APPENDIX 3

IMPROVING EFFICIENCY IN CANADIAN HEALTH CARE

[BACKGROUND FOR STRATEGIC SESSION 2]
APPENDIX 3: IMPROVING EFFICIENCY IN CANADIAN HEALTH CARE

RATIONALE

In 2011 the Canadian Medical Association (CMA) Board Working Group on Health Care Transformation convened an independent Advisory Panel on Resourcing Options for Sustainable Health Care in Canada. In their assessment of the current Canadian health care system, the panel noted that there are questions about the system’s efficiency and value for money. They noted that “many national indicators and assessments suggest strongly to us that Canadians are paying more than they should be for the results the system is achieving. We believe, as a result, that there are many areas to improve efficiency in the health system with no reduction and possibly an improvement in quality of care.”

The themes of efficiency and value for money ran through the panel’s report and efficiency was explicitly mentioned in two of their recommendations to the CMA:

- **Recommendation 3**
  We recommend that the Association provide leadership in working with its provincial and territorial affiliates to ensure methods of physician compensation that support quality care, efficiency and integration.

- **Recommendation 9**
  We recommend that the Association take a leading role in explaining to Canadians the importance of electronic records to their health outcomes, advocate for a re-thinking of Canada’s national electronic health information strategy, push for greater use of electronic records by Canada’s physicians, and ensure information is used to improve quality and efficiency.¹

OBJECTIVE

The objective of this note is to provide a preliminary overview of the concept of efficiency in health care as it pertains to Canada and the types of strategies that have been put forward to improve it.

The concept of efficiency has two applications in health care. The most common is “technical efficiency” and this is defined as the production of an output with the minimum amount of input. The second is called allocative efficiency and it refers to the production of the maximum output for a given amount of inputs. It is more commonly referred to as cost-effectiveness.

THE EFFICIENCY IMPERATIVE

The fiscal crunch occasioned by the worldwide recession of 2008 has resulted in a redoubling of governments’ focus on opportunities for improved efficiency in health care, and it is widely believed that considerable opportunities exist. Based on a macro system-level approach to estimating efficiency among its member countries, the Organization for Economic Cooperation and Development (OECD) has estimated that Canada could save 2.5% of Gross Domestic Product in public spending by 2017 if Canada were to become as efficient as the most efficient countries.² Indeed, the Canadian Institute for Health Information (CIHI) has estimated that provincial/territorial health spending grew by just 3.2% in 2011, - ½ the level of the 6%+ increases of the previous decade.³ Since 2007 when it was coined by the U.S. Commonwealth Fund, the expression “bending the cost curve” has been used to describe a variety of approaches to improving cost efficiency in health care.⁴

In 2008, Bentley et al set out a conceptual framework for the study of waste in the U.S. health care system.⁵ They applied it to technical efficiency as the difference between current cost and the efficient production cost, and to allocative efficiency as the difference between the cost of a service and its value. The framework is depicted below:
In the remainder of their article, they attempted to identify waste in the U.S. through high-level comparisons within the U.S. and between the U.S. and other countries and through sector or procedure-specific evaluations of inefficiencies. Most recently Berwick and Hackbarth have estimated the cost of waste to the U.S. health system in 2011 using a similar framework. Their lowest estimate is $558 billion and their midpoint estimate is $910 billion. These figures represent a range of 21% to 33% of the projected 2011 U.S. total health spending of $2.7 trillion.

This framework can be applied to Canada.

**Administrative Waste**

Administrative waste can be generally thought of as excess transaction costs associated with claims payment and excess costs of administration and management over and above what is required to deliver front-line health care. According to CIHI, administration accounted for just 3% of health care costs in Canada in 2011 but this is only the cost of providing health insurance by governments and private health insurance companies.

The only detailed analyses of comparative administrative costs available for Canada are against the U.S. and they are not current. For 1999 Woolhandler et al published the following estimates for Canada versus the U.S. as shown below:

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>Spending per capita, U.S.$</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>Canada</td>
</tr>
<tr>
<td>Insurance administration</td>
<td>259</td>
</tr>
<tr>
<td>Employers' health benefits administration</td>
<td>57</td>
</tr>
<tr>
<td>Hospital administration</td>
<td>315</td>
</tr>
<tr>
<td>Nursing home administration</td>
<td>62</td>
</tr>
<tr>
<td>Practitioners’ overhead/billing expense</td>
<td>324</td>
</tr>
<tr>
<td>Home care administration</td>
<td>42</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,059</strong></td>
</tr>
</tbody>
</table>

Source: Woolhandler et al 2004

They estimated that health administration accounted for 31% of U.S. health expenditures in 1999 versus 16.7% in Canada. The biggest difference by far was in the cost of insurance administration. This is no surprise given the number of health insurance plans in the U.S. In 2011 the National Commission Quality Assurance published ratings for 390 private insurance plans and listed a further 39 for which they were unable to assign ratings. Most recently,
Morra et al reported a survey on the insurance administrative costs in Ontario versus the U.S. and estimated that physician practices in Ontario spent $22,205 per physician per year interacting with Ontario’s health insurance plan compared to $82,975 for their U.S. counterparts.\textsuperscript{10}

In terms of other administrative costs, we do not know how Canada has evolved over time in comparison to other sectors of the economy or how we compare internationally. There have certainly been questions about the expansion and contraction of regional health authorities in Canada over the past two decades. Canada does not have a detailed set of health accounts that would permit such analysis. One potential source of information would be a detailed tabulation of occupation by industry over several census periods from Statistics Canada.

Another aspect of administrative waste would be the cost of duplicate collection and recording of health information. The health sector in Canada has been slow to adopt health information technology; however, this probably has a much greater impact on the operational side.

One significant administrative irritant for Canadian physicians is the variety of forms that they are required to complete for third parties such as insurance companies and government. Just to take the federal government for example, examples of health programs and forms include:

- Canada Pension Plan Disability
- Disability Tax Credit
- Employment Insurance (Sickness Benefits Claim)
- Non-insured Health Benefits (for First Nations people and Inuit)
- Veterans disability pensions
- Compassionate care leave
- Exception/limited use drug request form (to permit access to non-market drugs)

It is often the case that different definitions of concepts are found on these forms, but in many instances they are asking for similar information about the same patient.

Another aspect of administrative waste that is cited in Canadian health care is the proliferation of administration that has resulted from the extensive experimentation with regionalization that began in the early 1990s. The pendulum has been swinging back over the past several years, most dramatically in Alberta in 2008 when it was announced that the nine regional health authorities and three provincial health authorities would be consolidated under Alberta Health Services (AHS). AHS took effect on April 1, 2009 and in November of that year it announced that it had identified $227.1 million in cost savings in facilities management, procurement and administration, and that annualized these would amount to $659.5 million.\textsuperscript{11}

Similarly in 2008, New Brunswick consolidated their eight regions down to two. At the same time they established Facilicorp NB, a shared-services providing non-clinical services to the two regional authorities. It was projected that this would save $20 million annually within five years.\textsuperscript{12}

In Saskatchewan, Deloitte consultants conducted a review of administration as one element of the Patient First Review in 2009 and recommended the establishment of a single Provincial Shared Services Organization for supply chain, human resources and finance functions.\textsuperscript{13}

In its February 2012 report, the Commission on the Reform of Ontario’s Public Services (Drummond Commission) recommended (Rec 5-95) the centralization of all back-office functions such as information technology, human resources, finance and procurement at the level of the Local Health Integration Network (LHIN), which they estimate could result in savings of up to $1 billion in Ontario.\textsuperscript{14} In Nova Scotia the district health authorities and the
IWK Health Centre have announced the merger of several administrative services that will save up to $8.8 million over the next 18 months.15

**Operational Waste**

Bentley et al5 have provided a typology and suggested examples of operational waste, depicted below:

<table>
<thead>
<tr>
<th>Type of Waste</th>
<th>Description</th>
<th>Health Care Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duplication of services</td>
<td>Producing unnecessary repeated services</td>
<td>Tests or procedures done more frequently than clinically necessary</td>
</tr>
<tr>
<td>Inefficient processes</td>
<td>Poor process design that causes unnecessary movement or inventory in the production of services</td>
<td>Time spent waiting; unnecessary transport of people or material; useless motions; multiple stock items due to lost or misplaced supplies</td>
</tr>
<tr>
<td>Overly expensive inputs</td>
<td>Producing services with expensive equipment or personnel when less expensive inputs would suffice</td>
<td>Physicians providing services for which nurses are equally competent; use of brand drugs for patients who get equal benefit from generics</td>
</tr>
<tr>
<td>Errors</td>
<td>Quality defects that result in rework or scrapping</td>
<td>Defective medical devices; rework of tests or procedures; health and cost consequences of medical errors</td>
</tr>
</tbody>
</table>

These are pertinent to Canada. In terms of duplication of services, the lack of an interoperable electronic medical record is perhaps cited most frequently as the cause of repeat testing, although use (or not) of clinical practice guidelines (CPGs) is mentioned as well.

In terms of inefficient processes, the 2004 Wait Times Reduction Fund has provided an impetus to the research and uptake of operations research in the health care field, particularly in institutional settings. The “lean” techniques pioneered in the automotive industry are being applied in health care. Womack has distilled five key principles of lean management:

1. Specify the value desired by the customer.
2. Identify the value stream for each product providing that value and challenge and eliminate all of the wasted steps.
3. Make the product flow continuously through the remaining stops.
4. Introduce pull between all steps where continuous flow is impossible.
5. Manage toward perfection so that the number of steps and amount of time and information needed to serve the customer continues to fall.16

Fine et al have provided an account of how five Canadian hospitals have successfully implemented Lean techniques.17 In 2010 British Columbia’s Leadership Council adopted Lean as a process redesign tool for the province’s regional health authorities and it has published a report on seven case studies.18 In the primary care setting, the U.S. Institute for Healthcare Improvement has developed techniques such as advanced access

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iThis comprises the Health Authority CEOs, the deputy minister of health and Ministry of Health executives
scheduling that provides for same-day access appointments. These are being implemented in BC through the GP Services Committee and Alberta through the Access Improvement Measures (AIM) initiative.

In terms of overly expensive inputs, Canada has significant experience with generic pharmaceuticals and BC adopted reference-based pricing in the 1990s that reimburses the amount of the lowest price drug in class. In terms of utilization of lower cost providers, this has occurred in some settings, such as the use of registered practical nurses in home care. Most jurisdictions are expanding the scope of practice of nurses, pharmacists and other providers but it remains to be seen if those will either reduce costs or add on to costs. The Drummond Commission has recommended (Rec. 5-18) a shift in responsibilities from physicians to nurses and others in health teams, such as physician assistants. One issue that has been raised recently is the contention that Canada is paying too much for services whose delivery has greatly been facilitated by technology. The most frequently cited example is cataract surgery. The Drummond Commission has recommended (Rec. 5-61) that the government should “adjust fee schedules in a timely manner to reflect technological improvements, with the savings going to the bottom line of less expenditure on health care.”

With regard to errors, the Canadian Adverse Events Study (2004), found that in 2000 an estimated 7.5% of patients admitted to acute care hospitals in Canada experienced one or more adverse events, and that these were considered to have been preventable in more than one-third (36.9%) of cases. In terms of magnitude, it was estimated that between 141,250 and 232,250 hospital admissions were associated with an adverse event and that between 9,250 and 23,750 deaths could have been prevented.

In 2010 Ontario passed the Excellent Care for All Act, a main focus of which is quality improvement. Subsequently, Ontario established an Avoidable Hospitalization Advisory Panel, that reported in November 2011. The report noted that unplanned 30-day readmissions accounted for an estimated $705 million in Ontario hospital costs in 2008-09 and that many of them may have been avoidable. Moreover, it noted that there was significant variation across the LHINs, ranging from 13-18%. The report sets out 17 recommendations that focus on improving the transition from acute care to community settings.

The prevention of error/adverse events has received considerable attention in the U.S. over the past decade. The National Quality Forum published a consensus report in 2002 that listed 27 adverse events considered to be largely preventable. The U.S. Centers for Medicare and Medicaid Services (CMS) has adopted a policy of not paying for mistakes. Beginning in 2009, CMS will not pay for a procedure when the practitioner erroneously performs:

- a different procedure altogether
- the correct procedure on a wrong body part, or
- the correct procedure on the wrong patient

Moreover CMS will not pay for any services provided in the operating room when an error occurs, including performance of the correct procedure. One tool that has been developed and tested is a 24-item Surgical Safety Checklist that is to be completed in three stages; before anesthesia, before skin incision; and before the patient leaves the operating room. Eight hospitals in eight cities (including Toronto) conducted a before and after study of the checklist between 2007 and 2008, and they found that the death rate was cut by almost one-half and the in-patient complication rate cut by one-third.

The potential role of information technology in reducing quality problems is cited as well. A study done for Canada Health Infoway has estimated that some $436 million in benefits would accrue from the adoption of drug information systems, one-fifth of which would be attributed to reduced adverse drug events.
CLINICAL WASTE REDUCTION

The main issue associated with clinical waste is practice variation. John Wennberg and colleagues have generated the main body of work in this area since the 1970s. In 2009 U.S. surgeon Atul Gawande attracted attention from the White House with his comparison of Medicare costs between McAllen, Texas and El Paso County. Although both counties had similar demographics, in 2006 Medicare spent $15,000 per enrollee in McAllen, compared with $7,500 in El Paso (roughly the national average). Through a series of interviews, Gawande could find no superior service or quality advantage in McAllen. In his conclusion Gawande recommended that physicians and hospitals should come together to form “Grand Junction – like accountable-care organizations, in which doctors collaborate to increase prevention and the quality of care, while discouraging over-treatment, under-treatment and sheer profiteering.” Since that time, provision for such organizations has been included in U.S. President Obama’s 2010 Patient Protection and Affordable Care Act (mostly referred to as the Affordable Care Act).

Since their inception in the early 1990s, great hope has been held out for the potential of CPGs to reduce practice variation and thus lower costs. As defined by the Institute of Medicine in 1990, CPGs are “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.” Canada has been among the leaders in the development of CPGs. One of the highly publicized ones has been the Ottawa Ankle Rules (OAR), a decision rule on whether to order an x-ray for acute ankle injuries. Developed by Ian Stiell and colleagues, the OAR was shown to be 100% sensitive and 40.1% specific, and would allow a 36% reduction in the ordering of ankle x-rays. In a subsequent cost-effectiveness analysis, it was estimated that Ontario, as of 1993, would save $730,145 per 100,000 patients. However, two impact studies on the dissemination of OAR for ordering ankle x-rays (Ontario 1996 and Alberta 1995-1997) found no reduction.

Nonetheless, considerable effort continues to go into the generation of CPGs. Since the early 1990s, CMA has developed and maintained a CPG Infobase, which contains roughly 1,200 guidelines. In the U.S., the Agency of Health Care Research and Quality maintains a National Guideline Clearinghouse and in the U.K. the National Institute for Clinical Excellence (NICE) has an inventory of some 145 CPGs.

The Canadian Institutes of Health Research has launched a Strategy for Patient Oriented Research and one of its core elements is the improvement of guideline development, dissemination and uptake through support for guideline development and dissemination.

In November 2011 the CMA and four other organizations convened the Canadian Clinical Practice Guidelines Summit for the purpose of advancing a national strategy on CPGs. The summit identified five key recommendations spanning CPG topic selection to evaluation.

Canada’s Premiers have taken an interest in CPGs in the past few years. At their 2010 annual meeting they directed their health ministers to “work with health care experts to share and collaborate on clinical practice guidelines, evidence-based standards and best practices…” Coming out of their July 2011 meeting of the Council of the Federation, it was announced that “health ministers have agreed to collaborate in clinical practice guidelines, focusing on three to five specific ones where better care and cost savings can be achieved.” At their subsequent January 2012 meeting, Premiers announced the formation of a Health Care Innovation Working Group, one of whose three priorities is to be “accelerating the development and adoption of best clinical and surgical practice guidelines so that all Canadians benefit from up-to-date practices.” They expect to receive a report in time for their July 2012 meeting. The Drummond Commission has recommended (Rec. 5-46) that Health Quality Ontario become a “regulatory body to enforce evidence-based directives to guide treatment decisions and OHIP coverage.”
COST-EFFECTIVENESS

There is also considerable literature, although mainly theoretical to this point, on cost-effectiveness, which may be defined as the extent to which an activity is thought to be as valuable as it is effective. Cost-effectiveness is generally established by comparing one treatment to another. A related term that is used is “value for money.” The currency of cost-effectiveness is the cost per Quality Adjusted Life Year (QALY) as determined through various study means, usually the comparative study of the incremental cost per QALY of one treatment over another. In the U.K., NICE has a broad mandate to make recommendations on the cost-effectiveness of procedures/treatments. NICE considers a cost per QALY in the range of £20,000-£30,000 to be cost effective. To date, however, the rule of rescue and medical necessity continue to trump cost-effectiveness. Thanks to media coverage in prominent newspapers, health ministries will regularly authorize treatments costing $300,000+ per year on an individual case basis. The Canadian Agency for Drugs and Technologies in Health promotes the use of cost-effectiveness in the assessment and adoption of new drugs and other technologies (see www.cadth.ca).

Another issue that is cited is that new and more effective technologies may not displace old technologies.

Over the past few years, Elshaug has introduced the concept of disinvestment which is a process of identifying interventions that are not cost-effective and to assess their potential for reducing their use or removing them from government insurance benefits schedules. Elshaug has put forward a dozen criteria for identifying such interventions:

- geographic and provider variations
- temporal variations in volume
- technology development (e.g., 256-slice versus 4-slice computed tomography)
- public interest or controversy
- consultation with clinicians, administrators and funders
- assess new intervention – displace old
- leakage outside indications
- legacy technologies that have never been evaluated
- conflict between practice and CPGs

To date there has been no systematic uptake of this process. One approach to efficiency savings that addresses both practice variation and cost-effectiveness was proposed by Brody in 2010 when he challenged U.S. specialty societies to develop a Top Five list of diagnostic tests or procedures that are commonly ordered, expensive and demonstrated to be of little benefit for some major categories of patients. This challenge was taken up by the National Physicians Alliance and in 2011 they published Top Five lists for three primary care specialties. The Top five for family medicine include (very abbreviated):

1. No imaging for low back pain in the first six weeks.
2. No routine antibiotic prescription for sinusitis.
3. No annual ECGs for asymptomatic low-risk patients.
4. No Pap tests for patients <21 or women post hysterectomy for benign disease.
5. No dual energy x-ray absorptiometry screening for osteoporosis in women <65 or men <70.

This has since expanded to nine specialty societies under the banner of Choosing Wisely (choosingwisely.org).
CONCENTRATION OF HEALTH EXPENDITURES

In the past few years there has been growing recognition of just how concentrated a large proportion of health expenditures are on a small proportion of the population. A 2010 study based on Ontario data reported that:

- 1% of the population accounts for 49% of combined hospital and home care costs, and
- 5% of the population accounts for 84% of combined hospital and home care costs.48

Perhaps not as dramatically a Manitoba study found that in 2000-01 5% of Manitobans were taking 40% of all prescription drugs.49

Most recently Emanuel has discounted the potential for U.S. cost savings through malpractice costs, insurance profits, drug costs and high cost infants, arguing that the greatest savings potential is to be found among the 10% of the population, typically with chronic conditions, that accounts for about 64% of health care expenditures.50 He suggests that better tertiary prevention is needed and cites four strategies:

- electronic health records that track patients’ health status and physician performance plus decision supports to promote adherence to treatment pathways
- using the information for more intensive interactions between patients, care givers and clinicians/staff
- reducing use of specialists
- providing services not traditionally covered by fee-for-service reimbursement (e.g., transportation)

Another aspect of concentration in health expenditures is care at the end of life. It is a popular myth that a majority of health expenditures are concentrated in the last year of life. Data from the U.S. Medicare program have shown that roughly one-quarter of health expenditures are accounted for by beneficiaries in the last year of life. While significant, this is much less than commonly thought.51 Nonetheless, the use of advance directives and the availability of hospice/palliative care versus dying in hospitals are issues in Canada.

INCENTIVIZING EFFICIENCY GAINS

Historically there has been little incentive in publicly-funded health care systems to pursue efficiency gains. Global budgets for hospitals have been often painted as the villain, and likewise fee-for-service payment for physicians without linkage to resource utilization. Over the past decade however, a number of countries have adopted prospective reimbursement for hospitals, based on the Diagnosis-Related Groups (DRGs) that were pioneered in the U.S. in the 1970s and adopted by the U.S. Medicare program in 1983.ii A 2010 study of 29 OECD member countries found that 18 were using at least some degree of DRG funding for hospitals.52 DRGs work by assigning a national tariff (payment rate) to patients with similar conditions/resource requirements. Hence hospitals are competing on quality and there is an implicit incentive to become more efficient. Following some initial pilot projects, BC announced in 2010 that it would launch what it calls “patient-focused funding” (a term developed by CMA Past President Dr. Brian Day [2007-08]) province-wide.53 In development for a few years, Ontario has recently announced that it is moving to “patient-based funding” for hospitals, using a combination of a Health-Based Allocation Model and Quality-Based Procedures.54

Looking ahead, moves are being made to engage physicians and patients in the pursuit of efficiency. In the U.S., the Affordable Care Act provides for Accountable Care Organizations (ACOs), in which physicians and hospitals come together to provide care along the continuum for a group of a minimum of 5,000 Medicare beneficiaries. The ACOs

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ii Canada’s version of DRGs are called Case-Mix Groups (CMGs) and they are maintained by the Canadian Institute for Health Information.
will be able to participate in a Medicare Shared Savings Program in which the ACO will be able to retain a share of Medicare savings but also will share the risk of increased Medicare costs.\textsuperscript{55}

In the U.S., patients are being enlisted in the drive for improved cost-effectiveness through the introduction of Value-Based Insurance Design (VBID). VBID operates by reducing patient cost-sharing for effective interventions and increasing for those that are not. The amount of cost-sharing is set in relation to the clinical value of the drug or service. A 2010 survey of employers for the U.S. Center for Health Value Innovation found 53% have VBID programs in place, and that 87% of respondents indicated that they use incentives to promote prevention and wellness activity in their insured populations.\textsuperscript{56} VBID does not appear to have spread outside the U.S., for example to the European social insurance sickness funds.

On the physician side, CMS is introducing a Value-Based Payment Modifier (VBPM) for physicians that will be based on providing reports to physicians on the quality of care they provide to and the Medicare costs for their patients relative to their peers and on a risk-adjusted basis. The VBPM will begin to apply to physician payments in 2015.\textsuperscript{57}

Mulvany has listed the initial types of process measures and domains of measures that CMS will be using to determine the VBPM.\textsuperscript{58} These are shown below.

<table>
<thead>
<tr>
<th>Process</th>
<th>Outcomes</th>
<th>Care Coordination</th>
<th>Safety/Functional Status</th>
<th>Cost Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative care</td>
<td>Avoidable admissions</td>
<td>Post-discharge appointment</td>
<td>Use of surgical checklists</td>
<td>Per capita</td>
</tr>
<tr>
<td>Chronic disease management</td>
<td>Emergency department usage</td>
<td>Hospital alert to primary care physician of unscheduled admission</td>
<td></td>
<td>Per capita for select chronic conditions</td>
</tr>
<tr>
<td>Cancer treatment</td>
<td>All-cause readmissions</td>
<td>Receipt of results from testing/consult work performed as a referral</td>
<td></td>
<td>Episode-based cost measures</td>
</tr>
</tbody>
</table>

Source: Mulvany, 2011

**SENATE REVIEW OF THE 2004 HEALTH ACCORD**

The Standing Senate Committee on Social Affairs, Sciences and Technology released its review of the 2004 Health Accord on March 27, 2012. The report sets out 46 recommendations.

At least three of the recommendations touch at least indirectly on efficiency and value for money by increasing the use of electronic information and the sharing of best practices.

- **Recommendation 23**
  That Canada Health Infoway Inc. target its investments to:
  (a) Projects aimed at upgrading existing components to meet national interoperability standards set by the organization; and
  (b) Promoting the adoption of electronic medical records by health professionals in Canada, including working with stakeholders to identify effective incentives in this area.
• Recommendation 34
That the federal government, taking the lead, work with provincial and territorial governments to establish a Canadian Health Innovation Fund to identify and implement innovative and best-practice models in health care delivery, and the dissemination of these examples across the health system.

• Recommendation 37
That the federal government ensure ongoing funding dedicated towards health services and systems research, either through the Canadian Institute of Health Research or the Canadian Health Services Research Foundation.

The Prime Minister rejected the idea of a Health Innovation Fund in an interview prior to the January 16-17, 2012 meeting of the Council of the Federation but the idea may well re-surface in the run-up to the 2015 federal election.

CONCLUSION
In conclusion, many of the components of waste/inefficiency set out by Bentley et al are now being incorporated with fervour in recommendations to governments, particularly in Ontario. The Ontario Hospital Association has collaborated on two high-profile reports and the Toronto-based Mowat Centre issued one in the fall 2011. While there was much anticipation as to how the Ontario government would respond to the Drummond Commission’s report in the 2012 budget, in particular with respect to the 105 recommendations that address the health sector, they were not picked up in any significant number. However the government did state that it plans to constrain the growth in health spending to 2.1% annually over the next three years, and to “maintain total physician compensation at current levels,” clearly a major challenge in light of inflation, and utilization and population growth. The budget also states the intent to move procedures out of hospitals to non-profit, community-based clinics and to build on the mandate of Health Quality Ontario to link funding to evidence of value.

CMA RECOMMENDATIONS
1. The Canadian Medical Association supports the deployment and uptake of clinical practice guidelines that have been evaluated in an evidence-based manner in terms of patient outcomes, appropriateness and cost-effectiveness.

2. The Canadian Medical Association supports the availability of data on the cost and cost-effectiveness of treatment options at the point of care.

3. The Canadian Medical Association supports the integration of clinical practice guidelines with electronic medical records.

4. The Canadian Medical Association supports the development of chronic disease management and other supportive strategies that will provide high quality care to vulnerable patients at risk of frequent readmission to the acute care system.

5. The Canadian Medical Association will support the implementation of a pan-Canadian clinical practice guidelines strategy.
STRATEGIC QUESTIONS

1. What should be done to alleviate the administrative and financial burden on patients and physicians of federal health programs (e.g., Disability Tax Credit)?

2. What are the opportunities for process improvement in community-based practice?

3. How might quality of care be measured and monitored in community-based practice?

4. What can the CMA do to encourage the adoption of clinical practice guidelines?

5. Should cost-effectiveness information be explicitly incorporated in health care decision-making, including that which occurs between the patient and the physician?

6. How can physicians assist with the identification of patients at risk of concentrated health care utilization (e.g., frequent readmission) and how can they help to mitigate those risks?

7. How can governments, health authorities and medical associations create incentives to promote efficiency savings in the delivery of health and medical care?
REFERENCES


16 Womack J. Lean thinking: were have we been and where are we going? Manufacturing Engineering 2002;129(3):L2-6.


