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If Canada had a System-Wide Healthcare Strategy, What Form Could it Take?

WHITE PAPER - WORKING DRAFT

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Canada is richly endowed with healthcare strategies. Ten provinces and three territories each have their own strategic frameworks addressing in varying levels of detail and sophistication the delivery of healthcare within their constitutional jurisdictions. In addition, the government of Canada has strategies addressing its management and oversight roles in the federal health insurance legislation as prescribed by the Canada Health Act (1985), as well as its management and regulatory responsibility for consumer and product safety, drugs and health products, food and nutrition, and First Nations, Inuit, and military healthcare.

There is more strategy in the system. At the sub-provincial level, health regions (authorities, integration networks, etc.) have strategies. Canada’s more than 700 hospitals each have strategies. Equally, strategies exist within professional associations (such as the Canadian Medical Association, Canadian Nursing Association, and others), pharmaceutical companies, device manufacturers, technology companies, consulting firms, and a myriad of other corporate participants in Canadian healthcare.

Different missions and objectives guide and motivate the participants in this complex system, but to the extent that all can be circumscribed by the World Health Organization’s definition of a health system as “all the activities whose primary purpose is to promote, restore, or maintain health” (WHO, 2000, p. 5), the Canadian reality can be characterized as fragmented. Less charitably, Leatt, Pink, and Guerriere refer to it as “a series of disconnected parts,” and “a hodge-podge patchwork” (2000, p. 13). That the system has independent or even autonomous parts is not the main problem. Being so unconnected and un-integrated is the main concern. Even if the overall system performed with good outcomes, it would not be because we planned it that way. We could just be lucky, or benefitting from circumstances outside of our control. Further, we would not easily be able to explain why, or predict how well or poorly it would perform in the future.

In satisfaction surveys, Canadians are ambivalent about their system. As a whole they think it is unsustainable (Levert, 2013; Dodge & Dion, 2011; Kirby, 2002), but are generally positive about their own experiences (Health Council of Canada, 2007). As suggested by the Health Council of Canada (2007), perhaps this is because they consider current services to be sufficient but the system overall to be in jeopardy.

Still, more pointed questions show less satisfaction. For instance, in the Commonwealth Fund’s (2010) survey of 11 countries,1 respondents were asked if they became seriously ill, how confident/very confident they were about getting the most effective treatment (including drugs and diagnostic tests). Canadians were in the bottom half. When asked about their overall views of the system, 51% thought fundamental changes were needed. Only the Australians were less satisfied, at 55%.

As will be seen, from the evidence available to us, it is easy to appreciate that our system is not performing well. It may not be performing badly, but it is not doing well compared with other countries. This is especially of concern given how expensive the Canadian system is to operate. Would Canadians be more confident if we had a strategy, a system-wide plan that clarified where we should be headed and how we would get there? Would the system perform more efficiently, effectively, and equitably if we had an overall strategy that knit the disparate pieces together in a way that would allow us to predict and explain the causal relationships among the components of the system? If so, what form would a Canadian healthcare strategy take?

Discussions about Canadian healthcare are heavily influenced by political considerations – commonly cited as a reason for chances involving multiple political jurisdictions being hard to implement.2 That said, strategy and

1 The Commonwealth Fund (2010) survey comprised 11 OECD countries: Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States.
2 See the excellent study by Lazar et al. (2013).
governance are concepts at home in management theory and practice. Could a management perspective contribute usefully to the debate about a system-wide Canadian healthcare strategy in a way that could address the political obstacles?

For our purposes, we will take system-wide strategy to be interchangeable with “Canadian strategy,” “national strategy,” and “pan-Canadian strategy,” but not “federal strategy.” Based on this, we will address the above questions as follows. First, we will explore how well our system is performing. If it is as strong as it should be, we will have less of a reason for wanting to look beyond the existing Canadian structure than if it is poorly performing. Second, are there credible calls for a system-wide strategy? If not, and it is only a hypothetical possibility, there will be little urgency for strategic change. Third, what does having a strategy mean, and what form could such a strategy, or strategies, take? It is easy to misconstrue having a system-wide strategy as being equivalent to, or necessarily connected with, a specific form of governance, such as a federal government imposed top-down arrangement. This is not intended here. Fourth, I argue that a good prima facie case exists for a Canadian system-wide strategy. Building on this, I propose that the balanced scorecard approach is well suited not only to frame a Canadian strategy, but also to be used as a strategic management tool. Fifth, the scorecard of the newly restructured National Health Service, England, can be fashioned as an illustration of what a Canadian balanced scorecard might look like. This is not to say we should emulate the NHS model, only that it contains certain important features that we might consider adapting for our own purposes. Sixth, I set out two governance models, collaborative governance and corporate governance, and show why the latter has advantages over the former in providing a basis for governance oversight of a Canadian system-wide strategy. Finally, some concluding remarks will draw the discussion points together.

### Evaluating Canadian Healthcare

There are many ways of assessing health quality. The Organisation for Economic Cooperation and Development (OECD, 2011) uses 70 indicators in eight categories: health status, non-medical determinants of health, health workforce, health care activity, quality of care, access to care, health expenditures and financing, and long-term care. It is not feasible to evaluate Canada’s healthcare system in this depth, so what should we examine for the purposes of lending credibility to the call for at least some form of system-wide strategic framework? As Smith, Mossialos, Papanicolas, and Leatherman (2009, p. 8) point out, the wide array of data used to measure systems are often chosen, not because of their strategic value, but because of their accessibility and convenience of collection. Still, common to most approaches are five general categories: measures of healthcare provided by the system, responsiveness to individuals, financial protection to individuals from the costs of healthcare, productivity of the resources, and equity in terms of access. Smith et al. (2009) also maintain that prioritization is needed in data selection to fit the purposes for which it is being used.

How then should we prioritize? In a recent survey, the Canadian Institute for Health Information (CIHI, 2013a) determined that access, responsiveness, equity, quality, health promotion and disease prevention, and value for money are what Canadians rank as being most important. For our purposes, I propose to consolidate these into three categories: (1) cost of the system (value for money); (2) system performance (quality, responsiveness, health promotion, and disease prevention); and (3) access (access and equity).

We will briefly evaluate these three categories and use this discussion as a step toward answering the question about whether Canada needs an overall healthcare strategy.

### Cost of the Canadian System

Canada spends $211 billion on healthcare in an economy of $1.82 trillion (GDP), the 11th largest economy in the world. If Canadian healthcare expenditures represented a fictitious country’s economy, that country would be the 46th largest in the world by GDP – between Portugal and Ireland. These health expenditures have been rising steadily in both current and constant 1997 dollars since 1975, as Figure 1 shows. The same is in evidence when calculated as a percentage of GDP (see Figure 2). Although fluctuations have occurred, there seems little reason to think that expenditures to GDP will back down without either a reduction in the former or growth in the latter. The combination of population growth, new medical technologies and techniques, and the expansion of pharmaceuticals to treat illnesses explain continued expenditure growth both in absolute terms and as a percentage of GDP (CIHI, 2013b). These factors are likely to continue into the foreseeable future.

More than a decade ago, the Senate committee headed by Michael Kirby concluded in its report that “rising costs strongly indicate that Canada's publicly funded health care system, as it is currently organized and operated, is not fiscally sustainable given current funding levels” (Kirby, 2002, p. 2). At roughly the same time, the Romanow Report (2002) seemed to maintain the reverse, namely that the system was sustainable. The Report said:

- The system is neither unsustainable nor unfixable, but action is required to maintain the right balance between the services that are provided, their effectiveness in

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3 A federal strategy is mandated by the Government of Canada.
4 The World Health Organization (2013) uses approximately 80 measures in the following categories of indicators: life expectancy and mortality, cause-specific mortality and morbidity, selected infectious diseases, health service coverage, risk factors, health systems, health expenditure, health inequities, and demographic and socioeconomic statistics. Also, the Canadian Institute for Health Information (CIHI, 2014) measures system performance in terms of access, quality, spending, health promotion, and disease prevention and health outcomes.

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meeting the needs of Canadians, and the resources that we, as Canadians, are prepared to dedicate to sustain the system in the future. (p. 2)

In the end, Kirby and Romanow were not far apart: Kirby said the system is not sustainable without remediation; Romanow said the system is sustainable with remediation.

Nearly a decade later, Drummond (2011) added an ironic touch by suggesting that Canadians should be careful what they ask for. He said:

When asked, voters respond that they are prepared to pay higher taxes and consume less of other public services in order to preserve healthcare. But it is not clear they understand how severe this squeeze could become.

The question then becomes, how much tolerance do Canadians have? To date, it appears that the threshold is high.

A key part of the story for our purposes, though, is not just a matter of expenditure increases, but rather it is how much we spend compared to our peer group – the 34 OECD member countries. Measured as a percentage of GDP, Canada ranks 5th highest among 30 of the OECD countries (see Figure 4). In terms of per capita expenditures, Canada is 36% higher than the OECD average, and we rank 6th highest among member countries (see Figure 5). In both percentage of GDP and per capita expenditures, Canada is well below its usual comparator, the United States. However this is still above nearly three quarters of the rest.

Figure 1 - Total Canadian Health Expenditures in Billions of Dollars
Source: National Health Expenditure Database, Canadian Institute for Health Information.

Figure 2 - Health Expenditures as Share of GDP
Source: National Health Expenditure Database, Canadian Institute for Health Information.

Figure 3 - Per Capita Canadian Health Expenditures
Source: National Health Expenditure Database, Canadian Institute for Health Information.

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It is useful to note the relative position of the UK, as its system is less expensive than Canada’s. The UK ranks 14th in health expenditures as a percent of GDP, and 15th on a per capita basis. This is an interesting comparison with Canada because in the Commonwealth Fund (2010) study referred to earlier, 92% of UK respondents were confident/very confident that they would get most-effective treatment (including drugs and diagnostic tests) if they became seriously ill. Canadians were much less confident at 76%. Canada spends 33% more per capita than the UK, yet the UK respondents are considerably more confident about their quality of care.

We should not conclude from this review that an expensive system is unacceptable in itself, although it is clear that Canadians will need to be prepared to provide the resources to finance it, even if this means accepting diminutions of expenditure on other social programs such as education and social services. Rather, we should ask whether this expensive system is justified. Let us consider the two other evaluation criteria, namely performance and access.

7 The average confidence level in the 11-country survey was 79.9%. Germany was the median country at 82%, and Australia and Canada were tied at 76%. Only the United States and Sweden were below, at 67% and 70%, respectively.
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Figure 6 - Quality of Patient Care Performance for Canada
Source: Canadian Institute for Health Information, 2014.

Without going into the detail of the Chart here, it is easy to see that Canada performs at or above the average in community care and cancer care. Each indicator is within the middle 50 percentage points between the 75 and 25 percentiles. In two cases, Canada even performs above that band. However, performance is below the average for patient experience, though still within the middle band, except in one case where it is shown as below the band. Performance in patient safety, though, is considerably worse, with four of the seven indicators falling below the middle band. Finally, the hospital fatality measures in terms of acute care outcomes are split between above and below the OECD average, but both are within the 75/25 band.

The conclusion to be drawn here is not about definitive assessments of system performance. Rather, it is about asking whether our system could perform better. If so, this leads to the further question of whether its performance as a system could be improved by better planning? In other words, if we had a more strategic approach to knitting the pieces of our high cost system together, with a clear focus on patient outcomes, and on how the parts of the system could efficiently and effectively contribute to this effort, would we be better off? Of course, having a comprehensive strategy would not guarantee outcomes, but as we formulated the strategy (or strategies), we would evaluate the causal relations among the components and plan for successful connections between them.

Accessibility

There are two aspects of access to be brought out: wait times and cost to patients. Starting with the former, consider some of the results of the Commonwealth Fund (2010) survey summarized in Table 1.

<table>
<thead>
<tr>
<th>Medical Service Wait Times</th>
<th>Canadian Comparative Performance</th>
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</thead>
<tbody>
<tr>
<td>Access to doctor or nurse when sick — same or next day appointment</td>
<td>Worst (tied)</td>
</tr>
<tr>
<td>Access to doctor or nurse when sick — waited six days or more</td>
<td>Worst</td>
</tr>
<tr>
<td>Difficulty getting after hours care without going to emergency room</td>
<td>Second worst</td>
</tr>
<tr>
<td>Used emergency room in past two years</td>
<td>Worst</td>
</tr>
<tr>
<td>Wait time for specialist appointment — less than 4 weeks</td>
<td>Worst</td>
</tr>
<tr>
<td>Wait time for elective surgery — less than one month</td>
<td>Second worst</td>
</tr>
<tr>
<td>Wait time for elective surgery — four months or more</td>
<td>Worst</td>
</tr>
</tbody>
</table>

Table 1

It is not difficult to see the list of deficiencies. The first three items address basic wait times for seeing a doctor or nurse when sick. Canada performs worst in its
peer group in patients getting in to see a doctor or nurse the next day, or even within six days. The default option for those unable to get medical attention in the community is to visit the emergency department of a hospital – a very time consuming experience for patients, and expensive for the system. Canadians are the second worst in accessing after hours care without going to the hospital, and worst in terms of needing the hospital for medical attention that likely otherwise could have been dealt with in a physician’s office.

Surgical wait times, the following three items, score no better than family practitioner wait times. Canadians wait the longest to see a specialist. And the time it takes for elective surgery is second worst, in that there are wait times of less than one month; wait times taking longer than four months are worst of all.

The second issue relates to accessibility with respect to cost, precisely what the universal health insurance under the auspices of the Canada Health Act (1985) is supposed to address. A recent study (Sanmartin et al., 2014) shows that while healthcare costs have been rising for all Canadian income groups, the burden has been highest for those with lower incomes. This is accounted for by out of pocket spending on prescription drugs and dental care insurance premiums.

Returning to the Commonwealth Fund (2010), we are provided with useful, if sobering, results which show Canada in the bottom four (of 11) in each category. Table 2 summarizes this.

### The Commonwealth Fund 2010 International Health Policy Survey in Eleven Countries
(Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom, United States)

<table>
<thead>
<tr>
<th>Medical Service: Income Accessibility</th>
<th>Canadian Comparative Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answering yes to at least two of:</td>
<td>Fourth worst</td>
</tr>
<tr>
<td>• Did not fill prescription of skilled doses</td>
<td></td>
</tr>
<tr>
<td>• Had medical problem but did not visit doctor,</td>
<td></td>
</tr>
<tr>
<td>• Skipped test, treatment or follow-up</td>
<td></td>
</tr>
<tr>
<td>Out of pocket medical costs $1000 or more, past year</td>
<td>Fourth worst</td>
</tr>
<tr>
<td>Serious problems paying or unable to pay medical bills, past year</td>
<td>Fourth worst (three-way tie)</td>
</tr>
<tr>
<td>Confident will be able to afford needed care</td>
<td>Third worst</td>
</tr>
</tbody>
</table>

Table 2

Should we be satisfied with such poor accessibility? Given that we have an expensive system, is there a reason why these impediments to accessibility should be permitted? Could a national strategy address this? Many countries in our peer group do have national strategies. Could this partly explain why they perform better in managing their systems?

The UK, for instance, performs better than Canada in every category of both wait times and income access above. Indeed, it leads all 11 countries in each of the income access categories. By contrast, the US, which does not have a national strategy, is among the three worst in four of the seven wait-time categories and at the bottom in each income accessibility category. That said, since Canada usually compares itself to the US, we should note that the US performs better than Canada in all seven wait-time categories. In terms of income accessibility, Canada ranks better than the US in each category; but lest we be too sanguine, we share with the US the bottom four ranking in all categories.

A final observation from the Commonwealth Fund (2010) study has relevance for accessibility. First, when asked whether they were confident/very confident about receiving the most effective care if sick, Canadians were the third least confident, as indicated above. When the responses were broken out between above and below average income, it would be expected that a country such as Canada, that prides itself on being egalitarian, and that has the Canada Health Act (1985), which seeks to enshrine such values in the universal insurance scheme, would have a very small gap between the two income levels. Yet Canada is the third worst, ahead only of the US and Sweden. Further, when it comes to cost related access problems in the past year by income, it would again be expected that Canada would perform well. However, Canada is also third worst on this indicator (ahead of only the US and Norway).

In summary, it is difficult to see Canada’s very expensive system with its rising long-term cost trajectory, as performing at a satisfactory level. So we now address the matter of a system-wide (or national or pan-Canadian) strategy. The first question is, are there currently any demands from key stakeholders for this?

### Calls for a System-Wide Strategy

The foundation of any strategy is a common vision and shared goals. From this can be built strategic direction and prioritized courses of action, chosen from among competing alternatives. For decades, national discussions of Canada’s healthcare system have called for this. The idea of a Canadian strategy is not something new. As far back as 1964, a Royal Commission on Health Services (Hall Commission) brought forward recommendations for a national health policy and a comprehensive program for healthcare (Hall, 1964/1965). Hall recommended a universal health insurance system for all Canadian provinces based on the existing Saskatchewan model. Hall’s recommendations were influential in the creation of the Medical Care Act (1966), although the Act was presented.
not as comprehensive as Hall’s proposals.

In 1974, the federal and provincial health ministers endorsed a general framework, later produced in a white paper called, “A New Perspective on the Health of Canadians: A Working Document,” by Marc Lalonde, Canada’s Minister of National Health and Welfare. He states: “there are national health problems which know no provincial boundaries and which arise from causes imbedded in the social fabric of the nation as a whole” (1974, p. 6). Lalonde goes on to spell out broad objectives, main strategies, and a myriad of proposals, which he says, “constitutes a conceptual framework within which health issues can be analysed in their full perspective and health policy can be developed over the coming years” (p. 73).

The report of the Romanow Commission (Romanov, 2002) entitled, Building on Values: The Future of Health Care in Canada, contained 47 recommendations, many of which are parts of what could have been developed into a Canadian national strategic plan. Based on shared values represented by a publicly funded health system and compatible with jurisdictional nature of the Canadian political system in health information, health human resources, health education, research, primary care, immunization, home care, prescription, and many revisions to the Canada Health Act accommodate this. The establishment of the Health Council of Canada to bring collaborative leadership, coordination and common measures, and a performance metric was central to the overall strategy. By combining forces with nationally mandated institutions such as Canada Heath Infoway, with its mandate to invest in health technology projects, and the Canadian Institute for Health Information, the vehicle through which national health analysis and reporting could be conducted, a pan-Canadian framework could be established. Romanov (2002, p. xiii) introduces his report saying: Taken together, the 47 recommendations contained in this report serve as a roadmap for a collective journey by Canadians to reform and renew their health care system. They outline actions that must be taken in 10 critical areas, starting by renewing the foundations of medicare and moving beyond our borders to consider Canada’s role in improving health around the world.

Reporting at approximately the same time, the Senate Standing Committee Report, The Health of Canadians: The Federal Role, Chaired by the Honourable Michael Kirby (2002), covered much of the same ground with a similar starting point, namely that “Canadians want the provinces, the territories and the federal government to work collaboratively in partnership to facilitate health care renewal. Canadians are impatient with blame-laying; they want intergovernmental cooperation and positive results” (Kirby, 2002, p. 6). Kirby provided many recommendations concerning national practices, as did Romanow, but he stopped short of calling for national bodies with clear decision-making mandates for action, and with the legal authority to make change or sanction inaction. For instance, his proposal for system-wide governance ignored advice from academics and others to the Committee about independence and autonomy (Kirby, 2002, pp. 14–16), and instead proposed the National Health Care Council, which would substantially make reports and recommendations to governments (Kirby, 2002, p. 19).

Whatever their merits, Hall, Lalonde, Romanow, and Kirby all affirmed that a vision for Canadian healthcare was crucial, not just for sustainability, but also for achieving the level of healthcare that Canadians deserve. This overriding message taken in the light of the criticisms of sustainability, performance, and access might lead us to wonder if the voices for a national strategic approach have been strong enough.

Of course, not all calls for system-wide strategies are comprehensive. Many are specific to components of the system. For instance, a Federal/Provincial/Territorial Committee (2007) addressing healthcare delivery and health human resources said that “between 60 and 80 cents of every health care dollar in Canada is spent on health human resources (and this does not include the cost of educating health care providers)” (p. 1). The committee went on to recommend “a pan-Canadian framework that will help shape the future of HHR planning and health service delivery… [and that] builds a case for a pan-Canadian collaborative approach to planning...to achieve a more stable and effective health workforce” (p. 2).

In another case, with regard to patient safety, the National Symposium on Quality Improvement (Health Council of Canada, 2013) said:

> we have seen the good results that can come from pan-Canadian approaches in areas such as patient safety and accreditation in this country. We could achieve greater system transformation and improve quality of care if we were to adopt a common quality improvement framework through which we could learn from each other.

This perspective is shared by the Royal College of Physicians and Surgeons (2002), which proposed that we establish “a coordinated, national strategy…to reduce error in medicine, increase patient safety and thus quality of care” (2002, “Preamble”). On a related issue, the Canadian Medical Association conducted a survey (CMA, 2013) showing that “nine in ten Canadians agree having a national health care strategy for seniors would improve the entire health care system” (p. 6).

Outside the medical profession, there are other calls for a Canadian strategy. For instance, the Canadian Life and Health Insurance Association (2013) says that, “the industry believes that Canadians would benefit from the establishment of a common national minimum formulary” (p. 27). Further, with respect to electronic health records (HER), the Auditor General of Canada (2010) commented that, “implementing EHRs is a pan-Canadian initiative that requires the collaboration of the federal government, Canada Health Infoway Inc. (Infoway), provincial and territorial governments, as well as other organizations involved in the delivery of health care” (2010, “Shared Responsibility”). As well, the medical device industry, through its industry association MEDEC (2012),
in discussing health technology assessment, "recognizes the challenges of decision making in very complex and somewhat silo-based health systems, however, the true value of HTA (Health Technology Assessments) and innovative medical technologies will only be realized through a whole system approach to health care resource management" (MEDEC, 2012, p. 3).

What does all this mean? It shows that within government, industry, professional associations, and others, there are many voices calling for either or both a comprehensive pan-Canadian, system-wide strategy, or sector specific pan-Canadian, system-wide strategies that deal with aspects of Canadian healthcare. It certainly is not necessary to opt for one or the other. A Canadian strategy could be comprised of both comprehensive general strategies and more focused sector-specific strategies.

What the discussion so far does not show is what a Canadian strategy should necessarily contain, either with respect to its scope or the specific content of its recommended objectives, measures, targets, and activities. But it does point to the need for strategy. This is well summed up by the Institute for Public Policy Task Force on Health Policy. In its recommendations to First Ministers (IRPP, 2000), it said: "After nearly a decade of cost cutting, some Canadians have lowered their sights from an excellent healthcare system to one that merely meets minimum standards. This is unfortunate. Canadians should demand and expect excellence, not mediocrity" (p. 6). To this was added the explanatory note, the system lacks clear goals and is not sufficiently accountable to the public. While the original principles of the Canada Health Act remain valid, they are no longer sufficient to address the new realities and emerging challenges of health services delivery. Nor do principles substitute for strategic and long-term planning to anticipate the growing pressures on healthcare delivery and the changing healthcare needs of Canadians. (p. 6)

A Canadian System-Wide Strategy

What form could a Canadian system-wide healthcare strategy take? To repeat what was said at the outset, words like "system-wide," "pan-Canadian," or "Canadian" when modifying the word "strategy" are taken herein to be synonyms. And none should be construed as meaning an arrangement in which the federal government usurps the roles of provinces and territories. A Canadian strategy is something that must be acceptable to all, or at least most, provinces and territories as well as the Canadian government.

Next, it is easy to become confused about what is meant by a "strategy," and how it might apply to a national healthcare system. So let us start with some preliminary groundwork leading to a working definition.

Strategy has its roots in military and political contexts. As a management concept, though, it has grown exponentially from the mid 20th century to the present, mainly because of the vast increases in the scale and scope of corporations. It is not difficult to see how the concept of strategy applies to governments and their healthcare systems, because many corporations today have revenues that exceed the GDP of countries. For instance, the largest five companies in the world (Royal Dutch Shell, Wal-Mart Stores, Exxon Mobil, Sinopec Group, and China National Petroleum) have revenues ranging from $482 billion to $409 billion; each larger than the entire economies of countries falling below 27th in the world as measured by GDP. Even the 500th largest company (Ricoh) has annual revenues the size of Trinidad and Tobago, the world’s 100th largest economy. And many of the companies on the Fortune 500 list are very complex, having many different lines of business and operating in countries all over the world.

Strategy is discussed in the management literature from many perspectives, such as: (a) patterns of action that can be observed in an organization’s decision-making; (b) approaches that an organization takes to positioning itself in the marketplace to gain competitive advantage; (c) philosophical perspectives or images that an organization has of itself; (d) tactics used to compete in the marketplace; and (e) plans that an organization makes to guide decision-making and to achieve its goals.

While strategy can have various meanings, for a healthcare system, strategy needs to be prescriptive, i.e., providing guidance for the future. So (a) will not suffice because it simply describes what is occurring, rather than pointing to what should exist. Definition (b) focuses on competition, so it is better suited to business, or at most the business aspects of healthcare, not the Canadian system overall. Neither (c) nor (d) is sufficient for system-wide, forward-looking guidance, however both could be incorporated into (e), which is the most useful because its focus is planning. Planning the future is the most common meaning associated with strategy, so if we combine (e) with a philosophical approach and tactics, a working definition could be generated. Consider this proposal:

A Canadian healthcare strategy is the pattern of decisions that is justified and motivated by goals and principles that embody what we are committed to do in order to promote, restore and maintain the health of Canadians. The pattern of decisions is shaped by specific measurable objectives and activities for achieving desired Canadian health outcomes. The strategy is imbedded in a vision that reflects our aspirations for health based on fundamental Canadian values.

8 See for instance, Sun Tzu, The Art of War (1971); lived 544BCE–496BCE), and Carl von Clausewitz, On War, (1968; lived 1780-1831).
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Construed this way, the components of a Canadian healthcare strategy can be set out in Figure 7.

Figure 7 - Components of a Canadian Healthcare Strategy

It might be thought that such a framework could fit only institutions, such as hospitals, and be difficult to stretch out to cover a whole system. I will provide a more concrete system illustration in a moment, but for now keep in mind that system-wide strategies are common in Canadian at the provincial and territorial level. And as an example of a national strategy, the National Health Service in England (NHS England, 2013) has published its strategy in the form of a business plan for 2013–2016, with measurable objectives and targets. Systems can have strategic plans as well as organizations.

A system strategy is really a "strategy-of-strategies" because it incorporates the independent strategies in the various parts of the system. This is common in the corporate sector where some organizations are so large and diverse that they share many characteristics of a national healthcare system.

The next step in understanding the form of a Canadian healthcare strategy is to extend the definition into a structure that shows how the pieces of strategy relate to one another. The "balanced scorecard" (BSC) approach provides a good basis for this. In various forms, it is being used around the globe by governments, regional health authorities, hospitals, and others, as the vast and growing academic and professional literature shows.


13 See for example the use made of performance metrics by the Alberta Health Service (2014).


The Balanced Scorecard (BSC) Approach

The balanced scorecard (BSC) is not simply a dashboard for categories of decision-making. It is, rather, a strategic management system. Its purpose when applied to healthcare should be to ensure that the focus on patient health is paramount. To ensure good patient outcomes, it is essential that the healthcare delivery system is financially stable, and that management processes and procedures are efficient and effective. As we will see, the BSC approach functions as both guide and monitoring device for decisions and actions. Managers use the BSC to ensure continuous alignment of patient-centred priorities with the aspects of the system that support them.

As Figure 8 shows, the first planning step is to translate visions, aspirations, and commitments into concrete strategies that are measurable. Next, appropriate measures (quantitative or qualitative) need to be established. Then, targets for the planning period using the selected measures are set. Finally, at the end of the period, assessments of outputs are made to determine whether the targets have been met. This leads back into the planning cycle for the next period.

Figure 8

We consider certain essential aspects of the BSC next.

Strategy and Measurable Outputs

The first important feature of the BSC as a strategic framework is the connection that it makes between strategy and measurable outputs. This connection is built into the logic of the BSC approach. Even aspirational goals,
which are intrinsic to the very nature of healthcare, need to be translated into concrete measurable strategies in the BSC. For example, consider six World Health organization ideals (WHO, 2014): promoting development, fostering health security, strengthening health systems, harnessing research, information and evidence, enhancing partnerships, and improving performance. Each represents a valuable aspiration for the future, and all could remain as goals in the future no matter how far we progress toward them – there is always more to do. But words like “promoting,” “fostering,” “strengthening,” “harnessing,” “enhancing,” and “improving,” whether they are WHO goals or those of a hospital, need to be re-crafted and expressed as achievable and measurable outputs. These outputs are not synonymous with the aspirations. Rather, they are necessary (or at least causally connected with), but not sufficient for meeting the aspirational goals.

As an example, suppose that “fostering health security” in Canada is a goal that is defined as requiring strategies for dealing with pandemic infections such as SARS. We translate this goal into strategies to address quarantine of potential victims, treatment of infected individuals, and health system plans for containment that enable the system to continue operating. In the case of, say, quarantine, we determine that we need quantitative measures of success such as a specified number of days to isolate each new case. The next step in translating this strategy is to identify a target. Suppose we fix a target that is a range of three to six days. We could measure hospital efficiency rates against this. Further, we could set measures and targets for transmission rates in terms of percentage reductions from past pandemics, e.g., a 50-90% reduction. Once this has been fleshed out in detail, we will have a measurable strategy. It would then be measured when we actually had a SARS outbreak or other pandemic and had to rely on our strategy to address it.

Not all measurement must be strictly quantitative. In some cases, qualitative process measures are more appropriate. For example, returning to the WHO goals, we might interpret “enhancing partnerships” as meaning the development of research relationships between Canada’s medical schools and those in the UK. In the early stages of partnering, we might choose a process measure such as conducting a conference among medical school deans from both countries. The measure would be the process of setting this up and the target could be the date by which the first conference should take place. At some future date, the measures and targets might be expressed in terms of numbers and size of research grants, published papers, conference presentations, etc. But that would be developed in later iterations of the strategy.

Strategic Perspectives

The second component of the BSC framework is the segmentation of strategies. The classic corporate model of the framework treats all strategies that are generated by the vision, objectives, goals, and commitments as either being a, (a) financial perspective, (b) customer perspective, (c) internal-business process perspective, or (d) learning and growth perspective. The classic model holds that a causal relationship exists among these perspectives. That is, financial success is measured by how well the organization’s strategies are generating value. This is causally dependent upon how well the organization manages its customers by satisfying their needs, retaining them, and attracting new customers. Customer management is dependent upon focusing on processes that are most important to meeting customer needs and expectations. The internal business systems, or management systems, as we will refer to them, comprise technology, equipment, operating processes and procedures, and entrepreneurship and innovation. In dealing with customers, these systems are ultimately what help to generate the organizational value that is then delivered to the customer. Finally, how well the organization learns, adapts, and innovates is causally related to how well the other categories function. There are three main sources of learning and growth: first are the health human resources, specifically their knowledge, skill, and commitment to organizational goals and most especially to patients; second are the systems that enable healthcare teams to deliver the value to patients; and third are the organizational procedures that align the people and systems to add value.

The BSC is a framework for the implementation of strategy. It assumes that the process of establishing vision, objectives, goals, and commitments has taken place. Its main purpose is to establish processes and procedures of organizations, whichever they are, to add value as the strategy is moved to action.

Further, the classic BSC presumes that the highest priority in value extraction is financial in nature. This needs to be amended for healthcare (indeed
most public sector environments) by moving the financial perspective to a supporting role, namely as an enabling condition for adding value to patients, or those requiring care, in order to promote, restore, or maintain health. Placing the priority on patients and those in need by the healthcare BSC process is crucially important. Equally so is the focus on patients that drives both the internal-business process and learning and growth perspectives. Canadian healthcare has long been criticized for placing too much emphasis on what is in the best interests of the doctors or nurses, or on what processes best suit hospital schedules. As Porter and Lee (2013) write: “We must move away from a supply-driven health care organized around what physicians do and toward a patient-centered system organized around what patients need” (p. 50). The BSC shines a light directly on these issues, and it pushes its users to focus on what is best for the patient. The efficiency and effectiveness of the healthcare system have this patient focus as their end, not the practitioners and not governments.

If Canada had a System-Wide Healthcare Strategy, What Form Could it Take?

Table 3 presents a schematic outline of the BSC. For Canadian healthcare, strategic objectives would be established on the basis of each of the four perspectives. (While other perspectives might be created it is likely that the existing four will accommodate most strategies.)

<table>
<thead>
<tr>
<th>Balanced Scorecard Framework</th>
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<td>Perspectives</td>
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<td>Management System</td>
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<tr>
<td>Learning and Growth</td>
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</table>

Table 3 - Balanced Scorecard Framework

The scorecard is used to link the strategic objectives to measures that are appropriate. Targets for the planning period under consideration are set and expressed in terms of the measures that have been selected. The management activities (or sub-strategies, tactics, etc.) are expressed in summary form. The process should then track performance throughout the period and record the outputs of the activities. They are compared against the targets to determine how successful the plans have been. The cycle of re-planning for the next period begins from that point. In the process of assessment, it may be determined that the measures need to be refined or changed, and that targets for the new period need to be retained or changed in light of the experiences of utilizing the plan. Or, it may be that activities need to change, again based on the actual experience during the period.

**BSC and Focus and Cause**

The BSC approach emphasizes focus. The focus on what is really important to achieving the strategic objectives. Patient strategic objectives related to promoting, restoring, and maintaining health are the highest priority. If the financial perspective is crucial to achieving patient strategies, then so is mapping them to strategic activities and then to measureable outcomes. As we saw earlier, much of the economic sustainability discussion holds it to be central to public policy in its own right. But in terms of a Canadian healthcare strategy, it will need to play a facilitating role as the BSC encourages us to see.

It would be a mistake to conclude that money cures all healthcare problems, and that as much public funding as requested should be provided. The BSC approach clearly requires the causal connection to be a fundamental determinant of investment. Ill-spent support funding could meet the test of focus, but it does not meet causality. This was partly the problem with the implementation of the Romanow Commission’s recommendation that funding be increased to bring about change. The commission recommended both focus and causal legitimacy; the implementation met the former but not the latter test.

The business-system perspective requires that we focus directly on those innovative and system management practices and internal system procedures that link to patient objectives. Earlier it was pointed out that more than 70 indicators of health system performance are tracked by OECD, WHO, CIHI, Commonwealth Fund, and others. It is tempting to pick and choose from among them to support evaluations. The BSC approach would see this as a “cart before the horse” problem – using the information we have at hand, rather than determining what information is needed to support the management system evaluation, which in turn is focused on patients. The performance data tells us about the past. Strategy is about the future. What the BSC approach points out is the causal relationship between management systems and patient outcomes, and this relationship should drive our forward-looking requirements for information.

The learning and growth perspective is well suited to deal with the longstanding problem of doctors and hospital schedules and procedures that are self-referential. Schedules and value chains often place the doctors and nurses at the centre. The BSC recognizes the importance of health human resources, but in a strategic management system places them in a supporting role, causally connected to achieving patient outcomes.

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15 Even corporations that operate within the 30% private sector portion of Canadian healthcare, namely insurance companies, pharmaceutical manufacturers, drug stores, device manufacturers and distributors, and health sector technology companies, typically state their missions and values in terms of helping people.
If Canada had a System-Wide Healthcare Strategy, What Form Could it Take?

The BSC and Definition of Strategy

The balanced scorecard is a strategic management implementation framework, but it says little about the guidelines for strategy formulation. However, our definition of strategy bridges this gap. It sets out the key building blocks for developing the strategies, which the BSC shows us how to implement.

<table>
<thead>
<tr>
<th>Definition of Canadian Healthcare Strategy</th>
<th>Canadian Healthcare System-wide Balanced Scorecard</th>
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<tbody>
<tr>
<td><strong>Strategy Formulation</strong></td>
<td><strong>Strategy Implementation</strong></td>
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<tr>
<td>• Vision</td>
<td>• Patient perspective</td>
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<tr>
<td>• Goals and principles</td>
<td>• Financial perspective</td>
</tr>
<tr>
<td>• Aspirations</td>
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<tr>
<td>• Commitments</td>
<td>• Learning &amp; growth perspective</td>
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<tr>
<td></td>
<td>• Strategic activities</td>
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<td></td>
<td><strong>Strategy Implementation</strong></td>
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<td>• Qualitative</td>
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<td>• Quantitative</td>
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<td>• Targets</td>
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<td></td>
<td>• Outputs</td>
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<td>• Assessment and re-evaluation</td>
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The question arises as to whether the BSC could have application to a health system, or if it should mainly be restricted to smaller parts of the system, e.g., hospitals, community access centres, and private providers. To address this, an illustrative case is the newly restructured National Health Service (NHS England). The NHS has a new business plan, and it takes the form of an 11-point scorecard, which can be expressed in the BSC form. We turn to this now.

An example of the Balanced Scorecard – NHS England

On April 1, 2013, the National Health Service in England launched a massive restructuring. Driven by serious concerns about system-wide failures leading to unnecessary suffering and premature patient mortality, a public enquiry was launched. As a result, the Francis Report (2013) made sweeping recommendations for change that led to an overhaul of the entire system structure.

In the new structure, political responsibility and accountability remain with the Secretary of State for Health, and the national Department of Health provides strategic leadership for health and social services. However, management control of the entire system, along with budget authority, is devolved to the newly created NHS England, which is an arms-length entity that functions independently from government. The NHS thereby becomes the national standalone oversight body for healthcare, but one that is still accountable to the government.

The primary driver of the new structure is patient-centredness. To achieve this structurally, Clinical Commissioning Groups (CCGs) are created at the local level, and are overseen by local governing boards, to plan and design local health services in planned hospital care, urgent and emergency care, rehabilitation services, community services, and services related to mental health and learning disabilities. Their main function is commissioning (purchasing) services from hospitals, social enterprises, charities, and private sector providers. The new system also includes regulatory agencies and entities to gather public input into decision-making.

In this structure, there are three helpful points for our consideration. First, is the adoption at the national level of an 11-point scorecard reflecting core priorities, against which to measure performance system-wide. Second, is that the scorecard places its highest priority on patients by developing mechanisms for feedback from patients and families and direct feedback from NHS staff. The details are spelled out in the planning document, Putting Patients First: The NHS England Business Plan for 2013-2014-2015/2016 (NHS England, 2013). Third, is the attempt made in the reinvention of the NHS England to depoliticize control of the system, while retaining public accountability through the Ministry and Secretary of State for Health.

Let us start with the first and second points, namely the scorecard and its priority. NHS spells out in detail the content and rationale for the scorecard. We could not restate all of that here, but instead are only able to show how the NHS scorecard can be formatted as a BSC. What is shown in Figure 11 below are components of the NHS scorecard arranged into the BSC format. This is not an attempt to describe the NHS strategy per se. It is only to illustrate how a large and complex system-wide scorecard could be used in Canada. We certainly have scorecards at the provincial level; this provides an analogous look at a national BSC. That the complex English system strategy can be set out using a BSC approach should give confidence that Canada might be able to do so as well.
### Patient-Centred Perspective

- **Strategic Objectives**
  - Satisfied Patients
  - Motivated Staff

- **Measures**
  - Feedback from patients/friends/families (scale -100/+100)
  - (1) “Feedback from patients’”
  - (2) “Feedback from friends and family of patients, re. staff”
  - Progress against improvement indicators
  - Progress improvement indicators
  - Progress against indicators, potential years of life lost

- **Targets**
  - Launch customer service platforms by November 2013, full operation by 2015, and publish outcome data by 2015
  - 80% CCG funding to support patient participation in decisions

- **Activities**
  - Medical and nursing directors to provide clinical leadership
  - Establish nursing compassion in nursing strategy
  - Emergency care review

- **Outputs/Outcomes**
  - Feedback from patients/
  - Actual spend within budget

- **Strategic Objectives**
  - Prevent people from dying prematurely
  - Enhance quality of life for people with long-term illness
  - Help people recover from episodes of ill-health or injury

- **Strategic Objectives**
  - Promote equality and inclusion
  - NHS Constitution rights and pledges, including delivery of key service standards

- **Measure**
  - Progress in reducing identified inequalities on all indicators
  - Direct commissioning and support and assurance of processes to ensure continued delivery

- **Targets**
  - Save £20,000 by 2016 by reducing mortality to best in Europe
  - NICE guidelines, 30 indicators
  - Publish a strategy by March 2014

- **Activities**
  - Through health and wellbeing boards, develop plans for integrated care
  - Focus on earlier diagnosis, improved management in community
  - Improving acute care, mental health
  - Partnerships for quality

- **Finances and Economic Perspective**
  - **Strategic Objectives**
    - High quality financial management
    - Budget monitoring
    - Financial assurance systems
    - Manage NHS budgets within tight envelope

- **Measures**
  - Actual spend within budget

- **Targets**
  - Total budget of £1,155 million
  - Detailed breakdown budget targets (commissioning, technical, directorates)

- **Activities**
  - Assure CCG and QIPP plans are part of planning process
  - Monitor CCGs to deliver transformational change
  - Financial incentives for good financial performance

- **Outputs/Outcomes**
  - TBD

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Funded with generous support from the Joseph S. Stauffer Foundation.
If Canada had a System-Wide Healthcare Strategy, What Form Could it Take?

| Business System Perspective | • Becoming excellent organization | • 360 degree feedback from local and national partners | • Telehealth and telecare to 3 million by March 2017 | • Supporting, developing, assuring commissioning system |
| | • Ensure staff understands roles | • Staff survey results, 360 degree feedback | • Online access to primary care offered by 50% of practices by April 2014, 100% by March 2015 | • Direct commissioning |
| | • Staff properly supported | | • E-referrals service by December 2013, 100% of use by March 2017 | • Emergency preparedness |
| | • Staff well motivated | | | • Strategy, research and innovation for outcomes growth |
| | | | | • Clinical and professional leadership |
| | | | | • World-class customer service |
| | | | | • Developing commissioning support |
| Learning and Growth | • Learning by sharing ideas and knowledge, successes and failures | • Establish 10-year strategy for NHS | • 2014/2014 | • Range of programs throughout 2013-2014 to support diffusion and adoption of innovative practices and ideas |
| | • Plan for innovation | • Evaluate medical models | • 100,000 genome sequences over the next 3 years: cancer, rare diseases, infectious diseases | • Monitor CCG’s financial performance |
| | | • Establish Centre of Excellence | • 2,000 staff to complete by 2014 | • Contribute to Genomics Strategy |
| | | • Establish Leadership Academy | | |
| | | • Progress on six high impact changes | | |
| | | • Procurement of intellectual property | | |
| | | • Establish research strategy | | |
| | | | | |

The second point is that patients are at the centre of the BSC in England. This affirms a point made earlier here that the BSC approach generally needs a different focus in the public sector than in the private sector, with respect to the primacy of people and service outcomes over financial measures of success. In a Canadian system-wide scorecard, this would be paramount.

The third point is about depoliticizing the management of the system. The new structure of the NHS transforms a hierarchical system of centralized control into a more decentralized system of local control through Clinical Commissioning Groups. The CCGs are funded by the NHS, which also provides oversight. Both CCGs and the NHS are imbedded in an environment of regulation (e.g., Monitor and Care Quality Commission) and citizen oversight (e.g., Health Watch and local Health and Wellbeing Boards) to provide further layers of accountability. In this respect, the objective of the new NHS shares much with the notion that Canada could have a system-wide strategy. Canada’s starting point is decentralized provincial/territorial control, with limited centralized oversight by the federal government. Health Canada has its specific responsibilities under the Canada Health Act, but it does not exercise system-wide oversight as will the NHS England in its new role. The BSC approach has a chance of meeting the tests of focus on strategy and causal connections among components because oversight is in place. Canada could establish a scorecard. Let us assume that Canada did create a BSC. Who would oversee its application?

The BSC summarized above for the NHS serves to illustrate that something similar is, at least in principle, possible for Canada. As a national system, the NHS England is able to take direction from the Secretary of State for Health and the Ministry of Health in terms of the content of its scorecard. Canada is a federation, so agreement among the provinces and territories would need to be reached with the federal government, both on the need for a system-wide BSC and for a unified approach overall.
De politicizing the Management and Governance of a Canadian Balanced Scorecard

Interestingly, both Romanow and Kirby addressed the issue of a system-wide, or national (as distinguished from federal), independent body that would provide advice, analysis, and oversight to the system. Romanow (2002, pp. 53–59) recommended that the Health Council of Canada help achieve "an effective national health care system" (p. 54), by establishing common performance indicators and benchmarks, advising governments, and issuing public reports providing independent evaluations. It was to be an independent body "to drive reform and speed up the modernization of the health care system by 'de-politicizing' and streamlining some aspects of the existing intergovernmental process" (2002, p. 55). However, in reality, the Council had little authority to make change or require compliance from the provinces and territories.

Kirby recommended something similar. He had the opportunity to opt for a depoliticized arms-length entity, and received recommendations to this effect. The argument in favour of doing so was the importance of depoliticizing the oversight body, which is an important feature of the new NHS England. Kirby demurred, saying:

"The Committee agrees with the many witnesses who stressed the importance of taking measures to 'depoliticize' the management of the health care system. However the Committee feels that this will be a long-term process, and that it is important to begin with the evaluation function only."

So Kirby opted instead for a much weaker model. Nothing came of it.

For a Canadian system-wide strategy to be successful, not only an independent, but also a depoliticized entity with a broad management authority, is necessary. Whether the NHS England will achieve this over time remains to be seen.

What, then, should we consider for Canada? In terms of the governance of the oversight entity, it is helpful to contrast two governance models. A council, as proposed by both Kirby and Romanow, typically follows what could be termed a "collaborative governance model." This model usually comes into existence when a government identifies some policy or program that it wants to oversee in collaboration with other (usually, but not always) non-governmental partners. A council is formed with representation from the collaborators, who provide direction to the entity through a process of discussion and debate leading to consensus. Consensus is the hallmark of collaborative governance. In brief, the collaborative governance model receives its legitimacy from government; processes are collaborative; and collaborators represent the interests of their own groups as well as those of the collaborative entity.

Contrast this with a "corporate governance model." Shareholders (or stakeholders, in the not-for-profit sector) are entitled to the legal and economic property rights of the entity. Shareholders/stakeholders appoint or elect directors to act on their behalf, in order to oversee the managers of the entity to ensure that the managers are acting in the interests of the shareholders/Stakeholders. The directors, then, provide the "governance" function. In this model, authority and legitimacy arise from a grassroots level, not from the level of government. The de facto processes that describe how directors typically work with each other and management are consensus-based. But consensus is not a defining feature of the corporate governance model, which is based on formal processes and procedures, namely legal rights, contracts, and voting procedures.

The collaborative governance model fits with the entities supported by Romanow and Kirby. The model provides for independent governance oversight, which is valuable. But it has four main weaknesses. First, it is susceptible to unresolvable disputes, because consensus decision-making relies on informal mechanisms to bring about agreement. If unsuccessful, participants have little recourse other than to withdraw from the collaboration. Second, it is vulnerable to political interference. Governments provide legitimacy to the collaboration, but governments also must meet public accountability requirements. The latter can become so imposing that decision-making authority becomes skewed to the interests of the government collaborator and overwhelms the interests of others. Third, in the collaborative governance model, each collaborator has a divided duty of loyalty, split between the interests of their own organization and those of the collaborative entity. Such conflicts can become unresolvable, leading to impasse and potentially even withdrawal from the collaboration. Fourth, the BSC requires an unrelenting focus on strategy and the delivery of outcomes. This highly managerial approach is not conducive to such a heavy reliance on consensus, even in operational matters.

The advantage of the corporate governance model for our purposes resides in its source of legitimacy. Authority starts with stakeholders (shareholders, in the case of corporations) who are the "owners" of the rights. The definition and content of those rights, along with the goals and objectives of the entity, are set out in the form of legal agreements, such as charters, by-laws, and contractual relationships. Stakeholders, directors, and managers are all bound by those agreements. While consensus is preferred, the law provides direction and procedures for gaining agreement. So mandating a healthcare entity that would oversee and manage a Canadian BSC that was structured more along the lines of a corporate governance model would ensure it had a greater chance of operating at arms-length, and of avoiding, at least, the more debilitating forms of decision-making.
Governments should be comfortable with entities using the corporate governance model, since Canadians have many experiences with crown corporations, public-private partnerships, and service contract relationships that use this model. What would be crucially important for governments, in order to ensure they were able to discharge their public accountability mandates for healthcare, would be making sure that the charters, by-laws, and contracts were structured in a way that protected their obligatory roles, while at the same time promoting the benefits of an independent entity.

A Bicameral Governance Structure

The governance structure for a Canadian system-wide strategy must accommodate two basic needs. The first is to establish a management entity that can operate independently of government and be substantially free of political intervention in its normal course of business operations. The second is to enable governments (provincial/territorial and federal) to play their important role in establishing public policy in healthcare, and to fulfill their accountability requirements to their respective electorates. A single entity is unlikely to accommodate both. So the governance structure needs two entities. Let us call the first Management Company, and the second, Governance Council. Together, they form a bicameral governance structure.

Management Company is described above. It is the manager of the strategy, and its function is to manage the BSC and provide oversight to the strategies contained in it. The BSC is a system-wide strategy with implementation at local levels. While Management Company is the strategy manager, it too has a governance oversight body, namely its board of directors. The theoretical underpinning of this governance is the corporate governance model.

Management Company, on its own, is not sufficient for system-wide governance. A crucial piece is mission, namely the participation of governments. They are, after all, democratically charged with making healthcare policy and being accountable for their expenditures and outcomes. These are precisely the policies that become fashioned as the strategic objectives for a system-wide strategy. In turn, these strategies are what the BSC is designed to implement.

The policy making function needs to reside in a second, and senior entity. This is Governance Council. Its model is collaborative governance, because its function is to bring the partner governments together to work collaboratively with each other in order to establish policies. Their job is to reach deeply into the foundations of our healthcare strategy – its vision, goals, and commitments – and, from that profound level, establish the strategic objectives that are contained in the BSC. No member government of Governance Council is more senior than others in setting direction. All must agree; they must reach consensus. Failure to do so prevents the strategic objectives of the BSC from being established.

There must be a formal link between Governance Council and Management Company. Governance Council is the senior body, and although it must leave Management Company to do its work without political interference, it nevertheless must retain oversight responsibility. This should be accomplished through Governance Council appointing the board of directors of Management Company.

It is not necessary at this point to address the composition of either Management Company or Governance Council. The functions assigned to each should provide an adequate guide to the qualifications of participants. It is enough for present purposes to recognize that each of the entities is essential to establishing and operating a system-wide Canadian healthcare strategy. Neither is sufficient on its own; both are necessary. Each comes from a different conceptual tradition – Management Company from the management culture of the BSC, and corporate governance in terms of its oversight by a board of directors, and Governance Council from the world of collaborative governance.

This two-entity structure makes it clear that there are two distinct functions that councils such as those recommended by Romanow and Kirby could never have succeeded in fulfilling. Those bodies only had advisory mandates – neither management nor governance. So if a Canadian healthcare strategy is going to be possible, we need to accept the reality that governments will need to work together to form the strategic objectives in the BSC. And they will need to gain assurance that the Management Company will act in their interests, by virtue of the charter, bylaws, and other legal agreements that frame the purpose of the entity, and by confidence in the board of directors they appoint or elect to provide governance oversight of Management Company executives.

Finally, there are two important clarifications. First, the idea of a Management Company to oversee and manage a Canadian BSC is not a way of injecting federal government control. The reverse is true. What is contemplated is a collective vehicle that is “owned” by multiple governments, and perhaps other stakeholders. And Governance Council provides the assurance that the federal government is not acting on its own.

Second, nothing about the BSC approach requires centralized control of all operations. What it does offer is broad coordination based on the shared agreements of collective vision, goals and objectives, and commitments. Local implementation of healthcare would be promoted, not discouraged. Indeed, the NHS England restructuring is attempting to achieve precisely this.

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19 Examples include the Canada Pension Plan Investment Board, Export Development Canada, and Canada Post. Each operates independently through its own board governance structure.
to transform a highly centralized command and control system to one that has a national scorecard managed by the NHS England (a version of Management Company), but with decision-making about patient care devolved to local levels (i.e., Clinical Commissioning Groups).

Conclusion

The Canadian healthcare system is an uncoordinated system-of-systems. Thirteen provincial/territorial systems, along with several federal systems, operate independently of one another. They are loosely connected, not with each other, but with the federal government, through limited regulatory regimes addressing such things as drug approvals and funding conditions for universal health insurance for hospitals and doctors. The system is among the most expensive in the world to operate, and its results are middle of the road at best. For decades, there have been calls from national reviews, such as those by Romanow and Kirby, for collaboration among governments to build system-wide strategies. And there continue to be calls for national approaches to pharmacare, health human resources, electronic health records, primary care, seniors’ care, integrated care, and much else.

In light of this, I have attempted to make the case that a managerial perspective usefully contributes to the Canadian healthcare strategy debate by bringing forward two ideas. The first is to recommend a managerially rigorous approach to healthcare strategy by using the balanced scorecard approach. The BSC requires an unwavering focus on strategy when functional and operational decisions are made. It places patients at the centre of concern, and causally links decisions about finances, management systems, and organizational learning and growth to their contribution to patient health outcomes. This approach is based on evidence, analysis, and the achievement of measurable outputs.

Second, is a concept of governance that meets two important needs best achieved in a form of bicameral governance. On the one hand is the management of the BSC. This requires an entity that comes from the tradition of corporate governance. It is an operational entity with an independent board of directors to provide oversight and ensure the alignment of stakeholder (federal and provincial/territorial government) interests and management. On the other, is the council of governments that work from a collaborative governance model. This is the entity that establishes healthcare policies that will lead to the establishment of the BSC. Each entity in the bicameral structure is legitimated by a different governance theory. But both are necessary parts of the Canadian system-wide healthcare strategy framework.

Canada needs a system-wide strategy that is built to suit Canadian needs, not a turnkey model imported from elsewhere. A Canadian strategy should be created from a vision, aspiration, and commitments that we all share. Upon these shared values can be based the Canadian strategies, and the BSC as the framework used to implement and manage them. Further, it is by virtue of agreement among the governments and stakeholders that the BSC can get its legal and moral legitimacy.

Should we turn our attention to the establishment of a Canadian system-wide strategy, or strategy of strategies? If the time is not now, it is hard to see when would be better. Canada has an expensive and underperforming system. Provinces and territories are straining under the economic weight of maintaining it. Calls for a system have been heard for decades in national studies and reports, and many of the key stakeholders are asking for system-wide approaches. Can we afford to allow the opportunity to pass?

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The Need for a pan-Canadian Health Human Resources Strategy

WHITE PAPER - WORKING DRAFT

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INTRODUCTION

Health human resources (HHR) represents the single greatest financial component in health service delivery. How policy, planning, and management effectively align with this key resource will be integral to the sustainability of current business models to support the delivery of universally accessible healthcare. Paradoxically, despite being such a critical element of the healthcare system, HHR can sometimes be so pervasive as to be invisible. Indeed, HHR issues are often the elephant in the room when issues of healthcare reform are being discussed. Peeling away the layers leading to critical issues facing our healthcare system, such as wait times and lack of access to services, quickly reveal these to be largely HHR issues regarding the availability of healthcare professionals. Efforts to improve Canadian healthcare are often hampered by human resources challenges, including over- and under-supply of labour, changing skillset needs, and inflexibility in adjusting scopes of practice to meet shifting treatment standards. When addressed head on, there is increasing concern whether the supply and current mix of health professionals will be able to meet not only future health systems demand, but also population health needs more broadly.

This paper will make a case for the need for a pan-Canadian HHR Strategy, identify the key elements of such a strategy, and, finally, will suggest an implementation plan for aligning the key stakeholders (e.g., professional associations, regulators, educational institutions, accrediting bodies, federal/provincial/territorial health ministries, health professionals, and the public) in support of a strategy to address critical and systemic HHR challenges.

Three fundamental questions will be addressed:

1. What is the justification for a coordinated Canadian HHR strategy?
2. What would be the substance of a Canadian HHR strategy?
3. How might a Canadian HHR strategy be best implemented?

Central to effective HHR planning and healthcare service delivery that aligns with the needs of the population is a nationally coordinated strategy that is collaboratively built and continuously informed by evidence. This strategy should include a common orienting framework which defines scopes of practice across professions and jurisdictions, in order to facilitate more consistent and valid measurements of the current supply while allowing the flexibility required to support the unique cultural, linguistic, and demographic needs of Canada’s diverse populations. The success of this strategy would be highly dependent on engagement, contribution, and accountability from all stakeholders.

Framing these layers of the case we make for a pan-Canadian HHR strategy is an overarching acknowledgement that the system of health human resources is a complex, adaptive system. Complex adaptive systems are entities with multiple, diverse, and interconnected elements, often accompanied by feedback effects, nonlinearity, and other conditions that add to their unpredictability (c.f., Begun, Zimmerman, & Dooley, 2003). Disregarding this key feature of HHR has and will continue to result in the proposition of supposedly simple “solutions” to complex problems. Such solutions often result not only in inadequately addressing the problem they intend to solve, but also in a number of unintended consequences that reverberate through the system.

I. WHAT IS THE JUSTIFICATION FOR A PAN-CANADIAN HHR STRATEGY?

“The traditional approach to health human resources planning in Canada has relied primarily on a supply-side analysis of past utilization trends to respond to short-term concerns. For example, faced with shortages in a certain profession, jurisdictions tend to add training positions; faced with surpluses, they cut training positions; faced with budget pressures, they cut or reduce full-time positions. This approach has a number of critical weaknesses.” (ACHDHR, 2007, p. 5)
**HHR Highlights from the 2002 Romanow Commission, Building on Values: The Future of Health Care in Canada.** The Romanow report makes recommendations supporting the need for a coordinated approach to HHR planning. The report points to the need to:

- establish strategies for addressing the supply, distribution, education, training, and changing skills and patterns of practice for Canada’s health workforce.

- Substantially improve the base of information about Canada’s health workforce through concerted efforts...to collect, analyze and provide regular reports on critical issues including the recruitment, distribution and remuneration of health care providers. (Health Canada, 2009)

Making the case for the need for a pan-Canadian HHR strategy is not new. In its 2002 report, the Romanow Commission noted the importance of a need for a coordinated approach to HHR planning (Health Canada, 2009). In 2005, and again in 2007, the Federal-Provincial-Territorial Advisory Committee on Health Delivery and Human Resources (ACHDHR) noted in its pan Canadian Strategy that: “The status quo approach to planning has the potential to create both financial and political risks, to limit each jurisdiction’s ability to develop effective sustainable health delivery systems and the health human resources to support those systems” (ACHDHR, 2007, p. 5). In both this and other documents in the growing HHR literature, there are a number of indicators of problems in the healthcare system that are either implicitly or explicitly related to the misalignment of different elements of the system of health human resources in Canada. These can be categorized according to three key health workforce issues: supply, distribution, and mix.

**Health Workforce Supply:**

One of the key indicators is the waxing and waning of health human resources from shortages and surpluses and back for both the medical and nursing professions. With the advent of public health insurance schemes across the provinces in the late 1960s and early 1970s, there was a shortage of physicians and nurses to meet the needs of the now universally covered population of Canadian citizens. New medical and nursing schools were established, but in the short term, international recruitment helped to meet the needs; this recruitment was largely from the U.K. and Ireland. By the 1980s and 1990s, concerns over rising healthcare costs caused both federal and provincial governments to implement substantial cuts to healthcare spending. Often viewed as a significant driver of healthcare costs, this resulted in a decline in HHR in Canada.

In the early 1990s, a report prepared for the Conference of Deputy Ministers (CDM) of Health addressed issues regarding physician supply and demand in Canada – known as the Barer-Stoddart Report (1991). The context for this report was a perceived surplus of physicians, but as noted above, the broader context was of healthcare cost constraints. Although the report made 53 integrated recommendations covering a range of dimensions of the system of medical human resources, each of which were predicated on the others, little was implemented beyond reducing opportunities for international medical graduates (IMGs) and decreasing the number of undergraduate medical school positions by 10%.

The shift in HHR policy concerning physician human resources began to gain salience in the late 1990’s, when medical professional associations, working groups, and other politically active organizations started to discuss shortages of physicians. Although much of the blame for this was levelled at the Barer-Stoddart recommended reduction in medical school enrolment, a robust analysis by Chan (2002) revealed that the greatest impact was the shift in the length of postgraduate training, from a one-year rotating internship for GPs to a two-year residency training program for family physicians. Regardless of the source of the problem, a self-funded working group (Task Force One), created by a consortium of Canadian medical stakeholder organizations, raised the alarm bells about a growing shortage of physicians and lobbied the ministers and deputy ministers of health in November 1999, to: 1) increase medical school enrolment by nearly 30%, raising the number of positions available to 2,000 by the year 2000; and 2) increase the number of residency positions so that there would be approximately 20% more residency positions than Canadian medical graduates.

There has been a similar fluctuation in the supply of nurses in Canada. Between 1980 and 1991, it was claimed that there was an increase in the number of nurses from 629.1 nurses per 100,000 of the population to 819.9 (Romanow, 2002). From 1991 onwards, the ratio of nurses decreased as a direct result of cutbacks to the healthcare system. Similar to what happened in medicine, there were cuts to nursing school enrolment and to nursing positions, and there was a reduction in full-time employment opportunities and an overall casualization of nursing labour (CNA, 2002). By 1997, nursing organizations were sounding a similar alarm as their physician colleagues, warning that Canada was headed for a major crisis with respect to nursing shortages (CNA, 2002). There are a number of factors that contributed to the claimed nurse shortage, including a reduction in the number of nurses graduating, many nurses leaving the profession due to poor working conditions, aging of the Canadian nurse population, changes in healthcare delivery, and inter-provincial competition for scarce resources (Romanow, 2002).

In 2002, the CNA released its report on nursing supply, noting: “Since [1997], there have been changes to the funding of the health care system and changes to nursing education. Governments have increased funding to educational institutions, and a variety of innovative programs have been introduced. Students are applying for and snapping up available places” (p. 78). The report recommended that, although the output from Canada’s nursing schools was...

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1 This is now the Federal/Provincial/Territorial Committee on Health Workforce (CHW).
expected to double from approximately 4500 in 2000 to 9000 in 2007, and there was an expected 1200 per year recruitment of internationally educated nurses (IENs), continued increases in the enrolment opportunities for nursing education programmes should reach 12,000 per year.

More recent projections of nursing human resources take various HHR assumptions more explicitly into consideration. The CNA (2009) report on the nursing human resources landscape, Tested Solutions for Eliminating Canada’s Registered Nurse Shortage, provided new projections for how projected shortages need to take into consideration the changing health needs of the Canadian population. The report started first by projecting that if no policy interventions are implemented, Canada will be short almost 60,000 full-time equivalent RNs by 2022. Different policy scenarios were tested to see where the greatest strides toward reducing Canada’s RN shortage could be made. These included: increasing productivity, reducing absenteeism, increasing enrolment, improving retention, and reducing attrition rates in entry-to-practice programs.

Back to the case of physicians, fast-forward 10 years or so and we are facing a situation of reported under- and unemployment of physicians from particular medical specialties. A report published by the Royal College of Physicians and Surgeons of Canada (2013) raised concerns that, “a growing number of specialist physicians were unemployed or under-employed” (RCPSC, 2013, p. 2), accounting for approximately “sixteen percent of new specialist and subspecialist physicians [who] said they cannot find work; [and] 31 percent [who] pursue further training to become more employable” (RCPSC, 2013, p. 2). Not surprisingly, issues pertaining to ineffective health workforce planning were reported as one of the three key drivers that contributed to these employment issues. As Andrew Padmos (2013), CEO of the Royal College, stated, “the issue of specialist unemployment is far too complex to be interpreted as a simple case of supply versus demand” (n.p.). Rather, he called this an “egregious failure in workforce planning,” and stated that “a systemic problem requires systemic solutions.” That is, the issue of under- and underemployed newly certified specialists should be seen as a symptom of the lack of coordinated medical and health human resource planning and feedback.

The issue of under- and unemployed medical specialists alone illustrates the complexity of the health workforce and the potential reverberating impacts that one aspect of the health workforce can have on others. Evans and McGrail (2008) had commented earlier on the myth and muddle surrounding the impact of the recommendations of the Barer-Stoddart report. The myth, that the report simply recommended cutting enrolment in medical schools, resulting in a severe shortage of physicians, comes full circle to again reveal that the report simply recommended cutting enrolment in medical schools, or the earlier warning by Barer-Stoddart that the integrated 53 recommendations should not be cherry-picked because it “could easily do more harm than good” continue to go unheeded (Evans & McGrail, 2008, p. 20).

So, traditional approaches to HHR planning in Canada have resulted in cycles of over and under supply, high turnover and attrition, and a lack of stability in the health workforce. They have also done little to address the persistent problems with health workforce distribution in alignment with population health needs.

### Health Workforce Distribution and Misalignment with Population Health Needs

Among the inherent risks of continuing to plan in isolation are the unintended impacts on the mobility and distribution of the health workforce, which ultimately negatively affect access to services available to the population. Working independently to address such large-scale issues creates competition between jurisdictions for limited health human resources, and may inappropriately draw the health workforce from areas in need, resulting in severe shortages among vulnerable communities (ACHDHR, 2007, p. 1, 6; Task Force Two, 2006, p. 5; CRA/NHR, 2013). We focus here in particular on rural, remote, and Aboriginal communities, and concerns regarding access for minority language populations.

### Access to care in rural and remote areas:

Shortages in rural areas of Canada have been reported to be twice as severe as in urban areas of Canada. A 2011 report from the Canadian Institute of Health Information (CIHI) indicates that only 9% of all active physicians were found in rural areas, while the 2011 census shows that 18% of the Canadian population, or more than 6 million people, live in rural areas (Statistics Canada, 2011; CIHI, 2011). Some of the reasons listed to explain why the doctor shortage is twice as severe in rural Canada, according to the Society of Rural Physicians of Canada (2008), include that: 75% of Canadian physicians live and practice in urban areas; many medical students are from large urban centres; all medical students attend medical schools located in large urban centres, and, while there, develop personal and professional relationships that make it difficult to leave these areas.

Recruitment, unfortunately, is only one challenge to health human resource planning in this regard. Retention of rural physicians is also a significant barrier to alleviating the uneven distribution of doctors in Canada. For example, according to Liu, Bourdon, and Rosehart (2013), only 31% of rural family physicians are retained in their communities 10 years post registration, compared to 50% of urban family physicians. When rural-trained physicians move to urban areas, the decision-making process in this transition can be quite complex, including family and personal factors (Hanlon et al., 2010). For instance, a CMA survey of 260 physicians who switched from rural to urban practice indicates that the most important reasons for doing so were educational opportunities for their children and the heavy work hours associated with rural medicine (Buske, 2009). More specifically, the number of hours associated with work as a rural GP is considered the most negative aspect of working in rural communities (Buske, 2009). Of greater concern
is the fact that most physicians who move to urban centres after rural practice have no intention of returning to their rural medical practice (Pong et al., 2007).

Analyses of physician migration statistics not only expose a pattern of rural to urban migration within provinces, but also between provinces. Indeed, the 2007 National Physician Survey indicated that 7% of rural physicians plan to move to another province/territory within the next two years (Chauban, Jong, & Buske, 2010). British Columbia and Alberta typically gain from the migration of physicians, for example, whereas the jurisdictions that typically lose are Newfoundland and Labrador, Quebec, Saskatchewan, Manitoba, and the Yukon (CIHI, 2007).

Strategies to address issues of distribution need to be multifaceted in nature because the causes of the problem are also multifaceted. Simply adding more doctors to the system overall does not address the problems with distribution that have left rural areas perpetually underserviced (CFHI, 2012). A recent Cochrane review of the variety of strategies that have been adopted, including educational, financial, and regulatory approaches, found no well-designed studies to say whether any of these strategies are effective or not (Grobler et al., 2009).

Access to linguistic and culturally appropriate healthcare services:

Aboriginal communities (First Nations, Inuit, Metis) represent a large proportion of the population living in rural and remote areas of Canada, and the health disparities they face are significant (Health Council of Canada, 2013, p. 5). It is therefore no surprise that negative impacts resulting from shortages of healthcare providers in rural and remote communities are particularly acute among Canada's Aboriginal communities (Health Council of Canada, 2013, p. 5; ACHDHR, 2007, p. 1). According to a 2002 opinion poll conducted by the National Aboriginal Health Organization (NAHO), "43% of First Nations respondents said they prefer to visit an Aboriginal health care provider to a non-Aboriginal health care provider" (First Nations Centre, 2004, quoted in Assembly of First Nations, 2005, p. 4). Although governments have recognized the importance of developing a nationally coordinated and collaborative strategy to better align the needs of this population and include the production of Aboriginal healthcare providers in these communities (e.g., 2003 First Ministers’ Accord on Health Care Renewal), the recent decision to discontinue the Aboriginal Health Human Resources Strategy is a significant setback.

Access to linguistically appropriate healthcare services is also stressed among Francophone minorities, where, in the case of Ontario, it is suggested that poorer health status includes a “significantly higher prevalence of chronic illness (63%) compared to the Anglophone and allophone populations combined (57.4%)” that may be due to a "lack of access to French-language primary health care services" (CRaNHR, 2013, p. 1). This is supported by the Federation des Communautes Francophones et Acadienne du Canada, who reported that "only 26% of Franco-Ontarians have access to hospital services in French, yet a 2011 survey found that 75% of Franco-Ontarians find it important to receive such services" (CRaNHR, 2013, p. 1). The problem is that many do not have access to French language services in their community.

A nationally coordinated approach to production, deployment, and integration of the health workforce that aligned with the needs of these particularly vulnerable communities would play an important role in addressing the gap in health status between these communities and the majority of the Canadian population (First Ministers Accord, 2003).

Optimizing the Mix of Health Human Resources

Aching the right mix of health professionals that align with population health needs is yet another complex challenge, in that it is multi-dimensional and linked with both supply and distribution challenges. The 2007 Framework for Collaborative Pan-Canadian Health Human Resources Planning highlighted that, “Canada’s ability to provide access to ‘high quality, effective, patient-centred and safe’ health services depends on the right mix of health care providers with the right skills in the right place at the right time” (ACHDHR, p. 1). More recently, the Council of the Federation highlighted the importance of scopes of practice for healthcare transformation, identifying it as one of three priority areas for its Health Care Innovation Working Group.

HHR mix issues involving not only those within a profession – such as the balance of generalists and specialists and the need for different kinds of medical and nursing specialists – but also between professions. First, with respect to the mix within professions, the recent and rising concerns regarding under and unemployed medical specialists make clear the lack of coordination of their supply and distribution. In this case, the "lack of national (and few provincial) mechanisms to channel new graduates into the specialties where they are likely to be most needed rather than specialties most needed by teaching hospitals or most favored by students," and the lack of “integration between the education system that prepares providers and the health system that employs and deploys them” (Barer, 2013, n.p.), leaves us with a large and growing pool of highly skilled health medical specialists with precarious employment opportunities.

With respect to interprofessional mix, each uniquely defined skillset and the competencies of a given health profession are complementary; while there are scopes of practice defining a given profession, there is also overlap among these scopes of practice. How best to organize different health professionals into flexible models of care that support seamless, collaborative, patient-centred care is a key goal. The problem arises when scopes of practice and associated models of care are organized on the basis of tradition and politics rather than population health needs. Scopes of practice are often politicized as a proxy for professional advancement, resulting in service provision organized
III. WHAT WOULD BE THE SUBSTANCE OF A CANADIAN HHR STRATEGY?

Clearly a collective and coordinated approach to HHR planning, involving key stakeholders across all jurisdictions, is required to identify challenges and priorities for collaborative, tangible action that can be taken to achieve a more flexible and sustainable health workforce. The key elements of a pan-Canadian health workforce strategy that is informed by state of the art HHR research, including international precedents, would include:

- Creating a consensus HHR framework to reflect a common understanding of the key inputs, outputs, and goals/outcomes of an integrated HHR planning and deployment system to galvanize stakeholder support and foster collective action and evaluation.

- Coordinating and enhancing an HHR evidence infrastructure to support health workforce research and decision-making that align with the collective goals of the consensus framework.

- Developing a coordinated HHR action plan with evaluation, governance, and accountability targets that identifies the critical challenges that need to be addressed across the country, along with a set of short, medium, and long-term goals for each that will include measures and indicators to monitor the progress across jurisdictions.

Creating a consensus framework for HHR planning and deployment:

The purpose of designing a consensus framework for health workforce planning and deployment is to build a shared understanding using the common terminology of the “impact of a range of dynamic variables” (ACHDHR, 2007, p. 24), and to conceptualize or map out the relationship between different elements of a complex adaptive HHR system. The absence of a common language and agreement about key inputs, influences, and outputs makes collective action more challenging. A common understanding and language for health workforce planning also helps to minimize variability and strengthen our capacity to develop more accurate and comparable measures of key health workforce variables across sectors and jurisdictions.

The importance of a framework for coordinated planning was identified in the ACHDHR report. In an effort to better conceptualize health workforce planning and develop a better understanding of the impact of a number of dynamic variables, the ACHDHR highlighted the “Health System and Health Human Resources Conceptual Model” developed by O’Brien-Pallas et al. (2001) (see Figure 1). The core of this model was designed to help provide a guide for HHR policy makers and planners to recognize the need to align the health workforce with population health needs. It also begins to better take into consideration the dynamic interplay among a number of factors that have previously been conceptualized in isolation of one another, consistent with a system’s approach. This is primarily in the area of planning and forecasting. In addition, this model was envisioned as being used as “the basis for simulations which, in turn, can provide needs-based estimates of the health human resources required to achieve health, provider and system outcomes (ACHDHR, 2007, p. 25).”
Recognizing advances in the conceptualization of HHR planning since the creation of this model (e.g., Tomblin Murphy & MacKenzie, 2013), and also fleshing out the critical features of deployment, including the mix and distribution of HHR to an overall system (Bourgeault & Mulvale, 2006; Mulvale & Bourgeault, 2007; Nelson et al., 2014), the following model enhances certain elements of the 2001 O’Brien-Pallas et al. model (see Figure 2). Specifically, the planning and forecasting elements have been embellished to include: an explicit focus on productivity and activity rates, which vary within and between health professionals; technological as well as financial resources necessary for planning and forecasting; a requirement for enhanced data (see discussion re. evidence infrastructure below).

The first level of outputs from the planning and forecasting is a determination of an appropriate mix of human resources that now must be deployed. Thus, added to this model is a deployment and distribution module that has been embellished to include the micro/meso level influences of different models of care; supporting healthcare infrastructure at the meso level (or its absence); and, at the macro level, economic factors at the (i.e., funding, financing, and remuneration of health professionals), and legal, regulatory, and accountability/liability influences. The model continues to be situated within a broader social, political, economic, and geographical context, but these contextual features are more fully fleshed out in terms of their specific input into planning and deployment.
This model is presented as a heuristic device that could be revised according to consensus discussion amongst a range of stakeholders across Federal/Provincial/Territorial jurisdictions.

Enhance and coordinate the HHR evidence infrastructure:

Once a common language and consensus mapping of the key elements of a system of HHR have been achieved, it would be strategic to enhance and coordinate the evidence infrastructure to support more informed HHR planning and deployment at each step. A coordinated national arms-length evidence infrastructure could also be a central mechanism in which this common language could be further developed, defined, measured, and evaluated for consistency and validity. A number of HHR stakeholders in Canada have suggested “a national centre dedicated to assisting with the coordination of health workforce planning efforts across jurisdictions including a central location for collection and analysis of health workforce data that is independent and provides arms-length, evidence informed advice and cohesive reports to help address health workforce issues that have impact across jurisdictional boundaries” (IHWC Report, 2014, p. 7).

Such a coordinated effort could include: first, expanding the collection, liberation, linkage, and utilization of more comprehensive data on the health workforce and population health needs, thus fleshing out the integrated components of the framework; and second, developing tools and resources to coordinate, monitor, evaluate, and support more informed HHR decision-making, and guide health workforce policy and planning activities across the country.

An enhanced evidence infrastructure could build upon and coordinate the efforts of existing pan-Canadian organizations, including:

- The Canadian Institute of Health Information, which already has a
mandate to collect and/or act as the custodian of minimum datasets for a number of health professions. Existing national level collectors and custodians of health professional education data, such as the Association of Faculties of Medicine of Canada, the Canadian Association of Schools of Nursing, and accrediting bodies, such as the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada, could become additional members of a coordinate data custodian and analysis consortium.

- The Canadian Health Human Resources Network, a research and knowledge exchange network established with funds from Health Canada and the Canadian Institutes of Health Research, which has as its central goals to coordinate and build capacity in HHR research and foster knowledge exchange. It does so through its virtual infrastructure, linking national experts, researchers, and policy makers supported by an online virtual platform of resources, tools, and evidence-based information to help guide decisions and research around critical and stubborn health workforce issues. A key role in a coordinated consortium for CHHRN would be to evaluate the efficiency and effectiveness of existing health workforce planning and delivery models, to help guide further improvements and strategies for improving measurements of population needs, health workforce productivity, and health outcomes.

- The Canadian Foundation for Health Improvement, which fosters better informed healthcare decision-making amongst a range of health policy actors, could take on a central role in fostering the scale up of HHR innovations through a range of existing knowledge exchange tools they have developed and modified over a number of years.

These institutes, associations, networks, and foundations could be organized into a broad-based HHR consortium that draws upon each party’s relevant experience and expertise, and better coordinates an action plan that informs the planning and deployment of HHR across the country. Providing the strategic policy directions to this arms-length evidence consortium would be a link to the Federal/Provincial/Territorial Committee on Health Workforce.

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Promising Coordinated Data Linkage Effort: The Geoportal of Minority Access to HHR

Although there are many innovative tools and resources available to help support health workforce planning and research in Canada, one of the most recent and ground breaking innovative tools developed is the Geoportal of Minority Health, developed by Dr. Louise Bouchard through funding by the Ontario Ministry of Health and Long-Term Care, to “identify knowledge gaps and improve knowledge about health and access to health services in Francophone minority populations of Ontario” in 2013-2014. The Geoportal of Minority Health is essentially a centralized geographic database comprised of:

- Socio-economic data associated with different linguistic variables
- Data on health professionals including their ability to provide services in official language minority populations
- National health surveys
- Points of health services

These enable spatial analysis of data and online mapping, which health workforce planners, researchers, and other potential users can use to “create, organize and present spatially referenced data and to produce plans and maps” (CHNET-WORKS!, n.d.).

This innovative tool can be used by a wide range of knowledge users, including "health workforce planners for minority health, LHINs, public health and community organizations as well as researchers" to help "improve knowledge of social and structural factors underlying health disparities that disproportionately affect minority populations” (CHNET-WORKS!, n.d.).

Although the geoportal is largely comprised of Ontario data, Dr. Bouchard hopes to expand the activities of the observatory at the pan-Canadian level, which would help health workforce planners address health workforce challenges among this particularly vulnerable population. There is certainly potential to also apply the tool to address other similar health workforce issues.
What can a coordinated HHR effort achieve?
Health Workforce Australia

Australia is a country facing similar issues and structural arrangements as Canada, including those related to working across jurisdictional, professional, and geographical boundaries to address similar large-scale issues, including maldistribution, shortages in some professions and specialties, and constricted professional roles (HWA, 2013a; HWA, n.d. a). In 2010, Australia adopted and launched a national health workforce agency, Health Workforce Australia, to help guide nationally coordinated action towards strategic long-term healthcare reform and innovation, in order to address the challenges of providing a skilled, flexible, and innovative health workforce that meets the healthcare needs of all Australians (HWA, 2013a; HWA, n.d. a). Health Workforce Australia recognizes the complexity of the healthcare system, in that issues cannot be addressed in isolation. It has endeavoured to meet these challenges through holistic and collaborative means that see the development of a sound evidence base to be able to inform national policy, and reform the formation of policy programs that facilitate reform, “in training, workforce, workplace and international recruitment and retention and by working across jurisdictions, sectors, health and high education providers, professions and stakeholder groups” (IHWC, 2014, p. 66).

Their approach has yielded promising tools. Health Workforce 2025, for example, was released by HWA to provide national projections of the health workforce numbers, as well as models to determine the effects of different policy scenarios for a range of health professions. In line with HWA’s commitment to develop a sound evidence base, the purpose of these projections is to quantify the current health workforce, “and provide impetus and consensus for reform through the provision of evidence” (IHWC, 2014, p. 66). Moreover, the projections demonstrate a need for action that can be practically achieved through, among all else, collaboration. In addition to providing Australia’s first major, long-term national projections for doctors, nurses, and midwives, Health Workforce 2025 outlines why reform is essential. Without a “nationally coordinated reform Australia is likely to experience limitations in the delivery of high quality health services” (HWA, 2013b, p. 7). Health Workforce 2025 also presents “alternative, more sustainable views of the future, based on policy choices available to government” (HWA, 2012a, p. iii). Moreover, “to address the findings of Health Workforce 2025, a clear set of actions is needed. The work to be undertaken will require a coordinated national approach involving governments, professional bodies, colleges, regulatory bodies, the higher education system and training providers” (HWA, 2012b, p. 3).

Developing a nationally coordinated HHR action plan:

“The HWA also developed a strategic plan in consultation with stakeholders as a “three-year blueprint that outlines how HWA will build a sustainable health workforce” (HWA, 2013c, p. 3). It describes “the programs that HWA will undertake to achieve the three objectives set out by the strategic plan” (HWA, n.d. b): 1. “build health workforce capacity by supporting more efficient and effective training and migration pathways to ensure the workforce required is delivered as efficiently and effectively as possible” (HWA, n.d. b); 2. Boost health workforce productivity through technological advances and evidence-based policy and programs, new workforce models, new roles and the realignment of existing roles to ensure the workforce is deployed in the most effective way and that health workers are able to use the full range of their skills and competencies (HWA, n.d. b); and 3. Improve the geographic distribution of the health workforce and clinical education opportunities, as well as its distribution across professions, specialties and healthcare settings (HWA, 2013c, p. 10).

Guided by the needs of policy decision-makers, a consensus framework of the various inputs/outputs and outcomes of a system of HHR, and an enhanced and coordinated consortium of HHR stakeholders, the development of a nationally coordinated action plan is critical. This action plan will identify the top critical challenges that need to be addressed across the country, and establish a set of goals associated with each of these challenges – including common definitions, baseline measures, and indicators that can be used to inform an evaluation framework – to help track, monitor, and evaluate the progress across the country towards achieving these common goals. Most importantly, it will identify the key actors who will take the lead initiative in each of the action items with accountability targets. That is, a crucial component required in a national health workforce action plan/strategy would be responsive and accountable governance strategies, in order to more effectively guide appropriate actions that align with national goals.

There would, of course, be synergies between these different elements – adjustments to the consensus framework in response to system feedback would be important. The nationally coordinated arms-length infrastructure will help coordinate, monitor, evaluate, and guide health workforce policy and
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planning activities across the country, and report on the progress of a national plan – the necessary basic foundation upon which to effectively and efficiently coordinate and implement health workforce activities across the jurisdictional and professional boundaries in place. A responsive national health workforce strategy is one in which both intelligence strategies and governance strategies work together to inform and implement appropriate responsive actions towards health workforce issues.

III. HOW MIGHT THE STRATEGY BE IMPLEMENTED?

“The success of the framework and the action plan depends on the commitment of all involved in making the transition from the status quo to a more collaborative approach. The critical success factors to applying the framework and building that commitment are:

1. Appropriate stakeholder engagement
2. Strong leadership and adequate resources
3. Clear understanding of roles and responsibilities
4. A focus on cross-jurisdictional issues
5. A change in system or organizational culture
6. Flexibility
7. Accountability” (ACHDHR, 2007, pp. 12–13)

The recommendations regarding engagement and coordinated action still ring true today, but in the words of a colleague at the recent Physician Employment Summit: “Let’s all agree on where we need to go, but let’s not try to boil the ocean” (Danielle Frechette, 2014, personal communication). That is, although we agree with the above statement by ACHDHR, we need to be aware of some key factors that can have a profound influence on implementation. These factors include the barriers and limitations to implementation, and the role and value of evaluation, in promoting commitment, engagement and accountability, which is required to promote an effective, sustainable, national strategy. To this end, we argue that efforts to enhance the likelihood of success of a national strategy must start during the planning and design phase, and should focus on mediating obstacles and creating opportunities to promote commitment, engagement, and accountability (Wholey, Harry, & Newcomer, 2010, p. 26).

Many of the limitations related to implementation of national strategies are related to political and financial constraints, as well as competing ideologies, values, and goals among various stakeholders and interest and advocacy groups (Wholey, Hatry, & Newcomer, 2010). Understanding these barriers and limitations will help guide strategies for addressing them, and it is in this context that we argue that establishing common goals and values among all stakeholders plays a central role in the ability to effectively implement a national health workforce strategy, and moreover, that an evaluation framework would help promote the ongoing engagement, commitment, and accountability required to effectively build and sustain such a strategy.

The fragmented nature of health workforce planning and the competing values create significant barriers in establishing a common vision within and across jurisdictional and professional boundaries. Yet, establishing this common vision is key to promoting the ongoing, collaborative engagement and coordination required to support a national strategy. A key influence that will bind this common vision is establishing a common value which can be measured in the strength of the evidence produced, in the credibility to intended users, and, especially, in the use of the information to improve policies and programs (Wholey, Harry, & Newcomer, 2010, p. 4). As discussed in the previous section, Australia’s national health workforce agency plays an important role in the progress and advancements towards healthcare reform, through consultative and collaborative means that see the development of a sound evidence base as informing health policy and reform centred around a common vision, “to drive change, collaboration and innovation to build a sustainable health workforce that meets the healthcare needs of all Australians”; this base is built around common values shared by all stakeholders, which include innovation, accountability, respect, and collaboration (HWA, 2013c, pp. 6–7). There is also much to be learned from Health Workforce Australia in this regard, particularly with respect to their three-year action plans with their accompanying evaluation frameworks and progress reports.

Thus, it is critical that a strategy be informed by research, insights, and precedents, both locally and internationally. Indeed there is a wealth of knowledge to be garnered internationally with regard to effective and innovative approaches to health workforce planning and deployment that can be considered in terms of developing an efficient, collaborative, national health workforce strategy in Canada. Initiatives that bring together international health workforce stakeholders, such as the International Health Workforce Collaborative (IHWC), provide valuable opportunities for countries to develop a strong knowledge base with which to further develop or strengthen their own national strategies for health workforce planning.

Conclusion

It is clear that many of the issues related to health workforce supply, mix, and distribution can be addressed through a pan-Canadian system-based, collaborative strategy for health workforce planning. Despite the promise of a coordinated pan-Canadian HHR strategy, at present there are still too few strategies, mechanisms, or infrastructures in place to coordinate, monitor, measure, inform, or guide the production, distribution, and utility of the Canadian health workforce (Barer, 2013; Assembly of First Nations, 2005, p. 4). As a result, Canada’s healthcare system continues to be riddled with health workforce issues, persistently failing to meet the needs of the population in
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terms of quality and access to care, and the needs of the health workforce in terms of appropriate integration, scopes of practice, and quality of work-life (RCPS, 2013, p. 4; Barer, 2013; RCPS, 2014). Given that the health workforce is the most critical element of health systems, it is time to devote the appropriate time and resources to generating the knowledge needed to better address these concerns in a way that enhances patient care and population health.

References


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BACKGROUND AND PURPOSE OF THIS PAPER

The Canadian healthcare system is at a critical juncture. The cost of healthcare has been rising steadily and now consumes 40% of most provincial/territorial (PT) government budgets; our population is aging and living longer, thus requiring more care; and the ten-year Canada Health Accord between the federal and PT governments reached an end on March 31, 2014 with no clear path as to what the future holds (Canadian Institute for Health Information [CIHI], 2013; CIHI, 2011). This is indeed an opportune time to reinvigorate ongoing reform efforts as part of the natural evolution of the distinct brand of Canadian healthcare we have come to cherish. Over the years, jurisdictions in Canada have been investing in eHealth as part of a strategy toward a sustainable healthcare system. Investments have included the migration to electronic patient records in hospitals and physician offices, and the automation of service delivery to improve the efficiency, access, and quality of care provided. To date, the federal government has directly invested $2.1 billion in Canada Health Infoway (Infoway), an independent non-profit corporation, to accelerate eHealth implementation in Canada. The PT governments have also invested in the cost-sharing of eHealth projects with Infoway. The initial investment had been in the area of an interoperable electronic health record (EHR), defined by Infoway and PTs as a secure digital record of an individual’s lifetime health history that can be made available to authorized care providers and individuals at anytime and anywhere across the country. The 2010 Federal Budget expanded the scope of Infoway to support the adoption of integrated physician office electronic medical records (EMR) to enable a two-way exchange of an individual’s health information that can be made available to authorized care providers and individuals at anytime and anywhere across the country. The 2010 Federal Budget expanded the scope of Infoway to support the adoption of integrated physician office electronic medical records (EMR) to enable a two-way exchange of an individual’s health information that can be made available to authorized care providers and individuals at anytime and anywhere across the country.

The conference provided a forum for stakeholders to link strategy, policy, governance, process management, and quality assurance with healthcare reform in Canada. The core elements identified at that conference had four themes: EHRs, pharmacare, integrated continuum of care, and health human resources (Queen’s Health Policy Change Conference [QHPCC], 2013). The upcoming conference is the second of this three-part QHPCC series, to be held in May 2014. The focus of this second conference will be on Creating Strategic Change in Canadian Healthcare. This EHR white paper addresses one of the four themes being discussed at this second conference. In this paper, EHR is broadly defined to include both electronic patient records in healthcare facilities (e.g., hospitals) and physician office EMR systems. Since EHRs acquire their data from multiple sources, laboratory (lab), drug, and imaging information systems, and the Infoway EHR Blueprint, including the Health Information Access Layer (HIAL) as an example of an underlying interoperable backbone, all need to be included in the model. In particular, this paper will summarize how leading health systems and providers have implemented EHR systems, identify challenges in such processes, and propose strategies for Canada’s PT jurisdictions to work together to implement an effective EHR. The three key questions to be addressed in this paper are:

1. What is the justification for this EHR strategy?
2. What would be the key components of this EHR strategy?
3. How might this EHR strategy be implemented?

Rather than proposing a definitive EHR solution, this paper seeks to continue the dialogue on the need for a coordinated EHR strategy for Canada, and to stimulate debate on what the key components of this strategy should be and how they can be implemented. Most importantly, any EHR investments made in support of the healthcare reform effort in Canada must demonstrate value for money.

In June 2013, the first of the three-part Queen’s Health Policy Conference Series, entitled Toward a Canadian Healthcare Strategy, was held in Toronto.
JUSTIFICATION FOR A COORDINATED EHR STRATEGY

This section provides the justification for a coordinated EHR strategy for Canada. First, we describe an eHealth Value Framework for Clinical Adoption and Meaningful Use that we have adapted from existing models to make sense of EHR investment, adoption, and impact. Second, we summarize the current evidence on EHR benefits in Canada, based on a recent literature review related to this topic that we completed for Health Canada. Third, we summarize EHR implementation challenges to date as the means to justify the need for an overall coordinated EHR strategy for Canada.

A Holistic eHealth Value Framework

The eHealth Value Framework for Clinical Adoption and Meaningful Use (hereafter referred to as the eHealth Value Framework) describes how the value of eHealth, such as an EHR, is influenced by the dynamic interactions of a complex set of contextual factors at the micro, meso, and macro adoption levels. The outcomes of these interactions are complex. The realized benefits (e.g., value of EHR) depend on the type of investment made, the system being adopted, the contextual factors involved, the way these factors interact with each other, and the time for the system to reach a balanced state. Depending on the adjustments made to the system and the adoption factors along the way, the behaviour of this system and its value may change over time (see Exhibit 1 below).

The eHealth Value Framework incorporates several foundational frameworks and models from the literature. The underpinnings of this framework are the following: Infoway Benefits Evaluation (BE) Framework (Lau, Hagens, & Muttitt, 2007); Clinical Adoption Framework (Lau, Price, & Keshavjee, 2011); Clinical Adoption and Maturity Model (eHealth Observatory, 2013); COACH EMR Adoption and Maturity Model (COACH, 2013); HIMSS EMR Adoption Model (HIMSS Analytics, 2007); Meaningful Use Criteria (Blumenthal & Tavenner, 2010); and the Information Systems Business Value Model (Schryen, 2013). By combining features of these models, this framework provides a comprehensive view of eHealth, such as the EHR and its value. Specifically, there are three interrelated dimensions that can be used to explain the benefits of EHRs. They are: Investment, Adoption, and Value. Each is made up of a set of contextual factors that interact dynamically over Time to produce specific EHR impacts and benefits. These dimensions are described below:

1. Investment – Investments can be made directly towards achieving
EHR adoption or indirectly to influence larger contextual factors that impact adoption.

2. **Adoption** – Adoption can be considered at a micro level, consistent with the Infoway BE Framework. It also has contextual factors at the meso and macro levels, ranging from people and organizational structures to larger standards, funding structures, and legislations.
   - **Micro** – The quality of the system and its use can influence the intended benefits. The system in terms of the technology, information, and support services provided can influence how the system performs. This can impact the actual or intended use of the system and user satisfaction. If a system does not support certain functionality (e.g., system quality), or is not used appropriately or as intended (use), value is not likely to be seen.
   - **Meso** – People, organization, and implementation processes can influence the intended benefits of the system. People refers to those individuals/groups who are the intended users, their personal characteristics and expectations, and their roles and responsibilities. Organizations have individual strategies, cultures, structures, processes, and info/infrastructures. Implementation covers the system’s life cycle stages, its deployment planning/execution process, and the system’s fit for purpose.
   - **Macro** – Standards, funding, policy, and trends can influence the benefits. Standards include HIT, performance, and practice standards. Funding includes remunerations, incentives, and added values for the system. Policy refers to legislations, regulations, and governance. Trends cover the general public, political, and economic investment climates toward EHR systems.

3. **Value of EHR** – This is defined as the intended benefits from the clinical adoption and meaningful use of the EHR system. Value can be in the form of improved care quality, access, and productivity affecting care processes, health outcomes, and economic return. It can be measured by different methods and at various times in relation to adoption.

4. **Lag Time** – There is an acknowledged lag time to implement and realize benefits from EHR adoption. Lag effects occur as EHR systems become incorporated into practice and adoption factors at the micro, meso, and macro levels can all impact lag time.

**Summary of Canadian Evidence.** There is a small but growing body of evidence on the adoption, impact, and value of EHRs in Canada. The three data sources were: Infoway co-funded benefits evaluation studies; primary studies in peer-reviewed journals; and the 2010 federal government auditor report. The systems and functions examined were EHRs, drug information systems (DIS), lab information systems, diagnostic imaging and picture archival communication systems (DI/PACS), physician office EMRs, computerized provider order entry (CPOE), clinical decision support (CDS), ePrescribing, and provincial drug viewers. These findings are summarized below.

1. Twelve studies on 13 systems co-funded by Infoway and published during 2009–2013 were reviewed. Six focused on physician office EMRs; four were on DIS; two on DI/PACS; and one was on an EHR viewer. The study sites covered hospitals, community pharmacies, medical imaging clinics, primary care clinics, and physician offices. Of the studies, there were six controlled, five descriptive, and one mixed methods, based on statistical comparison, literature review, workflow analysis, survey, interview, chart usage review, service utilization review, document analysis, cost benefit analysis, and simulation modeling. Most included measures in the Infoway Benefits Evaluation Framework. Some looked at estimating economic return of the system.

2. Twenty-five Canadian evaluation studies published during 2009–2013 were found in the literature. Twelve of these studies were on EMRs; three were on DIS; three on ePrescribing; two on CPOE; two on EHR; two on chronic disease management (CDM); and one was on HIE. The sites covered hospitals, emergency departments, ambulatory and primary care clinics, office practices, and community pharmacies. Nine of the studies were focused on data quality; seven on system impacts; five on adoption; and one was on secondary use. The designs included randomized trials, retro/prospective cohorts, data validation, case studies, and time series studies.

3. During 2009–2010, the Auditor General of Canada and government auditors of six provinces conducted concurrent performance audits of EHR implementation projects in their respective jurisdictions. The provinces involved were Alberta, British Columbia, Nova Scotia, Ontario, Prince Edward Island, and Saskatchewan. The EHR components covered client and provider registries, diagnostic imaging systems, lab and drug information systems, and the interoperable EHR. The focus of the audits was on the planning, implementation, and public reporting of the results (e.g., OAG, 2010).

**Value of EHR.** Of the 38 studies in the review, 21 reported on value findings. These showed a combination of positive, mixed, neutral, and negative benefits. Below is a summary of the results based on the value dimension of the framework, which is made up of care process, health outcomes, and economic return (see Exhibit 2).
1. **Care Process** – Most of the studies reported benefits in care process (actual or perceived improvements). These care processes involved activities that could improve patient safety (Tamblyn et al., 2010; Gartner, 2013), guideline compliance (Holbrook et al., 2009; PWC, 2013; Gartner, 2013), patient/provider access to services (Gartner, 2013; PRA, 2012), patient-provider interaction (Holbrook et al., 2009; CRHE, 2011; Lapointe et al., 2012), and care coordination (Pare et al., 2013; PWC, 2013; Lau et al., 2013). There were also negative impacts with poor EMR data quality that affected drug-allergy detection (Lau et al., 2013), perceived inability of EMR to facilitate decision support (Pare et al., 2013), and increased pharmacist call-back in ePrescribing (Dainty et al., 2011).

2. **Health Outcomes** – The overall evidence on health outcome benefits is smaller and is more mixed. For instance, two controlled DIS studies reported improved patient safety with reduced inappropriate medications (Dormuth et al., 2012) and errors (Fernandes & Etchells, 2010), while a third study reported low accuracy of selected medications in a provincial medication dispensing repository (Price et al., 2012). Holbrook et al. (2009) reported improved A1c and blood pressure control levels in their controlled EMR study, while Pare et al. (2013), PWC (2013), and PITO (2013) all reported expectations of improved safety from the EMR. At the same time, PITO (2013) reported <25% of physicians believed EMR could enhance patient-physician relationships and Pare et al. (2013) reported few physicians believed EMR could improve screening. For ePrescribing and CPOE, there were no improved outcomes in patient safety reported (Tamblyn et al., 2010; Dainty et al., 2011; Lee et al., 2010).

3. **Return** – The evidence on economic return is also mixed. For EMR, O’Reilly et al. (2012) reported a positive return on diabetes care from Holbrook et al.’s 2009 RCT study, which showed an improved health outcome of 0.0117 quality-adjusted life years with an incremental cost-effectiveness ratio of $160,845 per quality-adjusted life year. PRA (2012) reported mixed returns, where screening was cost effective for breast and colorectal cancers, but not for cervical cancer. Pare et al.’s (2013) survey <25% of Quebec physicians reported a direct linkage between the EMR and the financial health of their clinics. The PITO (2013) survey also reported <25% of BC physicians believed EMR could reduce overall office expenses. The PWC study (2013) estimated the combined economic return from productivity and care quality improvements to be $300 million per year with full EMR adoption and use.

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**Explanation of the Findings.** The EHR value findings from the Canadian studies have been mixed. To better understand why the value of EHR is not consistently being realized, it is prudent to consider the contextual factors surrounding adoption that influence these findings. Put differently, the value derived from EHR is dependent on the contextual factors that affect the extent of system adoption within an organization. Not all studies addressed the issues of adoption to explain their findings, but 29 studies did report contextual factors for adoption. The identified factors were mapped to the adoption dimension of the eHealth Value Framework, highlighting specific examples within each category. These are summarized below.

1. **Micro level** – The design of the system in terms of its functionality, usability, and technical performance had major influences on how it was perceived and used, which in turn influenced the actual benefits. For instance, the PEI DIS (PEI Department of Health and Wellness, 2010) users had mixed perceptions on its ease of use, functions, speed, downtime, and security, which influenced their use and satisfaction. The quality of the clinical data in terms of accuracy, completeness, and relevance influenced its clinical utility. The actual system use and its ability to assist in decision making, data exchange, and secondary analysis also influenced the perceived usefulness of the system. For instance, seven of the EMR studies involved the development and validation of algorithms to identify patients with specific conditions (e.g., Tu et al., 2010), generate quality indicators (Burge et al., 2013), and conduct secondary analyses (Tolar & Balka, 2011). The type and extent of user training and support also influenced adoption. Shachak et al. (2013) identified different types of end-user support sources, knowledge, and activities needed to improve use over time.

2. **Meso level** – For people, the level of user competence, experience,
and motivation, the capability of the support staff, and the availability of mentors all influenced adoption. For instance, Lapointe et al. (2012) found providers had varying abilities in performing EMR queries to engage in reflective practice on their patient populations. The end-user support scheme identified by Shachak et al. (2012) influenced the confidence and capabilities of users and support staff. Even after implementation, time was still needed for staff to learn the system, as was reported by Terry et al. (2012) on EMRs that had been implemented for two years. For organizations, having management commitment and support, realistic workload, budgets, expectations, and an interoperable infrastructure influenced adoption. These factors were reported by McGinn et al. (2012) in their Delphi study with representative EHR users on successful implementation strategies. For implementation, the ability to manage project timelines, resources, and activities, as well as engage providers, all had major influences on successful adoption. An example was the HIE study reported by Sicotte and Pare (2010), where the implementation efforts had influences on the success/failure of two HIE systems. The auditor report (OAG, 2010) raised concerns with the EHR implementation initiatives in terms of insufficient planning, governance, systems, and public reporting that led to unclear value for money.

3. **Macro level** – One study addressed the standards, funding, and policy aspects of the Canadian plan to adopt an interoperable EHR (Rozenblum et al., 2011). Rozenblum et al. (2011) acknowledged Canada’s national EHR standards, funding, registries, and DI/PACS as tangible achievements over the past 10 years. Yet this Canadian plan fell short from having a coordinated EHR policy, active clinician engagement, a focus on regional interoperability, a flexible EHR blueprint, and a business case to justify the value of EHR. As recommendations, the study called for an EHR policy that is tightly aligned with major health reform efforts, a bottom-up approach by placing clinical needs first with active clinician and patient engagements, coordinated investments in EMR to fill the missing gap, and financial incentives on health outcomes that can be realized with EHRs. McGinn et al. (2012) and PITO (2013) also suggested physician reimbursement and incentives as ways to encourage EMR adoption. Burge et al. (2013), Holbrook et al. (2009), and Eguale et al. (2010) all emphasized the need for data standards to improve interoperability. Note that Infoway received additional funding in 2010 to expand their scope to include support for physician EMRs, which includes clinician engagement with such efforts as the Clinician Peer Support Network (Infoway 2013b).

The studies often have a different focus and vary in their methodological rigor, which can lead to results that are difficult to interpret and make relevant to different settings. The evidence is often mixed in its findings in that the same type of system can have similar or different results across studies. There can also be multiple results within a study that are positive, neutral, and negative at the same time. Even the reviews that aggregate individual studies have shown conflicting results on a given system in terms of its overall impacts and benefits.

To make sense of this evidence, an organizing scheme is needed to understand and explain the underlying perspective, the clinical focus being addressed, the type of EHR systems involved, what is being measured and how, and the contextual factors that can influence the results. In our earlier review, a proposed *eHealth Value Framework for Clinical Adoption and Meaningful Use* was applied to make sense of the assembled evidence. This framework suggests that for eHealth value, such as an EHR, to be achieved from the investments, there is a dynamic set of interactions of the healthcare system at the micro, meso, and macro levels. These factors impact the adoption of EHR systems and, ultimately, impact the realized value. The outcome of these interactions cannot be pre-determined as it will depend on the type of investment made, the system/function being adopted, the contextual factors involved, the way these factors interact with each other, and the time needed for the system to reach a balanced state. Depending on the adjustments made along the way, the behaviour of this system and its value can change over time.

Based on our earlier review of 38 Canadian studies published during 2009–2013, there is some evidence that suggests, under the right conditions, the adoption of EHRs are correlated with clinical and health system benefits: an improvement in care process, health outcomes, and/or economic return. At present, this evidence is stronger in care process improvement than in health outcomes, and the positive economic return is only based on a small set of published studies. Given the societal trends toward an even greater degree of information technology adoption and innovation in the near future, the question is not whether EHRs can demonstrate benefits, but under what circumstances EHR benefits can be realized and efforts be applied to address those factors to maximize the benefits. The challenges ahead are finding ways to coordinate efforts across the country to leverage initiatives already planned or underway, build on previous implementation success, and learn from past failures to move forward. Toward this goal, a coordinated EHR strategy is much needed.

### EHR Challenges and the Need for a Coordinated Strategy

The current state of EHR evidence on benefits in Canada is diverse, complex, mixed, and even contradictory at times. The evidence is as diverse as in healthcare: the studies are based on different contexts, questions, systems, and settings methods, and examine different measures. It is complex because

### COMPONENTS OF THIS COORDINATED EHR STRATEGY

This section describes the components of the proposed EHR strategy. First, examples of relevant EHR strategies and initiatives are included as sources for guidance. Second, key components of this coordinated EHR strategy are outlined, based on those described earlier.
Sources of Guidance for EHR Strategy

Infoway (2013a) has identified five key opportunities for action in its Pan-Canadian Digital Health Strategic Plan. These are to: (1) bring care closer to home; (2) provide easier access; (3) support new models of care; (4) improve patient safety; and (5) enable a high-performing health system. The key enablers to support these actions are: governance and leadership; policy and legislation; resource capacity, capability, and culture; finance; privacy and security; interoperable digital solutions; business case and benefits realization; and practice and process change. Most PT jurisdictions have published similar eHealth strategies. For example, BC’s Health Sector IM/IT Strategy (BC Ministry of Health, 2011) includes the introduction of an integrated system of primary and community care EMRs, acute care clinical information systems, and a provincial EHR. Manitoba eHealth has four key initiatives: MBTelehealth, eChart Manitoba, EMR adoption, and digital imaging (Girard, 2012). eHealth Ontario (2009) has three clinical priorities: diabetes management, medication management, and wait times. Health PEI (2014) already has a core provincial EHR and is working to expand its CPOE and to deploy an integrated EMR for physician offices. All of these plans represent prudent actions that are consistent with the recommendations in the government auditor report (OAG, 2010).

We can also draw on the experience from the United Kingdom (UK), Australia, and the United States (US), which have similar national eHealth investment programs to Canada. In contrast to its early strategy to implement a centralized EHR, the UK has now evolved to allow local health authorities to select and implement systems that better suit their needs. The National Health Service Information Strategy unveiled in 2012 focuses on a national infrastructure and core standards to integrate health and social care data at point of care (PWC, 2013a). The strategy builds on the Quality and Outcomes Framework to engage providers in clinical quality improvement efforts (Gillam, Siriwardena, & Steel, 2012) that are supported through HIT tools. The Australian government’s Personal Controlled Electronic Health Record initiative is refocusing its effort on: governance and engagement; business case and tangible benefits; technical infrastructure and connectivity; data integrity and reliability; product usability and fit-for-purpose; ability to share documents; provider input on personal record control; incentives for use; and awareness and education. The US embarked on a major health information technology (HIT) initiative with the HIT for Economic and Clinical Health Act in 2009. The focus is on building a nationwide health information network, providing leadership in the implementation of standards and certification of EHR systems, and supporting the meaningful use of EHRs. Financial incentives are being offered as extra payments to healthcare providers and organizations to have them become increasingly meaningful users of EHRs (Blumenthal & Tavenner, 2010; Office of the National Coordinator for Health Information Technology [ONC], 2013).

The focus on performance and outcomes (i.e., value) in both the UK and US initiatives has appeal for Canada since similar healthcare initiatives are already underway in this country (e.g., Hutchison, Levesque, Strumpf, & Coyle, 2011). The caveat is that early experience of such efforts in the UK has produced variable results. Iterative refinement is needed to better align incentives with tangible and meaningful intermediate outcomes, continuity of care, patient experience, and cost effectiveness (Gillam et al., 2012; Peckham & Wallace, 2010; Van Herck et al., 2010; Steel & Willems, 2010; Lagarde, Wright, Nossiter, & Mays, 2013).

Another source of guidance is the EHR evidence in our recent eHealth benefits review done for Health Canada, which is summarized above. The 38 Canadian studies identified in that review have provided a snapshot of some of the leading EHR projects in Canada. Admittedly, there are still gaps in the evidence on benefits, particularly with hospital based EHR systems and such functions as CPOE, CDS, and HIE. In moving forward, ongoing, rigorous, pragmatic evaluations with tangible impacts are needed to better inform the Canadian EHR strategy at the local, regional, and national levels.

Coordinated EHR Strategy Components

To address these challenges, a coordinated EHR strategy for Canada may be formulated according to the three dimensions of our proposed eHealth Value Framework of Investment, Adoption, and Value. Drawing on the lessons from the evidence in our review, we have found that to realize EHR benefits one has to make sufficient and targeted investments to support and address the micro, meso, and macro adoption factors in this framework in order to create value.

First, the type of investment can shape this coordinated EHR strategy at the national, regional, and local levels.

At the macro level, funding programs, healthcare standards, policy/governance, and socioeconomic and political trends should all be closely aligned with the EHRs to maximize their benefits. Indirect investments in pay-for-performance such as those in the UK are strong motivators for change in provider behaviours toward quality reporting that can only be done effectively with an EHR. In the US, the recently introduced meaningful use incentive program, EHR certification, HIE technical standards, and EHR data governance are all macro level efforts intended to maximize the benefits that cannot be achieved by system adoption and use alone. A Canadian example is the Manitoba PIN initiative, which combines EMR adoption and meaningful use with quality-based incentive funding for physicians and quality indicator reporting to improve chronic disease management in the primary care setting.

At the micro level, providers will only use an EHR if it is well-designed, easy to learn and use, secure and reliable, and has ongoing training and support. In particular, decision support and data quality in EHR systems are key features as they drive the quality and safety aspects of care through such actions as alerts and reminders at points of care. The EHR systems need to be carefully designed to facilitate users in entering correct and detailed data easily and the CDS
components need to fit the workflows to provide meaningful decision support that will be more readily acted upon and tracked.

At the *meso* level, the people, organization, and implementation aspects need to be carefully coordinated. For people, drawing on providers in leadership positions as champions and on those with EHR experience as mentors, and defining formal roles to support ongoing system use are important to achieve value. The EHR systems must be aligned with the organizational strategy, culture, structure, and process and infrastructure. As an example, having a positive quality improvement culture and clear goals for the EHR can provide the vision and realistic expectations of what the system should do. For implementation, the system adoption stages, project management, and fit-for-purpose are all relevant factors to be considered. The adoption stages, from initial planning through to design, deployment, and adaptation, affect how well the system is introduced into the organization. The adaptation process can take longer than expected and should be planned and budgeted for in EHR projects. For project management, the planning, activities, and resources required must be defined. An example is the Canadian Auditor General’s EHR assessment reports that emphasized the need for well-managed planning, execution, and monitoring of the EHR projects through their implementation stages. With fit-for-purpose, the ability of the system to fit the needs of the organization and have the provider workflows align with the design is critical to its successful clinical adoption and meaningful use. Alignment of factors at the macro, meso, and micro levels of adoption help translate investments into value.

Finally, to achieve *value* or benefit, one needs to consider what is meant by benefit, how it is defined, and who the recipients of this benefit will be. Also important are the ways by which benefit can be measured, and where and how to go about collecting the benefit results, taking into account the time lag effects that often exist before the benefit can be realized. The Infoway Benefits Evaluation Framework defines net benefits as improvements in care quality, access to care, and productivity (Lau et al., 2007). In the *eHealth Value Framework*, the concept of value is expanded to a more unified scheme through which care quality, access, and productivity may be further distinguished by the type of benefit generated under care process, health outcome, and economic return. Value can be considered in all of these categories.

**IMPLEMENTATION STEPS FOR THIS COORDINATED EHR STRATEGY**

A coordinated EHR strategy for Canada requires a balanced implementation approach that addresses the type and level of EHR investment desired, the degrees of adoption efforts required at the micro, meso, and macro levels, and the value for money to be expected from such efforts. There are 10 proposed eHealth directions described in the Health Canada discussion paper that can be translated as follows to illustrate implementation steps for a proposed EHR strategy:

1. **Decide on long-term EHR investment**
2. **Define EHR value**
3. **Align with healthcare reforms**
4. **Align incentives**
5. **Engage stakeholders in aligned projects**
6. **Adopt national EHR standards**
7. **Develop regional data sharing infrastructures**
8. **Integrate evaluation**
9. **Build EHR leadership**
10. **Invest in 3–4 short/intermediate term goals**

The 10 EHR implementation steps represent a balanced set of initiatives that can be undertaken to help ensure successful EHR adoption in order to achieve value as the long-term goal. These components are captured in Exhibit 3 below as they relate to the *eHealth Value Framework*.

1. **Decide on long-term EHR investment**
   First, there needs to be a consensus on the right level and type of EHR investment for Canada. With the experience from other countries such as the UK and the US in mind, it is clear that a national effort can accelerate the rate of EHR adoption in ways that are not achievable locally. Given the historical under-investment in EHR relative to other industries, one should be realistic about what benefits can be expected with the level of investment available. The type of investment can also influence the benefits, such as pay-for-performance in the UK as an indirect form of investment that can only be done effectively through the use of EHRs (Legarde et al., 2013; Blumenthal & Dixon, 2012).

2. **Define EHR Value**
   The expected value of EHR should then be articulated and defined from multiple stakeholder perspectives. There needs to be a common set of measures by which the value of EHR can be quantified. These should be objective, evolvable measures that can be reported, compared, and monitored over time (Payne et al., 2013). The subset of EMR-sensitive primary healthcare quality indicators from the Canadian Institute for Health Information (CIHI) is an example of the type of benchmark measures available that can be used to manage performance within and across primary healthcare organizations (CIHI, 2011a). A clear evaluation plan and requirements then need to be articulated (see item 8 below).

3. **Align with other healthcare reforms**
   To maximize value, EHR initiatives should explicitly align with other major healthcare reforms that are underway in Canada. For instance, the current restructuring of primary healthcare organizations such as those in Ontario and Quebec provides a unique opportunity where EMRs and health information exchanges can play a facilitating and enabling role to help reach the goals of improving continuity of care. As
larger healthcare organizations and networks are formed (e.g., family health teams in Ontario and primary care networks in Alberta), EMRs and EHRs can play a role as a backbone to improve continuity of care in these larger, shared care-oriented organizations. EHR systems can then support the workflows and appropriate data sharing needed to support new policies that evolve the structure and process of physician practice organizations (Baker & Denis, 2011; Hutchison, Levesque, Strumpf, & Coyle, 2011).

4. **Align Incentives**
   To further amplify value, one should align EHR functions and features with care-focused incentive programs for healthcare providers and organizations. For example, in BC, some of the required features of EMRs focused on supporting improvement in the quality of chronic disease management for common conditions such as diabetes. These requirements aligned with incentive payments for physicians for ongoing chronic disease management for the same conditions. Pay-for-performance approaches have also been implemented in the UK and US (Gillam et al., 2012; Blumenthal & Dixon, 2012), and these, along with the primary healthcare reform in Ontario and Quebec, provide ample lessons for Canada to take stock of what worked, why, and how EHRs can be leveraged in the design and implementation of these incentive programs (Rozenblum et al., 2011).

5. **Engage stakeholders in aligned projects**
   Stakeholder organizations such as healthcare organizations, professional associations, government agencies, regulatory bodies, academia, the private sector, and the public should be engaged in setting a coordinated EHR strategy for Canada and defining their respective roles to help achieve the goals. There are policy areas that may require legislative changes to reap the benefits of EHRs. For example, in some provinces, legislation requires a “wet signature” for any prescription or the use of special prescription pads for certain controlled substances. These requirements prevent the adoption of ePrescribing, thus reducing the effectiveness of prescribing modules in EHRs and more fulsome enablement of prescribing decision support. Broad engagement in the projects will be required to successfully align and overcome these kinds of legislative barriers and other professional practice barriers. There are data and system governance issues to be resolved due to the increasing volume of patient information, such as medications, lab and imaging results, and clinical reports, being stored in repositories that could be better harnessed for health system
improvement. Care providers and vendors need to work collectively toward EHR systems that are safer, more usable, and, have better fit-for-purpose. Such initiatives as EHR certification and safety reporting may help increase the clinical adoption and meaningful use of EHR systems by care providers (Middleton et al., 2012). Overall, these matters should be addressed in a thoughtful, transparent, and privacy-sensitive manner to minimize unintended consequences.

6. **Adopt national EHR standards**

EHR standards such as clinical terminology and structured messages/documents are critical components that need to be mandated, implemented, and shown to add value. Since EHR info/infrastructures and standards are foundational components, there need to be discussions on who should fund these components and how they should be maintained over time. Interoperability should also be seen as the means to achieve better healthcare through the increased sharing and use of patient information across care settings. For example, Infoway already has an EHR certification program and the Standards Collaborative in place as the foundations. These can be further strengthened by more active participation from the jurisdictions to mandate that the EHR systems being implemented can be demonstrated to be interoperable over time.

7. **Develop regional data sharing infrastructures**

Having an interoperable EHR at the national level is a laudable goal. However, greater attention is needed to incorporate a flexible info/infrastructure at regional levels that matches care flows. International experience has shown that regionally functional and adaptable systems, based on local needs, add value to care processes. These regional data exchanges must support national EHR standards.

8. **Integrate evaluation**

To ensure all of these efforts bring value for money, healthcare organizations should incorporate ongoing evaluation as an integral part of their EHR strategy and process. To ensure transparency, there should be public reporting of the evaluation results in ways that can promote learning and improvement (Rozenblum et al., 2011). Evaluation should be both formative and summative. Formative evaluations can be valuable to the development of EHR as they support improvements to the design and implementation as systems, so that each implementation is more likely to be successful. Summative evaluation should focus on tangible benefits in care process, health outcomes, and economic return, while recognizing the time lag effects of the expected EHR benefits. Value needs to be clearly linked through intermediate outcomes connected to EHR system use and behaviours.

9. **Build EHR leadership**

To bring value for money in EHR, one also needs to focus on building the necessary leadership, capacity, and resources to take on the work. To champion the value of EHR in Canada, leadership is needed across all stakeholders and at all levels of the health system. This will include governments, regulatory bodies, professional associations, healthcare organizations, academic and training programs, the private sector, and the public all working collectively on the policy, practice, research, and industry aspects of the EHR strategy. To achieve value in EHR systems, Canada needs to increase its capacity of EHR savvy (not just IT savvy) care providers and staff who understand what it means to adopt and meaningfully use the systems to improve care. The pan-Canadian Clinician Peer Support Networks funded by Infoway (2013b) and the Communities of Practice funded by PITO in BC (PITO, 2014) are two examples of initiatives intended to increase the EHR competency of care providers and support staff. Also needed are resources such as EHR certification programs, meaningful use criteria, and privacy regulations/policies that can help move the coordinated EHR strategy forward in Canada.

10. **Invest in 3–4 short/intermediate term goals**

Last, it is important to demonstrate value for money through some tangible means to gain the confidence of the stakeholders in order to continue their EHR investment. To do so, one may focus on 3–4 short/intermediate term goals through specific EHR initiatives.

**CONCLUDING REMARKS**

This white paper provides a snapshot of the current state of evidence on EHR benefits in Canada, based on an earlier review of 38 studies published during 2009–2013. An eHealth Value Framework for Clinical Adoption and Meaningful Use was applied to make sense of this Canadian evidence. The findings showed that many of the 22 controlled studies on EHR benefits reported actual or perceived benefits in improved care process, but had mixed results in health outcomes and economic return. The remaining Canadian studies reported various contextual factors that influenced EHR adoption, which in turn influenced the benefits. A coordinated EHR strategy for Canada may draw on the three dimensions of our proposed eHealth Value Framework in EHR investment, adoption, and value. Last, 10 EHR implementation steps are suggested in this paper for consideration if Canada were to move forward to develop this coordinated EHR strategy.

**References**


Toward a Coordinated Electronic Health Record (EHR) Strategy for Canada


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Toward a Coordinated Electronic Health Record (EHR) Strategy for Canada


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Integrating Care for Persons With Chronic Health and Social Needs

WHITE PAPER - WORKING DRAFT

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INTRODUCTION

Decision-makers in Canada and across the industrialized world face the dual challenges of meeting the needs of growing numbers of persons with multiple chronic health and social needs, while sustaining already stretched healthcare systems. There is a compelling need to transform the health system by restructuring the provision of care to deliver integrated patient-centred care for individuals with complex care needs. Integrating the many care services provided by a diverse array of providers has been identified as a key pillar of a Canadian healthcare strategy (Monieson Centre, 2013). This paper provides evidence-based recommendations for action by government, providers, and patients to better integrate care.

On the demand side, people are living longer. While aging is strongly associated with the rise of multiple chronic conditions, recent data from the Canadian Institute for Health Information (CIHI) show that utilization is increasing across all age groups (2011a). Most costs are related to people with multiple and complex needs that are higher among older persons, particularly amongst those over 85 years of age (Commonwealth Fund, 2012). This oldest-old population group is also now increasing very quickly in absolute numbers, driving most projections of very high future healthcare spending rates. Less remarked though is the fact that there are also growing numbers of children with complex medical conditions who, due to advances in medical technology, will live into adulthood outside of hospitals, requiring a range of community-based health and social supports. Similarly, more persons with disabilities, who would have previously lived all of their lives in institutions, are now aging in the community.

On the supply side, it is increasingly understood that fragmented “non-systems” of hospital-centred acute care are poorly equipped to support persons of any age with multiple chronic health and social needs in an appropriate, cost-effective manner. A series of recent policy reports and statements in Ontario have highlighted a number of persistent system problems, such as the high number of alternate level of care (ALC) beds in hospitals (Born & Laupacis, 2011; Access to Care, 2014). ALC beds are defined as those occupied by individuals who no longer require hospital care, but who cannot be discharged because of a lack of appropriate community-based discharge options. In his insightful analysis of the ALC problem in Ontario, Walker observed that a lack of coordinated community-based care options too often results in hospitalization and long-term residential care, as costly and often inappropriate “default” options for older persons (Walker, 2011); this impacts negatively on older persons themselves, and on the health system opportunity costs of providing care at too high of an intensity.
Such challenges are not unique to Canadian provinces. A recent EU study, funded by the European Commission, and conducted across 12 EU countries (Austria, Denmark, Finland, France, Germany, Greece, Italy, Netherlands, Slovakia, Spain, Sweden, the United Kingdom, and Switzerland), clarified that in addition to the challenges of encouraging joint working between formal care providers within and across sectors (e.g., hospitals, home care, community agencies), all countries continue to experience challenges in bridging the gap between formal and informal caregivers – the families, friends, and neighbours, who provide the bulk of the supports required to maintain the health, wellbeing, functional independence, and quality of life of growing numbers of individuals of all ages who cannot manage on their own. In addition to providing a range of physical and emotional supports, informal caregivers serve as the main interface with the formal care system, accessing and coordinating services on behalf of cared-for persons (Neuman et al., 2007; Hollander et al., 2009). Without informal caregivers, community care plans are rarely viable for growing numbers of older persons experiencing Alzheimer’s disease and related dementias who require 24/7 monitoring and support. Reflecting this, the OECD has estimated that a continuing decline in informal caregiving could increase formal system costs by 5% to 20%, thus eroding system financial sustainability (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011).

In response, there is a growing consensus that integrating care, particularly for populations with multiple chronic health and social needs, is where we want to go. However, there is less agreement on how to get there, and what approaches work best for whom in which context. Whereas in countries such as Denmark, integrating mechanisms have been embedded firmly within the mainstream of their care system, in others, integrating efforts have taken place more at the margins. Nevertheless, researchers have identified a range of integrating mechanisms (e.g., multi-professional teams, joint working, and service flexibility and adaptability) that can be implemented alone or “bundled” in combination in different care settings (including nursing homes, assisted living, home and community care, transitory care facilities, and hospitals) to improve the planning and delivery of services for high needs populations. A common feature of integrating approaches is that they seek to improve the quality of care for individual patients, service users, and informal caregivers by ensuring that services are what people need, rather than what providers currently provide. Integrated care with published evidence in randomized controlled trials, all from Canada and the United States (though this was not a restriction in our search). In the latter, we undertook in-depth case studies of exemplar programs of integrated care in seven countries, including Canada, the United States, Australia, New Zealand, the United Kingdom, Sweden, and the Netherlands.

We then consider three key design dimensions to inform integrating initiatives in Ontario:

- The first design dimension has to do with whom to target for integrating care. The literature is clear that not everyone needs extensive care coordination or related integrating mechanisms. Most individuals have relatively little contact with the health or social care and integrated care models that have generally been implemented for more complex patient populations, often older adults. Complex patient populations who could most benefit from integrated care are those who have many different health and social care providers caring for their needs. Their needs arise from multiple medical and functional impairments, and these individuals require a system of care that allows them efficient access to integrated community supports and medical care.
- The second design dimension has to do with “what” to integrate: the scope of the services covered. While some integrating initiatives may target particular conditions (e.g., diabetes care) or particular care transitions (e.g., discharge from hospital), others may extend across multiple providers and sectors, including, but not limited to, primary care, home care, community-supports, and mental health.
- The third design dimension considers “how” to integrate: which integrating mechanisms, whether individually or in combinations (e.g., inter-disciplinary teams, single plan of care), appear to work best and under what conditions.

We conclude by reflecting on barriers to and facilitators of achieving more integrated care, and on the advantages and disadvantages of strategies that attempt to achieve integration from the “top-down” or from the “ground-up.”

Overview

In this paper, we begin by reviewing the aims and achievements of ongoing, integrating initiatives in Ontario and other jurisdictions. We draw here on two reviews that we have completed – a summary of evidence for the management of older adults with multiple chronic conditions (Mery et al., 2013) and a summary of seven international case studies of integrated care conducted in partnership with The Kings Fund and The Commonwealth Fund (Goodwin et al., 2013). In the former, we undertook a careful review of five programs of
provision, these individuals do not generally require intensive coordination of care. Integrated care is particularly valuable for individuals with complex care needs, who benefit from services from a wide array of service providers. Most individuals who would benefit most from integrated care have numerous and/or very severe chronic conditions.

The problem of chronic conditions and their impact on the healthcare system is a worldwide concern (Yach, Hawkes, Gould, & Hofman, 2004; Bloom et al., 2011). In western societies, as the baby boomer cohort ages and chronic disease risk factors, such as sedentary lifestyle and obesity, increase in prevalence, an increasing number of individuals experience multiple chronic conditions (Wolff, Starfield, & Anderson, 2002; OMA, 2009; Cornell, Pugh, Williams, Kazis, & Parchman, 2007; Soubhi et al., 2010). Most OECD countries have developed comprehensive health systems to provide high quality and increasingly highly specialized care for a vast number of medical conditions. Life expectancy and survival after the incidence of medical conditions such as cancers or cardiovascular disease continue to increase due in large part to the success of these medical care systems. As a result, more and more people are living longer and longer with multiple chronic conditions and with concomitant functional impairment.

Most older adults have multiple chronic conditions. The Chief Public Health Officer’s report in Canada reported that more than 88% of adults aged 65 and over had at least one chronic condition. Twenty-five percent of adults between the ages of 65 and 79 had four or more conditions, and nearly 40% of adults aged 80 or over had four or more (Chief Public Health Officer, 2010). Studies in the United States also show that about half the population over 75 has three or more chronic conditions, and that individuals 85 years and older are six times more likely to have multiple functional impairments than individuals aged 65 to 69 years old (Anderson, 2011).

The evidence in Canada mirrors the experience of other jurisdictions. According to the Ontario Medical Association (OMA), chronic conditions affect 81% of Ontario adults aged 65 or over, of which 56% have more than one condition (OMA, 2009). An analysis of the British Columbia Linked Health Database found that, in 2000/01, 36% of adults of 18+ years had at least one confirmed chronic condition, and further, that 18% had at least one possible chronic condition – numbers that were 68% and 15% respectively for seniors of 65+ years (Bromeling et al., 2005. p. 7).

**System Impact**

Canadian and international studies demonstrate that persons with multimorbidities and symptoms that impact their daily living use health services disproportionately more than persons with single conditions (CIHI, 2011b), experience poor care coordination (Burgers, Voerman, Grol, Faber, & Schneider, 2010), generate high costs to the healthcare system (Marengoni et al., 2011), and are at risk of poor health outcomes (Marengoni et al., 2011; Bayliss et al., 2007). Estimates from the United States indicate that 75% of all government healthcare expenditures are for individuals with chronic disease (Chief Public Health Officer, 2010). Most of these expenditures are related to frequent admissions for ambulatory conditions and higher rates of preventable complications (Menotti et al., 2001; CIHI, 2011b). In a recent study using data at the Institute for Clinical Evaluative Sciences (ICES), Iron et al. (2011) found that, compared with individuals with one condition, those with three or more diagnoses had 56% more primary care visits, 76% more specialist visits, 256% more inpatient hospital stays, 11% more emergency department visits, and 68% more prescriptions. Research from the Health System Performance Research Network (HSPRN) has shown that about 86% of individual patient costs in Ontario are associated with one of 16 chronic conditions, and nearly half of healthcare spending is for individuals with these chronic conditions (HSPRN, 2013).

There is also evidence that the number of older people who are living alone is increasing at the same time as the availability of informal care by spouses or family members is declining (Coyte, Goodwin, & Laporte, 2008). These trends mean a growing demand for healthcare services to treat multiple chronic medical conditions, as well as services to help individuals cope with activities such as dressing, bathing, shopping, or food preparation. The latter, commonly referred to as social care services, are often provided by family members or informal caregivers, but can be provided by formal service providers, either as home care services or as part of residential long-term care. Often these formal social care services are organized and funded separately from healthcare or medical services, and this can result in fragmented care for people who need both types of services.

The challenges that this situation creates are multiple and complex (OMA, 2009; Boyd et al., 2005). The way healthcare services are currently structured, focusing on management of single diseases with an orientation toward managing acute events, including exacerbations of chronic diseases, fails to meet the ongoing needs of patients. Quality and outcomes of care for these people are often suboptimal.

**Design Dimension 2: What is integrated care?**

Integrated care can mean different things in different contexts. A common feature of integrated care is that it is an approach that seeks to improve the quality of care for individual patients, service users, and carers, by ensuring that services are well-coordinated around their needs. The essence of integrated care is that it completes the value chain by connecting the points of active care provision. There are three essential components to effective integrated care:

1. **intentional collaboration among care providers who share the care and responsibility for patients in team-based care**
2. coordination or active management of care for individuals across care providers who jointly care for patients
3. adherence to a common care plan that is shared among providers and patients and their caregivers.

There are many approaches to describing integration. We rely in this paper on characteristics of integrated care, including (after Nolte & McKee, 2008, and Valentijn et al., 2013):

- types of integration (service, professional, functional, organizational, and system);
- breadth of integration (vertical and horizontal);
- level of integration (macro- (system), meso- (organizational, professional), and micro-level (service and personal));
- degree of integration (from linkage to full integration); and
- processes of integration (bottom-up clinical, cultural, and social or top-down structural and systemic).

A fully integrated healthcare system would fully encompass all of the levels, dimensions, and degrees of integration suggested in Figure 1. However, in reality, integrated care has not fully matured in any health system in a way that fully encompasses an entire population of providers and patients. Instead, we see varying approaches to integrating care.

Integration rarely happens at the macro system and policy level. The best system integration example is likely Denmark, where it is compulsory for each region to establish a health-coordination board with representatives from the region (responsible for medical care) and the municipalities (responsible for social care) within the region. The purpose of the board is to coordinate regional and municipal health efforts and to create coherence between the health sector and adjacent sectors. This system integration initiative also connects to organizational and clinical integration. Danish municipalities’
granting of care services is based on an assessment of the applicant’s overall situation, and all types of healthcare, personal care, and housing are considered. In the case of people with complex needs, several providers may deliver the services, but it is the responsibility of the assessment team to coordinate the care provision through “purchasing” the services, and the team is obliged to monitor the situation on a regular basis (Hansen, 2009). Other examples of system integration for specific populations are health insurance and provider organizations in the United States, such as the Veterans Administration and Kaiser Permanente, or the Program for All-Inclusive Care for the Elderly (PACE) – a model of strong organizational integration that supports functional and service integration, which has also spread in specific localities for some population groups across the United States with varying success (McCarthy, Mueller, & Wrenn, 2009; Klein, 2011). However, the literature on integrated care suggests that organizational integration does not necessarily lead to integrated care as experienced by the patient (Curry & Ham, 2010). While there are clearly some advantages of having a unified organization with a common structure, for example, single budgets and accountability, the evidence from international examples suggests that a great deal of time and effort is required to merge and establish these organizations.

Even functional integration, such as that enabled by the sharing of patient health records, is insufficient on its own to cause professional or service integration. This raises the issue of whether the successful development of integrated care is possible only if it comes from the “bottom up” through the development of specific “micro-level” interventions. Professional, functional, organizational, and system integration would then come as a consequence rather than a cause, but might not occur at all.

Successful models of integrated care require service integration. Integrating care means that each individual with complex care needs receives a coordinated care experience at the clinical interface. System organization and functional integration are enablers that can sustain otherwise fragile integrated care initiatives. Strong models of clinical integration have surfaced without “higher” levels of integration at the system, organization, or even functional levels. A general conclusion is that integration is a “bottom-up” undertaking, but that systematic supports, such as the implementation of shared electronic health records, and financial supports for integrating activities (such as case conferencing) and roles (such as care coordinators) are “top-down” factors that enable the sustainability and spread of integrated care models.

Design Dimension 3: How is integration achieved?

In the international field, we find very different types of integration across the cases, ranging from “highly-integrated” health and social care providers to approaches that have instead sought to build alliances between professionals and providers to co-ordinate care, often based on contractual relationships between otherwise separate partners (Goodwin, Dixon, Anderson, & Wodchis, 2013). The Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) in Quebec is one example of a complex alliance with service coordination based in community care, but also extending to primary and acute care. On the other end of the spectrum, in the Norrtalje Local Authority in the County of Stockholm, Sweden, a new organization was created to merge the purchasing and provision of health and social care, which was otherwise split between municipalities and county councils. It appears, however, that the focus on organizational integration took up a lot of time and energy and that the changes to services have been slower. There are also examples that combine different types of integration, for example, in the Netherlands where the Geriant program is fully integrated horizontally (i.e., a single organization spanning health and social care), care is coordinated vertically (i.e., with hospitals and care homes) (Goodwin et al., 2013).

Most successful integrated care programs originate at the micro level and focus on coordinating services for individual patients/users. Many programs started with a patient vignette to engage providers in coming together to jointly develop a common care plan. In Torbay, a well-known example of joined-up medical and social care in the UK, patient pathways were developed based on a vignette for a “Mrs. Smith.” This followed the more famous Esther Project in Jönköping County Council, Sweden that was profiled by the Institute for Healthcare Improvement (n.d.). These programs represent important ways to engage front line providers in redesigning care. Across all programs it is evident that patient-centred care that enables coordinated care management across providers and care settings is a foundation for integrated care programs to ensure service integration. It is important though to distinguish that these approaches, while being patient-centred, did not clearly engage the patients in the care plan. Direct engagement of patients offers opportunities to increase self-management as patients are empowered to focus on their self-identified priorities.

Higher level integration (in contrast to service integration) becomes increasingly complex to implement. Integrated care models exhibit differing degrees of professional integration with many being based around multidisciplinary teams. Case conferencing among multidisciplinary professionals is essentially the most developed approach to professional integration. Surprisingly few examples of integrated care have much functional integration facilitated through fully accessible integrated information and communication technologies (ICT) systems, though many have attempted to implement linked or shared information systems. Some programs have achieved significant organizational integration, but for most cases, the organizational structures have been preserved and other joint governance or accountability arrangements have been created to oversee the specific service/program. For example, PRISMA in Quebec provides a systematic approach to their strategic, operational, and clinical governance structure. It is clear that among approaches to support better-integrated care to older people with complex needs, there is never a “single model” that can be applied universally.
What do integrated care programs do?

A 2005 analysis by Ouwens et al. of 13 systematic reviews of programs of integrated care for chronically ill patients identified reducing fragmentation and improving continuity of care and coordination of care as the main objectives of these programs (Ouwens, Wollersheim, Hermens, Hulscher, & Grol, 2005). The six most common components identified were: 1) self-management support and patient education; 2) structural clinical follow-up and case management; 3) multidisciplinary teams; 4) multidisciplinary evidence-based clinical pathways; 5) feedback and reminders; and 6) education for professionals. Other important elements mentioned were: a supportive clinical information system; a shared mission, and leaders with a clear vision of the importance of integrated care; finances for implementation and maintenance; management commitment and support; and a culture of quality improvement.

Our international study of seven exemplar models of integrated care found most of these factors to be in place in spite of considerable differences in the focus and implementation of models. In particular, the target populations varied from wide population-based management, such as in the PRISMA program in Quebec, to high cost patients in the Massachusetts General Care Management Program, to dementia patients in the Geriant, Noord-Holland province, the Netherlands, to respiratory disease in the Te Whiringa Ora (TWO) program in Eastern Bay of Plenty, New Zealand. One distinction across interventions was the use of care-coordinators, ranging from a provider who would connect with patients and arrange for care visits with other providers to a more intensive care management approach, where a care-coordinator would also directly provide services and train patients in self-care, such as diet, exercise, and medication management (Goodwin et al., 2013).

Integration is largely the product of improved care co-ordination and management across existing healthcare providers. Care co-ordination to people with complex health and social care needs usually comprises a number of core elements including:

- a single point of entry;
- a single and holistic care assessment;
- a care plan;
- eligibility criteria for receiving a care-coordinator and or care manager;
- and support from a multi-disciplinary team of care professionals.

These elements are almost universally applied across integrated care models suggesting that these core features of care co-ordination are indeed key features in successful approaches to older people’s care, regardless of the specific client group or care focus involved (Nies, 2009; Mery et al., 2013). Of all the care processes used, the most homogenous is the development of single care assessments and subsequent care planning supported by an individual with the power to provide and/or co-ordinate care on behalf of service users.

**ASSESSMENT AND CARE PLANNING**

Because not all chronic patients need multidisciplinary teams, targeting this resource to high risk and high cost patients is particularly important to ensure cost-effectiveness. The best evaluations of community based integrated care have found better outcomes for equal cost, but not yet any cost savings to the health system. However, RCTs of the System of Integrated care for Older Persons (SIPA) in Quebec and the GRACE program in the United States noted that the programs were cost saving among their high-risk patients (Beland et al., 2006; Counsell et al., 2009). This supports the use of comprehensive assessments, not only for care planning, but also for triaging the level of supports that should be made available to clients.

**ENGAGING PATIENTS AND CAREGIVERS**

Internationally, exemplar models have sought to promote engagement of service users and their informal carers or family members to some extent. In New Zealand, Te Whiringa Ora places the most emphasis on engaging service users and family members as the key to achieving its program’s goals, which are defined by the client rather than relying on professional clinical goals. This has even caused some challenges for physicians when patients choose goals that are not directly “healthcare” related. Greater self-determination may create challenges for healthcare providers, who may not feel that they have a direct role that will allow them to assist patients in achieving goals that are not “healthcare” related. In other programs, such as Geriant in the Netherlands, GRACE in the United States, or PRISMA in Quebec, care managers, clients, and informal caregivers jointly make a plan for care treatment each year. In some regions, PRISMA patients may also choose a direct payment option where they are given funds to purchase their own care services, an option mostly applied in retirement home settings where in-house services are already available (Goodwin et al., 2013).

**CARE COORDINATORS**

One of the distinguishing features of integrated care is the presence of a named care coordinator or care manager who takes personal and direct responsibility for supporting service users and usually informal carers/family members. These individuals work to update providers on changes in the individual’s status and treatment, and are in direct contact with the clients to ensure they attend appointments, adhere to their medications, and have access to the appropriate services. In many interventions, care coordinators have face-to-face contact with patients, often in physician offices, and also undertake home visits and telephone encounters. These vary in frequency and type of contact according to the level of need of the individual client. This highly personalized and flexible approach is a common feature of integrated care models. Whereas care coordinators tend to be non-clinicians (e.g., healthcare assistants or social care staff), whose role is to facilitate access to care services as well as provide a key point of contact, care managers generally have specific training and expertise.
in caring for older people with complex needs. Hence, care managers not only undertake the care co-ordination function, but also provide much of the care directly. In the GRACE program, a registered nurse and social worker function as a coordination team. The nurses are especially important in multidisciplinary team coordination and in addressing medical needs, whereas the social worker is especially important in connecting the multidisciplinary team within the social context of the patients and their families and available community supports.

PRIMARY CARE PHYSICIANS
The literature on care coordination for older people with complex medical problems and/or multimorbidity places high importance on the role of primary care, with many studies suggesting that the more effective approaches have a General Practitioner (GP) or primary care physician at the centre of a team-based approach (Bodenheimer, 2008; Coleman et al., 2006; Ham, 2010; Hofmarcher, Oxley, & Rusticelli, 2007). However, international case studies have suggested that primary care physicians are rarely part of the “core” team that provides the care coordination function with service users (Goodwin et al., 2013). In Canada and other jurisdictions, it has often been difficult to engage primary care physicians to share data about their patients and to play a pro-active role in care delivery, thus providing a barrier to driving primary- and community-care led integration. A number of reasons might be put forward to explain this. For example, many primary care physicians prefer to operate as independent practitioners (indeed, often have both professional and business motives to protect this status), and are not natural partners in collaborative initiatives even where they might agree with the principle involved. As many primary care physician practices have intensive workloads, the time to get involved in activities such as care planning or case reviews has also been cited as a common problem. In addition, payment for the work of physicians often sits outside of the wider health and social care system, making it problematic to integrate their services more formally with other providers.

INFORMATION AND COMMUNICATION TECHNOLOGIES
A common central tenet of integrated care programs is the use of a single integrated health record. In practice, however, this is often very difficult to achieve unless all providers are already part of a single organization that relies on a central health information system and consolidated technology infrastructure. In the case studies presented in Dixon et al. (see Goodwin et al., 2013), we did not find any universal application of fully shared electronic patient records accessible by all professionals involved in care. The managed care organization in Massachusetts had a partially integrated information system that was more extensive than other cases. In particular, many of the sites had found it difficult to fully integrate data across organizational and professional boundaries with primary care physicians. Most case sites either had partial data sharing capabilities electronically, or had ambitions to develop and/or improve such capabilities. PRISMA (Quebec) had the most developed, fully accessible electronic client chart, although even in this case there were a few non-affiliated doctors who could not access the information. Moreover, one of the key obstacles being faced in the spread of PRISMA beyond the initial regional implementation has been implementing the electronic client chart in other localities. While integrated exemplars did not always have integrated information systems (it is not a necessary condition), all agreed that it was a key enabling factor.

FUNDING
Integrated care programs nearly universally begin with a developmental or piloting process, often using specially allocated funds (e.g., research grants, growth monies, or pilot and demonstration projects). This aligns with the fact that the programs tend to be bottom-up processes. Programs often get underway with funding for specific initiatives. The way in which integrated care is funded has therefore necessarily differed according to pre-existing national, regional, and local health and social care funding arrangements. In locations where care funding is highly fragmented, such as the United States and Australia, approaches to integrated care have been supported by specific state or federal funding. In less fragmented funding systems, most have sought to create pooled budgets to purchase health and social care collectively, often supported by the creation of a “prime contractor” model, in which provider networks are given capitation-based funding to create “fully integrated” purchaser-providers (e.g., Sweden, New Zealand, and England). In the Netherlands, funding from multiple sources was pooled to get the Geriant program started, with different providers who received funding from insurers agreeing to flow funds to the program. In its mature state, a specialist independent provider of dementia services receives all funding for mental health patients from the public insurer, and then operates a range of contracts through which to provide integrated services in different communities. In Quebec, the PRISMA program has done little to consolidate funding, which may contribute to a lack of shared accountability for patients. It seems that a central pool of funding is highly useful in enabling shared clinical and financial accountability (Goodwin et al., 2013).

To What End?
Evidence of impact, sustainability, and spread
It is difficult to provide an overall comparative assessment of integrated care based on the literature or on our experience with international case studies. This is entirely because of the variation in the types of evaluations that have been conducted and the data collected and reported. There is no common approach to evaluating or measuring outcomes across published results of integrated care programs. Indeed, the degree to which impact measures to evaluate performance and/or care quality are used is highly variable and rarely robust. Nearly universally, integrated care programs report positive results in terms of improved end user satisfaction and reductions in the utilization of hospital facilities and/or care homes, though some of these results depend on pre- and post-utilization, which is problematic due to regression towards the
mean. Because exacerbations requiring hospitalization are sporadic, comparing hospitalization or costs among patients who have just had a hospitalization to their utilization in the period after hospitalization is likely to result in lower observed hospitalization rates in the post-utilization period. Most initiatives we observed also lacked any governance imperative or funding imperatives to collect data and demonstrate performance. The lack of evaluations or standardized monitoring of performance can reduce the opportunities for learning and improvement, as well as for ensuring the sustainability and spread of programs. It remains unclear in many cases whether care outcomes have been improved from the users’ perspective, while little formal work has been done to examine cost-effectiveness.

Sustainability is based on an ability to make an ongoing “business case” for value. Sustainable models appear to require a stable policy context, i.e., a clear business case or proven track record, demonstrated through robust evaluation. The most successful evaluations (Beland, Bergman, Lebel, & Clarfield, 2006; Hebert et al., 2010; Mukamel et al., 2006; Counsell et al., 2009) have shown equivalent total costs, generally with a shift of costs from acute to community care interventions. Where hospitalizations were reduced, costs were roughly equivalent in value to the cost of increased community-based supports. The PACE and PRISMA programs have also shown that cost results begin to show after the third year of operation (which was longer than the demonstration period for the SIPA and GRACE interventions, for example).

Summary

The generalizable lessons from the literature and international examples point to a number of key findings relevant for Canada to move toward integrating care. The first of these is that most successful integrated care models represent a “bottom-up” initiative, rather than a “top-down” structural change. However, these initiatives are only sustained if integrated care is a core top-down priority for all complex patients with stimulus and encouragement for local engagement, and if it is without highly prescriptive top-down organizational or clinical rules.

The second is that integrated care is not a unified or static concept. Integrating care can be achieved through a number of different organizational models and the starting point should be on the clinical/service model, rather than on structural design. Differences across local initiatives may include:

- the target population, from specific diagnoses (e.g., dementia) to a wide array of conditions that occur among targeted high cost or otherwise complex patients;
- what types of services are integrated, including medical, social, and housing, for example; and
- how integration takes place – stemming from system, organizational, professional, or clinical origins.

Without a doubt, success is achieved with good communication and relationships among and between those delivering and those receiving care. But it takes time to build social capital and foster trust among providers, effectively identify and enroll patients, organize services, and to begin to see demonstrable changes in distal outcomes such as readmissions and cost savings. The achievement of more integrated service provision is the culmination of a complex range of influences and processes that occur simultaneously at different levels over time.

What should we do?

Implementation Recommendations

As observed in the international experience, in general, the implementation of integrated care starts from local groups of providers, brought together through strong local leadership and trusting relationships. Some of these initiatives have then developed over time, conditional to the policy context providing top-down support through funding and infrastructure, which also enables the scale and spread of these models. This is, for example, the case of PRISMA in Quebec, now implemented provincially as RSIPA. However, we should not be mistaken and think that one-size-fits-all in integrated care; instead, we should try to directly transfer successful models. The approach that the US Patient Protection and Affordable Care Act has taken through the Accountable Care Organizations is to prioritize local integration, encouraging bottom-up innovation and collaboration and allowing Medicare to reward healthcare organizations with a share of the savings that would result from improving care quality and reducing the cost of care. Similarly, Ontario’s Community Health Links rely on local organization and innovation to develop models of integrated care that suit the local context of specific population needs and existing healthcare resources. Important roles for government and regional planning agencies (such as Local Health Integration Networks in Ontario, or the Ministère de la Santé et des Services Sociaux in Quebec) are guaranteeing adequate funding to facilitate processes of integration and to manage organizational change, ensuring that existing resources, such as for care coordinators, can be assigned to integrated care projects as well as resources to assist with the implementation of the shared clinical information available. In this light, we make three recommendations for Canadian provinces to move toward integrated care:

1. Establish a “top-down” mandate to innovate from the “ground-up.” Lessons from EU jurisdictions suggest the importance of sending a clear policy message that ground-up innovation and risk-taking will be supported. The provincial ministries of health and regional health authorities should articulate a clear vision focusing on person-centred care, with more emphasis on prevention to avoid exacerbations.
2. Encourage joint working. Providers should support service level integration by implementing:
   • inter-disciplinary and inter-organizational teams around the care of complex needs individuals, with a central role for care coordinators in the articulations of the healthcare team itself and of the healthcare team with the users.
   • common assessment, shared goal setting and care planning among providers of social and medical care, patients, and caregivers. Such assessments should include diagnoses and treatment goals, including physical, mental, and social conditions, and specific self-care components.
   • patient engagement in care planning. If patients and caregivers are not on board with the program, success will be extremely difficult to achieve. Providers themselves also have to support the patient’s goals, even if these goals may not be directly related to the care that a particular health professional is best suited to provide. Common assessments should be used to titrate the host of available services to meet individual needs, so that services that are not needed are not provided, and services that are needed are identified and provided to the patient and caregiver.

3. Payer support for integrating care functions:
   • Capitation-based budgets
     ◦ for integrating care services, including resources that are shared by multiple providers for high risk patients
     ◦ to ensure/provide/purchase services that are not currently provided (e.g., for adult day programs or housing)
   • Implement sharing of electronic health information for the same patients from multiple providers. The province could generate or purchase one technology that achieves the required functionality of accepting information from multiple sources into a standard template, and requiring local software vendors to be able to retrieve information from the standard template. (The province also needs to support regulation to ensure that privacy rules facilitate the sharing of patient information across providers included in the circle of care.)

How will we know when we’re successful?

Successful organizations never arrive. They are constantly and continuously re-organizing and re-invigorating themselves to better meet the evolving needs of their customers. So it is true with integrated care. While accomplishments need to be achieved and success celebrated, the ongoing desire for improvements must not have a clear and delineated point. Nonetheless, some key stages of accomplishment can be envisioned.

When provincial initiatives, such as RSIPA or Community Health Links, have an efficient means of enrolling, coordinating the care management of, and even discharging stable complex patients from their integrated care efforts, they will have put in place effective local programs that have achieved their goals. When every complex patient who needs integrated care across the province has access to high value integrated care, we can consider the spread of integrated practice to be adequate. When costs for patients with complex needs across the province are declining and health status is improving and freeing up resources to meet the new and evolving demands in the health system, we should celebrate that success. When patients report that they participated to the extent that they wished in setting their own care goals and in developing their care plans, we will have succeeded in implanting a patient-centred healthcare system for the segment of patients that we are working to better manage.

References


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Integrating Care for Persons With Chronic Health and Social Needs

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HEALTH POLICY REFORM IN CANADA: BRIDGING POLICY AND POLITICS

On May 15th and 16th, 2014, parties interested in Canadian health policy reform will gather in Toronto for Creating Strategic Change in Canadian Healthcare, the second of a series of three conferences organized by Queen’s University. This second conference should be informed by some clear directions coming out of the first gathering, Toward a Canadian Healthcare Strategy, in June 2013. The momentum should be continued toward the goal of contributing to the conditions that will encourage positive reforms across Canada.

Principles, priorities, and reform obstacles identified at the June 2013 conference

The participants of the first conference identified the following guiding principles for a Canadian healthcare strategy:

1. Clear standards for health outcomes and system performance
2. A feasible model of affordability
3. A focus on effectiveness and efficiency of care, including revised funding models
4. Patient-centred care, involving patients as partners in the development of goals/objectives, and providing patient access to medical records
5. A common vision/narrative that engages all providers and respects local preferences

From those guiding principles, the following priorities – here reordered with outcomes first, followed by inputs – were identified for reform:

1. A national pharmacare program
2. Better integrated care across the sectors – hospital, community, primary care, specialty, homecare, social welfare (particular attention was paid to integration of services under the “community/home care” umbrella)
3. Primary care reform with strengthened community care (i.e., home, home equivalent, clustered models)
4. Healthcare governance reform. Potential strategies include: implementing cross-party political leadership to set goals that reflect the priorities of the population; moving responsibility away from the political realm towards a stakeholder-based model; establishing a national arm’s-length council with the authority to develop and manage accountability and outcomes
5. Nationally integrated electronic health records
6. Increased investments in health information technology, communications improvement, smart systems provision, clinical coordination, and system analysis

Conference participants felt insufficient progress had been made on the reform agenda to date and identified the following major obstacles:

1. Lack of political will and political inertia. Health decisions are politically driven and dependent on the four-year cycles of re-election. Lack of strong leadership and decisiveness. (In other words, fear of getting it wrong and paying a political price)
2. The federal/provincial divide. Governance and decision-making are not unified
3. The public is missing in the conversation
4. We lack a national, empowered and independent health policy body

At considerable risk of over-simplifying, I propose that the highest-level summary of the deliberations from the June 2013 conference is that the path of health policy reform is clear, but politics impedes progress. One can lament the political
obstacles, but they are not going to go away. Although the circumstances differ, the problems being encountered by the U.S. Administration over “Obamacare” are going to make any government more likely to shy away from major health reform. So it is best to strategize on how policy and politics can be bridged to move the reform agenda more decisively forward. Removing the first, second, and fourth major obstacles identified above is to a considerable degree beyond the reach of those outside of government and politics. But the third, engaging the public in the conversation, is well within the reach of conference participants and thus should constitute a major component of the strategy to speed up reform in healthcare. Furthermore, those outside of government and politics can play a role in creating the conditions to bolster the political will to act. This is a primary focus of this paper.

Strong federal leadership not in the cards at this time

Many of the participants of the first conference expressed a desire to see strong federal leadership in health policy reform. Undoubtedly this would address some of the identified principles (e.g., the feasibility of setting national standards and having some common elements in the “vision/narrative” around which there could be local differentiation) and some obstacles (e.g., the federal/provincial divide and impediments to the creation of a national empowered and independent health policy body). Circumstances change over time at the federal level and such federal leadership on health may someday be feasible, but the current government has made it very clear it is not interested in playing such a leadership role on this file. So participants of the second Queen’s health policy conference would be advised to spend some time thinking about how the yardsticks can be moved toward the reform goals without a strong federal presence in the process.

A national perspective on health matters could be exercised by the provinces acting in collaboration, possibly without a strong federal presence. A potential model is through the Council of the Federation, which has been pursuing a health strategy initiative for several years. However, over for the foreseeable future, this is no more likely to strongly support the policy objectives identified at the June 2013 Queen’s conference than is federal leadership. To date, little has been accomplished on health reform by the Council of the Federation, and under their organizational structure this shouldn’t be expected to change. The political leadership of the initiative seems to change every few years, and the effort is not supported by a permanent Secretariat with the resources and stature necessary to convert statements into action.

Realistically, over the next several years, health policy reform will for the most part have to proceed with individual provinces. This may not be ideal, but it need not be a showstopper. It could, in fact, work quite well. After all, the current medicare system began in Saskatchewan and was subsequently adopted across the country. Many more specific policy changes have begun in one province and then spread. The Council of the Federation’s recent move to pay lower prices for generic drugs, which followed Ontario’s lead, is an example.

The Canadian system of federation affords the opportunity for experimentation in policy, along with the capacity for other provinces to import what seems to work well. If the “system” in any province demonstrates a way of achieving improvements in the effectiveness and efficiency of healthcare at minimum political cost, the probability of those changes being emulated throughout the country is reasonably high, although the record of the provinces’ provision of comparable pharmaceutical insurance is not reassuring.

Nonetheless, the likely absence of either federal or cross-province leadership does pose challenges to the reform scenario envisioned by the participants of the 2013 conference. On the process or input side, the common “vision/narrative” will be harder to generate. We are not likely to see a national empowered and independent health policy body, and nationally integrated electronic health records will face additional challenges. On the outcome side, any national pharmacare program will most likely have to follow the procedure of starting at the provincial level and then spreading. Clearly this will take more time.

Impediments to the “political will” to act boldly on health policy reform

Rather than devoting much time to lamenting the lack of federal or cross-province leadership on health reform, it is best to diagnose the current situation and devise the most appropriate strategies for moving forward. A starting point is to ponder why more effective reform has not already been achieved. A background paper by Steven Lewis (2013) to the first conference demonstrated that governments have at least been discussing, and in many cases, acting upon key elements of the reforms stakeholders advocate. So why haven’t they gone further? The conference participants identified the federal/provincial divide and the lack of a national empowered and independent health policy body as reasons. It is argued here that these circumstances will not likely change over the next few years and that we are best to get over it and move on. That leaves the other identified obstacles: the lack of political will and political inertia and the absence of public involvement in the conversation. The remainder of this paper will be devoted to ideas for addressing these obstacles.

Joey Smallwood, first and longtime Premier of Newfoundland, is commonly purported to have said that he had never had a conversation about healthcare that didn’t cost him votes. It is a poignant statement that powerfully connects the conditions to bolster the political will to act. This is a primary focus of this paper.

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best with confusion, and at worst with outright hostility. Search parties would be launched immediately to seek the hidden agenda (with suspicion likely cast on the matter being a public cost-cutting exercise).

Canadians do not think our health system is expensive because all they hear is that it costs much less than its American counterpart (instead, for example, of focusing on it being the second most expensive system among all developed countries). They think the quality is high because the benchmark is the almost fifty million Americans without health insurance. Yet international surveys do not rank Canadian healthcare highly. For example, in a comparison of Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States, the Commonwealth Fund ranked Canada sixth overall. On quality of care, Canada was ranked seventh, or dead, last. Canada also ranked last on the timeliness of care (Davis et al., 2010). As Canadians do not think our system is expensive and as they believe outcomes are reasonable, by definition they feel the system is efficient. Again, it is relative to that in the United States, but Canada fares badly in international comparisons of efficiency – a 2010 OECD report, for example, found that Canada spends thirty percent more on public healthcare than would be required under an efficient OECD benchmark (Organisation for Economic Co-operation and Development).

Canadians also believe we have a comprehensive publicly-funded system because more than half of US costs are in the private domain. Yet the thirty percent share of private health costs in Canada is much higher than among the rest of the developed countries, and our public coverage of pharmaceuticals and non-primary care is so low as to be almost without precedence other than in the United States. Few Canadians have likely heard of and would have difficulty relating to the finding that eight percent of Canadians responding to a 2013 Commonwealth Fund survey reported that they had not filled or had skipped dosages of prescription drugs due to cost (Health Council of Canada, 2014). As a bit of an aside, the lack of awareness of such important aspects of healthcare as Canadians not filling their prescriptions speaks to the inherent inefficiency with which information is used. The pharmaceutical information systems in place in some provinces are specifically for pharmacists and prescribing physicians to monitor the filling and re-filling of prescriptions and to report such information, providing a great opportunity for them to alert to both prescriptions not being filled and people needlessly and perhaps harmfully taking too many prescription medications (which might be issued by different physicians and filled at different pharmacies).

The Canadian public is clearly not as seized with the imperative of healthcare reform as analysts and stakeholders working in the sector. This situation must be understood and addressed before it can reasonably be hoped that politicians will lead a reform effort. At times, challenges in healthcare have seized the public’s attention. In the mid-1990s, the public supported governments squeezing health budgets and in the process implementing some reforms because they endorsed the imperative of addressing ballooning fiscal deficits. This support generally waned after a few years, however, especially as there were at least perceived, if not actual, costs such as increased wait times. Over the last few years, the public has again accepted the need to squeeze health, and almost all other public spending, as deficits have once again soared. Yet in neither case was there a public buy-in for comprehensive health policy reforms. Indeed, for the most part, governments did not seek to obtain a mandate to implement such reforms, nor did they put forward plans for reform.

**Conditions that foster the “political will” to act boldly**

The starting point for comprehensive healthcare reform is a messy misalignment of policy needs and public understanding and support. Health is not the first policy area to confront this situation. Before returning to health specifically, it may be instructive to ponder why and how other fundamental, controversial, and politically-sensitive reforms, such as free trade, the introduction of the GST, and the 1990s reform of the Canada Pension Plan, were implemented.

The major reforms described above were extremely controversial in their day. Free trade was a major issue of contention in a federal election. There were many detractors, as there were to the GST, where the Opposition used extraordinary tactics in the Senate in an effort to block it. The public knew little about the pending problems with the CPP when governments (the federal and provincial governments are joint custodians, although the federal government took the lead on much of the reform process) began the reform process, and there was considerable pushback to higher pension contribution rates and opposition from some provinces, particularly Alberta. So great political will was required in all cases. As an observer (and to a considerable degree, a participant) in these reform initiatives, I believe they proceeded because certain critical conditions were established that gave political leaders the comfort they required to proceed. In all cases the conditions were:

1. Identification of a clear, significant problem with negative externalities beyond the community directly affected
2. A critical mass of analysis/research suggesting a course for policy reform
3. A clear sense of the objectives of reform
4. Models upon which to base policy reform, often drawing upon international experience
5. Alignment of at least some key stakeholders with the intended direction of reform and vocal supporters
6. Options to phase in reforms

The conditions did not all get created simultaneously. They were more or less put in place in the chronological order above. And they were not independent. To a considerable degree, each condition supported the creation of the following. The identification of the problem created a wave of research and support from certain groups. An understanding of the problem and initial
research led to the search for international models. External support was felt to validate the reform proposals and process. The option of phasing in reforms either by degree or by component lessened some of the perceived political apprehension. Each condition, but most critically, all of them acting together, fostered the political will to act boldly.

The biggest problem is an unclear definition of the problem

The greatest pitfall for health policy reform is likely failure on the first point – identification of a clear, significant problem. Analysts and stakeholders will say they have identified the problem(s) and that will be true; but the identification will not have been communicated in a manner that reaches and instills understanding and concern in the general public. Hence, politicians have been reluctant to act.

In recent years, the problem that has likely been most communicated to the public is rising health costs. However, this tends to be a cyclical issue, flaring up when governments hit large deficits and quelling when the path to budget balance is restored within a few years. Those who have attempted to extrapolate longer-run health costs (see, for example, Drummond, 2011; Drummond & Burleton, 2010; Dodge & Dion, 2011) have identified the likelihood of a significant problem. Under the status quo, most analyses predict health costs to rise 6–6.5% per annum, whereas government revenues will likely only rise around 4% per annum (and in provinces with older populations and weak productivity growth it will be less than this). Budgets can only remain in balance if other spending areas (principally education, as it is the second largest program spending area for provinces) are chronically restrained and/or tax rates are raised substantially and persistently. Furthermore, ongoing restraint in spending in areas such as education will ultimately harm the health of the population because it will undermine the social determinants of health. The financial problem of rapidly rising healthcare costs is real. But again, the analysis has not reached the attention of the general public and the problem seems too far away to attract immediate attention.

On occasion, efforts have been made to grab the public’s attention through charges that aging will bankrupt the healthcare system in Canada and so should be the catalyst for reform. But the data don’t support the charge, so the efforts fail. Health spending is available by age. It is then a simple matter to extrapolate the current distribution of spending by age. If new and expensive approaches are discovered to deal with the negative effects of aging, the future cost impact will be larger than suggested by current data. Still, once the data are introduced, it is hard to sustain a drive to reform by playing only the aging card.

One could ask whether Canadian governments “let a good crisis go to waste” by not using the large deficits of the past few years to spearhead major healthcare reform initiatives. Most provinces succeeded in reining in healthcare cost growth, but few used the fiscal context to drive high profile health reforms. And as several provinces are already clearly on a path toward budget balance, the opportunity has to a large extent passed. But this is not necessarily a bad thing, as fiscal crisis proves to be a weak platform upon which to build health reform. It grabs the attention of the public and, as in the mid-1990s, can elicit at least temporary support for restraint, if not reform. However, it places the objectives of reform too decidedly in the fiscal camp as opposed to promoting the quality of care and the efficiency of its delivery.

The public might well get exercised around the inefficiency of health spending if they knew about it – they could have the same or better outcomes using a lot fewer tax dollars – but such messages are only contained in arcane reports by the OECD and others, and thus rarely reach public attention. More likely to excite public attention would be a consensus that our health outcomes are inferior relative to the money spent. But that finding is also mainly contained in reports that rarely reach the public’s attention, such as those put out by the Commonwealth Fund. We are indeed fortunate in Canada that some high quality journalists write on health policy matters on a regular basis; unfortunately the readership base is quite small.

In the free trade, GST, and CPP reforms, the presiding federal government played a leading role in communicating “the problem” to the public. But in each case they had important support from other players. The business community was heavily engaged in a communications exercise on explaining the threats to competitiveness created by high tariffs and the former manufacturers’ sales tax. The Chief Actuary of the CPP provided a credible, independent voice on the unsustainability of the former CPP regime. The government didn’t have to work very hard to instill public concern that the CPP might not be there for retirees at some foreseeable point in the future.

Communicating the “problems” with Canadian healthcare is where we can see the potential value of the sorts of institutions recommended by the participants of the June 2013 Queen’s conference – variously described as “a national arm’s-length council” or “a national empowered and independent health policy body.” To some degree, existing organizations such as the Canadian Institute of Health Information provide valuable information that should inform public understanding and opinion. But CIHI reports do not attract much public attention. And CIHI, and others – understandably, given the sources and mechanisms of their funding – pull a lot of punches, such as fastidiously avoiding inter-provincial comparisons of quality of care. Similarly, the six provincial health
research institutes do work that could inform the public, but they have not been successful in communicating directly with the public. They have also not followed comprehensive and consistent plans to address health policy issues.

A message for the 2014 Queen’s conference is to recognize that as obvious as the problems in the health system may be to participants, this has not been effectively communicated to the public and will not be done so by existing public bodies. An enormous responsibility and challenge falls to analysts and stakeholders to get the message out. The challenge is particularly acute because the relevant groups, whether they represent players in the healthcare system or academics such as the organizers of the Queen’s conference, are used to communicating to their peers and have little experience or expertise in engaging the public.

There is typically a sequence to the public’s reaction to policy revelations that might not be welcome. Initially the public recoils and does not want to embrace the problem or proposed solutions. But if the issue is communicated often enough, and there does not seem to be credible opposition, then the public becomes more accepting, perhaps even somewhat bored by the affair. That is the time for policy makers to move forward. These conditions are far from being in place for health reform.

### General Approach

<table>
<thead>
<tr>
<th>Current System</th>
<th>Reformed System</th>
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<tbody>
<tr>
<td>• Intervention after a problem occurs</td>
<td>• Health promotion</td>
</tr>
<tr>
<td>• Acute care</td>
<td>• Chronic care</td>
</tr>
<tr>
<td>• Hospital-centric</td>
<td>• Patient-centric</td>
</tr>
<tr>
<td>• Silos</td>
<td>• Coordination across a continuum of care</td>
</tr>
<tr>
<td>• Resource-intensive minority of patients in regular system</td>
<td>• Dedicated channels for the resource-intensive minority</td>
</tr>
<tr>
<td>• Accept socio-economic weaknesses</td>
<td>• Address socio-economic weaknesses</td>
</tr>
<tr>
<td>• Extraordinary interventions at end of life</td>
<td>• Pre-agreements on end-of-life care</td>
</tr>
</tbody>
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### HOSPITALS

<table>
<thead>
<tr>
<th>Current System</th>
<th>Reformed System</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Draw patients to hospitals</td>
<td>• Keep patients out of hospitals</td>
</tr>
<tr>
<td>• Historical cost plus inflation financing</td>
<td>• Blend of base funding and pay-by-activity</td>
</tr>
<tr>
<td>• Managed through central government</td>
<td>• Regional management</td>
</tr>
<tr>
<td>• Homogeneous, all trying to offer all services</td>
<td>• Differentiation and specialization along with specialized clinics</td>
</tr>
</tbody>
</table>

### LONG-TERM CARE, COMMUNITY CARE AND HOME CARE

<table>
<thead>
<tr>
<th>Current System</th>
<th>Reformed System</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Not integrated, underfunded and weight on long-term care</td>
<td>• Integrated with weight on home care</td>
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</tbody>
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### PHYSICIANS AND OTHER PROFESSIONALS

<table>
<thead>
<tr>
<th>Current System</th>
<th>Reformed System</th>
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</thead>
<tbody>
<tr>
<td>• Not integrated with hospitals and other sectors</td>
<td>• Integrated with primary care being the hub for most patients</td>
</tr>
<tr>
<td>• Work alone or in groups</td>
<td>• Work in clinics</td>
</tr>
<tr>
<td>• Mostly fee-for-service funding</td>
<td>• Blend of salary/capitation and fee-for-outcomes</td>
</tr>
<tr>
<td>• Few standards for medical approaches/conduct of practice</td>
<td>• Evidence-based guidelines (through quality councils)</td>
</tr>
<tr>
<td>• Unclear objectives and weak accountability</td>
<td>• Objectives from regional health authorities and accountability buttressed by electronic records</td>
</tr>
<tr>
<td>• Inefficient allocation of responsibilities</td>
<td>• Allocation in accordance with respective skills and costs; and where feasible, shifting services to lower-cost care providers</td>
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### PHARMACEUTICALS

<table>
<thead>
<tr>
<th>Current System</th>
<th>Reformed System</th>
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</thead>
<tbody>
<tr>
<td>• Little cost discipline from governments</td>
<td>• Cost discipline through purchasing power, guidelines for conduct of practice</td>
</tr>
<tr>
<td>• Cost of plans to private employers driven in good part by employees</td>
<td>• Greater control exercised by employers</td>
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Inside the beltway considerable analysis of health policy reform is available

A second condition found behind successful policy reforms is a critical mass of analysis/research suggesting a course for policy reform. The health field is relatively well served on this front. There is fairly tight and growing agreement among analysts and even stakeholders on the direction of appropriate reform. Some of this was reflected in the priorities for reform identified by the participants of the 2013 conference. A broader set of general policy reforms was set out in the 2012 Commission on the Reform of Ontario’s Public Services, *Public Services for Ontarians: A Path to Sustainability and Excellence* (chaired by Don Drummond), and over the succeeding two years the road map seems to have met general agreement.

A schematic of the Commission’s recommendations (as shown in Chapter 5 of the Commission report; Drummond, 2012) on the direction of reform is reproduced below. Similar recommendations can be found elsewhere. Of course, the schematic represents somewhat of an exaggerated sense of the divide between the current and reformed systems as in many areas some progress has already been made.

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<th>Current System</th>
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Clear objectives need to be established for health policy reform

The lack of clarity over the problem of the healthcare system naturally poses a difficulty in presenting a clear sense of the objectives of reform. But analysts and many stakeholders are quite clear on the objectives (as were the participants of the 2013 conference), and it is quite likely that at least internally most governments have a fairly clear idea about what they would like to do. They just have some difficulty communicating that to a public that does not share their diagnosis of the problem, and herein lies the third condition for healthcare reform.

The objectives of health care reform will have to be very carefully communicated to the public. Analysts and stakeholders can and should help governments with this. Indeed, this should be a primary focus of participants in the 2014 and 2015 conferences of Queen’s. A “vision” piece does not need to be born uniquely within government corridors. It could be developed and articulated by bodies representing the non-government stakeholders in the health and healthcare systems. Such an outcome from the Queen’s conferences could fill a vacuum and if done well could ultimately be adopted by a government or two.

Some attention must be paid to, if not lowering the cost of healthcare, then at least dampening future cost increases to some extent. It is unlikely that healthcare costs could, or even should (if health is the most important thing to people, it is natural that healthcare form a growing portion of public budgets) grow less rapidly (compared to only about 4% revenue (and nominal economic) growth. Yet it would be a political disaster to lead a health reform initiative with a cost-cutting mantra. It might work temporarily when deficits are at their peak, but that moment has already passed for all Canadian governments. And the mentality of driving the reform agenda through the fiscal lens hardly had a very good track record in the 1990s, as the reforms didn’t go deep enough nor were they sustained in many cases. The focus should be on improving the quality of care at an affordable price. The “quotient” of such a formula, of course, is improving efficiency.

The first guiding principle identified for reform by the participants of the 2013 conference was “clear standards for health outcomes and system performance.” This is another area in which governments will have difficulty coming up with specifications on their own. Analysts and stakeholders will need to go much further in promoting and adopting ideas that could potentially be funded and adopted by governments.

Successful policy reform models provide comfort

Identification of successful policy models helps to guide the specification of policy objectives and can inform the policy reform process. It is important to

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**Service Delivery**

<table>
<thead>
<tr>
<th>CURRENT SYSTEM</th>
<th>REFORMED SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly public sector</td>
<td>Blend of public and private sector (within public payer model)</td>
</tr>
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</table>

**INFORMATION TECHNOLOGY**

| Little used by physicians and especially across the system | Extensive use that is key to coordination across system and accountability |
| Information conveyed in doctors’ offices | Information more easily available and conveyed through multiple sources (phone, Internet, etc.) |

**MEDICAL SCHOOLS**

| No attention to system (cost) issues | Course(s) on system issues |
| Little attention to labour supply issues | Role in directing physicians to areas of demand (by area of medicine and geographically) |

**COVERAGE OF PUBLIC PAYER MODEL**

| Hybrid with almost 100 percent primary, less than half of drugs and limited mental health | Broader coverage widely recommended but not at all clear this will be acted upon |

The policy reform process would be facilitated by individuals and institutions that could compile the various pieces of analysis and research on aspects of policy reform into a compelling, broader vision of how an effective and efficient system might work. Participants of the 2013 conference clearly wished to see a new, national body created to do this, among other things, but we should not lose sight of the existence of several bodies that could play a role. One example will be set out here. The first objective set out by the Council of the Federation health initiative upon inauguration in 2012 was the development of “clinical practice guidelines” (as with NICE in the United Kingdom) that would drive “evidence-informed care.” For some reason, this no longer appears explicitly in the objectives as re-formulated at the 2013 gathering of the Council: pharmaceutical drugs, appropriateness of care, and seniors’ care (Council of the Federation, 2013). But it remains a worthy endeavour of such a body. It is also surprising that the Council has not more specifically asked the six provincial health research institutes to more formally engage in identifying these clinical practical guidelines. This could address the weakness of the structure of the initiative in not having a permanent Secretariat.

Incidentally, development of protocols on clinical practice guidelines is another example of where progress could still be made despite the absence of the kind of government leadership participants of the 2013 conference called for. Much of the work on stroke, cardiac, and cancer care guidelines was initially done “in the field” and this experience could be extrapolated to other areas. Through collaborations between providers and their institutions, compelling practices could be put forward that governments would likely be interested in funding and implementing.
note not only the outcomes of the reforms, but also the processes followed and the political ramifications. Were the reforms accepted politically? If there was resistance, why and how did the governments respond?

The fourth common condition for policy reform, of having models that have been tried and tested elsewhere, is available for the Canadian provinces, although not in an ideal form. There does not seem to be any jurisdiction in the world that has “perfected” the healthcare model. In its 2010 report on getting more value for money from healthcare systems, the OECD noted that “there is no health care system that performs systematically better in delivering cost-effective health care” (p. 8). In constructing its “benchmark system” against which to compare the efficiency of healthcare in each country, the OECD used bits and pieces from various countries rather than comparing to the entire system in any country. Not surprisingly, the OECD suggested that each country should adopt best policy practices from other countries as opposed to mimicking any one complete system (2010, p. 8). There are examples of parts of systems that work very well (primary care in much of continental Europe, home care in Denmark, etc.). And there is enough variation across Canadian provinces that any government can pick and choose the models that seem to work well. The first Queen’s conference dedicated much attention to drawing out best international practices. This will again be a focus of the May 2014 gathering. Attention could broaden to defining interesting practices within Canada, as it may prove easier to import a practice from another province than another country.

Governments love to hear supporting voices

The fifth condition of having some key health stakeholders aligned with vocal support is coming along in Canada, but needs further work. Many organizations, including the physicians and nurses, have published thoughtful pieces on their reform ideas, but to a large extent their ideas circulate amongst their peers rather than being digested by the public. That is the major, and largely unprecedented, communications challenge for these groups. And for the most part the stakeholder groups work alone. If the public’s fears of change are to be quelled, it will be helpful to have various stakeholders appearing to work together and being jointly comfortable that their suggested changes will be in the public’s interest. In this regard, the coalition between the physician and nurses associations could be promising, and all the more so if the effort extends beyond the national associations to involve the provincial bodies as well. A further problem in communicating the messages of some of the stakeholders is the divide between their national and provincial bodies. The Canadian Medical Association is a good example. The national body has historically engaged with the federal government over national policy matters. The provincial bodies have largely occupied themselves with engagement with their provincial government over compensation. As argued here, however, the policy action, at least over the next several years, will be at the provincial rather than the federal level. Can the national CMA body become more relevant on provincial policy or can the provincial bodies engage more on policy?

“Big bang” reform or “stealth”

Governments take comfort in having options for the design of policy, and in particular for the nature of implementation. In almost every case of past major policy reform, there has been great internal debate over the nature of implementation. The debate has particularly focused on whether reforms should be implemented quickly and broadly or phased in by degree or sector. For example, it was decided to proceed rather quickly on all fronts in the federal government’s 1995 Program Review because it was felt that hitting all sectors rather simultaneously would mitigate charges of unfairness. In contrast, the British Columbia government, having decided in 2008 on the bold move of introducing a carbon tax, started it off at a low level with legislated future increases in the rate.

In most policy areas, there is an option to roll out reform as a series of changes opposed to a big bang approach. Each successive (and hopefully successful) change can lead to another until a comprehensive reform is in place. This notion has considerable appeal in the health space. Indeed it could be argued we are already doing this, as some action on elements of a major health reform are already being pursued by governments across the land.

Two somewhat different notions can be applied to the practice of incremental reform. First, even if the reforms are implemented in a piecemeal fashion it is useful for a government to set out an overall vision. That way people can relate each change to the whole. Even if there are some wobbles and perhaps some negative feedback to an individual reform, stakeholders and the public can see that it is part of a bigger picture that embraces commonly-held objectives. And the reform process could stay on track if the road map is laid out. As discussed above, a “vision” piece does not need to be born uniquely within government corridors, and could, indeed, be developed by participants at the Queen’s healthcare reform conference series. This could fill a vacuum and if done well could ultimately be adopted by a government or two.

Second, just as in a health procedure, the reform process can be triaged. Much of what analysts and stakeholders think needs to be done can be accomplished with limited public engagement. These are internal administrative matters affecting mostly stakeholders, but not the public in a direct, or at least negative, way. Once governments set out a vision for the reformed system, they can and should proceed forthwith on the items that can be handled with limited public engagement. Health records and the way physicians and hospitals are financed are examples. Other needed reforms involve the public, but in ways that will almost certainly be positive, while yielding cost savings. An example is more effective and efficient care for the small percentage of the population that accounts for a very large percentage of overall costs. In Ontario, one percent of the population accounts for one-third of overall public health costs.
(Drummond, 2012, Chapter 5). The figure is likely similar in other provinces. Naturally, healthcare spending will always be extraordinarily skewed to the very sick or those who have suffered a horrific accident. But a more efficient, integrated approach to their care would bring down the cost substantially and almost certainly improve the quality of their care. Much of the cost for the one percent is driven by an avoidable cycle of being admitted and released from hospital without appropriate support upon release.

Only a few of the recommended reforms will require full scale engagement with the public. The call from the participants of the 2013 Queen’s conference for a national pharmacare program is an example of a reform that would require heavy public engagement. Many task forces and commissions have long called for this. Some provinces have introduced partial insurance schemes for pharmaceuticals, but we are no closer to a comprehensive national program than we were 50 years ago. There would also be some tough arguments to deal with. For example, taxpayer dollars would be required to support a public system. For some people, this might simply mean a shift from paying for a private system (through their employer for example) to contributing to the public one, but people might not see it this way. The fiasco with the implementation of Obamacare shows some of the potential pitfalls. Governments will thus need support from analysts and stakeholders to make the case for such a reform. But challenges over a national pharmacare program should not be an excuse to forestall other reforms that will be less politically contentious. The reform agenda does not have to proceed on all fronts simultaneously. For example, it might be determined that home care is a higher priority at this time than pharmacare, and further, that it might be less controversial to implement.

“Political will” is more a product of the conditions than an independent force

The political drive to act boldly and the willingness to accept risk are really contingent on the preceding six factors. They will not be there if politicians anticipate a significant backlash against proposed changes. And that risk remains when the public doesn’t understand the problem and the objectives have not been clearly and persuasively put forward. So there seems little point in simply lamenting the lack of political will and risk taking. Rather, the supporting conditions must be worked on.

Debates of the Canada Health Act and privatization are distractions

Before summarizing, I will dismiss two factors that commonly and needlessly distract the healthcare reform process. The first is the notion that sensible things cannot be done due to the restrictive nature of the five principles of the Canada Health Act (public administration, comprehensiveness, universality, portability, and accessibility). The objectives of reform set out by the participants of the 2013 conference seem unlikely to negatively impact the principles of the CHA. More generally, it should be recognized that there is much more flexibility than some claim, as several of the principles are hardly in place now and the federal government certainly doesn’t seem bent on taking punitive action.

The second distraction is the suggestion that sensible reform must move health more into the private domain, out of the public. It is critical to distinguish between private delivery of services covered under the single, public-payer model and a two-tier system with more services being paid for privately. The former has been evolving for a long time and will undoubtedly continue. The public no longer seems particularly concerned with who provides the service as long as they can pay with their public card. Effectiveness and efficiency should guide which service provider is chosen. A great deal more could be done on utilizing private resources within the public payer model. For example, more publicly funded services and procedures could be tendered to privately-operated organizations. Putting more costs into the private sphere would be much more controversial. The likely public resistance to higher private costs would substantially raise the bar for the amount of nerve required by governments – probably to the point where it would cripple the desire to proceed on other aspects of reform. At any rate, a debate about public versus private costs seems premature. The main issue at the moment is that costs are too high relative to the outcomes generated by Canada’s healthcare system. Making the system more effective and efficient should be the first priority and then attention can be turned to who pays.

Policy and Politics can be bridged on health policy reform

In summary, there remain challenges to bridging the policy and political sides of needed healthcare reform. It is a waste of time to simply lament the lack of political will. Rather, the focus should be on understanding and addressing the conditions that drive political reticence. The attendees of the 2014 Queen’s health policy conference can play a major role in this. This note will close by returning to the seven conditions found in common behind major policy reforms in other areas, and will suggest how the participants in the 2014 conference and the Queen’s health policy initiative itself can help create the winning conditions for health reform.

1. Making a clearer case for the problems faced by the current system. In turn, this will require unprecedented communications moves by the people and groups involved. A careful balance must be struck to refrain from being relentlessly negative or becoming myopic on single issues, such as costs, but instead show the public (and in turn the politicians) the reform process can transition from identification of problems to...
solutions (solutions being the critical ingredient).

2. The background papers and discussion can sharpen the definition of valuable reforms.

3. The analysts and stakeholders can help governments properly frame the objectives of reform that will not only be acceptable but also appealing to the public. The process must move beyond generalities and make specific proposals. For example, where the 2013 conference left off at identifying the need to establish standards of care, the reform process must now propose some standards.

4. The 2013 conference put a lot of emphasis on drawing in promising healthcare practices from around the world and this will be continued in 2014 and beyond. Greater attention could be paid to some interesting variations in practices across Canada.

5. Stakeholders should continue to work on their own ideas for reform and find better ways to communicate these to the public. But a key to creating the winning conditions for reform will be generating the sense that there is general consensus on how to make improvements. The wide sectoral representation at the Queen's conferences is helpful in this regard. A major challenge will be to communicate the messages in a way that reaches the public.

6. Analysts and stakeholders can help governments triage the needed reforms so political necks are not always on the line. In particular, priorities for reform can be identified. For example, improving home care and its supporting elements may be a higher priority at this time than a national pharmacare program.

If the conditions are created, governments will act. But they will only be ready to act when they peer out of the bunker and assess the air to be relatively calm. Conference attendees can help calm the air with insightful ideas on policy substance and communication.

The health policy reform process is unlikely to unfold as some participants in the 2013 conference urged. There is not likely to be strong federal, or even national, leadership – at least not for the next several years. There won't likely be new national institutions to, if not lead, then at least inform the process. More likely reform will proceed with the players currently on deck. But it can proceed – if the existing players up their game and create the winning conditions so governments don’t fear the Joey Smallwood phenomenon of losing votes every time something is said about health. Change will most likely proceed with a provincial government or two embracing good ideas that will have minimal or positive public reaction and then others flattering them by copying their success. Under this process, it will take a while to get to the end game envisioned at the 2013 Queen's conference. But when the problems have been around for as long as they have, steady progress on reform should be welcome.

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Don Drummond

Don Drummond is the Matthews Fellow in Global Public Policy and Adjunct Professor at the School of Policy Studies at Queen’s University. In 2011-12, he served as Chair for the Commission on the Reform of Ontario’s Public Services. Its final report, released in February 2012, contained nearly four hundred recommendations to provide Ontarians with excellent and affordable public services. Mr. Drummond previously held a series of progressively more senior positions in the areas of economic analysis and forecasting, fiscal policy and tax policy during almost 23 years with Finance Canada.
Evaluating Health Policy and System Performance: Are We Moving to a Network Model?

WHITE PAPER - WORKING DRAFT

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INTRODUCTION

While governments are responsible for monitoring and evaluating health reforms and overall performance, this discussion paper explains why some of this function has shifted in recent years to specialized intergovernmental bodies and, increasingly, to organizations and networks external to governments. In particular, this discussion paper examines academic networks that have emerged in response to the need for better comparative data and analysis both abroad and in Canada. Finally, this paper explores some of the potential implications of policy networks for Canadians in general and their governments in particular.

What is the Problem?

Since the 1970s, there has been much talk about the decline of the welfare state and the rise of market liberalism in industrialized Western countries. It is true that there has been a rollback of the state in many public policy domains and a retreat from universal social programs in favour of targeted, less expensive (at least in terms of government budgets) means-tested approaches. The one exception to this general trend has been healthcare. And given that healthcare expenditures constitute such a large share of gross domestic product (GDP), it is a major exception to this general rule. However, unlike the usual “elephant in the room,” healthcare is one of the most openly debated policy domains in all high-income countries.

In almost all member countries of the Organisation for Economic Co-operation and Development (OECD), real per capita government expenditures have grown since 1970. In addition, the share of public funding of healthcare relative to private funding has also been rising in most countries, although here there are a few more exceptions including Canada, which has seen a gradual drift down from a 75:25 ratio in the mid-1970s to a 70:30 ratio of public to private spending (CIHI, 2013). At the same time, almost all OECD countries, including Canada, have seen the government spending on healthcare increase as a share of gross domestic product over the last 40 years (Marchildon & Lockhart, 2012).

This is the crude quantitative evidence for a more profound qualitative trend. Governments have taken on greater responsibilities for the healthcare needs of their respective residents. The stewardship role of the state for healthcare has increased even if many governments have reduced their roles and responsibilities in other areas of public policy. In Canada, the increasing role of the state has occurred in three main stages. The first was the introduction of universal coverage for hospital and medical care services in all provinces from 1947 until 1972. The second stage was the introduction of targeted coverage for hospital and medical care services in all provinces from 1970 until 1972. The third stage was the introduction of targeted coverage and subsidies for prescription drugs and long-term care services in the 1980s. The third, most recent stage saw provincial governments attempting to manage, cost contain, and coordinate a range of publicly-funded health services through arm’s-length public bodies known as regional health authorities in most provinces.

Funded with generous support from the Joseph S. Stauffer Foundation.
At the same time, in almost every OECD country, healthcare is perceived to be in crisis. In response, governments have been initiating individual reforms as well as altering health system structures in an effort to increase satisfaction and improve overall performance (Marchildon & Lockhart, 2012).

The problem is that it has been difficult to know whether (and which) governments are making progress and, if so, to what degree. While governments have been responsive to public demands for improvement, they have not been as good at evaluating the outcomes of individual reforms, or at benchmarking and assessing overall system performance relative to other health systems. While we as citizens of these governments can bemoan this fact, the reality is that it is understandable why governments are reluctant to engage in rigorous evaluation of individual health reforms or provide rigorous assessments of overall health system performance. Moreover, even when governments have evaluated individual reforms or benchmarked system performance against other jurisdictions, they have been reluctant to present the results in a form that allows for meaningful public scrutiny. There are two principal reasons for this.

First, the stakes are very high. The substantial political and fiscal investment in an individual health reform or larger structural change, combined with the high public profile of healthcare, make any mixed result—much less outright failure—a hostage to fortune in any vigorous democracy. The governing party faces media and opposition parties that will focus on the perceived weaknesses and shortcomings revealed in any public analysis of the reform. While this form of public oversight is essential to a democracy, it does mean that governments, and the governing parties that stand behind them, will generally avoid rigorous evaluation. Moreover, given the presence of freedom of information legislation and the governing parties that stand behind them, will generally avoid rigorous evaluation. Moreover, given the presence of freedom of information legislation and its use by the media, governments will also be reluctant to engage in an internal and confidential evaluation, knowing that such information could be requested by the media, or made publicly available through intentional or unintentional leaks.

Second, whether an individual health reform or overall system performance, the exercise requires some form of benchmarking and comparison with other jurisdictions. Such comparisons are always capable of embarrassing the government. Indeed, even if the benchmarking exercise places the government’s performance in the middle of a pack of comparable jurisdictions, this result is likely to be translated as “mediocre” performance by the media, and as “poor” performance by opposition parties.

Such judgments will pale in comparison to the “disaster” assessed by the interest groups who have lost something because of the reform. As they require some change in the status quo, health reforms inevitably upset those who benefit from, or are comfortable with, the way things are. They, in turn, will fight the reform and exact some price on the government of the day. Little wonder that the impetus of any government is to declare an immediate victory after implementing any individual reform or larger structural change—based on minimal evaluation and evidence—and move on to dealing with the next crisis or reform.

These dynamics are more complicated in a federal system such as Canada’s, where you have two orders of government involved in financing, administering, and even delivering healthcare. Here you have two levels of government attempting to take the credit when things go right and, more commonly these days, assigning blame to the other when things go wrong. This blame shifting—common enough in all federations—is generated by the mixed accountabilities and responsibilities in a federal system.

Contrary to popular opinion, healthcare is not an exclusive provincial responsibility under the Canadian constitution. In the two sections laying out federal and provincial heads of power under the original British North America Act of 1867, the phrase “healthcare” never appears. Instead, there is a phrase that refers to hospitals and similar institutions being under provincial jurisdiction. Beyond this, there is nothing specific to healthcare, and we are left interpreting more general clauses to determine whether a specific healthcare sector (e.g., public health or prescription drugs) or group served (e.g., “Indians” or inmates of a penitentiary) falls under federal or provincial jurisdiction (Braën, 2004; Leeson, 2004).

Adding to this complexity is the spending power, and its use by all central governments in OECD federations to set standards (Watts, 2009). In Canada, the federal government has used the spending power to uphold some criteria for provincial coverage of that narrow basket of services that make up what we call Medicare—medically necessary hospital and physician services. Although the criteria of the Canada Health Act combined with the Canada Health Transfer constitutes the most “conditional” provincial transfer in the Government of Canada’s arsenal, the fact remains that it is paltry stuff relative to the conditions imposed by central governments in other federations (Marchildon, 2013b). Although the federal spending power is not part of the constitution, the courts have upheld the right of the federal government to “make payments to people or institutions or governments on which it does not necessarily have the power to legislate” (Richer, 2007, p. 2).

Over time, a complex system has evolved in which the federal and provincial governments each have specific regulatory and administrative roles. To deal with the inevitable policy overlaps and interdependencies, a thick system of intergovernmental processes and institutions has grown up over the last decades.

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1 The UK government’s transparency and health open data initiative is an important exception to this general rule (see http://www.hscic.gov.uk/transparency). While no individual government has embarked on a similar initiative in Canada, the Canadian Institute for Health Information does release health performance data based on an agreed-upon protocol with its government funders.
Intergovernmental Coordination and Decision-Making

In the immediate postwar period, the chief coordinating mechanism was the Dominion Council of Health – a committee of federal and provincial ministers and deputy ministers of health, chaired and led by the federal government. As provincial responsibility and policy ambitions grew, the Dominion Council of Health was superseded by a more equal federal-provincial relationship, one marked by substantial provincial input and direction. With increasing devolution of policy authority from Ottawa to the territories, this relationship eventually embraced the territorial governments as full partners.

Since the 1970s, at least some health system stewardship at the national level has been provided by regular conferences, known as the federal-provincial-territorial (FPT) Committee of Ministers of Health, and the FPT Committee of Deputy Ministers of Health, both of which have been co-chaired and co-directed (O’Reilly, 2001). While the working committees set up under this conference system were able to address discrete issues over short time horizons, this structure proved limited when it came to longer-term initiatives and challenges. As a consequence, the ministers and deputy ministers of health eventually established special purpose and arm’s-length intergovernmental bodies to support work in priority areas, including health technology assessment, database management, analysis and dissemination, electronic health records and associated information and communications technology initiatives, patient safety, and the assessment of health reforms throughout Canada (Marchildon, 2013a).
These are the so-called “C organizations,” such as the Canadian Agency for Drugs and Technologies in Health, the Canadian Institute for Health Information, Canada Health Infoway, the Canadian Patient Safety Institute, and the Health Council of Canada. These organizations as well as Canadian Blood Services, a C organization formed by provincial and territorial governments, are all relatively new organizations, but form an important part of the health system landscape in Canada, as can be seen in Figure 1.

On top of this must be added the first ministers and the direction they have provided through their periodic meetings, a particularly significant process for healthcare from 2000 until 2004. Finally, the premiers of the provinces and territories have very recently used their own organization – the Council of the Federation (which grew out of the Annual Premiers’ Conference) – to provide some direction to health reform, even if avoiding the issue of benchmarking or assessing the performance of provincial and territorial health systems (Meekison, 2004; Council of the Federation, 2012).

Monitoring and Evaluating Health Reforms

What has been the impact of these intergovernmental processes and organizations in terms of monitoring and evaluating individual health reforms and overall health system performance? The results have been mixed, a not surprising result given some of the inherent weaknesses of intergovernmental mechanisms. Accountable to their own electorates, governments can only cede so much responsibility and authority to these non-legislated processes and institutions. Lacking legal authority, these bodies do not have binding decision-making processes. Membership is voluntary and based on each government’s perception of the benefits that flow from participation.

There are no major efforts by the FPT Committees of Minister or Deputy Ministers of Health to monitor and evaluate individual health reforms across jurisdictions. However, in 2003, the first ministers of 12 FPT governments created the Health Council of Canada to report on progress in key reform areas identified by First Ministers. At the time the structure and mandate were being negotiated, the governments of Alberta and Quebec (together representing roughly 35% of the population of Canada) rejected the legitimacy of an intergovernmental body exercising this “public monitoring” mandate and refused to join the Health Council.

Similar to other intergovernmental organizations of this type, it took a few years before the Health Council found its feet so that its reports and assessments of key Canadian reform initiatives grew in quality and impact. In fact, Health Council of Canada reports were written in a direct and simple style that could be easily understood by multiple audiences, including the general public and individuals working in health systems without any specialized knowledge of government or policy process.

As we know, the federal government withdrew its support and the Health Council ceased to operate on March 31, 2014. While the federal government perhaps no longer wanted to be part of a pan-Canadian organization that did not have full provincial support, it is important to remember that even the government of Alberta decided to join in 2012. Ottawa’s decision might be better understood as part of a broader effort to withdraw from engagement with provincial governments on healthcare more broadly (Marchildon, 2013b), as it would not have appreciated the Health Council’s insistence on the continuing importance of some national role in healthcare – a message that the Harper government preferred not to hear.

Monitoring and Evaluating Health System Performance

In one of the first intergovernmental efforts to benchmark change if not performance, the FPT Committee of Ministers of Health established the Performance Indicator Review Committee (PIRC) in 2000. The purpose of PIRC was to get agreement among all jurisdictions on comparable reporting in 14 categories of indicators within two years. Five jurisdictions – Canada, Ontario, Quebec, Alberta, and Newfoundland and Labrador – led the exercise, but provincial and territorial responses were mixed, resulting in numerous null responses to the data required for the 67 individual indicators making up PIRC.

While some jurisdictions no doubt found it difficult to obtain the requested data for PIRC (Fafard, 2013), it is reasonable to surmise that a number of PT
governments were highly sensitive to, and concerned about, being compared to other jurisdictions, and the negative media and public commentary that would be triggered by the comparisons. As a consequence, these same governments did not invest the required human or financial resources to make PIRC successful.

Indeed, as the experts in the field have long observed, a focused mandate and dedicated resources are essential to generating the data collection protocols and common definitions that are essential to any performance measurement initiative (Smith et al., 2009). This was the original concern that was foremost in the minds of the country’s Ministers and Deputy Ministers of Health when they established the Canadian Institute for Health Information (CIHI) in 1994. Like the Health Council of Canada, CIHI struggled in its first years, but by the end of the 1990s had established an enviable track record as a repository of provincial, territorial, and professional databases, and an active agent in setting data collection protocols and common definitions. Its publicly disseminated reports and databases have since become essential infrastructure for health systems, services, and policy research in Canada.

However, CIHI has also been careful not to exceed its original mandate and engage in analytics and interpretation that could be perceived as entering the policy fray. As a consequence, CIHI generally left it to others to interpret its data as part of any evaluation of health reforms or health system performance. However, in the last couple of years, CIHI has cautiously moved into some comparative health system performance work, including the Canadian Hospital Reporting project and a public website (http://ourhealthsystem.ca) that allows Canadians to compare health system performance results in five areas: access; quality of care; spending; outcomes; and health promotion and disease prevention.

Over time, some think tanks have stepped into the policy arena, and used CIHI data to benchmark and compare health system performance among provincial governments. A recent example is the Conference Board of Canada’s successive report cards on provincial health system performance (Conference Board of Canada, 2006, 2012). Still, the Conference Board has only limited resources to expend on this policy area relative to its long-established strength in assessing economic performance in Canada.

Although Canadian think tanks have periodically addressed health reform and health system performance, none have been systematic in their approach. BEstfitting organizations whose mandate is to deal with a broad range of policy issues, no think tank in Canada has the internal or even contract capacity to complete a small portion of what the Commonwealth Fund in the United States or The King’s Fund in the United Kingdom is able to accomplish. There are simply no major non-governmental think tanks in Canada devoted to monitoring and evaluating health reforms and health system performance, and looking ahead, there is little reason to think that a foundation with the same range, scope, and capacity as the Commonwealth Fund or The King’s Fund will be created in Canada.

The closest we have to a specialized pan-Canadian think tank is the Canadian Foundation for Healthcare Improvement (CFHI). However, limited in part by a modest endowment, which it is rapidly drawing down to pay for operational expenses, CFHI’s current mission and mandate is more focused on case-based health reform and change management research than on systematic monitoring and performance evaluation. It would take a major new endowment and the substantial expansion of in-house capacity before CFHI could perform a role in Canada similar to roles performed by the Commonwealth Fund in the United States and the King’s Fund in the United Kingdom.

In other words, there is a vacuum in Canada. Fortunately, a new academic-policy network has emerged to fill at least part of the gap in Canada, following a trend in Europe where a non-governmental academic-policy network has been established since the late 1990s. These networks tap into what have been underutilized scholars in universities and research institutes, helping reshape scholarly work so that it is more useful to policy practitioners. The European and Canadian networks disseminate their “policy products” through platforms that are readily accessible to decision-makers and experts. Heavily utilizing online forms of dissemination, these networks have created a new meeting ground between scholars and policy practitioners.

### Academic-Policy Networks: The European Experience

With a strong focus on health system financing, insurance, and healthcare outcomes, the World Health Organization’s Regional Office for Europe in Copenhagen is a unique organization in the WHO constellation. As a result of representing a majority of middle to low-income countries, the World Health Organization’s central office in Geneva and WHO’s other regional offices in the rest of the world tend to focus much more on public health and population health and much less on healthcare reforms and benchmarking and evaluating health system performance.

Even with this focus, however, the WHO’s Regional Office for Europe was limited in its comparative work by its governing council, the European Ministers of Health, who are naturally concerned about the political implications that might flow from any potentially poor results in comparisons with other countries. The second limitation was the capacity of the organization and the lack of a strong connection to the broader academic community. Finally, the WHO is bound by the United Nations’ rules and protocols concerning liaisons and contracting out of expertise and with member countries. In response, the special operating agency at arm’s length from WHO Europe was established by a small group of academic entrepreneurs, led by Dr. Josep Figueras, a former university academic and WHO official.

Although an outgrowth of the WHO’s Regional Office for Europe that remains a key stakeholder, the European Observatory’s network includes two universities...
– the London School of Economics and Political Science, and the London School of Hygiene and Tropical Medicine. Funding sources are diversified through a number of international partners, including the European Commission, the World Bank, the European Investment Bank, eight European countries (Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, and Sweden), the Veneto Region of Italy, and the French National Union of Health Insurance Funds.

Since the late 1990s, the Observatory has produced comparative studies of health reforms across mainly high-income countries concentrated in Europe for a target audience of researchers, policymakers, and experts. These studies have often included comparisons to similar health reforms in non-European countries, in particular Australia, Canada, New Zealand, and the United States. The Observatory also produces policy briefs on topics of great interest to health system decision-makers in Europe. This work is extended in even more accessible form through EuroHealth, a quarterly journal in magazine format. All of these publications are disseminated free of charge through the Internet as well as in paper form.

The flagship product of the European Observatory is a book-length profile of the health systems of Western and Eastern European countries as part of the Health Systems in Transition (HiT) series. The HiT profiles provide a degree of comparability through a common template providing extremely detailed guidance to contributing authors (Rechel et al., 2010). Historically, these HiTs were supplemented by profiles of Australia, Canada, and New Zealand due to the universal coverage programs. Recently, with the introduction of the Affordable Care Act in the United States and the effort to extend coverage to almost all Americans, the United States has now also been included in this series.

Most of the authors of the individual HiT country studies are scholars working in universities or research institutes, independent of the governments responsible for the health systems they are analyzing. Although not paid to produce these studies, the authors have some (albeit limited) incentive to produce these studies as part of their academic workload and the credit they receive for producing peer-reviewed publications. More importantly, they see themselves as benefitting from the effective manner in which the Observatory is able to disseminate their output to decision-making communities throughout the world.

As an organization with a proactive mandate to provide policy advice to its country and organizational members, the European Observatory also provides a quick response service. The Director selects key scholars supported by Observatory staff to provide policy advice and options on urgent and emerging issues to health ministers and senior officials in face-to-face meetings. At times, this evolves into the commissioning of research and writing on the topic in question.

Recently, the European Observatory has leveraged its country HiTs and academic contacts to create the Health Systems and Policy Monitor, a multi-country website platform that allows scholars, policymakers, and experts to access continually updated versions of country HiTs along with health policy updates and health reform logs from each of the contributing countries. When researching a given health reform or health system dimension, researchers can use the platform to create compilations on a given reform or structural feature for the countries selected by the user.

The Health Systems and Policy Monitor (HSPM) is, in effect, a network of networks. The national lead institutions for each HSPM country member are almost invariably non-governmental in nature. These lead institutions are university research groups and think tanks either independent of their national governments or operating at some arm’s length from these governments. Since there was no university-based research group or specialized think tank that could represent all of Canada on the HSPM, a new organization had to be created before Canada could become a member of the HSPM network. How and why this university-based policy network emerged is part of the larger story recounted below.

### An Emerging Academic-Policy Network in Canada

In Canada, governments have been conspicuous due to their absence in terms of monitoring and evaluating health reforms and health system performance. Even before the Harper Conservative government was elected in 2006, successive federal administrations eschewed this role largely because of the centrality of provincial jurisdiction over, and responsibility for, the funding and management of healthcare services. Instead, the federal government worked with the provinces through various intergovernmental processes to create special purpose institutions to address these monitoring and evaluative functions, and was the major funder of the two most important initiatives (CIHI and the Health Council of Canada). However, as discussed above, these initiatives have still left a gap when it comes to comparing and evaluating health reforms or health system performance on a systematic basis.

Nature abhors a vacuum, and in the fall of 2011, a small group of researchers located in different provinces from different parts of the country assembled at McMaster University’s Centre for Health Economics and Policy Analysis (CHEPA) to see what they could do to address the situation. Within months, the members had formed a virtual network called the Pan-Canadian Health Reform Analysis Network (PHRAN) with the goal to have at least one network representative from each province and territory.

PHRAN representatives have the latitude to organize researchers within their own jurisdictions in the way they deem most suitable and effective. Some representatives said they would form a network of scholars within their own provinces and that they would work with these networks in order to prepare analyses of new provincial and territorial health reforms. Two provincial networks – one in Quebec and the other in Nova Scotia – were immediately established, eventually followed by a network in Saskatchewan. These networks...
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To carry out its mandate of providing rigorous evidence-informed analyses of provincial and territorial health reforms, PHRAN members established a peer-reviewed journal that would be responsive to the needs of governmental and health organization decision-makers as well as scholars. In 2013, PHRAN launched its open access online journal, the Health Reform Observer – Observatoire de Réformes de Santé.2 The journal’s ambition was to provide “the best evidence available on reforms related to the governance, financing and delivery of health care in the Canadian provinces and territories” and “be a bridge between scholars and decision-makers and facilitate the flow of rigorous, evidence-based information” (Health Reform Observer, 2014). Its main product, the Health Reform Analysis, is structured in such a way as to meet the needs of both audiences. Approximately 2,000 words in length (not including abstract, key messages, references, and further links), these analyses can be read quickly. Indeed, PHRAN has no other presence on the Web except through its online journal, a purposeful decision made by PHRAN members given its limited fiscal and human resources.

While the structure of a Health Reform Analysis (HRA) appears to bear more resemblance to a governmental briefing note than to a traditional research article, it must nonetheless be supported by evidence and referencing similar to an academic journal article and it must be peer reviewed by two scholars in the field. The turnaround time for the review and resubmission is kept extremely short to ensure that the journal is as responsive as possible to the timelines of decision-makers. Although the majority of HRA authors are academics, the journal accepts submissions from decision-makers willing to submit to the review process as well as have their position stated clearly in the article. In addition, decision-makers are encouraged to respond in print to the content of the HRAs.

The journal is also encouraging longer (4,000 word) submissions comparing reforms across jurisdictions, in order to encourage scholars to exploit any natural experiments that may arise within the Canadian federation or, indeed, among jurisdictions outside Canada for health reforms under serious consideration by governments in Canada. A comparative Health Reform Analysis (cHRA) truly affords a platform that should take advantage of the natural policy experiments that may arise within the Canadian federation or, indeed, among governments in Canada. The turnaround time for the review and resubmission is kept extremely short to ensure that the journal is as responsive as possible to the timelines of decision-makers. Although the majority of HRA authors are academics, the journal accepts submissions from decision-makers willing to submit to the review process as well as have their position stated clearly in the article. In addition, decision-makers are encouraged to respond in print to the content of the HRAs. However, unlike the European Observatory, which has the requisite budget and full-time staff, PHRAN is not structured in a way to bring scholars and decision-makers together. Indeed, it is unlikely that PHRAN could perform this type of role – the kind of role usually performed by a think tank or a special operating agency like the European Observatory with strong ties to member governments.

This leaves considerable scope for other types of organizations – either existing or new think tanks, intergovernmental agencies, or networks – to play this more immediate role with governments in Canada. In other words, PHRAN has a role to play within what should become a more complex ecosystem of governmental and civil society organizations and hybrids that are, together, capable of providing more effective, more sophisticated, and less parochial evaluations of health policy and system performance in Canada.

Conclusion

This discussion paper speaks to the emergence of a new phenomenon capable of assisting governments to improve their stewardship of publicly financed healthcare. The new academic-policy networks that have emerged are at least doing part of the job of monitoring and evaluating individual health reforms as well as assessing health system performance. These policy networks are...
self-forming virtual organizations tapping the skills and expertise of university-based researchers.

While we are used to talking about the public and private sectors, academics (and the universities that pay their salaries) are neither government employees nor members of the private sector. That said, the majority of funding for academics in Canada comes from provincial government revenues, and a policy research network such as PHRAN offers these academics a way of contributing to the policy responsibilities of these governments. As governments continue to lose policy capacity within their own civil services, policy networks based on civil society organizations and participants become ever more important (Montpetit, 2003). This is particularly true for provincial governments, which must bridge the gap between their policy responsibilities and ambitions on the one hand, and their policy capacities on the other hand (Atkinson et al., 2003).

The gap that such an academic-policy network could fill is quite large due to the peculiarities of the institutional environment in Canada. While CIHI ensures that high-quality data are assembled, refined, and disseminated, CIHI’s mandate does not extend to comparing and evaluating either individual health reforms or the performance of provincial health systems. Although the Health Council of Canada was given this mandate by the federal government and, with two important exceptions, by all provincial governments, the Council felt constrained, particularly in its early years, to avoid criticizing member governments. However, even this was not enough to protect the Council from the federal government and its decision to withdraw both its membership and its substantial funding of the Health Council’s work.

It remains an open question whether the Harper government – should it achieve another majority government in the next federal election – will also abandon CIHI. Although decision-makers and experts would likely be unanimous in decrying such a decision, we should keep in mind the Conservative government’s elimination of the compulsory long-form census despite the advice it received from Statistics Canada and experts throughout Canada.

In any event, there are good structural reasons why governments will never be able to critically evaluate their own reforms or system performance. This will require external actors. While think tanks can, and have, filled some of the vacuum left by governments, there has been no single think tank or non-governmental organization to provide ongoing monitoring, analysis, and evaluation of health reforms or health system performance in Canada. While a virtual network of health policy scholars cannot have the reach and capacity of a well-endowed think tank, the ability of such networks to create strategic affiliations – in effect to create nested networks with both local and international linkages – facilitates comparison and breaks down the parochialism that has so long been part of health systems and policy research.

A final word of caution is in order. In terms of monitoring, PHRAN fills a need. However, this can never be the type of systematic monitoring that a specially mandated organization – properly funded and staffed – could provide. In addition, as a loose group of academics, PHRAN could never be a catalyst in facilitating governments to act on evidence created through health system monitoring and evaluation. This would require an intergovernmental or special operating agency with much closer links to the governments – the implementers of any change – than could ever be sustained by a purely academic network such as PHRAN.

References


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Politics and the Healthcare Policy Arena in Canada: Diagnosing the Situation, Evaluating Solutions

WHITE PAPER - WORKING DRAFT

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From a political perspective, healthcare in Canada is a strange policy arena indeed. On the one hand, it represents a core function of modern states worldwide. For Canadians, having a reliable healthcare system that is universally available and publicly funded continues to be a national aspiration and at the top of their political priorities.

And yet, on the other hand, there is little in the way of a pan-Canadian health policy, nor is there a national "medicare" system. It bears repeating, lest we forget, that healthcare policy remains primarily and primordially in the realm of provincial government responsibilities, both in terms of organization and financing.

The unique challenge of this policy area in the Canadian context is also highlighted by the task at hand in the scope of this conference: discussing a national strategy for healthcare, engaging national stakeholders, cross-national comparisons … without any of the usual and necessary “nation-wide” policy mechanisms for the formulation and implementation of reform.

This paper attempts to address this conundrum by unpacking some of the particular political features of healthcare policy and politics in Canada: the tension between perceived citizenship rights and practical service delivery and financing; the juxtaposition of provincial innovation and federal leadership; and the unique form of decentralized policy-making in the context of national stakeholders. The paper then proposes a dose of realpolitik in suggesting avenues for attaining a better dialogue and road to reform in healthcare.

Citizenship right or provincial government service?

For scholars of the welfare state, healthcare is seen as part of the development of the "social rights" of citizenship. This notion of a link between citizenship and social policy has its origins in the work of T.H. Marshall, who described the full rights of citizenship as including not only civil and political rights, but social rights as well (Marshall, 1950). It was a theme that has had quite a bit of historical resonance in Canada, particularly during the post-war reconstruction phase of the 1940s and the so-called "golden era" of the welfare state that followed. In an ironic twist, however, the single most powerful – and popular – symbol of these "social rights," namely healthcare, is not technically a right of citizenship in Canada.

This point is illustrated by what are referred to as international and national recognitions of rights (see Backman, 2008). Canada, like many other countries, is in effect a signatory to several international treaties that refer to the "right" to health; for example, the United Nations’ Universal Declaration of Human Rights (1948) was much influenced by its Canadian contributor, John P. Humphrey, who supported the idea of the "right to health," even though this was initially considered to be a humanitarian consideration rather than a functional feature of international law (see Tobin, 2012). In 1946, the World Health Organization defined a more specific right to health as “access to timely, acceptable, and affordable healthcare of appropriate quality.” Successive Canadian governments have since been considered to exert substantial leadership in health promotion worldwide.

But Canadians do not enjoy a constitutional right to health, and this puts them in the company of two-thirds of countries the world over, including those that...
they would consider a peer group (e.g., Germany, the UK, France, Sweden; Backman, 2008). The rhetoric about healthcare as a right for Canadians is a popular adage in public opinion; until quite recently, polls still showed that Canadians believed in this right (Mendelsohn, 2002). This confidence has been shaken somewhat, at the same time that it has been dissected and debated in and outside of courtrooms. For example, the Senate report on the health of Canadians (Mendelsohn, 2002) outlined in detail the absence of such a right; however, some judicial scholars claim that the courts have “shown greater openness” to considering such a guarantee through the Charter of Rights and Freedoms (Jackman, 2002). And, in the well-known *Chaoulli v. Quebec* case (2005), differing judicial opinions prevailed, from the Quebec Superior Court Justice Ginette Piché, who concluded that access to healthcare is a right (even though the choice of provenance of that care is not), to the ruling of Supreme Court Justice Beverely McLaughlin, who wrote that “access to a waiting list is not access to health care” (Manfredi & Maioni 2006).

If healthcare is not technically a right of Canadian citizenship, it nevertheless represents a political and financial responsibility of the highest order for governments. And yet, this is not a national responsibility, but instead a provincially regulated service provided by non-public actors and funded through tax-generated revenues. Here, Canada differs even with respect to its comparator countries where, even in the most decentralized of systems, a national – or federal – responsibility is recognized as primordial in healthcare.

In fact, healthcare has become a behemoth for provincial governments for a number of reasons, not the least of which is the increase in the price of services. While economic arguments abound about how public monopolies in medical and hospital care payments can control costs better than mixed or privately-financed alternatives (see, for example, Detsky, 2012), it remains a heavy burden for provincial governments to keep pace with the competitive and expensive market for healthcare providers, and the technology and infrastructure that the ever-complex delivery of care requires. To put it in blunt terms, provincial treasuries are responsible for the income of the highest paid professionals in Canada today, specialists and family physicians (Picard, 2013). They spend billions of taxpayer dollars on healthcare without, for the most part, any way of exactly gauging the quality or outcomes of these services.

The exact split between federal and provincial monies in these health expenditures is a topic of considerable bureaucratic wrangling, but the estimates are usually in the vicinity of a 20–80% split. As the 10-Year Plan to Strengthen Health Care (Ten-Year Plan) (2004) winds down after 2014, and wanes over time as the Canada Health Transfer returns to a per capita amount tied to economic growth, the federal portion will likewise shrink. This means that provincial governments pay – and will continue to pay -- the lion’s share of funding healthcare services funding, and at the same time take the largest political risks in health policy-making. Meanwhile, the most politically popular healthcare statute – the Canada Health Act – is a federal statute, which is limited in application to the monetary transfers in play from federal to provincial governments.

An icon of Canadian values, or so it seems to many, the Canada Health Act itself does little to provide an essential framework for health reform. It served federal leaders well in the past – particularly Liberal governments – in shoring up a powerful discourse of Canadian values identity, the apogee of which is the Romanow report (2002), based explicitly on the values motif. Today, the Canada Health Act and the federal role are practically absent from Conservative government conversations about values or national character. In the provinces, meanwhile, much of that debate has become moot. In Quebec, however, critics of the public monopoly have argued – with considerable backing from the provincial Liberals – that the Canada Health Act has become a “dysfunctional” element in the quest for health reform (Castonguay, 2008).

**Provincial innovation or federal leadership?**

Much ink has been spilled in describing and explaining the development of healthcare policy across Canada (see, inter alia, Taylor, 1987; Shortt, 1981; Maioni, 1998; Tuohy, 1999; Boychuck, 2009). These studies have pointed to a number of factors that account for the distinctively Canadian experience: some scholars point to the innovative edge of a social-democratic government in Saskatchewan and the demonstration effect of provincial experiments; some indicate the federal-provincial dynamic that allowed for the creation of a “collaborative” fiscal federalism framework; and some look to the elusive notion of “nation-building” that is sometimes attached to the historical experience.

Two enduring legacies stand out, however, in the historical narratives. The first is that institutions matter; the second is that politics paved the way for policy. The absence of federal policy leadership, combined with an interventionist social-democratic government, led to provincial innovation (the Saskatchewan experience). The stability, diffusion, and expansion of this experiment in Saskatchewan and across the other provinces, however, depended on the fiscal involvement of the federal government, which attempted to use fiscal levers in the absence of policy-making capacity.

But the history of these fiscal levers has shown that, while effective in deterrence and compliance, they are less useful in trying to deploy or encourage policy reform or system change. Instead, they have become part of the ebb and flow of fiscal federalism in Canada – an instrument of federal budgetary exigencies, rather than a specific instrument for health policy-making. This “pendulum” effect applies to a range of policy areas (see Robinson & Simeon, 1990), but the case of healthcare illustrates it best. In the earliest years of cost-sharing programs, through the Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Care Act of 1966, there was a hefty financial commitment – an investment, in many ways – on the part of the federal government to pay specific amounts engendered by provincial
spending. But between 1977 and 2003, block transfers became the financial instrument of choice, severing federal financing from provincial healthcare policy. Even with the introduction of the Canada Health Transfer and the Ten-Year Plan, as of 2004, federal fiscal involvement has amounted to the equivalent of a series of blank cheques, rather than a commitment to policy leadership.

In the meantime, in order to create the considerable administrative capacity necessary for the implementing and financing of health programs, provincial governments embarked on substantial “state-building” enterprises, often without the benefit of prior experience or national expertise. In the case of Quebec, for example, it meant building from the ground up, replacing Church administration and professional control with new delivery systems that attempted to breach both health and social services (Maioni, 2010).

All of this becomes even more interesting when contrasted against other “comparable” countries. In Great Britain and France, and even in federal polities such as Germany and the United States, state involvement in the organization and financing of healthcare services was, for all intents and purposes, a national initiative, even if in some cases it involved sub-national actors and institutions. This sense of national purpose remains very much in evidence today. And it has a real effect on policy formulation and implementation, giving central governments a considerable amount of leverage in shaping policy, imposing some sort of national direction in formulation, and providing effective scope for policy learning in implementation.

Indeed, in many of the suggestions that have been made about where Canada could go for “lessons” in strategies for coordination (see for example, Carson, 2014), the elephant in the room is that these kinds of initiatives need political leadership, clear and direct accountability, and, to bring in a term from international affairs, some kind of “hegemon” to corral and compel government and stakeholder involvement and engagement.

Decentralized policy-making and centralized stakeholders?

Health reform in Canada is caught up in a classic public goods conundrum (Olson, 1965): the benefits may be diffused to a large swathe of people, but a smaller and more tightly organized group (or “special interest”) may be more powerful in shaping the policy outcomes. This seems logical since the diffuse benefits something provides are less tangible than the specific costs that may be imposed. The history of healthcare reform around the world attests to this dynamic, in particular in the way in which professional interests such as medical lobbies initially blocked public funding of medical care. Sometimes, public goods can be championed by an interest group – the case of organized labour as a counterweight in healthcare is a good example. Labour movements in both Canada and the US lobbied for public health insurance despite the “free rider” effect; that is to say, the benefits of such reform would accrue to a larger population than their members alone. Today, in Canada, unionized healthcare workers are caught in the same dilemma as other special interests in the health field: how to effectively protect their interests while contributing to the overall coherence of the healthcare system. And physicians, meanwhile, are caught up in trying to lobby for increased public financing of healthcare as a way of sustaining their own financial interests in the reimbursement of services they provide.

Interest groups and health care in Canada are particularly interesting in the case of organized medicine. They exercise a “professional monopoly” in terms of expertise (Alford, 1975), and at the same time are part of the essential bargain at the root of the model of “public payment, private delivery” in provincial healthcare systems (Naylor, 1986). As “talking chameleons” (Pross, 1978), they adapt to governmental institutions and political realities in a nimble fashion and with laser focus, and, depending on their resources, expertise, and reach, this allows them to have considerable influence in policy-making.

In Canada, healthcare policy decision-making remains in the hands of provincial governments caught up with the immediate challenges of governance and the partisan exigencies of retaining power. What can ensue is a combination of entrenched bureaucratic immobilisme and short-term (in some cases, short-sighted) political action. This mix does little to encourage long-term thinking or set substantive reform change processes in place, nor does it provide for the kind of inspiration for provincial leaders to contribute to a national strategy for health reform.

At the same time, political leaders and public opinion are highly sensitive to stakeholders as a source of information and as influential political actors. For example, professional associations have both provincial and national organizations, which have different roles in pursuing sub-national policy input for funding and delivery decisions, while maintaining an active national scope in policy leadership.

This leads to a curious situation: “national” debate about healthcare reform has tended to be shaped – and in some cases led – by policy communities dominated by national stakeholder interests rather than the pressing needs of systemic reform itself. Consequently, reform debates became hostage to crisis discourse, even though the evidence to support such arguments was difficult to validate. A good example of this is the “wait times” issue that has dominated public discourse for over a decade. Unpacking wait times is more complicated than it looks, since waiting can be related to: the timely delivery of a service, such as non-urgent care; a number of hours related to specific situation, such as in an emergency department; or broader access to care, such as seeing a specialist or finding a family doctor. All of these situations are symptomatic of much more complex organizational and financial issues at hand. And yet, the “national” policy debate was dominated by needs and strategies to respond to wait times crises, with little attempt to understand the underlying forces at
The challenges of implementation:

Implementation is often the wild card in the policy process, and the literature on healthcare reform in Canada is riddled with questions as to why reform avenues often end up in dead ends (e.g., Renaud, 1977; Hutchison et al., 2001). Much of this has to do with the fact that implementation itself is “a struggle over the realization of ideas” (Majone & Wildavsky, 1979), where politics and administration meet.

The discussion above about the realpolitik of healthcare policy-making in Canada comes to three overall observations about the challenges of implementation. First, there is little coordination between governments or systemic structures in place that could serve to generate the kind of information and measures necessary to evaluate healthcare performance across Canada (e.g., delivery, quality, spending), or reach toward new initiatives that could target specific areas (such as those under study at this conference).

Second, the institutional contours of the Canadian polity have led to a situation in which publicly accountable actors tend to have less of a national reach than non-public actors and stakeholders, making it even more difficult to “think” strategically or “do” practically in building a “system-wide” strategy for healthcare reform in Canada. And, third, this situation is at odds with what is happening in other countries, and at odds with what Canadians actually believe to be the most important issues at play in healthcare, including the need for cross-provincial learning and pan-Canadian leadership.

Attempts to break this cycle in the past have suffered from fundamental problems of federalism: namely, the perception of federal unilateralism (National Forum on Health), the inability to come to meaningful intergovernmental consensus (Social Union Framework Agreement), and the incapacity of maintaining a national body by consensus without real heft in reform debates (Health Council of Canada). Since 2006, meanwhile, the absence of federal intergovernmental initiatives in health reform, and the political void this has engendered, has meant the Council of the Federation has come to occupy a greater space, and one that includes Quebec.

There are also three main problems with these past initiatives. First, they inject an element of competition – between federal and provincial levels of government, and between the provinces themselves – that is inimical in trying to create something that is larger than the sum of its parts. Second, they buy into the myth of provincial “equality” when it is evident that there are asymmetries in size, wealth, population, and organizational capacity that need to be taken into account, and that all partners can play the same roles and have the same responsibilities when trying to envision workable solutions that can address health reform in a realistic and sensible way. Third, they tend to seal off stakeholders to “neutralize” their power in policy decisions or, in reverse, to “protect” them; rather, what a health reform strategy should do is assign responsibilities to key interest groups, making them integral actors who must not only be accommodated but be willing to accommodate in likewise fashion, and this means not only bilaterally with governments, but also multilaterally in a wider policy community.

What kind of new way forward, then, could be imagined and implemented to try to achieve some kind of pan-Canadian strategy for healthcare? The papers and discussions at this conference suggest some interesting avenues, such as national strategies in certain sectors (Carson, 2014), an evolutionary process of provincial coordination (Drummond, 2014) or an eschewing of governmental leadership in favour of other kinds of information networks (Marchildon, 2014).

In a way, none of these options is mutually exclusive, and in some senses, they could reinforce one another. Thus, we could envision a network of knowledge that could focus attention on the evidence needed to power up pan-Canadian
strategies; at the same time, moving toward provincial coordination could set
the stage for an eventual national oversight or standards-seeking body that
could give policy direction and lead to meaningful evaluation and reform.

If the recent past is any guide, however, both the ideal of a national
coordinating oversight body and provincial processes for coordination are
difficult to realize in the Canadian political context. The provincial leadership
that was shown in the late 1990s (e.g., the Ministerial Council on Social Renewal;
see Courchesne, 1996) contributed toward pressure for increased federal
funding and later toward the 2014 Health Accord, and ultimately heralded the
kind of collaborative rhetoric underpinning the Council of the Federation’s
latest actions on healthcare. But it also opened up a political window to delve
into debates about “fiscal imbalance” (both vertical, via Quebec, and horizontal,
via Ontario).

As such, cross-provincial initiatives in healthcare have mainly been at the level of
“executive politics” designed to drive consensus, which, realistically, can
never get that far on all the essential elements of health reform. They lack the
kind of extensive coordination rooted in a permanent commitment toward
data collection, information sharing, and, ultimately, some kind of leadership.
In other words, without a different kind of evolutionary scenario that sets rules
and goalsposts, and topics and targets, and that extends the conversation to
mindful contributions from stakeholders, there is little in the way of motivating
political will.

Canada’s experience in healthcare has led to one of the most decentralized
arrangements in healthcare governance, at least in a comparative perspective.
And I have argued in the past that things like the Social Union Framework
Agreement (SUFA) and the Health Council of Canada were probably doomed –
not least of all due to seeing these initiatives through the perch of an observer
from Quebec. But that does not mean that some form of “responsible”
governance that engages both levels of government should be summarily
dismissed (Maioni, 2004). It is a policy domain that is just too costly in monetary
terms, and too important in human terms, to be left in intergovernmental
limbo. We need to have some form of real, functional coordination in the
strategies toward both immediate concerns and long-term planning, not only
between governments, but also among stakeholders as well.

Lessons of coordination:

There are plenty of lessons to be learned from elsewhere on this kind of
“responsibleization” and “coordination.” The German example of “concerted
action” in the healthcare sector involves an active role for government
vis-à-vis stakeholders, who are obliged to come to the bargaining table at
which all parties are held to account collectively (see Moran, 1999). Regional
governments buy into this type of corporatist arrangement as a way of
controlling costs and ensuring some measure of equality across populations.

The lessons here are that: cost-control requires national and sub-national
coordination, and stakeholders have to be at that table; all of the actors must
recognize the utility and responsibility of such negotiation, as a way of ensuring
the sustainability of the healthcare system for all players.

In the UK, the NHS has developed its own institutional identity as an “arm’s-
length” body, and in the process “de-politicized” itself in a way that is very
different from healthcare systems across Canada. And yet, while decisions
about funding remain political, and oversight functions remain accountable
to government, specific policy directions are very much influenced by the NHS
and its ability to garner evidence and coordinate sector-specific strategies
in working toward specific goals and objectives. The lesson here is that
coherent policy-making in healthcare requires a “global vision” based on
reliable evidence and constant coordination, and that such policy-making
may be best achieved in a “depoliticized” policy environment that remains
firmly accountable to government, but in some way that is protected from the
political crises of the day.

In Australia, a new modus operandi seems to be emerging through the
establishment of a “national strategic framework” (e.g., in primary care),
which brings together all stakeholders (including patients) in planning and
coordinating policy change. These changes will then be implemented through
both bilateral agreements (between the states and the Commonwealth) and
the work of the existing Council of Australian Governments.

The Australian example underlines three elements about federalism and
healthcare that are of particular resonance for Canada. The first is that strategic
efforts can be directed within a certain sector (in this instance, primary
care) without the necessity of remaking the constitutional or organizational
policy-making playbook. The second element is that it helps to have a robust
intergovernmental structure in place, along with a willingness of governmental
players to recognize the pragmatic considerations and mutual benefits of
exchange and coordination.

Could Canada benefit from this kind of model? There is a certain caveat in the
fact that health policy and federalism have a very different history in the two
countries (Gray, 1991). In Australia, the federal government has wider powers
in certain features of healthcare delivery. But despite, or perhaps because
of, these policy overlaps, there are already established intergovernmental
mechanisms in place, such as the annual conference of health ministers and its
advisory council, as well as the Council of Australian Governments, which also
has a functional role in negotiating federal block grants. In Canada, meanwhile,
intergovernmental relations in the health sector can be described as limited
at best (France, 2008). This is due to functional realities (the “watertight
compartments” approach to the division of powers in this instance), but it is
also due to the high stakes politics of healthcare. Despite a dialogue between
provincial health ministers, and the existence of a Council of the Federation,
there has been little in the way of institutionalized federal-provincial relations...
in healthcare. The 2004 negotiation of a multi-year health accord may have been a step in that direction, but it did not set up a formal process, nor, as we now know, a political precedent for future negotiations. And the Health Council of Canada had a role that was both broad and narrow: “to monitor and make annual public reports on the implementation of the Accord” (First Ministers, 2003), in addition to “reporting annually on health status and health outcomes” (Health Council of Canada, 2011, p. 5). However, its role was not one that involved the delivery of policy direction through a truly collaborative process.

Still, the idea of sectoral reform is appealing as a way of breaking an impasse in direction and dialogue. Part of the necessary thinking for this kind of an approach has already been accomplished through the identification of key reform needs in the scope of this series of conferences. What’s needed now is to build a model that can “test” the boundaries of a new dialogue about health reform and stretch intergovernmental parameters, allowing for new partners and players. While it would not (and does not, even in the Australian model) “de-politicize” healthcare, it could compel both political actors and private interests to focus on public needs, provide a public education function, and lead to coherent policy direction removed from the “crisis management” approach to health reform.

Any such model needs to have: 1) an understanding that pooling information and expertise is a value-added proposition for all players; 2) a common purpose for sectoral reform as the means to an end result, i.e., improving healthcare delivery, controlling health costs, enhancing health outcomes; 3) the formal and sustained involvement of policy “delegates” from government and stakeholder groups; 4) specific processes for the exchange of information that do not focus on regionalized blaming and shaming, but rather on identifying positive examples and serious needs; and 5) a commitment toward policy learning that could, ideally, be the basis for some form of coordination or mutual agreement.

Conclusion

The analysis of the politics of intergovernmental relations shows that there is a “missing link” in the governance of healthcare in Canada. In the expensive, challenging, and complex world of modern healthcare, what is needed is an increased capacity to be able to analyze and plan in the longer term with clear evidence and coherent implementation. While much of this could be done by provincial governments, system performance outcomes and the health of Canadians would be greatly enhanced by some kind of policy direction that would benefit from coordination – among governments who need to reach out in finding solutions, and stakeholders who need to pull up their stakes and start collaborating. Every other healthcare system in the industrialized world realizes this necessity. If the basic attraction of publicly funded healthcare is the ability to spread risk, guarantee access, and control costs, we need to think bigger about the kinds of scaling up and value-added services that a larger, pan-Canadian strategy could provide. Otherwise, we are locking ourselves in to widening the gap between money spent and care delivered, without being able to decipher results or respond to challenges, and to being forced to deal with crisis management, rather than long-term investment in healthcare, to the detriment of our collective wealth, and the health of Canadians.

References:


Politics and the Healthcare Policy Arena in Canada: Diagnosing the Situation, Evaluating Solutions


Antonia Maioni

Dr. Antonia Maioni is Associate Professor at McGill University, in the Department of Political Science and the Institute for Health and Social Policy. From 2001 to 2011, she served as Director of the McGill Institute for the Study of Canada, while holding the position of William Dawson Scholar at McGill University. Trained as a political scientist, Professor Maioni earned a B.A. in Political Science and French at Université Laval, an M.A. from Carleton University’s Norman Paterson School of International Affairs, and a Ph.D. in Political Science from Northwestern University.
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<tr>
<td>8:00</td>
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<td>8:30</td>
<td>Welcome &amp; Opening Remarks</td>
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<td><strong>Dr. David Dodge,</strong>&lt;br&gt;Chancellor, Queen’s University; past Governor, Bank of Canada</td>
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<td><strong>Dr. Scott Carson,</strong>&lt;br&gt;Director, The Monieson Centre for Business Research in Healthcare and Professor, Strategy and Organization, Queen’s School of Business</td>
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<td>Morning Theme: Designing Strategic Change in Canadian Healthcare</td>
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<td>8:45</td>
<td>KPMG Day 1 Opening Keynote: Global Healthcare Strategies</td>
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<td><strong>Dr. Mark Britnell,</strong> Chairman and Partner, Global Health Practice KPMG, UK</td>
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<td>9:45</td>
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<td>10:15</td>
<td>Plenary Panel: International Perspectives on Healthcare Strategies</td>
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<td>Experts from the OECD, Germany, Denmark and France discuss approaches to development and implementation of national healthcare strategies and alliances</td>
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<td><strong>MODERATOR:</strong> Don Drummond, Matthews Fellow in Global Public Policy, Queen’s University</td>
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<td><strong>Dr. Divya Srivastava,</strong> Health Economist, OECD, France</td>
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<td><strong>Professor Karsten Vrangbaek,</strong> Professor, Political Science, University of Copenhagen, Denmark</td>
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<td><strong>Lena Hellberg,</strong> Ministry of Health and Social Affairs, Division for Public Health and Healthcare, Government of Sweden</td>
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<td>12:30</td>
<td>Lunch - sponsored by Sun Life Financial</td>
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<td>1:00</td>
<td>Sun Life Lunchtime Panel: The National Primary Health Care Strategic Framework – A Case Study from Australia</td>
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<td>Senior delegates from Australia’s policy, physician, and government sectors discuss lessons learned from the recent introduction of their National Primary Health Care Strategic Framework</td>
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<td><strong>MODERATOR:</strong> Dr. Duncan Sinclair, Former Vice-Principal (Health Sciences), Past Dean, Faculty of Medicine, Queen’s University</td>
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<td><strong>Dr. Steve Hambleton,</strong> President, Australian Medical Association</td>
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<td><strong>Dr. Justin Beilby,</strong> Executive Dean, Faculty of Health Sciences, University of Adelaide, Australia</td>
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<td><strong>Professor Michael Reid,</strong> Member, National Health Performance Authority, Principal, Michael Reid &amp; Associates</td>
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<td>Break - sponsored by Spencer Stuart</td>
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### Panel Discussions: Building the Pillars of a Canadian Healthcare Strategy

Break-out groups will discuss the justification, substance and way forward for four pillars of a Canadian healthcare strategy identified through a facilitated brainstorming session with participants at the 2013 Toward a Canadian Healthcare Strategy conference. Each panel will engage senior thought leaders from industry, government, and academe to develop substantive content of a Canadian healthcare strategy.

#### Pharmacare

**Moderator:** Dr. Roger Deeley, Vice-Dean, Research, Faculty of Health Sciences, Queen’s University

**Dr. Dorian Lo,** Executive Vice-President, Pharmacy & Healthcare, Shoppers Drug Mart

**Stephen Frank,** Vice-President, Policy Development & Health, Canadian Life and Health Insurance Association

**Russell Williams,** President, Rx&D

**Colleen Flood,** Professor & Canada Research Chair, Faculty of Law, University of Toronto

**Deborah Maskens,** Director, Medical Relations, Kidney Cancer Canada, past Board Director, Canadian Cancer Advocacy Coalition (CACC)

**Dr. Chris Simpson,** President-elect, Canadian Medical Association; Chief of Cardiology, Queen’s University

#### GSK Human Resources

**Moderator:** Dr. David Walker, Professor, Emergency Medicine & Policy Studies, past Dean, Faculty of Health Sciences, Queen’s University

**Dr. Ivy Lynn Bourgeault,** Professor & CIHR Research Chair in Health Human Resources, University of Ottawa

**Dr. Richard Reznick,** Dean, Faculty of Health Sciences, Queen’s University

**Dr. Jesse Pasternak,** Health Human Resources Committee Chair, Canadian Association of Interns & Residents

**Danielle Fréchette,** Executive Director, Royal College of Physicians & Surgeons of Canada

**Sandra MacDonald-Rencz,** Nursing Executive & Acting Senior Director, Health Human Resources Policy Division, Health Canada

#### Atkearney Electronic Health Records

**Moderator:** Dr. Michael Green, Associate Professor in the Departments of Family Medicine and Community Health and Epidemiology, Queen’s University

**Dr. Richard Birtwhistle,** Professor, Family Medicine, Queen’s University

**Richard Alvarez,** President & Chief Executive, Canada Health Infoway

**Dr. Francis Lau,** Professor, School of Health Information Science, University of Victoria

**Dr. Michael Guerriere,** Vice-President, Transformation Services, TELUS Health

**Scott Murray,** Vice President and Chief Technology Officer, Canadian Institute for Health Information (CIHI)

#### BLG Integrated Care

**Moderator:** Leslee Thompson, CEO, Kingston General Hospital

**Chris Power,** CEO, Capital Health Authority, Halifax

**Dr. Janice MacKinnon,** Professor, School of Public Health, University of Saskatchewan

**John G. Abbott,** past CEO, Health Council of Canada

**Paul Williams,** Professor, Full SGS Member, Institute Health Policy, Management and Evaluation, University of Toronto

5:00 - Break

6:00 - Cocktail Reception - jointly sponsored by CPA, KPMG, and Rx&D
### CONFERENCE DAY 1 (THURSDAY MAY 15TH)

- **7:15 -** Rx&D Dinner Keynote Address
  - **Dr. Richard Reznick,**
    Dean, Faculty of Health Sciences,
    Queen’s University
  - **Professor Chris Ham,**
    Chief Executive,
    The King’s Fund, UK

### CONFERENCE DAY 2 (FRIDAY MAY 16TH)

**Day 2 Theme: Implementing Strategic Change in Canadian Healthcare**

- **8:00 -** Breakfast - sponsored by Microsoft
- **8:25 -** Opening Comments
  - **Dr. David Saunders,**
    Dean, Queen’s School of Business

**Day 2 Opening Keynote Address: A Strategy for Integrated Care in Canada**

- **8:30 -** Janet M. Davidson,
  Deputy Minister, Alberta Health

**Microsoft Panel: Redesigning Canadian Healthcare for the Age of Complex Care**

- **9:45 -** Senior change agents from healthcare delivery and government will discuss emerging strategies in Canada to manage rising healthcare costs and the changing nature of healthcare demand.
  - **MODERATOR:** Janet Knox,
    President and CEO,
    Annapolis Valley District Health Authority
  - **Sean Nolan,**
    Chief Architect and General Manager, Health Solutions Group,
    Microsoft
  - **Dr. Walter Wodchis,**
    Associate Professor,
    Institute of Health Policy, Management and Evaluation, University of Toronto
  - **Dr. Tom Noseworthy,**
    Associate Chief Medical Officer, Strategic Clinical Networks,
    Alberta Health Services
  - **Dr. Greg Marchildon,**
    Professor & Canada Research Chair,
    University of Regina

- **11:00 -** Break - sponsored by Telus Health

**Discussion Panel: Driving Change Forward**

- **11:20 -** Three leading thinkers in healthcare policy will address the nature of Canada’s multijurisdictional structure, and the critical roles that healthcare stakeholders – including providers, patients and the private sector – play in its delivery and reform. The result will be a shift from ideas to implementation, illustrating potential ways forward in the Canadian context.
  - **MODERATOR:** Dr. Kim Nossal,
    Director, School of Policy Studies,
    Queen’s University
  - **Don Drummond,**
    Matthews Fellow in Global Public Policy,
    Queen’s University
  - **Dr. Antonia Maioni,**
    Professor, Department of Political Science,
    McGill University
  - **Dr. Greg Marchildon,**
    Professor & Canada Research Chair,
    University of Regina

- **12:30 -** Lunch - sponsored by Shoppers Drug Mart

**Funded with generous support from the Joseph S. Stauffer Foundation.**
### Shoppers Drug Mart Lunch Panel: Driving Change through Cooperation

1:00 - Presidents of leading associations and healthcare providers will highlight opportunities for collaboration and cooperation, and identify innovative roles for stakeholders in Canadian healthcare reform.

| MODERATOR: Maureen O’Neil, President, Canadian Foundation for Healthcare Improvement | Dr. Chris Simpson, President-elect, Canadian Medical Association; Chief of Cardiology, Queen’s University | Shirlee Sharkey, President, Saint Elizabeth Health Care |
| Mike Brennan, CEO, Canadian Physiotherapy Association | Anne Sutherland Boal, Chief Executive Officer, Canadian Nurses Association |

2:00 - Break

2:15 - CPA Closing Keynote Address

Rick Waugh, Past President & CEO, Bank of Nova Scotia

3:15 - Closing Remarks & Wrap-Up

Dr. Daniel Woolf, Principal and Vice-Chancellor, Queen’s University

Dr. Scott Carson, Director, The Monieson Centre for Business Research in Healthcare; Professor of Strategy & Organization, Queen’s School of Business

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