Moving from a Learning-Disabled to a Rapid-Learning Healthcare System: Good Governance for Innovation

GUEST EDITORIAL

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This issue of *Healthcare Papers* was conceptualized, and the papers that it contains were solicited, in early 2015. For many of us with hopes for a better Canadian healthcare system, early 2015 was very much the "winter of our discontent." The Health Accords that had provided the framework for shared federal–provincial priorities and principles for our national healthcare system had lapsed and the federal government gave every indication that it was walking away from working with the provinces on healthcare issues. The Canadian economy was contracting and provincial governments could no longer cope with the steady demands of increased funding for healthcare. Sustaining what we had was the hope, and it was increasingly clear that what we had was not very good.

In February 2015, the Canadian healthcare system, once our national pride, was described very accurately in the world's most influential medical journal as an "underachiever" at the bottom of international measures of system performance (Lewis 2015). Where once we felt our system was a paragon that others should emulate because of its successes, the author of the article, the always acerbic Steven Lewis stated "… we learn more from failure than success. If that is true, other countries have a lot to learn from Canada" (Lewis 2015). Our national success was now seen as an international failure. A main driver of this failure was neither lack of money nor lack of talent, but a system that is "learning-disabled" (Lewis 2007) and that suffers from, in the words of the Advisory Panel

on Healthcare Innovation (Report of the Advisory Panel on Healthcare Innovation 2015), "arrested development" because we had lost our ability to successfully innovate.

Although these papers were first drafted in this rather bleak context, the authors have produced a series of wonderful and insightful papers that, while showing the Canadian trait of polite niggling about meaning and scope, share a common thread of hope for making the Canadian system better through innovation.

The central thesis in the paper by Verma and Bhatia is that the Triple Aim assessment framework – outcome, experience and costs – provides a framework for understanding the impact of innovation at the system level, and provincial governments, through the policy levers that they hold, can support, coordinate, link and incent system innovation. Provincial governments can be the Triple Aim Integrators.

Although the responding authors provide some discussion around the focus of the evaluative framework, there is an overall agreement on its value and, more broadly, that the Triple Aim framework has currency with both federal and provincial governments. The authors also engage in some back and forth about the scope of innovation, but there is an overall consensus that innovation includes a broad range of initiatives, strategies and technologies. Triple Aim innovation is presented by Verma and Bhatia as an activity that has an impact on each of the then three aims and, although this definition appears a bit self-referential, it is consistent with the recent Report of the Advisory Panel of Healthcare Innovation that defines healthcare innovation as activities that "generate value in terms of quality and safety of care, administrative efficiency, the patient experience and patient outcomes" (Report of the Advisory Panel on Healthcare Innovation 2015).

The main area of debate across the papers is focused on the traditional Canadian question of "good government" and how "governable" healthcare innovation is in a system that has legislative structures and historical nuances around the roles of providers, the private sector and provincial and federal governments.

Verma and Bhatia make a strong case that good governance for innovation involves provincial governments using the Triple Aim framework and playing the role of Triple Aim Integrators by using the policy levers that our system has put in their hands. As the "single payer" for many healthcare services, they can develop procurement strategies and more importantly use payment reforms as a tool to incent and coordinate innovation. As pointed out by some of our responding authors, this is easier said than done, but at least possible to do. As agents who are spending a large proportion of the funds that taxpayers give them on healthcare, provincial governments could and should provide a vision for how they plan to use that money and provide information to the public where the money went and what was achieved. This provincial stewardship function should also include two very important aspects of being an effective Triple Aim Integrator. One is the ability to promote collaboration across sectors. Health is more than healthcare, and health innovation cannot only be new pills or devices but also new ways to think about the broader determinants of health and new ways to think cross-sectorally about "health in all policies." The other function is the ability provincial governments have to keep track of what works and what does not and to share that knowledge – to learn from what they do.

The notion of a learning healthcare system is at the heart of successful innovation. The model of a rapid-learning health system is based on systematically and rapidly drawing knowledge from real-world care delivery to promote and support innovation (Greene et al. 2012).

This is one area where I feel it is important to add to the vision articulated by Verma and Bhatia. Our "non-system," with different healthcare realities in each jurisdiction and our support of autonomy for providers has led to an enormous array of new strategies and initiatives across this country. There have been some wonderful successes and some horrible failures. We could do a better job of learning from both. This is an area where I think we do need a pan-Canadian strategy and where there is a clear role for the federal government. I will declare a bias and a conflict of interest. I am a researcher and I am biased towards the value of research and evidence in successful innovation. More specifically, I am the research lead on one of the CIHR-SPOR Pan-Canadian Primary and Integrated Health Care Innovation networks. I think this network model, where CIHR funds are matched with other funds to support cross-jurisdictional rapid-cycle research to "support evidence informed transformation and delivery of more cost-effective and integrated healthcare" (SPOR Network in Primary and Integrated Health Care Innovations: Objectives of the pan-Canadian Network 2014), is an essential component of successful healthcare innovation.

The final policy lever discussed by Verma and Bhatia is resource generation. This deals with the infrastructure and human capital investments. They specifically talk about information technology as an important innovation category that can have direct impacts across the Triple Aim. This is undoubtedly true, but it is also true that information technology is importantly linked to the notion of learning health systems. The investments we have already made in information technology can make rapid-cycle evaluation and learning from all of what we do possible (Greene et al. 2012). Information technology is not only an important category of innovation but it has also helped create the environment that will allow us to more rapidly identify the innovations that work and that do not.

The need for strategic investment in innovation is another area where there may be a role for our federal government. This is clearly articulated in the primary recommendation of the Report of the Advisory Panel on Healthcare Innovation (2015) to create a Healthcare Innovation Fund, supported by federal financial commitments, that would support high-impact initiatives, break down barriers to change and accelerate spread and scale-up of promising innovations. The funds would flow to "coalitions of the willing" that would bring together provincial governments, providers, patients and the private sector. All stakeholders are welcome as long as they have a shared commitment to innovation. This is sound advice. The report recognizes that new investment is difficult when money is tight but argues cogently that a substantial investment, in the range of $1 billion a year, is both necessary and justified.

A model for good governance of healthcare innovation can and should have a central role for provincial governments. However, as the Report eloquently states, "Canadian patients and taxpayers have every right to ask that all levels of government collaborate fully in restoring Canada to the international leadership position in healthcare that this country once proudly held" (Report of the Advisory Panel on Healthcare Innovation 2015). The federal government can play an important role, if it wants to.

In Shakespeare's *Richard the Third*, Richard opens the play with the line "Now is the winter of our discontent, made glorious summer" as a statement of his hope that a change in the national leadership will lead to good fortune. In terms of innovation and healthcare renewal and transformation, I hope that the new federal government can provide the impetus and leadership required for a new pan-Canadian approach to innovation

and to creation of a rapid-learning healthcare system. The identification of innovation as a shared priority at the recent Federal-Provincial-Territorial Minsters of Health meeting (Government of Canada 2016) is a very promising sign that we have entered a new era of government collaboration that will foster, evaluate, spread and scale promising approaches that can improve the quality of care and value-for-money. There now is new hope that good governance can help create the rapid-learning health system we need. In the words of our new Prime Minister "Sunny ways my friends, sunny ways, this is what positive politics can do" (O'Connor 2015).

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