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A CANADIAN PERSPECTIVE ON OBAMACARE
WHAT CAN WE LEARN FROM U.S. HEALTH REFORM?

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Check Against Delivery
Dean Postl, Honoured Guests, Dear Friends and Colleagues,

It is a great pleasure to be back in Winnipeg tonight. It is a city I have learned to love and where I count many friends.

You won’t be surprised, but when I try to explain to people outside of Canada how rooted, how securely rooted a nation we are, I always start by talking of Winnipeg.

I don’t have the leisure to tell you the full story tonight, but you may know, for example, that it is impossible to explain how health research has been transformed to the heart in this country, twenty to fifteen years ago, without mentioning the decision made by intellectual giants such as Arnold Naimark or Henry Friesen to come back to their roots, to come back to Winnipeg.

It is a treat to be among such a group of distinguished practitioners. I want especially to congratulate the awardees. I am so impressed, so humbled.

I have spent most of my career at the edge of academic medicine. Actually, my first academic appointment was with a medical school. For all sorts of reasons, most of them quite honourable, you have a firm and consistent interest in health policy - it is my trade and like most people, I tend to be partial to those who pay attention to what I do or what I say. (Which doesn’t mean you cannot spend the next 20 minutes looking at your phone...)

What I have been asked to do tonight - telling you what we should envy and copy in the US health care system - is the equivalent of addressing an assembly of Catholic bishops to praise the virtues of freethinking or selling cheap bourbon whisky to an amateur of single-malt...

In fact, I have been trained to believe that there was nothing that can be learned from US health policy. (Incidentally, I was also taught that we should never compare American and Canadian federalism, for some undisclosed, mysterious reasons. Health
policy is not the only domain with an American taboo. This is material for a good psychoanalysis.)

During the Romanow process, in 2001-2002, there was no mention of anything American in the evidence we were presented, unless it was to remind the Commission how lucky we were to have nothing in common with the USA. Remember we commissioned forty-two original research papers and heard hundreds of presentations.

The crack in the mirror, at least for me, came with the publication in 2002-2003 of a series of important and in fact, quite stunning research papers in the BMJ, first by a group led by Sir Richard Feachem, now with UCSF, and second by Chris Ham, the current head of the King’s Fund. These iconoclastic researchers decided to compare costs and health outcomes of patients between an integrated American health care system, Kaiser Permanente in that case, and the English National Health System.

To the surprise of everyone at the time, Kaiser fared way better than the NHS on all counts, even controlling for social and health conditions. Like many other supposed experts, from all parts of the world - they had to put up a training program in Oakland, California, for the likes of me - I went to Kaiser soon after the release of the papers. It was my first deep immersion in an American innovative health care organization. I came back a different person.

Not a zealot. I kept and still keep my eyes wide open. The American health system is a monster of waste, inefficiency, and injustice. Like many other aspects of daily life in the USA, it is marred by a bureaucracy that has no equivalent elsewhere in the world. (Remember that I worked in three Canadian provinces and three European countries, including a few hospitals and universities - I know what bureaucracy can do to you.)

I am not arguing for American style health care in Canada. I just think it is helpful to look at what is going on in the USA at this moment.

(Because many innovations happen at state level, we tend to ignore what our neighbours are doing, or doing right. I will mention Maryland later on; it is a state with
a population and size that makes it comparable to Denmark. If Denmark were to
conduct a hospital reform as innovative as Maryland, we would have Danish presenters
in all our health policy conferences...

The context of my presentation tonight is the big sweeping reform that President
Obama initiated in 2010. It is sometimes known as “Obamacare”, but this particular
nickname is mostly used by the president’s political opponents and critics. We should
prefer to call it the ACA, which is the abbreviated form for Patient’s Protection and
Affordable Care Act.

You probably remember it was a massive piece of legislation, with ten huge sections
covering everything from insurance markets to human nutrition. I have compared it to
a collection of apps for a smartphone: the commonality is that they all work on your
phone, but they are not necessarily connected one with another. It will take years
before we understand fully all the consequences of some of the measures enacted as a
result of the ACA. (In fact, some dispositions will only take effect as late as 2020.)

The consensus is that the ACA will essentially achieve three policy objectives: provide
health insurance coverage to something like 35 million Americans; that it will stabilize
the coverage of even more people by enacting minimum standards; and that it will
successfully curb the health cost curve.

The last numbers we got, according to last Sunday’s edition of the New York Times,
indicate that 31 million Americans have already benefited from the ACA. When the
different provisions of the act will be fully deployed, this number could reach more
than 50 million people. This is huge. This is bold. Obama will have insured a
population the size of Canada.

It is also clear that costs now rise at a lesser pace. In some high costs programs like
Medicare, the cost curve is now equal or less than GDP increase, including for
prescription drugs. To be honest, this is not only an effect of the ACA. It is a secular
trend and it happens all over the OECD. But the fact that the USA are not an exception
to that trend and the fact they even lead this movement in some areas are clearly a consequence of the bundle of policies that have been implemented.

The ACA has transformed the USA into a huge laboratory for health policy. Everything that we think should be done is currently tried, measured, and appraised, from integrated care to active prevention to careful evaluation of effectiveness. We would be fools not to try to learn from this colossal experiment.

You may have read a few times now that Canada fares quite badly in international health system comparisons, usually just above the US. We tend here to accept these numbers without questioning them. And it is true they help focus on real, important problems.

My American colleagues, however, while being ready to concede that their system is not a model, usually add that a few important values, central to their vision of health care, are taken out of these surveys.

I would like to explore some of these values with you.

*Innovation* comes first to mind. It is the case, quite obviously, at clinical level. US health care constantly experienced the equivalent of an arms race: drugs, technology, treatments: everything new must be tried; anything new must be acquired.

This is a source of waste, overtreatment, and therefore, of many, many wrongs. Not every headache should be investigated with a MRI. I’m Canadian, with just enough Scottish blood to be suspicious of anything but “cheap but effective old medicines and technologies,” to quote a recent blog post by my colleague Steve Morgan from UBC.

Yet, as Malcom Gladwell remarked once, in the midst of a debate with Adam Gopnik on the virtues of the Canadian health system, the American love affair with new medicines and new technologies has to be put in perspective.

First, because of the size and heterogeneity of the system - keep in mind, we are talking of a country ten times the size of Canada - not every therapeutic or clinical
innovation is adopted everywhere, by everyone, at the same time. There is no central bureaucracy and no marching orders that everybody must follow.

Second (and I’m conscious it is quite debatable) the American system tends to “internalize” all costs related to health problems. If given the choice between a procedure that keeps me out of work three days and a procedure that requires one week or ten days of recovery, I would most often opt for the first ... if I can afford it in the first place, of course. Remember this is a country with limited or inexistent maternity leaves, few sick days, and very limited personal or familial networks...

Now, it would be an error to focus only on procedures and technology. Innovation is also a value in health system design, from the clinic to the whole organization or system. The US health care system goes through permanent transformations, reorganizations, re-engineering.

At this time, the trend is for consolidation and integration. In New York City, where you have a population the size of Ontario, there will be four or five integrated systems left in three or four years. Yet remember the same movement in the 1990s ended with most large research hospitals disinvesting from their networks, largely because they discovered at one point that costs tend to diffuse from the centre, where care is very expensive, to the community hospitals and primary care settings.

Between the new funding models and the ACA’s insistence on patient health, the current pattern of integration makes a lot of sense. These large health systems have a redistribution function - they care for less advantaged patients with the money they make with well-insured, highly profitable patients. By giving more people access to care, the ACA has increased the responsibilities of insurers and hospitals.

One caveat: in a system wide open to innovation, it would be an error to believe that the world is moving only in one direction. In fact, at the same time you see the emergence of these big health conglomerates, concentrating care, prevention, and insurance functions, a disruptive innovation is taking place quietly in the retail world. Pharmacies and chain stores are entering the primary care market, taking advantage
of the solvability of millions of ordinary Americans and of their needs for affordable, simple, accessible care. Target, for example, has recently contracted with Kaiser to conceive and operate walk-in clinics in its stores.

What is happening in Quebec at this moment is, by contrast, illuminating. Minister Barrette dreams of a better-integrated, holistic system. He sounds as if he prefers a system integrated on the basis of roles and functions, rather than territory - more like an American integrated health care system than a Canadian regional authority. Let’s admit for an instant he is right.

The big difference is that Minister Barrette has to impose his vision, wall to wall, without any room for divergent models or differential development. In New York, nobody is forcing the hands of NYU or Mount Sinai. Nobody is dictating what New York Presbyterian must include under its new partnership arrangements.

Innovation happens because experimentation is not only possible, but also encouraged. This again is not measured well in international comparisons. The American system is unbelievably flexible.

Let me give an example. Here in Canada, we love to discuss national standards. They exist in the USA as well. But one very intriguing characteristic of American public administration is the use of “waivers.”

Maryland, the state where I now reside, has made a very aggressive use of waivers to pursue its own, innovative approach to hospital funding. The state has developed its own rates, its own evaluation schemes, its own information system, and its own package of agreements with providers and provider organizations. Maryland has to demonstrate on a regular basis that it does better than the national average in terms of costs and health outcomes. But if it does so, it can do it its own way.

Waivers create a fantastic incentive for experimentation and innovation. Of course, it means things are not organized the same way everywhere. Of course, it means the system is complex, way more than it is here. But complexity is a problem only if there
is no flexibility, no capacity for adaptation. Or if you believe uniformity is a virtue by itself.

Innovation exists in part because of competition. Even a virtuous non-profit organization like Kaiser needs to protect its market share. Therefore, it has no choice but to introduce an innovation if it proves important for its patients or significant for the care-cost ratio. It is not impossible to generate innovation through regulation (versus competition), but as we know too well in Canada, it is very difficult.

However, competition is only one part of the story. *Measurement* is the other. Maryland knows its approach works because they have a way to measure what they do. The hospital system that invests in preventative care knows it is, so to speak, profitable, because it measures precisely every cost.

You think integrated care is a fundamental objective in health system design? I share your views, but I know it is not a magic bullet. I know it really works only with certain patients. I know it produces economies and good outcomes, but that the results are not spectacular. I know it works better when I can combine and align funding reform with system reform with strong clinical governance. No need to say, I know all this because I have numbers, good and robust measures.

(If you let me digress for just a second, the reason our neighbours have good and reliable numbers is the same reason we have not. At the heart of it, it is a question of finance. When you charge everything, you count everything. Back in the time when the federal government was reimbursing half of every dollar spent in our hospitals, in the interval between public hospital insurance and Medicare, there was an army of accountants in our institutions making sure every drop of saline solution was duly registered...)

The combination of experimentation and measure should be something that we contemplate with envy, especially when it happens to be so deeply ingrained in the culture.
I will give you an example close to your own experience. My institution, Johns Hopkins, is now leading a national initiative to evaluate the impact of duty hours on quality of care; this is a national randomized design trial with a large number of participating institutions. You may be aware that a Hopkins’ study of internal medicine residents had shown that patient safety and quality of training actually decrease with a relaxation of traditional duty hours, contrary to what common sense would have let us believe.

The reaction was not to ignore the facts or to negotiate a new compromise among stakeholders. It was to start a new, wider, more certain process of exploration and validation.

This is a culture that is never satisfied with experiments of one, even if the pilot looks in line with original expectations. I have always thought that Monique Begin’s famous line about Canada as the international champion of pilot projects was not properly understood. Our problem is not that we don’t experiment, here and there. It is that we don’t care.

Last fall, I wrote a piece with a good colleague from Harvard, Dr. Andrew Boozary, on a similar theme. His own fascination with the US health culture was centred on yet another dimension of the information-measurement craze: transparency.

I totally concur with him. Transparency is a value in itself and once more, it is not something we often include in international comparisons of health systems. Nothing is perfect, of course, but it is a progress to see payments to physicians and hospitals in the public domain, notably when they come from the pharmaceutical and medical device industries. (The AMA website has this warning for its members: “Be prepared for inquiries from the media, your patients, and your friends.”)

As you probably know, it is customary in the US to access performance ratings of health care organizations and individual physicians. It bodes well with a tradition of doctor shopping, which hurts my public minded conscience every time a colleague or a friend tells me he would see three or four different physicians before making a
decision on a course of treatment. I don’t easily accept the idea there is not one and only one way of dealing properly with my problem.

The paradox at this moment is that the ACA is inciting health insurers and health organizations to reduce the choice offered to the patients. More information, more transparency, but fewer options.

This is known as the trend toward narrow networks. In clear: to claim benefits from your insurance, you must stick with a limited number of doctors and organizations. If you fool around, sometimes for reasonable motives, it is just too bad. You’ll have to pay the terrifying “Chargemaster” rates or some other stiff financial penalty.

This is made possible because Americans, insured Americans I should say, overwhelmingly subscribe to managed care plans.

The numbers are striking. It concerns more than 95% of all insured Americans. Of course, depending on your wealth, your age, your personal situation and your values, the “managed” part of your care will greatly vary. Still...

Managed care, you may remember, was Richard Nixon’s own health care revolution. The 1973 federal legislation opened the way to the first and second generations of HMOs, including the big debacle of the 1990s.

It helped Medicare find its second wind and, to be honest, most of the spectacular experiments taking place now are a direct consequence of the generalization of managed care: bundled payments, high value primary care, ACOs, and so forth.

(Another digression, if I may. Medicare covers all Americans aged over 65. It is a federal program and it looks from the outside much like our own health insurance program. Medicare A covers hospitals. Medicare B covers physician services. Interestingly, though, there is a Medicare C, barely discussed or noticed, because it is taken for granted, which deals precisely with managed care. I keep telling my friends that Medicare D, which covers prescriptions drugs, wouldn’t exist without Medicare C.)
If you prefer: pharmacare without managed care is nothing else but an open bar for big pharma...)

I have said a few times now in public that managed care can well be the best hope for American health care and who knows, for health care in general. This is a contentious statement, to say the least. Very few people, including in the US, are ready to accept the notion that the next revolution can start there rather than in Sweden or Switzerland or Scotland or Singapore.

But the truth is that managed care is the only real-life type of health organization that can be adapted to a new health paradigm where less is more.

The values I have mentioned: innovation, experimentation, measurement, transparency all converged to make possible a system in which appropriateness of care and long term health outcomes become central issues. The US government is spending millions of research dollars each year to look at clinical effectiveness - and it does it in the perspective of patient-centered managed care. Hospitals are investing in population health. This makes me hopeful.

To tell the truth, however, the revolution is not for tomorrow. And of course, we cannot wait; we shouldn’t wait for the Americans to show the way.

Barrette asked me one day: what would you do first? His answer as we have seen, was to dynamite the existing structures, in an attempt to get rid of all that he perceived as obstacles to his grand scheme.

My answer is different. Imposition might be the right remedy in the absence of competition, but it does not represent a substitute for experimentation, robust evaluation, or transparency.

In fact, I think it even goes against what we still miss the most, which is authentic health management. Clinical governance is underdeveloped in our country, for historical reasons. Managed care is just starting to emerge, timidly, thanks to primary
care reforms attempted here and there. The IT component of authentic health management, which supposes complete interoperability of data among a wide spectrum of services, is still a distant dream in most jurisdictions. Let’s start there.

We should also make more room for experimentation. What are we scared of? Quebec established its universal pharmacare program in 1996. It is imperfect, but it exists. The province did not wait for Ottawa or anybody else before it addressed the issue. Tommy Douglas didn’t wait for Ottawa.

We’re Canadians. The paradigm might be frozen, but we know that even the harshest winter must end.

Thank you for your patience and attention.