effects should become apparent in higher-level data sets. The provision of key information at point of use in healthcare seems to lag badly behind other sectors. I have recently had experience (as a clinician) of a clinical access portal that provided, via the web, all of the available physiological, pathological and imaging information for each patient I was looking after. This was brought together in a very nice user interface. This enabled me, at home, at night or during the weekend, to access a great deal of information before I discussed the patient with the doctors or nurses on duty. This made patient management easier for me and meant that telephone discussions with staff at the hospital were not consumed by verbal transfer of information but concentrated on management. Now this was about equivalent to weather information that I could get online – that is, *not* that sophisticated by community standards; but it was a huge step forward in healthcare information terms and represents the sort of development that must and will occur. But evaluating it is complex.

**HQ: What do you hope will be your legacy at ICES?**

**DH:** I think ICES should expand and look externally, a process commenced under the previous chief executive officer and the current board. The two pillars of ICES are its normative functions for policy makers and the exciting investigator-initiated research. I hope to maintain that balance and the involvement of researchers in policy formulation and evaluation. I would like to follow the plan to enable ICES data to be more widely available to bona fide researchers in other institutions – I think this is in the public interest. I would also like to see ICES continue to push the boundaries of what can be achieved with linked data sets – and include nested studies that maybe collect good qualitative economic and genetic data. I do not know yet how realistic that is ... I would also like to find ways for ICES to work more closely with the field to enhance the uptake of ICES knowledge in practice. **HQ**

## Top 10 Reasons to Improve Health Promotion, Disease Prevention and Chronic Disease Management in Canada

1. The burden of chronic conditions on Canadians, the healthcare system and our economy is enormous.
2. The World Health Organization estimates at least one-third of all disease burdens are caused by tobacco, blood pressure problems, alcohol, cholesterol levels and obesity.
3. The World Health Organization has determined that the impact of many risk factors can be reversed quickly, most benefits will accrue within a decade and even modest changes in risk factor levels can bring about large improvements.
4. The economic burden attributed to physical inactivity and obesity has been estimated to be in the billions of dollars per year. Close to half of Canadians are not active enough and more and more Canadians are obese.
5. About 1 in 3 Canadians report having at least 1 chronic condition and more than one-third of people in this group have multiple long-term health problems.
6. Chronic conditions are generally more common with increasing age, within certain populations (Aboriginal people) and among those with low income.
7. The quality of chronic illness care could be improved as less than half of Canadians with diabetes, for example, get all the laboratory test and procedures that experts recommend.
8. Underuse, overuse and inappropriate use of medications are ongoing concerns, and prescribing practices can vary widely across the country. Too few people with diabetes, for example, receive medications that are effective at preventing cardiovascular problems and more than half of people with diabetes have poor heart health.
9. Modest life-style changes – like losing four kilograms over three to six years – have been shown to dramatically delay or prevent the onset of diseases such as diabetes in high risk populations.
10. We owe it to our parents, our neighbours and our children.

– Health Council of Canada





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