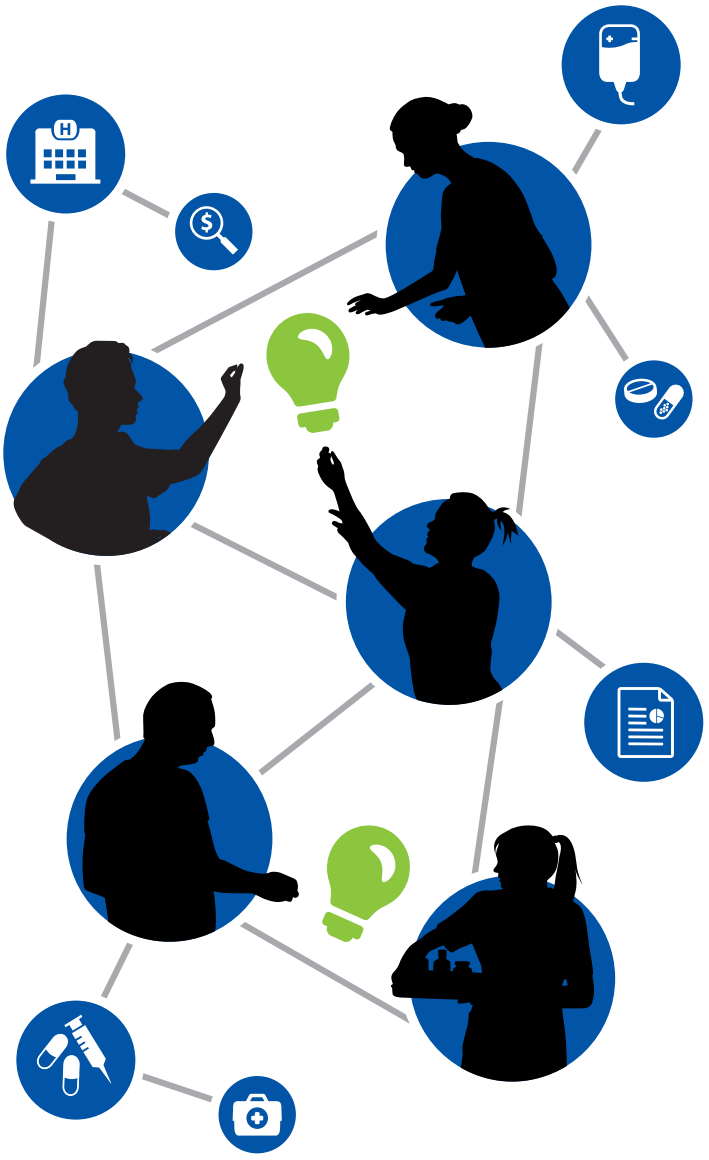
CANADA'S HEALTHCARE INNOVATION CHALLENGE

Industry Leaders Discuss the Future of Canadian Healthcare Innovation at this Year's National Healthcare Supply Chain Conference

For Canadian healthcare professionals grappling with rising costs, innovation has become more than just a cost-saving strategy – it is now critical to the sustainability of our healthcare system. This is a system which 40 per cent of Canadians believe will provide a lower quality of care to their children's generation than their own, according to a 2014 Nanos Research poll. So how can Canada improve its track record on healthcare innovation and ensure a sustainable healthcare system for future generations?



To answer this question, hospitals, shared service organizations, health authorities, group purchasing organizations and governments are turning their attention to two underutilized levers for adding value to healthcare: procuring for innovation, and developing more innovative procurement practices. However, balancing these strategies and building processes capable of accepting them in a diverse healthcare environment, will be anything but easy. Should organizations procure for innovation or first figure out how to innovate their procurement practices? Should they evaluate and compare an innovative technology to an existing technology within a traditional RFP? Or, should they take a leap of faith, trusting that the most promising technologies will pay off in the long run?

Intent on exploring these issues, Health*PRO* Procurement Services Inc., in partnership with the Healthcare Supply Chain Network (HSCN), convened an expert panel to discuss our country's healthcare innovation challenge at this year's National Healthcare Supply Chain Conference. Here is an edited transcript of their conversation with moderator **Toby O'Hara, General Manager of Healthcare Materials Management Services:**

Toby O'Hara: What does healthcare innovation mean to you?

Krista Stagliano, Vice President, Materials Management, Health*PRO* Procurement Services: When it comes to innovative healthcare procurement, innovation isn't necessarily about the latest and greatest product. I think about it in terms of innovative procurement processes: ensuring strategies are structured to carry out maximum value overall. That means we need to consider the total cost of ownership and full life-cycle costs of products and services, and how to work that into our process. Critically, procurement needs to be at the table when clinicians and senior leadership are talking about the problem, as opposed to getting involved when it is time to go to market.

David Cox, Vice President and General Manager, Trudell Medical Marketing Limited: Innovation is about solving an unmet patient need. There is no shortage of innovative concepts and ideas – it's also about applying and utilizing innovation in ways that generate and implement best practices. So translating what we know into practice is an equally effective form of innovation.

Jitendra Prasad, Chief Program Officer, Contracting, Procurement and Supply Management, Alberta Health Services (AHS): What can we do from a process standpoint to bend the cost curve without introducing new costs into the system on a long-term basis? Introducing complexity to the healthcare system can be damaging, so innovation also means identifying and stopping what currently doesn't work.

Brian Lewis, President & CEO, MEDEC: In terms of medical devices, I think when we talk about innovation we are really talking about improving outcomes. To do that, we need to look at the context in which the device is utilized, the processes that use it, and the training of the physician. So it's not the shiny new widget that's going to bring about innovation, but the combination of product, clinician and how it interacts with the patient. Although a meaningful innovation may increase the direct purchase price, we need to consider the broader value it provides the system, as it could also reduce treatment costs and be worth it in the long term if it improves patient outcomes.

O'Hara: What are the greatest barriers to innovation in Canadian healthcare?

Prasad: Let me be clear: trade legislation is not a barrier to innovation, despite what people may say. In Alberta, one barrier to innovation is the point at which procurement becomes involved in discussions about innovation. Procurement needs to be involved at the inception of innovation, not later. The second barrier boils down to the size of our healthcare organizations today and how we engage our clinical stakeholders. We need a more focused view of how we should be engaging physicians in this process. Finally, we need to consider how policy imperatives are implemented at the operational level. As a result of consolidation, we don't yet have the infrastructure needed to receive innovation given the size of our healthcare organizations.

Cox: There are three key barriers to bringing a new product to the market. One is fiscal constraints: departments are

risk-averse and beholden to this year's operational budget. Another is reluctance to evaluate new technologies because everyone is at capacity in terms of available clinical resources. The third has to do with difficulty commercializing new products; cash flow is like oxygen to suppliers. Regulatory delays and the need to get manufacturing processes right and keep prices down are barriers to procuring innovative devices.

Stagliano: From a procurement standpoint, there are fewer policy barriers than people think. There are creative ways to procure products within existing rules and regulations. It is from a risk mitigation standpoint that we may encounter barriers to innovation. Rightfully, clinicians want to ensure that a product is effective prior to integrating it in their practice. But we must assess whether it is economically feasible to produce the studies that would unequivocally prove a considered innovation. Limited hospital budgets can also be a barrier to innovation. Given that many innovative products tend to cost more at the outset, it can be difficult to make a case for adopting them in the short-term, even though they may be able to reduce costs or readmission rates in the long-term. Finally, innovative processes take time – often months and years as we measure processes throughout their life cycle.

O'Hara: What are the benefits of healthcare innovation, and what can we do to improve our success?

Lewis: Achieving savings, better health outcomes more quickly, fewer patient visits, the ability to treat in the community, and better use of electronic tools are great examples of what's at stake here. Ultimately, better patient outcomes will bend the cost curve. To improve innovation, we need to create an environment where suppliers can thrive. Eighty to 100 per cent of sales for medical devices are currently directed outside of Canada, so we need to ensure suppliers of innovative products have a robust marketplace to turn to, and that they aren't disadvantaged in the Canadian market.

Prasad: If we don't innovate, we will start to lose relevance and become stale-dated in how we provide care. Innovation must therefore become an inherent part of the healthcare system. We must also place greater focus on moving things into the community so that processes and funding mechanisms can adapt to deliver care closer to home and generate overall savings to the system. The last piece has to do with social impact and changing our procurement paradigm: How do we impact populations by using procurement organizations as economic engines in their regions?

Stagliano: From a supply chain perspective, increased competition is critical. If innovative suppliers are active in the market, other suppliers will be compelled to compete or lose ground. There is always risk inherent in innovating, but innovation will drive more strategic relationships between suppliers and customers, building longer-term relationships that allow them to plan better. When procurement professionals are at the table with senior leaders and clinicians from the beginning of the procurement process, together we can write innovative procurement processes that solve a particular problem, as opposed to going to the market for a product or list of products. From Health*PRO*'s perspective, we would like to find an area within a hospital with an identified need for improvement and a group of clinicians who are eager to do things differently – we need a case where we can show results Innovation is not one big solution.

O'Hara: How can suppliers expect innovative healthcare technologies to be adopted by hospitals without validations such as third-party health technology assessments and value for money reports?

Lewis: We need government ministries and medical device companies together at the table early on if we are going to adequately determine value for money. The UK, for example, uses a 12-week medical technology briefing to determine the potential value of a product. Health Canada recently changed its rules such that industry can now talk to hospitals much earlier than before about treatments. This is in conjunction with similar activity in Quebec, British Columbia and other provinces, which suggests everyone is thinking in the same direction. But in the absence of direct evidence, linked evidence is necessary – a surrogate or other intermediate term marker that helps determine how a product links to long-term results. For medical devices, no one size of research fits all. You have to determine in advance, with industry at the table, "How are we going to measure outcomes?"

Cox: Canada is generally slower to adopt innovation than the US. One reason may be that the US model holds people accountable through funding based on outcomes. Preventing infection, for example, costs a whole lot less than treating infection. In the US, if a patient returns to the hospital with infection within 30 days, or an issue related to their procedure, the US facility may not be compensated as per the Hospital Readmissions Reduction Program. Their funding gets cut on that basis. So you see them wanting to adapt and bring in innovative technologies quite rapidly if it can prevent an infection – something we could look at rewarding in Canada. Funding based on accountability to outcomes like reduced infection rates, as one example, could have an impact here, too.

O'Hara: How can a provider such as AHS justify procuring for an innovative technology?

Prasad: At the end of the day, as procurement professionals, what we have to get better at in collaboration with our clinical partners, is the ability to look at total cost of ownership of the device to the point where you can start factoring in things like length of stay and patient outcomes. Most shared service organizations and health authorities are in their infancy, so there's still a need to develop that capability – certainly for those things that have a significant impact on the system. But healthcare procurement needs to evolve a more "clinical face" that allows us to make better justifications for new products. We also need processes to adopt new technologies, or else clinicians will, through other mechanisms, find ways to bring innovative products into the system. It behooves all of us in the healthcare supply chain and other procurement organizations to figure out a way to work with clinicians to determine what can be afforded, how it can be costed out to show a net benefit to the healthcare system, and, finally, to demonstrate to senior leadership that if you don't do this, you're still going to end up paying, and probably paying more, because you didn't have the right people involved in introducing new technologies into your system.

O'Hara: In more general terms, is procuring for innovation a risk we can afford to take given the state of our healthcare system? Or is it a risk we cannot afford to take?

Cox: I think it's clear that it's a risk we cannot afford to pass up. Innovation can bring terrific therapeutic benefits that serve a broader group of patients and reduce costs to the system. I believe national healthcare costs were 11.2 per cent of our GDP, or $216 billion this year. In the context of provincially reduced funding increases, some hospitals start the year tens of millions of dollars behind because of mechanized agreements in place and cost of living increases. This may lead to reduced spending on quality of healthcare products and capital purchases in order to meet overall budget requirements. For example, products selected may have a lower unit price but not

a lower total cost of ownership. Purchasing groups are providing tremendous savings to hospitals. But we cannot depend on a constant, endless stream of savings from RFP'ing commodities. We need to work more collaboratively between buying groups and clinicians to change the way we procure for products, and change the parameters used to measure success.

Prasad: I've been very clear. This is not even about taking a risk, it's about doing the right thing. And I think the right thing is to look at innovation as a platform to improve patient outcomes and patient care. If we don't make this move, then as a healthcare system, we will constantly be behind the eight ball compared to our peers in other The Organisation for Economic Co-operation and Development (OECD) countries. Innovation is, in my opinion, one of the key things we have to focus on – in terms of innovation in procuring and buying products, but also in terms of how services are delivered, how products are going to influence service delivery, and how that is going to result in increased capacity to see more patients and move those patients through the system. We face a lot of barriers, but I'm confident that we can eliminate them if we work together.