

**A SUBMISSION ON THE FUTURE  
OF HEALTH CARE IN CANADA**

**Respectfully submitted to the  
Commission on the Future of Health Care in Canada by  
the Nonprescription Drug Manufacturers Association of Canada  
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**ndmac**

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## TABLE OF CONTENTS

EXECUTIVE SUMMARY .....	ii
SUMMARY OF RECOMMENDATIONS .....	iii
1. HEALTH CARE AND CANADIAN VALUES .....	1
2. FINANCIAL SUSTAINABILITY OF THE CANADIAN HEALTH CARE SYSTEM.....	2
2.1 Supply and Demand.....	2
2.2 Allocating Resources .....	3
2.3 Managing a Burden, or Managing a Resource?.....	5
2.4 The Self-Care Policy Gap .....	6
2.5 Filling the Policy Gap .....	9
2.6 Primary Health Care Reform .....	9
2.7 Managing the Financial Incentives .....	11
3. FOSTERING A CULTURE OF CONTINUOUS IMPROVEMENT.....	12
3.1 Health Care and Disruptive Innovation .....	13
4. MAINTAINING AN ENVIRONMENT OF CONSTRUCTIVE COLLABORATION.....	15
5. CONCLUSION .....	15
6. BIBLIOGRAPHY .....	16
APPENDIX A: Nonprescription Drug Manufacturers Association of Canada .....	17
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## EXECUTIVE SUMMARY

Our approach to health care has long been a defining characteristic of Canadian society. Canadians demonstrate a great deal of pride in the accomplishments of their health care system. In recent years, that pride has been tempered by concern about the system's continued ability to meet expectations, and to do so at a cost affordable to Canadian society.

Annual spending on health care by governments has increased by more than \$22 billion over the past five years. Despite this increase of more than 40 per cent, dissatisfaction with the system and concern about its future erosion remain very high. Clearly, the solutions to Canada's health care problems will not be found entirely within the financial realm.

Meeting the infinite (for practical purposes) demand for health care in Canada, with the finite resources available, will require a change in the way we view the role of individual Canadians within the health care system. The most fundamental part of that reassessment should be the recognition that individual Canadians are not merely the consumers of, and the ultimate source of funding for, the health care system, *they are also its largest and most important human resource.*

Harnessing this resource will require a long-term commitment to patient-centred reform. An important first step in this commitment will be to identify and fill the self-care policy gap that currently exists in our overall approach to health. The potential for responsible self-care to improve patient outcomes and satisfaction, while reducing overall health costs, has been well demonstrated. What is now needed is a coordinated policy that reduces the barriers to evidence-based, responsible self-care; empowers Canadians with the knowledge tools they need to practice it; and, provides the framework and incentives for health professionals to support it.

Many of the barriers to responsible self-care stem from current health policies and regulations that are developed without a fully informed analysis of their impact on self-care. The ability of governments to conduct such analyses is hampered by the lack of self-care expertise within their bureaucracies. An important first step toward developing this expertise would be for Health Canada to centralize, as much as is practically possible, functions relating to self-care product regulation within a single organizational entity, and for provincial governments to continue their efforts to harmonize those elements of self-care regulation which come under their jurisdiction.

Of the major areas of health care reform currently under discussion, primary care is the most closely intertwined with self-care. Many of the primary care reform elements gaining popularity in these discussions involve improvements to patient choice and access to health information, including self-care advice (e.g., expanding the primary care team to include nurses, pharmacists and other professionals, the creation of primary health care networks, and the provision of 24/7 access to professional guidance via toll-

free telephone lines). These measures hold the promise of simultaneously improving patient access to, and satisfaction with, needed care as well as reducing the cost of delivering such care.

The rapid evolution of the science and technology underpinning much of modern health care has not been met with a corresponding evolution of the roles and responsibilities of players within the health care system. This contrasts sharply with most other areas of society, where technological change has generally resulted in greater empowerment for end users of the products and services affected. The ability of the system to change and adapt with the emergence of such “disruptive innovations” needs to be improved.

Ready, equitable access to a high quality health care system has developed into a hallmark of Canadian society. The expectations of Canadians in this regard are significant. They are ready and willing to make a greater contribution towards meeting those expectations than merely providing the funding. Our challenge is to give them the tools to do so.

#### **SUMMARY OF RECOMMENDATIONS:**

Therefore, the Nonprescription Drug Manufacturers Association of Canada recommends that:

- Health Canada should consolidate all activities pertaining to the regulation of self-care health products into a single organization within the department.
- Federal and Provincial Governments should undertake the development of a health policy approach that ensures that all new initiatives incorporate a self-care impact analysis.
- Primary health care should be reformed to give patients more options and empower them to take greater control over their own health needs.
- Health Canada should pursue research into approaches to providing Canadians with detailed health information that can help divert unnecessary physician and emergency room visits toward responsible self-care interventions.
- Federal and Provincial Governments should devote a portion of sales tax revenues collected from self-care product sales to public education on responsible self-care.

## 1. HEALTH CARE AND CANADIAN VALUES

Our approach to health care has long been a defining characteristic of Canadian society. The emphasis on fairness and equity, the high standard of achievement expected, and the public policy/private enterprise balance we have pursued all speak to core Canadian values. These values have translated into a record of achievement on health care over the past several decades that is second to none in the world.

More recently, there has been an increased emphasis on the need for greater accountability within the Canadian health care system. The progress of medical science and technology, and the enormous outlay of financial resources on health care have worked together to create high expectations from Canadians as both patients and taxpayers. Canadians are justifiably concerned that their health needs will be met and that their tax dollars and private expenditures will be well spent.

As the demand for greater accountability has expanded, another core Canadian value has emerged as an important factor in Canadian health care: personal responsibility. The past ten years have been marked by a sharp increase in interest in all things related to personal health and self-care. Consumer demand for health information rose sharply during the 1990s, as did interest in health-related lifestyle changes, the use of self-care products and complementary/alternative medicine, and the desire to exercise more control over personal health care options. Taken together, these developments point to the emergence of personal responsibility as a key value underpinning the Canadian health care system.

## 2. FINANCIAL SUSTAINABILITY OF THE CANADIAN HEALTH CARE SYSTEM

The financial sustainability of Canada's health care system, as it is currently constituted, is now clearly in jeopardy. Inflation-adjusted, per capita spending on health care has grown at almost twice the pace of per capita GDP over the past two decades<sup>1,2</sup>. Health spending has risen from 28.7 per cent of all provincial expenditures in 1980 to 37.3 per cent in 2000<sup>3</sup>. Figure 1 shows the sharpness of this increase in recent years. Interim figures indicate that Ontario may devote over 47 per cent of all program spending to health in 2001<sup>4,5</sup>.

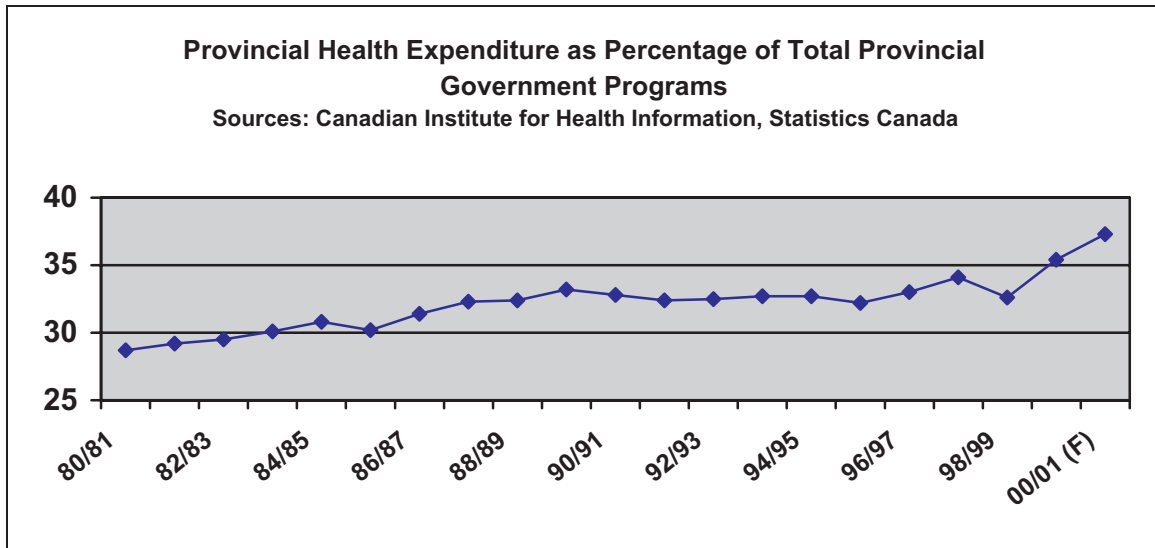


Figure 1

### 2.1 Supply and Demand

The paradox that must be addressed is that while our financial and human resources are finite, the demand for health care is (for practical purposes) infinite. Over the past five years, government health spending has risen by almost \$22 billion<sup>6</sup>: more than 40 per cent. Despite this spending increase, resource tension within the health care system is higher than ever and significant human resource shortages exist amongst almost all of the health professions. Yet, even as we stretch these resources to the limit, a recent poll found that almost two-thirds of Canadians feel that health care services in their provinces have got somewhat worse or much worse over the past couple of years<sup>7</sup>. While perception may be different from reality, it is worth noting that those with the greatest exposure to the health care system tend to be the most dissatisfied with the state of that system<sup>8</sup>. A survey of physicians suggests that specialist referral and hospital treatment waiting times in 1999 had increased by 5.3 per cent over the previous year, and by 53 per cent since 1993<sup>9</sup>. These and other findings all point to the likelihood that even the most heroic increases in health spending are unlikely to bridge the gap between the supply of and demand for health care.

Due in large part to its own successes, the health care system is now experiencing the natural consequences of a system that has developed an ever-increasing number of ways to prolong life and improve well-being in a growing population. If these successes are to be built upon, however, the system will obviously need to change in order to be sustainable over the long-term.

As long as our health care system continues to successfully “supply” the demand for new, expensive, high technology interventions against a widening array of health conditions, without simultaneously finding ways of reducing the cost of providing pre-existing services, the share of our total resources that is devoted to health care will continue to rise at a non-linear rate.

## 2.2 Allocating Resources

Part of the current burden on the health care system is clearly avoidable. A 1992 Ontario study<sup>10</sup> found that the most commonly presented ailments in general practice that year were upper respiratory tract infections (largely colds and flu), generating a cost to the province’s health care system of \$200 million in physician billings alone that year. As Figures 2 and 3 demonstrate, many of the most common, generally self-manageable ailments result in physician visits (sometimes even multiple visits) by a very significant percentage of sufferers each year. Using the Ontario study as a benchmark, it would follow that these ailments account for a very large proportion of physician visits every year.

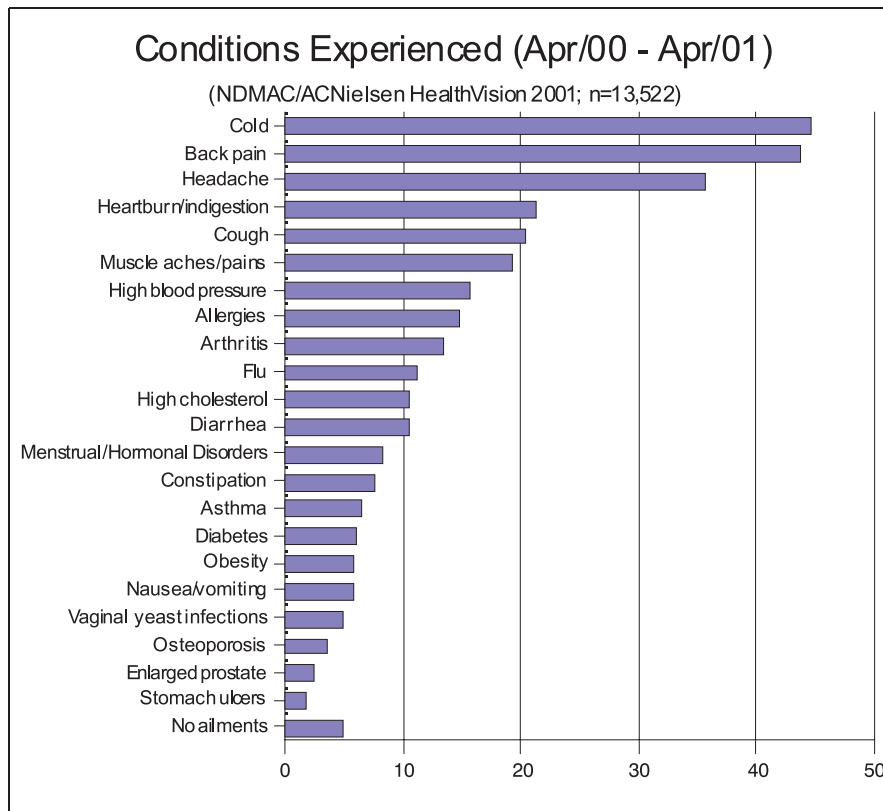
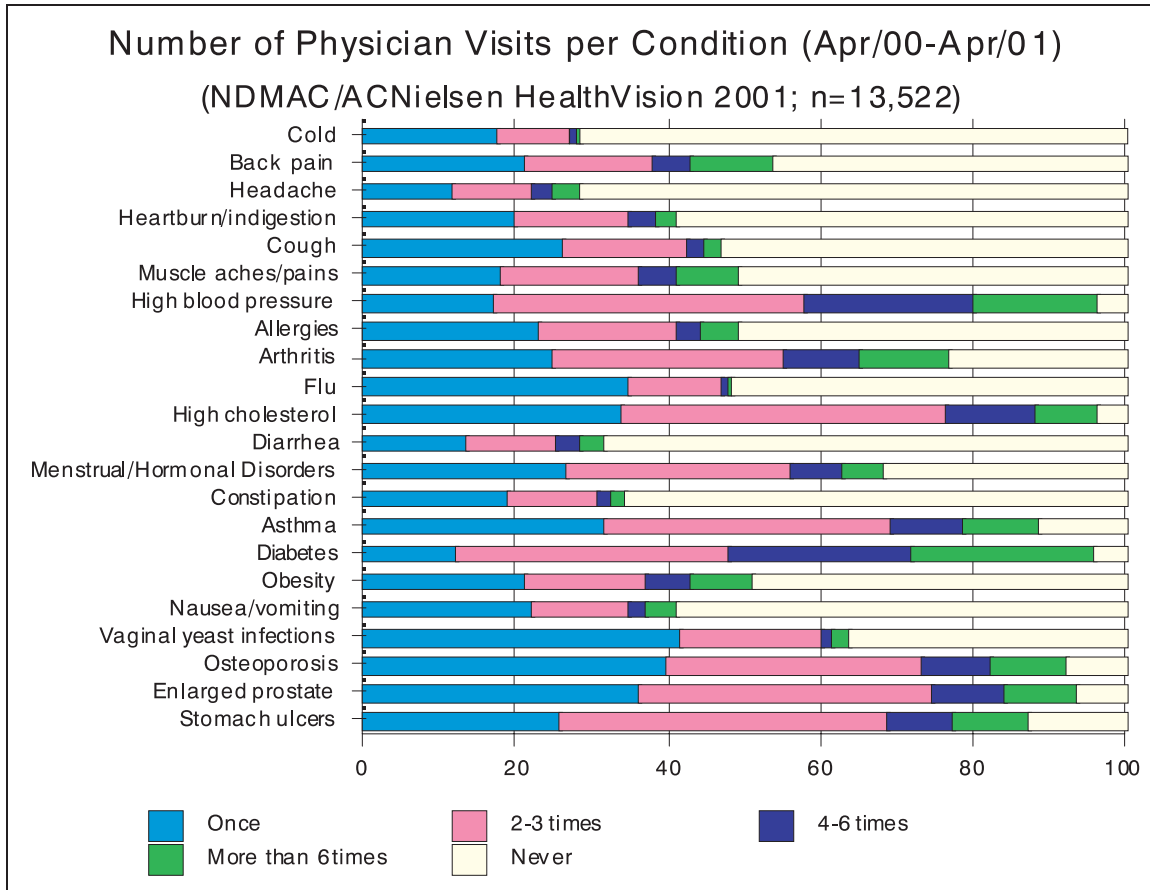


Figure 2



For example, the above data, taken from a survey conducted among a representative sample of more than 13,500 Canadians in April/May 2001<sup>11</sup>, suggest that the common cold, headaches, heartburn/indigestion and coughs generated a total of over 30 million physician consultations in Canada that year. This is greater than the total number of consultations for high blood pressure and high cholesterol combined, despite the vastly greater impact on mortality and morbidity of the latter two conditions. It should be noted that not all of the above consultations would have generated separate physician visits (i.e., consultations on multiple ailments will have occurred in a single visit). Given the acute, episodic nature of the minor ailments, however, it is likely that these generated *at least* as many separate visits per consultation as the more serious chronic ailments, as the latter could reasonably be expected to be addressed in a high proportion of all physician visits by those patients suffering from them.

Certainly, not all physician consultations for minor ailments are inappropriate. Yet these data certainly do suggest the existence of a resource allocation problem. It cannot be satisfactory that such a high level of physician resources are being allocated to ailments that the majority of Canadians can easily self-manage; and particularly not in an age when resource shortages are limiting access to crucial health services.

### 2.3 Managing a Burden, or Managing a Resource?

This resource allocation challenge has only been minimally recognized in the majority of health care reform discussions that have taken place so far, due perhaps to a perceived lack of effective tools to remedy the problem. The erection of barriers, such as user fees, against what might be deemed frivolous use of the system has been proposed as one approach. But while there is some evidence to suggest that such barriers can impact patient behaviour<sup>12</sup>, there is also evidence to suggest that they can impede access to needed care<sup>13</sup>.

What has been largely overlooked is the potential for *reducing* the barriers to appropriate self-care of these ailments as a means of reducing inappropriate reliance on physician services. Reform initiatives have been hampered by a yawning self-care policy gap in the Canadian health care environment. Throughout the vast complex that is the Canadian health care system, there are structures in place to develop policy for the various elements of that system. There are public and private institutions devoted to policy matters regarding the health professions, health institutions, health research, health finance, health administration and pharmaceuticals. There are no such policy centres dealing with patient self-care. This gap must be addressed if needed improvements in self-care practice are to be achieved and make their vital contribution to the sustainability of the Canadian health care system.

The key to the development of a positive self-care policy within a national health care policy framework would be a radical re-evaluation of the role of individual Canadians in their own health care. At present, this role is usually defined by two main considerations: Canadians as patients or consumers of health care services; and, Canadians as taxpayers and private payers of health care costs. This approach ignores what must become a central tenet of Canada's health care policy: individual Canadians are not merely the consumers of, and the ultimate source of funding for, the health care system, *they are also its largest and most important human resource*.

In an age where individuals have been empowered to take greater control over so many areas of their increasingly complex lives, the limited progress in this regard within the health care system is an aberration. The willingness of Canadians in this regard cannot be in question. Growing interest in health related matters and, ultimately, in taking greater control over personal health, has been a well-documented phenomenon over the past decade and a half<sup>14</sup>. Among the many elements of this trend is the growing demand for health information, as evidenced by the explosion of health related editorial and advertising content in the print and broadcast media as well as the Internet.

Even more striking has been the explosion of interest in complementary and alternative health care practices and products. Through the use of annual surveys of Canadian health care attitudes and behaviours<sup>15</sup>, NDMAC has measured a meteoric rise over the past five

years in the number of people reporting use of natural health products<sup>i</sup>, from fewer than one in seven Canadians, to more than one in three. Over this same period, the number of people who reported having availed themselves of the services of a complementary or alternative medicine practitioner also grew substantially: from less than ten per cent of the population to just over 17 per cent<sup>16,17</sup>. While not all of these practices constitute self-care *per se*, even those that involve some form of professional intervention represent a major departure from the historically passive role of individual Canadians in their own health care.

## 2.4 The Self-Care Policy Gap

This type of growing health activism by Canadians has in many ways been stymied by the lack of a compelling, responsive national self-care policy. In the case of the natural health products, the lack of an appropriate regulatory framework has meant that these have for the most part been available through a sort of “gray market,” wherein products of a medicinal nature are registered with Health Canada for regulatory purposes as foods. This approach prevents manufacturers from making health claims on product labels (based on scientific evidence) or providing adequate directions for use (such as warnings, precautions and contraindications). Thus, by depriving Canadians of the tools they need to practice responsible, informed self-care, a significant opportunity to relieve stress on the health care system is being missed. A regulatory proposal that will address these shortcomings has recently been published in *Canada Gazette Part I*. However, by the time it is fully phased in (realistically, by 2005), almost two decades will have elapsed since industry and consumer groups first began seeking such measures.

This missed opportunity to relieve stress on the health care system has been compounded by the organizational structure Health Canada has established to regulate these products. Natural health products will be regulated by a separate directorate, segregated from the one that regulates other self-care products (e.g., nonprescription drugs). Thus a second opportunity, the chance to at least focus self-care product regulation within a single organization, has been missed. This continues a trend that began in 1995, when the Health Canada bureau devoted to self-care products was folded into the one responsible for prescription drugs. Given the distinctly different issues surrounding the regulation of prescribed and non-prescribed health products and the much larger and more complex task of the former, the merger of operations has resulted in the virtually complete loss of self-care-specific human resources within Health Canada, and allowed the overwhelming influence of policies centred on prescription drugs to eclipse self-care considerations. Predictably, the main impact of this change has been regulatory delays that have been disproportionately long for self-care products and an almost complete lack of proactive regulatory initiatives on the self-care front.

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<sup>i</sup> e.g., herbal and homeopathic remedies, nutritional supplements other than multivitamins and minerals, Traditional Chinese Medicines

While the most obvious loser in this chain of events is the self-medicating consumer, government itself has also paid a price. Numerous studies have demonstrated that responsible self-medication generates very significant savings to the health care system. For example, a study conducted by the Health Policy Unit at Queen's University in Kingston, Ontario<sup>18</sup> showed that the switching of non-drowsy allergy medications (nonsedating antihistamines) from prescription to nonprescription status saved the Ontario health care system \$11.6 million, and consumers a further \$4.4 million in 1994 alone. These savings were generated by products that represent a scant 0.3 per cent of the total self-care products market, clearly indicating that the overall scale of savings to the health care system from the practice of responsible self-care must be measured in the billions of dollars. It is notable that the regulatory time frames for prescription to nonprescription switches in Canada are approximately three times longer than those of the United States and of the United Kingdom.

The inter-relationship between self-care policy and formal health care costs was further demonstrated by a recent study conducted at the University of Ottawa School of Health Administration<sup>19</sup>. This study compared the health care system savings generated by the prescription to nonprescription status change of medications for heartburn and indigestion relief, and for the treatment of yeast infections, in the provinces of Ontario and Quebec. While these switches generated the expected positive results in both provinces initially, the investigators were surprised to discover that the savings virtually disappeared in Quebec in the second year of nonprescription sale. A careful examination of the Quebec policy environment effectively ruled out changes to that province's prescription drug plan as the source of the problem. Instead, the disappearance of the savings to Quebec's health care system appeared to coincide with the introduction of new restrictions on the sale of the switched products in pharmacies. Again, the lack of a coordinated self-care policy centre appears to be the culprit in this missed opportunity, as the new restrictions were not even imposed by the Quebec Ministry of Health, but by the Office of Professions (administered by the Ministry of Justice), which is responsible for regulating the pharmacy environment.

Other examples of policy missteps created by the self-care policy void include:

- The legislation and regulations governing the Patented Medicine Prices Review Board (PMPRB) fail to recognize the fundamental differences between the markets for prescribed and non-prescribed drugs. Unlike prescription drugs, which are not self-selected nor directly paid for (in most instances) by consumers, nonprescription drugs are sold in a highly competitive, cash-paying *consumer* market. As a result of this fundamental difference, the average cost of nonprescription drug therapy has historically been in line with (or below) the consumer price index for all goods. Not only does this render nonexistent the need for price regulation for nonprescription drugs, but also the structure of the price regulating mechanism itself fails to recognize the entirely different dynamics of the self-care consumer marketplace, as it was designed for the prescription drug environment. For example, the pegging of the lifetime price level of drugs to their

- introductory price plus inflation, while appropriate for prescription drugs which generally decline in price over their life cycle, is counterproductive in the nonprescription drug market where introductory price promotions are the norm. Through this type of policy conflict, combined with the administrative cost burden to companies created by PMPRB reporting requirements, it is likely that the current approach to patented nonprescription drug price regulation has actually increased the prices of these products artificially.
- Health Canada's regulatory rules serve as a strong disincentive to research and innovation in the self-care sector. For example, in order to gain approval for new uses for existing drugs (including switching a drug to nonprescription status), a manufacturer must submit supporting evidence to Health Canada. Once the new use is approved, Health Canada issues a revised labeling standard for that drug, effectively making the fruits of that manufacturer's research effort available to its competitors, who can then get their product to market at a fraction of the cost incurred by the innovator. In the prescription drug sector, ingredient patents more often than not provide sufficient intellectual property protection to make this a non-issue, but such protection is extremely rare in the self-care sector. As a result, there is little incentive for manufacturers to pursue innovations that could benefit the entire health care system by driving down costs.
  - Health Canada limits certain drugs to prescription-only status by including them in a Schedule to the *Food and Drugs Act*. Once a drug is approved for sale – following a departmental review of its safety, quality and efficacy – it may be marketed pending the formal amendment of that Schedule. But if a departmental review approves the switch of a drug from prescription to nonprescription status, the product cannot be marketed until the Schedule is formally amended. As a result, products that can save the health care system millions of dollars per year face additional regulatory delays of six to eighteen months.
  - In 1995, a national model system for regulating the distribution of self-care products was devised by nine of the ten provincial regulatory authorities<sup>ii</sup>. Since then, only four provinces have formally adopted this approach. Consequently, there is much needlessly duplicated effort in the non-harmonized provinces and timely access to safe and effective self-care products varies substantially from province to province.

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<sup>ii</sup> The National Drug Schedules, as maintained by the National Association of Pharmacy Regulatory Authorities.

## 2.7 Managing the Financial Incentives

The fourth element of this primary care consensus may be in some ways the most challenging to implement. The fee-for-service model of physician compensation is not only long established and familiar, it is also relatively simple to administer. But almost all in-depth reviews conducted on primary care reform so far have identified a need to better align the economic interests of physicians with their professional interests and the health care needs of patients. Various structures have been proposed, most of which blend a number of approaches, including fee-for-service payments, salaries and capitation payments with adjustments for patient population characteristics and outcomes.

NDMAC recognizes the logic behind attempts to align the economic and professional interests of health professionals. However, it is important to note that a similar imbalance exists with respect to the economic incentives influencing health care consumers. As a rule, the Canada Health Act aims to ensure that all “medically necessary” health services are available on a “first-dollar” insured basis. By contrast, almost all self-care costs are incurred directly by consumers. Achieving a better balance of these incentives would be consistent with the approaches being considered for health professionals.

Achieving this balance will be a challenge. One approach, of course, is to take away first-dollar coverage for some or all primary health care services, perhaps through the introduction of modest user fees. This approach promises much controversy and, as previously highlighted in this submission, carries the risk of creating financial barriers to needed care for some Canadians. Another possibility would be to give consideration to providing tax incentives for self-care. The options here range from the provision of income tax deductions for self-care product expenditures, to providing GST and/or PST relief for same. As the self-care products market is a fully functional consumer market with high price elasticity of demand, such measures could reasonably be expected to stimulate self-care, possibly reducing formal health care costs to a degree that would offset or exceed the tax expenditure.

The total market for self-care products in Canada was approximately \$3.6 billion<sup>20</sup> in 2000. This would translate into roughly \$540 million in PST and GST revenues. While it is entirely possible that forgoing these revenues could be offset by reduced costs elsewhere in the health care system, a surer and perhaps more cost-effective approach might be to give consideration to devoting a portion of these revenues to public education on self-care. With this approach, not only would the potential health care system savings more than offset the relatively modest expenditure, but a degree of self-financing could be expected by sales tax revenue growth generated by increasing self-care product sales.

**RECOMMENDATION: Federal and Provincial Governments should devote a portion of sales tax revenues collected from self-care product sales to public education on responsible self-care.**

The various proposed methods of organizing these primary care teams all emphasize the importance of readily available, around-the-clock access to care and information. Most involve the creation of networks of professionals serving rosters of enrolled patients.

This, on the one hand, restricts patient choice in that it would limit their access to professionals to those within their network (although all proposals would permit movement from one network to another). On the other hand, the networks would be structured in such a way that there would always be an appropriate primary care team member available to rostered patients, something that is virtually impossible with a physician in a stand-alone practice.

The net effect of these two elements should be improved and timelier access to health information and the appropriate level of professional care. At the same time, they could also act to improve patient education opportunities, including those related to the practice of self-care (for example: the Ontario Tele-Health program has fully integrated self-care advice into the telephone triage algorithm).

An even more aggressive approach was rolled out in British Columbia recently. In this program, detailed self-help manuals were distributed to over a million B.C. households. These manuals provide advice on symptom recognition and the appropriate self-management of ailments that do not require professional intervention. Similar programs have been instituted in HMO settings in the United States and in NHS group practice settings in the United Kingdom. While further research is needed to ensure that appropriate public information campaigns and supporting programs in physician practices are developed to bolster this approach, this type of public health education holds the promise of truly empowering individual Canadians to play a greater role in their own health care.

**RECOMMENDATION: Primary health care should be reformed to give patients more options and empower them to take greater control over their own health needs.**

**RECOMMENDATION: Health Canada should pursue research into approaches to providing Canadians with detailed health information that can help divert unnecessary physician and emergency room visits toward responsible self-care interventions.**

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### 3. FOSTERING A CULTURE OF CONTINUOUS IMPROVEMENT

In most areas of Canadian society and enterprise, innovations in technology and service delivery have typically been accompanied by greater end-user empowerment in a manner that saves the service provider operating costs and gives the end-user greater control over the service or product. The result is a type of transformation which one group of observers has termed “disruptive innovation”<sup>21</sup>. The pattern typically consists of an innovation that simplifies a process sufficiently to allow its operation to be delegated to a less specialized group of people, thus freeing up more sophisticated resources to deal with more complex processes. A few examples of this widespread phenomenon include:

- The development of the personal computer in the 1970s transformed the role of computing in business, science and society at large. Starting from a focus on ever larger and more complex mainframe computers with brute force capabilities best suited to highly complex tasks, computer development quickly shifted over to the pursuit of simplicity, ease of use and affordability. The result was to virtually render obsolete corporate and institutional computing centres, while putting more computing power directly into the hands of end users (including, ultimately, consumers). It has been strongly argued that this “disruptive innovation” made a very sizable contribution to the growth of labour productivity in North America over the last decade.
- Over the past hundred years, continuous technological developments have transformed the delivery of telephone service. The transition from individual operator-connected lines, to electro-mechanical switching, to digital switching and finally to digital routing has vastly expanded the utility and flexibility of the telephone system. At the same time, it has remained affordable by transferring the vast majority of operations to the end user from telephone company staff.
- Even the notoriously staid banking industry has used technological innovation to vastly broaden the range of services accessible to its customers in a sustainable and affordable fashion. Despite privacy and fraud prevention challenges on at least the same order of magnitude as would be found within the health care system, the banking industry has been able to use information technology to put their customers in more direct and convenient control over their own transactions and other banking needs, while keeping costs down (and, it must be said, increasing profitability).

In all of these instances, technological or other types of innovation led to or were accompanied by the transfer of simplified processes to less specialized operators, allowing more specialized resources to be focused on new, more complex and productive purposes. In the case of computing, the focus shifted over to the development of ever more useful applications for computer technology, such as word processing, the Internet and desktop publishing. For the telephone system, the transfer was to the development of uses other than voice transmission, such as data and video transfer, Internet service

provision, remote monitoring and mobile telephony. In banking, the resources once applied to processing transactions have moved over to more specialized financial services such as investment management. All of these involved a disruption of pre-existing business models, rapidly changing roles for the people within the affected organizations, increased productivity and greater end-user empowerment.

### **3.1 Health Care and Disruptive Innovation**

Despite a pace of technological change that is more rapid than in most sectors of Canada's economy, health care has historically been largely resistant to disruptive innovation. Notwithstanding all of the advances in scientific medicine, diagnostic technology and pharmaceutical development, the roles of the various players in the health care system have remained remarkably consistent. For example, despite technologies that have greatly simplified many diagnostic procedures and permit them to be administered by less specialized professionals (or even patients themselves), access to most of these procedures and tests continues to be funnelled through doctors' offices. The transfer of such functions to less costly and more efficient settings – enabled in part by improvements to the health care system's ability to manage patient information – would be an example of the type of disruptive innovation that is virtually absent in the system today.

The slow progress of primary care reform, in spite of a broad consensus on the need for it, is a measure of the degree of resistance to disruptive innovation in health care. The barriers to such change are many. The transfer of functions from physicians to other health care workers is complicated by the fee-for-service model of physician compensation, which ties such transfers to lost economic opportunity for doctors. This potential conflict may be reduced or eliminated in those instances where primary care reform is accompanied by reform in the mode of physician compensation.

Complex legislative and regulatory regimes for health professionals limit the speed of professional change as well. For example, the professional demands on pharmacists have evolved dramatically over the past forty years from a largely technical product-compounding role to a patient and drug information management role that complements the advances in pharmacotherapy over the same period. Notwithstanding this and a rapidly escalating shortage of pharmacists, the regulatory barriers to delegating the more routine elements of drug dispensing to pharmacy technicians remain largely intact.

The organization of health care financing and administrative organizations into isolated "silos" also increases the difficulty of coordinating reform efforts. For example, hospital administrators may seek to improve cost efficiency by eliminating or reducing certain services that could be better provided in the community or other less costly environment, but have no control over the community-based services needed to fill this gap. Private sector drug insurance providers have little economic motive to cover new drugs that increase their share of total expenditures for a given ailment, even if that increase results in corresponding or even larger savings elsewhere in the system.

Overcoming these barriers to change will not be easily achieved. Ultimately, however, the driving force that must predominate is accountability to patients and taxpayers. Once again, the key here will be public education and patient empowerment. In order to create a culture of continuous improvement that embraces positive change, there must be an increase in accountability to patients whose needs, ultimately, will drive that change.

#### **4. MAINTAINING AN ENVIRONMENT OF CONSTRUCTIVE COLLABORATION**

In 1996, the Federal, Provincial and Territorial governments of Canada signed the Social Union Framework Agreement, committing them to a collaborative approach to social policy development. There can be no stronger test of their commitment to that agreement than health care reform.

Once again, accountability to Canadians must be the driver of change in this dimension of health care reform. An improved public understanding of the Social Union Framework and its application to Federal/Provincial health care reform discussions could help transform these discussions in a positive way.

#### **5. CONCLUSION**

Reforming Canada's health care system to meet the challenges and opportunities of the twenty-first century is one of the most important public policy issues of our time. The long-term challenges go beyond the jurisdictional, financial, and technological problems that dominate current discussions. One of the most important of these challenges is to reassess the roles and responsibilities of individual Canadians in their own health care, and to devise ways in which the health care system and its surrounding infrastructure can support these.

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**APPENDIX A:  
Nonprescription Drug Manufacturers Association of Canada (NDMAC)**

The Nonprescription Drug Manufacturers Association of Canada is the national association representing manufacturers, marketers and distributors of self-care products including nonprescription medications, herbal remedies/natural health products, nutritional supplements, home diagnostics, and other personal care products.

Since 1896, NDMAC has been dedicated to improving the quality of life and providing cost-effective health care for Canadians by supporting the growth of responsible self-care. The Association achieves this objective by fostering an environment for the growth of evidence based, cost-effective self-care products. NDMAC member companies are at the forefront of a \$3.6 billion industry in Canada, accounting for the vast majority of all self-care products sold nationally each year. This market is expected to grow in tandem with the increasing worldwide recognition that self-care products go beyond their traditionally acknowledged role in maintaining wellness and treating the symptoms of self-limiting ailments, to having a role in the treatment of previously diagnosed chronic conditions by increasing access to treatment and providing effective cost-containment.

Together with government and health care professionals, NDMAC member companies maintain leadership in the establishment of the regulatory framework that safeguards the development, registration, advertisement and sale of safe and effective self-care products in Canada. To further ensure the safety of Canada's self-care products, NDMAC members subscribe to self-regulating industry guidelines on responsible marketing practices, child-resistant packaging, tamper-evident packaging features, labeling features, environmentally responsible packaging, and the provision of information to the POISINDEX Information System.

The Association also serves as an information hub, keeping the industry alert to the latest domestic and international developments and their effect on the self-care industry. As a member of the World Self-Medication Industry (WSMI), a non-governmental organization with official links to the World Health Organization, NDMAC helps to promote the worldwide recognition of the expanding role of self-care and self-care products in health care.

## **NDMAC Member Companies**

Abbott Laboratories Ltd.  
Ashbury Biologicals Inc.  
AstraZeneca Canada Inc.  
Avon Canada Inc.  
Bayer Inc., Consumer Care Division  
Blistex Ltd.  
Carolwood Corporation  
Carter-Horner Inc.  
CCL Custom Manufacturing  
Combe Inc.  
Contract Pharmaceuticals Limited  
Crombie Kennedy Nasmark Inc.  
Dormer Laboratories Inc.  
Durex Canada  
GlaxoSmithKline Consumer Healthcare  
J.L. Mathieu Ltd.  
Lander Co. Canada Limited  
McNeil Consumer Healthcare  
Mead Johnson Nutritionals, Division of Bristol-Myers Squibb Canada Inc.  
Mentholatum Co. of Canada Ltd. (The)  
Merck Frosst Canada & Co.  
Novartis Consumer Health Canada Inc.  
Patheon Inc.  
Pfizer Consumer Healthcare  
Pharmacia Consumer Healthcare  
Procter & Gamble Inc., Health and Beauty Care Division  
Purdue Pharma  
Quixtar Canada Corporation  
Roche Consumer Health  
Sanofi-Synthelabo Canada Inc.  
Santé Naturelle Ltée  
Schering Canada Inc.  
Schering-Plough Healthcare Products Canada Inc.  
Stiefel Canada Inc.  
Vita Health Products Inc.  
W.K. Buckley Ltd.  
Whitehall-Robins Inc.  
Wyeth-Ayerst Canada Inc.