Creating Strategic Change In Canadian Healthcare

CONFERENCE SUMMARY

May 15-16, 2014, Toronto

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Creating Strategic Change in Canadian Healthcare is the second in the three-part Queen's Health Policy Change Conference Series. A joint initiative of Queen's School of Business and Queen's University's Faculty of Health Sciences and School of Public Studies, this collaborative forum asks the question, what is the potential for a Canadian healthcare strategy? Hosted in Toronto on May 15-16, 2014, this conference builds on consensus developed at the first conference, Toward a Canadian Healthcare Strategy. In particular, it focuses on four themes identified as needing pan-Canadian collaboration: pharmacare, health human resources, electronic health records, and integrated care.

Welcoming the 150 senior Canadian healthcare leaders participating in the event, Queen's University Chancellor David Dodge, reiterated the motivation behind the conference:

"What we're here to talk about is the future of Canadian healthcare and our health system. In order to move forward to meet the challenges that are ahead, we need continued innovation. It is important in every field and every segment of the economy, but perhaps not more than in healthcare, because doing so will pay enormous dividends for the health of the population and the strength of the economy.

"Innovation is an overused word but it's what we're here to talk about. To move forward will require collaboration across a wide group of people: providers, researchers, business, and more.

"There are no magic bullets, but if we can learn from each other, we create new potential for innovation in our healthcare system."

This report provides a summary of the conference discussion.

(From L to R):

Michael Brennan, *CEO, Canadian Physiotherapy Association,* ***Anne Sutherland Boal,*** *Chief Executive Officer, Canadian Nurses Association,* ***Dr. Chris Simpson,*** *Chief of Cardiology, Queen's University and President-elect, Canadian Medical Association,* ***Shirlee Sharkey,*** *President and CEO, Saint Elizabeth*

DESIGNING STRATEGIC CHANGE IN CANADIAN HEALTHCARE

KPMG Keynote: Global Healthcare Strategies

The conference opened with a keynote presentation from Dr. Mark Britnell, Chairman and Partner with KPMG's Global Health Practice. Dr. Britnell considered the question, "Is it possible to have a national healthcare strategy in a federated political system?" by looking at several international examples of national healthcare strategies. Looking at the cases of Australia, Germany and South Africa, he argued that federated healthcare systems can operate in a number of different ways.

Australia, for example, allows for its states to play a significant role in healthcare delivery and policymaking. For the patient, however, some elements of their care are provided by the federal government, while others are provided by the state. Recent reforms, then, have driven towards a more uniform national approach to pricing and performance. They have done well to maintain local flexibility alongside national agreement, although having different governments responsible for primary and secondary care has made integration of services challenging. Germany, on the other hand, takes a decentralized approach to both payment and provision of healthcare services. This has led to a collaborative approach to reform, led in part by the Federal Joint Committee, a negotiation platform for sickness funds, hospital associations and professional groups. This model has required a careful balancing of many interests, but has enabled an easier shift to integrated care, both because the government is able to regulate the insurance market, and because one body – the sickness funds – covers the full continuum of care and is thus incentivized to integrate. South Africa takes a siloed approach with clear delineations between national and provincial areas of responsibility for policy and delivery. Strategy is determined by the federal government, while different aspects of care are delivered by federal, provincial and local governments. While federal involvement is beneficial for large-scale challenges (e.g., antiretroviral coverage), the system is often siloed, making integration difficult.

In his work around the globe, Dr. Britnell has found that integration is a priority everywhere, but acted on very little. The challenge, he has found, is that most healthcare leaders recognize the need for change, but believe their own organizational plans are robust and sustainable. Thus, while wide transformation is necessary, the majority of resources are spent on transactional change. The short-term political drivers behind healthcare play a large role in such neglect of transformational change.

For federated systems like Canada's, Dr. Britnell sees great potential. The recent Drummond Report in Ontario is one of the best articulated cases for integrated, patient-oriented care. A patient-orientation in which patients are empowered to participate in their own care is critical for improving health outcomes. To enable such transformational reform, Britnell argues, "It is probably not desirable to have a comprehensive national strategy, but it makes sense to have some national strategies." The key to success, then, is to "federate where necessary, localise where possible," using arms-length bodies to overcome political barriers and federal/provincial divides.

Georgia Black, *Partner and National Healthcare Lead, KPMG Canada*

Dr. Mark Britnell, *Chairman & Partner, Global Health Practice, KPMG, UK*

SUN LIFE FINANCIAL PANEL: THE NATIONAL PRIMARY HEALTH CARE STRATEGIC FRAMEWORK – A CASE STUDY FROM AUSTRALIA

Having recently launched the National Primary Health Care Strategic Framework in collaboration between federal and state governments, Australia provides a helpful example of many principles raised in Mark Britnell's keynote address.

Professor Justin Beilby, Executive Dean for the University of Adelaide's Faculty of Health Sciences, opened the panel by discussing the conditions that led to the development of the strategic framework. Australia faced many challenges similar to its developed world counterparts: fragmentation between federal and state services, complexity of funding, governance and reporting structures, a lack of coordination between planning and delivery, and a rise of workforce shortages and other system limits. Healthcare inequities also continued to create pressures on the system, particularly urban-rural differences and access for indigenous peoples.

A major impetus for reform came through the 2009 National Health and Hospitals Reform Commission, whose A Healthier Future for All Australians report contended, "we have a fragmented health system with a complex division of funding responsibilities and performance accountabilities between different levels of government. It is ill-equipped to respond to these challenges. We believe we can do better, and now is the time to start." With "connecting care" becoming one of the commission's pillars of healthcare reform, reforming primary care became one of crucial building blocks for Australia's vision for enhanced healthcare.

Dr. Steve Hambleton, President of the Australian Medical Association, noted that with primary care established as a policy priority, public and professional engagement then became another key driver behind the new strategic framework that was developed by the Health and Hospital Reform Commission. This created a context in which the Prime Minister could talk directly with hospitals, as healthcare reform became a critical issue. Public support was complemented by improved evidence as the implementation of activity-based funding brought about improved access to health performance data.

Ultimately, though, it was a long process of consultation and engagement of primary care stakeholder groups that led to the release of the primary care strategic framework. Federal and state governments embraced a spirit of cooperation and a wealth of face-to-face stakeholder consultations led to the plan's acceptance.

The result of the plan is a map with key deliverables of a GP-led primary healthcare system that forms the bedrock of integrated care for Australia. Although endorsed by all health ministers, the framework has come under fire for not providing any new funds to implement the reforms. While cost savings should be realized in secondary care in the future, many stakeholders including the AMA argue that an injection of funding in primary care is required to enable implementation.

"Now one year old, the strategic framework has already made five key impacts," stated Michael Reid, of the National Health Performance Authority. First, it has led to localized governance, with Medicare Locals overseeing local primary care delivery and District Hospital Boards taking responsibility from the province for hospitals. These have resulted in improved local autonomy and joint planning. Second, the establishment of the National Health Performance Authority, funded by the federal government, is improving healthcare transparency, particularly with the forthcoming first report on poor performance. Third, the Independent

Dr. Justin Beilby, *Executive Dean, Faculty of Health Sciences, University of Adelaide, Australia,* ***Dr. Steve Hambleton,*** *President, Australian Medical Association,* ***Mr. Michael Reid,*** *Member, National Health Performance Authority, Principal, Michael Reid & Associates*

Dr. Richard Reznick, *Queen's University,* ***Dr. Ivy Lynn Bourgeault,*** *University of Ottawa,* ***Dr. Jesse Pasternak,*** *Canadian Association of Interns & Residents*

Hospital Pricing Authority is creating transparency in hospital spending. There is now consistent pricing for all treatments across the country, and the extension of the pricing authority into community care is driving hospitals to improved models of chronic care. Fourth, some progress has been made on e-health. The National e-Health Transition Authority is a joint federal-states initiative to develop foundations and services with national e-health capability. 1.5 million Australians have signed up for the Personally Controlled Electronic Health Record since 2012, which allows them to port their personal health record across different providers. Fifth, the Australian Commission of Safety and Quality in Health Care is a bottom-up initiative which addresses key problems in a given state, and then transfers best practices from those initiatives across the nation.

One benefit to the recent reforms has been a shift towards nationalization of licensure. Through this progress, health professionals now move easily across states. Such workforce reforms have allowed for more consistent approaches to rural/remote care delivery. Further, accreditation changes and the emphasis on general practice have meant that rural practitioners can span the primary/secondary care divide, providing general care as well as certain types of specialist care such as emergency or obstetric.

In terms of governance, Australia is able to establish and abolish arms-length bodies as needed because they are set up under commonwealth legislation. Canada might not share this legal framework. With the right oversight bodies in place, Australia has been able to focus on what it views as the central issue in healthcare reform: effective workforce planning.

A PERSPECTIVE FROM ENGLAND

Professor Chris Ham of The King's Fund argued that citizens in both Canada and Britain place a high value on their healthcare systems. The performance of the National Health Service (NHS) had improved greatly as a result of investment and reform since 2000, but is now under pressure because of flat budgets for the last 4 years. The Commonwealth Fund's international comparisons had shown the NHS to be second only to the healthcare system in the Netherlands when assessed on various criteria. He recalled advising health ministers in 2000 that unless investment was linked to reform then the NHS would end up like Medicare in Canada: costing a lot more, but with persistent problems of access and quality of care.

Reform in England had been driven by a combination of targets and performance management, inspection and regulation, and competition and choice. All three of these approaches had been used by successive governments, which had placed increasing pressure on the NHS in the quest to improve care. Evidence showed that both inspection and regulation and competition and choice within the NHS had had limited impact. Targets and performance management, however, had made a bigger impact, contributing to shorter waiting times for treatment and improvements in areas of clinical priority such as cancer and cardiac care. There had also been negative effects, including evidence in some organizations of gaming and misreporting of performance data. Mandating reform through top down directives could also be disempowering.

The view of The King's Fund is that complementary approaches to reform, combining top down and bottom up, hierarchies and networks, collaboration and competition, and innovation and standardization are needed. The transformation of the Veterans Health Administration in the 1990s showed the positive impact that complementary approaches can have. The challenge this presents is that using such approaches is very demanding of system stewards like health ministers who often have little experience with leading large scale change.

Leaders of hospitals and other healthcare organizations need time and persistence to bring about sustainable improvements in performance and these are often lacking. Policy and politics work on different cycles, meaning that short-term initiatives make it difficult to stick to long-term improvement

Dr. Brett Skinner, *Executive Director of Health and Economic Policy, Rx&D*

Dr. Mark Britnell, *Chairman & Partner, Global Health Practice, KPMG, UK,* ***Professor Chris Ham,*** *Chief Executive, The King's Fund, UK*

programmes. This is compounded by the neglect of leadership development and investment in quality improvement skills. Reforms at the national and provincial levels need to address this neglect and help to strengthen care at the front line by placing greater focus on clinical microsystems than has often been the case.

BUILDING STRATEGIC CHANGE IN CANADIAN HEALTHCARE

Having looked to international examples of strategies for healthcare reform, the conference turned to the Canadian question. 2013's conference, *Toward a Canadian Healthcare Strategy,* identified four key areas in need of pan-Canadian collaboration: pharmacare, health human resources, electronic health records and integrated care.

For each of these topics, an interdisciplinary panel sought to answer three questions:

1. What is the justification for this strategy?
2. What could such a strategy contain?
3. How might we move this strategy forward?

Pharmacare Panel

Pharmacare panel moderator Dr. Roger Deeley, Vice-Dean, Research at Queen's University Faculty of Health Sciences, introduced the panel noting that the need for a Canadian-wide drug policy has been talked about for 50 years and yet little has happened. Dr. Chris Simpson, President-elect of the Canadian Medical Association and Chief of Cardiology at Queen's University reiterated the need for a national policy, noting that the lack of adequate pharmacare is behind medical non-compliance for many of his patients. Thus, a mother with heart failure has fluid on her lungs because her prescription is not filled, or a trucker cannot take the best evidence-based drugs for his condition because he cannot afford it, leaving the physician to prioritize which drugs the patient should take. He cites access to prescription drugs as "the unfinished business of healthcare." In Canada today, one in five households do not have supplementary healthcare coverage.

Dr. Colleen M. Flood, Professor & Canada Research Chair at the University of Toronto, Faculty of Law concurred, noting the growing evidence indicating lower socioeconomic classes have worse health outcomes, such as increased stroke-related deaths. The difference between income groups disappears beyond age 65, however, a result of existing pharmacare programs for seniors. What remains, though, is a gap between those who have private insurance, some groups on welfare who receive government assistance, and those left in the middle. Recently, there have been some efforts to address this. Quebec has implemented a universal model, but at great financial cost. To move action forward, policymakers need to assess the range of private/public models that could be used to realize pharmacare in Canada. For governments, though, the primary focus needs to be on equitable access for all Canadians.

Brett Skinner, Executive Director of Policy for trade association Rx&D identified innovation in pharmaceuticals as a key issue to address. While innovative drugs are often the best treatment, they come at a cost. While pharmacare needs to be financially viable, insurance reform needs to ensure access to the best prescription. Pharmacare, then, needs to look at delivering value to patients. Canadian Life and Health Insurance Association Vice-President Stephen Frank also highlighted how, in Canada, a challenge remains in its fragmented nature, with each province building its own insurance and formulary policies. Industry partners would like to have an opportunity to dialogue with governments and building one centralized system would better enable such a forum.

Dr. Justin Beilby, *Executive Dean, Faculty of Health Sciences, University of Adelaide, Australia,*
Mr. Michael Reid, *Member, National Health Performance Authority, Principal, Michael Reid & Associates*

Janet M. Davidson, *Deputy Minister, Alberta Health*

New opportunities can be created, but this can only be achieved by moving beyond a siloed approach, contended Shoppers Drug Mart Senior Vice President, Professional Affairs & Services, Jeannette Wang. With community pharmacists playing an increased role in providing patient care, we could provide better treatment for those living with chronic conditions, especially as pharmacy networks extend to almost all communities across the country. In Canada, we have world-class drug safety and distribution, but patchwork coverage remains as a challenge. A major roadblock to reform remains in access to accurate patient and outcomes data.

Putting the focus on patients, Deborah Maskens, Director of Medical Relations for Kidney Cancer Canada, argued that universal prescription coverage is urgently needed. Patients dependent upon the public drug plan might find a drug is available in another province, but not where they live. Many patients with private coverage find an annual cap (e.g., $2000) does not come close to meeting their needs for costly new cancer medications that can cost thousands each month. Co-pays and deductibles are causing significant financial difficulty. The result is that some patients turn to less than optimal therapies and others manage costs by skipping doses. Noted Professor Flood, "research suggests that as many as 5,000 deaths and nearly 2,700 heart attacks or strokes could have been avoided among younger and middle-aged adults with diabetes in Ontario if they had prescription drug insurance coverage." If wide-scale reform will take time, policymakers need to think collaboratively to implement some solutions immediately.

Rod Barr, *President and CEO, CPA Ontario*

Dr. Michael Green, *Associate Professor in the Departments of Family Medicine and Community Health and Epidemiology, Queen's University*

In discussions with conference delegates in the audience, the case of Canadian Blood Services (CBS) emerged as a best practice. Graham Sher, CEO of CBS, discussed how his organization buys and distributes $500m of drugs for patients with hemophilia and a range of other blood diseases that require expensive drugs. They provide universal access while also offering patient choice, in part by involving patients on decision panels. They are funded collectively by the provinces, yet act at a national level, providing an example of how national pharmacare could be implemented in Canada.

The panel and conference participants discussed further how pharmacare needs to be understood in the context of the broader healthcare system. Investments in pharmaceuticals can realize efficiencies elsewhere in the system. Further, enabling patient choice and maintaining a diversity of choice should be seen as a strength of an effective system.

Diverse opinions exist on first steps, though. While some support quick, incremental solutions, others argue these would be "band-aids" which don't heal the underlying problem: lack of access. A coherent system is one that provides adequate coverage for all Canadians. This could be implemented in one of several modes, each of which might be agreeable to political parties of different stripes. Catastrophic coverage exists in Ontario for expenses beyond 4% of household income, now we need to address the difference. Dr. Simpson argued, however, that catastrophic coverage is not enough because for many patients any out-of-pocket costs will act as a disincentive for them to pursue evidence-based treatment.

One suggestion was to shift the focus from cost reductions to effective care. If pharmaceutical coverage enables optimal patient care, it can reduce the burden of unnecessary acute care needs. Viewed through this lens, the provinces can move away from a zero-sum game of allocating finite resources, towards working collaboratively to find ways to manage best care. To that end, new reforms in Quebec and New Brunswick are innovating the role of the private sector in pharmacare; a debate ensued about the possibilities for moving forward using these models, and there were differing views as to the prospects of this working and the relative merits of this kind of approach relative to a single-payer approach. Next steps need to build collaboration across provinces to share innovations and create a role for the federal government and industry to join the existing stakeholders at the table.

ATKearney Panel on Electronic Health Records

Dr. Francis Lau, Professor at the University of Victoria's School of Health Information Science, opened the discussion of a Canadian electronic health records (EHR) strategy by presenting his e-Health Value Framework for Clinical Adoption and Meaningful Use, which was recently proposed in a discussion paper to Health Canada:

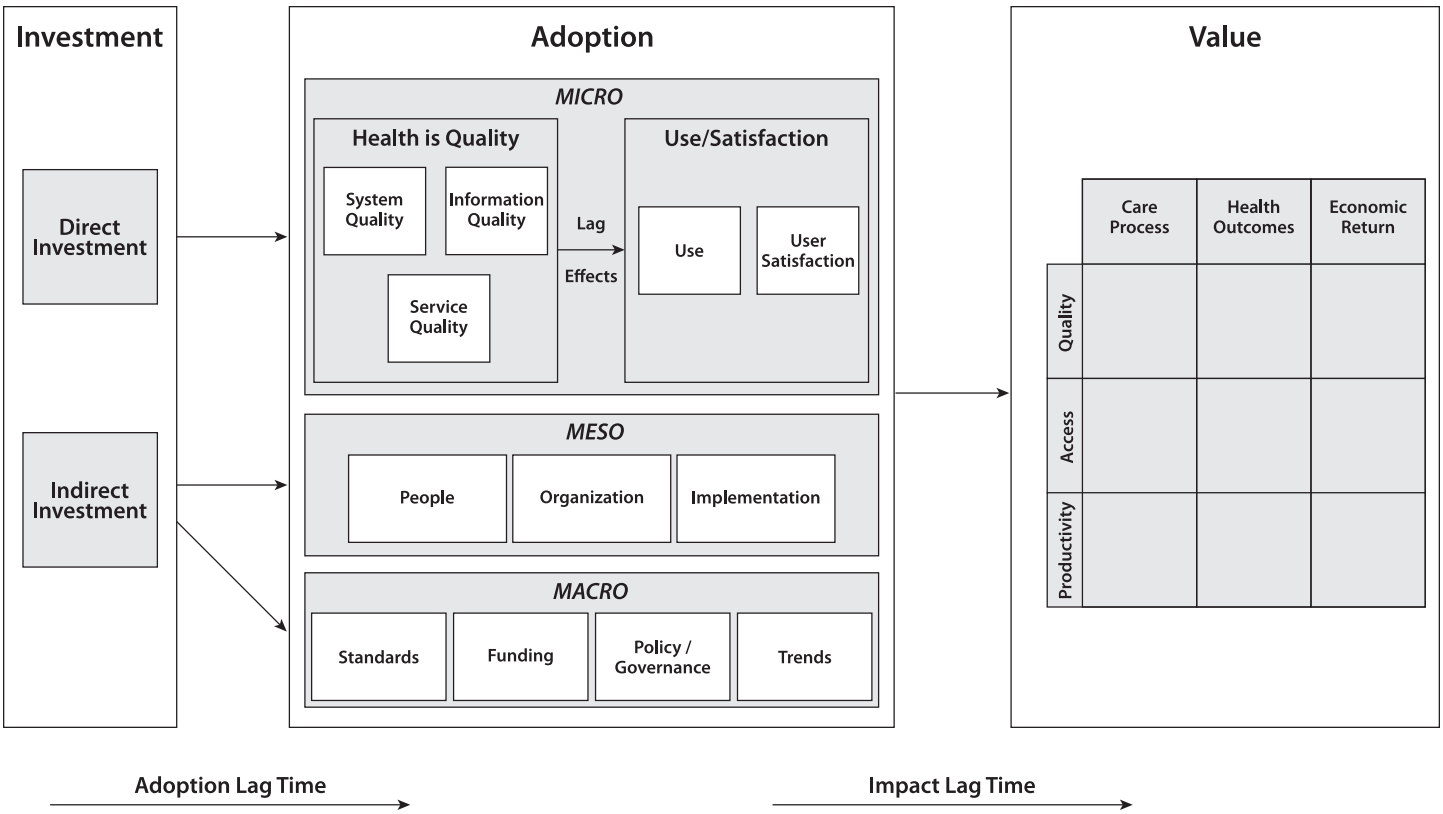

Exhibit 1 - The eHealth Value Framework for Clinical Adoption and Meaningful Use
Source: eHealth Observatory, 2014.

This model takes a comprehensive approach, addressing micro factors (e.g., system performance and quality of data), meso (organizational) factors like people, strategy, structure, process and culture, as well as macro factors, including technical, professional and performance standards, and broader social and political trends. This leads to a 3x3 matrix with which policymakers can assess the value of EHR investments. Duncan Sinclair, Professor Emeritus at Queen's University questioned whether macro factors should be the first consideration; however, the framework is designed as an iterative process. While it might be tempting to work from policy goals first, in general it is difficult to predict technological innovations, so technology can drive policy and vice versa.

Canada Health Infoway CEO Richard Alvarez argued that the ultimate challenge for realizing value in EHRs is pushing adoption, to which Steve Hambleton highlighted the challenges Australia has faced on this front by implementing an opt-in model. The major benefits to be realized from EHRs will come from using them not only for administrative use, but more so for clinical use. Telehealth is now an established mode of delivery, where Canada leads the world. Much progress has been made in EMR's community physician setting, however Canada still lags behind countries like Australia and New Zealand. He thus identified five areas where technology can move forward in Canadian healthcare: bringing care into the home, improving the patient experience, supporting new models of care through enabling multidisciplinary teams, improving patient safety and allowing for better understanding of health through big data analysis.

Drawing from his experience with family physicians through Canadian Primary Care Sentinel Surveillance Network (CPCSSN), Queen's University's Dr. Richard Birtwhistle discussed how Kaiser Permanente in the U.S. has used technology to enable remote patient care. In Canada today, three provinces – Ontario, Alberta and B.C. – have now created a fee schedule for e-consultations, but uptake remains slow. Mitchell Fagan, Vice-Chair of the Langley Division of Family Practice, noted how, although e-consultations are now being used, particularly in rural B.C., it is still critical to find ways to establish the doctor-patient relationship.

As raised in Dr. Scott Carson's conference white paper, it is critical to measure performance if healthcare reform is to be driven forward. Scott Murray, Chief Technology Officer with the Canadian Institute of Health Information, stressed this point, but identified standardization of data as a major barrier. EHRs require physicians to enter data, but global examples show they are reluctant to use standardized codes. The onus thus falls on technology providers to integrate coding into the back end, creating a user-friendly portal for physicians which accurately converts free-entry data into usable information. In Germany, however, there are examples of doctors coding data because the right combination of micro, meso, and macro factors as described in Dr. Lau's model were in place to support the effective implementation. The ability to access standardized data, reminded Dr. Birtwhistle, is radically improving disease surveillance. The benefits are realized less for an individual patient, and more in how healthcare providers understand populations.

The panel was challenged to consider the difference between electronic medical records, which deal specifically with physician data, and electronic health records, which would include information from a range of healthcare providers. Canada has made progress on the former, but has not gone far to engage a variety of professions towards the latter. To that end, Dr. Michael Guerriere, Chief Medical Officer with TELUS Health, highlighted how, as a private sector firm, they look at the issue from a consumer standpoint. TELUS recently introduced a consumer portal that enables customers to interact with their pharmacists to better manage their medications and order refills. Adoption has been rapid, and now has 1200 pharmacies participating and over 300,000 active users. Other emerging technologies that promise to engage consumers on a broad scale are biometrics and continuous health monitoring. Healthcare systems, however, tend to have difficulty nurturing and developing such innovations into system-wide successes.

The panel agreed that the way forward is to focus on providing value to the patient and aligning technological investment with policy priorities. Where many past initiatives have been treated as IT projects with little oversight from a policy standpoint, investments in EHRs – and e-health more broadly – need to be better understood and considered by policymakers. Developments which empower patients while protecting their privacy are ultimately the ones that will succeed.

BLG Panel on Integrated Care

The fourth strategic priority discussed at the conference – integrated care – is a challenge to which the former Health Council of Canada devoted significant energy. Past CEO John Abbott said that, while many localized models have been implemented, not much is understood about integrated care from a systems or outcomes perspective. The starting point for better integrated care, he argued, is understanding the needs of different patient groups and organizing care around those needs.

Paul Williams, Professor at the University of Toronto's Institute of Health Policy, Management and Evaluation, used the example of a regional health authority to compare the logic of disintegrated and integrated care systems. He argued for "ground up" change, which would allow community-based organizations and networks to take clinical and financial responsibility for the care of persons (including older persons as well as children and persons with disabilities) with multiple chronic health and social needs. Because of current funding arrangements, legislation, and regulations which narrowly specify what organizations can do, silos persist, care remains fragmented, and the incentive is to give people what providers can provide, rather than what they might actually need. This echoes what Walker concluded in 2011, that many older persons "default" to hospital ALC beds and residential LTC, not because it is best for them, but because the current system does not have sufficient capacity to maintain them in their homes and communities.

Richard Alvarez, *President, Canada Health Infoway*

Leslee Thompson, *CEO, Kingston General Hospital,* ***Chris Power,*** *CEO, Capital Health Authority, Halifax,* ***Dr. Janice MacKinnon,*** *Professor, School of Public Health, University of Saskatchewan,* ***John G. Abbott,*** *past CEO, Health Council of Canada,* ***John Morris,*** *Partner and National Coordinator of the Health Law Group, BLG*

It is often the financial incentives, agreed Dr. Janice MacKinnon, Professor of Public Health at the University of Saskatchewan, that contribute to such problems, and funding for Canadian healthcare is based largely on a system built in the 1960s. As costly long-term care beds fill up, there is a growing recognition that the funding model needs to change. As a hospital CEO, Capital District Health Authority's Chris Power cited the Canadian Partnership Against Cancer as an example of how progress can be made on healthcare integration. Where cancer agencies were previously fragmented, they came together in partnership with many other stakeholders, mapped out a collaborative vision and proposed a new funding model to the federal government. The change succeeded because it drew on shared agreement, was driven by many organizations, and built in clear accountability structures. Dr. MacKinnon noted how countries with better health outcomes provide broader health coverage, but also share the burden with the public through income-based medicare and co-payments.

While this proposition was controversial, there was agreement that the desire for a national strategy stems from a shared value: that all Canadians have equal access to care. This becomes challenging when integration of care is generally seen as a local issue. For Donna Segal, Chair of the South East Local Health Integration Network, her organization is implementing Ontario's healthlinks program, which is providing better integrated care for the 1-5% of the population who have the majority of healthcare issues. This population group in her community is different from frequent system users in a neighbouring region, making local solutions all the more important.

In closing, the panelists made several recommendations. First, policymakers need to ask why patients are arriving in ERs, and look to communities to generate solutions to change these results. Second, there needs to be an emphasis on health over healthcare, to address the determinants of health. Third, there needs to be coordination rather than conflict between ministries of health and social services, so that they work collaboratively. And last, healthcare professionals need to be involved in developing solutions, rather than being viewed as the enemy.

GSK Panel on Health Human Resources

Dr. David Walker, Professor of Family & Emergency Medicine, and Policy Studies at Queen's University opened the panel with Canadian medical school enrolments: graduates are increased, but Canada lags as a country in the number of physicians per capita. There is increasing use of teams, but the questions about how many and what kind of practitioners remain unanswered. Other issues are: attrition modified, delayed retirement, and increased mobility moves physician in and out of country. A confounding issue is that we have poor data, and varying conflicting data.

Dr. Ivy Lynn Bourgeault, Professor and CIHR Research Chair in Health Human Resources, University of Ottawa referred to her conference white paper on the need for a pan Canadian health human resources strategy. The issue she raised is that health policy more broadly often fails to explicitly address the importance of the health work force, in particular the implications of reforms for the workforce. Reforms to address patient wait times and improve patient flow implicates the workforce and reveals how the organization of the workforce is out of balance.

Dr. Bourgeault address three fundamental issues to move forward on a coordinated health human resource strategy. First, she clearly justified there is a need for a coordinated strategy. Second, she outlined the key elements of that strategy should not only address planning but also deployment of the health workforce. Third, she concluded which how a strategy might best be implemented.

Canada has a waxed and waned between shortage and surplus supply with little warning to health care providers, health system managers and the public. Canada has problems with geography and distribution of health human

Dr. Michael Green, *Queen's University,* ***Dr. Michael Guerriere,*** *Vice President Transformation Services and Chief Medical Officer, Telus Health,* ***Richard Alvarez,*** *President, Canada Health Infoway,* ***Scott Murray,*** *Chief Technology Officer, Canadian Institute for Health Information*

Dr. Daniel R. Woolf, *Queen's University,* ***Dr. Scott Carson,*** *Queen's School of Business,* ***Dr. David Dodge,*** *Chancellor, Queen's University*

Chris Paddison, *Partner, Healthcare Practice, AT Kearney*

Jim Flett, *Chief Operating Officer, Kingston General Hospital*

Dr. David Saunders, *Dean, Queen's School of Business*

resources, and the lack of integration with its education system that prepares and deploy them. Questions for Canada are "how many health workers do we need, how to deploy them, and what is the different mix that we need?" Overall, a health workforce strategy would need to address the three key health workforce policy problems which are supply, mix, and distribution.

Dr. Bourgeault concluded that the best way to move strategy forward from the 2005 success depends on commitment from all involved to a more collaborative approach. She drew insights from Australia where there have been successful attempts to link health workforce needs and deployment through the national Health Work Force Australia agency. In Canada, the lack of appropriate stakeholder engagement, resources, flexibility, and accountability caused the log jam in the commitment from 2005. The substance of a health human resources strategy would be to bring together existing organizations in a much more coordinated fashion.Questions for Canada are: "how many doctors, how to deploy them, and what is the different mix that we need?" The substance of a health human resources strategy would be to bring together existing organizations in a much more coordinated fashion. Dr. Bourgeault concluded that the best way to move a strategy forward from the 2005 success depends on commitment from all involved to a more collaborative approach. Lack of appropriate stakeholder engagement, resources, flexibility, and accountability caused the log jam in the commitment from 2005.

Sandra MacDonald-Rencz, Nursing Executive & Acting Senior Director, Health Human Resources Policy Division, Health Canada, reported that there are many players on many levels involved with health human resources. While Health Canada can fund the research into health human resources, the provinces have much more control around the funding of healthcare. Current health human resources data is not as strong as it should be, but there have been advancements. Macdonald-Rencz hopes that Canada will be able to move to a national dataset and receive funding to the Canadian Institute for Health Information.

Health Canada is looking to develop a needs based planning framework and the need for integrated planning. In Canada, we need strong partnerships and liaison so that we can support and complement one another. The future in healthcare is working together as a team, and moving from a professional perspective to an inter-professional perspective.

Danielle Frechette, Executive Director, Office of Health Systems Innovation and External Relations, Royal College of Physicians and Surgeons of Canada, reported that high intensive, high research are the disciplines where doctors cannot find work, for example, in nuclear medicine, opthomology, neurosurgery, etc. These disciplines are costly and healthcare is accelerating the same way it was in the 1990s, where demand for these disciplines has been slowing in terms of reduced operating room times (because that is how hospital budgets are reduced). The gold standard in healthcare is in inter-professional practice; there is compelling evidence that when providers work in teams, cross impact results.

Professor Chris Ham, *Chief Executive, The King's Fund, UK*

Dr. Tom Noseworthy, *Associate Chief Medical Officer, Strategic Clinical Networks, Alberta Health Services*

Jim Flett, *Chief Operating Officer, Kingston General Hospital,* ***Jeannette Wang,*** *Senior Vice President, Professional Affairs & Services, Shoppers Drug Mart,* ***Dr. Janice MacKinnon,*** *Professor, School of Public Health, University of Saskatchewan*

Canada has been reducing the need for the number of physicians, but where we have systems that do not work that well, the resident is still covering that service, therefore improved collaborative planning is needed. With respect to personal preferences of job seekers, practitioners go into practice where they have families and where they can find work. The problem is that a region might not have a nearby elementary school.

Frechette asked if we should care about unemployed doctors. Canada currently spends hundreds of thousands to train a doctor, however wait times are still high. She questioned whether Canada should train as many physicians when the resources for them to practice are scarce; federal leadership is required.

Jesse Pasternack, Health Human Resources Committee Chair, Canadian Association of Interns and Residents, has heard many people who want a surgeon in small communities, however there are also no jobs there. There are many ways even before medical school where physicians-to-be form opinions of what they want to do. When residents were asked if they will practice in inner city underserved areas, two thirds of residents responded that they would be happy doing that. In a rural/community setting more than half said they would practice there, of those >75% were family residents and 25% were specialists. A third of family physician residents would work in remote areas.

In all surgical specialties, 85% of residents were not confident in finding employment, while 85% in family medicine were. Twenty percent of specialists responded that they would go to the U.S.

Pasternak concluded that the over-arching idea is that residents want to go into specialities where they will find services for Canadians, the universities make residency spots accordingly, and they are allocated at the university level. Trainees are flexible and can work with the government on a national strategy.

Dr. Richard Reznick, Dean, Faculty of Health Sciences, Queen's University, spoke to three topics: politics, paradoxes and understanding the changing profession. He argued that on the topic of health human resources, there is a paucity of comprehensive national data and Canada lacks a coordinated national approach to HHR planning. The situation is further complicated by the fact that there are five to six thousand Canadian students. Dr. Reznick cautioned that we have had a roller coaster approach to HHR issues, and referred to the most famous report (Barer Stoddart) from the 1990s, which purported that Canada, at the time, had too many physicians, which led to the closing of 10% of medical seats. HHR planning is complex, and, for example, the Barer Stoddart report did not adequately take into account the sea change in practice patterns that were about to occur over the ensuing decades.

Dr. Reznick also talked about the paradox that recent reports have suggested we have physician underemployment, but that we still have a massive problem with wait times. Another paradox is the discord between Canadian (anecdotal)

Rod Barr, *President and CEO, CPA Ontario,* ***Dr. Justin Beilby,*** *Executive Dean, Faculty of Health Sciences, University of Adelaide, Australia,* ***Mr. Michael Reid,*** *Member, National Health Performance Authority, Principal, Michael Reid & Associates*

data, and current projections in the U.S. which show a significant impending shortage of physicians in that country.

With respect to the politics of the issue, Dr. Reznick reminded attendees of just how profound a crisis we have had in the past with lack of physician manpower. For example, not that long ago, a starting Nova Scotia physician had to run a lottery to see which patients she would accept into her practice. He opined that we are currently in a time of financial constraint, and cautioned that knee jerk reaction to reports, such as the recent one from the Royal College, could lead to disastrous consequences. He also referred to impending changes in scopes of practice amongst the professions which will impact greatly on future HHR needs. He argued strenuously for the need to use comprehensive data, accrued nationally, and work towards a thoughtful national strategy. In economic difficulties, politicians are looking to grasp at straws to save money, rather than looking at it from a systems perspective. Canada still ranks amongst the worst for wait times in OECD provinces.

There is a need to understand the changing profession: the blurring of job descriptions between nurse practitioners and doctors, physician assistants were not in the medical lexicon 10 years ago, but it has to be adequately resourced.

George Thompson asked if anyone has done this health human resources planning, or should we be pessimistic? The Australian model that worked across provinces and territories was arms-length and decisional modelling.

Danielle Frechette responded that a national agency could really collaborate, and test and connect data, to help build that strong evidence base that is needed. Other countries are not federated. There are a number of provinces that have begun to invest, some more than others.

IMPLEMENTING STRATEGIC CHANGE IN CANADIAN HEALTHCARE

Keynote Address: A Strategy for Integrated Care in Canada

Alberta Health Deputy Minister Janet Davidson turned the discussion to matters of implementation, challenging, 'If we can get healthcare transformation in Canada right, we will be global leaders." At the heart of effective reform, she argued, will be the right regulatory environment.

Alberta is making great strides towards better integrated care, part of which involves addressing the social determinants of health and connecting healthcare with other social services. A new addiction and mental health strategy, for example, seeks to find housing for those struggling with mental illness. Elsewhere, the wellness strategy provides specific strategies for families, employees, and children, helping different population groups think about healthy living. All of this ties into the province's economic strategy, in which services are integrated to support healthy, productive people.

In traditional healthcare delivery, integrated care is being rolled out in priority areas such as cancer care and primary care. For primary care, the emphasis is on enhanced delivery of care, whereby each Albertan has a "health home," leading the culture change in which patients take an active role in their care, and establishing the building blocks required to bring about the change including the right compensation models and frameworks to support team-based care. Part of the strategy also allows patients to see some specialists without first seeing their family physician, and other specialists – e.g., pharmacists, optometrists – expanding their scope of practice.

Integrated care, however, represents a sea change in the way healthcare is delivered in Alberta, Canada and around the world. Success, then, hinges on effective change management. A patient-based model depends on public support, and politicians have benefited from the issue moving into public forums. Further, Alberta has, for many healthcare professionals, been in a constant state of change for several years. While Ms. Davidson opined that "the new norm is constant change," she also recognized that the province is finding a new equilibrium following the 2008 shift from regional authorities to one central group. While change can be difficult, professional groups must work together to provide the best possible care for the most important people in healthcare: patients.

MICROSOFT PANEL: REDESIGNING CANADIAN HEALTHCARE FOR THE AGE OF COMPLEX CARE

In building a strategy to provide better integrated care, there is increasing recognition that patients with complex co-morbidities require a different form of care than the average Canadian. Microsoft Health Solutions Group Chief Architect Sean Nolan challenged the audience to seek ways to change patient behaviours. "We've taught our citizenry they don't need to take part in their own care: go to the hospital and let the doctor 'do their thing'… but how can we enable our citizenry?" The solution lies in redesigning care.

Dr. Walter Wodchis, Associate Professor at the University of Toronto's Institute of Health Policy, Management and Evaluation, presented research on high cost users in Ontario. He found that of the 5% of patients who use the most healthcare resources, 46% of that group remain in that class in the following year, suggesting there is a persistence amongst high-usage patients. Likewise, of the 50% of patients who are the lowest users of the healthcare system, only 1% move into the high usage category. The problem is that too often these persistent high-usage patients are treated using acute care because an integrated model targeted to their needs does not exist. While they might enter the system because of an acute incident, such as myocardial infarction, such events belie a more serious chronic condition.

Wodchis thus advocates several steps for developing a new approach to their care. First, refocus efforts to address patients' adverse events and iatrogenic illness. Second, develop models which identify and address chronic co-morbidities and palliative care for patients who appear in the system as "unplanned medical admissions." Third, build integrated pathways for elective surgeries. And, fourth, provide new approaches to mental health.

Marc Seaman, *National Director, Corporate and Public Affairs, Microsoft*

Drawing on his experience as an educator at the University of Calgary and as Associate Chief Medical Officer with Alberta Health Services, Dr. Tom Noseworthy identified new trends in addressing complex needs patients. Alberta Health has used cluster analyses to identify such patients and has found that the top 5% of healthcare users account for 66% of system resources. While some of these patients are, as expected, older patients with complex co-morbidities and the frail elderly, there are other patient groups to consider as well, including high needs children and youth, complex infants, and adults with reproductive health issues. While new care pathways as discussed above will help, they are insufficient on their own. Rather, models for developing targeted, individualized care plans are the best way forward. It is here that technology can help, reminded Sean Nolan. The ability to look at patients through a customer lens, each with their own unique needs, and to use technology to identify said needs and build specialized models of care for each case creates new opportunities for treating complex patients. By changing the culture, however, and engaging patients in their own care, even larger steps can be taken to transform the care of high-volume healthcare users.

DISCUSSION PANEL: DRIVING CHANGE FORWARD

As noted throughout the conference, healthcare strategies cannot be implemented without leadership from the worlds of policy and politics, and yet making such reforms can be as monumentally challenging as changing the organizational cultures of healthcare practitioners. Don Drummond, Matthews Fellow in Global Public Policy at Queen's University, highlighted the role of forums like the Queen's Health Policy Change Conference Series which, while not making change directly, can provide politicians with a clear vision of healthcare reform priorities. In Canada, however, the hope of a political champion for healthcare reform seems slight at best. Other paths to policy reform thus need to be sought.

In the absence of federal leadership, then, Drummond suggests healthcare stakeholders support the development of several pre-conditions for political change in Canada: a clear definition of the problem, a solid body of analysis, a clear set of end objectives for reform, and understanding of international best practices and workable models, a clear voice from stakeholders which reaches the general public, practitioners who are prepared for reform by working on continuous, incremental change, and a proactive bureaucracy. Already, the Queen's Health Policy Change Conference Series has worked to achieve many of these goals, identifying workable strategies which could be amenable to parties of different stripes depending on their given form.

As McGill University Political Scientist Dr. Antonia Maioni queried, though, "Why if we have an obsession with healthcare as part of the Canadian identity, is there nothing about healthcare in the Canadian policy environment?" Indeed, compared to the Australian and British examples, Canadian public debate is largely silent on the realities facing healthcare sustainability. Canada has a world-class healthcare system, but it has grown expensive and underperforms when assessed in terms of cost-quality ratios. The major challenge is that Canada lacks any formal structures to evaluate healthcare delivery, forecast future needs, or implement policy for the emerging state of Canadian health.

While Canada's decentralized model allows for decision-making close to the people, it also creates blinders to what is working or failing elsewhere in the country. To drive forward a Canadian healthcare strategy, governments and stakeholders need to find a common purpose, something that could likely be found around, first, the concept of healthcare as an investment rather than an expense, and, second, our shared need for information. Working across jurisdictions can create new and better opportunities for the gathering and sharing of health sector information. Sadly, she reminded, Quebec is often used, "as a whipping post for what doesn't get done," but this is a poor excuse. A Canadian healthcare strategy could allow asymmetry so long as there is a shared larger vision enabled by stakeholders laying aside some of the traditional claims to work with others towards the bigger goal.

The critical role of information was further reinforced by Johnson-Shoyama School of Public Policy Professor, Dr. Greg Marchildon. Where other nations have high-performing think tanks and evaluation bodies, Canada lacks both. No think tank in Canada is dedicated solely to health system performance, and what evaluation bodies exist are either not at arm's length from government or they lack the power to hold delivery bodies accountable to the outcomes they measure. Academics, he argues, could step up and act as a measurement and evaluation network akin to the WHO's European Observatory on Health Systems and Policies.

The challenge remains in building a shared vision across the provinces, especially as healthcare is one arena where the provinces can essentially act as independent states. Working collaboratively would mean relinquishing some of this autonomy. Maureen O'Neil, CEO of the Canadian Foundation for Health Improvement, reminded the delegates of the many innovations happening in regions across Canada. Investment is needed to help these ideas spread nationwide.

Again, given that six provinces have now set up clinical evaluation institutes akin to the UK's NICE, there is an opportunity for data measurement and sharing to provide the first step to pan-Canadian collaboration. Dr. Marchildon noted how such evaluation is often quite effective for small incremental reforms, but can be difficult to implement in the context of large "big bang" changes. In closing, Queen's University's Centre for Health Services and Policy Research Director, Dr. Michael Green, contended that the challenge now becomes determining who might fund an independent think tank to drive evaluation forward.

Don Drummond, *Matthews Fellow in Public Policy, Queen's University*

Shirlee Sharkey, *President and CEO, Saint Elizabeth*

Jeannette Wang, *Senior Vice President, Professional Affairs & Services, Shoppers Drug Mart*

Professor Karsten Vrangbæk, *Professor, Poitical Science, University of Copenhagen, Denmark,* ***Lena Hellberg,*** *Senior Advisor, Ministry of Health and Social Affairs, Division for Public Health and Healthcare, Government of Sweden,* ***Dr. Norbert Schmacke,*** *Deputy Chair, [Gemeinsamer Bundesausshcuss;] Associate Fellow, Instituts für Public Health und Pflegeforschung, Germany*

Dr. Norbert Schmacke, *Deputy Chair, [Gemeinsamer Bundesausshcuss;] Associate Fellow, Instituts für Public Health und Pflegeforschung, Germany*

SHOPPERS DRUG MART PANEL: DRIVING CHANGE THROUGH COOPERATION

The final panel looked at how, in the absence of strong government leadership, healthcare stakeholders might begin to cross traditional boundaries to move towards a healthcare strategy. Canadian Nursing Association CEO, Anne Sutherland Boal, quickly identified how she disagrees with the frequent refrain that "doctors are the problem." Instead, she contended, "nurses and doctors have a lot in common, and together we have a lot of tools to address population health challenges." The way forward would be, as stakeholders, to agree to work on a small range of key issues such as population health and palliative/end-of-life care.

Dr. Chris Simpson, President-elect with the Canadian Medical Association, noted that while such national associations do not operate on the same level as the provincial governments who deliver healthcare, the national associations can be primary vehicles for setting the vision and communicating it through their provincial partners. Mike Brennan, CEO of the Canadian Physiotherapy Association agreed, citing how each national organization has board members from each province or, as in his own case, oversight for the provincial agencies. Looking ahead, he said, a culture of entrepreneurship is the best way forward. If the professions can embrace innovation, then they will be more open to models of community-based care and changed scopes of practice. The panel agreed that a spirit of creativity and invention could radically impact the way Canada approaches key priorities like seniors' care. Shirlee Sharkey, President of Saint Elizabeth Health Care asked, "are we modifying or redesigning the system?" She contended that the desired shift towards integrated care requires less thinking about formal modes like home care, and broader inspiration around "virtualizing" care. That is, how can technology and new environments for care transform existing notions of provider-patient interactions, such that care is provided and experienced in radical new ways. It is up to the professions to rethink how they deliver care and cast a renewed vision for better integrated care in Canada.

PLENARY PANEL: INTERNATIONAL PERSPECTIVES ON HEALTHCARE STRATEGIES

Dr. Norbert Schmacke, Associate Fellow, Institut für Public Health und Pflegeforschung, Bremen, Germany, described the some of the current characteristics of the German healthcare system: a self-administration / self-government system where the Ministry of Health sets general rules, while

the details are regulated by self-governing bodies. The results are a highly developed infrastructure, with almost no waiting lists in hospitals (partly due to oversupply). The problems are: integrated care is missing in an aging society, and costs (greater costs especially for hospitals and pharmaceuticals).

The Federal Joint Committee G-BA is the main decision-making body in the German healthcare system. Established in 2004 (predecessor committees date back to the 1920s), it represents physicians, hospitals, sickness funds and patients. The G-BA issues directives and guidelines on a sophisticated HTA basis, and thus determines the benefit package for hospital care, dental care, psychotherapy, quality assurance, disease management programs for chronic diseases and pharmaceuticals. The G-BA does not pay doctors, nor determine the amount paid for pharmaceuticals. The GBA is composed of a federal association of office-based doctors, federal hospitals' association, health care payers, and patients' representatives. G-BA decisions are under the legal supervision of the Ministry of Health. The challenges are that procedures and decisions about benefit assessments take too long, and in some cases coverage of new innovations are delayed. Regulation is discrepant for coverage decisions for the outpatient and hospital sector, with a privileged situation for inpatient medicine with almost no barriers for the introduction of any kind of innovation.

Dr. Divya Srivastava, Health Economist, OECD, reported that OECD looked to compare countries on healthcare systems. Canadians think healthcare is very good, however Canada has high health spending relative to the OACD average. There is no one efficient health system. If you hold spending constant how much could you gain on life expectancy? You can gain 2-3 years so the overall conclusion is that no one country stands out.

France launched substantial payment reform to motivate GPs, who are a strong lobby group. France looked at three things: vaccination, DM, and generic prescribing. GPs got an extra salary, but no penalty though, and no public reporting. GPs make more money now nationwide, and the body in charge of this scheme has decided to expand this to other specialties. Evidence for payment reform has mixed data. For the most part the problem is that there is no sense of what is happening to cost. Evaluation was not embedded into the process.

Korea had a number of social health insurers, however the administration cost was too high so they went with one, a social health insurance fund, with successful implementation. They now have the best health data amongst OECD countries. Hospitals were given rewards to decrease targets. There are also penalties, however none have been handed out yet. Korea did spend a lot of money to look into reform for physicians who were given incentives. In Holland, there is reform for chronic conditions as these are the high cost patients. Even though there has been more coordination in care, the size of the care is substantial. There has been some success, but more so in Parkinsons. GPs were hardly involved, as patients could share health information.

Lena Hellberg of Ministry of Health and Social Affairs Sweden presented on "National Coordinators – an Example of Non-traditional Forms of Central Government Steering." The organization of healthcare in Sweden is comprised of three political and administrative levels: national, regional, and municipal. Interestingly, the 300 municipalities are responsible for domestic care of the elderly and disabled.

Good healthcare exists on equal terms for the entire system. A number of government agencies help supervise, monitor and evaluate. The regional level ensures that all citizens have access to good healthcare, while the shape and structure of that healthcare is according to local conditions due to the Swedish principal of local government. Since 2006, there has been open comparison in health public reports regarding how they perform and what is good and bad, and this has been a successful way to work in Sweden.

Michael Brennan, *CEO, Canadian Physiotherapy Association,* ***Anne Sutherland Boal,*** *Chief Executive Officer, Canadian Nurses Association,* ***Dr. Chris Simpson,*** *Chief of Cardiology, Queen's University and President-elect, Canadian Medical Association,* ***Shirlee Sharkey,*** *President and CEO, Saint Elizabeth*

Sandra Macdonald-Rencz, *Nursing Executive & Acting Senior Director, Health Human Resources Policy Division, Health Canada*

Walter Robinson, *Vice President, Government Affairs, Rx&D*

Scott Graham, *Chair of the Board, Canada Health Infoway,* ***Janet Knox,*** *President and CEO, Annapolis Valley District Health Authority*

Dr. David Dodge, *Chancellor, Queen's University,* ***Dr. Daniel Woolf,*** *Principal and Vice-Chancellor, Queen's University*

Currently, national coordinators have been created to move from words to action and get stakeholders on board in the implementation work. The National Coordinator is appointed by government and operates outside agency structures. Since 2006, there have been about 34 national coordinators. Four of the national coordinators have been: i) efficient use of resources in health care, ii) freedom of choice provider, iii) improved care for people with chronic illnesses, and iv) the most ill/elderly (they should be able to grow old with security and access to good care).

The freedom of choice provider model was introduced in 2008. The strategy for the 'improved care for people with chronic illness' coordinator is: i) patient centeredness and patient participation, ii) implementation of clinical guidelines through improvement actions, and iii) prevention and early detection. In 2014, $70,000,000 will be invested in the issue for patients with chronic illnesses.

Professor Kasten Vrangbeak, Political Science, University of Copenhagen, reported that a few years ago there was structural reform in healthcare in Denmark. Denmark is comparable to the Canadian provincial level in terms of size, however Denmark's wealth is comparable to Canada's GDP. Denmark's small size makes integration of healthcare easier to deal with. The major reform of the government structure in 2007 created smaller municipalities to strengthen the individual power for each. Long-term care for chronic diseases will be increasingly important and municipalities are now better enabled to restructure the hospital system. In Canada it may not be possible to do this kind of amalgamation. Denmark's current macro trends are: demographic transition necessitates a stronger emphasis on services for the elderly, chronic care, and multi-morbidity. There is a strong belief in benefits of scale in specialized healthcare. Denmark's situation is similar to Canada in that there is no clear platform documenting the flaws and shortcomings of the healthcare system. There is a need, however, to develop a geographic strategy for more sustainable healthcare practices.

CPA KEYNOTE ADDRESS

With change management and, particularly, vision setting as the major priority for developing a Canadian healthcare strategy, Rick Waugh, past President and CEO of the Bank of Nova Scotia, provided a closing keynote address, eliciting lessons from his banking career. While banking and healthcare operate in different worlds, they share a key commonality: the need to manage complexity and change. He argued, too, that healthcare remains a major priority for private sector firms because effective healthcare results in healthy, productive employees.

Mr. Waugh focused on five key lessons on change from his leadership at Scotiabank. First, he reminded that major projects always underestimate costs and timelines; however, they also usually overestimate the results. For healthcare, then, although shifting towards better integrated care is a monumental task, the results for Canadians cannot yet be conceived. To overcome the daunting nature of these hurdles, "big changes should be evolutionary and not revolutionary," he stated. Second, the key to getting desired results is building in the right incentives, a point that was driven home throughout the conference. Third, to move change forward, leaders must set out their expectations and establish clear accountability frameworks to get the results they hope to realize. Champions at every level of the system are critical to drive performance. Fourth, he warned against an overreliance on measuring all risks and possibilities. While data and statistics are important, there are many elements of change processes, particularly the behavioural aspects, which will be hindered rather than aided by data. Last, he contended that collaboration and communication are key to enacting change. When communication fails, leaders must be willing to take responsibility, admit where they went wrong, and correct their course of action to maintain cooperative energy.

Richard Waugh, *past President and CEO, Bank of Nova Scotia*

Reiterating themes drawn out in the discussions of EHRs, Mr. Waugh also noted the important role of technology. In his view, technology is a strategic tool which should not be viewed from a technical standpoint. It is equally important for a Chief Information Officer, then, to understand the business as well as understand technical details. In healthcare, too, the desire for technical innovation must be driven by the greater good.

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