# Rushing the Value Cockpit

COMMENTARY

*Peter W. Vaughan,* CD, MA, MD, MPH
Former Deputy Minister of Health and Health and Wellness, Nova Scotia
Halifax, NS



ABSTRACT

*The 2015 merger of health authorities in Nova Scotia was aggressive in pursuit of greater value. The goal was to create an integrated, accountable care network across the entire province. Years of pent-up frustration, death by a thousand cuts, declining service and growing expectations merged into a slow, insidious bleeding of support for change. The lessons learned from Nova Scotia are vital to achieving a value-based health system. The article describes some of the barriers to progress and the steps needed to achieve the goal of a value-based healthcare system for Canadians.*

## Introduction

Pundits sometimes use dubious analogies like the one about change in healthcare is like trying to retrofit an airplane in the air. Heck, everyone knows that's not possible. But it is possible to change healthcare delivery if you keep your hands on the wheel and your eyes on the dials. That is, if you know your destination, focus on governance, culture, communication, co-leadership and data sharing. Maybe then you'll be ready to straighten up and fly right even as the inevitable pesky stochastic snags rush the cockpit.

A long time ago Sophocles reminded us, "One must learn by doing the thing, though you think you know it, you have no certainty until you try (Sophocles 2007: 191)."

## Background: Integration of Health Authorities in Nova Scotia

In 2015, the merger and integration of nine health authorities in Nova Scotia was a "new order of things," aggressive in pursuit of greater value.

The idea of merging health boards took off several years earlier with a promise the Nova Scotia Liberal Party made in the

run-up to a provincial election to reduce administrative waste by cutting the number of district health authorities from nine to one provincial authority (the IWK children's and women's hospital board and management would be untouched).

Nova Scotia has one of the oldest populations and some of the worst health outcomes in Canada (Statistics Canada 2015). Clearly, continuing to do the same things and expecting different results wasn't practical. It needed rejigging.

The consolidation of health authorities in 2015 embarked on an ambitious plan to expand primary care collaborative networks, strengthen regional specialty services and upgrade the highly specialized tertiary services located in Halifax and some regional sites.

The goal was to lay the foundation for continuous improvement by significantly building analytical capacity to measure health outcomes against the cost of delivering care, especially access to safe care to avoid harming patients; effective care based on levels of evidence to achieve scalability; access to care focused on individuals; efficient care that reduces waste, time, energy and supplies; and equitable care that ensures a system is in place that mitigates differences in geography and socio-economic status. In other words, to create an integrated, accountable care network across the province.

What happened was more along the lines of a slow, insidious bleeding of support for change. Years of pent-up frustration, historical death by a thousand cuts, declining service and growing expectations merged into a cauldron of bubbling impatience and mushrooming dissatisfaction.

Every business student knows strategy comes before structure. Governments, on the other hand, frequently conflate strategy and structure. So, this is where our story begins.

## Challenges Faced in the Process

Structural change gives the appearance of change. Long-standing service, staffing, quality of care and technology issues that can benefit from mergers take time, robust communication and transparent political focus.

Governments of all stripes are loath to articulate an academic sounding research-based healthcare strategy. If they do, they can be held accountable, and that is risky terrain for any politician. Most successful governments successfully avoid it.

Culture is often used to describe the morass of ill-defined dynamics that are said to eat strategy for breakfast. Culture is chthonic. It's tribal. It's rooted in the atavistic fabric of community, which often means there is more than one, and frequently at odds over differing visions of community.

One of the biggest challenges Nova Scotia had was unifying the entrenched cultures in the nine separate health authority fiefdoms, that were, after all, forced to merge.

In the multiple health authority days, competition for limited provincial resources often pitted each region against the other. Resources were doled out like royal favour with politicians clamouring to announce funding even for pedestrian things like new bedpan washers.

There are strong status quo forces at work to this day that seek to undo the merger in order to reinstitute the dominance of local politics in resource allocation.

Some argue that is a good thing. The loudest voice gets the most attention. However, in an era of limited financial resources, rapid innovation, rising demands and concerns over quality of care, the quest for value has never been greater.

Value might be measured from the economic perspective of decision-makers but when it came to front-line staff, physicians

and those struggling to meet the increasing demands for care, they wanted to know exactly how the integration would make things better for them and for the public.

The vast majority of people I spoke with on my many travels around Nova Scotia after the merger of health authorities were enthusiastic. Some people were skeptical but prepared to wait and see. They wanted to see for themselves how things would be better.

Communication, the most important and critical determinant, was also the most fractious and disorganized.

Bottom-line, there was a consequential reluctance at the political level to tell the people of the province where we were going with healthcare beyond the merger.

Escalating stories about the lack of access to primary care physicians, an issue that had been building over a decade, became the flashpoint. Lost in the media rancour was the meaning of the quest for value.

## Goal of the Health Merger

Supreme Court Justice Emmett Matthew Hall, Chair of the Royal Commission on Health Services, whose recommendations led to the creation of Medicare, said in his keynote address to the packed audience at the National Conference on Health Services in Ottawa, November 28, 1965:

"This emphasis on economic goals might make one believe that all our values are strained through the bars of the dollar sign." He went on to say that Medicare has "certain underlying unwritten assumptions so that when we come to assess the impact of policies we do so usually in economic terms."

Hall dared to "hope" that future policy makers will "make explicit the values" that "bind together the diversity which is Canada."

The goal of the health merger in Nova Scotia wasn't merely to save $5 million dollars out of a $4.2 billion dollar budget. It was to harness the collective energy of all those people working every day to make healthcare safer; to improve health outcomes. We sought to articulate one of Hall's "unwritten assumptions."

Another "unwritten assumption" in healthcare is that healthcare providers want to deliver the best care to every patient, each and every hour of the day. That's really why we go into medicine and other health-related fields. I've sat on many admissions committees and hired many people over the past 40 years. The vast majority of people show up every day to do their very best. How is it then that so many feel disenfranchised?

First, we need to re-imagine clinical governance. Clinical co-leadership is needed to address so many of the day-to-day challenges. For too long, doctors, nurses and other staff have felt disconnected from decision-making.

At a time when doctors, as leaders, were desperately needed to be part of major health system change, they were made to feel like they were collectively part of a problem, rather than part of a wider transformation of healthcare delivery that everyone had been so optimistic about when the merger began. An important initiative that was side-tracked was physician co-leadership. Co-leadership might even be one of Hall's "unwritten assumptions," one that is critical to reaching the goals of better outcomes, higher user satisfaction and reduced health spending.

The model best suited to the Canadian context is one that ties remuneration to achievement of quality metrics through a collaboration of providers and facilities that share responsibility for providing coordinated care. To do that, hospitals and care providers need to be part of a network of teams delivering coordinated care responsible for providing care in and across communities. Ideally, everyone on the team shares risk

and reward. That is, there are incentives to improve outcomes and reduce unit cost by focusing on population health, data and people.

In order to create networks of accountable care, legislative changes will be required in most jurisdictions to move away from a gatekeeper model limiting access in favour of a network of teams to deliver care using digital tools. If networks are patterns of activity in a social system (Valente 1995: 31), a digital health network is a matrix of data patterns that reflect events and needs in a community (human, technological and socio-economic) that are also unique to each community. Variability of community need is one of the acute lessons from Nova Scotia's health system integration. Modernizing health information systems is foundational, therefore, to achieving value, and to move beyond the hospital-based "wall of analytics" to community and province-wide real-time health system "air traffic control."

Regulatory changes are needed to allow for either no-fault or global liability insurance coverage across teams. The current liability insurance model encourages isolation more often referred to as "autonomy," resulting in siloed care. Recent history in Canada has seen medical malpractice insurance costs largely picked up by payers helping to drive up costs, hampering transparency for clinical quality improvement (medical error is the third leading cause of death in Canada) and inhibiting team-based shared care by having one member disproportionally "carry the can" (Nova Scotia Department of Health and Wellness 2015).

Legislation to distribute liability across teams or better no-fault insurance would significantly reduce system cost and add value to patients harmed as a result of treatment without having to resort to the intentionally high bar of tort law.

## The Most Significant Barriers to Progress

Finally, here's the really onerous part. The most significant barriers to progress are rooted in 19th-century ideas expressed in legislative structures both constitutionally and in provincial legislation governing health professions.

Some jurisdictions have begun modernizing health professional legislation (British Columbia n.d.), although there is reluctance to take on the medical liability regime. Autonomy is antithetical to effective cockpit resource management or team functioning and, therefore, the enemy of efforts to achieve a value-based model.

Legislation is needed that defines the digital health space in the same way legislation created a pan-Canadian air traffic control system. Digital health legislation would enable pan-Canadian meaningful use of data, access, advanced analytics, augmented intelligence, cybersecurity and consequences for failure and breach, as well as pan-Canadian digital health licensure and oversight agency.

One of the changes long overdue is the regulation governing access to health data and secondary use of aggregated data. Some provinces are making progress to modernize access to health data (Government of Ontario, 2019; Publications Québec 2019). Federal legislation could build on the work of jurisdictions that have begun to modernize, not only to ensure consistency and greater protection for privacy and security, and stronger consequences for breaches, but to enable the development of advanced analytic tools to create innovative pan-Canadian value-based products and services.

Imagine citizens taking control of their own healthcare enabled by secure networks of connected care starting with hospitals and virtual care providers as the foundation; hospitals incentivized to accelerate adoption

of digital technology, innovation and research, cybersecurity, with citizen access to services and data as strategic foci. Make it somebody's job. And hold them accountable, which means good governance and reporting. Define success in days, months and years. Incorporate real-time feedback and evaluation on your device of choice.

The world is witnessing the delocalization of healthcare, which means your provider might be virtual, accessible on any of your devices, which might actually achieve one of the pillars of the *Canada Health Act* – universality – and help reduce the environmental impact of unnecessary, inconvenient and expensive travel, the resulting carbon offset enough to justify the investment.

## Conclusion

A new *Canada Health Act* for the 21st century is needed to set in motion the modernization of the health industry by democratizing, de-localizing and digitizing healthcare.

Legislation is one thing, disrupting the status quo is another, because as Niccolò Machiavelli (1961: 51) reminds us, "There is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than the creation of a new order of things … Whenever his enemies have the ability to attack the innovator, they do so with the passion of partisans, while the others defend him sluggishly, so that the innovator and his party alike are vulnerable." Better fasten your seatbelt value voyageurs, a myriad of pesky stochastic snags are bent on rushing your value cockpit, too.

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