Dr. David Zitner is Director of Medical Informatics at Dalhousie University Medical School, chairs the Capital District Utilization Committee in Halifax Nova Scotia and is Health Policy Fellow with the Atlantic Institute for Market Studies.

**IS SANE MANAGEMENT POSSIBLE IN A CRAZY WORLD?**

**Summary:**

Most people benefit from health care. However, Canadians remain dissatisfied because too often we receive faulty care and delayed care, not supported by evidence.

Browman and colleagues relate successful efforts to introduce evidence-based care. They show that strong champions can be effective even in insane environments. The collaborative approach suggested is moving and thoughtful. Sharing between knowledge and financial stewards, including the use of stories, is especially valuable when financial stewardship is not possible because we lack information about the local outcomes of care. Good will between stewards is especially necessary when there are few external incentives to provide excellent care.

In health care good deeds are punished, not rewarded. Canadian governments fail to regulate health care because of the conflict of interest arising when the same group not only regulates care but also functions as insurer, governor, administrator and evaluator.

We need radical change to eliminate the perverse incentives and bizarre management practices that bedevil our health care system, and impede the use of evidence. Fundamental changes in organization and evaluation proposed by the Halifax Chamber of Commerce, Kirby and Mazankowski committees will help. Separating the functions of insurer, administrator, evaluator and regulator is ethical and necessary.

**IS SANE MANAGEMENT POSSIBLE IN A CRAZY WORLD?**

“Many bad decisions about healthcare are made every day in Canada because decision-makers lack the right information, at the right time, and in the right place. These bad decisions can cost the country millions of dollars and rob Canadians of the health care they need and deserve. Decisions that are made about the health system- like funding for diagnosis and treatment of many diseases are only as good as the information on which they are based.” (Healnet, 1999 -- George Browman was the first program leader of this National Centre of Excellence)

**Introduction:**

Browman and colleagues’ thoughtful article is a poignant cry and rational effort to solve a problem which future health workers will regard as one of the major scandals of the 21st
century: the Canadian health system’s tolerance for management and clinical practices that are harmful to people and not evidence based

Does the public know more than we think? The percentage of Canadians who believe our health care system works pretty well and needs only minor change fell from 56% in 1988 to 20% in 1998 (Gallup Canada Poll, 1998 cited in Blendon, 2001). Canadians take pride in having a health care system that cares for the poor and elderly. Yet in the area of responsiveness, the Canadian Health Care system ranks fourteenth worldwide, based on the views of its poorer and older citizens, slightly below the United States (Blendon, 2001). Only 20% of Canadians report having confidence in the health care system and barely 50% say that the medical care they and their family personally received in the last year was very good or excellent. (CIHI, 2001; Roos, 2000) “One in eight Canadians said their health needs were not met in fiscal 2000-2001, a substantial increase from one in 17 in 1998-1999” (MacLean’s Magazine, 2002 page 26). Canadian governments insist that our system is “the best in the world” yet other countries are not clamoring to imitate us.

The Institute of Medicine report on quality minced no words in its assessment of the capacity of today’s health care system to achieve its aims: "In its current form, habits, and environment, American health care is incapable of providing the public with the quality health care it expects and deserves." (Berwick, 2002)

Patients suffer from unnecessary death, disability and discomfort because of the failure to use appropriate evidence for clinical care and management. This is true not only for cancer care in Canada and Britain (Vass, 2001), but also for primary care (Norton, 1997; Campbell, 2001) and other forms of specialty care (Wolf, 1999). For example, at every birth weight below 2500 grams African-American babies born in the USA have better survival compared with Canadian low birth weight babies (Ferguson, 2002).

So, increasing the use evidence and feedback for clinical and management decisions is a worthy goal. Dr. Browman and colleagues suggest rational solutions, for a rational world. But, health care in Canada is managed in an environment which would be very familiar to Lewis Carroll’s Alice (Carroll, 1865). Perverse incentives, lack of information and the failure of governments to effectively regulate make health care a truly wondrous industry -- an industry where few organizations make effective and widespread use of evidence.

WHAT IS THE PROBLEM:

Health workers, clinicians and administrators alike, ignore evidence, make intutitive decisions, and often achieve sub-optimal results yet show no signs of shame. Why? Because they can! Perhaps they are even encouraged to ignore evidence when interventions are expensive. Resources are allocated based on political negotiation, not on negotiations for health outcomes at a particular cost.

In Nova Scotia Bill 34, which enables district health authorities, imposes a serious conflict of interest. The role of each district is “To govern, plan, manage, monitor, evaluate and deliver health services in a health district” (Nova Scotia Legislature Bill 34,
Each district is asked to deliver care and evaluate its own performance. Health care in Canada is an unregulated monopoly and functions as such because the regulator (government) is the monopolist. Consequently, there is a failure of regulation. (Zitner, 2002; Halifax Chamber of Commerce, 2001; Kirby Committee, 2002; Mazankowski, 2002).

Browman et al. suggest “that managers act as a catalyst facilitating the application of evidence based medicine”, implying a choice. Normally, regulators insist that industry adopt appropriate practice. Usually poor performers do not survive even in the absence of effective regulation. Canadians are unable to search for, develop or patronize competing health care systems (although quasi-governmental agencies like workers compensation boards, the military and the RCMP, develop strategies to obtain more ready access to health care than is routinely available to most of us).

Private insurers and almost all Canadian organizations must comply with certain regulations. Even the Canadian Broadcasting Company reports to the CRTC (Canadian Radio-television and Telecommunications Commission) an independent agency responsible for regulating Canada's broadcasting and telecommunications systems.

Governments are vigorous promoters of automobile inspection, but less so for preventive health care and screening. Seat belt use is regulated and mandatory, even though the cost per life year saved is estimated to be very high in the order of $1,943,893 per life year saved (National Centre for Policy Analysis, 2002). Contrast this with breast cancer screening, every three years, for women between 50-65 with an estimated cost of $2,700 per year of life saved. (National Centre for Policy Analysis, 2002) or screening for colorectal cancer at an estimated cost of $92,900 per life year saved. (Agency for Health Care Research and Quality, 2002) or universal hepatitis b vaccination of adolescents at a cost of $2100 per life year saved (Krahn, 1998).

The Nova Scotia Provincial Health Insurance system has no fee codes for periodic screening. (although pap smears are an insured service) Screening tests for hypertension, for diabetes in a person with family history, for prostate cancer, and for osteoporosis are not covered by the government insurance plan (without creative billing practices). Doctors in the Capital District in Halifax just learned that colonoscopy screening for average risk patients cannot be provided because only a “minority of patients have organic disease” and waiting time for symptomatic patients excessive (Leddin, 2002). But, this is exactly the reason for screening, to find the minority of patients with treatable conditions before they progress. The cost per life year saved from colon cancer screening is substantially less than the cost per life year saved from seat belt use.

The evidence is clear that removing wax from your ear, when you cannot hear because your ear is plugged is very beneficial. In Canada this is only done by a physician or under a doctor's supervision. However, recently the Nova Scotia Provincial government health insurance agency decided not to provide coverage.
Negotiating between knowledge workers and financial stewards is necessary in an environment where a $20 procedure with major benefit becomes an uninsured service and where the insurer (government) is not required to negotiate or explain the changes in coverage to the policy holders (the Canadian citizens). If saving money is the measure of administrative success then it is hardly surprising that administrators rarely negotiate for results.

Appliance sellers and auto repair shops routinely canvass people to learn about satisfaction and results. Not so for health care. When were you last called to find out if you were better or worse following hospital treatment or a medical office visit? Financial stewards have little formal appreciation for what they purchase and so must rely on stories from knowledge stewards (clinicians). In the absence of information about results, policy makers cannot know if changes to health services delivery made care better, worse or were irrelevant.

**STEWARDSHIP: THE PURPOSE OF CARE**

Those responsible for spending our health care dollars are as honest as the rest of us and unlikely to steal. However, spending in health care is valuable only if it helps to improve the health (comfort, function, life span) of individuals. Unfortunately, despite huge investments in information processing, benchmarking, and chart reviews, no large multi-specialty health organization in Canada can report to the public how many people got better or worse following treatment, or who is waiting, how long have they waited and what is the fate of people on waiting lists (Zitner and Crowley, 2002). Administrators can tell us how much money was spent, how many nursing hours were paid for, or what drugs were purchased, but they can’t answer the most important questions: how many people had better or worse health? who were these people? Consequently, financial stewardship has been at best limited, at worst non-existent. So, financial stewards must, as Browman and colleagues suggest, obtain information about clinical access and outcomes from clinicians as knowledge stewards.

Administrators are charged with constraining costs, but not with getting value for the dollars spent. The system offers few incentives for rational budgeting. Individuals or organizations aren’t held accountable for the health outcomes they achieve, relative to money spent. Consequently, doctors, hospitals, and regional health authorities have few incentives to maximize value for money (best service or product at the most reasonable cost) (Crowley, 1999).

Using stories and anecdotes, as suggested by Browman and colleagues, is one way to provide the information financial stewards need to do their jobs. It would be better if the necessary information about access to and the results of care were routinely available as a by-product of health care activities.

Browman and colleagues suggest that there is an overemphasis “on formal research that addresses broad generalizable conceptual barriers and insufficient attention to local practice barriers ... which do not account for unique factors in the local environment”.
Clearly, there is also a need to implement systems that regularly and systematically collect appropriate information relating health care activities and administrative practices to the results they produce. This very concept was unanimously endorsed by the Deputy Ministers of Health when they agreed that “Timely access to services either in the hospital or the community must be guaranteed and information about waiting times made public” and “That quality of care will be ensured by ongoing monitoring and publication of patient outcomes as changes are implemented” (Federal/Provincial/Territorial Deputy Ministers, 1994).

$400 million dollars wasted: A story about the failure to collaborate and negotiate.

Administrators, as financial stewards, are unable to meet their obligations because they have no idea if increments in spending are associated with improvements in health or decreases in waiting times. Dr. David Rippey (2001), speaking for the Nova Scotia Department of Health, said, “In the last few years the health care budget has been increased by 400 million dollars. If you asked Nova Scotians has health care improved most would say no”. This sad result is not surprising in an environment where meaningful consultations and collaboration between knowledge stewards (clinicians and academics in medicine and health policy) and administrators (financial stewards) is not mandatory and happens rarely.

Negotiation between financial and knowledge stewards must be a normal part of work and compulsory in circumstances where financial stewards have little access to reliable and objective information about access to care or the results of care.

Penny Wise: Pound Foolish: Why clinical and financial stewards need to meet:

Using Canadian Institute for Health Information material MacLean’s Magazine (2002) reported variations in vaginal birth rates across the country for women who previously gave birth by c-section and said “The higher the rate the better”. But Greene (2001) says that elective cesarean section (after a previous cesarean section) must be the accepted policy because there is an unacceptably high morbidity and mortality rate when the policy is to try vaginal delivery after an initial c-section. The cost of routinely trying a vaginal delivery after an initial cesarean section is high and includes an additional 2.4 perinatal deaths per 1000 births, and a very substantial increase in the risk of uterine rupture (Lydon-Rochelle, 2001). The clinical belief, based on evidence, is that a lower rate of vaginal delivery after c-section is better. Browman’s model suggests that collaboration between clinicians and administrators could use data mining techniques to develop the intelligence necessary to know which particular patients are at highest risk.

The preceding paragraph might generate controversy, which further supports the need for an independent arbitrator.

INCENTIVES AND REGULATION TO SUPPORT EVIDENCE BASED CARE
While governments recognize that certain activities improve health and reduce future human and financial costs, there is a reluctance to set standards for the use of evidence because government is also responsible to pay the cost of implementing and maintaining each standard.

Any maneuver which raises the cost of care, even when evidence based, for example screening, timely surgery, providing adequate capacity for inpatients and emergency departments, investments in information technology and searching for evidence is a cost devoutly to be avoided.

Private insurance companies must deal with insurance claims in an appropriate and timely way or suffer legal consequences. There are no waiting time standards for publicly insured health care services. The failure of knowledge workers and financial stewards to reach appropriate accommodation has led to an intolerable situation for many patients, one where needless deaths will occur because of a failure of early detection and prevention and a failure to properly use known beneficial interventions.

The Canada Health Act is an icon of Canadian belief. My colleague Brian Lee Crowley states “It is the third rail of Canadian politics. Touch it and you die”. However, even this supposedly sacred trust is not the subject of administrative evidence. Denis Desautels, the former Auditor General for Canada, in response to Operating in the Dark (Crowley et al., 1999) said “In relation to the Canada Health Act, I observed that Health Canada does not have the information it needs to effectively monitor and report on compliance. So...it is clear that better quality information is required” (Desautels, 2000). The lack of evidence means that financial stewardship becomes impossible and reinforces the belief that meaningful negotiation must occur between financial stewards and knowledge stewards.

Volume 5 of Senator Michael Kirby’s influential Senate Committee (Senate Committee on Health, 2002) studying health care reform issues, quoted extensively from "Public Health, State Secret,” (Zitner and Crowley, 2002) particularly picking up on the themes of the poor quality information available to manage the health care system, as well as the diagnosis that the system’s ills flow chiefly from its nature as an unregulated monopoly without clearly defined goals or a focus on the needs of consumers.

On November 6, 2001, Senator Kirby asked me “how is management possible in a system where there are no measures of access or results, and no one knows the cost of delivering each of the elements of care.”

Indeed, how is management possible in a system devoid of information and consequently insane for management? Is this lunacy?

Browman’s stories are one way to deal with the lack of reliable information.

Browman and colleagues are also correct when they suggest health workers must acknowledge conclusions which are drawn not only from generalizable studies from
formal research, but also conclusions drawn from local stories and from information about what works in one’s own community.

Stories or anecdotal evidence is an important source of knowledge. To be persuasive, stories must have a basis in fact. So, it becomes absolutely necessary to systematically collect information about the results of care. The independent evaluator, who would have access to systematically collected information, would become the arbiter between financial and knowledge stewards, insisting that financial stewards buy valuable outcomes, and that clinical stewards don’t waste money on superfluous or harmful activities.

We need radical change to eliminate the perverse incentives and bizarre management practices, which bedevil our health care system, and impede the use of evidence. Fundamental change in organization and evaluation proposed by the Halifax Chamber of Commerce, Kirby and Mazankowski committees will help. Separating the functions of insurer, administrator, evaluator and regulator is ethical and necessary and will provide an impartial arbiter for negotiations between knowledge and financial stewards.

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