DRIVING DIGITAL INNOVATION IN THE ONTARIO HEALTH CARE SYSTEM

EVENT SUMMARY

September 19, 2017

ontario chamber of commerce

ABOUT THE ONTARIO CHAMBER OF COMMERCE

For more than a century, the Ontario Chamber of Commerce (OCC) has been the independent, non-partisan voice of Ontario business. Our mission is to support economic growth in Ontario by defending business priorities at Queen's Park on behalf of our network's diverse 60,000 members.

From innovative SMEs to established multi-national corporations and industry associations, the OCC is committed to working with our members to improve business competitiveness across all sectors. We represent local chambers of commerce and boards of trade in over 135 communities across Ontario, steering public policy conversations provincially and within local communities. Through our focused programs and services, we enable companies to grow at home and in export markets.

The OCC provides exclusive support, networking opportunities and access to policy insight and analysis to our members. We also work alongside the Government of Ontario on the delivery of multiple programs, and leverage our network to connect the business community to public initiatives relevant to their needs.

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INTRODUCTION

On September 19, 2017, the Ontario Chamber of Commerce (OCC) hosted expert stakeholders from government, research and the private sector for a day-long discussion on digital innovation within the Ontario health care system. Speakers identified opportunities for improved integration of digital health technologies and data analytics in our system and provided insight into the considerations for, and barriers to, their use. As a theme, participants were invited to discuss how to activate private sector innovation in service of the public good.

The following pages summarize each session and identify a series of key insights of value to both public and private stakeholders.

KEY TAKEAWAYS FROM EACH SESSION

1

KEYNOTE: A "PRESCRIPTION" TO ENABLE TRANSFORMATION

- Set realistic goals. Change isn't going to come quickly, and the fiscal crisis faced by many health care systems still isn't forcing change – nor is patient consumerism.
- Resist reinventing the wheel. Getting a technology to scale is better than introducing a widget that is just slightly better.
- Bring successful pilots to roll-out. If it works, then remove the barriers to scale.
- Create new procurement models based on desired outcomes.
- Align incentives, and create incentives for adopting technologies.

2

PATIENTS AS CONSUMERS PANEL

- Creating alignment between patient and clinical goals and patient and policy goals is where we can best achieve change.
- Patients are ready to use more sophisticated technology across their health care journey, but policy and organizational change need to happen before that integration can successfully occur.
- The proper use of data – at both an individual and population level – would be transformational in our health care system and move it from being provider-centric to patient-centric.
- Overall, the panel sees a real opportunity for technology to bring improved patient centricity into the Ontario system.

3

HEALTH DATA AND PRIVACY PANEL

- Allowing health data to be used, rather than just collected, can have a tremendous impact on improving population health outcomes. If we ensure the public understands this – and are participants in this process – we can achieve great things.
- Artificial Intelligence (AI) has tremendous potential for health care organizations, and the barriers are either exaggerated (legislation) or can be overcome with the right resource management (cloud computing).
- In many ways, health data is a form of consumer data, and so requires similar legislation and similar consumer activism. But there is no consumer advocate for health care in Canada.
- Canadians are generally unaware of where their bank stores their data and how they use it, but they know that it is secure and they can access it when they need it. Hospitals are expected to take appropriate and reasonable measures to keep data secure; banks have outsourced for years and consumers trust them.

4

HOW TO BUILD PATHWAYS PANEL

- Over the next two years, the panelists want to see the following actions to improve the flow of information between public and private nodes within the broader health care system:
    - Care pathways that are dynamic and personalized.
    - A system that can use data to make informed decisions both clinically and from a business planning perspective.
    - Public and private partners aligned around what needs to go into a data-sharing agreement as well as proper governance to bring stakeholders together.

5

THE HEALTHCARE SECTOR SUPPLY CHAIN STRATEGY EXPERT PANEL

- Procurement and supply chain reform are fundamental to creating a patient-centric health care system.
- A single procurement entity will allow for data collection and integration, upskilling and leadership development, and economies of scale.
- It is not necessarily the BPS Directive that must change, but the culture of conservatism and bean-counting around it.

6

THE INNOVATION BROKERS

- Office of the Chief Health Innovation Strategist (OCHIS) has seen positive change over the past two years, as leveraging health as an economic driver is now front and centre in Ontario government strategy.
- Innovation for innovation's sake is not the goal. Innovation must inject value into the system.
- Innovation Brokers act as resources and matchmakers in order to mitigate challenges facing innovative companies attempting to "break in" to Ontario's health care system.
- Ultimately, OCHIS and the Innovation Brokers want to be catalysts to grow the Ontario health innovation ecosystem and ensure the province has a competitive advantage in the knowledge economy.

1 KEYNOTE

Dave Wattling
Chief Corporate Development Officer, TELUS Health

Dave Wattling believes that the barriers to innovation in the health care system are political, largely related to the alignment between funding and incentives. He also sees inertia among Canadians to take control of their own health care journey. As such, he believes that innovation can only be realized when we tackle those barriers, ideally through mechanisms like the creation of a health marketplace in which actors compete for a health outcome as opposed to a technology.

In order to create such a marketplace, a substantive public/private dialogue is necessary. The private sector is very used to and comfortable with risk, and are prepared to bring that same attitude to the health care system. Unfortunately, private sector innovation tends to be invited into the health care system through pilot projects – and Canada is a nation of endless pilot projects. Even when the pilot has a good outcome, we can't scale it. That's why TELUS Health has outlawed the word "pilot" – they will only develop projects that will go to market.

The company aims to think of Canadians as consumers of health all the time, not just when they are patients. The key to this is moving data securely and appropriately identifying stakeholders, and then connecting those dots in our siloed health care system. TELUS Health has launched a number of projects to accomplish this goal, including e-prescribing with Canada Health Infoway and exploring social impact bonds through a hypertension project in conjunction with the federal government.

1

KEY TAKEAWAYS

TELUS Health has a "prescription" to enable transformation:

- **Set realistic goals. Change isn't going to come quickly, and the fiscal crisis faced by many health care systems still isn't forcing change – nor is patient consumerism.**
- **Resist reinventing the wheel. Getting a technology to scale is better than introducing a widget that is just slightly better.**
- **Bring successful pilots to roll-out. If it works, then remove the barriers to scale.**
- **Create new procurement models based on desired outcomes.**
- **Align incentives and create incentives for adopting technologies.**

2 PATIENTS AS CONSUMERS PANEL

Anna Greenberg, *Vice President of Health System Performance, Health Quality Ontario;* **Andre Bertram,** *Co-founder & Chief Executive Officer, HelpWear;* **Dr. Sacha Bhatia,** *Director, WCH Institute for Health System Solutions & Virtual Care, cardiologist, Women's College Hospital & University Health Network;* **Dr. Michael McGillion,** *Associate Professor and Assistant Dean, Research at the School of Nursing, Faculty of Health Sciences, McMaster University*; **Moderator: Tatum Wilson,** *Director of Stakeholder Relations, Council of Academic Hospitals of Ontario.*

This panel wrestled with the questions, How do we support and nurture a burgeoning patient consumer movement? And, how do we embrace patient-generated health data?

We know that patient transition is one of the most stubborn issues in the health care system, as patients feel abandoned by the health system when they experience a transition. The ability to reach into how disease is managed across providers would be a game-changer, and could achieve the promise of what Canadians have always wanted from their public health care system.

In meeting this goal, there is a lot of room for low-tech, personalized solutions, i.e. assigning a point person to look after a patient and develop a comprehensive, shared discharge strategy. But for most patients, being able to own and carry their own data could provide peace of mind and aid transitions – especially given that the vast majority of care happens outside of the institutional health care system's reach.

In response to a question about inertia amongst Canadians to take control over their health care journey, panelists noted that there is good reason for this inertia: How many of us think about actively engaging with our health care if we don't need to? Most Canadians just need to know the system will work when it needs to work, and in turn, the system is not designed to be responsive. If it were, people would be more engaged with their health.

The real struggle with patient readiness for innovative change is that the health care system is not equipped to integrate with consumer health technology, and consumer technology does not meet the clinical standard – so consumer products are not adding any real value at this time. Clinical-grade data is essential, but there is little incentive for companies to create that for consumer products due to the disconnect with the health care system.

In theory, if clinical-grade health technology looked and functioned like the technology patients use everyday, there would few barriers to integration. Unfortunately, it is designed for the lowest comfort level with technology – which means uptake and integration into daily life are less than seamless. Patients and health care providers are used to a certain level of technology and so expect that; this drives competitive and innovation. However, system incentives are not aligned to capture this drive.

The panel considered who is the most effective driver for integrating technology into the health care system: innovators, providers, or patients?

Although innovators may work explicitly to integrate technology into the system, they cannot be the sole drivers, as a system has to exist around them to allow them to drive change. They must work with health care providers and patients to understand their needs and respond to them; these groups are the deciders more than system executives or administrators. Above all, policies must exist to support this kind of collaboration and innovation.

For health care providers, their focus is less on evaluating technology and more on evaluating the model being created around it. Technology needs to come with a cost-effectiveness and utility analysis, as well as improved patient experience. Unfortunately, clinician adoption as a driver is a bit of a "myth". Clinicians may have ambition, but administration-level barriers such as risk aversion often prove too high and so they back down from driving change.

Without the policies that enable a model for technological integration, or support providers as they seek to make change, patients cannot be effective drivers. Even if they choose to be a high-tech consumer of health products outside of the formal health care system, without a seamless continuum of care there is a gulf in their care management between home and hospital.

The panelists concluded there is little economic incentive in our system to treat patients as customers, and there are few consequences if they have a poor customer experience. They agreed that what is not desired is incentivizing technology for the sake of technology. Instead, the system should incentivize better outcomes and a better experience for patients. Ideally, the government would be able to drive technology adoption without having to pick winners and losers, as a market created by the health care system would make those decisions instead.

2

KEY TAKEAWAYS

- **Creating alignment between patient and clinical goals as well as patient and policy goals is where we can best achieve change.**
- **Patients are ready to use more sophisticated technology across their health care journey, but policy and organizational change need to happen before that integration can successfully occur.**
- **The proper use of data – at both an individual and population level – would be transformational in our health care system and move it from being provider-centric to patient-centric.**
- **Overall, the panel sees a real opportunity for technology to bring improved patient centricity into the Ontario system.**

3 HEALTH DATA AND PRIVACY PANEL

Michael Watts, *Chair, Health Industry at Osler, Hoskin & Harcourt LLP;* **Dr. Muhammad Mamdani,** *Director – Li Ka Shing Centre for Healthcare Analytics Research and Training (LKS-CHART), St. Michael's Hospital;* **Alison Paprica,** *Director, Strategic Partnerships, Institute for Clinical Evaluative Sciences;* **Paul Sywulych,** *VP, Innovation, Morneau Shepell;* **Moderator: Danielle Peters,** *Co-Founder, Cross Border Health Foundation.*

This panel identified the inherent tension between the growth of data technology and existing legislation, as well as a lack of alignment between the general public and innovators on key questions surrounding health data privacy.

The clinicians on the panel noted that health care providers are already very data-driven, but ironically struggle at managing and using data, resulting in data siloes and lost opportunities. Health care centres need rigorous data governance models but, currently, standards are inconsistent.

For insurers, the challenge is creating a better flow of information between physicians and patients and then to employers (where appropriate), in order to answer the question, "How can we predict the things that cost employers money and make employees' lives less satisfying?" There is no one place to pull all the data together to get comprehensive a impression of a person's health. This means that as long as the costs of poor health are spread across payers, we are limited in our ability to build a business case to improve the health of an individual. But how do you get consumers on board with this kind of information sharing?

An inability to share information prevents the use of artificial intelligence (AI) models that could provide new perspectives and unlock population-level insight and predictive power. Unfortunately, AI requires an incredible amount of data to find patterns as well as a human point between the AI and the patient to provide context and judgement.

AI also requires cloud storage in order to work faster and conduct projects at scale. This raises questions of data localization and data havens; clinicians may have the right data but need help to anonymize or de-identify it, and then conduct analyses. Canada Health Infoway has identified the cost benefits of cloud computing for the public sector, as it releases them from having to hire expensive, sophisticated experts to effectively provide security. There are also crowd-sourcing benefits, as seen with the MIMIC Critical Care Database in Boston.

How do we enable this scenario? Panelists believe it begins with legislation and a principle-based approach rather than a cost-saving approach. While utilizing the cloud in Canada should not be a problem under existing legislation, we lack as comprehensive a law as the *Health Insurance Portability and Accountability Act* of 1996 (HIPPA) in the US – although, even with HIPPA, there are still individual state laws with which organizations must comply. Furthermore, few hospitals have a deep understanding of their own data security, much less how to utilize it to its best advantage. Finally, the public sector is competing with the private sector for the necessary skill-sets. With all these competing pressures, Ontario (and Canada) is looking at a distant future before we can create the kind of privacy and security environment in which health data is best lived.

The final hurdle is changing public opinion around data collection and use. The Institute for Clinical Evaluative Sciences (ICES) conducted public focus groups on these issues, and found some surprising results. In the public mind, privacy and security are indistinct. Removing names of patients is not enough; privacy at a group level is also valued. They want to see external oversight and as few users of the data as possible. While focus group members understand that data can be used for good, they were very sensitive to what was perceived as "Big Brother" observation.

This means that beyond a legal license, organizations that manage health data also need a social license to engage in the kind of work they want to do. They should consider three kinds of transparency: informational (does the public know that the organization is holding and using data?), participatory (are the public involved in the process?), and accountability (is the public integrated into the decision-making process). At the moment, the UK is a good example of effective transparency.

3

KEY TAKEAWAYS

- **Allowing health data to be used, rather than just collected, can have a tremendous impact on improving population health outcomes. If we ensure the public understands this – and are participants in this process – we can achieve great things.**
- **AI has tremendous potential for health care organizations, and the barriers are either exaggerated (legislation) or can be overcome with the right resource management (cloud computing).**
- **In many ways, health data is a form of consumer data and, therefore, requires similar legislation and similar consumer activism. However, there is no consumer advocate for health care in Canada.**
- **Canadians are generally unaware of where their bank stores their data and how they use it, but they know that it is secure and they can access it when they need it. Hospitals are expected to take appropriate and reasonable measures to keep data secure; banks have outsourced for years and consumers trust them.**

4 HOW TO BUILD PATHWAYS PANEL

Arun Ramasubramanian, *Vice President of Technology, R&D and Innovation/CTO, Medtronic Care Management, Medtronic*; **Michael Hillmer,** *Executive Director, Information Management Data and Analytics, Ontario Ministry of Health and Long-Term Care;* **Jason Evans,** *President & Co-Founder, Pentavere Research Group;* **Arnab Kundu,** *Chief Data & Analytics Officer, Great-West Life*; **Moderator: Ross Wallace,** *Principal, Santis Health.*

This panel began by emphasizing the importance of interchange between public and private data within the health care system. Health care is moving from managing sickness to encouraging wellness. This means it is important to look at the continuum of care and leverage data to drive the right technology to the right patients at the right time. There is useful information everywhere, whether patients collect it themselves or it is collected by the system. Unfortunately, most health data is not being made use of because it is not structured. So how do we meaningfully bring together sectors that have not traditionally worked together in order to overcome these challenges?

Currently, there is an imperfect information pathway between health care providers and their patients, one that insurers are left out of entirely. There is very little data that is not useful, but challenges abound: collecting data, merging it, gathering consent, anonymizing it, and then making it available to the relevant parties. On top of that, data without context is not helpful. Providers need actionable intelligence, not just information, such as: Why was a decision made? Was it effective? Could we do something different next time?

The panel agreed that governance is central to solving these problems, as we require standards that dictate how stakeholders connect to and use data. Proper governance allows for projects that improve patient health and experience including, for example, powerful tools of prediction and prevention. St. Michael's Hospital in Toronto and Pentavere are currently working on a project regarding the subtleties of health care, hoping to understand factors such as homelessness and opioid disorder, and how they predict emergency room visits.

Central to governance is determining the appropriate management of privacy, security, and public comfort with data use. The Ontario government recently doubled fines for data breaches and, given that financial and health data are the two most sacrosanct types of information, the government takes their security extremely seriously. Privacy officers tend to default to "no" because it is the simplest and safest answer – they want to be conservative because they are dealing with the most sensitive information. The provincial *Personal Health Information Protection Act* (PHIPA) is not necessarily as conservative as the privacy officers who enforce it. It has clear parameters for data use and consequences if there is a breach, but there are many myths about privacy regulation. There is room within PHIPA to solicit consent for data sharing from patients and clients, i.e. having a conversation that makes clear, "This is what I can and can't do with your data, this is what you want me to be able to do with your data".

As such, the barriers to data sharing are less technical and more cultural. When it comes to health information, it is difficult to remove bias from the system (i.e. if your mental health status is disclosed to your employer). The public needs to understand why a provider is sharing their data in order to improve understanding through context and, ultimately, to build trust.

This notion of context is linked to the value of historical data – we are looking at a future where data is plentiful and inexpensive to collect and store. Historical data can help build models, as long as we have clinical experience that can help contextualize older data, or data that was collected using different methodologies. Generally, there is always some value in data, so it is better to collect it now and figure out how to use it later.

4

KEY TAKEAWAYS

- Over the next two years, the panelists want to see the following actions to improve the flow of information between public and private nodes within the broader health care system:
  - Care pathways that are dynamic and personalized.
  - A system that can use data to make informed decisions both clinically and from a business planning perspective.
  - Public and private partners aligned around what needs to go into a data-sharing agreement as well as proper governance to bring stakeholders together.

5 THE HEALTHCARE SECTOR SUPPLY CHAIN STRATEGY EXPERT PANEL

Neil Sentance, *Member, The Healthcare Sector Supply Chain Strategy Expert Panel*
Interviewed by: **Lydia Lee,** *Partner, National Digital Health Lead, KPMG.*

Neil spoke about how the Healthcare Sector Supply Chain Strategy Expert Panel (the Panel) approached their task, and what next steps stakeholders can take to build on the group's recommendations.

The reason why supply chain was the assigned area of focus (along with procurement), is that it has the capacity to extract value for taxpayers and create value for clinicians and patients. The supply chain is a channel for capturing and deploying innovative solutions. Fundamentally, any procurement process run by a public institution is a reflection of that institution's public policy values and goals – albeit, with the inherent tension that implies.

The Panel did considerable work to understand the importance of value-based procurement (VBP). Neil noted that it is important to view procurement as a continuum: from commodities-based to services-based purchasing, to a joint solutions development model (with VBP closer to the latter end of the continuum).

The Panel's process for undertaking their task was to conduct considerable stakeholder consultation. They heard a clear message that any new approach to supply chain could not be more bureaucratic than it already is – it needs to be less prescriptive and more sensitive to stakeholder (including vendors, providers, and patients) needs. Patient-centricity and regional sensitivity were important aspects of this. However, there was not always alignment, including within the Panel – considerable debate was had over making the supply chain less hospital-centric and more systems-centric, and whether they were making correct assumptions about the context in which patients would be receiving care in 10 years.

The most foundational recommendation made by the Panel in their report is to create a single, province-wide, integrated structure for purchasing. While stakeholders do not agree on whether one entity is best, or if a small number of entities is preferable, the Panel recognized that the system that exists today is not popular. A single purchasing entity would require fewer repetitive processes and could achieve scale to leverage best market opportunities as well as integrate and leverage data to support the linkage between supply chain and patient outcomes.

The Panel therefore determined that Ontario does not need one organization that is bigger than what we have now, but one that is better than what we have now. This entity would engage in VBP, commodities purchasing, data integration, and act as strategic advisor to clinicians, but not be transactional.

Lack of appropriate skills is a key challenge that institutions will face as they move toward more sophisticated forms of procurement and supply chain management. Institutions tend to have a bias to design processes without thinking about who is there to make them work; who are the people and what are the skills they need to make the Panel's recommendations come to life?

The entity should, therefore, be thought of not as a buying agency, but a strategic advisor and centre of excellence, offering opportunities for upskilling and developing leadership capabilities. The government

can design all kinds of elegant procurement models but handing them to an organization that cannot execute on them will not be effective. For example, a solutions-based deal that evolved over time cannot be managed as a commodity; it needs to be managed as a relationship.

Another major issue the Panel heard from stakeholders was the perception of the BPS Procurement Directive. Some view it as overly prescriptive, while others believe it is open to interpretation, and even contains latitude for VBP. The Panel found that, relative to Ontario Public Service rules, BPS is "a paragon of simplicity". However, procurement officers are asked to balance a series of competing demands from administrators, vendors, lawyers, and users – so, asking them to take creative risks is difficult. The role of the new entity therefore must be to encourage senior leadership to assume accountability within institutions, to then free junior staff to interpret BPS creatively. To innovate, you have to "give people the license to think outside the box".

The need for leadership and accountability is linked to a perception among stakeholders that senior administrations within an institution may be on board with change, but mid-level staff is not. This is due, in part, to a sense that the procurement function has become disengaged from senior leaders at major institutions. This can be solved by putting decisions in the context of solutions, rather than talking simply about purchasing. But it requires a change in the perception of the procurement role from widget managers to strategists.

Finally, information management is key to making a new system work. Institutions do not have the capacity to understand fully what they are buying, and rarely know the impact on the patient – this is true of both sophisticated technology and commodities. How does an institution collect and learn from that information, to do procurement and supply chain better? Performance metrics and performance management must, therefore, be part of the entity's work.

The momentum for all this change can already be seen, in activities like mergers of existing group purchasing organizations, as well as the recent review of the BPS Directive. Dialogue on these topics and more will continue between the government and stakeholders.

5

KEY TAKEAWAYS

- **Procurement and supply chain reform are fundamental to creating a patient-centric health care system.**
- **A single procurement entity will allow for data collection and integration, upskilling and leadership development, and economies of scale.**
- **It is not necessarily the BPS Directive that must change, but the culture of conservatism and bean-counting around it.**

6 THE INNOVATION BROKERS

William Charnetski, *Ontario's Chief Health Innovation Strategist;* **Jennifer Zelmer,** *President, Azimuth Health Group;* **Rena Menaker,** *Interim Director, Policy and Member Relations, Council of Academic Hospitals of Ontario.*

William Charnetski noted that there has been a lot of change since the Office of the Chief Health Innovation Strategist (OCHIS) was founded two years ago. Leveraging health as an economic driver is now front and centre in Ontario government strategy – this was not previously the case. It may not be "instinctive" yet, but he believes that we are getting there.

OCHIS has three goals: Put patients at the centre of the system, inject value into the system, and use the system as an economic driver. These are driven by two challenges. The first is that Ontario needs to "win" in the knowledge-based economy. We need to pick a high-growth industry in which we have a competitive advantage, i.e. our single payer health system that is, in reality, a $52 billion business. OCHIS wants to leverage this business to grow and scale existing SMEs in Ontario.

The second challenge is that our health care system is not sustainable; care management will only get you so far. We need to drive innovation into the system faster and deeper if we want to seriously improve outcomes.

However, innovation has to be more than just "cool" – it needs to inject value. OCHIS is run like a business: success is based on the impact the office has, not the activity it generates. The office should act as a catalyst to grow the health innovation ecosystem, driving behavioural change and mitigating risk aversion in the system. It should help make the public system a pull to innovation, the way the private sector is.

A major contributor to achieving these goals are the Innovation Brokers. They are field-based, senior individuals who know how to facilitate and how to "get deals done".

One Innovation Broker is an organization – the Council of Academic Hospitals of Ontario (CAHO). They see that individuals within hospitals struggle with innovation adoption and hospitals generally lack processes to guide them. As a Broker, CAHO is providing a streamlined process for innovators to be matched with real-world validation test sites, creating one doorway to their 23 research hospitals. This includes a framework for change management, building capacity for CAHO's member hospitals and positioning them as leaders in the innovation economy.

The other Brokers are individuals, who identify organizations that have a beachhead in the health care system and who are looking to scale. They try to solve three problems:

1. Large organizations have staff that can scan for opportunities, do government relations work, and so forth. However, SMEs do not have these resources, and therefore, miss opportunities that can help them grow or establish the relationships they need.
2. SMEs may lack sophisticated pitching skills for convincing health care organizations to take a chance on their innovation. This includes the ability to convey the social good implications of their product or service.

3. The difficult path to value-based health care. We cannot just build capacity on the system side; the innovator side also needs to know how to operate in a value-based system.

The Brokers act as resources and matchmakers in order to mitigate these challenges.

One of the major challenges in Canada is "pilot-itis": continued greenlighting of pilot projects without any attempt to expand or scale successful projects. OCHIS notes that the BPS Directive does not prevent an institution from procuring through the pilot phase; the issue is cultural, not legal, regulatory or policy-related. Procurement is only one piece of the puzzle, as change management and innovation adoption are also required to scale or formalize a pilot. Similarly, what allowed innovators to land a pilot are not the same factors that will allow them to be successful at the next stage. What is required is a change in thinking and an understanding of the health technology assessment process.

OCHIS understands the importance of measuring the impact of the Innovation Brokers, but does not want to claim to be solely responsible for firm growth – the program should just be a catalyst to grow the larger ecosystem. The metrics they will examine may include a survey of companies, which identify how much additional investment they received, how many were able to penetrate the health care system, growth in sales to the system, employment statistics, and export data.

6

KEY TAKEAWAYS

- **OCHIS has seen positive change over the past two years, as leveraging health as an economic driver is now front and centre in Ontario government strategy.**
- **Innovation for innovation's sake is not the goal. Innovation must inject value into the system.**
- **Innovation Brokers act as resources and matchmakers in order to mitigate challenges facing innovative companies attempting to "break in" to Ontario's health care system.**
- **Ultimately, OCHIS and the Innovation Brokers want to be catalysts to grow the Ontario health innovation ecosystem and ensure the province has a competitive advantage in the knowledge economy.**

NEXT STEPS

Large organizations have staff that can scan for opportunities, do government relations work, and so forth. However, SMEs do not have these resources, and therefore, miss opportunities that can help them grow or establish the relationships they need.

Increasingly, we see alignment between public and private stakeholders about the potential for our health care system to be both an economic driver and a competitive advantage. Both sides also view procurement and supply chain reform as a critical vehicle for injecting innovation and increasing patient-centricity in the system. Public institutions are demonstrating leadership on data analysis and partnering with private organizations to build powerful tools for prediction and prevention.

However, there is also room for change. A lack of alignment between system funding and incentives, as well as a lingering distrust between public and private actors, is preventing a faster and more effective roll-out of new technologies and business models.

Since 2016, the Ontario Chamber of Commerce has dedicated itself to convening a diverse group of health stakeholders to discuss, analyze, and offer solutions to many of the barriers listed in these pages. We intend to continue this work in 2018, expanding our focus to include the entire life sciences sector and seeking to bring better alignment between government priorities and private expertise.

For more information about the OCC's health and life sciences policy work, visit transformhealth.ca or contact:

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