

# TRANSFORMATION THROUGH VALUE AND INNOVATION: Revitalizing Health Care In Ontario



PART I OF THE ONTARIO CHAMBER OF COMMERCE'S 2016  
HEALTH TRANSFORMATION INITIATIVE

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## ABOUT THE ONTARIO CHAMBER OF COMMERCE

For more than a century, the Ontario Chamber of Commerce (OCC) has been the independent, non-partisan voice of Ontario business. Our mission is to support economic growth in Ontario by defending business priorities at Queen's Park on behalf of our network's diverse 60,000 members.

From innovative SMEs to established multi-national corporations and industry associations, the OCC is committed to working with our members to improve business competitiveness across all sectors. We represent local chambers of commerce and boards of trade in over 135 communities across Ontario, steering public policy conversations provincially and within local communities. Through our focused programs and services, we enable companies to grow at home and in export markets.

The OCC provides exclusive support, networking opportunities, and access to innovative insight and analysis for our members. Through our export programs, we have approved over 1,300 applications, and companies have reported results of over \$250 million in export sales.

The OCC is Ontario's business advocate.

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## A LETTER FROM THE PRESIDENT AND CEO

Our single-payer health care system has long been a source of pride for Ontarians. Unfortunately, paying for that system has increasingly become a source of concern. Between demographic shifts and economic challenges, health care costs to government, individuals, and employers are projected to grow well beyond sustainable levels. Health spending in Ontario alone represents nearly half the provincial budget, holding at that level only because of an artificial and damaging limit on spending growth.

Polling conducted by the Ontario Chamber of Commerce (OCC) has found that 77 percent of Ontarians are concerned about the sustainability of the health care system.<sup>1</sup> In order to solve this dilemma, the government must find a way to provide better value to taxpayers for their health care dollars. Ontario cannot afford to spend more on health; still others would say that we can't afford not to. What we know for certain is that we cannot be afraid of confronting many of the challenges within our health system, and doing so by entertaining real and meaningful broad-based reform. Ontario cannot remain globally competitive with a health care system that is a drag on government budgets.

But the OCC's approach to health is not merely about fixing the fiscal crisis - it is about acknowledging that it can be an economic driver. Health is a growing sector world-wide, with incredible expansion in both demand and innovation. Ontario, with its world-class talent and top-notch research facilities, sits at the crossroads of this opportunity. For this reason, our health care system should be able to tap into that potential to deliver both positive health and fiscal outcomes.

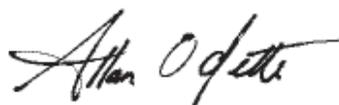
The OCC believes that now is the right time to enter the health reform conversation. The federal government is about to re-negotiate the health accord, while the Ontario government has made its intentions clear with the creation of the Office of the Chief Health Innovation Strategist, the province's first Patient Advocate, and the release of directional documents like *Patients First*.

Our concern, however, is that cultural opposition to what is perceived as "two-tier" health is inhibiting Ontario's ability to have a meaningful conversation about strengthening our universal health-care system. Canadians have a genuine fear of "American-style" health care, and any discussion of private partnership in health is quickly quelled for this reason. But this ignores both the considerable share of health care already delivered by the private sector as well as the robust and equitable role of industry in other single-payer models such as the UK's National Health Service or Australia's Medicare. When it comes to health care, Canadians' understanding comes only from the limited context we see here in North America, and not from a wider view of the world.

As the Government of Ontario begins to reform the health care system, the OCC wants to ensure that all solutions are considered as the conversation takes shape. We intend to contribute to that conversation by thinking more broadly about reform – and we believe that the private sector is an important part of that.

To that end, the OCC is embarking upon a year-long research initiative on health transformation. Fundamentally, our aim is to answer the question, “How can the private sector be a productive partner to government as it reforms the health care space?” Our series of reports and events will explore this role for industry in the health care system and examine how best to develop the health sector as an economic driver while improving patient outcomes. This work will be done in partnership with major health care providers, research, finance, and technology organizations across Ontario, as well as our extensive chamber network. In this report, we summarize the direction and themes of the project. It will be followed by three policy studies and a concluding document that will outline steps forward for the Ontario government.

The OCC, along with its chamber network and corporate partners, shares the Government of Ontario’s goals of healthy Ontarians and a healthy economy. We believe that the time is right to take collaborative action and transform the health care system for the better.

A handwritten signature in black ink that reads "Allan O'dette". The signature is written in a cursive, flowing style.

Allan O’Dette, President & CEO  
Ontario Chamber of Commerce

<sup>1</sup> Results from a survey of 1004 Ontarians conducted on behalf of the OCC by Leger, between February 22 and 25, 2016. The margin of error for this sample is 3.1%, 19 times out of 20.

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## GLOSSARY

Within this report, the OCC will use three words to define and conceptualize our approach to health system reform. Transformation, value, and innovation are too often thought as “buzzwords”; however, all reflect the results of analysis within the larger body of international health system research. By utilizing well-defined and relevant concepts, stakeholder discussions can start from a place of alignment.

*Transformation:* Enacting change across the entire health care system, from the structure and delivery of services to how system success is envisioned. Transformation requires policy and regulatory reform but also a re-alignment of priorities at the highest level.

*Value:* In the health care context, value is a return on investment that considers patient outcomes alongside cost. It is demonstrated through long-term savings to the system as a whole, not just an immediate reduction in the cost of a good or service.

*Innovation:* A new technology, technique, process, model, or other solution that adds value and provides a meaningful benefit over the status quo. The impact of innovation should be measurable.

# EXECUTIVE SUMMARY

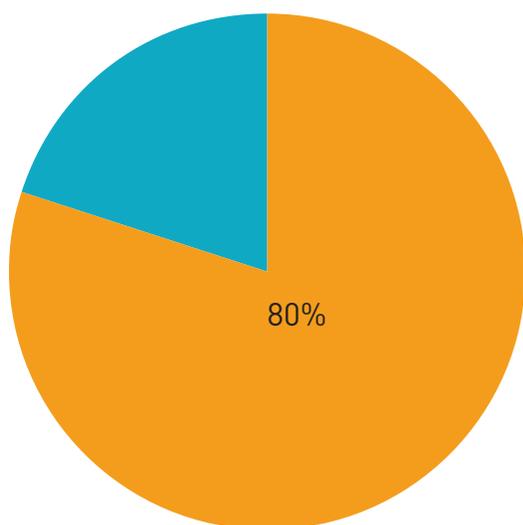
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If the past 25 years of investment, budget cuts, and “streamlining” have taught us anything, it is that health care funding decisions cannot be guided solely by fiscal considerations – instead, they should be guided by patient needs.

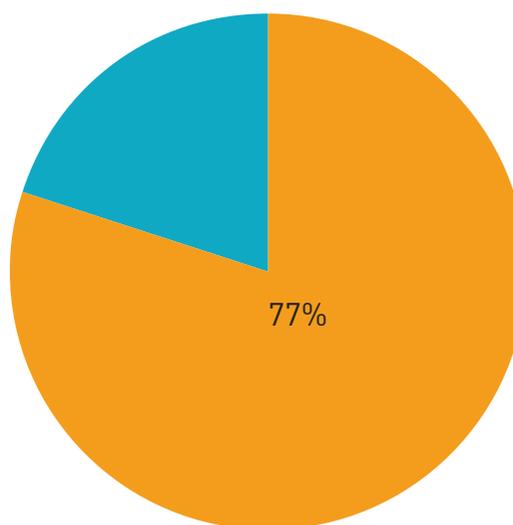
Ontario’s health care system is facing a series of key challenges and impediments to reform:

- » A population that is aging rapidly and increasingly suffering from chronic illnesses, while demanding access to new and costly medical innovations.
- » Unsustainable growth in government health costs that is being managed by artificially limiting spending growth, rather than increasing efficiency or value for dollars spent.
- » A health system that is “silo-ed”: Access to care is not uniform across geographic or population needs, knowledge is not being shared or even properly warehoused within the system, and capital and resources are limited and fragmented.
- » A fertile health and life sciences sector that is encumbered by a lack of capital and has too few opportunities to bring their innovations to market within Ontario.

Fundamentally, the way in which we currently execute health care means decisions are dictated by our financial circumstances rather than what is in the best interest of Ontarians. Although Ontarians have tremendous faith in our health care system, 80 percent agree that it will have to undergo broad reform in order to meet the challenges of changing demographics.<sup>2</sup> The OCC believes that our commitment to publically-funded health care, within a single-payer model, must be sustained. The model through which that goal is sought, however, must see real and meaningful reform.



80 percent of Ontarians agree that the health care system will need to undergo broad reform in order to meet the challenges of changing demographics.



77 percent of Ontarians are concerned about the sustainability of our health care system

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Through its 2016 Health Transformation Initiative, the OCC has three objectives:

- » Determine how the private sector can be a productive partner in the transformation of our shared health care system, while maintaining the integrity of the single-payer model.
- » Examine holistic and long-term solutions to health care challenges, not just short-term fixes like budget or service cuts, rationing, or artificially limited growth and funding rates.
- » Recognize that global health trends such as a shift towards patient-centric and value-based models are relevant to Ontario, and that there are international best practices to assess and implement.

We plan to do this by focusing on two guiding concepts for transformation: value and innovation. We will apply these to our central question – “How can the private sector be a productive partner to government as it reforms the health care space?” – and examine three opportunities to promote transformation through policy and action on the part of both the public and private sectors. This report will act as a framing piece for the initiative, by outlining the challenges facing the Ontario health care system today, defining the concepts of value and innovation; identifying what a transformed approach to health could look like, and summarizing our policy priorities for the year.

Ontario’s health care system requires system-level thinking, and system-level transformation. Today, the Government of Ontario is putting considerable financial and human resources towards a system that, in its current configuration, is unable to achieve the outcomes that we as a society desire. While 76 percent of Ontarians believe that our system has better outcomes than those of comparable countries, both Ontario and Canada receive middling marks on international health rankings (Davis et al, 2014; Conference Board of Canada, 2015).<sup>3</sup> Through a series of efforts such as the Ontario Health Innovation Council and the *Patients First* white paper, the Ministry of Health and Long-Term Care has acknowledged the need to change the way we approach health care. The OCC and its partners intend to be a part of this conversation, and a part of the solution.

<sup>2</sup> Results from a survey of 1004 Ontarians conducted on behalf of the OCC by Leger, February 22-25, 2016. The margin of error for this sample is 3.1%, 19 times out of 20.

<sup>3</sup>Ibid

# ONTARIO'S HEALTH CHALLENGES

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Much has been written about the two major challenges facing many health care systems across the industrialized world: a population that is aging rapidly and increasingly suffering from chronic diseases, and unsustainable growth in health costs. Ontario is not immune to global demographic or economic trends; in fact, the unique structure of our health care system makes us particularly vulnerable to them.

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Total Ontario Government Health Expenditures (In Billions)  
1975-2016



Source: Canadian Institute for Health Information, 2015.

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Health spending in Ontario consumes nearly half of the provincial budget, constituting approximately \$54 billion in the 2016 budget. But spending is not out of control: in 2015, the government announced a projected overall spending growth of just 1.2 percent for hospitals, doctors, and similar services. This is not only short of inflation and population growth, but less than half the size of the previous year's spending increase. While the public resources available to the health system grow slowly or simply stagnate, demand is only increasing: an aging population requires more services and in greater numbers, gaps in coverage and care access continue to grow, and patients are increasingly interested in accessing new and costly medical innovations. When care is accessed, there is limited integration of services and providers, meaning a patient's experience is fragmented, impersonal, and inconvenient (Snowdon et al, 2011; Muzyka et al, 2012).

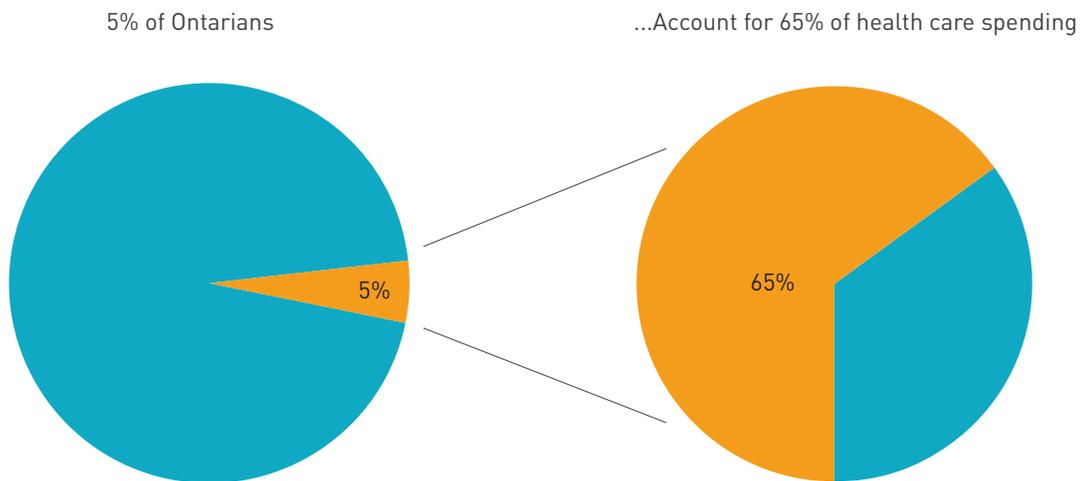
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## The Impact Of Aging On Ontario Health Spending

The number of seniors living in Ontario will nearly double over the next **20 years**

The cost of senior care is **2-3 times** that of the average person

Source: OBIO, 2013



Source: Wodchis et al, 2016

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## A 20th century system for 21st century problems

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In Ontario, this problem is driven by the structure of our system, which is not designed as a “health care” system but a “disease management system” (Snowdon et al, 2014). We conceptualize care as managing disease, when it should be about managing health.

The Ontario Health Insurance Plan (OHIP), as designed in the mid-20th century, was intended to protect Ontarians from catastrophic financial harm in the face of acute injury or disease. For this reason, the system’s central node is the hospital and its central source of information is the general practitioner. Today, conditions that once required specialist care or hospitalization can now be managed through alternative means, such as home care and self-treatment. Health care in this century will be individualized, preventative, focused on “whole-person” wellness, and will largely (and ideally) take place outside of cost-intensive centres like hospitals, emergency rooms, and doctor’s offices. Unfortunately, the health care system is not structured in a way that allows it to easily respond to such change.

Health care in Ontario exists in silos – professional, sectoral, and budgetary. Access to care is not uniform across geographic or population needs, knowledge is not being shared or even properly warehoused within the system, and capital and resources are limited and fragmented. This lack of alignment is inefficient from a fiscal perspective, but also reflects poor alignment of goals across the system. How can population health be top of mind when each moving part does not collaborate and, in fact, are often in direct competition for limited resources?

### CASE STUDY: MENTAL HEALTH

A striking example of the unique health challenges in the 21st century is the increasing understanding of, and importance placed upon, mental health and addiction issues. The Mental Health Commission of Canada estimates that mental illness costs the economy at least \$50 billion annually (MHCC, 2013), a cost driven by lost productivity, hospitalizations, community mental health and substance abuse programs, law enforcement, supportive housing, and countless other related services and challenges.

Currently, there is fragmentation in mental health responsibility in Ontario – services are provided or funded by at least ten different ministries (Legislative Assembly of Ontario, 2010). This patchwork struggles to deliver consistent or comprehensive care, and lacks the necessary links to related services such as physical health care, housing, social services, and youth outreach. The government has recognized this, releasing a comprehensive mental health and addictions strategy in 2011. As mental health is part of the nexus of interrelated factors that impact an individual’s health and well-being, fully integrating it into the continuum of care is critical to any reform of the health care system.

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## THE CANADA HEALTH ACT

Although single-payer health coverage in Canada dates back to the mid-20th century, the Canada Health Act was only adopted in 1984. It was written to standardize what is considered “medically necessary” across all provincial health coverage arrangements. However, this definition is framed in terms of providers, not illnesses. Section 9 states that provincial health insurance plans must cover “all insured health services provided by hospitals, medical practitioners or dentists and where the law of the province so permits, similar or additional services rendered by other health care practitioners”. This inflexibility in the legislation means that it is difficult for provinces to adjust to care innovations, such as when a disease that was treated by specialists in the 1980s transforms into one primarily self-managed by the patient today. The result has been confusion across the country as new treatments and technologies arise – will they be covered? At what price? Often, responsibility is left to the patient and the private sector to arrange access and to pay (McKenna et al, 2015). This violates the spirit of Canadian health care universality and creates a mindset that puts structures ahead of people within our system design.

In contrast, the recent Affordable Care Act in the United States defines care coverage by condition rather than by health care provider. This has already encouraged new care structures, such as integrated provider teams, which can better address the many needs of a patient as they move through an episode of care, or through their continuous engagement with the health system (McKenna et al, 2015).

# CONCEPTUALIZING HEALTH TRANSFORMATION

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In order to achieve system-level transformation, the Government of Ontario must align its policy with two fundamental concepts: value and innovation.

## Value

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In their 2015 report, *The Catalyst: Towards an Ontario Health Innovation Strategy*, the Ontario Health Innovation Council defined the concept of value as Social Impact + Health Systems Benefits + Economic Benefits. This is a definition that largely captures the OCC's perspective. Value is created when populations are healthier, reducing the demand for traditional health services. It is also created when health sector sustainability can be strengthened, easing the fiscal pressure on governments. Finally, value emerges through technical or procedural innovation that drives efficiency and productivity. Value is demonstrated through long-term savings to the system as a whole; a return on investment that considers patient outcomes alongside cost.

Health care systems in Canada generally evaluate quality performance against metrics such as volume, cost, and safety. While important, these are not patient-focused; they do not measure outcomes against the goals of health and wellness, of which the system is supposedly in service (Snowdon et al, 2014; ICHI, 2012). Without that kind of measurement, we cannot drive stakeholders to deliver what matters most to Ontarians: quality of life, patient empowerment, and healthy communities.

Value is also missing from the incentive structure of our system. Under the fee-for-service model (FFS), health care providers (HCPs) are incentivized through compensation to increase the volume of their services. Although providers are dedicated, as professionals, to delivering positive outcomes against patient care, the system does not reward them for this. The market that exists today is not designed for patient health, but merely for treating episodes of disease (OMA, 2015). Value for dollars spent is therefore not present, as patient outcomes are not a factor in pay out. This means the right behaviours are not rewarded, and in fact may be penalized, as some forms of patient care reduce volume.

This has been the structure in place since the 1960s, and is the cause of many of the silos within Ontario health care. In order to break the cost-volume incentive structure, a risk-sharing based solution such as value-based payment (VBP) models - in which outcomes and overall, long-term value are the measures on which payment is based - is critical.

The Government of Ontario need not look far to find examples of VBP reform being enacted. In 2015, the New York State Medicaid program released a roadmap to shifting from volume- to value-based payments, as part of their Delivery System Reform Incentive Payment plan. This roadmap outlines each transitional stage in moving from FFS to VBP, including identifying risk and defining how cost and quality benchmarks will be established. The goal is to move 90 percent of FFS payment to the new model by 2020.

As the Conference Board of Canada notes, “Health care should put less emphasis on counting transactions and interventions and more on knowing whether these interventions make a difference in patients’ lives.” (Muzyka et al, 2012). This requires a realigned focus from measuring short-term value to measuring long-term value, and a redefinition of the system’s goals from self-maintenance to population well-being. It also requires a increase in accountability, as service providers at all levels must deliver and be evaluated on outcomes, rather than merely meet a volume or cost threshold.

## VALUE-BASED PAYMENT PILOTS IN ONTARIO

The Government of Ontario has already begun to experiment with value-based payment models, with bundled care. Under this scheme, a single payment is supplied to a team of health care providers, intended to cover patient care both in the hospital and at home. It is the patient’s needs that dictate service co-ordination, and these services are delivered by a consistent HCP team. Incentives to deliver efficient and high-quality care are built into the payment agreement: if the cost to providers of treating a patient is less than the set funding amount, providers keep the difference. However, if the cost exceeds the funding allotted, providers must cover the difference – otherwise known as “pain and gain sharing”.

Examples of bundling from other jurisdictions have resulted in fewer emergency department visits and a lower risk of hospital re-admittance. Under a bundled model, payment covers an entire episode of care rather than collecting charges on individual services provided. Bundling is therefore most appropriate for conditions that have a clear clinical path (UBC, 2014).

# Innovation

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Regardless of sector, innovation is described as a new technology, technique, process, model, or other solution that adds value and provides a meaningful benefit over the status quo (OBIO, 2013). When we talk about innovation in health care we must be mindful of two things: that innovation requires an openness and an appetite for risk, and that its adoption should be monitored and evaluated to ensure it meets both fiscal and health outcomes.

Slow or poorly-administered innovation has been an issue within the Ontario health system for decades: from a move to electronic health records that has yet to arrive, to limited patient access to the latest technologies and techniques such as MRI machines. Simply put, Ontario is not offering its citizens the most up-to-date care that exists today. This environment exists in Ontario for a series of reasons: high up-front/short-term investment costs, a government aversion to risk, a lack of trust between the private and public sectors, and a failure of stakeholders to align around patient needs. Frustratingly, when innovation is adopted, it is embedded within a service delivery model that has been unchanged for half a century and so may be unable to exploit the full fiscal or health potential of the innovation (Snowdon et al, 2010).

The result is a situation in which the private sector, providers, and patients are driving innovation – and government is struggling to keep up. These stakeholders have seen a vacuum and have acted to fill it, through means such as incorporating everyday smartphone technologies into wellness and treatment plans to piloting online medical record programs. Retailers are increasingly involved in bringing free or low-cost health services to their customers, such as placing pharmacies and walk-in clinics in their stores, and exploring generic drug programs. While these are welcome innovations for population health, this only increases the silo-ing of Ontarians' health services.

Although the private sector, providers, and patients all have important roles to play in creating, adopting, and driving innovation, there are many areas in which they lack the capacity to bring about substantive change. Thus, it is critical that the government be a partner in innovation.

But how do we drive innovation within a single-payer model? As it stands today, Ontario requires innovation that is technological, procedural, and cultural (Snowdon, 2010). The delivery model needs to be aligned with patient expectations and act as a pipeline to use health innovation to encourage economic growth. The Government of Ontario's goal should be to create a cycle of innovation, driven by the mechanics of supply (supporting research and its commercialization) and demand (using mechanisms such as procurement to purchase new care solutions) (OBIO, 2013).

In order to do this, we must adopt an innovation culture in Ontario that is founded on three pillars: health leaders that value innovation and have the acumen to nurture it; financial incentives that encourage both cost savings and health outcomes; and an information technology structure that can support the adoption of other innovations.

# WHAT COULD TRANSFORMATION LOOK LIKE?

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## Patients at the centre of the system

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As it stands today, there is a disconnect between what patients want from their health care system (health and wellness) and what the system is offering (essentially, disease management) (Snowdon et al, 2014). The system is reactive, rather than proactively managing illness. It needs to be re-oriented towards a patient-centric design, in which we are able to support people when they are sick *and* when they are well.

System structure needs to follow function, as it is the care of patients that is the *raison d'être* of health systems. Patient-centric design re-frames the provision of health care around the patient and his or her needs rather than slot them into designated, delineated points of care. A continuum of care, in which a series of co-ordinated and consistent health care resources are assigned to an individual patient in order to treat all aspects of their health in concert, is increasingly becoming the central organizing tenet for many health providers around the world. This structure has the ability to treat patients through a “whole-person” perspective, shifting from episodic care to continuous care, and giving providers more power to practice preventative and personalized medicine.

Patient-centric system design also gives health care providers more control within the system. It is their first-hand knowledge of a patient that is critical to deciding on a best course of care, and their co-ordination with other types of providers within a care continuum structure that can result in improved outcomes. A system in which a patient's care – from general practitioners to specialists to nurses to pharmacists to social workers to counselors and more – operates as one is a system in which patient needs are less likely to fall through the cracks, compliance to treatment regimens is higher, issues are caught before they become catastrophic, and re-hospitalizations are reduced. This means patients are more satisfied and confident, and system resources are used more effectively, reducing cost (OMA, 2013; Snowdon, 2011).

Patients today want to be actively involved in their health decision-making; they want transparency, convenience, and choice. In that way, they are more like consumers (Snowdon et al, 2011; Muzyka et al, 2012; Deloitte, 2015). If we are to create a patient-centric system, we must recognize that consumer demand should play a larger role in how we organize and fund health care. Unfortunately, the Ontario health care system is currently unable to respond to this shift in priorities, even as the province has recognized this shift in both the Ombudsman's report and policy white papers. This convergence of patient demand and consumer demand – and the failure of the government to respond as necessary – is contributing to greater independent private sector involvement in health.

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## Greater private sector participation

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Within Ontario, there is considerable cultural opposition to incorporating private resources into our public health system (Drummond, 2012). However, this ignores the fact that considerable aspects of medically necessary care – such as prescription drugs – operate largely outside of OHIP. The Canadian Institute for Health Information has calculated that 30 percent of total spending is covered by private sources, while a large share of the remaining 70 percent (such as laboratory work and homecare) is delivered privately. Clearly, our system is already a public-private mix – but one that is not making use of its private sector partners to their fullest extent. Other single-payer model countries such as the United Kingdom and Australia have successfully tapped into private sector know-how, innovation, and service delivery while still maintaining the goal of subsidized health care for all their citizens. A notable example is VirginCare, a private provider of services in the UK, which has won a series of National Health Service (NHS) contracts since 2006 and now runs 230 services across the country under the banner of “Care good enough for our families”. The NHS has also successfully introduced commissioning, a process by which practices work together to commission the best services for their population; this mechanism is attracting interest in Ontario and will be discussed in depth in a subsequent report. (See sidebar for a discussion of reform within the NHS.)

There are many benefits of better integrating with the private sector: By making use of industry expertise, the government can achieve its goals without “re-inventing the wheel”. Furthermore, by using mechanisms like procurement and alternative service delivery, the government has a transparent and coherent means of adopting innovation while reducing its risk. The government can also use procurement and similar means to increase local market adoption of Ontario innovations, which is not only good for business generally, but may help to keep innovative firms in-province by giving them a stronger foothold in the Ontario health market (OBIO, 2013). Finally, partnering with the private sector can help mitigate the burden of delivery, allowing the government to focus on policy, regulation, and stewardship while the private sector drives innovation and disperses risk.

So what is preventing Ontario from making use of private sector know-how, services, and products? In one word, trust. Public-private partnerships are simply not happening at the rate at which they should because of suspicion and skepticism that partnership could be successful or valuable. Many commentators have identified this mutual distrust between government and industry as one of the most significant barriers to innovation in Ontario health (OBIO, 2013). This is particularly frustrating because public-private partnerships can help develop solutions and share risk as the health care system undergoes reform.

This lack of trust may stem from concerns that private involvement in health care is a slippery slope to “American-style” health care; that it somehow jeopardizes a key tenet of our social welfare state. However, private providers are not only currently fundamental to the provision of health care in Ontario (particularly within those areas OHIP does not subsidize) but they have been proven to be a fruitful partner in other single-payer model countries, where a combination of public and private funding mechanisms have meant more choice and reduced wait times for patients (Mossialos et al, 2016).

In order to overcome this trust issue, public-private collaboration should begin with the development of a shared vision, including defining the specific problem that needs to be solved and setting measureable goals. This charting of common ground can be powerful in convincing the public sector that interests are not so misaligned, and providing industry with tangible outcomes against which it can deliver. Ultimately, collaboration and trust can and should be built around the shared value of promoting the health of Ontarians.

## BEST PRACTICES

There are considerable lessons to be learned from other single-payer model jurisdictions, many of which are undertaking similar transformations in order to adopt a value-based care perspective and an open-arms approach to innovation.

### The United Kingdom

The UK's National Health Service has greatly improved its outcomes over the past fifteen years, resulting in their placement atop The Commonwealth Fund's most recent ranking of health systems in 11 highly industrialized countries. Canada, in contrast, ranked 10th (Davis et al, 2014).

In particular, the NHS in England has been on a journey to change the way their system is structured and care delivered. In their *Five Year Forward View*, they identified three gaps within their system that should be familiar to Ontarians:

1. **The health and wellbeing gap.** Without a focus on prevention, the NHS' ability to fund innovative and effective new treatments will be limited by the need to devote budget space to avoidable, often chronic, illness.
2. **The care and quality gap.** Patients' changing needs will not be met if variations in care continue to exist and new technologies are not harnessed.
3. **The funding and efficiency gap.** Poor services, treatment rationing, staff shortages, and deficits will emerge without dramatic, wide-ranging transformation of system efficiencies.

They have devised – and are acting upon – policies to address these gaps. These include managing networks of care, not merely individual facilities or specialties; increasing out-of-hospital care; becoming patient-centric in service delivery; applying international best practices; and evaluating new care models as they are introduced to ensure they are meeting expected outcomes. Additionally, the English NHS has expanded its already robust partnership opportunities for private partners in order to better meet their goals.



## Australia

The Australian Medicare program is remarkably similar to Canada's own system structure: Comprehensive health insurance financed by taxes, with a division of duties between state and federal governments. However, there are two key differences between the Australian single-payer model and that of Canada: a greater role for the private sector in both financing and service provision, and higher health outcomes.

Like many industrialized countries, Australia has its own struggles with fiscal sustainability and fragmentation. In recognition of this, the federal and state governments signed the National Health Care Agreement in 2011, which outlined the common goal of Australian public health care: sustainability of the system and improving outcomes for all. It also indicated policy priorities at a national level, identified key areas of reform (i.e. in chronic disease management), and outlined the performance indicators against which progress will be measured.

Three initiatives in particular may be useful for Ontario to examine:

1. The Practice Incentives Program (PIP), which financially incentivizes providers to develop care plans for patients with chronic conditions like diabetes, asthma, or mental health challenges.
2. Primary Health Networks (PHNs), which are funded by the federal government. These work with HCPs and local health networks to improve co-ordinated care for those who are most at risk for poor health outcomes. In service of this goal, PHNs actively engage with Aboriginal community health care centres.
3. The National eHealth Transition Authority. Among other objectives, this body is in the process of establishing an infrastructure to enable communication across the Medicare system: namely, through electronic medical records. As of 2015, 8,000 providers and 2.5 million patients have registered, and soon an "opt-out" approach will be tested in place of the "opt-in" method (Mossialos et al, 2016).



# OUR POLICY PRIORITIES

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The bulk of the Health Transformation Initiative will be three “deep dive” reports on topics that reflect our aim of transforming the Ontario health care system for the better, through a productive role for industry in the health care system and developing the health sector as an economic driver. These reports will provide concrete direction for how Ontario can move towards a more effective and efficient health care system.

## Alternative service delivery and procurement

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The OCC has long advocated a strategic use of alternative service delivery or similar techniques for building an efficient and results-oriented public service economy. We believe that leveraging private sector know-how, capital, technology, and processes can provide greater value for money within our single-payer health care model and promote improved population health outcomes.

Looking at best practices from comparator jurisdictions, we see incredible opportunity for system transformation through innovative procurement and service delivery. Updating these tools can inject new techniques and technologies into care delivery and administration, can better link patient information across providers, can stimulate and grow Ontario businesses, and can provide government with more resources to achieve both the health and fiscal outcomes they desire.

*Relationship to Value:* Reform of the procurement and service delivery protocols is one of the first steps towards re-orienting the health care system around the concept of value. Public-private partnership can bring about greater efficiency for dollars spent and improve the level of service. But it also allows risk to be shared by both government and the private sector, and can be structured so that success is defined not by volume of patients served but by type of outcomes achieved. This can improve patient satisfaction while also reducing the fiscal burden on government.

*Relationship to Innovation:* Changing the way government interacts with the private sector through service delivery and procurement is a form of innovation – innovation of process. It drives innovation of technology, as private partners can provide access to new equipment or the capital required to introduce that equipment, and it encourages industry to experiment with innovative business models because they know that the largest buyer of care – the government – is able to respond to their offers.

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# Capitalization of made-in-Ontario health and human sciences research

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Ontario is seemingly the perfect storm of health and human sciences sectoral achievement: globally ranked universities and research institutions, a highly-skilled workforce, a high rate of foreign direct investment, the presence of major health sector firms, and a series of burgeoning life sciences clusters. Yet this sector is underperforming as an economic driver, and the Greater Toronto Hamilton Area cannot match the power or output of clusters like Boston, Raleigh-Durham, or the San Francisco Bay area. Today, local health and human science start-ups are able to find initial funding through dedicated government seed funds and/or private matching capital sources. However, when attempting to scale or fund this sector's notoriously long development cycles, the money is insufficient or simply not present. The health sector is only growing in global importance - Ontario should be able to harness its tremendous intellectual capital and turn it into profit.

*Relationship to Value:* Value within the system is created by new efficiencies and better alignment with desired outcomes. The kinds of discoveries that emerge from Ontario's health and human sciences research institutions and corporate entities are the source of tomorrow's value - new therapies that reduce the need for in-hospital care, new devices that track patient diagnostics in order to prevent catastrophic health events, or more effective drugs that improve quality of life. They also create value through economic growth, contributing to a strong, wealthy Ontario.

*Relationship to Innovation:* Ontario's health and human sciences sector can be a creator and driver of new innovation within our health care system - as long as it is able to fully develop and implement those innovations. The government must match this innovation with their own - innovation in process through procurement, and in capital acquisition through regulatory change. Ontario should be able to aggressively and seamlessly incorporate local innovation into local health care.

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## Health technology access and value

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Health system reform is not limited to those services which the government primarily or exclusively funds. Increasingly, the driver of personalized and preventative medicine is patient empowerment: giving them the tools to manage their health. This means utilizing technologies that can move testing and treatment outside of the hospital and doctor's office. The system currently evaluates these tools largely on cost – a short-term perspective that does not assess their larger impact on patient quality of life or the overall public health budget. There is a considerable role for technologies like pharmaceuticals and medical devices in supporting a re-alignment of the system from front-of-line care towards in-home and individualized care.

However, these technologies are often paid for by patients or by private insurance. How can we improve access while still driving innovation in these industries? How can these industries play a role in creating the value-oriented, outcomes-based public health care system of tomorrow?

*Relationship to Value:* In order to achieve the greatest gains from innovative health technologies, the government must use the concept of value as a tool for assessment, rather than principally evaluating on price. This means applying a systemic view and whole-patient perspective to purchasing. Outcomes such as improving quality of life or reducing hospital re-admission and condition escalation bring value to both the patient and the system as a whole. While the government may have spent more on the drug or the device up front, savings are returned to them in a healthier population.

*Relationship to Innovation:* It is well-recognized that the accelerated development of technology results in a reduction of the cost of that technology, meaning that consumer access can grow. Harnessing this trend can benefit both government coffers and patient well-being. Innovation drives costs down, both at a micro (individual technique or technology) and macro (the health budget) level. The government is well-served to access innovation in personal medical technologies and therapeutics to shift patients away from the most expensive areas of the system, thus putting its fiscal investment to better use.

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## CONCLUSION

The solutions to Ontario's health care crisis are already written – other countries are experiencing the same problems we are, and countless stakeholders have identified how to solve them. We know the Government of Ontario is aware of these solutions, as they have already indicated that they intend to put patients first and prioritize innovation.

But achieving sustainable transformation requires a tangible, collaborative effort alongside health care providers, patients, and the private sector. It requires building trust and making meaningful and lasting connections. It requires pushing the dialogue further, in order to inspire and drive real change. Most importantly, it requires a strategic way forward.

The OCC has over 100 years' experience as an advocate and convener, of representing business but also bringing together all sectors to discuss, evaluate, plan, and act together. With this project, we intend to start a long-term conversation that uses the combined power of our networks and know-how to move Ontario forward on health transformation.

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