# The Federal Role : Quality in Health Care

Honourable Carolyn Bennett M.D., M.P.

Canadian Association Nuclear Medicine

January 31, 2015

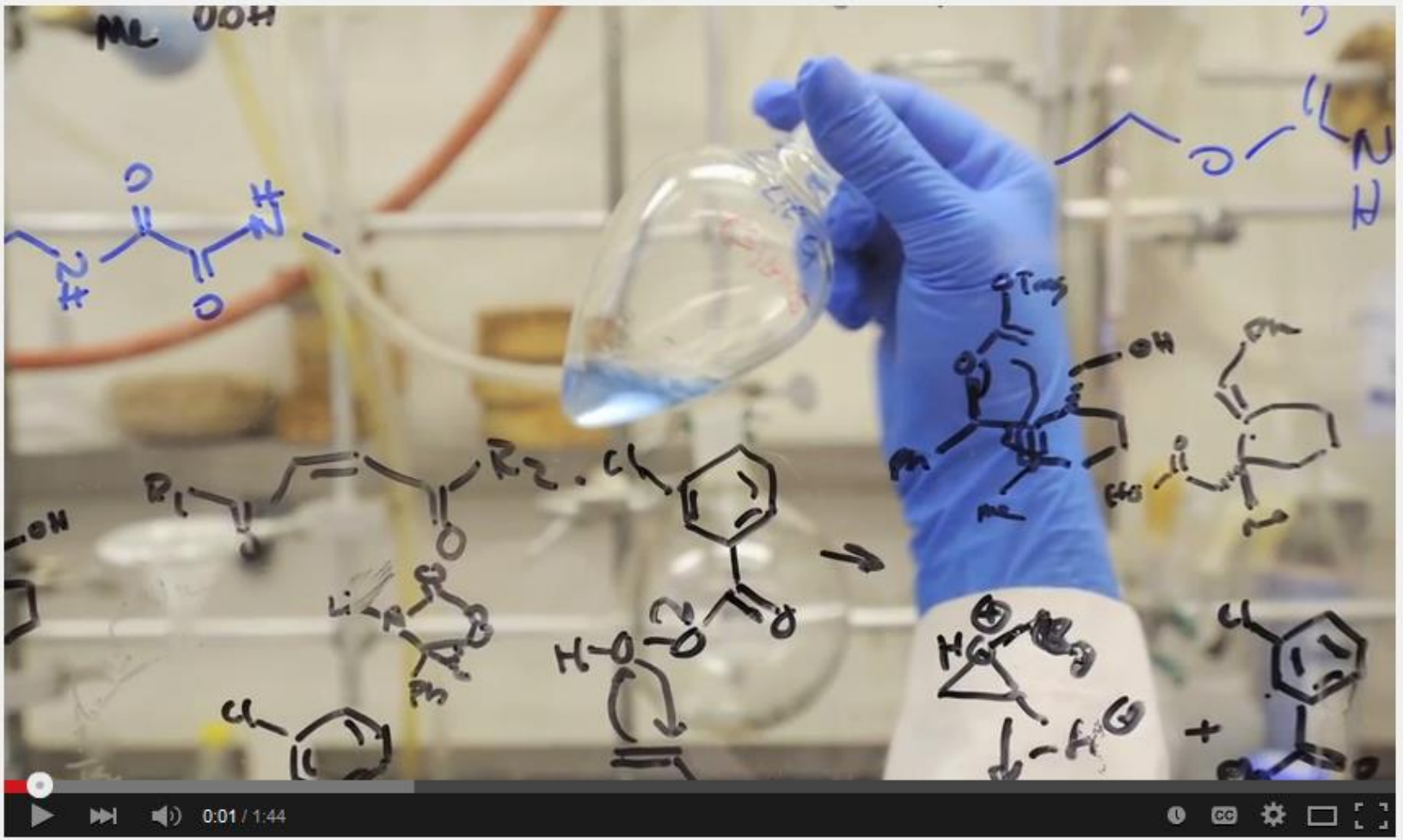
CANM - ACMN

# Reuters, Tue Jan 20, 2015

## Obama calls for major new personalized medicine initiative

WASHINGTON | Tue Jan 20, 2015 10:03pm EST

U.S. President Barack Obama delivers his State of the Union address to a joint session of the U.S. Congress on Capitol Hill in Washington, January 20, 2015.




# The Promise of Precision Medicine

The White House

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# Focus on **QUALITY** saves $$ and lives

"Many attribute the quality problems to a lack of money. Evidence and analysis have convincingly dismissed this claim. In health care, good quality often costs considerably less than poor quality."

Fyke Report 2001 (Saskatchewan)

Canadian Cancer Society
Société canadienne du cancer

"PET scan machines are expensive to buy and operate, so they are not readily available. This test is only available at a very limited number of centres in Canada."

Read more: http://www.cancer.ca/en/cancer-information/diagnosis-and-treatment/tests-and-procedures/positron-emission-tomography-pet-scan/?region=on#ixzz3Q48BIRA2

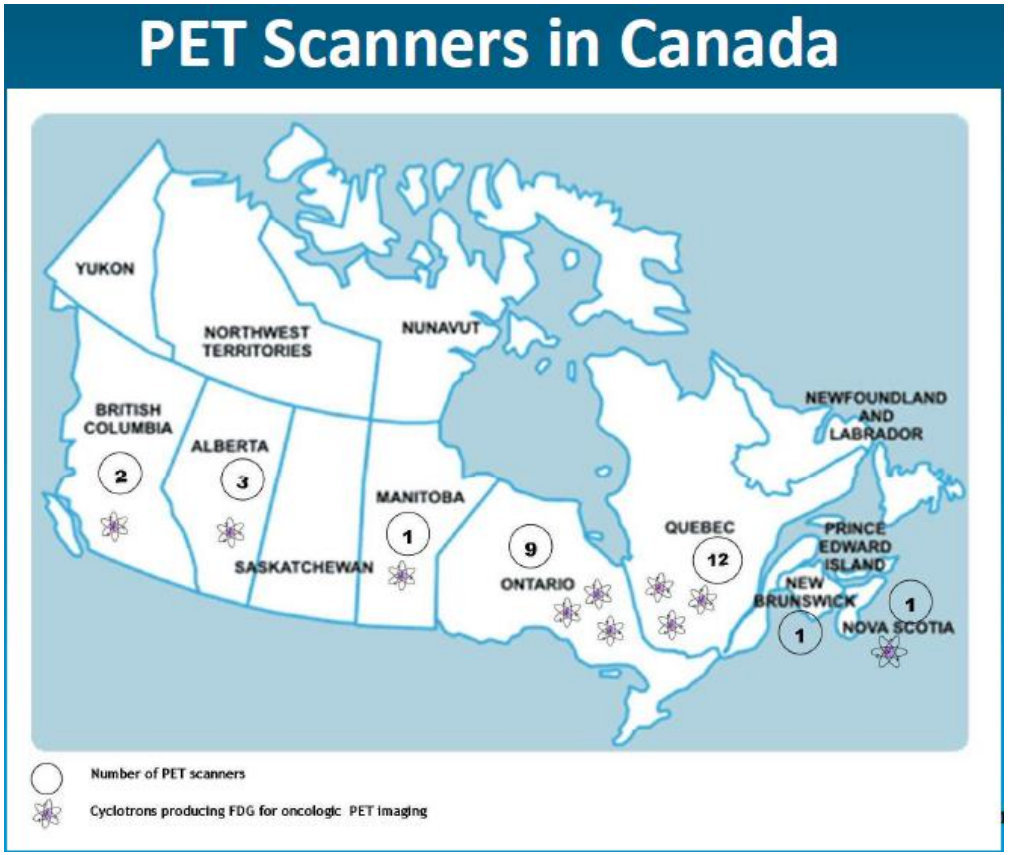
# PET Scanners

**FINDINGS**

**Canada is far behind the United States Europe and in adopting PET technology:**

- **Canada has 29 clinical PET scanners**
- **Europe will have 742 PET scanners by 2013**
- **The United States currently has about 2,000 PET**
- **scanners**
- **WHO – recommends a ratio of 2.0 PET scanners per million**

**Canada's current ratio = 0.86**




Susan Martinuk, Triumf and AAPS, *The Use of Positron Emission Tomography (PET) for Cancer Care Across Canada: Time for a National Strategy, 2012*

# Canada Health Act

**PREAMBLE**

"that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians.

# Canada Health Act

**PREAMBLE**

The primary objective of the 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."

# Canada Health Act

To do so, the act lists a set of criteria and conditions that the provinces must follow in receive their federal transfer payments: Public administration, Comprehensiveness, Universality, Portability, and Accessibility.

There is also a requirement that the provinces ensure recognition of the federal payments and provide information to the federal government.

# Health of Canadians

## Health Care

Canada Health Act
Health care delivery: provincial
Federal Government is the 5th biggest provider:
    First peoples, military, veterans, corrections

SHARED

Health promotion, disease prevention
Social determinants of health
Regulator
Research

# Many, many reports

National Forum on Health 1997

Fyke – Saskatchewan 2001

Mazinkowski – Alberta 2002

Kirby – Senate 2002

Romanow – Federal Commission 2002

Castonguay – PQ - 2008

# Cry for Federal Leadership

First Ministers' Meeting 2000

First Ministers' vision of health is that:

*Canadians will have publicly funded health services that provide quality health care and that promote the health and well-being of Canadians in a cost-effective and fair manner.*

# Cry for Federal Leadership

. **Clear Accountability - Reporting to Canadians**

Respecting each other's responsibilities, all governments believe in the importance of being accountable to Canadians for the health programs and services which they deliver. Clear public reporting, with appropriate, independent, third party verification will enhance the performance of health services, and is important for achieving the vision and accomplishing the priorities set out above.

The purpose of performance measurement is for all governments to be accountable to their public, not to each other. The amount of federal funding provided to any jurisdiction will not depend on achieving a given level of performance.

# 2003 Health Accord

2003 First Ministers' Accord on Health Care Renewal

**Agreement to report on Indicators**

Timely Access,

Quality,

Sustainability,

Health Status & Wellness

**Diagnostic/Medical Equipment Fund**

**IT & EHR**

# 2003 Health Accord

2003 First Ministers' Accord on Health Care Renewal

**QUALITY INDICATORS**

**Patient Safety**

**Patient Satisfaction**

**Health outcomes**

# 2004 Health Accord

## 2004 First Ministers' Meeting on the Future of Health Care

A 10-year plan to strengthen health care

**"bought peace with the provinces, did not buy change"**

# 2004 Health Accord

**Reducing Wait Times & Improving Access**

**HHR**

**Home Care**

**Primary Care Reform**

**Access to Care in the North**

**National Pharmaceutical Strategy**

**Prevention, Promotion & Public Health**

**Health Innovation**

**Accountability & Reporting to Citizens**

**Dispute Avoidance & Resolution**

# Sustainability=Prevention + Quality

PREVENTION

Decrease the demand side

QUALITY

Increase the cost effectiveness on the supply side

# Lessons learned from SARS

Germs don't respect borders

Naylor report

- Collaboration
- Cooperation
- Communication
- Clarity of who does, what, when

Public Health Agency of Canada

Chief Public Health Officer for Canada

Public Health Network Canada

# Health Goals for Canada 2005

As a nation, we aspire to a Canada in which every person is as healthy as they can be –

physically,
mentally,
emotionally and
spiritually.

"A strong system for health and social well-being responds to disparities in health status and offers timely, appropriate care"

# The Goal

- Most appropriate care
- In the most appropriate place
- By the most appropriate person – paid and unpaid

# Quality accountability

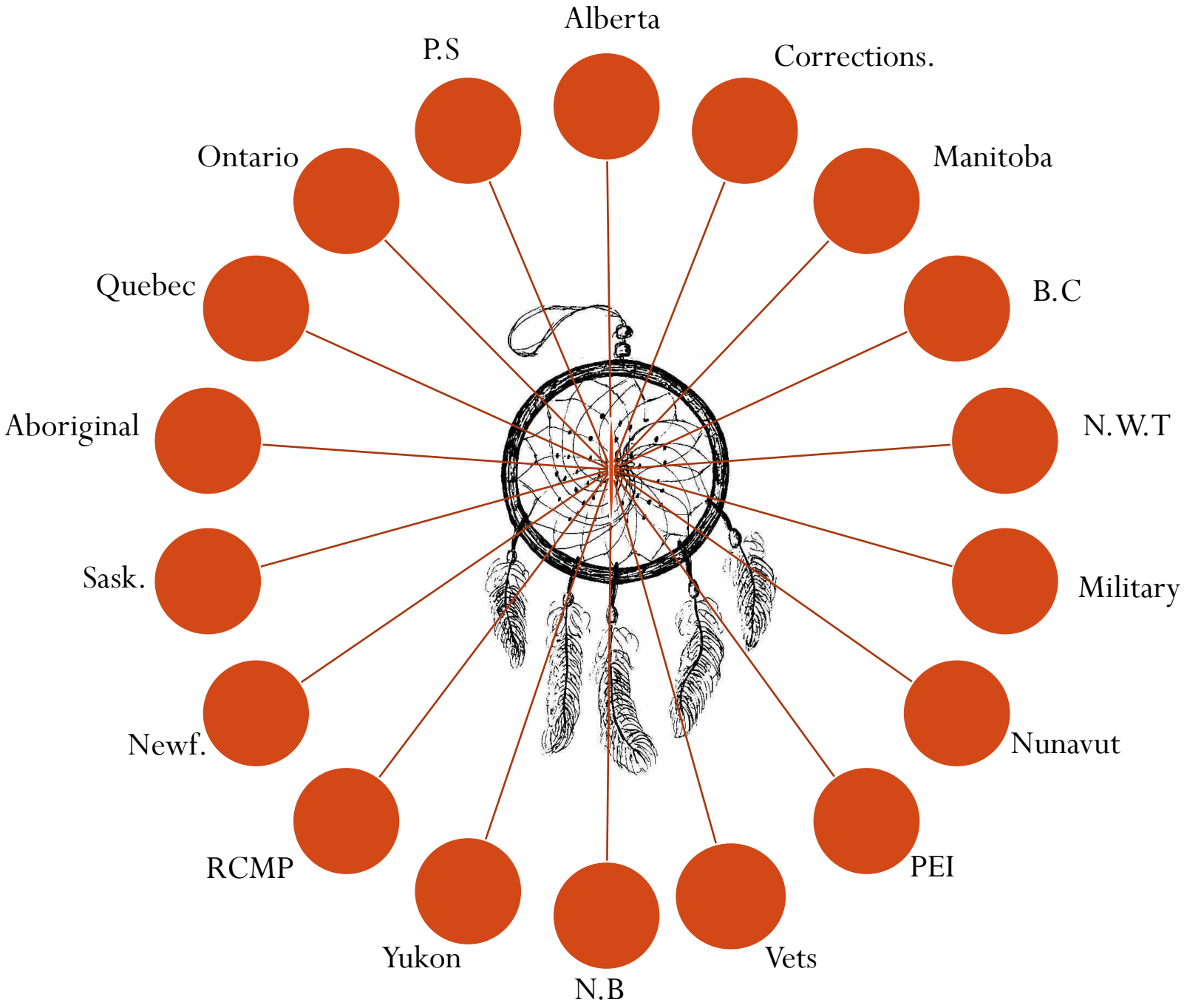
Federal Government must lead by example

- Aboriginal, Military, Vets, Corrections, RCMP
- Federal Government exemplary employer

Quality Councils in 6 provinces

- Should there be 13 ? 14 ?
- Could they work together ?

Central command & control ?????


Alberta
P.S
Corrections.
Ontario
Manitoba
Quebec
B.C
Aboriginal
N.W.T
Sask.
Military
Newf.
Nunavut
RCMP
PEI
Yukon
Vets
N.B

# The Six Domains of Health Care Quality

A handful of analytic frameworks for quality assessment have guided measure development initiatives in the public and private sectors. One of the most influential is the framework put forth by the Institute of Medicine (IOM), which includes the following six aims for the health care system.

**Safe**: Avoiding harm to patients from the care that is intended to help them.

**Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

**Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

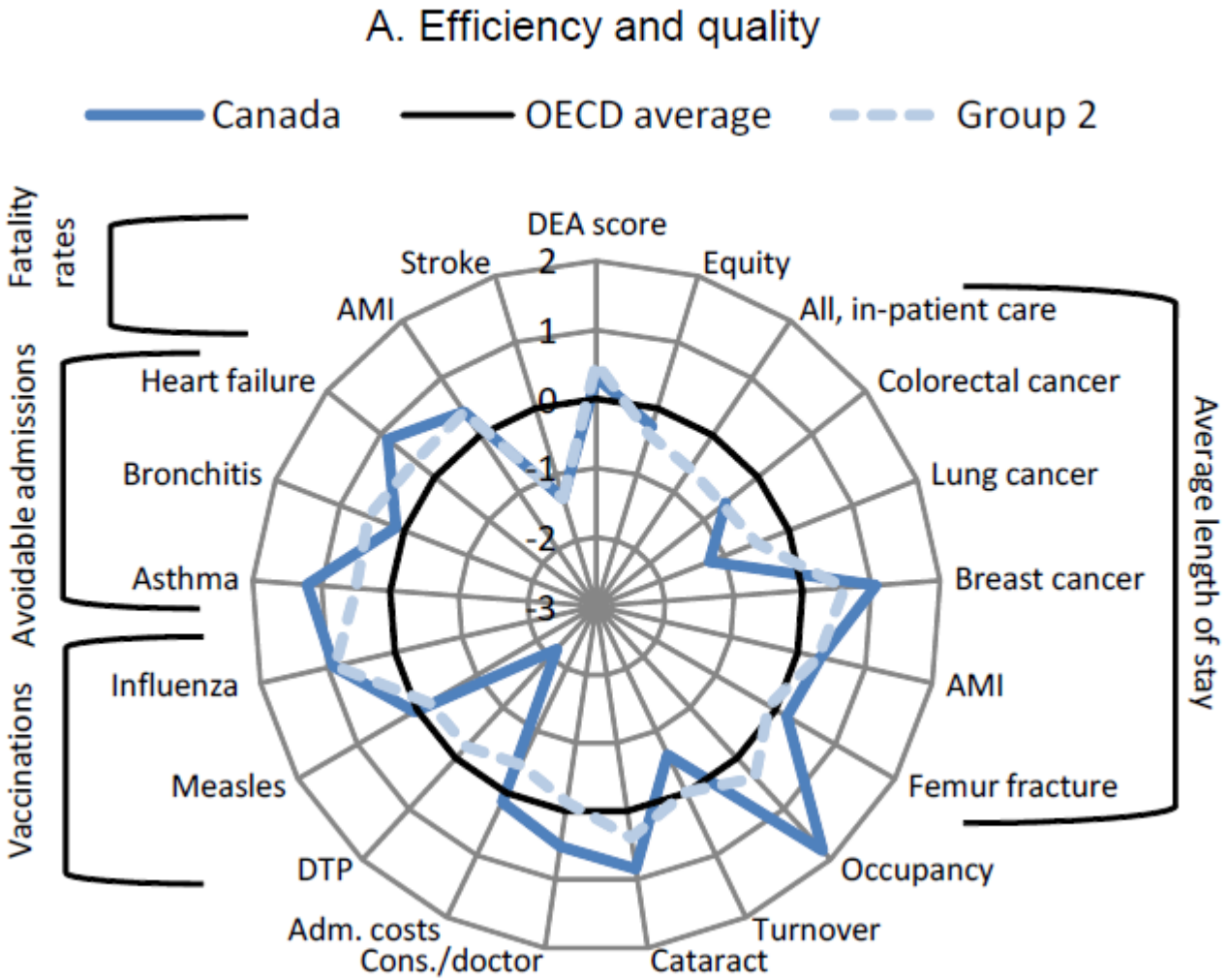
**Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care.

**Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

**Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

# Canada: health care indicators

**Group 2:** Australia, Belgium, Canada, France



**GROUP 2:** Public basic insurance coverage combined with private insurance beyond the basic coverage. Heavy reliance on market mechanisms at the provider level, with wide patient choice among providers and fairly large incentives to produce high volumes of services contained by gate-keeping arrangements.

| Efficiency and quality | Prices and physical resources | Activity and consumption | Financing and spending mix | Policies and institutions | Weaknesses and policy inconsistencies emerging from the set of indicators |
|---|---|---|---|---|---|
| High DEA score but slightly higher inequalities in health status. Low rate of amenable mortality | | | Higher PHI share | Lower scope of basic insurance coverage and heavy reliance on (supplementary) PHIs | Assess the main causes of the inequalities in health status and, in particular, the role of the supplementary insurance system and of the scope of the basic insurance package |
| Mixed signals on output/hospital efficiency | Less high-tech equipment and acute care beds | Less hospital discharges *per capita* | Lower in-patient share | Less choice among providers and more gate-keeping | |
| High quality of out-patient and preventive care | Less doctors and medical students | Less consultations of doctors *per capita* | | Less private provision and volume incentives. More regulation on provider prices and on workforce and equipment | Regulations on hospital employment and equipment may need to be softened if hospitals are increasingly paid on the basis of their activity |
| Lower administrative costs | Higher relative income level of GPs | | | Less regulation on prices paid by third-party payers. Higher decentralisation but less consistency in responsibility assignment. Less priority setting | Higher consistency in the allocation of responsibilities across levels of government could deliver efficiency gains |

# OECD 2013 data

| | | |
|---|---|---|
| Physicians per capita: | 2.5/1000 | 2.5/1000 |
| Nurses: | 9.4/1000 | 11.1/1000 |
| Acute care beds: | 2.6/1000 | 1.7/1000 |
| MRIs: | 31.5/1 million | 8.5/1 million |
| Life expectancy at birth: | 78.7 years | 80.7 years |
| Infant mortality rate: | 6.1/1000 live births | 4.8/1000 |
| Obesity in adults: | 33.8% | 24.2% |

# Who pays for health care? (2011)

| | U.S. | Canada |
|---|---|---|
| Total Health Expenditure | 2.7 Trillion | $187 Billion |
| | | |
| Per capita | $8508.00 | $4,665.80 |
| % GDP | 17.7 | 11.2 |
| % publicly paid | 47.8%<br>Seniors, disabled, poor, veterans | 70.4%<br>tax, no ext-billing |
| % privately paid | 52.2%<br>employer/personal insurance | 29.6%<br>drugs, dental, vision, home |
| Uninsured/ Underinsured | 16.1%<br>52% | universal coverage for doctors and hospitals |

# "Achieving Health Reform's Ultimate Goal: How Successful Health Systems Keep Costs Low and Quality High“

U.S.Senate Committee on Aging Sept 30, 2009

1. INSURANCE COMPANIES:
   - 30% of costs go to insurance companies.
   - Patients and taxpayers support massive organizations.
   - These insurers set premiums, design packages, assess risk, review claims and decide who to reimburse for how much.
   - But they don’t deliver health care.

# U.S. Senate Committee on Aging Sept 30, 2009

2. ADMINISTRATION:

- Our single payer system is simpler, allowing us to run the administration of our offices and hospitals with much fewer staff – about 4%.
- We don't have to deal with multiple payers, or chase bad debts.
- We don't have to charge higher fees to compensate for unpaid for procedures

3. PHARMACEUTICAL PRICE CONTROLS:

Although drug costs are rising in Canada as here, we're able to exercise more control over the cost of drugs as a result of our Patented Medicine Prices Review Board.

## U.S. Senate Committee on Aging Sept 30, 2009

4. MALPRACTICE INSURANCE:

- The not-for-profit Canadian Medical Protective Association covers medical malpractice for all Canadian physicians with comparatively low premiums.
- Doctors' remuneration does not have to reflect those extra costs and our justice system has successfully kept the awards in a reasonable range.

# U.S. Senate Committee on Aging Sept 30, 2009

## 5. EVIDENCE-BASED CARE:

- From vaginal births after C-sections to, lumpectomy, to x-rays for sprained ankles, applying evidence to determine the appropriateness of tests and procedures translates into fewer unnecessary tests and procedures and less defensive medicine.
- We are committed to moving from the error of pure cost-containment approach of the early 90s into true evidence-based cost effective care.

# U.S. Senate Committee on Aging Sept 30, 2009

6. PREVENTION:

- Diseases are cheaper to treat if they're caught early, and since all Canadians are insured, they're more likely to have pap smears, mammograms and other early detection visits and tests, than US patients who are not covered.

# U.S. Senate Committee on Aging Sept 30, 2009

7. FAMILY MEDICINE:

- A long-standing speciality in Canada,
- Family Doctors are trained to help patients navigate their care;
- We interpret the difference between what patients think they `want`, and what they actually `need` .
- A point of first contact, a trusted coach to explain the evidence and the choices.

# OECD Reviews of Health Care Quality: Denmark 2013 Raising Standards


Denmark is rightly seen as a pioneer in health care quality initiatives among OECD countries

- sophisticated array of quality assurance mechanisms
- like all other countries, health care challenges including increasing public & political expectations around the continuity of care
- increased specialization in the hospital sector, which translates into shorter stays and earlier discharge back into the community
- rise in the number of elderly patients with multiple long-term conditions, requiring safe and effective co-ordination of care and avoiding unnecessary hospitalization.

This quality review assesses how well Denmark's quality assurance mechanisms are placed to address these challenges.


## Focus Areas

Improvement Capability *Ensuring that improvement science drives our work and that we extend the reach and impact of the improvement community*

Person- and Family-Centered Care *Putting the patient and the family at the heart of every decision and empowering them to be genuine partners in their care*

Patient Safety *Making care continually safer by reducing harm and preventable mortality*

Quality, Cost, and Value *Driving affordability and sustainability through quality improvement*

Triple Aim for Populations *Applying integrated approaches to simultaneously improve care, improve population health, and reduce costs per capita*

# Research

- Evidence-informed practice
- Practice-informed evidence

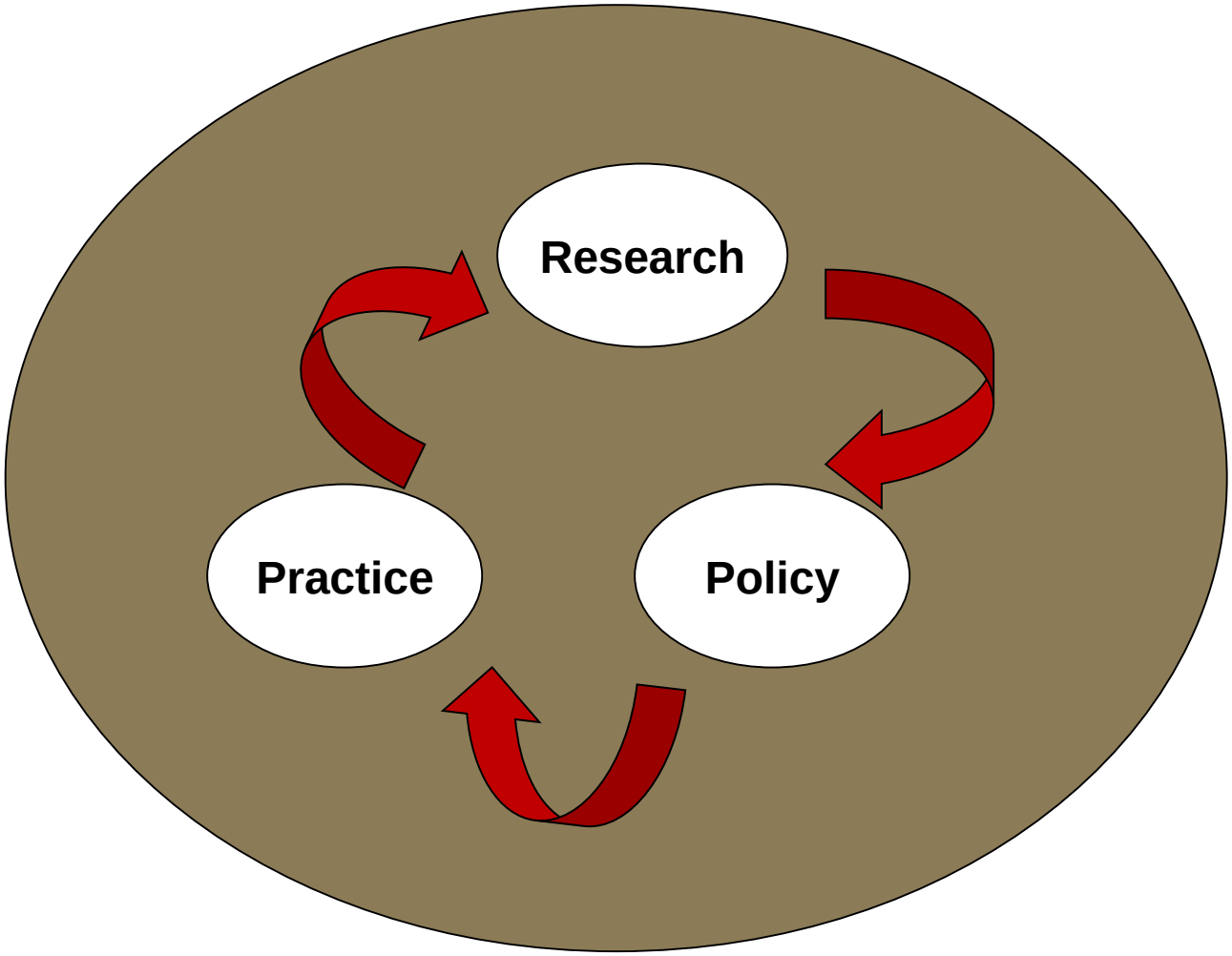
- Courage to fund what works
- Courage to stop funding what doesn`t

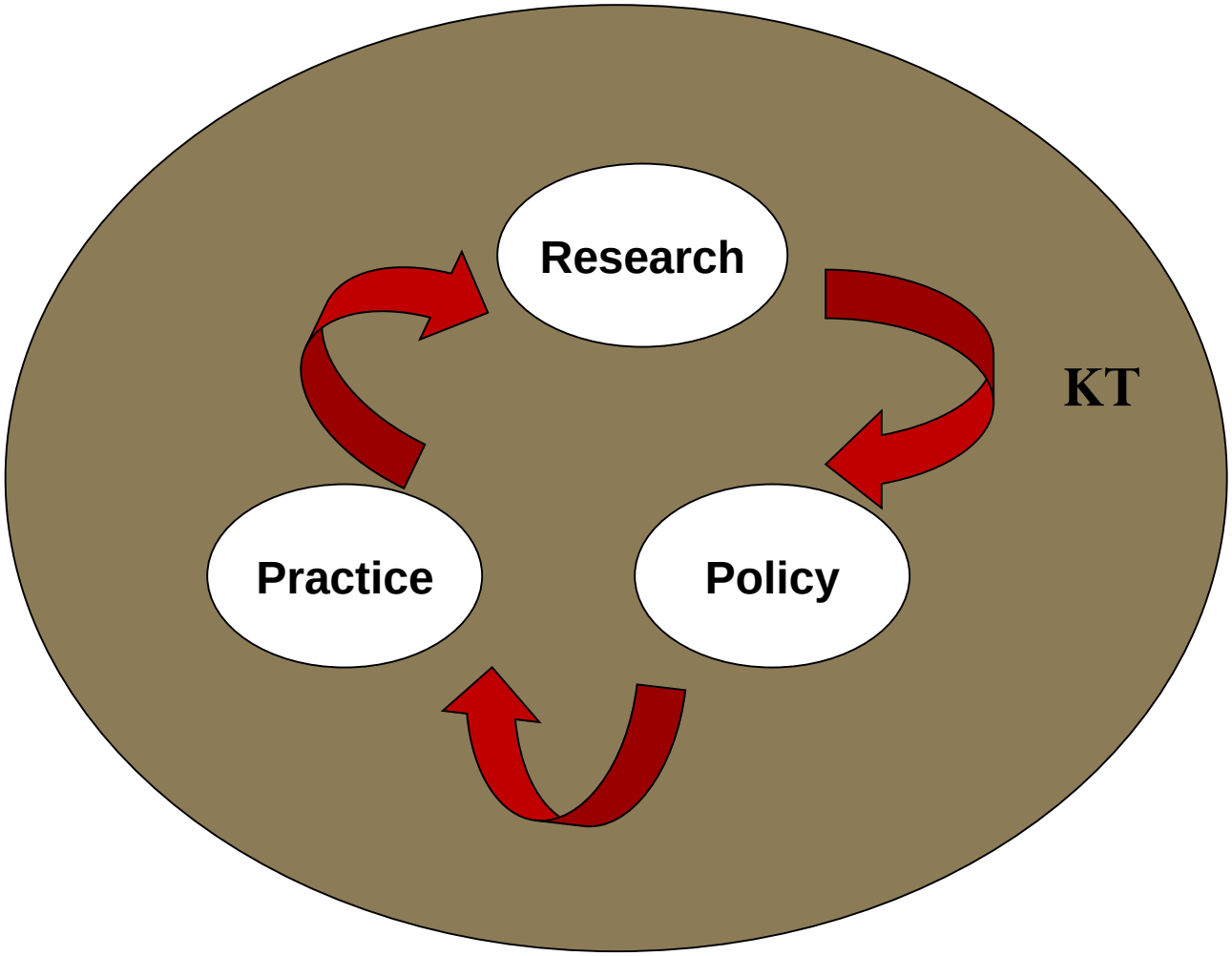
**Complex adaptive systems**

# Sir Michael Marmot

Sir Michael Marmot

"Evidence is not enough. There has to be the desire, the political will for change. Given that will - a big given but I am an optimist - the evidence of what works will be a great help."


Research
Practice
Policy


Research
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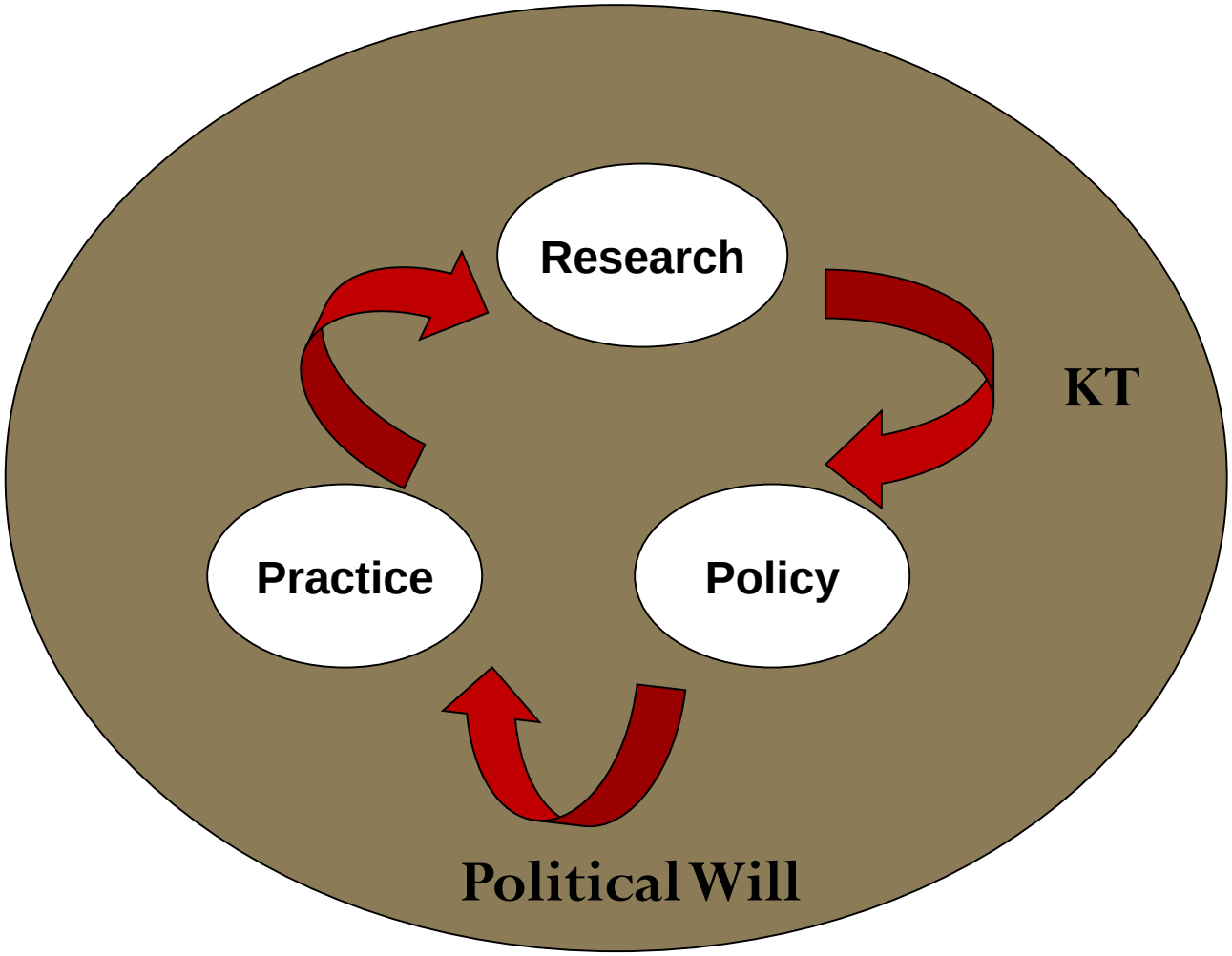
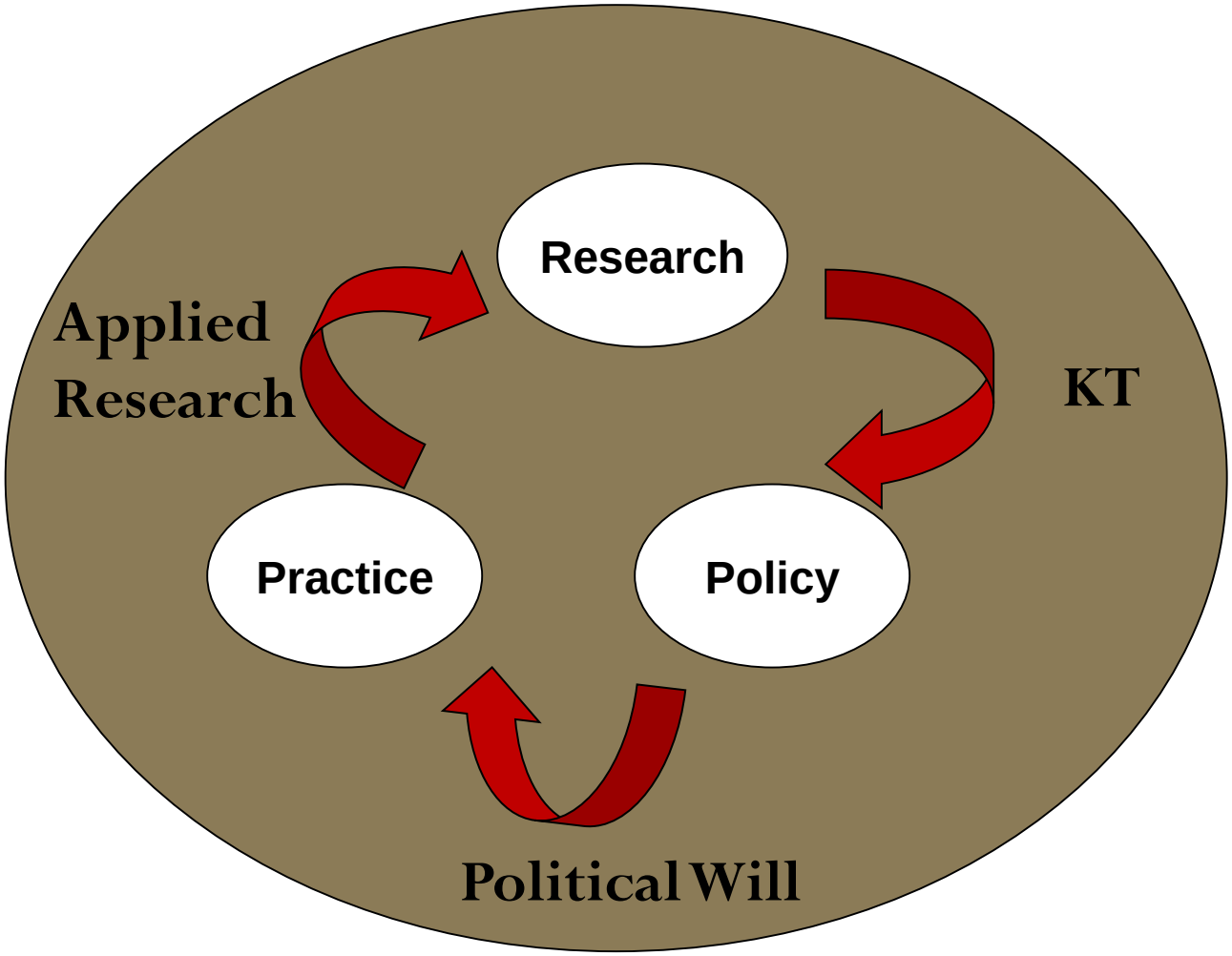
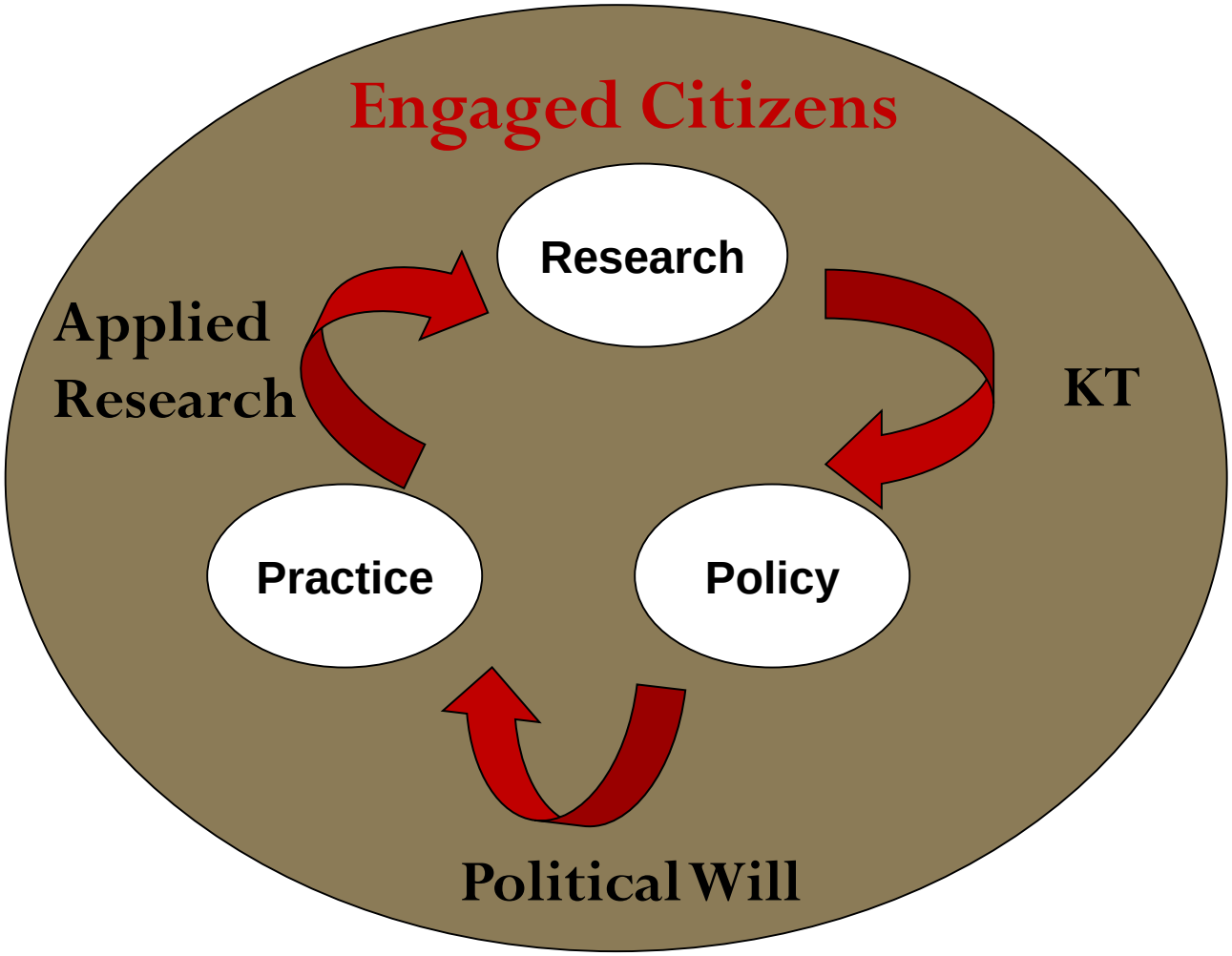

Research
KT
Practice
Policy
Political Will


Research
Applied
Research
KT
Practice
Policy
Political Will


Engaged Citizens
Research
Applied Research
KT
Practice
Policy
Political Will

# Empowered Patients
# Effective Advocates
# Engaged Citizens

**Use the system wisely**

- Keeping our families well
- Clinical guidelines
- Self Care Manuals

Choosing Wisely®

An initiative of the ABIM Foundation

# Five Things Physicians and Patients Should Question

SNMMI's list identified the following five recommendations:

- Don't use PET/CT for cancer screening in healthy individuals.
- Don't perform routine annual stress testing after coronary artery revascularization.
- Don't use nuclear medicine thyroid scans to evaluate thyroid nodules in patients with normal thyroid gland function.
- Avoid using a computed tomography angiogram to diagnose pulmonary embolism in young women with a normal chest radiograph; consider a radionuclide lung study ("V/Q study") instead.
- Don't use PET imaging in the evaluation of patients with dementia unless the patient has been assessed by a specialist in this field.

Choosing Wisely®

An initiative of the ABIM Foundation

# PET scans after cancer treatment
# When you need them—and when you don't

If you've been treated for cancer, it's normal to want to do everything you can to be sure that it doesn't come back.

Your doctor will watch you closely for many years to check for a possible return of the cancer. To be extra sure, some doctors will order imaging tests, known as PET scans. They are often combined with CT scans. These scans take pictures of your body where cancer might be growing.

But you may not need the tests. And their risks may be greater than the benefits. Here's why:

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# PET scans after cancer treatment
# When you need them—and when you don't

**PET and PET-CT scans usually don't help people who have completed cancer treatments and don't have symptoms.**

For most cancers, these tests don't help you live longer or with a better quality of life. If you are scanned without a good reason, it can lead to anxiety, wrong diagnoses, false alarms, unnecessary procedures, and more costs.

Often, there are better ways to keep track of your condition:

Be aware of symptoms that could mean cancer has returned. (See Advice column on right.)

Get regular checkups that include a medical history and physical exam.

For some cancers, there are simple tests you should get, such as mammograms for women who have been treated for breast cancer.

Ask your doctor which test, if any, is right for your situation.

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# PET scans after cancer treatment
# When you need them—and when you don't

**PET and PET-CT scans have risks.**

Having PET and PET-CT scans can add to your stress as a cancer survivor. These tests often find health problems that are not serious. This may lead to more tests and procedures, including follow-up scans, and even biopsies and surgery.

Also, PET, and especially PET-CT scans, expose you to high levels of radiation. The effects of radiation add up over your lifetime. This can increase your risk of cancer.

Multiple scans should not be done unless medical evidence shows that they would help. Ask your doctor if multiple scans are a good idea.

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# PET scans after cancer treatment
# When you need them—and when you don't

**The tests are expensive.**

A PET-CT scan can cost $7,000 or more, according to one U.S. medical center. That does not include the cost of added tests and procedures due to false alarms. Some insurance plans do not pay for routine (surveillance) PET scans in a healthy patient who has completed cancer treatment.

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# PET scans after cancer treatment
# When you need them—and when you don't

**So, when are PET scans a good idea after treatment?**

A PET or PET-CT scan may be helpful if your doctor suspects your cancer has returned, based on your symptoms, a physical exam, or other tests. A scan may also be recommended if you were treated for advanced cancer and your doctor needs to find out if your most recent treatment was effective.

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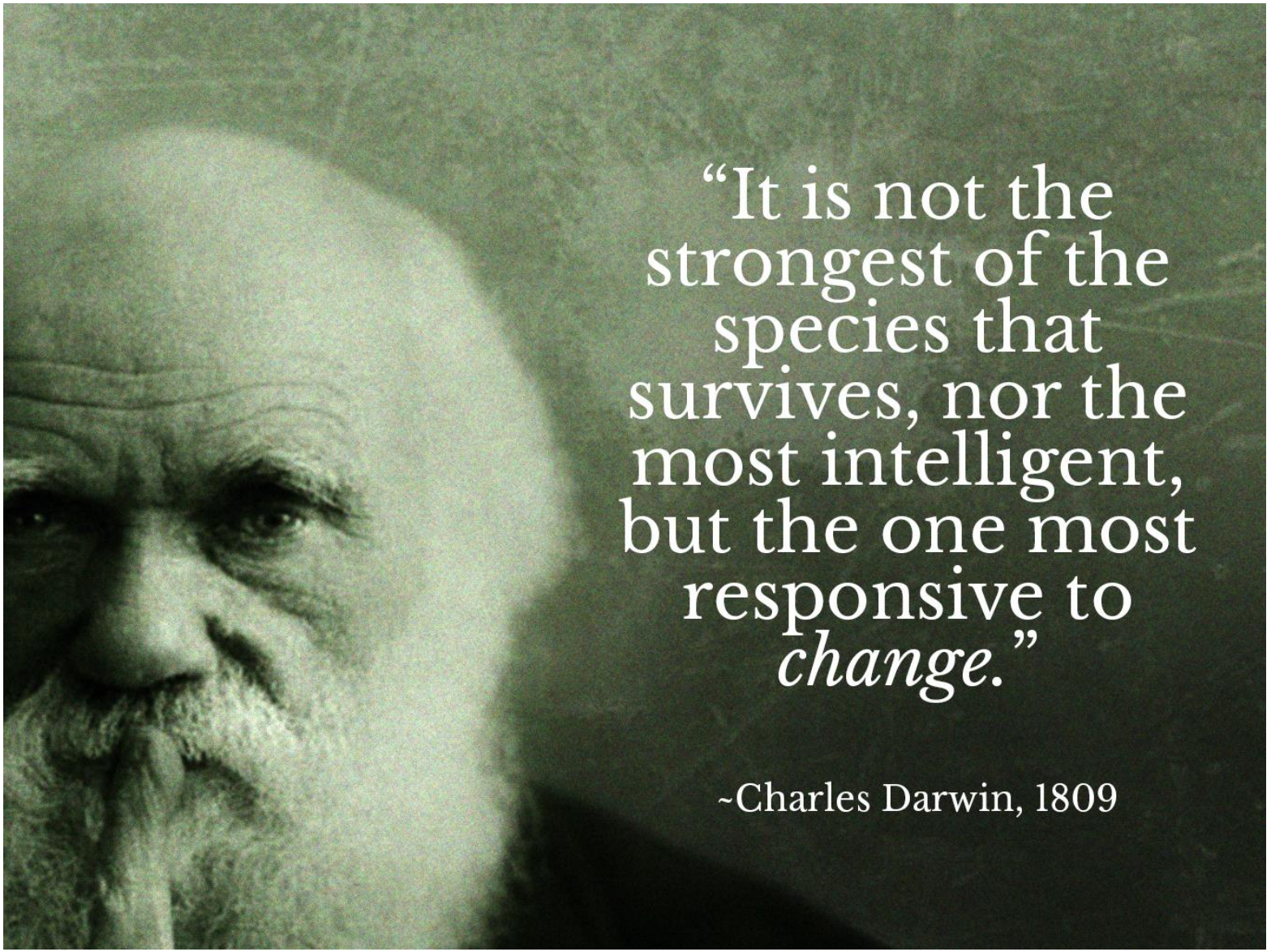
"It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to *change*."
~Charles Darwin, 1809

**“The care of the public health is the first duty of a statesman."**

Benjamin Disraeli