Managing a Canadian Healthcare Strategy

CONFERENCE WHITE PAPER WORKING DRAFTS

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Managing A Canadian Healthcare Strategy: An Introduction

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The three-part Queen's Health Policy Change Conference Series is now in its third year. The broad question we have been exploring is: "If Canada had a system-wide healthcare strategy, what form could it take?" This is challenging to answer because Canadians have not fleshed out a picture or model of what a Canadian healthcare strategy could look like. We have nothing concrete to which we can point and approve or reject. Granted, there are indications of what a strategy should contain from national reports such as the Romanow and Kirby reports of 2002. But we lack a framework that sets out ideals and objectives that can then be translated into measurable goals with specific targets. Unfortunately, we have only the status quo and a long list of barriers and impediments – reasons why change can only occur at the provincial and territorial levels, and not for Canada as a whole system. As a result, we go on living with inequities in access, availability, and costs to patients between provinces; discrepant performance metrics across jurisdictions; and few of the efficiencies that could be achieved by working together.

What we have learned in our first two conferences, "Toward a Canadian Healthcare Strategy" (2013) and "Creating Strategic Change in Canadian Healthcare" (2014), is that participants believe we should have a Canadian healthcare strategy. It would need to respect the single payer health insurance framework and the equity-preserving values of universality and accessibility enshrined in the Canada Health Act; be fiscally responsible and sustainable; and address electronic health records, health human resources, primary care, seniors' care, and pharmacare. In terms of structure, a Canadian healthcare strategy would need to be seen as a system-wide "strategy-of-strategies." It would need to be collaborative rather than employ a top-down command and control approach. And within the family of constituent strategies we would have an amalgam of "federal" strategies that are authorized and operated by the government of Canada, such as the Canadian Forces Health Services; "national" strategies for organizations that operate across Canada at arm's length from government, such as Canada Health Infoway and Canadian Blood Services; pan-Canadian strategies, such as the pan-Canadian Pharmaceutical Alliance formed by the provinces and territories to negotiate prices for publicly covered drugs; and provincial and territorial healthcare delivery strategies that each work independently, but are all in collaboration.

These issues are addressed in a new book, *Toward a Healthcare Strategy for Canadians* (A. S. Carson, J. Dixon, and K. R. Nossal (eds.), McGill-Queen's Press, 2015). It contains twelve chapters written specifically to address the themes of structure, content, and political context for a Canadian system-wide strategy. Eight of the chapters appeared in earlier versions as white papers for the two previous Queen's Health Policy Change Conferences. Four chapters were specially commissioned for this book.

We now come to our third conference: "Managing a Canadian Healthcare Strategy," May 6–7, 2015. The challenge before us is in answering the question: "How should Canadians move forward?" This conference will explore three interconnected themes. First is "Measuring and Monitoring a Healthcare Strategy." In this we consider how we could establish a performance scorecard for a Canadian system that is acting as a whole. We will draw on the experiences of and country case studies by speakers from the U.S., UK, Australia, Sweden, and Denmark. It is not a template from abroad that we seek. Rather, we require our own model. But learning from the experiences of other countries can benefit us greatly. An issue of equal importance for us is not just the establishment of "measurement" analytics, but also determining how we can use these tools to "manage" the Canadian system. Our May 6th lunchtime panel of Canadian experts from New Brunswick, Ontario, Manitoba, and Canada nationally will address this with Theme 2: "From Measurement to Management."

Theme 3, "How Stakeholders can Change Canadian Healthcare," is the third major theme. We are taking a different approach to addressing this issue. What is commonly heard in debates about healthcare reform is what governments can, should, don't, or won't do! Governments are seen to be both enablers of and barriers to positive change. In four concurrent sessions, we will be asking: Who are the other agents of change? What are the roles and potential impacts of focused and consolidated efforts by the business community? Can patients be agents of change? Does systems leadership offer an approach to bottom-up change in healthcare? And, what can we learn about change from pan-Canadian entities that already function within the Canadian system, such as the Canadian Partnership against Cancer, Canadian Forces Health Services Group, Canadian Blood Services, and Canada Health Infoway.

The next step in our "change" agenda takes place on May 7th over three sessions. First, Nigel Edwards, CEO, the Nuffield Trust (UK), will set the stage for the Canadian task by explaining key principles that have been the foundation for change in many countries around the world which have struggled with national approaches to healthcare. Following this will be a key panel representing a very important agent of change, namely the healthcare professions. A panel comprising the heads of the Canadian Medical Association, Canadian Nurses Association, Canadian Physiotherapy Association, and Canadian Pharmacists Association will take the stage to answer the questions: What do you see as the key areas in need of a national focus? What is your profession prepared to do to bring about change? What can your four associations do to bring about change together? What needs to happen next?

The final panel brings the discussion to the realm of government. Five deputy ministers – the deputy minister of Health Canada, and his counterparts from British Columbia, Alberta, Ontario, and Nova Scotia – will speak with each other and with the audience in an open forum moderated by Steve Paikin, *TV Ontario*'s host of the public affairs program "The Agenda." Canadians are very aware of the impediments and barriers to Canadian healthcare reform. However, we need to get beyond that. What can the governments of Canada do together to bring about positive healthcare reform? How can we build a Canadian strategy together?

In support of this year's Queen's Health Policy Change Conference, The Monieson Centre for Business Research in Healthcare has worked with scholars and other experts from across Canada to develop a series of white papers addressing the conference themes. Topics include using measurement and monitoring to drive system management, empowering stakeholders – patients, the private sector, and the professions – as agents of change, and looking at ways forward for health policy reform. Working drafts of the papers are provided in the following pages to conference participants. The papers will be further revised following the conference.

MEASURING AND MONITORING A HEALTHCARE STRATEGY

- **Using Performance Measurement and Monitoring for Performance Improvement**
  Jeremy Veillard (Canadian Institute for Health Information (CIHI), University of Toronto), Keith Denny (CIHI), Brenda Tipper (CIHI), and Niek Klazinga (University of Amsterdam)

  This paper presents the state of performance reporting and monitoring in Canada and discusses strengths and weaknesses in health system performance from an international perspective. Further, it discusses how performance reporting and monitoring are instrumental to efforts to better manage the performance of the Canadian healthcare system, and what additional performance information and policy changes are required to strengthen the ability of Canadian jurisdictions to better manage health system performance and achieve better outcomes that benefit Canadians and patients in the health sector.

- **Harnessing Patients' Voices for Improving the Healthcare System**
  Sabrina Wong (University of British Columbia)

  Patients are the definers of care that meets their needs. Their experiences tell the system about the quality of healthcare delivery. This discussion explores the influence of patients' voices on contributions to health reforms, specifically in the area of primary healthcare.

HOW STAKEHOLDERS CAN CHANGE CANADIAN HEALTHCARE

- **Harnessing Patient Engagement for Healthcare System Change**
  Monica C. LaBarge, Jay M. Handelman, and Alex Mitchell (Queen's School of Business)

  This white paper addresses the ways that patients attempt to influence healthcare system change through individual and collective advocacy, and how healthcare organizations can harness that patient involvement to create systems and structures that genuinely place the patient at the centre of care.

- **The Role of the Private Sector in Canadian Healthcare: Strategic Alliances, Accountability, and Governance**
  A. Scott Carson (Queen's School of Business)

  In this white paper it is argued that there is much room in Canadian healthcare for the private sector, but in a way that does not impede the goals of social justice or fairness, namely access and equity. In fact, the reverse is likely true: the involvement of the private sector in the right places in the system can promote access and equity by adding resource capacity and expertise.

- **Health Policy Advocacy: The Role of Professional Associations**
  Christopher S. Simpson (Canadian Medical Association) and
  Karima A. Velji (Canadian Nurses Association)

  This paper documents the experiences and key learnings of the Canadian Nurses Association (CNA) and the Canadian Medical Association (CMA) in collaborating to advocate for a national health policy agenda since the early 1990s. This ongoing collaboration has enhanced both collective and individual effectiveness by building a unified voice and providing members with tools and information to engage in health system transformation.

MOVING HEALTHCARE REFORM FORWARD

- **An Action Plan for Reforming Healthcare in Canada**
  Don Drummond and Talitha Calder (Queen's School of Policy Studies)

  This white paper sets out a strategy for government action to reform healthcare in Canada. The time has come for governments to broaden and deepen the piecemeal reforms underway. But they must do so strategically in this, perhaps the most politically sensitive of all policy fields.

Using Performance Measurement and Monitoring for Improvement: From Performance Measurement to Performance Management

WHITE PAPER - WORKING DRAFT

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INTRODUCTION

There has been a dramatic growth in the use of performance measurement and reporting in the health sector in the last twenty-five years. In England, provisions for public reporting include Annual Quality Accounts for all healthcare organizations and an Outcomes Framework for the National Health Service (Department of Health 2011). In federal systems, the Patient Protection and Affordable Care Act in the United States (United States of America Congress 2010) mandates quarterly public reporting of performance information by institutions caring for Medicare patients, while in Australia quarterly and annual reports on health system performance are mandated (Council of Australian Governments 2011). The Netherlands has been reporting on a national healthcare performance framework since 2006 (van den Berg, Kringos, Marks, and Klazinga 2014).

A number of factors have contributed to this growth in public performance reporting in the health sector, including pressure to contain healthcare costs, patient and citizen expectations of access to information, growing accountability imperatives, and advances in information technology (Smith, Mossialos, and Papanicolas 2008). International comparisons have added to this emphasis on performance reporting, especially in countries where international rankings have shown poor or uneven performance across a range of comparable indicators for OECD countries (Commonwealth Fund 2011; OECD 2013; CIHI 2014a). Linking performance measurement with strategic goals for the performance of the healthcare system as a whole, or the services of which it consists, is increasingly seen as a key driver toward better results.

In Canada, most provinces have now defined clear strategic priorities and related performance indicators for their systems and/or services. For example, in Alberta, strategic priorities for government are supported by a small core set of twelve performance indicators covering the domains of health status, health system outcomes, and health system performance (Alberta Health 2014). Yet there is no common set of performance expectations or performance indicators for the health sector that would apply to the entire country, despite repeated efforts to create these since 2000 (Fierlbeck 2012; Fafard 2013). Most recently, for example, the Council of the Federation's Health Care Innovation Working Group released a common framework specifying key domains of quality of care (Health Care Innovation Working Group 2012).

One notable but limited exception is the joint effort undertaken in 2004 by Canadian provinces to reduce wait times for a small number of priority procedures. The provinces agreed to establish common, medically acceptable benchmarks and performance indicators for wait times in five areas: radiation therapy for cancer, hip and knee replacement surgery, cataract surgery, cardiac bypass surgery, and diagnostic imaging. A third party organization, the Canadian Institute for Health Information (CIHI), was mandated to monitor the provinces' progress. Interestingly, the addition of financial resources combined with independent public reporting, investments in information systems, innovation in payment systems, and initiatives to redesign care delivery processes and share best practices among provinces resulted in notable reductions in wait times and led Canada to become a better performer than many other OECD countries for cataract surgeries and joint replacement surgeries (OECD 2013).

This focus on performance measurement and reporting as a key policy instrument is tightly connected to the emergence of performance management as the dominating paradigm in the delivery and management of public services. This movement is rooted in the influence and expansion of different waves of new public management and management by results since the 1970s (Groot and Budding 2008). Importantly, the concept of performance management is pivotal to different waves of new public management. It has been influenced by a variety of theoretical contributions from different disciplines, which can be grouped into three broad categories: neoclassical public administration and public management, management sciences, and new institutional economics (Groot and Budding 2008). These perspectives share the common objective of transforming public services through a greater focus on managing performance and service improvement (Osborne and Gaebler 1992). In the health sector, the emergence of greater demand for accountability and transparency since Codman's work a century ago (Donabedian 1989) has been an additional driver for a focus on performance measurement and reporting.

Still, although health system performance management has become an area of interest for policy makers, health system managers, and researchers, it remains poorly defined. We can build a working definition from the component parts of the term "health system performance management." The World Health Organization (WHO) defines *health systems* as all actors, institutions, and resources that undertake health actions – where the primary intent of a health action is to improve health (2000). Although they vary throughout the world in their design and organization, health systems generally share the same core goals of good health, responsiveness to people's expectations, social and financial protection, efficiency, and equity (Smith, Mossialos, Leatherman, and Papanicolas 2009; World Health Organization 2000).

Performance can be defined as the maintenance of a state of functioning that corresponds to societal, patient, and professional norms (Veillard et al. 2005). Daniels and Daniels (2004) define performance management as a technology for managing behaviour and results, two critical elements of what is known as performance, while for Smith (2002) it is a set of managerial instruments designed to secure optimal performance of the healthcare system in line with policy objectives. In this paper, our definition of *health system performance management* includes both the instruments and processes to improve health system performance (Veillard et al. 2010).

This paper reviews the state of affairs of performance measurement and reporting in Canada, and discusses how performance measurement and reporting could be better positioned to support the emergence of performance management as the dominant paradigm focused on driving performance improvement in Canada's healthcare system.

THE INSTITUTIONAL LANDSCAPE OF PERFORMANCE MEASUREMENT AND REPORTING IN CANADA

The healthcare performance measurement and reporting landscape in Canada includes multiple players, including provincial governments, their agents and other provincial entities, the federal government, non-governmental pan-Canadian organizations of different stripes, and international organizations whose comparative performance measurement projects encompass Canada.

As indicated, since 2004, the provinces have worked toward the development of benchmarks and indicators for wait times and all provinces now report wait time information publicly. Beyond wait times, progress across provinces in performance measurement and public reporting in general has been uneven. Most provinces report on health system performance to varying degrees through their ministries of health. In addition, provinces with specialized agencies responsible for performance reporting and/or quality improvement (such as New Brunswick, Ontario, Quebec, and Saskatchewan) tend to have a well-established performance reporting function in place. These agencies produce regular reports on health system performance and health status at the provincial and, in some cases, the health region level. Health Quality Ontario, for example, was created in 2011 with a mandate to monitor and report on progress on health system performance following the introduction of the Excellent Care for All Act.

In addition to the reporting of provincial ministries and quality councils, there are other health information and research organizations – such as the Newfoundland and Labrador Centre for Health Information, Ontario's Institute for Clinical Evaluative Sciences (ICES), the Manitoba Centre for Health Policy, and the University of British Columbia Centre for Health Services and Policy Research – that analyze and report on healthcare system data for their jurisdictions. The Manitoba Centre for Health Policy, for example, has produced the province's Indicators Atlas for Regional Health Authorities, which measures the health of Manitobans and their use of healthcare services. Cancer Care Ontario's Cancer Quality Council of Ontario monitors and publicly reports on the performance of the provincial cancer system.

The federal government is also a player in health system performance measurement, most notably through Statistics Canada, but also through Health Canada, the Public Health Agency of Canada, and Employment and Social Development Canada. Statistics Canada conducts the Canadian Community Health Survey and the Canadian Health Measures Survey, which are widely used across the country to inform the generation of performance indicators for the health sector. As the nation's statistical agency, Statistics Canada has access to a wide range of data and draws on the census and other sources of Canadian socioeconomic data to report on health and healthcare.

The Public Health Agency of Canada (PHAC) Chronic Disease Infobase includes the Chronic Disease and Injury Indicator Framework, which consists of a set of indicators grouped within six domains, and the Canadian Chronic Disease Surveillance System, a network of provincial and territorial surveillance systems.

Perhaps less known, Employment and Social Development Canada publishes the *Indicators of Well-Being in Canada*, which includes a section specifically on health, reporting on health status, mortality, and influences on health, such as health behaviours, access to primary care, and patient satisfaction. Other sections include indicators on employment, education, housing, and social networks.

In addition to these major contributors to pan-Canadian health performance reporting, there are other national organizations that report publicly on health system performance. Most obvious among these is the Canadian Institute for Health Information (CIHI), created in 1994 to address what was then deemed the "deplorable" state of the country's health information infrastructure. With a mandate to collect and disseminate standardized, comparable pan-Canadian data and analyses, CIHI has since become Canada's lead agency for health system information and reports on health system performance at national, provincial, territorial, regional, and hospital levels through its website (www.yourhealthsystem.ca). As of June 2015, CIHI will also release publicly a core set of quality indicators for 1,200 long-term care homes across the country.

Other organizations reporting on performance in terms of specific diseases or sectors of health system performance include the Canadian Partnership Against Cancer (CPAC), specific disease-based associations, and private organizations such as the Conference Board of Canada and the Fraser Institute, both of which routinely produce performance reports on the healthcare sector.

Finally, several prominent international organizations have health system performance reporting projects that include Canada. Most notably, these include the OECD's Health Care Quality Indicators Project, initiated in 2002, and the Commonwealth Fund's International Health Policy Surveys of adults. Canada also participates in QUALICO-PC, an international project established to monitor the performance of primary care and its contributions to the broader health system.

A Proliferation of Indicators in Canada

Clearly, the performance measurement and indicator agenda has been adopted enthusiastically in recent years, producing a great deal of activity in the area. However, it is striking that besides the general objective of greater transparency and accountability, the objectives and incentives related to public reporting initiatives in the health sector are often unclear or unspecified. The crowded field of performance measurement, marked by multiple players and

a proliferation of indicators, has led to a situation that has been described as "indicator chaos" (Quality Council of Saskatchewan 2012). In practice, while a focus on measurement has taken hold and indicators have multiplied, from a big picture perspective there has been an inadequate focus on developing an overarching logic for this activity to give it consistent purpose, common standards (in indicator development), coordination and coherence, and to harness it in the interest of health system improvement. A number of organizations including CIHI are now reviewing indicators published and retiring the indicators that show the least value for health system performance improvement (CIHI 2015a).

Attempts to Frame and Strategically Align Health System Performance Indicators in Canada

Over the last twenty years, CIHI has worked in collaboration with Statistics Canada to develop measurement standards that enable pan-Canadian reporting of health indicators. In 1999, CIHI and Statistics Canada initiated a joint health indicators project that has since become internationally recognized. The indicators were identified through extensive consultation and developed primarily to support regional health authorities in monitoring progress in improving and maintaining the health of their populations and in the functioning of the health system, as well as enabling reporting to governing bodies, the public, and health professional groups.

In 2012, CIHI launched a new initiative focusing its public performance reporting efforts on a small number of cascading indicators determined by a clarified health system performance framework and aligned with the strategic priorities of Canadian provinces. This initiative aimed to: stimulate performance improvement by reporting publicly on a small number of indicators aligned with priorities of the general public and of Canadian jurisdictions; focus public reporting instruments on the information needs of well-segmented audiences as defined through various engagement mechanisms; and implement complementary analytical, research, and capacity building initiatives supporting the performance improvement efforts of jurisdictions.

A health system performance framework aligned with the main strategic objectives of Canadian provinces and territories (shown in Figure 1) was designed to address questions about the quality of healthcare services, the health system's contributions to the overall health of the population, and the extent to which our healthcare systems are optimizing the investments we put into them.
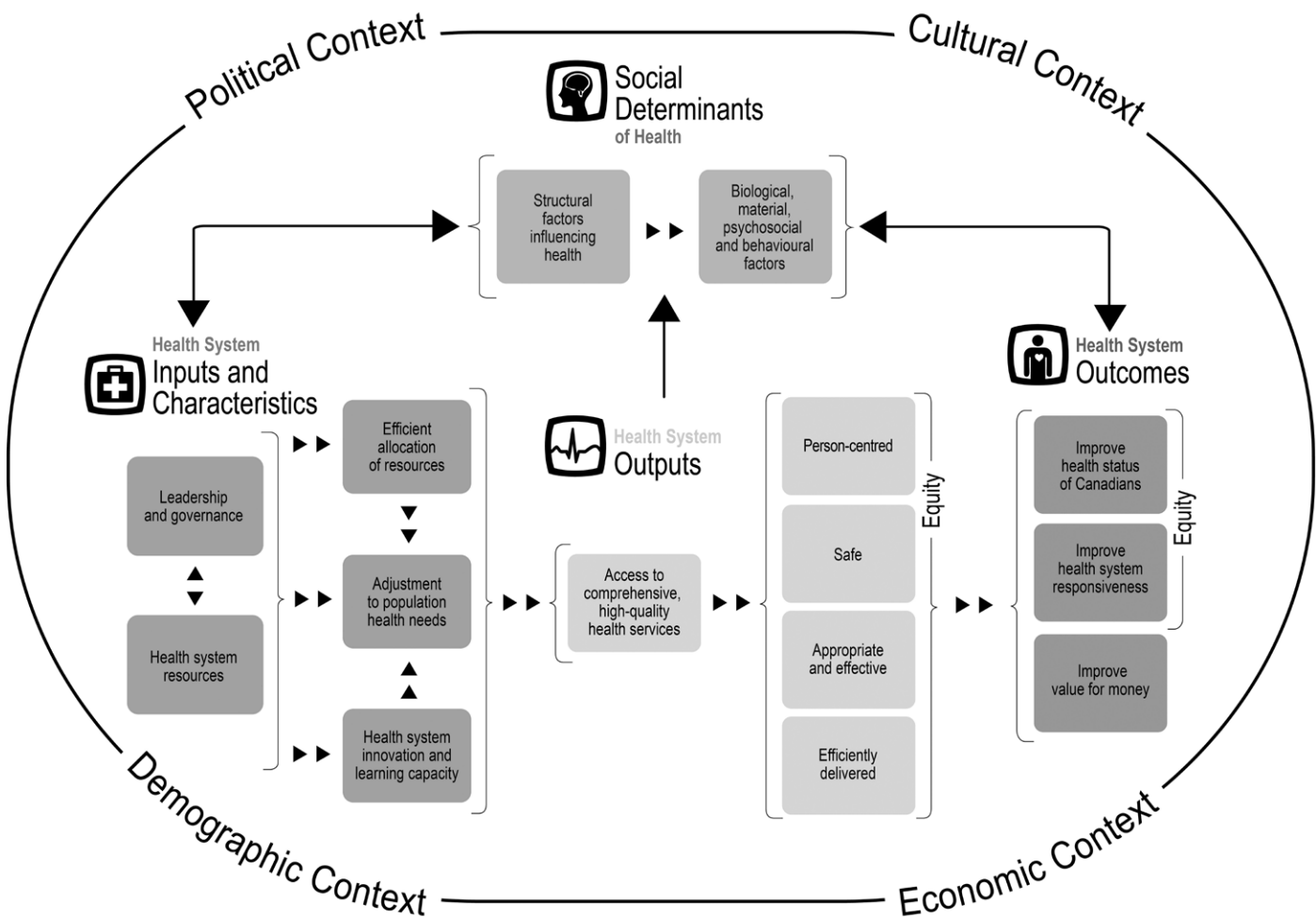
Figure 1: Canada's Health System Performance Framework, 2013

This health system performance measurement framework incorporates Donabedian's (1966) framework for evaluating health services and the quality of care – the triad of structure (inputs and characteristics), process (outputs), and outcomes – for its general framework of performance measurement. It also adopts the three categories of the Triple Aim (Berwick, Nolan, and Whittington 2008) specifically for the measurement of health system outcomes to: improve the health status of Canadians (in terms of health conditions, functioning, and well-being); improve health system responsiveness (the extent to which healthcare "meets the needs and expectations of the people it serves"); and improve value for money.

Taken together, the elements of the framework comprise a more holistic orientation to performance measurement and improvement and incorporate an inherent logic that was lacking in earlier indicator frameworks. The framework was used to derive a small set of fifteen performance indicators aimed at meeting the information needs of the general public and high level policy makers, and then expanded to a set of thirty-seven indicators designed for health system managers and covering more detailed performance information at the level of regional health authorities and hospitals. An additional set of nine indicators focused on the quality of long-term care homes will be released in June 2015 (CIHI 2014b). Appendix 1 provides a summary of the strengths and weaknesses of the Canadian health system based on an analysis of the core set of fifteen performance indicators selected for the general public and policy makers, and presents complementary information on performance comparisons with other OECD countries and within Canadian provinces.

Putting the Framework to Work: Canadian Health System Performance Management Beyond Wait Times

The extent to which this initiative will have an impact on performance improvement will depend, in part, on institutional accountability cultures and strategic commitment to service improvement through performance

management. Canada's recent experience with wait times provides a useful case study in this regard. The 2004 Health Accord focused on a narrow set of wait times with the expectation being to provide care within wait times that were clinically acceptable. Provinces worked together to define what were clinically acceptable benchmarks, the federal government provided financial support to the initiative, and CIHI was designated as the third party organization responsible for working together with data suppliers (the provinces) to ensure the quality and comparability of the data provided, and to report on progress on an annual basis. Ten years after signing the accord, not only are provincial governments reporting on an annual basis through CIHI on wait times for key procedures and interventions, but much progress has been made despite a substantial increase in the volume of services delivered for these procedures (CIHI 2015b). In 2014, about eight Canadians out of ten received these services within the clinical benchmarks. International comparisons have also shown that for cataract surgeries and joint replacements Canada has made enough progress in the last ten years to become one of the OECD countries with the best access for these specific procedures. Clearly, the combination of additional financial resources, political attention, and comparative performance reporting, and specific interventions such as innovative financing mechanisms, introduction of financial and organizational incentives, process redesign, and spreading and scaling of best practices, delivered better results for Canadians despite the pressures of demographics, aging, and changes in medical practices.

On the other hand, wait times reporting also provides a useful example of what can occur in the area of performance reporting in the absence of the coordination and commitment described above – a situation that for the most part characterizes health system reporting beyond wait times. Table 1 illustrates that there is a great deal of consistency in the reporting of those areas identified as priorities. As noted above, this is at least partially due to the role of the federal government in providing financial support, and organizations such as CIHI and the Wait Times Alliance in reporting the data. Sustainable performance improvement through the use of standardized performance measurement, available evidence, and policy and political commitment is possible in Canada, given the appropriate support. However, Table 1 also shows that for wait times reporting for non-priority areas there is much less consistency across jurisdictions and a considerably less coherent picture. In some cases, indicators are reported by jurisdictions, but with non-comparable methodologies.

		BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Federally-Funded Indicators†											
Priority Areas	Joint replacement (hip and knee)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
	Radiation therapy	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
	Cataract surgery	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
	MRI scans		✔	✔	✔	✔		✔	✔		
	CT scans		✔	✔	✔	✔		✔	✔		
	CABG	✔	✔	✔	✔	✔	♦	✔	✔	✸	✔
Other Wait Time Indicators‡											
Cancer Care	Wait time from referral to consult (all body sites combined)		✔	♦		✔			✔	✔	
	Wait time from decision to treat to start of treatment (all body sites combined)	✔	✔	✔	✔	✔		✔	✔	✔	✔
Cardiac Care (scheduled cases)	Electrophysiology								♦	✸	
	Cardiac rehabilitation								♦		
	Cardiac nuclear imaging				♦				♦		
Plastic Surgery	Breast reconstruction	♦	♦	♦		✔			✔		
Pediatric Surgery	Advanced dental caries: carious lesions/pain						♦		♦	♦	
	Strabismus						♦		✔	✔	

Note. CABG = coronary artery bypass graft; MRI = Magnetic resonance imaging; CT = computerized tomography.

† **Source:** Canadian Institute for Health Information (CIHI), "Wait Times for Priority Procedures in Canada" (2014).
‡ **Source:** Wait Time Alliance, "Report Card on Wait Times in Canada" (2014).
♦ Provinces report wait times for this specific procedure, but in a manner that could not be compared to the others.
✸ PEI does not offer cardiac services; patients receive care out of province.

Table 1: Comparison of the Provincial Reporting of Access to Care Measures, 2014

TOWARD A LEARNING HEALTHCARE SYSTEM: FROM PERFORMANCE MEASUREMENT TO PERFORMANCE MANAGEMENT

A growing body of research indicates that the use of strategy-based performance management tools in the public sector can result in substantial improvements in both health outcomes and cost effectiveness. Specifically, the literature on balanced scorecards (Kaplan and Norton 1992) and strategy mapping (Kaplan and Norton 2001) illustrates the importance of linking strategy, performance measurement, and performance expectations (Veillard et al. 2010) into a coherent path toward a specified and shared destination. While the balanced scorecard provides a means for organizing strategic objectives and embodies the cause and effect relationships between them, the strategy map forms a framework – a common point of reference – to guide the implementation of strategy. It is the scorecard and map in conjunction that move an organization beyond performance measurement to strategic system management (Kaplan and Norton 2001). If measurement involves reporting on the past, it also identifies areas for emphasis in the future, enabling organizations "to accomplish comprehensive and integrated transformations" (Kaplan and Norton 2001, 102).

Conventionally, the unit of application of the balanced scorecard and strategy maps is the organization. Adaptation is required if the approach is to be mobilized for the entire health system. In Ontario, for example, the Ontario Ministry of Health and Long Term Care developed, in 2006, a health system performance management framework that adapted the seminal work of Kaplan and Norton to a system level, and used this approach for the development of its new accountability policy for newly created Local Health Integration Networks (Veillard 2010). This process is graphically depicted as a performance management cycle in Figure 2, in which a jurisdiction (a) sets its strategic priorities; (b) selects key performance indicators to monitor progress of the strategy; (c) uses these indicators to support resource allocation; (d) holds those receiving resources accountable for results; and (e) assesses whether performance improvements have the desired impact on the performance of the health system in order to adjust strategies accordingly.

To create an environment conducive to this form of system-level performance management requires forms of stewardship and governance that ensure a proper alignment between health system design, resource allocation and incentives, and health system goals and performance expectations (Veillard 2010). It also requires that health ministries ensure a fit between strategy and institutional and organizational structure, and that there are efforts in place to reduce system duplication and fragmentation. It also implies that the health system has the capacity to adapt its strategies and policies to take into account changing priorities and health needs (Porter 1996).
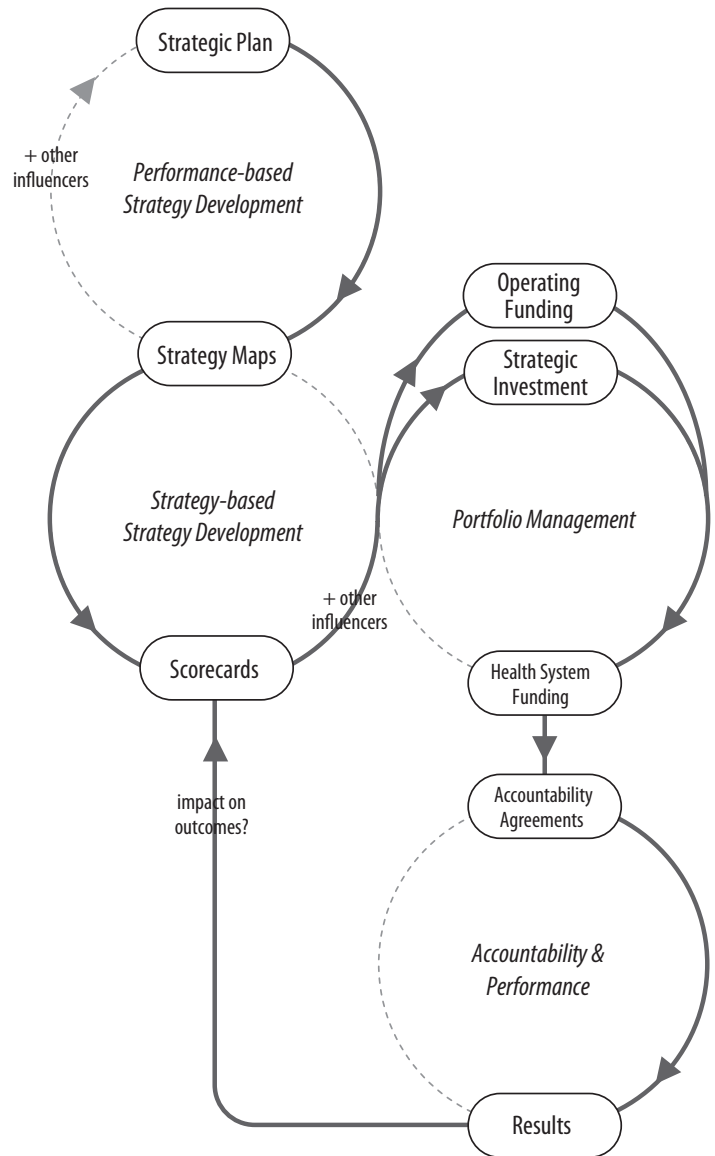
Figure 2: A strategy-based performance management cycle

Besides legislative and regulatory instruments, there are various policy tools that can be mobilized by provincial governments and system managers in Canada to manage the performance of the healthcare system. Table 2 below presents a menu of possible instruments that can be used to manage health system performance. Depending on goals pursued and context, a different combination of these policy instruments will be required to achieve performance expectations. Importantly, these policy instruments all rely heavily on the strategic use of performance information and evidence.

Instrument	Definition	Examples
Public reporting	Data, publicly available or available to a broad audience free of charge or at a nominal cost, about a healthcare structure, process, or outcome at any provider level (Totten et al. 2012).	Provincial Quality Councils CIHI
Target setting	Determining the level of performance that an organization aims to achieve for a particular activity (Bourn 2001).	Wait Times and recent work at Health Quality Ontario
Accountability mechanisms	Instruments through which an agent is answerable to another for progress towards meeting defined objectives (Deber 2014).	Contractual arrangements with regional health authorities Cancer Care Ontario
Resource allocation and portfolio management	Processes of (dis)investment of resources and prioritization in pursuit of organizational goals.	Ontario Ministry of Health experience
Financial incentives	Payment incentives intended to promote or discourage certain activities, e.g., Pay for Performance (Oliver 2014).	Activity Based Funding (Ontario, Alberta, British Columbia) Quality Based Procedures (Ontario)
Non-financial incentives	Non-payment incentives intended to promote or discourage certain activities, e.g., public reporting, ranking (Oliver 2014).	Excellent Care for All Act (Ontario 2010)
Quality improvement	A systematic approach to making changes that lead to better patient outcomes, stronger system performance, and enhanced professional development (Health Quality Ontario).	Saskatchewan Lean Initiative Wait Times process flow redesign

Table 2: A possible menu of policy instruments for health system performance management

Criticisms of the Performance Management Paradigm

It should also be noted that a number of potential drawbacks and undesirable consequences have been identified with regard to the use of performance measurement to manage the performance of health systems (Exworthy 2011). These criticisms pertain to a number of issues, with gaming of financial incentives at the forefront (Bevan and Hood 2006). Other observers have raised a range of concerns, including: the fact that improperly mobilized performance indicators can result in sub-optimal service delivery, or a focus on meeting the target rather than substantively improving performance (Klazinga 2011; Mannion and Braithewaite 2012); the difficulty of improving performance in targeted areas while ensuring that other non-reported aspects of care or health system performance are not adversely affected (Mannion and Braithwaite 2012); the challenge of balancing formal (quantifiable) and informal (non-quantifiable) aspects of performance when measurement imperatives are predominant (Mannion and Braithwaite 2012); the difficulty of improving performance when interrelations and trade-offs between the different dimensions of health system performance are complex and poorly understood (Plsek and Greenhalgh 2001); and the need to act simultaneously on primary, secondary, and tertiary factors influencing health to achieve better outcomes (Mannion and Braithewaite 2012; Commission on Social Determinants of Health 2008).

More generally, the political role of the performance management paradigm in an era of retrenchment, characterized by a political context focused on budgetary discipline with little financial capacity to make significant new investments, has been questioned. Other criticisms have been typified by scepticism with regard to whether key measures related to public satisfaction will improve, incredulity toward the ability of government to deliver transformative changes, and a lingering hesitancy to "call out" poor performers.

It would be an error, however, to conclude on the basis of the challenges that have been identified that performance management is not an obvious way forward for health system performance improvement in Canada. The challenges, as Eddy (1998) points out, "are a necessary phase in the development of any program to solve a difficult and important social problem." All levels of the health system need performance information to clarify what they are seeking to achieve (aspirations); measure progress against aspirations (management); and understand whether investments deliver value for money (accountability) (Hughes 2013).

From a more operational perspective, those who manage and provide health services need detailed management information to understand which services perform well, and which need to improve. Good performance information is essential for health systems striving to deliver value for money, and improved services, especially in times of scarce resources.

In other words, performance measurement is vital for effective performance management and improvement: for creating, maintaining, and demonstrating excellence, and for making optimal decisions and use of resources. Measurement is not an end in itself – the purpose of course is to improve healthcare quality – but "persistent questions about quality and the tension between quality and cost cannot be resolved without measuring quality" (Eddy 1998). Our collective task with regard to performance measurement and management, as Mannion and Braithwaite (2012) point out, "is to reap the benefits, but beware of the pitfalls."

Queen's SCHOOL OF BUSINESS

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HOW TO MAKE PERFORMANCE MANAGEMENT WORK IN CANADA

The nature of healthcare in Canada's federal context means that, within the parameters of the Canada Health Act, provincial governments have considerable leeway in shaping their health systems in ways that respond to their population and economic needs. This is one of the system's strengths and a valuable source of innovation. One consequence, however, is that decisions in jurisdictions may not be optimally informed by a broader perspective and by experience (both successful and otherwise) in other provinces. Further, opportunities for alignment are not readily available. Although the structure of Canada's health system enables responsiveness to local priorities and contingencies, it does not lend itself easily to the identification and pursuit of shared policy goals and common performance priorities. Despite variations in health system performance, all of Canada's provinces are facing similar challenges when it comes to healthcare, and there is much to be gained from a coherent and coordinated approach to health system performance measurement and management. In this context, there are a number of ways forward to be considered to make performance management work in the health sector in Canada.

Create Alignment Between National and Provincial Performance Measurement Frameworks

Driving health system improvement for all Canadians will involve preserving provincial government autonomy and flexibility with regard to delivering health services appropriate to population needs while bringing greater coherence to the relationship between provincial and federal levels. One way to achieve this would be by developing shared strategic goals and objectives through the alignment of federal and provincial frameworks centred on the elaboration of shared health system priorities. Of course, provincial autonomy and flexibility will continue to be a defining hallmark of health services delivery, but the alignment of federal and provincial frameworks would encourage coordination and learning across jurisdictions and lead to a common sense of performance improvement priorities and opportunities for shared progress. The success of the wait times initiative and recent work by the Council of the Federation and its Innovation Working Group are partial illustrations of the potential for greater alignment.

In addition, addressing the issue of indicator chaos requires processes for establishing priorities and identifying what to measure, and to ensure synergy in the institutional landscape that supports performance measurement at the federal and provincial levels. These processes will need to take into consideration the concerns of patients and citizens as well as input

from healthcare providers regarding the importance and usefulness of performance indicators.

Seek a Balance Between Parsimony and Actionability of Well-Designed Sets Of Performance Indicators

Different audiences are interested in different aspects of health system performance and require different levels of reporting. A teaching hospital, for example, may require detailed information to pinpoint which surgical programs and care processes require improvements, whereas a provincial policymaker may need to see performance trends at a higher level to understand which parts of the system are working well and not so well. As users and funders of the healthcare system, Canadians also have a vested interest in health system performance and want to know whether they are receiving good care relative to the public expense of providing it. A key challenge, therefore, in advancing the performance measurement agenda is the inherent tension between providing information tailored to the needs of different audiences (the general public, provincial health ministries, regional health authorities, and healthcare facilities) and ensuring that reporting is parsimonious and focused on a small number of indicators aligned with the system transformation priorities of jurisdictions.

The vision for the health system reporting initiative currently being implemented by the Canadian Institute for Health Information through their website (www.yourhealthsystem.cihi.ca) is to propose a focused set of cascading metrics meaningful to and useful for their respective audiences (Figure 3). Information is presented at the international, national, provincial/ territorial, health region, and facility levels, where available.
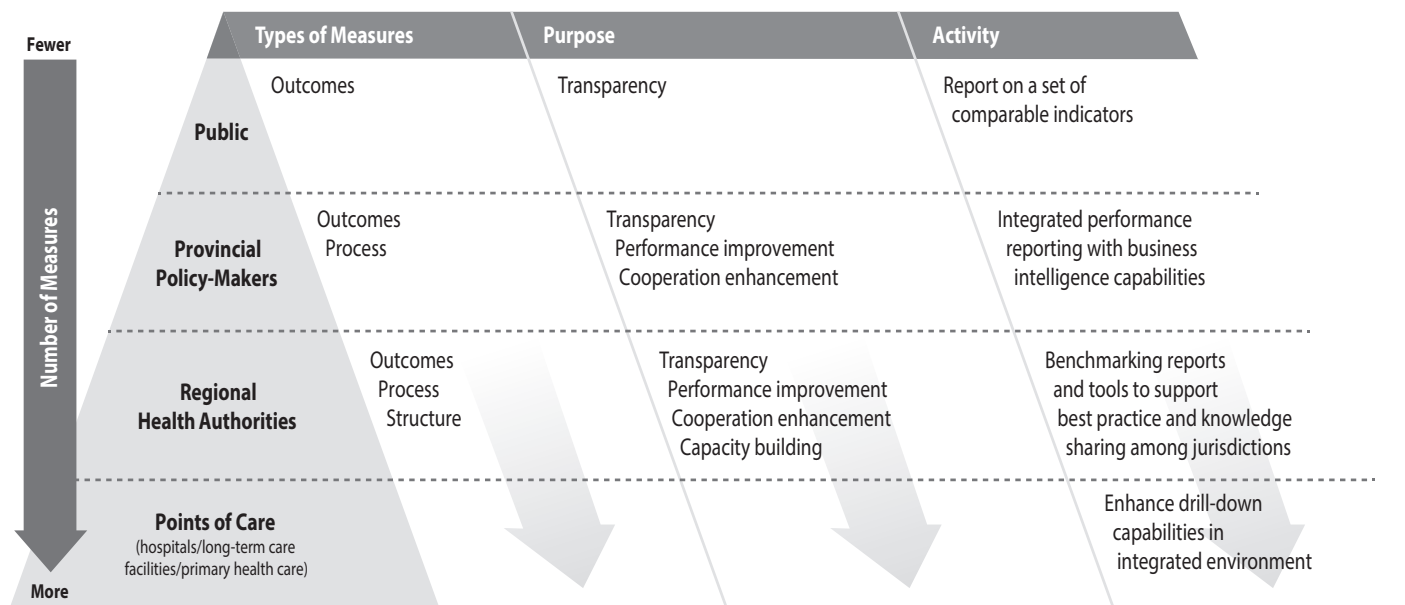
Figure 3: Cascading indicators for performance measurement

Promote Cross-Provincial Learning

In addition to public reporting via their website, CIHI is improving and expanding the functionality of health system reporting tools at the facility level with enhanced benchmarking features and improved analytical capabilities. Ultimately, the goal of this program of work is to be able to provide policy makers and health system managers with an integrated view of health system performance that cuts across sectors of care through an enhanced business intelligence solution called health system performance insight. In this system, health system managers and decision support staff can drill down into high level performance indicators reported publicly (such as hospital readmissions rates, mortality from major surgery, or wait times for emergency rooms) in a private and secure environment respectful of privacy. This technology enables the use of real time data (the indicators are updated on a monthly basis as data is submitted by hospitals), and the ability to drill down to the chart level for those who have the authorization to do so, enabling, for example, decision support teams to slice and dice the data to understand what the main drivers are for the performance results reported publicly (e.g., is a high readmission rate in a given hospital driven by patients admitted on Fridays or by a specific clinical unit such as an intensive care unit?). This practice allows in effect the reconciling of high level performance reporting (a burning platform for change) and analytics to understand underlying drivers of performance patterns. But more fundamentally, this platform also provides the opportunity to compare organizations, health regions, and provinces on a small number

of carefully selected performance indicators, to which contextual measures, peer groupings, and functionalities to identify true outliers (such as funnel plots and the naming of top performers) are added to provide a richer context for benchmarking and interpretation. In order to promote cross-provincial learning, it will be important to link rich data platforms such as the one proposed by CIHI through its website initiative with repositories of best practices and innovations linked to these indicators, and documentation of the conditions necessary to spread and scale successful innovations. From that perspective, pan-Canadian organizations such as CIHI, the Canadian Foundation for Healthcare Improvement, the Canadian Patient Safety Institute, and Accreditation Canada, among others, should be working collaboratively with provincial quality councils, other agencies, and provincial governments to provide an improvement platform that would build on the strengths of these organizations and accelerate the spread and scale of performance improvement through use of performance information and best available evidence about best practices. Finally, more research efforts should be made to develop novel methods to identify and study positive outliers, and strengthen established benchmarking networks (such as the Western CEOs Forum) and emerging benchmarking initiatives (such as the Collaborative for Excellence in Health Care Quality).

Fill in Performance Information Gaps

The Canadian Institute for Health Information and Statistics Canada hosted a national consensus conference on indicator development in late 2014, gathering senior representatives from each province and territory in Canada, the federal government, national and international experts, and national organizations. The conference had two objectives. The first of these was to consider retiring identified CIHI indicators from public reporting that had become less relevant over time, helping to reduce indicator chaos. The second and primary objective was to identify priorities for future indicator development, focusing on areas of strategic importance for health system performance improvement and on how to fill gaps in the performance measurement framework. Through a modified Delphi process with facilitated working group and plenary discussions, the conference participants identified five theme areas for future development:

- Health care outcomes
- Value for money
- Care transitions and trajectories, focusing on integration and continuity of care
- Community care and in particular mental health care
- Upstream investments in population health determinants

Of key importance was the need to fill the gap in indicators that could measure performance in community care and in how the health system responds to the needs of patients with multi-morbidities for access to care that is coordinated and integrated across all providers. Conference participants also recognized the need for indicators to reflect the perspectives of patients and caregivers on their needs for and experiences with healthcare, as well as on their outcomes of care.

The Need for Better Leadership and Governance

Experience demonstrates that notwithstanding the advantages of the federal model, the sum of the parts does not always amount to more than the whole. Coordination, consistency, and standardization do not emerge spontaneously. To move Canada's currently fragmented health system to a performance management model characterized by some degree of harmonization will call for provincial and federal leadership. As noted, there are recent historical precedents for this and the urgency has never been greater. There are also opportunities for forms of health system governance more able to facilitate the development and articulation of performance expectations and priorities, and to create clearer, evidence-informed relationships between strategy, targets, and improvement.

There is also a need for forms of governance capable of encouraging a mature conversation with Canadians and professionals about Canada's health sector and what will be required to transform it into a high performing population

health system. This conversation needs to engage multiple players – provider organizations as well as funders, policy makers, and managers. This will contribute to the emergence of a health democracy where patients and citizens have a meaningful voice in the governance of the health system. If ways to engage patients and citizens in decision making and system management are not consolidated, many positive experiments under way, such as the appointment of citizens or patient representatives on boards of governors of various institutions, and the engagement of patients in the co-design of clinical programs that benefit them such as Health Links in Ontario, will be wasted. It is important that these innovations be built upon and evaluated for further spread and scale across the health sector. Ongoing and better public reporting of health system performance measures aligned with the interests of citizens, patients, and families is obviously one important intervention towards democratizing healthcare and stimulating informed public discourse that should be strengthened.

CONCLUSION

Performance management as we have described it in this paper is very much focused on quality improvement and health system transformation. But in its insistence on transparency and its focus on results (particularly those valued by patients), it also renders systems more visible to the scrutiny of the citizens who pay for and use their services. What is more, the need to identify clear goals and objectives that will be used to identify what is to be measured calls for broader engagement of patients and of the general public in discussing performance expectations.

The visibility and accountability ushered in by the performance management model emerging in Canada is an important condition to the emergence of a health democracy that will enable a meaningful dialogue between the ultimate stakeholders of the healthcare system (Canadians and in particular patients) and their elected governors. But how to consolidate the so far timid gains of a fragile, yet emerging, health democracy remains a challenge that confronts us and keeps on calling for greater leadership, governance, investments in information systems, and research that support the consolidation of health systems capable of adaptation and improvement.

Appendix 1: Strengths and Weaknesses in Health System Performance in Canada

Quadrant: Health System Outputs

Dimension of Health System Performance	Canada Compared to Other Countries	Provincial and Territorial Variation Within Canada	Identified Indicator Development Priorities
Access to comprehensive, high-quality health services	**Have a regular doctor** 85 percent of all Canadians and 95 percent of Canadians over 55 have a regular doctor. These results are similar to higher performing countries in CMWF and OECD results. However, having a regular doctor does not imply access when needed, with only 22 percent of Canadians reporting they could get an appointment the same or next day. Rates for CMWF and OECD countries are much higher.	There is significant variation among provinces and territories in Canada, with many provinces having rates around 80 percent while others are well over 90 percent. Also, rates are extremely low (under 50 percent) in some sparsely populated regions of the country.	Wait times for community health and social services, in particular • mental health services for children and youth • social services to support health of individuals with multi-morbidities and complex needs • home care and long-term care Access to and use of palliative care and appropriate settings for end-of-life care
	Specialist wait times In the 2013 CMWF survey, 29 percent of Canadians reported waiting longer than two months for a visit with a specialist, compared to the next highest rate of 18 percent for Australia and France. Some countries had rates of less than 10 percent.	In the Statistics Canada 2013 survey, 23.8 percent of patients in the province with the highest rate reported waiting more than three months for a specialist visit, nearly double the 12.3 percent in the province with the lowest rate. However, due to small sample sizes in this survey, there are wide margins of error in the results.	
	Radiation treatment wait times No international comparisons available.	Performance is high across the board and there is little variation within Canada on this measure. With two exceptions, 95 percent of patients in the ten provinces began their radiation therapy treatment within four weeks. The two exceptions had rates of 88 percent and 90 percent. Wait times are not reported by the three Territorial governments.	
	Joint replacement wait times Median wait times in Canada for hip and knee replacement compare favourably with six peer OECD countries. Canada's median wait time for both procedures was 2nd only to the UK (CIHI 2015b).	There is variation across provinces in wait times for joint replacements. The percentage of patients receiving a hip or knee replacement within six months ranged from close to 90 percent in three provinces to results in the 60s for four others. One small province had a result of 48 percent.	

Dimension of Health System Performance	Canada Compared to Other Countries	Provincial and Territorial Variation Within Canada	Identified Indicator Development Priorities
Person-centred	**Potentially inappropriate use of anti-psychotics in long-term care** In an international comparison of results for five countries (Feng et al. 2009), Canada's rate of roughly 26 percent was similar to that of the U.S., and lower than the rates of 34 percent and 38 percent reported in Switzerland and Finland.	Of the eight provinces where some or all facilities report continuing care data, results varied, from highs of roughly 35 percent of long-term care residents on anti-psychotic drugs without a diagnosis of psychosis for two provinces to lows of 20–25 percent for two other provinces.	Patient and caregiver perspectives on continuity of care across sectors. This is also related to examining alignment of patients' treatment goals across various healthcare providers and organizations, particularly for individuals with multi-morbidities. Engagement of patients in managing their own health and healthcare.
	Repeat hospital stays for mental illness In the 2011 report, Canada's results were above the OECD average, but under the top 25 percent.	Results across provinces ranged from a high of 13.3 percent of mental health patients with at least three hospitalizations in a year to results under 10 percent. A small province and territory had rates under 10 percent, but these were not statistically significantly different from the national average.	
Appropriate and Effective	**Hospital deaths (HSMR)** International comparisons of HSMR are not appropriate without a standardized measure of expected hospital deaths. However, on two measures of in-hospital deaths (within thirty days following AMI and stroke), Canada's results are mixed. On in-hospital deaths following admission for AMI, Canada's result is in the top third of OECD countries; however, for deaths following admission for stroke, the result for Canada, at 9.7 percent, is below the OECD average of 8.5 percent.	The two best performing provinces had HSMR results in the low 80s. Three smaller provinces had results just above 100 (actual hospital deaths in 2013 greater than expected deaths based on 2009 results).	Medication reviews in community-based care, including flagging for inappropriate medications or combinations. Appropriateness of care settings, for example, patients cared for in hospitals who could be cared for in residential or home care settings, as well as inappropriate use of emergency departments for non-urgent problems.
		8.8 percent of hospital patients in Canada were readmitted within thirty days following discharge. There were two small jurisdictions with results close to 11 percent. However, all other results were less than 10 percent, with some provinces having results just over 8 percent.	
Safe	There is no high level measure of patient safety available in the core set of performance indicators reported yet.	There is no high level measure of patient safety available in the core set of performance indicators reported yet.	Measures of in-hospital infection and hospital harm to become part of pan-Canadian reporting on performance in 2015.

Dimension of Health System Performance	Canada Compared to Other Countries	Provincial and Territorial Variation Within Canada	Identified Indicator Development Priorities
Efficiently-delivered	**Age-adjusted public spending per person** In 2011, Canada's total health expenditure per person was 6th highest among thirty-four OECD countries. The proportion of spending from private sources, however, tends to be higher than many countries at close to over 30 percent. Of the countries with higher total levels of per-person spending, only the U.S. and Switzerland have a greater proportion of private spending.	Age-adjusted public spending per person varies significantly across jurisdictions in Canada. Spending is generally lower in larger provinces – Quebec is the lowest, at $3,360, followed by B.C. and Ontario, while all three territories have the highest per person spending, at close to or over $10,000.	Extra spending related to (in)appropriate care settings. This would include, for example, patients cared for in hospitals who could be cared for in residential or home care settings, as well as inappropriate use of emergency departments for non-urgent problems. Explore "waste" in healthcare – spending on inappropriate diagnostic and treatment interventions.
	Cost of a standard hospital stay	The average cost in Canada for a typical hospital stay is just over $5500. As with spending per person, costs of hospital stays tend to be lower in larger provinces, with Quebec and Ontario having the lowest costs at $4900 and $5300 respectively. A number of jurisdictions had average costs over $6000, including Alberta at $7300 and Saskatchewan at $6500.	

Quadrant: Health System Outcomes

Dimension of Health System Performance	Canada Compared to Other Countries	Provincial and Territorial Variation Within Canada	Identified Indicator Development Priorities
Improve health status of Canadians	**Life expectancy at birth** Canada's life expectancy at birth was close to the OECD 34-country average and was 17th highest. This is a significant drop from the 3rd highest in 1990 and 8th highest in 2000.	The three largest provinces have life expectancy above the Canadian average of 81 years, with B.C. having the highest rate at 81.7 years. There are three provinces with results below 80 years. The territories have life expectancy results in the mid to low 70s.	Mental health status of children and youth Patient-reported outcome measures including: • population-based functional health status • outcomes for specific interventions (e.g., joint replacement) Improvement in the health status of the elderly Overall health and well-being
	Avoidable deaths In a comparison of thirty-one OECD countries published in 2011 (OECD 2011), Canada ranked eleven of thirty-one countries on amenable mortality (avoidable due to treatment).	Canada's rate per 100,000 for avoidable mortality (includes avoidable due to treatment and prevention) was 171. In a pattern similar to that for life expectancy, the results for the territories were significantly higher at over 230. The best results were for B.C. and Ontario, at 158 and 163 per 100,000 respectively.	
Improve health system responsiveness			Measures of burden on informal caregivers from caring for relatives and friends. The burden of treatment and illness for patients.
Improve value for money			Costs for "bundles of care" that could be related to outcomes; for example, costs of joint replacements across all sectors of care related to long-term patient-reported outcomes and economic benefit.

Quadrant: Social Determinants of Health

Dimension of Health System Performance	Canada Compared to Other Countries	Provincial and Territorial Variation Within Canada	Identified Indicator Development Priorities
Structural factors influencing health			Measures of structural and contextual factors to better understand the impact on the health system and on population health. Expansion of capacity to disaggregate health status outcomes to focus on results for marginalized and vulnerable population groups (e.g., aboriginal peoples, refugees, people with disabilities). Summary measure of the impact of income inequality on health status.
Biological, material, psychosocial and behavioural factors	**Smoking** Canada had the 8th lowest rate of smoking among 34 OECD countries at 15.7 percent of adults compared to the OECD average of 20.9 percent..	The provincial rates of smoking among adults varied from highs of over 20 percent in a number of provinces to the lowest rate of 16.2 percent in B.C.	
	Obesity Canada had the 5th highest rate of obesity among the 34 OECD countries, with a measured rate of 25.4 percent compared to the OECD average of 17.6 percent. While Canada's rate was lower than the measured rates of four other countries, it was still higher than the measured rates in many other countries, including the U.K.	The average rate of obesity in Canada based on self-reported height and weight was 18.8 percent. There is significant spread among provinces and territories, with six provinces and territories having rates of 25 percent or over, including some that were nearly 30 percent. The lowest provincial rate was almost half this, at 15 percent.	
	Children vulnerable in areas of early development	Just over 1 in 4 children at age 5 were identified as being vulnerable in one or more areas of early development. For the 8 provinces and territories with reported results, the rates ranged from over 30 percent for 4 of these to a low of 17.2 percent with other results in the low 20 percent range.	

Source: Unless otherwise noted, all results referenced from one or more of: Your Health System In Brief (http://www.yourhealthsystem.cihi.ca) (with various sources), OECD Health at a Glance Publications, or the 2014 Commonwealth Fund results.

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Harnessing Patients' Voices for Improving the Healthcare System

WHITE PAPER - WORKING DRAFT

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Patients define the care that meets their needs. What they report from their experiences tells the system about the quality of healthcare delivery. In considering the transformative role of evaluation, also referred to as performance measurement and reporting, this white paper explores the incorporation of patients' voices in contributing to health reforms, specifically in the area of primary healthcare.

INTRODUCTION

Strong community-based primary healthcare (PHC) leads to a more equitable system of care with better population health outcomes at reduced cost (Martin-Misener et al. 2012; Starfield 1998; WHO 2008a; WHO 2008b). We use the term PHC[1] to represent the various community- based first-contact healthcare models that deliver general medical services, as well as those incorporating health promotion and community development to address the social determinants of health. Over the last decade, in response to various commissions (Clair 2000; Fyke 2001; Mazankowski 2001), and reports of poor PHC performance (Blendon et al. 2001; Schoen et al. 2000; Schoen et al. 2004; Schoen et al. 2005; The Commonwealth Fund 2011), Canada has seen extensive reforms and investments in PHC totaling over $1 billion (Aggarwal and Hutchison 2012). This has unleashed a myriad of innovations, only some of which have been evaluated.

In 2000, Canada's first ministers produced the Action Plan for Health System Renewal, which identified the need to monitor the impact and effectiveness of PHC investments. They promised regular, comprehensive, public reporting to Canadians using agreed upon indicators of health status, outcomes, and service quality. Yet the Canadian Institute of Health Information's (CIHI) review of ten years of healthcare system performance reporting describes PHC as a black box (CIHI 2009b). The Conference Board of Canada (2008) has found little credible PHC performance data. A more recently tabled report by Drummond (2012) stated that Ontario health professionals face unclear objectives and weak accountability. There are ongoing calls for better transparency and reporting on these renewal initiatives (Drummond 2012; Cohen, McGregor, Ivanova, and Kinkaid 2012). After extensive consultation with many stakeholders, the Canadian Working Group for Primary Healthcare Improvement published a PHC Strategy for Canada (Aggarwal and Hutchison 2012), which, citing research linking performance measurement to high-performing systems, recommended such practices as a strategic priority.

Performance Measurement and Primary Healthcare

Performance measurement provides information on the quality of care to relevant stakeholders (e.g., clinicians, policy makers, patients) for accountability and quality improvement in healthcare (Adair et al. 2006a; Adair et al. 2006b; Smith, Mossialos, Papanicolas, and Leatherman 2009). Performance measurement is one mechanism to evaluate the extent to which health systems meet their objectives (Institute of Medicine 2006). Information about performance can be used in many ways including public reporting, pay for

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1. As per the Alma Ata Declaration (WHO 1978), primary health care is: "…essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. Primary health care has been used to describe both a philosophical approach to care delivery and differentiate the types of health services delivered. It can encompass various social institutions, different sets of scientific and professional disciplines and technologies, and different forms of practice" (WHO 2008a).

performance programs, accreditation/benchmarking, or for internal use within healthcare organizations (quality improvement) (Panzer et al. 2013, Stange et al. 2014). Importantly, the provision of timely, high quality, relevant performance information is central to a continuous learning health system (Etheredge 2014; Smith, Mossialos, Papanicolas, and Leatherman 2009). Over the last twenty years, there has been growing experience with and recognition of the benefits of health performance measurement and reporting (Chassin, Loeb, Schmaltz, and Wacther 2010; Larsson et al. 2012; McGlynn 2003; Okun et al. 2013; Powell et al. 2014; Sinha et al. 2013; Stelfox and Straus 2013), including consumer/patient awareness and improved quality of care (Boivin et al. 2014; Powell et al. 2014).

Performance in PHC refers to the extent to which this sector meets its objectives. Though patients, clinicians, and decision makers have multiple (at times competing) objectives for PHC, most agree that we need responsive first-contact care for emerging problems, capacity to resolve common health problems, ongoing care for most chronic conditions, routine delivery of preventive and health promotion services, timely coordination with other actors concerning specific diseases, and action on social determinants of health (Haggerty and Martin 2005; Kringos et al. 2010). Moreover, Canadians expect an ongoing relationship with a trusted clinician or team, respectful treatment, and empowerment to achieve their health goals (Wensing et al. 2011; Wong, Peterson, and Black 2011). Despite some efforts (see below), no single data source can capture or represent PHC performance in Canada.

In addition to improving the health of populations, an important goal of PHC is achieving healthcare equity: care that is delivered in response to a health need, without systematic variations related to the social, economic, demographic, or geographic characteristics of groups (Browne et al. 2012). Delivery of healthcare that is equitable, particularly through the PHC sector and especially to groups who are made vulnerable due to multiple intersecting determinants of health, can reduce health inequities. Thus, PHC performance for complex vulnerable patients is itself a test of health system performance. Our experience suggests that, far from being a small minority, 20 to 25 percent of patients in the waiting room could be considered complex vulnerable.

What is Already Known

Reporting is the immediate goal of performance measurement. In a democracy, transparency and public accountability are goals that have inherent worth, and there are growing demands for performance reporting in PHC from many stakeholders, including patients (Berta, Barnsley, Brown, and Murray 2008; Shortell and Casalino 2008). However, PHC performance reporting is challenging because of the dearth of concise and synthesized information, and because many clinicians prefer to be accountable only for their individual role and do not view themselves as elements within a larger system (Veillard et al. 2010). Despite uncertainty about how best to report PHC performance

results (Gardner, Sibthrope, and Longstaff 2008; Health Council of Canada 2012; Marshall, Shekelle, Letterman, and Brook 2000; Powell, Davies, and Thomson 2003), regional case studies of performance reporting (Smith, Wright, Queram, and Lamb 2012; Young 2012), and evidence from the hospital sector (Tu et al. 2009) indicate these results can influence quality improvement agendas and improve performance. Past work shows that public performance reporting may improve performance (Faber et al. 2009; Hibbard et al. 2012; Smith, Wright, Queram, and Lamb 2012; The Commonwealth Fund 2011; Watson 2009), as it has the potential to "improve the quality of care, increase accountability, facilitate public participation in health care" (Ellins and McIver 2009; Powell, Davies, and Thomson 2003, 62), impact societal and professional values, and direct attention to issues not currently on the policy agenda (Oxman, Lavis, Lewin, and Fretheim 2009; Oxman, Lewin, Lavis, and Fretheim 2009). It may also facilitate collaboration among stakeholders as they set a common agenda (van Walraven et al. 2010). While performance reporting in the hospital sector grows, performance reporting in PHC lags behind.

There are examples of national public reporting of PHC performance in other countries, but public reporting is limited in Canada. International examples include recent work from the National Health Performance Authority in Australia (NHPA 2014; NHPA 2015), NAMCS in the U.S. (CDC 2015), and the Quality and Outcomes Framework in the United Kingdom (HSCIC 2014; Roland 2004). There has been some provincial PHC reporting by provincial health quality councils (Health Quality Council; Health Quality Ontario; BC Patient Safety and Quality Council). The only significant national effort in Canada was the joint CIHI/Health Council of Canada report of a 2008 population survey (CIHI 2009a). The most commonly referenced performance information about PHC in Canada is from The Commonwealth Fund's patient and clinician surveys in industrialized nations (Blendon et al. 2001; Blendon et al. 2003; Schoen et al. 2000; Schoen et al. 2004; Schoen et al. 2005; The Commonwealth Fund 2011). The surveys are based on samples of one thousand patients or clinicians per country in independent surveys, and show that PHC performance in Canada is poor compared to other countries. These disappointing results have helped put PHC on Canada's policy radar. Yet, The Commonwealth Fund surveys have limitations. Notably, the small sample size does not permit meaningful analysis at the regional level, where policy decisions are often made. Currently, the data existing in Canada that would enable a better understanding of which regional features of PHC can be improved upon are nascent, with most lacking the view of patients or those who do not or cannot access PHC.

Beyond surveys, most analyses that help us understand PHC performance depend on using provincial administrative data. Yet, performance measures based only on administrative data cannot address core PHC dimensions such as health promotion, interaction with social sectors, or interpersonal care. Not only is the PHC portrait of performance incomplete, there is no national level information since each system is provincially based and produces different data. For instance, administrative data usually includes only activity for physicians and

omits contributions of PHC team members. As increasing numbers of physicians are paid by salary or capitation, the quality of data are reduced.

PHC is very complex, managing as many as 450 conditions, including chronic conditions and complex care needs. So examining PHC performance requires an information system linking contextual, organizational, clinician, and patient level data to administrative and clinical data. Beyond assessing the variation within and across jurisdictions in PHC performance, a measurement system has the additional dividend of making it possible to identify innovations and combinations of innovations that are associated with better PHC performance and healthcare equity through secondary analysis of the data. We must assess and report on these variations so decision makers can respond to regional performance gaps and select which investments to maintain, expand, or discard.

THE ROLE OF PATIENT VOICES

Increasingly, patient voices[2] are recognized as a necessary part of measuring and monitoring PHC performance. Patients can offer valuable contributions toward the improvement of their own care as well as that of their loved ones. Over twenty years ago, Donabedian (1992) and others pointed out that patients could be definers of good quality, evaluators of healthcare delivery, and reporters of their experiences (Hadorn 1991; Wensing et al. 1998). As participants in healthcare delivery, they can also influence the quality of care in more direct ways, such as through involvement in decisions concerning medical and other healthcare treatment. Using patients' perspectives for assessing the quality of care focuses on aspects of service delivery that are important for consumers (Hadorn 1991; Wensing et al. 1998). Ongoing, routine feedback to PHC providers using self-report surveys can lead to practice improvements and internal quality control (Cleary and Edgman-Levitan 1997).

Decades of work have shown that actively engaging patients in their own care increases their adherence to a recommended treatment and better understanding of their condition. Thus, it is more likely that they can achieve a better quality of life and satisfaction with PHC (Davis, Schoenbaum, and Audet 2005). Outcomes include adherence to medical advice (Bartlett 2002; Brown 2001; Golin, DiMatteo, and Gelberg 1996), fewer complaints (Taylor, Wolfe, and Cameron 2002), fewer grievances (Halperin 2000), and reductions in the level and seriousness of malpractice claims (Hickson, Clayton, Githens, and Sloan 1992; Hickson et al. 2002), and actual improved functional health outcomes (Cleary and Edgman-Levitan 1997; Covinsky et al. 1998; Houdsen, Wong, and Dawes 2013; Maly, Bourque, and Engelhardt 1999).

2. An overarching term that includes individuals with personal experience of a health issue and informal caregivers, including family and friends (see Abelson 2015).

Significance of Patients' Voices

Capturing patients' experiences is important to two of the three basic elements of accountability (Denis 2014), providing some clear definitions of the desired goals of PHC and the ability to measure and monitor goal achievement. Moreover, a democratic accountability goal is based on the principle that those who are affected by the PHC sector (as well as the whole healthcare system) have a right to contribute to determining what publicly funded PHC services are delivered and how they are delivered (Abelson 2015). Abelson's (2015) recent work also points out that engaging patients in providing feedback on PHC naturally leads to a second goal which is developmental. When patients engage with other PHC stakeholders (e.g., policy makers, organizations, their regular place of care), public understanding of the PHC system increases, as well as strengthens their ability to make decisions for themselves and their families.

Taking patient experiences in PHC seriously for the purposes of performance measurement and reporting enables a diversity of perspectives to inform the delivery and organization of health services. Their lived experience of accessing and using (or not using) PHC, as well as living with an ill-health episode, or one or more chronic conditions, positions patients well to contribute to making the PHC and other parts of the system more effective and efficient.

Patients' Views of The Desired Goals of PHC

A valid system of quality assessment is essential for effective functioning of the PHC sector. Yet, the majority of indicators used in PHC for performance measurement and reporting are about the technical quality of care. That is, most evidence- and consensus-based quality indicators (Barnsley et al. 2005; Healthcare Commission 2006; Kerr, Asch, Hamilton, and McGlynn 2000; Performance Measurement Coordinating Council 1999) that are relevant to PHC include only some of the dimensions of PHC most important to patients. The measurement of many indicators relies on proxy measures found in administrative data (Langton et al. nd.).

An emerging body of research attempts to learn more directly from patients using PHC to find out what healthcare quality means to them (Coulter 2005; Gerteis, Edgman-Levitan, Daley, and Delbanco 1993; Ngo-Metzer et al. 2003). These studies report patient-defined desired goals in terms of the quality of PHC in six dimensions:

- Patient-centred/Whole Person Care: patients would like to have their physical and emotional needs met. They would like to receive individualized care; have providers who have personalized knowledge of the whole person and who respect and know about their health beliefs, including alternative health practice beliefs; and be able to involve family and friends, if requested.

- Access: patients are concerned about accessibility of services. They would like to have convenient places and times for visits; spend enough time with the provider; and receive assistance in navigating the health system.
- Interpersonal Processes: patients are interested in quality of communication, shared decision making, and interpersonal style of staff and providers. This includes open communication and information flow; prompt communication of test results; involvement in decision making, if appropriate; elicitation of concerns; interpersonal style of the staff and providers, such as listening, explaining medical information in lay terms, and showing respect.
- Continuity: patients define three types of continuity: relational – the ongoing therapeutic relationship between a consumer and provider; informational – the use of information on past events and personal circumstances to make care appropriate; and management – a consistent and coherent approach to the management of a health condition.
- Technical Effectiveness: patients, for the most part, assume their provider is technically competent. They expect PHC to provide effective treatments, accurate diagnoses, and diligent and efficient services.
- Efficiency of Care: patients expect efficient care with the appropriate type of provider, depending on the health issue, and coordination between the individuals and organizations involved in their care. They also expect accurate billing, efficient referral and prescription refill processes, short wait times for appointments, co-location of ancillary services, such as lab and pharmacy services, and increased personal ability to manage their own illness episodes.

Capturing Patients' Experiences

There are multiple ways to capture patients' experiences with their care. Determining which depends on the goal at hand. Within performance measurement, qualitative data (e.g., patient stories of their experiences, deliberative consultations) can be used to identify areas that matter to patients. In the example below, one can determine that measuring transitions in care and coordination between healthcare providers is important. Qualitatively capturing whether care coordination is being achieved can tell us whether the current approach is working and provide information to guide development of performance indicators within this dimension.

Take for example a family member's account of a recent healthcare experience:

"Mr. P, a 75 year old male with a diagnosis of dementia, was seen in the ER because he had fallen. He was admitted and medicated because he started having seizures. While in the hospital #1, he was catheterized because there was some discussion amongst the providers about his prostate and whether he would be a candidate for surgery. Due to his dementia, he kept pulling the catheter out, trying to get up to go to the bathroom. A referral was made for Mr. P to see the urologist. During his hospitalization, the urologist did not see him. Mr. P remained catheterized and was subsequently discharged to a "short term" stay program at a different hospital #2.

After 2 weeks in his placement at the hospital #2, his wife was called letting her know that Mr. P would need to discharged home next week. Mrs. P states that her husband cannot come home because she is unable to care for him alone given his dementia with the added inability to walk and catheter still in situ. Mrs. P asks for the hospital to arrange some home support as she has no idea how to assist him with walking or do catheter care. The hospital calls a few days later and declares they are discharging Mr. P but has not home supports in place. Mrs. P calls her daughter as she is unable to advocate for herself or her husband.

The daughter calls the hospital #2 and strongly states that Mr. P cannot be discharged home. After several phone calls between the daughter and the hospital, Mr. P is being discharged to a residential care home. One day of being in the residential care home and Mr. P's catheter bag is filled with blood; the staff at the care home were having difficulty with the catheter.

Mr. P is transported back to hospital #1. A referral to the urologist is made again. His daughter witnessed this referral being made. The urologist stated he had received the referral but would follow up with Mr. P via outpatient (and not in the ER).

Mr. P was discharged from the ER with his catheter still in-situ to the residential care facility. He spent a total of 2.5 months in between hospital #1 and #2. He is still waiting to be seen by an urologist."

Prior to entering the ER, Mr. P was an avid walker and biker. Now he is in a residential care home, unable to walk without help, and has a urinary catheter. His daughter has had to take time off work and his wife's functional and mental health are declining because of the whole string of events. There is no single provider or place that is most responsible or accountable for Mr. P's care. Mr. P's decline in health means he cannot advocate for himself, and his family is unable to successfully navigate the healthcare system.

As illustrated in the example above, care remains fragmented to the extent that primary care providers may not know their patients are hospitalized, and

when patients are discharged from the hospital they (or their families) are left to navigate the system, which could include "sectors" of healthcare that have no incentive or motivation to coordinate with each other. This is especially problematic for those who are unable to advocate for themselves and who may or may not have family in close proximity to assist.

Another way to capture patient experiences is by using deliberation methods. Performance measurement in primary care benefits from patients being involved in deliberating on and prioritizing healthcare decisions affecting the population. In some recent work, Boivin and colleagues (2014) conducted the first randomized controlled trial assessing the impact of patient involvement on primary healthcare improvement priorities at the community level. Their results showed that patient priorities of quality indicators were more aligned with core components of the Medical Home and Chronic Care Model. This includes access to primary care, self-care support, patient participation in clinical decisions, and partnership with community organizations. Priorities established by professionals alone placed a greater emphasis on the technical quality of single disease management indicators. Patient involvement fostered mutual influence between patients and professionals, which resulted in a 41 percent increase in agreement on common priorities of quality indicators.

The most common approach to capturing patient experiences is through the use of self-report surveys. While patient surveys have been part of measuring and monitoring the quality of the acute care healthcare system for many decades, incorporation of self-report surveys in primary healthcare is more recent (Totten et al. 2012). Indeed there is international interest in the use of patient reported outcome measures (PROMs) to monitor the effectiveness of healthcare services and interventions. Regulatory agencies, including the U.S. Food and Drug Administration and the United Kingdom's National Health Service, now require the use of PROMs (Devlin and Appleby 2010) and patient reported experience measures (PREMs). The recognition of patient reported outcomes, in particular, is not new. According to Devlin and Appleby (2010), "outcomes, by and large, remain the ultimate validators of the effectiveness and quality of medical care" (169). This interest in incorporating PROMS or patient experiences is driven by the fact that, in most situations, individuals, or those who can advocate for individuals, are the best judges of their own health and well-being (Bryan et al. 2014). Moreover, incorporating patient reported data fills a gap where more common data such as mortality and hospitalization fail to capture many important aspects of their lives (Bryan et al. 2014; Bryan, McGrail, and Davis 2012; McGrail, Bryan, and Davis, 2012).

There are examples of surveying patients at a national level to inform PHC performance reporting in other countries. However, there are only limited efforts in Canada, as mentioned in the previous section. The most commonly referenced performance information about PHC in Canada is from The Commonwealth Fund patient and clinician surveys in industrialized nations. In more recent years, the Canadian Institute for Health Information and provincial organizations interested in performance measurement have worked with The Commonwealth Fund to obtain a sample large enough to report at the provincial level (CIHI 2014).

MOVING PERFORMANCE MEASUREMENT AND REPORTING FORWARD IN PRIMARY CARE

Patients can be agents of change in the area of performance measurement and reporting by sharing their experiences through qualitative (e.g., stories, deliberative methods) and quantitative (e.g., surveys) methods that are used to collect information in a rigorous and systematic way. Patients can also allow and advocate for linked clinical and administrative data generated about them to be used in rigorous research that will inform health services research.

An example of clinical data that could be linked to administrative data in primary care comes from the Canadian Primary Care Sentinel Surveillance Network (CPCSSN). The CPCSSN is a pan-Canadian network of networks where clinical data are extracted from about ten different electronic medical record systems. These data are anonymous clinical and utilization data of a national sample of patients who have a family physician. Currently, CPCSSN provides standard feedback reports every three months to its over 500 hundred sentinels, representing almost one million patients across Canada. The CPCSSN aims to generate and use knowledge to improve the quality of care for Canadians suffering from chronic conditions such as hypertension, osteoarthritis, diabetes, depression, and Parkinson's disease. The CPCSSN has completed a pan-Canadian data validation as well as several manuscripts that outline the extent to which these chronic conditions are seen in primary care (Godwin et al. 2015; Williamson et al. 2014; Wong et al. 2014). Linking of clinical and administrative data has recently taken place in Ontario with two of CPCSSN's networks. Studies using these linked data have the potential to inform health service delivery across primary and tertiary care.

Role of Stakeholders

The role of PHC stakeholders is to ensure information that is best reported by patients is incorporated into decision-making processes. Information from patients is likely to be best incorporated at the coalface between patients and their regular providers. Aggregated information from patients has been most challenging to incorporate at a practice, or higher, level, where decisions about allocation of funding and other resources take place (e.g., division of family practice in British Columbia, health authority).

Developing and maintaining a pan-Canadian PHC information system that includes patients' reports of their experiences and outcomes, and their clinical and administrative as well as other relevant data (e.g., provider and organizational information), would provide a valuable asset for Canada. This system could be used to inform the work of individual providers with a practice panel, whereby patients are assigned to a physician/nurse practitioner within a practice, but may be treated at any given time by any of a number of healthcare practitioners. A robust information system could produce information to be used for targeting health promotion, communicable disease prevention, chronic disease management, and even end-of-life care.

Worldwide, there is an interest in improving the science of comparative health system reporting (Smith, Mossialos, Papanicolas, and Leatherman 2009; Smith and Papanicolas 2012). One of the twelve Community Based Primary Health Care innovation teams funded by the Canadian Institute for Health Research provides an example of researchers, decision makers, clinicians, and patients working together to create a comprehensive performance portrait. They are using data from the most appropriate sources (e.g., administrative, provider, organizational, and patient surveys) to measure and report on dimensions of primary healthcare, and these dimensions are driven by what is most important to stakeholders, instead of simply relying on easily available data or expert opinion (Wong et al. 2013). This kind of work could help to make Canada a leader in evaluating the effectiveness of PHC innovations. The goal of this program of research is to demonstrate the feasibility and usefulness of comparative and comprehensive PHC performance measurement and reporting in regions, as a foundation to inform innovation in the delivery and organization of the Canadian PHC system. As health service researchers, clinicians, and stewards (e.g., health authorities, decision makers) of the healthcare system, our role is to ensure we have information on patient experiences and, importantly, outcomes, and that we investigate what systems or structures produce performance.

Acknowledgement and Reconciliation Between Paradigms

It has been argued that there is a need to reconcile competing paradigms (Lavoie, Boulton, and Dwyer 2010; Tenbensel, Dwyer, and Lavoie 2014). Within the PHC paradigm, the international community has highlighted key characteristics that must be met in order for PHC to be effective, especially when serving vulnerable populations:

- Services must focus on and be responsive to existing and emerging health needs;
- Providers must establish trust based and enduring personal relationships;
- Services must be comprehensive, continuous and provide person-centred care;

- PHC services must be responsible for the health of all in the community;
- PHC services must take responsibility for tackling determinants of ill-health, and be prepared to act as advocates; and
- PHC providers must consider that the community and individuals seeking care are partners in managing their own health and that of their community (World Health Organization 2008a).

Indeed, the "patient-centred" approach, which emerged in the late 1960s, is a foundational piece in today's movement of the medical or primary care home. Mead and Bower's (2000; 2002) reviews of the literature identified the following key criteria for a patient-centred clinical encounter: 1) exploring both the disease and the illness experience (biopsychosocial perspective); 2) understanding the whole person (patient-as-person); 3) finding common ground regarding management (sharing power and responsibility); 4) incorporating prevention and health promotion (the therapeutic alliance); and 5) enhancing the doctor-patient relationship (the doctor-as-person) (2000,1087–88). Within this framework, providers are called upon to understand the social and family context, culture, and history of their patients. Providers and patients are expected to interact in ways that are non-biased, demonstrating understanding and acceptance of the other's potentially diverse background (Barlow and Reading 2008).

On the other hand, the New Public Management (NPM) paradigm focuses attention on competition among providers. PHC is reduced to a collection of programs and services that can be tendered separately to different providers (Lavoie, Boulton, and Dwyer 2010). Within the NPM, there is a conceptualization of health services users as "consumers" that navigate between interchangeable health providers that at times is contrary to PHC objectives, which emphasize the importance of long-term trust-based relationships between services users and providers, and a determinants of health focus.

Internationally, contractual relationships have been influenced by the emergence of the New Public Management (NPM) paradigm in the 1970s, and its language of "empowering consumers," which translated into the contracting out of public services, the promotion of competition between providers with the stated intent to increase consumer choices, and an increased emphasis on private (often for-profit) investments in capital and financial incentivization (Diefenbach 2009; Dunleavy, Margretts, Bastow, and Tinkler 2005). While in Canada, the NPM did not result in a wholesale contracting out of health services as seen in New Zealand or the UK (Petsoulas et al. 2011), but it was nevertheless discussed extensively within the federal public service, namely by the Auditor General of Canada, the Office of the Comptroller General, the Treasury Board Secretariat, and all offices with a regulatory mandate over public administration (Aucoin 1995; Savoie 1994).

An awareness of the PHC and NPM paradigms by stakeholders is needed. Careful attention to the purpose for which we use data collected on patient experiences and other performance measures is necessary. Measures in isolation of context that are used to evaluate performance for accountability purposes promote isolation rather than helpful conversation (Jordan et al. 2009). Organizations, groups, and cultures that use metrics to foster reflection, experimentation, and assessment help providers advance knowledge, not just deliver knowledge that was advanced elsewhere (Saba et al. 2012). As Stange et al. (2014) point out, these settings focus on effectiveness, not just efficiencies, emphasizing long-term goals over short-term productivity. These kinds of settings attempt to successfully navigate between the two paradigms, trying to find a balance between achieving the goals of PHC and the realities of contractual relationships.

CONCLUSION

In summary, patient voices are important in examining where we can improve primary healthcare in order to better meet patient needs. Their voices can be harnessed using a variety of different approaches, ranging from having patients tell their healthcare experience stories, to having them fill out surveys and provide self-reporting information, to getting their consent to link their clinical and other data that is already being collected. The role of stakeholders is to incorporate patient experience data into an information system that can provide the data for a performance measurement and reporting environment that is meant to stimulate and evaluate innovations in care delivery. Stakeholders need to be aware of two overarching paradigms, PHC and New Public Management, in determining the purpose for which performance measures are used. Focusing on using measures to improve quality and effectiveness of care over efficiency will enable organizations to meet long-term goals.

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Harnessing Patient Engagement for Healthcare System Change

WHITE PAPER - WORKING DRAFT

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In this white paper, we address the ways that patients attempt to influence healthcare system change through individual and collective advocacy, and consider how healthcare organizations can harness that patient involvement to create systems and structures that genuinely place the patient at the centre of care. We examine individual level advocacy by first exploring some of the current, existing tensions between a previously physician-centred care system and the newer approach of patient-centred care, and then drawing on perspectives of individual complaining behaviour and (dis)satisfaction from the marketing literature to understand how, within a patient-centred healthcare context, health organizations can benefit by effectively tending to this dynamic. Having established these individual level dynamics, we then investigate the broader socio-political collective dynamics that facilitate this patient-centred trend. Last, we present a case study of a mid-sized healthcare organization that has effectively tended to both individual and collective level issues in order to arrive at lessons learned.

UNDERSTANDING PATIENT-DRIVEN ADVOCACY

Patient-centred care has rapidly become the new paradigm within healthcare organizations. The concept pervades practical discussions about quality and efficiency of care and the organizational structure necessary to enact such a patient focus, as well as more philosophical deliberations about the roles of and relationships between patients and doctors. From a definitional perspective, patient-centred care seems simple enough: it is care that is centred around the patient, a model in which healthcare providers partner with patients and families to identify and satisfy the full range of patient needs and preferences (Planetree and Picker Institute 2008). A broader perspective argues that the originators of the concept were driven primarily by moral arguments based on a deep respect for patients as "unique living beings, and the obligation to care

for them on their own terms; thus patients are known as persons in context of their own social worlds, listened to, informed, respected and involved in their care – and their wishes are honored…during their health care journey" (Epstein and Street 2011).

Accompanying this rise of patient-centred medicine, with its goals of improved quality, safety, and efficiency, as well as an expanded role for the patient in the equation of healthcare delivery, has been a concurrent transformation of the individual, who was previously simply a member of society, into a "consumer" – of commercial products, of public goods and services, and also of healthcare. As identified by Bardes in an editorial in the *New England Journal of Medicine* (2012, 782–83), "if the patient is reconceived as a consumer, new priorities take center stage: customer satisfaction, comparison shopping, broad ranges of alternatives, choice, and unimpeded access to goods and services." While perhaps overly simplistic in his description of the priorities of a patient in a healthcare "service" encounter, Bardes is nonetheless correct when he identifies that this shift towards "patient as consumer" sets up a conflict between "a Ptolemaic universe revolving around the physician [against] a Copernican galaxy revolving around the patient" (2012, 782–83), and that the favouring of one party over another fails to recognize the need for an ongoing, functional, and trust-based relationship between the two in order to achieve both patient goals as well as broader societal health goals.

And yet, this conflict between the desire of physicians to dispense treatment in the way that they feel is superior versus the happiness (or lack thereof) of the patient with that treatment is not new. What is new is the increasing visibility of patients who feel the need to express displeasure at (real or perceived) substandard care, at the same time as there has been an explosion in the media that shares that sentiment, ranging from within small social groups to a broader, sometimes global, scale. In order for organizations to cope with and manage this feedback, it is important to understand what we have learned from years of studying both consumers and organizations about how and why individuals

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behave the way they do when they are unhappy with the provision of a service, and the implications of those behaviours for the service-providing organization.

In this white paper we identify and examine the various ways that patients express displeasure, both informally and formally, with the healthcare they receive and the providers they encounter on their healthcare journey. We also examine the dynamic created when this patient voice becomes amplified by the use of social media, which has the effect of drawing in a broader range of stakeholders as patients express their healthcare experiences. Finally, we present a case study in which a healthcare organization has undertaken the challenge of developing true patient-centred care, and look at how patient concerns have been structurally integrated into the organization to improve the patient experience.

INDIVIDUAL LEVEL PATIENT-DRIVEN ADVOCACY

Patient Complaining

We first examine individual level patient-driven advocacy by discussing what we know from the marketing literature about patient complaining and dissatisfaction. In marketing, we have always known that consumers complain when they are unhappy and, in fact, that complaining is an important part of social life. Complaining can be broadly defined as "a behavioral expression of dissatisfaction" (McGraw, Warren, and Khan 2015), and in the context of marketing has typically either been expressed as direct communication of that dissatisfaction to the service provider via in-person complaints, calls or letters, or word-of-mouth conversations with friends and family. Over the years, however, the reach of negative experiences and dissatisfaction has expanded, whether through traditional media interested in airing (and sometimes obtaining redress for) major service failures, or through digital forms like social media and websites where consumers (including patients) can expound at length about their dissatisfying encounter with a service provider. Depending on the forum, these complaints can be directed at a small number of people an individual knows personally, or at a wider range of individuals they may want to "warn" about their interactions with a service provider, through to a disclosure of appalling treatment that receives national or international attention and widespread media coverage.

A variety of reasons or purposes for such complaining behaviours emerged in a recent review of consumer complaining behaviour (McGraw, Warren, and Khan 2015). People may complain to simply make small talk or to vent frustrations, which can help reduce the detrimental emotional effects of coping with negative thoughts and feelings as a result of a product failure or negative service encounter. People also complain in order to influence the perception and behaviour of others, either for their own or others' benefit. Complainers may want to warn people about a negative experience so that they may avoid a similar fate, they may want to obtain redress, which could range from a simple apology to something more material such as a refund, or they may simply want to receive sympathy and/or moral support. Complaining, however, is not always beneficial for the complainer and can have unintended consequences. People who complain frequently or about what others perceive as "trivial" matters are frequently viewed negatively – as grumpy, argumentative, or boring. Other times, people believe that complaining will not have the effect that they are hoping for, or they do not have time to seek redress. Due to these costs of complaining, people sometimes do not complain even when they are greatly dissatisfied (McGraw, Warren, and Khan 2015).

Patient Complaining in a Healthcare Environment

It is important to recognize, however, that much of our understanding about consumer complaining, as described above, comes out of a context that is not at all similar to that experienced by patients in a healthcare environment. First, a commercial context is frequently characterized by competition – if consumers are unhappy, they will first complain, and if that complaint is not addressed then they will take their business elsewhere. As a result, organizations are primarily motivated out of self-interest, as they must make consumers happy or risk financial loss. In healthcare, however, particularly in Canada, it is rare for patients to have the flexibility of being able to choose healthcare providers. In many cases, patients are aware that they are lucky to have a primary healthcare provider who will see them on a somewhat timely basis and provide regular care; switching to another provider is often difficult, if not nearly impossible, and this has been made more so with governmental systems (e.g., in Ontario) that require patients to un-enroll from one provider before being able to switch to another. For patients who have ongoing health issues that may need regular or emergency care, the risk of having a period of time without a regular provider is often too great to bear, and thus patients are essentially forced to stay with a provider regardless of their level of satisfaction.

Secondly, while occasionally expensive and certainly frustrating, the vast majority of marketplace transactions that stimulate complaining behaviour are not critical to consumers' immediate or long-term emotional and physical well-being. The same cannot be said for a healthcare environment, in which many patients only engage in interactions with their healthcare provider when they are unwell. That provider is, at least in some sense, what stands between a patient continuing to feel unwell or being provided with some immediate relief (or hope for some future relief as a result of further testing and consultation with a specialist) from the discomfort they are experiencing. As a result, it is reasonable to assert that a patient may feel that they have to maintain a positive relationship with that provider at all costs, regardless of their desire to complain

about their treatment. In this way, the costs of complaining about some aspect of treatment may be very salient to the patient, and extreme dissatisfaction may need to occur before the patient is willing to risk a deterioration in the physician-patient relationship by expressing dissatisfaction with some aspect of care. They may fear being labeled a "difficult patient," and having their future healthcare concerns affected as a result. Since the physician acts as a gatekeeper to specialists and advanced forms of testing that the patient would not otherwise be able to access, these are not unreasonable concerns. The author of an essay on the impact of doctor disillusionment with our current medical system recounts hearing countless stories of patients in pain who worry that asking for more pain medication "will be construed as entitled meddling" (O'Rourke 2014). It is therefore not altogether surprising that, if a patient is dissatisfied with some element of their care and feels like they are unable to secure redress from the provider themselves, they will want to vent that frustration to other people, either face-to-face or via social or traditional media, as a way of coping with the negative thoughts and feelings that McGraw, Warren, and Khan (2015) have identified as one of the causes of complaining behaviour. Depending on the severity of the perception of mistreatment, such negative feelings may range from simple frustration and disappointment to anger, humiliation, worthlessness, and even abandonment, and have deep and lasting psychological effects (Boodman 2015).

But this increased likelihood that an unhappy patient will engage in indirect rather than direct complaining is ultimately a bad thing for the provider, as it fails to allow providers to address problems as they occur and instead forces them to be reactive when those problems get a broader airing. At that point, an organization is more likely to be engaging in crisis management, rather than working to actually address the original issue, and very often the focus on the patient is lost in favour of managing impressions among a larger community of stakeholders. It is due in no small part to the hope of becoming proactive rather than reactive to patient complaints that more and more healthcare organizations are attempting to measure patient satisfaction, through tools such as the Patient Experience Survey being developed by Health Quality Ontario to assist primary care providers in assessing potential problems within their practices. In the United States, Medicare has taken the lead in requiring hospitals to collect information about patient satisfaction, with the federal government and some private insurers considering these survey results when setting reimbursement levels for hospitals (Boodman 2015). It is to the topic of patient satisfaction and how it relates to patient experience that we next turn.

Patient Satisfaction and Patient Experience

In marketing, we have been examining customer satisfaction (and lack thereof) since the late 1970s. It is now well recognized that satisfaction has both cognitive and affective components, each of which contribute to a consumer's global judgment of (dis)satisfaction. The cognitive component is most often described in terms of expectation disconfirmation theory, which explains how individuals compare expectations against perceived performance to both directly and indirectly (through disconfirmation of beliefs) affect judgments of satisfaction. The emotional component of dissatisfaction arises as a result of an assessment of what that shortfall between expectations and reality means for the consumer's values, goals, and beliefs, and possibly also from attributions made as to why that shortfall occurred (Giese and Cote 2000). The more central those values, goals, and beliefs are to the individual, and the more impact the shortfall has on their well-being, the stronger the emotional response generated in response to that dissatisfaction is likely to be. In the context of healthcare, given the centrality of physical well-being to overall well-being, the experience of dissatisfaction as a result of a healthcare encounter is likely to be emotionally acute.

Using the principles of expectation disconfirmation theory, we can approach management of patient satisfaction from two possible routes: attempting to increase patient perceptions of performance, and/or managing patient expectations. If we assume that improved performance (which in the healthcare context can reasonably be interpreted as "curing" a patient, or at least improving their well-being as much as possible) is the goal regardless of concerns about patient satisfaction, then we can put that aside and focus on managing patient expectations. It is in the latter area that the greatest change has occurred in recent years. In particular, there has been a marked increase in patients who want to feel empowered in their healthcare choices and involved in decisions about their care, rather than simply receiving wisdom dispensed to them from doctors, often with little explanation. A common expectation of this new breed of empowered patients is that they are partners in their healthcare, and when that expectation is not met or they are made to feel that that expectation is unreasonable, it is unsurprising that they are disappointed and ultimately dissatisfied with their care – and they are more likely to complain as a result.

Measurement of patient satisfaction has taken several routes. Some organizations focus on what can be termed "process" or "operational" concerns, such as in-clinic wait time, friendliness of reception and nursing staff, comfort of reception area, cleanliness of exam room, and so on. Still others concern themselves with broader "relational" questions that are more in line with measuring patient expectations of a positive healthcare experience, such as the physician listening to a patient's concerns and treating them with respect, spending enough time with them, and encouraging them to ask questions. A recent study indicates that patients' care experiences will shape their perceptions of their relationship with their provider, independent of simple satisfaction measures, and that the stronger the relationship with the provider, the better the interpersonal continuity of care (repeated visits to the same provider), which is often considered a major goal of primary care (Beeson 2006; Tabler et al. 2014). Anecdotal data also suggests that satisfied patients are more likely to comply with treatment plans suggested by their doctor, more likely to

assume an active role in their care (i.e., be more empowered), and more likely to continue medical care with their current physician; this echoes the results of the study described previously with respect to the relationship between satisfaction and continuity of care (Beeson 2006). While discussion of how to best assess, measure, and deliver a superior patient experience is still in its infancy, it is clear that there are likely to be both organizational and medical benefits to determining how to best engage a patient in care in ways that more closely address their varied medical, social, and personal needs.

Patient-centred care reduces patient complaining behaviour, which would typically occur behind the backs of healthcare providers as patients voice their displeasure to a broader audience. With patient-centred care, better channels of communication are forged between the patient and healthcare provider. Further, patient-centred care leads to higher levels of patient satisfaction that will lead to better interpersonal continuity of care, greater patient compliance with treatment plans, and improved patient engagement in their own care. In addition to these important benefits, embracing patient-centred care also benefits healthcare organizations in the more macro-political environment. We will now examine the collective level issues that arise, contrasting it with the foregoing discussion of how patients as individuals approach healthcare advocacy.

COLLECTIVE LEVEL PATIENT-DRIVEN ADVOCACY

It is important to note that the dynamic surrounding patient complaining behaviour and dissatisfaction does not only concern the patient-healthcare provider relationship. Healthcare organizations have come to be immersed in a social and political environment that comprises a growing number of diverse social actors with an array of interests. The Internet and social media have given rise to a form of communication that empowers individual patients to connect to a network of social actors made up of individuals, small groups, and formal organizations, all of which present various narratives surrounding the nature of healthcare provision. Empowered by digital communication, this wide spectrum of social actors poses new challenges to healthcare providers. As one illustration, healthcare providers not only must track and report on formal government mandated measures of patient satisfaction, but must also consider patient satisfaction measures and reports from a growing and diverse list of "informal" but influential websites that might seemingly be unrelated to healthcare. Increasingly, patients turn to Facebook pages, hospital reputation websites, and even "Trip Advisor," all of which provide patient-driven commentary on experiences with various healthcare providers.

More traditional perspectives of activism regard organizations as typically confronted by politicized and organized social activists who see themselves as "outsiders" in relation to the target system. These organized activists protest what they consider to be problems within the dominant economic, political, and ideological systems with which they see traditional organizations, such as healthcare providers, as being complicit (Glickman 2009). Traditional tools of activism involve lobbying governments, boycotting, and engaging in formal protests as activists seek to trigger change to the dominant system. This traditional perspective regards change to dominant institutions, such as healthcare, as being triggered by activists who have a particular passion for and concern about a given social and political arrangement. These activists are seen to mobilize people into a collective effort to change the current social order so as to bring about a more desirable state of the world (Den Hond and Bakker 2007; Fligstein and McAdam 2012).

However, digital technology has enabled a democratization of communication, challenging some of the basic assumptions underlying the traditional view of activism and change in the healthcare system. The "average" patient is now able to access information from any part of the globe with an ease never before possible. Likewise, the online environment provides this patient with the ability to find an audience for their views in a forum previously only accessible to an elite few. For instance, an individual patient's blog espousing some concern about the healthcare system can attract an audience of a size and form never possible before the digital age. These democratized forms of communication challenge the more centralized and unified structure of past activist movements.

What emerges is considered a "field" of social actors who take each other into account in their attempts to achieve both instrumental ends (such as specific changes to certain healthcare practices) as well as existential ends (such as individual meaning making and identity building). All of these ends are achieved through a confluence of actions between social actors within the field. However, rather than a "consensual frame that holds for all actors [there are] different interpretive frames reflecting the relative positions of actors within the strategic action field" (Fligstein and McAdam 2012, 89). The field comes to comprise a diverse range of social actors and roles, bringing a range of interests, perspectives, experiences, and expertise. In this field, the line between the "experts" and the "average person" becomes blurred as all social actors share the same tools of communication. What differentiates the voice of one social actor from another is not necessarily expertise, but rather the skill to navigate this social media space. The social actor with the best blog or Facebook page and the ability to distribute and share commentary using the Internet and social media may arise as an influential player in the field. Furthermore, these social actors may not necessarily be driven by well-defined instrumental objectives, but rather by self-identity building projects, such as the pursuit of recognition for one's own points of view, and the corresponding social status that recognition affords within a given field.

Therefore, the healthcare organization is not being confronted by a unified and elite class of activists demanding some common end. Instead, organizations

find themselves as but one social actor having to navigate a complex field of a whole range of social actors, presenting healthcare providers with a complex and even confusing social terrain. While the diffused and seemingly confusing nature of this terrain may tempt healthcare providers to ignore this space, there are reasons that emerge as to why this may be a perilous choice when one considers the underlying social change that inadvertently arises from this social dynamic. We next consider this dynamic in more detail.

As noted previously, patients turn to social media to present their complaints about their healthcare experience to a broader audience. In order not to come across simply as a "complainer," these patients will instead work to construct themselves as worthy of having a voice to be heard. Therefore, patients will want to legitimate their voice over that of healthcare "experts." As such, patients will work to present themselves as insightfully aware of the intricacies of some aspects of the healthcare system. These knowledge claims may be based on their own direct experiences with healthcare providers, on their own "research" as they search for information online from other contexts, or on their examination of the experiences of others combined with their own research. Either way, the field comes to be characterized by patients who are working to construct themselves as "in-the-know," insightfully aware of the arrangements underlying the healthcare system. In this identity pursuit of the "in-the-know" citizen worthy of their voice being heard, these "patient activists" will inevitably and inadvertently not only confront healthcare organizations, but also end up informing and confronting each other with their diverse range of views and opinions. Healthcare organizations that follow these field level narratives may experience great frustration as they hear vast amounts of "misinformation" being espoused. It would be understandable for these organizations to be tempted to jump into the field in an effort to "set the record straight" and "educate" patients as to the "facts." To do so, however, is to miss an unexpected and seemingly stealth form of social change that is occurring.

As patients present and debate their positions based on their own "research" and experiences, a social trend towards the legitimacy of "local knowledge" and a simultaneous refutation of "expert knowledge" is emerging. Local knowledge refers to the knowledge claims that arise from an individual's own experiences, perspectives, and insights into a given situation, which is contrasted against the "expert knowledge" that is handed down from authoritative organizations. In this context, there are two problems with this expert knowledge. First, the acceptance of this hierarchical knowledge would be completely counter to the social actor's endeavour to construct themselves as a knowledgeable individual whose own claims are worthy of legitimacy. To accept expert knowledge claims would present the social actor as a cultural dupe, hoodwinked by the "system," and thus violate the identity of an in-the-know individual whose own knowledge is worthy of attention. Second, these hierarchical, expert knowledge claims are often met with suspicion and presumed to be tainted with agendas and interests of control. Therefore, the fundamental nature of the social change that emerges from this field dynamic is the increasing legitimacy of "local knowledge" claims and the simultaneous de-legitimation of "expert knowledge."

Healthcare providers must re-examine their roles within the fields to which they unwittingly belong. To ignore the field is perilous as patient activists construct narratives and views to which healthcare providers become completely out of touch and uninformed. To attempt to dominate the field by seeking to "educate" or "correct" what providers view as misinformation will simply violate the core nature of the social movement in such attempts to supersede local knowledge with expert knowledge. Such domineering actions will also subvert the legitimacy of an individual's complaints and therefore further contribute to the healthcare provider-patient problems raised above. This can only be met with more resistance by the patient. However, to understand and work within this field dynamic can present a tremendous opportunity for healthcare providers. Patient-centred care can not only involve lowering complaint behaviour while increasing rates of satisfaction, it can also involve engagement with, rather than refutation of, the "local knowledge" of patient activists.

Having now discussed both the individual and the collective approaches to advocating for a patient-centred healthcare system, the following case study presents one healthcare organization that has enacted system-wide reforms to create a patient-centred environment, not only at the level of the individual patient, but also in the broader field.

CASE: TRANSFORMING PATIENT EXPERIENCES THROUGH PATIENT-CENTRIC CARE

Putting patients at the core of the service delivery model overturns conventional healthcare approaches in which the patient is often considered as separate from the healthcare delivery team. In the same way that commercial organizations seek to understand and satisfy customer wants and needs, considering patients as customers pushes healthcare organizations to develop a deeper understanding of patient needs in order to provide experiences that are valuable from the patient's perspective.

Over the last few years, a large, regional healthcare institution in Eastern Ontario has embarked on a program to develop a patient- and family-centric healthcare service delivery approach in line with a customer-oriented philosophy. Conceptually, the patient- and family-centred initiative establishes patients and families as co-creators of healthcare outcomes by including them as partners in the decision-making processes. In addition to reinterpreting the role of patients and families in individual healthcare delivery, the organization has also created a new role of patient experience advisor, which occupies a unique, multifaceted, voluntary position. The advisors are recruited from individuals in

the local community who have direct knowledge of the patient experience at the healthcare institution, either as patients themselves, or as family, friends, or acquaintances of patients. These advisors volunteer to serve in a decision-making capacity within the institution, to provide a patient perspective on organizational issues that have material impact on the experience of patients, including the hiring of new staff. The creation of these new positions legitimizes the value of the "local" knowledge of patients and their advocates, as well as acknowledges the role of the patient as a partner in their own healthcare. Through the patient advisors, the organization is able to integrate informal feedback within its institutional structure so as to proactively address patient needs as well as legitimize patients as important stakeholders within the organization.

The changing stakeholder relationships amongst healthcare staff and patients in response to the patient-centric model of care reveal the challenges associated with organizations implementing customer-centric transformational practices. We outline some of these challenges below.

Challenging Existing Power Structures

The move to patient-centric care, as well as the creation of the patient advisor role, was a direct challenge to existing power hierarchies within the organization. Many of these hierarchies are legacies of the healthcare sector as a whole, while others are particular to the individual departmental arrangements specific to the organization. In these hierarchies, physicians occupy a privileged position relative to nurses, who in turn often leverage greater authority than social workers, respiratory therapists, and other members of the organization. The movement towards a patient-centric model shifts these power dynamics because the emphasis is not placed on status claims linked to healthcare roles, but rather on the degree to which those roles provide value as determined by the patient. No particular provider role is privileged relative to others, and non-provider roles such as religious figures or family members may hold greater influence.

As key members of the healthcare decision-making team, patients, their families, and patient advisors have a voice in the ways in which the organization delivers healthcare services. This presents challenges to traditional, often paternalistic, modes of healthcare delivery and organizational decision making, in which patients and families are assumed to be passive and deferential to the authority of physicians, nurses, and other healthcare staff. Patient advisors sit on internal committees that deal with all aspects of the organization's operations. This involves more than just transparency; by bringing voice to their experiences at the decision-making table, patient advisors attune the organization to patient values and concerns in ways that focus groups, feedback forms, and surveys simply cannot achieve. The trade-off is that entwining patients and families in such an intimate way with organizational decision making means

the organization must be willing to work effectively with those individuals to achieve common goals, and to determine how to reconcile and manage patient goals that may not align with organizational priorities. Healthcare staff in this organization report that they increasingly view their conversations with patients, families, and patient advisors as negotiations in which all sides present their case, and outcomes are driven through mutual understanding and compromise. While in some cases this is not different from traditional dialogue between healthcare providers and patients, increasingly the pathway to agreement is a fluid approach in which evidence-based medicine and processes act as only one pathway to achieving goals. This approach is atypical, given the evidence that many patients futilely seek to be more engaged in decisions related to their care, but are often rebuffed by their medical care providers (O'Rourke 2014).

Patient-Focused Outcomes

Healthcare has been focused on reducing risk and preserving life, but patients are voicing their preference to, in some cases, pursue riskier courses of treatment in the hopes of achieving outcomes that they deem preferable. In one case, a young mother diagnosed with early-stage cancer opted to pursue alternatives to Westernized medical approaches, only to return later with an advanced form of the disease that was no longer treatable. By including patients and families in the decision-making process, the healthcare provider has to adjust their interpretations of, and expectations for, success. The healthcare staff had been trained to follow courses of treatment that would minimize risk to patients, particularly of death, and so often limited the options presented to reflect this training bias.[1] In contrast, a patient-centred approach would require including the patient in the decision making, and accepting that patients, as in this case, will sometimes prefer riskier courses of action. Some healthcare providers will react by distancing themselves from the decision-making process by making treatment choices entirely the patient's responsibility. However, if providers choose to dissociate themselves from patient choices rather than opting to delve into the deeper meanings patients associate with courses of treatment, then patient experiences have not been improved, and patient empowerment (which implies truly informed consent) has not been achieved. True patient-centric approaches involve all staff associated with healthcare delivery actively listening to understand a patient's desired outcomes as representative of a patient's value system, and resisting the temptation to layer on value systems based on professional education or training.

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1. This tendency to privilege medical preferences over other patient concerns and the attendant negative effects it can have on quality-of-life (especially in the case of terminal diseases) is discussed eloquently and extensively in physician Atul Gawande's best-selling book *Being Mortal*.

Communication Flows and Transcending Boundaries

Management and operations practices have infiltrated healthcare institutions as these organizations seek to become more efficient and effective, as well as accountable to their key stakeholder groups. One consequence of this operational focus is the silo structure that many healthcare organizations employ. In this model, departments are structured as distinct from one another, and separated within the physical space the organization occupies. This structuring extends to the various boundaries, both physical and virtual, that exist between healthcare organizations such as hospitals and primary care providers, such as family physicians. As patients traverse the boundaries within and between healthcare organizations, the patient-centric focus requires that the organization with which the patient interacts be constantly providing feedback to all other members of the service delivery chain. Within the organization studied, healthcare staff found that there were significant communication breakdowns at the points where patients transcended these boundaries. These breakdowns are now identified as missing or incomplete records of care or treatment. A patient-centric model focused on patient experiences and outcomes will attune the healthcare organization to ensure these trans-boundary barriers are removed.

One role within the organization that appears to be underutilized in assisting with boundary issues is the social worker. Individuals in this role are frequently engaged with patients at multiple points during the service delivery process, and have a holistic perspective on patient values and concerns, including those that transcend purely health-related issues. For example, one social worker discussed how a severely ill patient was more concerned with the administration of their disability insurance payments than with following their treatment conditions. This concern was due to the financial situation of the patient's dependent family members. Once the administration of payments was coordinated by the social worker, the patient was able to focus on their treatment plan and their health subsequently began to improve. Despite this patient-centric focus, the degree to which other healthcare staff within the service delivery chain engage with information provided by the social workers is variable, and there are disproportionately few social workers working within the organization relative to other healthcare positions.

BROADER IMPLICATIONS FOR HEALTHCARE ORGANIZATIONS

Day and Moorman (2010) urge organizations, public and private, not-for-profit and for-profit, to engage in what they call an "outside-in" strategy. This involves the organization's leadership coming to understand the value sought by their key stakeholders and then structuring the organization to ensure the ability to deliver this value to those stakeholders. The fundamental argument is that an organization that is unable to deliver value to its key stakeholders will be constantly sidetracked by issues that deflect attention away from the organization's core purpose. Therefore, an "outside-in"-driven healthcare organization would be a patient-centred organization. However, it is important to recognize that a patient-centred care system does not necessarily mean a patient-"driven" system; as one writer comments, "the patient, unlike the customer, can't always be right, though few of us want to hear that" (O'Rourke 2014). It is important to recognize and legitimize the "local" knowledge of patients, while balancing it with the "expert" knowledge that the patient is unlikely to have.

To become "outside-in"-driven, the organization must tend to three imperatives: its structure, culture, and metrics. We will examine each one of these imperatives in the healthcare sector context, drawing on the above case study to illustrate.

Organizational Structure. An "outside-in" organization first looks to its key stakeholders to understand the needs that they have and the problems they are looking to solve. To achieve this understanding, the organizational structure must be focused on and attuned to understanding stakeholders' needs rather than focused on internal organizational arrangements. The key structural imperative to achieving this is for the organization to break down its internal silos and allow for cross-functional team coordination. As demonstrated in the case study above, the needs of patients do not necessarily fit into predefined organizational silos. A patient's medical needs, social needs, spiritual needs, life goals, financial concerns, family dynamics, and so on, all interact. Many healthcare organizations, however, are structured around internally driven arrangements that most likely mirror professional hierarchies. Consciously breaking down these internally driven structural constraints in order to design healthcare systems that reflect the inter-related dynamics of each patient would be a major step towards delivering patient-centred care.

A second important structural consideration is establishing those organizational roles that help to facilitate an integrated approach to patient care. In the case study above, the role of the social worker was emphasized as a key player in helping the healthcare organization transcend professional boundaries in order to ensure the patient receives value in all aspects of their healthcare concerns. Beyond social workers, the organizational structure must formally include those whose role is specifically designed to transcend these internally driven professional boundaries.

A third structural consideration is having formal organizational mechanisms that integrate the patient voice into all aspects of organizational decision making and operations. The organization outlined in the above case study used patient advisors. There are, of course, many other roles and mechanisms that can be used to ensure the integration of the patient voice throughout the organization. Some for-profit organizations are increasingly turning to "Chief

Cultural Officers" (McCracken 2011), people trained and tasked with the job of scanning and engaging the social media environment to understand the kinds of social changes (such as the trend from expert knowledge to local knowledge) that may provide opportunities for the way in which the healthcare organization delivers value to patients.

Organizational Culture. Organizational culture refers to the beliefs and norms that guide day-to-day activity within the organization. A patient-driven organization would have a culture in which organizational members firmly believe in and embrace the core principle that decisions about organizational practices must be made from the patient's perspective, and that everyone in the organization, regardless of their position and rank, has a role in delivering this value. But it is not only changes in patient empowerment and the increased impact of patient satisfaction measures on financial performance that are driving this cultural shift. Physicians are also experiencing a crisis that spans their profession; according to a 2012 survey, nearly eight out of ten American physicians rated themselves as somewhat or very pessimistic about the future of the medical profession, and only 6 percent of doctors surveyed in 2008 rated their morale as positive, compared with 85 percent in 1973 (O'Rourke 2014). Increasingly, it is being recognized that what can be a deep divide between patient and physician, with correspondingly poor health outcomes and dissatisfaction on the part of the patient, as well as disillusionment and frustration on the part of the physician, may be addressed by training doctors not only in the physical and technical aspects of medical care, but also the emotional and psychological ones. Driven by an increased emphasis on patient-centric care, as well as insiders within the healthcare system who were encountering patients recounting "devastating" interactions with doctors that were not just "innocuous, but often experiences that were profound and deeply affected [their] lives" (Boodman 2015), a range of programs have been developed to train physicians (and other healthcare providers) in delivering medical care with empathy. Studies have linked empathy to greater patient trust in the physician, increased patient satisfaction, decreased physician burnout, a lower risk of medical errors and malpractice suits, and demonstrably better health outcomes and medical efficacy (Boodman 2015). For instance, a study found that the rate of severe diabetes complications in patients of doctors who rated high on a standard empathy scale was 40 percent lower than in patients with low-empathy doctors, an effect comparable with the benefits seen as a result of the most intensive medical therapy for diabetes (O'Rourke 2014). As such, starting in 2015, the Medical College Admission Test will contain questions about human behaviour and psychology, in recognition that being a good doctor "requires an understanding of people, not just science," according to the American Association of Medical Colleges (Boodman 2015).

Such training is just one illustration of how a cultural shift within an organization can have substantial benefits for multiple stakeholders, and yet result in relatively small costs. The need for such a philosophical shift is not an easy one to identify or to determine how to implement, but as accountability

for healthcare metrics continues to focus on not only medical outcomes but also patient perceptions, such a cultural reorientation may be the best way to authentically connect with the true needs and values of multiple organizational stakeholders.

Organizational Metrics. Finally, the organization must be geared towards gathering key indicators that reflect the organization's performance in delivering value to patients and their families. Even patient advocates recognize that, to a certain extent, the measures of patient "satisfaction" currently in place are incomplete at best and deeply flawed at worst. Take, for instance, the patient satisfaction survey data collected by the U.S. Centers for Medicare & Medicaid Services. Consistent with the idea of managing to measurement, most hospitals have improved in the areas the surveys track, such as how clean and quiet their rooms are and how well doctors and nurses communicate, but the surveys have resulted in little shuffling in the rankings of high- versus low-performing hospitals (Rau 2015). In some cases, small variations in patient responses (which are well-recognized as being a normal part of using surveys as a research tool) can have drastic financial impacts; in determining how much to reimburse, the government only gives credit when patients say that they "always" got the care they wanted during their stay (such as their pain was "always" well-controlled). If a patient indicates that the hoped for level of care was "usually" provided, it doesn't count at all, and on an scale of 0 to 10 for rating a hospital stay, an organization must get a 9 or 10 in order for Medicare to fully reimburse them (Rau 2015). This approach to measurement fails to reflect or appreciate the complexities associated with self-report measures of any service experience, let alone a healthcare experience that takes place over an extended period of time, across multiple individuals, and which could reasonably be assumed to be affected by emotional and physical factors that may have little to do with the experience itself.

This approach also highlights a limitation of the assumption that only things that are quantitatively measureable are "real" and thus can be managed and controlled. That this perspective dominates within healthcare organizations and their assessors is not altogether surprising, given the typical "evidence-based" approach of traditional medicine. But many social science disciplines (including marketing, organizational behaviour, sociology, and anthropology) have demonstrated that there is much to be gained in true understanding by employing qualitative methodologies that yield "thick description" (McCracken 1988), making them better suited to fully exploring complex and ongoing interactions, such as those commonly observed in a typical "patient experience." Medical researchers could thus benefit from taking a cross-disciplinary approach that would better capture the occasionally intangible nature of the "patient experience" in order to truly embody the "outside-in" philosophy espoused by Day and Moorman (2010).

CONCLUSION

As identified here, organizations involved in healthcare delivery and policy can no longer afford to focus on organizational or systemic priorities at the expense of ignoring the patient voice. As primary stakeholders in the healthcare system, patients are becoming more empowered and more vocal about what they expect from healthcare providers and from the system itself. There are a variety of ways that organizations can integrate patients into organizational decision making and priority setting, thereby harnessing patient engagement for optimal healthcare system change.

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The Role of the Private Sector in Canadian Healthcare: Accountability, Strategic Alliances, and Governance

WHITE PAPER - WORKING DRAFT

A. Scott Carson

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Canadian healthcare is very expensive compared to other developed countries. In 2014, total healthcare expenditures were forecast to be $214.9 billion, which is 10.9 percent of GDP, making it the seventh highest among OECD countries (CIHI 2014). In terms of per capita expenditures, based on 2011 data, Canada has the sixth costliest system, 36 percent higher than the OECD average (OECD 2013). Yet, system-wide, Canada's performance compared to OECD countries is relatively mediocre across a wide range of quality measures (CIHI 2014). Indeed, in a recent Commonwealth Fund comparative study of eleven developed countries (2014), Canada ranked second-to-last overall in measures of quality, access, effectiveness, efficiency, and healthiness, ahead only of the United States.

Despite the mismatch between cost and performance, Canadians generally approve of their healthcare system. Canadians favour their system because they believe it is "public," by which is meant that it is universal and has a single government insurance payer. What many do not realize is that 30 percent of the system's expenditures are private, not public. Still, approval is very high. Says Nanos: "There are very few, if any, pillars of Canadian public policy of which Canadians approve as strongly as the principle of universal health care, which has been with us since it was first adopted by the Pearson government in the 1960s" (2009). This view is sustained in a poll commissioned by the *Globe & Mail* in 2012, in which 94 percent of respondents called our universal system "an important source of collective pride."

What lies behind the desire for universality is social justice. The social principles upon which Canadian healthcare is based are grounded in a sense of fairness. These are the principles that are reflected in the Canada Health Act, which declares the primary objective of Canadian healthcare policy to be "to protect, promote and restore the physical and mental well-being of residents of Canada and facilitate reasonable access to health services without financial or other barriers" (Sec. 3). This has been likewise articulated in various national healthcare reviews. For example, in his 2002 report, *Building on Values: The Future of Health Care in Canada*, Romanow says, "Canadians have been clear that they still strongly support the core values on which our health care system is premised – equity, fairness and solidarity" (xvi).

In other words, what Canadians want is a healthcare system that meets certain crucial tests of social justice. The first criterion is financial security for patients and families. Universal government-funded and administered health insurance is seen to protect against financially ruinous hospital and physician costs, which are presumed to be a potential consequence of a private healthcare system. Second, universally available and government insured healthcare benefits need to meet the tests of both "fairness" in the form of universal "access" and "equity" in the availability to everyone of the same level of services. Both access and equity would allegedly be at risk in a private system in which the service model is connected with private profit. A third consideration is "democratic control" in order to meet the responsibility for policy formation and accountability for outputs. Healthcare is seen to be a fundamental good and as such should

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be controlled, not by corporations and market forces, but by democratically elected governments.

What does this mean for the role of business in Canadian healthcare? Many proponents of a public system fear that if business plays a significant role in the system of healthcare this will be tantamount to a private sector intrusion into the delivery of a Canadian public good. It would be, as Canadians often say, "like the American system." As such, many people think it would stand in opposition to the principles of social justice.

In this white paper, I will argue that there is much room in Canadian healthcare for the private sector that does not impede the goals of social justice or fairness, namely access and equity. In fact, the reverse is likely true: the involvement of the private sector in the right places in the system can promote access and equity by adding financing, resource capacity, expertise, innovation, institutional learning, and reputation enhancement.

The focus of the discussion will be mainly on the third consideration above, i.e., democratic control of the healthcare system. I want to show that democratic policy making and system oversight are compatible with various forms of partnerships between the public and private sectors. The focus on the issue of system oversight and management is important because considerations one and two above, namely of personal financial security and system fairness (i.e., access and equity), fall within the purview of governments. So long as governments are not abdicating these responsibilities or ceding control of the healthcare system, they are not prevented by the private sector from living up to their responsibility to pursue the objectives of social justice. Instead, the private sector can be a valuable partner in meeting them.

In what follows, I will consider, first, the role that the private sector plays in Canadian healthcare today. Second, different forms of partnership that are applicable to healthcare will be outlined, and I will explain how they can relate to each other. Third, I will propose a collaborative governance model that could provide oversight of public private partnerships that respects and promotes the democratic obligations of governments to exercise oversight in the healthcare system. Fourth, a case will be made for considering strategic alliances as a key form of partnership between the public and private sectors.

THE ROLE OF THE PRIVATE SECTOR IN CANADIAN HEALTHCARE TODAY

Whether making a case to support or to oppose participation by the private sector in Canadian healthcare, it is important to understand what is meant by the attribution of "private," because in healthcare discussions there is ambiguity, both in the meaning of the word, and the circumstances in which it is used. First,

consider how the Canadian system is funded. Public funding means coming from a government. For example, insurance coverage for payments to hospitals and physicians is provided by provincial/territorial governments, which in turn fund these payments from general tax revenues and (indirectly) from federal transfer payments. However, when we say that funding is private, such as payments made for prescription drugs, this can mean either funding by private sector corporations who provide insurance, or from the pockets of individuals. Opponents of private sector involvement in healthcare are more likely to be targeting corporations than private individuals, yet both are picked up by the word private.

Second, reference to the private sector can also be taken to be synonymous with "business," but there is also some ambiguity in this. Opponents of business participation in healthcare may be thinking of large corporations, such as multinational pharmaceutical or medical device manufacturers, but not a family-owned neighbourhood pharmacy or a biotech start-up. Both, however, are businesses – and businesses are part of the private sector, but different from individual patients and families who are also private payers for portions of their healthcare.

Third, when private is taken to be a proxy for business, the business being referred to may not pertain to funding but rather to a "business perspective." For instance, business schools teach undergraduate and MBA students the concepts, core principles, subject knowledge, and skills that not only generate competence in dealing with business problems but also a way of looking at problems – from a business perspective. Equally, someone who works in a business, whether in a multinational corporation, start-up venture, or small owner-operator company, is likely to develop a business perspective. This too can be what is meant by private, or by private sector.

Fourth, private sector can refer to "practices" that are commonly associated with what is found in businesses and what business schools research and teach. For example, the boards of directors of many of the large hospitals are structured and function in ways that are based on the theory and practice of corporate governance. Hospitals and other healthcare organizations have widely adopted, or adapted, these practices. Similarly, strategy processes such as the "balanced scorecard approach," which originated in business, are often used in hospitals and other healthcare institutions. Much the same can be said about financial systems, control and reporting, human resource theory, value creation processes such as the "lean" principles and techniques, and so on.

Taking all of this into account, when we talk about the private sector participating in healthcare, we have many possible ways in which that can occur. In the next section, I will be more specific about how much "participation" is in evidence in Canadian healthcare.

Funding of Healthcare

Think of private participation in healthcare in relation to how the healthcare system is funded. As indicated above, public sector expenditures are goods and services for which a government pays. As well as the operating costs of hospitals and patient visits to physicians, this includes the cost of government health ministries and the funding of capital expenditures in hospitals, clinics, and entities in the other parts of the system. The private sector financing applies mainly to expenditures attributable to private insurance companies and out-of-pocket payments by patients.

Government Funding

A public/private split exists in most countries. Using 2011 data, Table 1 shows the relationship between public and private spending across OECD member countries. Mexico, Chile, and the United States have larger private sector funding percentages than the remainder of the 34 countries. Canada's private sector participation is the 12th highest, slightly higher than the OECD average, and higher as well than 22 other countries.

and private healthcare expenditures in both Sweden ($55.6 billion) and Austria ($49.3 billion) (using data from The World Bank 2014). So it is clear that the private sector is currently playing a significant role in Canadian healthcare in funding terms.

Apart from the relative size of the private sector, it is useful to consider the roles that the private sector plays in healthcare delivery in other OECD countries. Canadians often focus on the U.S. because of its size and proximity to Canada, but our comparators should be more broadly based. In the UK, for instance, specialists can practice simultaneously in both state funded and private clinics. The Swedish system is comprised of both public and private hospitals. And the French system is a hybrid.

Healthcare Institutions

Hospitals are Canada's primary institutional service providers. They account for 29.6 percent, or $63.5 billion, of all healthcare expenditures, of which about $2.4 billion is paid by private insurance and out of pocket by households. However, outside of the hospital, the private sector role has been growing either

% of total expenditure on health
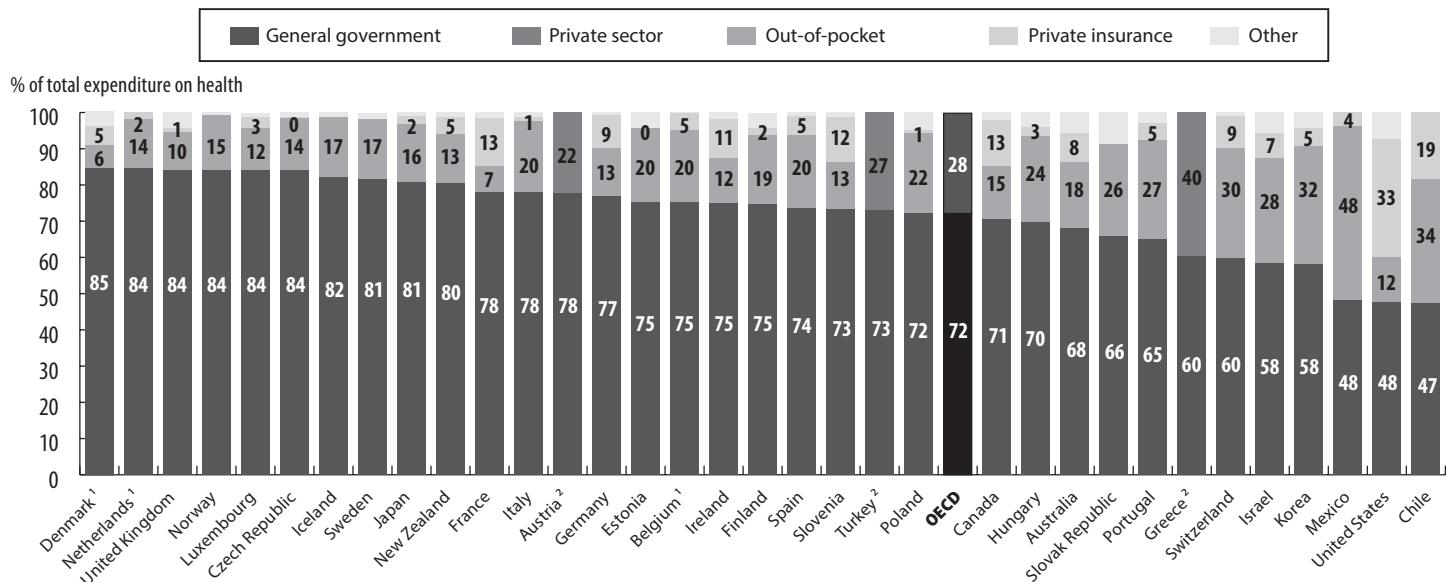
1. Current expenditure.
2. No breakdown of private financing available for latest year.
Source: Adapted from OECD Health Data 2011

StatLink   http://dx.doi.org/10.1787/888932526274

Table 1: Expenditures on health by type of financing, 2009 (or nearest year)

In absolute terms, Canada's private sector expenditures are $60.3 billion (CIHI 2014). By comparison with other developed countries, Canadian private expenditures are sizable. For instance, they are greater than the total public

to provide new services or take over some hospital functions. There is private sector ownership of some specialized surgical hospitals (e.g., Shouldice Hospital), and a growing number of private clinics provide diagnostic imaging,

laser eye surgery, optometry, and so on. In other healthcare fields such as dentistry, psychological counselling, chiropractic medicine, naturopathic medicine, and pharmacy (external to the hospital), entities are owned and operated variously by individuals, small practitioner groups, or corporations. Ownership of pharmacies ranges from owner operators, to large corporations, to food chains (e.g., Loblaws), to box stores (e.g., Walmart). Clearly, institutional healthcare delivery is dominated in financial terms by public hospitals, but in the scope of healthcare entities, the private sector is broadly represented and likely increasing.

Product and Service Providers

Ranging from small entrepreneurial entities to large corporations, businesses research, create, design, and manufacture medical technology, devices, and pharmaceuticals. In addition, private sector contractors design, build, finance, maintain, and operate hospitals (see Appendix A); businesses provide services such as maintenance, janitorial, laundry, audit, legal, architectural, and purchasing; and consultants and lawyers provide advice, on everything from policy formation to risk management to organizational restructuring, to government policy makers, regional health authorities and hospital boards, and administrators.

Further, private clinics are increasingly providing diagnostic services such as MRIs. Optometrists/opticians, chiropractors, psychological counsellors, and other health service professionals provide services that lie outside of the Canadian health insurance system. Even physicians, physiotherapists, and pharmacists are for the most part in the private sector. For instance, of Canada's over 16,389 physiotherapists, 40.3 percent are in private professional practice (CIHI 2010). Also, of the 38,737 thousand pharmacists in Canada, 73 percent practice in the community or other non-hospital settings (National Association of Pharmacy Regulatory Authorities 2015). Within the domains of health policy, healthcare services, and healthcare institutional operations, the private sector is well represented. And of course, by private sector, we mean professionals who are practicing privately.

Business Perspectives

In hospitals, clinics, and community care centres, there is an important difference between the "care" of patients and the "operating" aspects of the entities. Consider the very considerable influence of business thinking that exists in the operational side of hospitals and other healthcare institutions. For instance, a hospital CEO's executive team includes not only the chiefs of medicine and nursing, but also the operational executive leads from finance, risk, human resources, information technology and systems, and strategy and communications. The subject knowledge of these operational areas

comes directly or is derived from business disciplines (i.e., finance, accounting, organizational behaviour, MIS, and strategy). As well, the management processes employed in the hospital, such as strategic planning, balanced scorecards, lean processes, and so on, have their origins in business thinking and practice.

In addition, the executives, and many of their staff members, are often graduates of business schools or executive training programs, and many have private sector work experience. For example, both the vice president of finance and their reporting line staff may be graduates of commerce or business administration programs who have articled with a public accounting firm while completing the CPA designation. Those persons may have worked in the private industry before later moving into the healthcare sector. Similar cases would be found in MIS and human resources. Indeed, business schools anticipate the need for business-trained hospital and other healthcare leaders. To this end, there are MBA programs at Queen's University, the University of Toronto, York University, McGill University, Western University, and the University of British Columbia that have healthcare management specializations to prepare graduates for such positions.

Business perspectives are in evidence even beyond management. Boards of directors of hospitals (especially in Ontario's 151 hospitals) comprise both internal hospital members (ex officio and appointed) and external elected members. A significant number of the elected members are employed in the private sector, e.g., banks, consulting firms, manufacturing companies, and technology firms, and bring a business perspective to the governance of institutions. Table 2 shows the results of an analysis of external directors' business and academic/professional backgrounds in 17 of Ontario's academic hospitals. From a total of 256 external directors, 70 percent have business experience and 75 percent have either business experience or a business degree/professional designation. In 9 of the 17 hospitals, 80 percent or more of the directors have either business experience or a business degree/professional designation. Clearly, business thinking plays a significant role in hospital governance.

Selected Academic Hospitals in Ontario (Hospitals with publicly available director bios)	Elected Directors	Ex-Officio/ Appt. Directors	Total Directors	Elected with Business Experience (%)	Elected with Business Degree/ Professional Designation (%)	Elected with Combined Business Experience *and* Business Degree/Prof. Designation	Elected with Business Experience *or* Business Degree/Prof. Designation
Hospital 1	17	6	23	15 (88)	8 (47)	7 (41)	15 (88)
Hospital 2	17	4	21	12 (71)	7 (41)	6 (35)	13 (76)
Hospital 3	16	6	22	8 (50)	5 (31)	4 (25)	9 (56)
Hospital 4	16	4	20	10 (63)	3 (19)	3 (19)	10 (63)
Hospital 5	12	5	17	8 (67)	5 (42)	4 (33)	9 (75)
Hospital 6	15	4	19	9 (60)	7 (47)	7 (47)	9 (60)
Hospital 7	18	6	24	17 (94)	9 (50)	9 (50)	17 (94)
Hospital 8	13	4	17	10 (77)	8 (62)	8 (62)	10 (83)
Hospital 9	11	6	17	3 (27)	4 (36)	3 (27)	4 (36)
Hospital 10	26	6	32	23 (88)	9 (35)	9 (35)	23 (88)
Hospital 11	12	5	17	9 (75)	4 (33)	5 (42)	10 (83)
Hospital 12	15	5	20	6 (40)	3 (20)	2 (13)	7 (47)
Hospital 13	15	3	18	9 (60)	7 (47)	4 (27)	12 (80)
Hospital 14	15	7	22	8 (53)	5 (33)	5 (33)	8 (53)
Hospital 15	7	11	18	7(100)	2 (29)	2 (29)	7 (100)
Hospital 16	15	8	23	13 (87)	5 (33)	5 (33)	13 (87)
Hospital 17	16	9	25	13 (81)	9 (56)	8 (50)	15 (94)
TOTALS	**256**	**99**	**355**	**180 (70)**	**100 (39)**	**91 (36)**	**191 (75)**

Table 2: Business Experience and Education of Elected Directors in Selected Ontario Academic Hospital

In addition, the board's processes, committee structures, self-assessment, and reporting frameworks are derived from private sector theory and practice. Equally, the governance of regional health structures like the Local Health Integration Networks (LHINs) in Ontario, as well as their fundraising foundations, share these private sector characteristics. So private sector thinking, processes, and experience pervade healthcare institutions.

It should be noted that there is controversy in the field of management education regarding the extent to which the emphasis in business schools on profit and competitive advantage develops in students a worldview based on self-interest and lack of appreciation for broader social goals. This may overstate the importance that students attach to finance and strategy courses, and give insufficient recognition to the perceived value of course work in organizational behaviour and corporate social responsibility. But certainly a corporate and commercial way of thinking does affect students, which does reasonably lead to

the conclusion that business graduates are in general financially oriented, results focused, and taught to think in terms of rational decision-making frameworks. It is in this way that leaders in healthcare institutions come to adopt a business perspective.

This perspective should not be confused, however, with excessive attention to financial matters at the expense of patient health and safety. To do so would fly in the face of the principle of patient-centredness. Indeed, the restructuring of the NHS England in 2013 was strongly influenced by the results of a national investigative commission that linked unnecessary deaths and very poor patient safety in many hospitals to the over-concern of management and boards with budgetary matters at the expense of patients (Francis 2010).

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While the patient care and operational aspects of healthcare institutions are "different," they are not "separate" from one another. Executives and their departments work together as a team in the enterprise of delivering healthcare to patients, families, and communities. Modern healthcare therefore blurs the dividing lines between public and private to deliver institutional healthcare.

Business Practices

Healthcare institutions today are strategic planners. The demands of accountability to governments, agencies, and the public require hospitals and other institutions to plan strategically. They must consider: (a) how they will function strategically in relation to the health system (e.g., LHIN) of which they are a part; (b) how they will be able to partner with community health and social services; (c) how to strategically focus and prioritize their medical services; (d) how to assess financial needs and sources of funding for operational and capital expenditures; (e) how to plan, prioritize, and fund research and teaching (for medical centres); (f) how to allocate health human resources; and address primary care (g) how to establish plans for information and management technology; and (h) how to establish management processes, such as lean operations.

In each of these categories of practice, the theories, core concepts, processes, and practices are derived at least in part from management theory, research, and practice. Of course the implementation is adapted to healthcare, but the conceptual origins are traceable to business.

At the provincial/territorial level, a similar connection to management can be seen. Of course, healthcare policy development is more traditionally the role of governments even if institutional application is business based. But even policy is influenced by business thinking when advisory commissions, councils, and consultations include private sector participants.

To conclude, private sector participation in Canadian healthcare can be thought of in terms of how the system and its components are funded, the infusion of business perspectives into the governance, management, and operations of the healthcare system, and the practices of managing and operating healthcare institutions that are derived or adapted from business. Looking at the delivery of Canadian healthcare today, it is not realistic to question whether business should be present in our "public" system. The question should be, where is the participation of business most likely to contribute to achieving the ideals and strategic objectives of our system?

In order to answer this, we need to understand the ways in which business and government are related to each other in Canadian healthcare. If the healthcare system requires democratic oversight in order to be in accord with social principles such as fairness, access, and equity, then we must understand why

business should participate and how business and government relate to each other in ways that make this oversight possible.

Why Should the Private Sector Participate?

The benefits of private sector participation in healthcare should be assessed primarily on the basis of how well it promotes the interests of patients and their families. The overriding commitment should not be to the self-interests of professionals, organizational convenience of providers, pragmatic interests of politicians, or theoretical commitments of ideologues. It was said above that Canadians want healthcare to be guided by the principles of social justice, namely fairness to patients and families in the form of access and equity. So the justification for private sector participation should be assessed on the basis of its contribution to the efficient and effective performance of the system that generates healthcare outcomes to meet the social principles.

While this will be addressed more fully below, it is useful to introduce the key points here. Figure 1 summarizes a "framework" that shows what a collaborative relationship can yield in terms of benefits. The framework sets out two categories of contribution – resources and growth. Within those categories are six types of benefit. Working together toward the potential beneficial outcomes for the healthcare system are efficiency and effectiveness. In turn, these contribute to improved access and equity for patients.
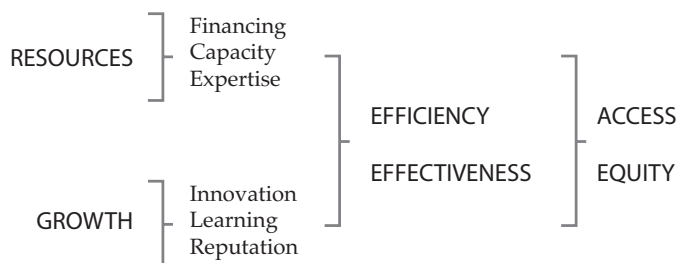
Figure 1: Public and Private Sector Collaboration Framework

The framework categorizes the benefits of public and private entities working together, first, in terms of the resource contributions that derive from private sector strengths, and second, in the growth opportunities for the entity that constitute the relationship between the public and private sector. In more detail, the benefits are as follows.

The first is "financing." The private sector partner may have access to financing for certain projects. If so, this not only adds financial resources to the project, but also it transfers financial risk from the government to the private sector partner. Collateral benefits to the government are both freeing up finances for spending on other programs and removing the need for borrowing. The latter is

important because adding debt to government balance sheets can affect bond ratings, which in turn can have a negative impact on future borrowing costs.

Second is "capacity." Projects and other joint undertakings have non-financial resource requirements: human resources, technology, plant and equipment, business processes, and so on. Even limitations on time availability can be a capacity constraint. In some cases, a public sector partner may not possess the needed resources; even if they do have the resources, the government may need to deploy them elsewhere. Partnering with the private sector can offer a solution to capacity problems.

"Expertise" is the third enabler that a private partner may be able to contribute. This could be in the form of unique experience in executing tasks required for the project to be successful. Or it could involve proprietary technologies or business processes, which are valuable to the project, rare in terms of availability, and difficult to imitate, or for which there are few viable substitutes.

Fourth is "innovation." Invention and discovery of feasible solutions to problems through new products and services is a strength of the private sector, especially when capacity is combined with expertise. To say that private and public sector entities working together will necessarily innovate is an overstatement. Innovation occurs when the conditions are favourable. However, the potential for innovation should be a consideration when evaluating private sector participation if, based on the best available evidence, innovation has a better chance of occurring if the public and private sectors work together than if they do not.

Fifth is "institutional learning." In the process of working together, public and private sector individuals and institutions can learn much from each other. There is the human dimension of working together in which an individual learns the perspectives of the other as they develop a working rapport. Much was said about the business perspective above; for those whose careers have been in the public sector, the business orientation takes getting used to, and vice versa. In addition, new business processes can be learned – from the balanced scorecard approach to translating strategic objectives into measurable goals with targets, lean value enhancement processes, and so on. Finally, innovations and discoveries can be leveraged, extended, and transferred to other aspects of each partner's business (subject to contractual agreements).

Sixth, "reputational enhancement" is important to the ongoing work of both the public and private partners. For example, a research institute that, because of a private public alliance, has state of the art facilities and technology, combined with a reputation for leading edge research, makes recruitment of new high quality researchers much easier. As well, it improves the chances of success in applications for additional grants and other forms of research funding.

With these points in mind, we turn now to consider what forms participation between the private sector and public sector can take.

RELATIONSHIP BETWEEN PUBLIC AND PRIVATE SECTORS

In this section, I first explore three ways in which the public sector, mainly governments, can relate to the private sector: regulation, ownership/control, and partnerships. Second, I will set out a framework for assessing which forms of relationship are most suited to addressing healthcare issues.

Regulation

Public policy in healthcare is in the purview of governments. The implementation of policy is often delivered or implemented by sub-levels of government or the private sector. In either case, in advancing a policy aim, a government provides a regulatory framework within which the policies must be implemented. For instance, the Canadian government oversees the implementation of the Canada Health Act, and in doing so acts as a regulator for other governments (provincial and territorial) in terms of universal health insurance, and for private sector corporations with respect to pharmaceutical approvals. In turn, provinces and territories regulate medical device approvals.

Regulatory frameworks in healthcare function in much the same way as they do in other areas of public policy. They ensure oversight while recognizing that other entities are better positioned to deliver products and services.

Ownership and Control

Canadians are very familiar with crown corporations such as the Export Development Corporation and Canada Post Corporation. These are not-for-profit corporations, the shares of which are owned by the government, that compete with private sector counterparts. Agencies such as provincial securities commissions, gaming and lottery, and alcohol sales may have different legal structures (depending on the jurisdiction) in not having shares that are owned by the government.

A government may prefer to own rather than regulate in order to implement its policies directly. Sometimes governments change their minds about ownership and divest their corporations. The government of Canada divested itself of both Air Canada and Canadian National Railway. Similarly, the Ontario government announced recently that it intends to sell part of its ownership of Hydro One, its electricity transmission system. Alternatively, governments sometimes transfer

control of entities by means of long-term leases. The Canadian government did this in the 1990s when it leased major airports in Canadian cities to regional airport authorities.

Since governments still retain a public policy interest in many of their divested entities, they can continue their oversight by way of regulation as above. For example, the Ontario government constructed a toll highway (Hwy 407) as a means of achieving a public policy objective, namely relieving traffic congestion on another major highway (Hwy 401) in close proximity. Ontario subsequently sold the toll highway in 1999. Part of the sale involved a regulatory mechanism that tied future toll price increases to mandatory traffic volume targets. There were stiff financial penalties if the higher tolls resulted in reductions in the volume of traffic below a required threshold. As long as the toll road carried the required volume of traffic, it was deemed to be meeting the public policy objective of relieving traffic congestion on the other major highway. The regulatory structure was the government's tool for achieving this.

Regulation is an indirect way for governments to engage with the private sector. Except in cases where regulation is directly tied to a single company, the connection is usually impersonal because it is at an industry level. Ownership by contrast is more direct. But even here, the extent of direct involvement between owner and owned depends on the particular situation. A government can be more or less involved in the oversight and management of the entity it owns.

Assessing whether either regulation or ownership is a desirable form of relationship in promoting public policy or programs by using the private sector requires us to think of the particular situation under consideration in relation to the four tests above: finance, capacity, expertise, and innovation.

Let us compare regulation and ownership with another important form of business and government relationship, namely partnerships.

Types of Partnership

Contracting Out

At one end of the spectrum of partnerships is "contracting out" for goods and services. Governments enter into contracts with businesses to have them perform custodial and cleaning services in government buildings, highway snow removal, road construction, facilities maintenance, supply chain management for procurement, and so on. Hospitals contract out for laboratory services, linens, parking, legal and audit, and other services. The rationale for contracting out is often a matter of cost and expertise: it is less expensive to purchase the service, the service requires competency that does not exist in-house, there is insufficient capacity within the existing in-house resources, or the service required is not a core activity of the organization.

Characteristic of this form of partnership is that the relationship is: (a) established by the government partner; (b) contractually bound; (c) performance-based; (d) limited in scope by the terms of the contract; and (e) time limited. In sum, governments pay for a service to be performed. Once the service has met the completion test established by the contract, the relationship ends, at least until it is renewed or reconstituted by a further contract.

Public Private Partnership

A partnership is created when two or more parties undertake some form of project or activity toward which each makes a contribution to establish the partnership and continue its operation. Contributions can be financial, real property, plant and equipment, expertise, or indeed anything of value that contributes to the venture. Often one partner takes the lead in managing the partnership. A partnership is not a defined legal entity such as a corporation; rather it gains legal status by virtue of legal agreements that the partners enter into between themselves. For example, lawyers and accountants establish partnerships to practice law or accounting together by sharing premises, administration, and business development expenses. Also, mining companies, even competitors, sometimes create a partnership to develop a mine where the cost would otherwise be prohibitive for either partner on its own; rival technology companies will also establish a jointly owned company to develop a new technology or application.

Another common form of partnership of importance to the healthcare discussion is a "public private partnership" ("P3"). This is a joint venture among partners, which, as the name implies, involves a government, either directly through a ministry, agency, or controlled entity, and at least one private sector partner. Each contributes to the establishment of the partnership.

A P3 shares certain features with contracting out, namely that the relationship is government established and led, it is contractual in nature, and it typically has a finite life that is usually coincident with the completion of a project for which the partnership has been formed. What makes it different from contracting out is that the undertaking in which the partners are venturing together is more complex than a simple contract – in some cases because multiple contracts are combined to achieve different but connected objectives.

In Canadian healthcare, a common form of P3s can be observed in hospital infrastructure projects. In a new or redeveloped hospital project, the government (or ministry) engages a partner, or partners, to design, finance, build, operate, or maintain a hospital. The partnership often involves a combination of some or all of these functions. See Appendix A for a chart outlining some of the P3s used for Canadian healthcare projects.

The rationale for P3s typically focuses on resources and expertise. The resource implications for governments are twofold. The first is financial. In contracting out, a government provides the funding to support the partner's performance of the contract. However, in a P3, the private sector partner often provides the financing for the partnership. Indeed, in all 84 healthcare projects listed in Appendix A, the private sector partner provides financing, in addition to design, build and other functions. This relieves the government of either or both income statement or balance sheet pressure, which is to say that the government is thereby not required to use its own operating or capital funds for the project and it does not need to add debt to its balance sheet through borrowing. The second implication is that governments may not have the resource capacity – e.g., workforce, equipment, technology – to take on a large construction or other project. Since the private sector partners are in business to perform these roles, it makes sense for their resources to be utilized by government.

Expertise is not always present within government, but it can be sourced from the private sector. Project design, construction, and management are the specific expertise of some companies, which can be leveraged by governments through industry partnerships.

What is key for a government in the determination of the viability of a P3 is to ascertain whether it, or potential private sector partner, has the greater expertise in the evaluation of the risks and benefits of a given project, and who is in the best position to manage those risks once identified. Matched with the question of expertise is the matter of resource capability and capacity. Granted, not all projects should be P3s. Each case needs to be evaluated on its own merits. However, where there is a stronger argument for partnering based on resource and expertise considerations, P3s should be seriously considered as an option.

As a further note, we must keep in mind that it is in the nature of "partners" in any undertaking to have aspirations, objectives, and motives that differ from each other. A partnership must accommodate these differences in a way that "corporations" do not. The latter can remove dissonances that inhibit the corporate purpose. They can fire recalcitrant executives, refuse to accept divisional strategies and plans that do not align with the corporate objectives, and harmonize the corporate culture to promote conformity of purpose and perspective. However, partnerships must accommodate differences. Successful partnerships achieve this accommodation whereas unsuccessful partnerships fail and dissolve.

In the realm of healthcare P3s, then, it is to be expected that the private sector partners will have commercial objectives and the government partners will want to achieve public policy ends. Successful P3s are those that accommodate both because doing so allows each partner to achieve outcomes that promote its own objectives, while together partners achieve outcomes that fulfill

collective goals. In sum, partners learn to work together, rather than one subsuming the other.
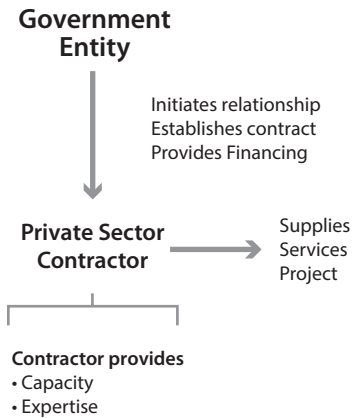
Strategic Alliance

Strategic alliances are a form of joint venture partnership. Often the terminology of joint venture and strategic alliance is used interchangeably. However, strategic alliance as I use the term here refers to a partnership that is more open-ended than a project. Alliance partners have a purpose in going beyond existing projects (Carson 2015a). They come together in order to explore opportunities for the future that are in pursuit of broader strategic goals (Doz and Hamel 1998). The Canadian Partnership Against Cancer is an example of this. It is funded by the federal government to promote cancer control by bringing together cancer experts, charitable organizations, governments, cancer agencies, national health organizations, patients, survivors, and other groups, to implement a Canada-wide cancer control strategy. Its main functions span a continuum encompassing prevention through healthy communities and lifestyle, cancer screening, system performance and quality guidelines, treatment, and follow-up and survivorship (Canadian Partnership Against Cancer 2015).

A project can be a part of such a relationship, but the purpose of the alliance is to pursue business opportunities that go beyond a pre-defined project to include ventures that explore new processes, technologies, or products that may not yet have been identified. An illustration from the technology industry is an alliance that formed in the 1960s between Fuji and Xerox to compete against Canon and Ricoh in the paper copier market. That partnership later grew to include a new partnership that formed between Xerox and Rank Organization and many smaller companies. Collectively they were able to pursue new technological innovations, even though they individually had their separate corporate objectives (Gomez-Casseres 1996).

Some alliances are "pooling" in that they bring together organizations that have similar resources, for example a purchasing alliance that involves a group of hospitals and preferred device suppliers. A "trading" alliance brings together organizations with different resources. An example is the alliance formed in 2011 between General Electric's healthcare unit and M+W Group to produce biopharmaceuticals such as vaccines, insulin, and biosimilars for emerging nations. GE brought its technical expertise to the partnership, and M+W contributed its global engineering, construction, and project management (General Electric Company 2011). Indeed, the Premier healthcare alliance in the U.S. includes 2,300 hundred hospitals and $33 billion in purchases (Zajac et al. 2011).

Figure 2 compares in summary form the three main forms of partnership.

Contracting Out

Government Entity

Initiates relationship
Establishes contract
Provides Financing

Private Sector Contractor → Supplies Services Project

Contractor provides
• Capacity
• Expertise

Pubic Private Partnership (P3)

Government Entity

Initiates contractual relationships

Partner A

Partner C

Partner B

Partners provide
• Financing (potential)
• Capacity
• Expertise

Strategic Alliance

Partner B ↔ **Partner A**

Government Entity

Partner C ↔ **Partner D**

Alliance partners provide
• Financing
• Capacity
• Expertise
• Innovation
• Institutional learning
• Reputational enhancement

Figure 2: Partnership Form Comparison

The P3s model, which is common in healthcare, especially with respect to infrastructure development, tends to have many of the features of a strategic alliance. Yet the strategic alliance may hold a special promise for Canadian healthcare because it brings partners together around shared strategic priorities. Could governments in Canada feasibly pursue strategic alliances in healthcare with business? The opportunities that could be explored are considerable insofar as the private sector is able to contribute re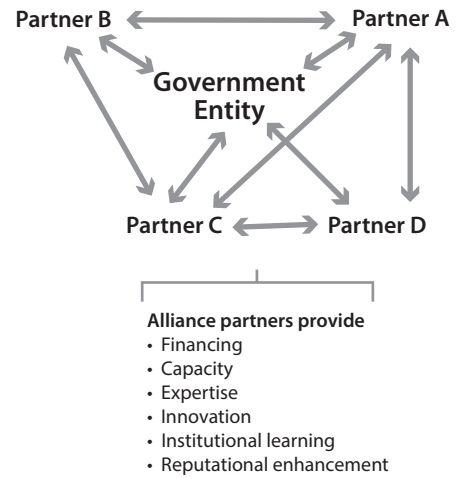sources and expertise to the alliance. The public sector contributions would include public policy strategic objectives and alliance leadership. Let us consider this more fully.

Public Private Strategic Alliances

There are two important questions to answer: In what parts of the healthcare system would strategic alliances be most appropriate? How should strategic alliances be structured in order to ensure that governments retain their public policy and accountability roles and responsibilities?

There are many places where strategic alliances are appropriate in the healthcare system. For example, in the U.S., General Electric, Siemens, and Philips have developed strategic alliances with academic medical centres, hospital systems, and physician groups. In a Canadian example, a group of hospitals in south eastern Ontario have established a supply chain company to purchase and deliver medical supplies to achieve cost synergies. Further, a possibility exists for a cluster of hospitals to partner with a device manufacturer or technology company to leverage resources and to explore new clinical practice models. Finally, there are possibilities for strategic alliances in which

the private sector provides financing and management expertise to build laboratories and the hospitals provide research programs and resources. None of these are radical or untried, but they are not as well developed or far-reaching as they could be.

In short, alliances can form between "suppliers" such as pharmaceutical and biotech firms for drug development and commercialization, or medical device and information technology firms for such things as remote monitors; "suppliers and providers" as in the case of hospital researchers and medical imaging firms; "clusters of providers" such as pharmacies and retail stores; "buyers and providers" such as a manufacturing company establishing on-sight clinics for employees; and "buyers and other buyers" such as a medical device manufacturer, which, as an employer, forms an alliance with a health insurance group (Zajac et al. 2011).

Alliances are not a panacea. Conditions many not conducive to success. The macro environment – political, economic, technological, and social conditions – needs to be supportive of the strategic objectives of the alliance. And the strategic priorities of the partners need to align or success will be difficult to achieve. Further, the alliance partners need to be able to establish a management and governance structure that enables them to work together collaboratively, i.e., that matches their specific behavioural characteristics. Finally, the behavioural complexion of the alliance needs to be compatible with working together. Some partners are better at working cooperatively than others. Indeed, there is a gradation in the degree of cooperativeness: fully cooperative to quasi-cooperative to indifferent to competitive to vengeful (Zajac et al. 2011). At some stage, cooperativeness can fade to the point where the alliance is untenable. Finding and maintaining a collaborative relationship

is difficult but potentially valuable if it can be sustained. Still, even successful alliances have limitations to their life.

Of course, conflicts of interest and other problems can arise in strategic alliances. However, this does not provide an argument against alliances per se, but rather points to areas where management of the relationship requires attention. As the public and private sectors gain more knowledge of each other's perspectives through the infusion of business thinking in healthcare, and the expansion of private sector service delivery across the continuum of care, the ability to resolve issues and problems increases.

Strategic alliances are a powerful form of partnership, and they can help to promote social justice objectives. This does not mean that all projects and undertakings need to involve this or any other form of business and government partnerships. Rather, it is certain specific undertakings that should be considered, such as projects, strategic research and development, product research and development, service delivery innovations, system integration prototypes and experiments, and so on.

The challenge for a government in a strategic alliance relationship is that it is a "partner" in a strategic venture rather than being in "control" as in a P3. Even though a P3 does not always allow for the immediacy of control that exists in the contracting out relationship, there are, nevertheless, levers of control. These levers are less available in a strategic alliance – a partnership of equals. The question then is, how does government build into the relationship a control feature that allows it to exercise its democratic policy and accountability oversight?

The answer, I suggest in what follows, is at the governance level. I propose a bicameral governance structure in the context of a collaborative governance model.

BICAMERAL COLLABORATIVE GOVERNANCE

Collaborative governance is emerging as a powerful oversight model in multi-stakeholder undertakings, which involve a government and two or more non-government partners. The non-government partners may not include a private sector partner, but for present purposes these collaborations of interest will involve a private sector partner. In a collaborative governance entity the partnership is initiated by the government partner. The government's objective is to create a multiparty entity that will implement a policy or program. While the government is the originator of the collaborative entity, it may or may not be active in its operations. The new Ontario Health Links are an example of such an entity: the government seeks to achieve certain of its local healthcare integration policies through entities that link multiple health providers, such

as hospitals, nursing homes, community social services, medical teams, and so on. The governance of such a collaborative entity is a body that is representative of the collaborators. Their relationship to each other may be contractual, but is more likely determined by informal agreements in reference to the government's policies, mandate assignments, and regulations. Typically, collaborative governance functions by discussion and consensus, rather than legal authorities and performance deliverables (Ansell and Gish 2008).

The collaborative governance model has broader application than entities such as Health Links. It could apply to strategic alliances that address major strategic challenges such as health system transformation, in which the collaborators could involve different private sector companies. If so, one of the weaknesses of the collaborative governance model should be easy to see. With such a reliance on discussion and consensus, collaborative governance is most compatible with entities that are closely aligned in terms of overarching objectives, purpose, and values. Corporations have commercial objectives such as growth, profitability, and enhancement of shareholder value. This does not always align with patient-centred and broader social goals. How then could a collaborative governance model effectively address conflicts and contrasting objectives? The answer is that in order for governments to be satisfied that they have a mechanism for asserting some form of control over the entity, something must be added to the governance model.

What is proposed is a bicameral governance structure, which contains a dual oversight component (Carson 2015b). First is the board of directors of the collaborative entity. Call this the Operating Board. The mandate of the Operating Board is to provide oversight of the management and operations of the collaborative. The role of management of the collaborative is to ensure the operation of the collaborative and the achievement of its objectives. The Operating Board oversees management to ensure that it is doing its job. To ensure that clarity exists between the Operating Board and management, there must be an "operating agreement." The day-to-day functioning of management within the terms of the agreement is the responsibility of the Operating Board.

In thinking of strategic alliances, the Operating Board would provide the control feature of management oversight. The ongoing operations of the alliance would be the responsibility of management. The Operating Board would provide the same governance role as any corporate board exercises with respect to management.

The second component of the bicameral structure is what we will call the Policy Council. This is a board comprising the government and private sector representatives, whose role is to ensure that the collaboration is continuing to serve the policy purpose for which it was formed. The Policy Council is the vehicle through which the government is able to ensure that its policy authority and accountability requirements are met. It is not the role of the Policy Council

to concern itself with day-to-day operations, or to intervene in the sphere of the Operating Board's responsibility.

The Canadian Blood Services provides an illustration of the bicameral structure. As an operating entity the corporation and its management are overseen by a board of directors. The board's responsibility is to ensure that management is acting in the best interests of the corporation in accordance with its mandate. In our terminology this is the Operating Board. But the Canadian Blood Services has a second component to its governance structure. The corporation's activities are funded by the provinces (except Quebec), so each province has an interest in ensuring that its objectives are being met overall. The Canadian Blood Services version of what we would call the Policy Council is the entity that reviews the corporation from this overarching point of view. There is a council that is comprised of government officials who review the broad functioning of the corporation in relation to its purpose for being. This is not its operational role. In this way the corporation's bicameral governance structure provides two types of oversight (Sher 2015).

It is important to distinguish between a "bicameral model" and what we might call a "two-level model" in which one board provides oversight to the other. The upper level board is thereby more senior than the lower level board. This is different than in a bicameral structure where the boards have different purposes and roles.

It must be recognized though that the Policy Council has a more senior level standing than the Operating Board, for the Policy Council has the power to end the relationship between the government and its alliance partners. But its senior position does not imply a duty of oversight or a duplication of its role in supervising the senior management of the organization.

Figure 3 summarizes the structural difference between a two-tier governance model and a bicameral model.
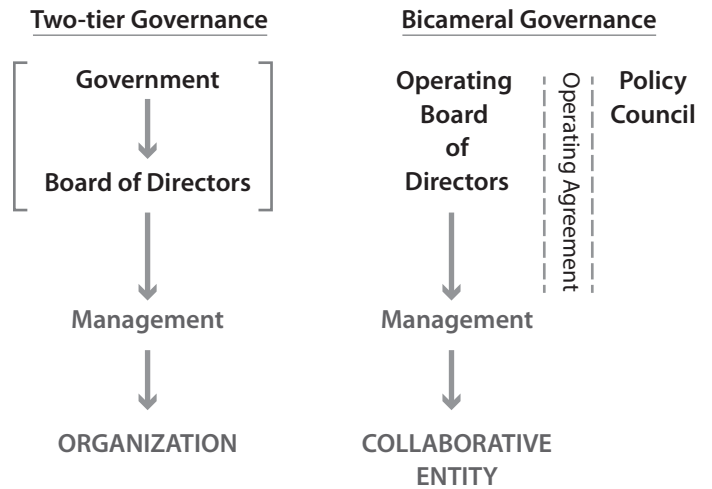
Two-tier Governance

Government

↓

Board of Directors

↓

Management

↓

ORGANIZATION

Bicameral Governance

Operating Board of Directors | Operating Agreement | Policy Council

↓

Management

↓

COLLABORATIVE ENTITY

Figure 3: Two-tier and Bicameral Governance

STRATEGIC ALLIANCES IN CANADA

What is being proposed herein is a non-politicized approach to advancing Canadian healthcare in spheres that can best benefit by organizations and individuals from both public and private sectors working together in collaboration. This is not the place to outline in detail where specific opportunities might lie. However, the six-point framework outlined above (i.e., financial, capacity, expertise, innovation, institutional learning, and reputational enhancement) is a useful evaluative tool, both for assessing the viability of an alliance candidate and for seeking out and prioritizing new opportunities.

In these challenging times of resource constraint, many public sector healthcare institutions focus on the first three components of the framework, namely financial, capacity, and expertise, as a way of bolstering what might be absent or in short supply. As an illustration, the Council of Academic Hospitals of Ontario (CAHO) expresses a deep concern about funding for the research enterprise in its 2013–14 Annual Report. Referring to its own study of funding pressures it says:

> These findings by the CAHO community provide the basis for an informed discussion with investment partners in government, industry and the philanthropic community. CAHO will continue to work to develop a model for sustainable, long-term investment in health research…

In this statement, CAHO is recognizing the importance of public private collaboration, but the focus is placed on resource constraint. This is not a criticism of CAHO because this was the purpose of their study. Still, it draws attention to the importance of looking for strategic opportunities beyond the financial aspects.

The opportunities in Canadian healthcare are numerous and varied. Many involve connecting entrepreneurs or corporations who have developed a new technology with providers and patients. For instance, the Ontario Telemedicine Network is a world leader in telemedicine that links technology, specialists, primary care professionals, and patients. As an example of the available services, a patient in a remote location can send a photograph of a mole on her arm to a dermatologist who then responds with a diagnosis in days, rather than the patient waiting weeks or months for an in-person consultation. Or, a patient wearing a remote monitoring device can be monitored by a practitioner who interprets the data for early intervention at the local level, rather than in the emergency room of a hospital. Alliances such as these achieve not just cost savings, capacity, and expertise, but also innovation, new learning, and reputational enhancement.

Some alliances form because the partners conceive of an innovative solution to a problem coming from an application of an existing technology. In other cases, the alliance partners begin with a problem and together design an original solution that itself can give rise to future applications. Both alliances bring value that goes beyond other forms of partnership with respect to innovation. The latter, though, has the potential to generate more learning and reputation than the former. When thinking of the continuum of partnerships discussed above in relation to Canadian healthcare, all are valuable, but the strategic alliance has the most to offer.

As a summary of partnership structures, Table 3 sets out the considerations for selecting the most appropriate form of partnership for the objectives to be met.

Forms	Contracts	Public Private Partnerships	Strategic Alliances
Roles	• *Services:* Maintenance, professional (accounting, audit, IT) • *Supplies:* Hospital medical, technical, devices, equipment	*Projects:* Hospital, clinical, and other infrastructure design, build, finance, operate, maintain. *Services:* Pooling of resources to achieve shared objectives.	• *Strategic system change processes* • *Research and development* • *Strategic technology transformation:* At either system or institutional levels: strategy, planning, management
Relationship	• Government strategy, management • Government funded	• Government as policy and strategic lead • Private sector responsible for management and execution of project • Funding government or private sector	• Government and private sector as co-leads • Private sector responsible for management and execution of venture • Funding government or private sector
Value Contributions	• Cost saving • Resource efficiency • Expertise availability	• Revenue generation/financing availability, risk reduction • Cost saving • Capacity expansion • Expertise	• Revenue generation, cost saving, risk transfer • Capacity expansion • Expertise • Innovation • Institutional learning • Reputation enhancement
Risk to Democratic Accountability	*Minimal* Government establishes contract details. Service and supply providers tender.	*Medium* Governments are partners. Contracts often contain flexibility for private sector. Potential to extend outside government control.	*High* Governments are equal partners in the venture. Dispute mechanism and exit arrangements are essential for both parties.
Control Feature	Legal contractual control	Partnership influence, legal remedies, cancellation of partnership	BICAMERAL COLLABORATIVE GOVERNANCE

Table 3: Partnership Summary

Choosing the most appropriate form of partnership should be based on a clear understanding of the risks and benefits to be derived. Contracting out for services or supplies is a government-driven relationship that can result in cost savings, capacity enhancement, expertise availability, and reduction of risk by transferring it to a contractor. Alternatively, P3s enable government-led partnerships to provide opportunities of revenue generation or alternative financing availability, resource capacity expansion, expertise availability for each of the partners, and risk reduction or sharing. Further, the strategic alliance provides virtually all of the benefits of a P3, but it adds something very important, namely the capacity of the partners to innovate – to explore new opportunities for research, and system or technology transformation – to learn and grow, and to develop an enhanced reputation for excellence that leads to further opportunities.

However, strategic partners still have their differences. The private sector has commercial goals that it cannot ignore. This leaves government vulnerable to being unable to achieve one of its most important goals, namely responsibility and accountability. The bicameral governance structure provides a mechanism for drawing together both the public and private sector partners in a way that enables both to achieve common strategic objectives while ensuring they meet their obligations to their stakeholders.

CONCLUSION

In the Canadian healthcare system, the public and private sectors have been coming increasingly together in recent years. The private sector is participating ever more broadly as the role of healthcare providers expands outside of hospitals and across the continuum of care. As well, the influence of business theory and practice is found throughout the governance and management of institutional delivery of care. This convergence of purpose and thinking presents valuable opportunities for partnerships and alliances.

Public private partnerships have the potential to contribute much to the development of infrastructure and other capacity in the Canadian healthcare systems. But in pushing the boundaries of partnership structures, strategic alliances have the capability to bring in further resources and expertise to achieve certain public policy objectives. They represent a special type of partnership in which both the government and the private sector partners can have an alignment of strategic objectives and pursue their objectives more successfully by working together rather than apart.

A strategic alliance shares many of the features of a public private partnership, but the essential difference is in the coming together of strategic priorities between the government and the corporation. A public private partnership may be a very effective way of achieving an overall public policy goal, but this is often achieved despite the fact that the private sector party's goals are more commercial than public policy related. Strategic alliances are different than public private partnerships precisely because they represent an opportunity for business and government to come together in a joint undertaking where both have strategic objectives that do in fact align. It is this alignment that creates the exceptionally strong capability of the partners working together – both want substantially the same things because each has found a way to integrate its individual goals with those of the alliance.

Appendix A: Public Private Partnerships in the Healthcare Sector Across Canada

#	Project Title	Province/Territory	Current Stage	Model
1	Abbotsford Regional Hospital & Cancer Centre	British Columbia	Operational	Design-Build-Finance-Maintain-Operate
2	BC Cancer Agency Centre for the North	British Columbia	Operational	Design-Build-Finance-Maintain
3	BC Children's and BC Women's Redevelopment Project	British Columbia	Under Construction	Design-Build-Finance-Maintain
4	Bluewater Health Sarnia	Ontario	Operational	Build-Finance
5	Brampton Civic Hospital	Ontario	Operational	Design-Build-Finance-Operate
6	Bridgepoint Health	Ontario	Operational	Design-Build-Finance-Maintain
7	Cambridge Memorial Hospital Capital Redevelopment	Ontario	Under Construction	Build-Finance
8	Casey House Facility Replacement Project	Ontario	Under Construction	Build-Finance
9	Centracare Psychiatric Care Facility	New Brunswick	Operational	Design-Build-Finance-Maintain
10	Centre for Addiction and Mental Health Phase 1C Redevelopment Project	Ontario	RFQ	Design-Build-Finance-Maintain
11	Centre for Addiction and Mental Health (CAMH)	Ontario	Operational	Design-Build-Finance-Maintain
12	CHU Sainte-Justine	Quebec	Under Construction	Design-Build-Finance
13	Credit Valley Hospital Phase II Redevelopment	Ontario	Operational	Build-Finance
14	Credit Valley Hospital Priority Areas Redevelopment Phase III	Ontario	Under Construction	Build-Finance
15	Devonshire Care Centre	Alberta	Operational	Design-Build-Finance-Operate
16	Erinoak Kids Centre for Treatment and Development	Ontario	Financial Close	Design-Build-Finance
17	Fort St. John Hospital & Residential Care Project	British Columbia	Operational	Design-Build-Finance-Maintain
18	Gordon & Leslie Diamond Health Care Centre	British Columbia	Operational	Design-Build-Finance-Maintain
19	Halton Healthcare Services (Oakville Hospital)	Ontario	Under Construction	Design-Build-Finance-Maintain
20	Hamilton Health Sciences (Hamilton General Hospital)	Ontario	Operational	Build-Finance
21	Hamilton Health Sciences (Juravinski Hospital and Cancer Centre)	Ontario	Operational	Build-Finance
22	Hamilton Health Sciences McMaster Children's Hospital	Ontario	Under Construction	Design-Build-Finance
23	Haut-Richelieu-Rouville (Montérégie) Long-Term Care Centre (CHSLD)	Quebec	Under Construction	Design-Build-Finance-Maintain-Operate
24	Haute-Yamaska (Montérégie) Long-Term Care Centre (CHSLD)	Quebec	Under Construction	Design-Build-Finance-Maintain-Operate
25	Hawkesbury and District General Hospital Redevelopment	Ontario	Under Construction	Build-Finance
26	Humber River Regional Hospital	Ontario	Under Construction	Design-Build-Finance-Maintain
27	Interior Heart and Surgical Centre Project	British Columbia	Under Construction	Design-Build-Finance-Maintain
28	Jardins-Roussillon (Montérégie) Long-Term Care Centre (CHSLD)	Quebec	Operational	Design-Build-Maintain-Finance-Operate
29	Jim Pattison Outpatient Care and Surgery Centre	British Columbia	Operational	Design-Build-Finance-Maintain
30	Joseph Brant Memorial Hospital Redevelopment Phase 1	Ontario	Financial Close	Design-Build-Finance
31	Kelowna and Vernon Hospitals Project	British Columbia	Operational	Design-Build-Finance-Maintain
32	Kingston General Hospital & Cancer Centre of Southeastern Ontario	Ontario	Operational	Build-Finance
33	Lakeridge Health	Ontario	Operational	Build-Finance
34	Laval Long-Term Care Centre (CHSLD)	Quebec	Operational	Design-Build-Finance-Maintain-Operate
35	London Health Sciences Centre (M2P2)	Ontario	Operational	Build-Finance
36	London Health Sciences Centre (M2P3)	Ontario	Under Construction	Build-Finance
37	MacKenzie Vaughan Hospital	Ontario	Shortlist	Design-Build-Finance-Maintain
38	Markham Stouffville Hospital	Ontario	Operational	Build-Finance
39	McGill University Health Centre (MUHC) Glen Campus	Quebec	Construction Complete	Design-Build-Finance-Maintain
40	Milton District Hospital Redevelopment	Ontario	Financial Close	Design-Build-Finance-Maintain
41	Montfort Hospital	Ontario	Operational	Build-Finance
42	Montreal University Hospital Center (CHUM)	Quebec	Under Construction	Design-Build-Finance-Maintain
43	Montreal University Hospital Research Centre (CRCHUM)	Quebec	Operational	Design-Build-Finance-Maintain
44	Niagara Health System (St. Catharines Hospital)	Ontario	Operational	Design-Build-Finance-Maintain
45	North Bay Regional Health Centre	Ontario	Operational	Build-Finance-Maintain
46	North Island Hospitals Project	British Columbia	Under Construction	Design-Build-Finance-Maintain

#	Project Title	Province/Territory	Current Stage	Model
47	Ottawa Paramedic Service Headquarters	Ontario	Operational	Design-Build-Finance-Maintain
48	Ottawa Regional Cancer Centre (Ottawa Hospital)	Ontario	Operational	Build-Finance
49	Ottawa Regional Cancer Centre (Queensway Carleton Hospital)	Ontario	Operational	Build-Finance
50	Peel Memorial Centre for Integrated Health and Wellness	Ontario	Under Construction	Design-Build-Finance-Maintain
51	Penticton Regional Hospital Patient Care Tower	British Columbia	RFP	Design-Build-Finance-Maintain
52	Phase 1 Patient Tower Project at Etobicoke General Hospital	Ontario	Shortlist	Design-Build-Finance-Maintain
53	Providence Care Hospital	Ontario	Under Construction	Design-Build-Finance-Maintain
54	Public Health Laboratory at MaRS Center Phase 2	Ontario	Under Construction	Build-Finance
55	Quinte Health Care Belleville Site	Ontario	Operational	Build-Finance
56	Restigouche Hospital Centre	New Brunswick	Under Construction	Design-Build-Finance-Maintain
57	Rouge Valley Health System (Ajax-Pickering Hospital)	Ontario	Operational	Build-Finance
58	Royal Jubilee Hospital Patient Care Centre	British Columbia	Operational	Design-Build-Finance-Maintain
59	Royal Ottawa Mental Health Centre	Ontario	Operational	Design-Build-Finance-Maintain-Operate
60	Royal Victoria Hospital (Barrie)	Ontario	Operational	Build-Finance
61	Runnymede Healthcare Centre	Ontario	Operational	Build-Finance
62	Saint-Lambert Long-Term Care Facility (CHSLD)	Quebec	Operational	Design-Build-Finance-Maintain-Operate
63	Saskatchewan Hospital North Battleford - Integrated Correctional Facility	Saskatchewan	RFP	Design-Build-Finance-Maintain
64	Sault Area Hospital	Ontario	Operational	Build-Finance-Maintain
65	St. Joseph's Health Care London (M2P1)	Ontario	Operational	Build-Finance
66	St. Joseph's Health Care London (M2P2)	Ontario	Operational	Build-Finance
67	St. Joseph's Health Care London (M2P3)	Ontario	Under Construction	Build-Finance
68	St. Joseph's Healthcare Hamilton - West 5th Campus	Ontario	Operational	Design-Build-Finance-Maintain
69	St. Joseph's Regional Mental Health Care (London and St. Thomas)	Ontario	Under Construction	Design-Build-Finance-Maintain
70	St. Michael's Hospital Redevelopment Project	Ontario	Financial Close	Design-Build-Finance
71	St. Thomas Elgin General Hospital	Ontario	Shortlist	Build-Finance
72	Stanton Territorial Hospital Renewal Project	Northwest Territories	Shortlist	Design-Build-Finance-Maintain
73	Sudbury Regional Hospital	Ontario	Operational	Build-Finance
74	Sunnybrook Health Sciences Centre	Ontario	Operational	Build-Finance
75	Surrey Memorial Hospital Redevelopment and Expansion: Emergency Department and Critical Care Tower	British Columbia	Operational	Design-Build-Finance-Maintain
76	Swift Current Long Term Care Centre Project	Saskatchewan	Under Construction	Design-Build-Finance-Maintain
77	Toronto Rehabilitation Institute (University Centre site)	Ontario	Operational	Build-Finance
78	Trillium Health Centre	Ontario	Operational	Build-Finance
79	University of Ottawa Heart Institute: Cardiac Life Support Services Redevelopment Project	Ontario	Under Construction	Build-Finance
80	VIHA Residential Care & Assisted Living Capacity Initiative	British Columbia	Operational	Design-Build-Finance-Operate
81	Waypoint Centre for Mental Health Care	Ontario	Operational	Design-Build-Finance-Maintain
82	Windsor Regional Hospital (Western Site)	Ontario	Operational	Build-Finance
83	Women's College Hospital	Ontario	Under Construction	Design-Build-Finance-Maintain
84	Woodstock General Hospital	Ontario	Operational	Build-Finance-Maintain

Source: The Canadian Council for Public and Private Partnerships (Canadian PPP Project Database, 2015),
http://projects.pppcouncil.ca/ccppp/src/public/search-project?pageid=3d067bedfe2f4677470dd6ccf64d05ed.

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Health Policy Advocacy: The Role of Professional Associations

WHITE PAPER - WORKING DRAFT

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This paper documents the experiences and key learnings of the Canadian Nurses Association (CNA) and the Canadian Medical Association (CMA) in collaborating to advocate for a national health policy agenda since the early 1990s. There are two main underlying reasons for our policy advocacy efforts. First, advocacy for the health and well-being of Canadians was foundational to why we were established and why we continue to exist today. Like most national health organizations, the CMA and CNA have a two-fold mission of representing the interests of our members and the Canadian population. The CMA's vision includes being "the national voice for the highest standards for health and healthcare" (2015a), and the CNA's objects and goals include: "to advocate in the public interest for a publicly funded, not-for-profit health system" and "to shape and advocate for healthy public policy provincially/territorially, nationally and internationally" (2015).

Second, the CMA and CNA have long contributed to health policy capacity and advocacy in Canada. We were established in 1867 and 1908 respectively, well before the federal Department of Health in 1919. We would argue that this capacity has become more important in the past few decades as the federal government has become increasingly disengaged in the health policy arena, starting in the late 1970s when the original 50:50 cost-sharing for medicare was replaced by the combination of tax points and per capita cash grants with the Established Programs Financing (EPF) Act of 1977.

The last unilateral broad health policy initiative from the federal government was the striking of Prime Minister Jean Chrétien's National Forum on Health (NFH) in 1994, which was reported in February 1997. The NFH recommended that the Medicare program be expanded to include prescription drugs and home care, and a $150 million Health Transition Fund was established in the 1997 budget to explore these and other issues such as primary care reform. In January 2000, health minister Allan Rock wrote to his provincial and territorial

(PT) counterparts to propose a cost-shared home care program, new models of primary care, and wait time standards, and was immediately rebuffed by the PT health ministers (McIlroy 2000). Since that time, the national health policy agenda has evolved primarily through a series of three First Ministers' Accords, and since 2012 through the Council of the Federation Health Care Innovation Working Group.

The federal and provincial-territorial dynamics since the 1990s have provided both challenges and opportunities to us and to other health stakeholders. We have certainly learned the value of collaboration between our organizations and in working with others. While the CNA and CMA have had some common objectives since the beginning, bilateral collaboration did not start until 1991, when both became two of seven charter members of the Health Action Lobby (HEAL).[1]

HEAL was established following the 1991 federal budget, which contained the measure that the health and social transfers would be frozen in per capita terms through 1994–95, after which they would grow at a rate of GNP growth minus three percentage points (Finance Canada 1991). HEAL was established out of concern that the federal freeze in EPF transfers would have a destabilizing effect on medicare. One of HEAL's first activities was to commission a report on the EPF program. The report documented that the changes to EPF would result in $30 billion in healthcare funding reductions from 1986 to 1996, and that as a result of the growth in the value of the tax point transfer, the cash component was on track to disappear over the next decade (Thomson 1991). HEAL was concerned

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1. Seven charter members were Canadian Hospital Association, Canadian Long Term Care Association, Canadian Medical Association, Canadian Nurses Association, Canadian Psychological Association, Canadian Public Health Association, and Consumers Association of Canada.

that this would eliminate the ability of the federal government to enforce the Canada Health Act (CHA). Early in its activities, HEAL established ten guiding principles (Figure 1) (1991).

Figure 1 – HEAL's Guiding Principles for Health and Healthcare

1. Health goals (national and provincial)
2. Continuum of care
3. Shared responsibility for safeguarding Canada's health system
4. Consumer participation in healthcare decision-making
5. Individual rights
6. Cooperation (interdisciplinary, intersectoral, intergovernmental)
7. Stability of funding
8. Efficient and effective management
9. Voluntarism
10. Professional self-regulation and licensure

In its early years, there was frequent interaction among HEAL members. This fostered trust in working together that has facilitated other collaborations. Another lesson from HEAL was the value in bringing credible evidence to the table. The initial report on EPF was followed by the commissioning of other expert reports. HEAL continues to this day and now includes some forty members.

One of the challenges of collaboration at a national level is trying to raise awareness and support among provincial/territorial constitutional associations and the grassroots membership. Indeed, just one year after HEAL was formed, a motion was put forward at CMA General Council in 1992 that called for CMA to disassociate itself from HEAL, but it was defeated. At one point there was discussion of creating provincial-level HEAL organizations, and Manitoba tried it, but ultimately this was not pursued.

The stage for continued collaboration between CNA and CMA was set with the 1995 federal budget, which announced the consolidation of health and social transfers in the Canada Health and Social Transfer (CHST). The CHST was set to take effect on April 1, 1996, at which time the federal government reduced the cash transfer by $6 billion over two years. This was on the heels of restraint from the recession of the early 1990s that saw a small decline in real per capita public spending on healthcare from 1993 through 1996. As a result, the issue of long wait times for tests and procedures began to rise steadily as a concern among both the public and providers.

In late 2003, the CMA commissioned international research among key stakeholders in Australia, New Zealand, and Europe on the issue of wait times, which was discussed at an invitational roundtable in April 2004. The roundtable deliberations informed the development of a joint CNA-CMA discussion paper,

"The Taming of the Queue: Toward a Cure for Health Care Wait Times," (CNA, CMA 2004) that was released in July of that year. This paper set out a 10-point plan for the measurement and management of wait times (Figure 2).

Figure 2 – 10-Point Action Plan for Managing Wait Times

1. Set priorities through broad consultation
2. Address patient/public expectations through transparent communications
3. Address immediate gaps in health human resources and system capacity
4. Improve data collection through investments in information systems
5. Develop wait time benchmarks through clinical and public consensus
6. Strengthen accountability by way of public reporting
7. Maximize efficiencies by aligning incentives properly
8. Address upstream and downstream pressures by investing in the continuum of care
9. Expand inter-jurisdictional care options by enhancing portability provisions
10. Commit to adoption of best practices

The discussion paper was followed by a telephone survey of both physicians and nurses in late July of that year. The results showed that physicians and nurses were very much on the same page in terms of experiences with wait times and the impact on patients. Access to family physicians topped both of their lists of access problems. Both groups shared the same view on declining access for services of specialists, nursing care in hospitals, emergency room services, and surgery. Large majorities of each group agreed that Canada needs a national system that measures waiting times for health services and diagnosis (Ipsos Reid 2004).

The "Taming of the Queue" discussion paper and poll results were released on the eve of the First Ministers' conference that was convened by Prime Minister Paul Martin from September 13–16, 2004. Throughout the meeting, the CMA and CNA were onsite at the Government Conference Centre in Ottawa, along with senior representatives of the Canadian Healthcare Association and the Canadian Pharmacists Association. During the meeting, Newfoundland and Labrador premier Danny Williams waved the "Taming of the Queue" paper in the air at one point. The effect of the combined advocacy effort of the premiers and the stakeholders was seen in the difference between the federal government's initial proposal and the outcome. Going into the meeting, the federal government circulated a proposal with an offer of $24.9 billion in additional health funding over a 10-year period (Canada 2004). At the

conclusion of the meeting, however, the federal government had increased its commitment to $41.3 billion, including a $5.5 billion Wait Times Reduction Fund (Canadian Intergovernmental Conference Secretariat n.d.).

Since the initial small roundtable in 2004, *Taming the Queue* has become an annual conference planned by a consortium of stakeholders with funding support from Health Canada that regularly attracts over 160 participants from governments, health authorities, and the broader health community. The 12th conference took place on April 16–17, 2015.[2]

Another key commitment of the 2004 Health Accord was an agreement by governments to increase the supply of health professionals, and to make their action plans public by December 31, 2005. This commitment inspired a new collaboration between the CMA and CNA to develop a set of core principles and strategic directions for a pan-Canadian health human resources plan, something that we had both long advocated for separately. The resulting green paper contained ten core principles, each of which had strategic directions identified (Figure 3). The report (CNA, CMA 2005) was released jointly by the CMA and CNA at a special session at the CMA General Council in August 2005.

Figure 3 – Core Principles for a Pan-Canadian Health Human Resources Plan

1. Needs-based planning
2. Collaboration among disciplines
3. The health workforce is a national resource
4. Greater self-sufficiency
5. Recognize the global environment
6. Inclusive policy planning and decision-making processes
7. Competitive human resource policies
8. Healthy workplaces
9. Balance between personal and professional life
10. Lifelong learning

The release of this report was followed soon after by the release in September of *A Framework for Collaborative Pan-Canadian Health Human Resource Planning* by the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, and there is significant commonality between the two reports (ACHDHR 2007).

Policy analysts have been too quick to discount the leadership role of the federal government in promoting health reform in a pan-Canadian context. The

$800 million Primary Health Care Transition Fund (PHCTF) was a federal government commitment under the First Ministers' 2000 Health Accord that resulted in a series of national and provincial/territorial projects that were directed at five common objectives to promote and enhance the delivery of multidisciplinary primary care (Health Canada 2007). The CMA and CNA collaborated with eight other health professional organizations on an initiative funded under the PHCTF to develop a set of principles and a framework to enhance interdisciplinary collaboration in primary healthcare (EICP). In the course of this project all collaborating organizations reached out to engage both our grassroots members and our leadership. During one large leadership gathering, it became evident that one of the barriers to effective collaboration was a lack of awareness about the role and function of the different providers. The EICP initiative resulted in six principles and seven framework elements (Figure 4) (EICP 2006a).

Figure 4 – Enhancing Interdisciplinary Collaboration in Primary Health Care: Framework and Principles

Framework Elements	Principles
Patient/client engagement	Health human resources
Population health approach	Funding
Best possible care and services	Liability
Access	Regulation
Trust and respect	Information/communications technology
Effective communication	Management and leadership Planning and evaluation

During the course of this project, one positive development was the release of a joint statement, in 2005, by the Canadian Medical Protective Association and the Canadian Nurses Protective Society on liability for nurse practitioners and physicians in collaborative practice (2013). This statement identified the liability risks in collaborative practice and set out seven stops to decrease those risks.

At the conclusion of the project, the EICP principles and framework were endorsed by all participating organizations. It is difficult to judge the direct impact that the project has had on the ground, but there is little doubt that it influenced other stakeholders at the national and provincial-territorial levels. Indeed thirty-nine organizations, including professional associations, regulatory bodies, and health regions, signed on as supporters of the final document (EICP 2006b). Importantly, the intense and continuous collaboration over its course has also continued to foster trust among the participating organizations that paved the way for further joint efforts.

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2. Presentations and summary reports from *Taming of the Queue* conferences may be found on the website of the Canadian Foundation for Healthcare Improvement at http://www.cfhi-fcass.ca/NewsAndEvents/Events/Taming_of_the_Queue/TamingQueue2014.

Aside from our collaborative endeavours, our organizations have both undertaken major efforts over the past several years with a view to outlining a path forward for transformational change in healthcare. While we have carried these out independently, they are highly congruent in embracing the Institute for Healthcare Improvement's (IHI) Triple Aim approach (2015). In developing the Triple Aim, IHI has taken the approach that optimal health system performance can only be achieved through the simultaneous pursuit of three dimensions:

- Improving the experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of care.

CMA – HEALTHCARE TRANSFORMATION

The 2008 meeting of the CMA General Council adopted a resolution calling for the development of "a blueprint and timeline for transformational change in Canadian health care to bring about patient-focused care." The first phase of the Health Care Transformation (HCT) initiative was an international study tour, whereby CMA President Dr. Robert Ouellet and two staff members interviewed 75 people from 36 organizations and groups in five European countries that were selected on the basis of having introduced significant change in their health systems (Canadian Medical Association 2009a). The focus of the interviews was on both the "what" and the "how" of transformational change, and was modelled loosely on John Kotter's eight-stage process of change, beginning with establishing a sense of urgency through to institutionalizing new approaches (Kotter 1996).

The findings of this study served as the foundation for a discussion paper that was examined at the General Council in 2009 (Canadian Medical Association 2009b), and which was further refined into a policy document in 2010 (Canadian Medical Association 2010). The policy document set out a framework for transformation that is based on five pillars:

- Building a culture of patient-centred care;
- Providing incentives to enhance access and improve quality of care;
- Enhancing patient access along the continuum of care;
- Helping providers help patients; and
- Building accountability and responsibilities at all levels.

This was followed in early 2011 by a series of six public town hall meetings held across Canada, conducted in partnership with *Maclean's* magazine, in which members of the public were engaged on issues of value in healthcare, the responsibility that patients and their families have for their health, and the expansion of the CHA (Canadian Medical Association 2011). Further external engagements have included the striking of an expert Advisory Panel on

Resourcing Options for Sustainable Health Care in Canada in 2011 and a second cross-national series of town hall meetings on social determinants of health in 2013.

CNA NATIONAL EXPERT COMMISSION

In 2011, the CNA established an independent National Expert Commission (NEC), comprising ten leaders from the fields of nursing, medicine, law, academia, economics, and healthcare policy. The NEC was organized around the Triple Aim framework and it carried out extensive stakeholder and public consultation, including:

- Nineteen public roundtables carried out in partnership with YMCA Canada;
- Stakeholder meetings;
- Public polling;
- A call for submissions that resulted in almost fifty individual submissions from nurses, the public, and other health professionals, and eight organizational submissions; and
- Three commissioned research syntheses on each of the Triple Aim elements of better care, better health, and better value (National Expert Commission 2015).

Reports were published on all of these activities.

The NEC's final report (National Expert Commission 2012) was published in June 2012, and it contained a nine-point action plan (Figure 5).

Figure 5 – National Expert Commission: Nine-Point Action Plan

1. Challenge all Canadians to rank in top five nations for five key health outcomes by 2017
2. Set pan-Canadian goals through local solutions
3. Implement primary care for all by 2017
4. Invest in social determinants of health
5. Identify the health and health care needs of vulnerable and marginalized people
6. Governments should integrate health in all policies
7. Use best evidence to promote safety and quality
8. Train providers to match system transformation
9. Use technology to its fullest

Following the release of the report, the CNA engaged Drs. Adelsteinn Brown and Terrence Sullivan to conduct an interactive, evidence-based process to select the top five indicators (2013). The final five indicators are shown in Figure 6.

Figure 6 – CNA Top 5 in 5 Indicators for 2017

1. Increase the percentage of primary care practices offering after-hours care
2. Increase chronic disease case management and navigational capacity in primary care
3. Increase Canadians' access to electronic health information and services
4. Decrease hospital admissions for uncontrolled diabetes-related conditions
5. Decrease the prevalence of childhood obesity

Through our respective transformation initiatives the CMA and CNA have come to fully embrace the Triple Aim framework and its three elements, which we have termed better care, better health, and better value. In 2011, we developed guiding principles for healthcare transformation that build on the foundational principles of the Canada Health Act. These consist of six principles that are organized under the Triple Aim framework (Figure 7).

Figure 7 – CMA-CNA Guiding Principles for Health Care Transformation

Better Care
• Patient-centred care that is seamless along the continuum of care
• Quality services appropriate for patient needs

Better Health
• Health promotion and illness prevention
• Equitable access to care and multi-sectoral policies to address the social determinants of health

Better Value
• Sustainability based on universal access to quality health services
• Accountability by stakeholders – the public/patients/families, providers and funders – for ensuring the system is effective

Upon the release of the principles in July 2011, we began to solicit endorsements from national and provincial/territorial organizations starting with our own PT bodies. They have since been endorsed by all of the provincial/territorial medical and nursing organizations, and in total by some 130+ organizations.

The healthcare transformation initiatives of the CNA and CMA, as well as those of other organizations, were motivated in significant measure by the anticipated negotiations around the renegotiation of the 2004 First Ministers' Health Accord that was set to expire in March 2014. Based on the precedents of the 2000, 2003, and 2004 Accords, there was every reason to believe that this would be the case. Indeed, the morning after the May 3, 2011 election, Prime Minister Harper said that "in terms of renegotiating the Health Accord for 2014, and those negotiations will begin sooner rather than later, it is critical that we sit down and talk about how we can ensure that the system is used properly to achieve better outcomes and results. Now that is a collaborative discussion I want to have with the provinces" (*CBC News* 2011).

However, this was not to be the case. At a meeting of federal/provincial/territorial (FPT) finance ministers on December 19, 2011, finance minister James Flaherty made the announcement that the 6 percent escalator in the CHT would be extended through 2016–17, and thereafter lowered to 3 percent or the rate of nominal GDP growth through 2023–24, and would be reviewed in 2024 (Department of Finance Canada n.d.). Although in hindsight there were signals that such a pre-emptive move might occur, this nonetheless caught the premiers by surprise. Coming out of their summer meeting they had agreed to meet in January 2012 to "work together on identifying key principles that should govern a new agreement on health care with the federal government" (Council of the Federation 2011). They also planned to continue their work on an alliance for drug procurement and on the uptake of clinical practice guidelines. It was also noteworthy that the PT health and wellness ministers endorsed the Triple Aim framework in the communiqué from their November 24, 2011 meeting, at which they discussed how they could address issues including sodium consumption, obesity, and mental health (Canadian Intergovernmental Conference Secretariat 2011).

Going into their January 2012 meeting, the premiers remained hopeful that the federal government might consider an "innovation fund," but the prime minister pre-empted them in a January 16th interview with *CBC's* Peter Mansbridge. In response to a question from Mr. Mansbridge about such a fund, Mr. Harper replied: "What I think we all want to see now from the premiers who have the primary responsibility here is what their plan and their vision really is to innovate and to reform and to make sure the health-care system's going to be there for all of us. So I hope that we can put the funding issue aside…" (*CBC News* 2012). Notwithstanding Mr. Harper's rejection of the innovation fund, at the conclusion of their January 17th meeting, the premiers announced the formation of the Health Care Innovation Working Group (HCIWG), to be co-chaired by Saskatchewan premier Brad Wall and Prince Edward Island premier Robert Ghiz. The initial six-month mandate of the HCIWG comprised the following:

• Scope of practice (team-based models): examining the scope of practice of healthcare providers and teams in order to better meet

patient and population needs in a safe, competent and cost effective manner;

- Human resources management: address health human resource challenges and explore more coordinated management to address competition across health systems; and
- Clinical practice guidelines (CPGs): accelerating the development and adoption of best clinical and surgical practice guidelines so that all Canadians benefit from up-to-date practices (Council of the Federation 2012).

They also indicated that the HCIWG would consult with healthcare providers in carrying out this work and the CNA, CMA, and Health Action Lobby were invited to participate in the team-based models and CPG elements, although it was made clear at the outset that the premiers owned the process.

Just prior to getting involved with the HCIWG, in early 2012, the CNA invited CMA to co-host a Health Stakeholder Summit (CNA, CMA 2012) focused on Primary Health Care (PHC) to provide Health Canada with recommendations for future policy directions, by identifying and prioritizing key opportunities and mechanisms to support the integration and implementation of PHC across Canada. With funding support from Health Canada, the summit was designed as a facilitated policy dialogue that:

- Explored fresh perspectives, promising practices, and key enablers to advancing PHC
- Identified policies and mechanisms to increase access to quality PHC for Canadians
- Identified how PHC can be fully integrated into the Canadian healthcare system

The Summit was attended by thirty participants from six jurisdictions, and a wide variety of professional backgrounds was represented, including a patient representative. The participants identified barriers to advancing PHC and reached consensus on seven strategies to move forward, including a call to support the development of innovative integrated delivery models for PHC through interprofessional teams designed to meet the needs of the patient populations served. The Summit built on previous collaborations of the CMA and CNA and other health organizations, and we were well-positioned to contribute to the HCIWG's team-based models initiative.

The team-based models working group adopted principles and criteria based on the Triple Aim to identify models that promote optimal collaborative and interprofessional care. The principles are shown in Figure 8 (Health Care Innovation Working Group 2012b).

Figure 8 – Principles for Selection of Team-Based Models of Care

1. Patient-centred
2. Enhances the integration of care
3. Increases equitable access to care
4. Evidence-informed
5. Supports health promotion and illness prevention
6. Sustainable
7. Incorporates innovations
8. Optimizes skills and scope of practice

Similarly, the CMA and CNA had experience in the area of CPGs to contribute. In the 1990s, the CMA developed the CMA Infobase, a searchable database of some 1,200 CPGs developed or endorsed by authoritative medical or health organizations in Canada (2015b). As part of the development of the HCIWG CPG initiative, our organizations developed a paper to guide the selection of the initial topics (CMA, CNA 2012).

The HCIWG's first report was tabled at the premiers' summer meeting in Halifax. It contained twelve recommendations. In the area of CPGs, it was recommended that ministers work with clinical communities to adopt the C-Change Guidelines for Heart Disease and the Registered Nurses' Association of Ontario Guidelines for the Assessment and Management of Foot Ulcers for People with Diabetes. In the area of team-based models, eight models were identified to address needs in the following areas:

- Access to primary care;
- Access to emergency services in rural communities; and
- Access to enhanced homecare (Health Care Innovation Working Group 2012a).

Premiers Ghiz and Wall agreed to continue to lead the work for a next phase. One year later, the HCIWG reported that success was being achieved in lowering the price for both generic and brand name drugs. The premiers asked the HCIWG group to look at appropriateness of care and seniors' care, and directed the team-based models working group to identify opportunities to increase the role that paramedics and pharmacists play in the delivery of front line services. At this time, the responsibility for the HCIWG was transferred to premiers Kathleen Wynne (Ontario), Alison Redford (Alberta), and Darrell Pasloski (Yukon Territory) (Council of the Federation 2013).

One of the challenges of the HCIWG is that it has not been provided with the resources to put a secretariat in place, although at their September 2014 meeting the PT health ministers announced that Ontario would establish an office for the Pan-Canadian Pharmaceutical Alliance (Canadian Intergovernmental Conference Secretariat 2014). The senior government

officials and the CNA/CMA/HEAL staff who have contributed have been doing so "off the edge of their desks."

On February 18, 2015, a summit was convened to review ten models that feature the roles of pharmacists and paramedics. This meeting finalized the HCIWG's work on team-based healthcare delivery models. The focus of this phase was on collaborative models where pharmacists and paramedics play enhanced roles in the provision of team-based front line services, and examples were selected by a task force that consisted of representatives from FPT governments and health provider groups. Local professionals presented ten innovative models with an emphasis on the needs identified by the team, the tools and resources developed, and barriers, enablers, and impact of the model on patients and providers. There was also discussion around the nature of innovation, which is based on local population health needs, emphasizing the importance of creating conditions to support change. Research and evaluation of models should seek to find those that are best for the patient, cost effective, and that support quality of care. The outcomes of this meeting will be part of a final report on the work on team-based models that will be submitted to deputy ministers, ministers, and premiers for further consideration.

At their summer 2014 meeting, the premiers announced the formation of a task force for the purpose of launching a dialogue with Canadians and stakeholders on the issue of population aging, and to examine the impact of the aging population on Canada's social and economic future (Council of the Federation 2014). The issue of seniors and their health and healthcare is of longstanding interest to both the CMA and CNA. It is not clear when or how the task force is proceeding. Immediately prior to the premiers' January 30, 2015 meeting, we wrote to the co-chairs to urge them to place the future mandate of the working group on seniors' care on the agenda. We were pleased to see that this was discussed, and in their communiqué the premiers called on the federal government to provide funding in support of services that enhance the well-being of Canada's seniors (Council of the Federation 2015). We look forward to seeing a progress report coming out of their July 2015 meeting.

CNA/CMA/HEAL SUMMITS ON INTEGRATED CARE

Starting in 2012, the CNA and CMA, in partnership with HEAL, initiated a summit process that brought provider groups, governments, and patients together to introduce and define new and existing evidence to support the transition to a fully and functionally integrated person and family-centred health system that offers the right provider, at the right time, for the right care. A central dimension to this shift called for the enhancement of access along the full continuum of care and a strong focus on not only ensuring smooth transitions as people navigate their journey through the system, but also on addressing social and environmental determinants of health. It was clear that governments alone would not be successful in achieving the necessary change, but that physicians, nurses, pharmacists, and other health providers must also provide leadership.

Within a rapidly changing context and with the imperative of bringing expert advice to guide health system transformation in Canada, CNA and CMA conducted a three-phase summit process in 2012–2013, which was grounded in two sources: The *Principles to Guide Health Care Transformation in Canada*, and the Triple Aim framework. This was an important opportunity for health providers to explore the core elements and design of a functionally integrated health system that enhances access across the full continuum of care.

The purpose of the first phase of the summit process involved a national workshop focused on mapping out the continuum of care using a chronic disease prevention and management framework in three high impact areas, to be selected from hypertension, cardiovascular disease, stroke, diabetes, colorectal cancer, and chronic obstructive pulmonary disease. After identifying the characteristics of an ideal continuum, workshop participants created seven functionally integrated continuums of care that resulted in visual concepts of what an ideal continuum might look like. The Phase II workshop, held in February 2013, built upon Phase I from the perspective of individuals' needs. It further considered seamless healthcare pathways (along and within the continuum of care) that account for the factors that determine and maintain health and have an impact on how well we deliver the right care, to the right person, at the right time, and in the right place (CNA, CMA 2013).

As a result of the Phase I and II summit workshops, it became clear that a strong foundation in primary healthcare principles, as well as collaboration and communication within and between different health professionals, was essential for achieving functionally integrated care. A third summit workshop was held in June 2014, at which time survey results from the HEAL membership and patients about patient and provider expectations were discussed. The expectations for the five foundations of integrated care that had been identified were confirmed by summit participants: (1) patient access; (2) patient-centred care; (3) informational continuity of care; (4) management of continuity of care; and (5) relational continuity of care. Expectations for each of the five foundations were created using five scenarios: aboriginals with diabetes, adults with COPD, children with obesity, seniors with dementia, and youth with mental health concerns (Vogel 2014). When the expectations that follow are in place to support these five foundations of integrated care, the result will be better health, better care, and better value for Canadians.

A hopeful sign that federal leadership in health has not been abandoned was the striking of an Advisory Panel on Healthcare Innovation by health minister Rona Ambrose in June 2014, chaired by Dr. David Naylor and including six other distinguished Canadians. The panel is charged with identifying the five most promising areas of innovation in Canada and internationally that have the

potential to reduce growth in health spending while improving access to and quality of care, and with recommending five ways that the federal government can support such innovation (Health Canada 2014). We were saddened by the untimely passing of panel member Dr. Cy Frank, CEO of Alberta Innovates Health Solutions, in March 2015. Both of our organizations participated in roundtables convened by the panel and submitted briefs that focused on the delivery of care to patients with complex care needs. There is growing attention to the high concentration of healthcare utilization among a small proportion of the population. In Ontario, it has been shown that the top 1 percent of patients used 34 percent of publicly funded health resources in 2007, and the top 5 percent used 66 percent (Wodchis et al. 2012). Similarly, in Alberta, the top 5 percent of patients accounted for 65 percent of health system costs in 2010 (Alberta Health 2015). We look forward to seeing the panel's report after it is submitted to Minister Ambrose in May 2015, and we hope that the federal government will establish an innovation fund to enable the implementation of its recommendations.

We are now at a crossroads with respect to our medicare program and its national character. The original program was designed at a time when healthcare was mostly about doctors, nurses, and hospitals, and the provision of acute care. At the time of the 1964 Hall Commission report, hospitals and physicians accounted for 76 percent of total health spending and prescription drugs for only 6.5 percent. Fifty years later, in 2014, hospitals and physicians accounted for 45 percent of total spending and prescription drugs had more than doubled to 13.4 percent (CIHI 2014). The fact that greater than 90 percent of hospital and 98 percent of physician expenditures continue to be publicly funded is a testament to the CHA, but beyond those services access to home and community care and prescription drugs is a patchwork quilt across the country.

In a consensus statement released in December 2014, following a discussion paper built on wide stakeholder consultation, HEAL called on all levels of government, and the federal government in particular, to commit to a renewed and sustained working relationship to improve Canada's health system. The document proposes the following vision statement for the federal government in health and healthcare:

> To advance the health and health care of Canadians, working collaboratively with the provinces and territories, health care providers and the public to ensure the promotion and delivery of appropriate, integrated, cost-effective and accessible health services and supports.

It calls for a framework for performance improvement and innovation modelled on the Triple Aim and underscores the need to promote fiscal fairness with respect to the CHT in light of the changes since 2011. The statement identifies three areas where there is a significant leadership opportunity for the federal government, including the aging population, prescription drugs, and fostering innovation. It recommends a National Health Innovation Fund that focuses on three priority areas:

- Primary healthcare
- Mental health and addictions
- A national health human resources organization to promote coordinated planning efforts across disciplines and jurisdictions

How the federal government responds to the advisory panel report will be a test for the prospects of the HEAL consensus statement.

SENIORS AND THE 2015 FEDERAL ELECTION

The next federal election is scheduled for October 19, 2015. In the lead-up to this election, both the CMA and CNA have invested considerable resources in complementary initiatives to advance the health and healthcare of seniors on the national policy agenda. The reasoning behind this is simple. Today, seniors 65+ represent one in six (15 percent) of Canadians and account for just under half (47 percent) of provincial/territorial government health spending. By 2036, these figures are projected to increase to one in four (25 percent) and just under two-thirds (62 percent) (assuming that the 2012 age-sex pattern of per capita health spending remains unchanged). While most provinces have initiated some form of seniors' strategy, there is wide variability among them and there has been no concerted national policy discussion about the prospects of seniors beyond retirement income security.

For its part, the CNA has focused on issues of healthy aging, improved access to home care, and support for family caregivers. On November 25, 2014, the CNA held an advocacy day on Parliament Hill, meeting with MPs and senators to make the case for national home care standards, making the Family Caregiver Tax Credit refundable, and expanding the New Horizons for Seniors Program to support healthy and active aging (CNA 2014). This call was strongly supported by the results of a national Nanos poll of the public:

- 93 percent agreed on the importance of having the ability to age at home with access to home care;
- 89 percent supported improving financial support to family caregivers; and
- 90 percent supported an enhanced role for nurses in providing home care to seniors and helping them navigate the health system (Nanos Research 2014a).

The CMA held a Doctors on the Hill Day on April 8, 2014, focusing on the need for a national seniors' strategy. In conjunction with this event, a Nanos poll was released that was conducted in ridings that were won by 3 percent or less in the 2011 election:

- 86 percent of those polled agreed that federal parties should make seniors' care a top priority in their political platform for the next election; and
- 87 percent supported the position of Canada's doctors and nurses in calling for a pan-Canadian strategy on seniors' care (Nanos Research 2014b).

Subsequently, seventeen parliamentarians have taken up CMA's offer to cohost a roundtable on seniors in their ridings and more are in the works.

In addition to calling on all federal parties to include a seniors' strategy in their policy platforms, CMA initiated a broad stakeholder consultation beginning in 2014 to contribute to the development of the national seniors' strategy policy framework. As part of this consultation, thirty-five organizations representing medical, patient, and health and community stakeholders (including the CNA) participated in six working groups modeled on six key components of the continuum of care: prevention and wellness; primary care; hospital care; home care and community supports; long-term care; and palliative care. The central role of the working groups was to contribute to: defining the continuum of care with a focus on seniors; identifying key issues, challenges, and enablers, both cross-cutting and for each area of the continuum; and identifying leading and promising practices in seniors' care in Canada and internationally. The resulting strategy document will be released later in Spring 2015. Most recently, the CMA has launched an Alliance for a National Seniors Strategy in partnership with the CNA and thirty other organizations, with a website (DemandAPlan.ca) to continue to build grassroots support.

We will surely know by the end of 2015 how immediately successful these efforts have been, but regardless of the outcome of the election we believe that seniors will have secured a toehold on the policy agenda. The approach we have taken on seniors reflects our key learning that effective advocacy must engage the full range of stakeholders, including patients, clients, the public, providers, and payers.

CONCLUSION

In closing, it is fair to say that, over the past two decades, the CMA and CNA and other national healthcare organizations have come to subscribe to the African proverb, "if you want to go fast, go alone, if you want to go far, go together." Aside from the collaborations discussed above, we trade notes in advance of

every opportunity to advocate to the federal government, including federal elections, pre-budget consultations, and presentations to various parliamentary committees. We believe that this ongoing collaboration enhances both our collective and individual effectiveness.

Looking over the period since 1991, we believe that we have had a positive influence in maintaining the engagement of the federal government in the healthcare system and preserving the publicly funded character of the medicare program. However, the job is far from completed. Wait times for non-emergency services remain too long, and access to health services beyond those provided by doctors and in hospitals remains unaffordable to many Canadians, and can also depend on where they live. While we and other health organizations and governments subscribe to patient and family-centred care, the reality falls short. Consider the following list of indicators set out by Leatt, Pink, and Guerriere in 2000, by which patients will be able to tell when an integrated health system exists (Figure 9).

Figure 9 – How Patients Will Know When an Integrated Healthcare System Exists

When they:
- Do not have to repeat their health history for each provider encounter;
- Do not have to undergo the same test multiple times for different providers;
- Are not the medium for informing their physician that they have been hospitalized or treated by another provider;
- Do not have to wait at one level of care because of incapacity at another level of care;
- Have 24-hour access to a primary care provider;
- Have easy to understand information about quality of care and outcomes in order to make informed choices about providers and treatments;
- Can make an appointment for a visit to a clinician, a diagnostic test or a treatment with one phone call;
- Have a wide choice of primary care providers who are able to give them the time they need; and
- With chronic disease, are routinely contacted to have tests to identify problems before they occur, and are provided with education and support to maximize their autonomy.

Source: Adapted from Leatt, Pink, and Guerriere (2000)

We would venture that very few, if any, Canadians would be able to check off all nine indicators. This speculation is certainly borne out in the recent findings of the Commonwealth Fund's 2014 International Survey of Older Adults, on which Canada ranks poorly among the eleven countries surveyed (Osborn et al. 2014).

If we are going to "move the yardsticks" on indicators such as these, we are going to have to build on the good work we have done on public and member engagement. Reflecting on our work with the HCIWG, we acknowledge that while governments can provide incentives, they do not directly implement new models of team-based care or follow CPGs. This is done by providers at the coalface. We must redouble our outreach efforts to our members to provide them with tools and information to enable them to engage in health system transformation.

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An Action Plan for Reforming Healthcare in Canada

WHITE PAPER - WORKING DRAFT

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The purpose of this white paper is to set out a strategy for government action to reform healthcare in Canada. The paper supports *Managing a Canadian Healthcare Strategy*, the third in the Queen's Health Policy Change Conference Series. It picks up from Don Drummond's paper for the second conference, "Health Policy Reform in Canada: Bridging Policy and Politics,"[1] which argued that there is enough of a consensus on the substance of meaningful healthcare reform in Canada but a lack of political will to deliver. Furthermore, it suggested that the conditions could be put in place to bolster that political will and create an environment in which governments would deliver meaningful reform over the next few years. Recent studies and events, including the Queen's series of conferences and papers, have done a great deal to create the conditions needed for political will. In particular, they have illuminated the problems with healthcare at present and offered good suggestions for improvement. Perhaps most importantly, they have conditioned the public to expect and even want to see reform. The absence of a sharp rebound in government revenues since the 2009–10 recession has kept the fiscal imperative of containing healthcare cost growth top of mind. The time has come for governments to broaden and deepen the piecemeal reforms underway. But they must do so strategically in this, perhaps the most politically sensitive of all policy fields.

"Health Policy Reform in Canada: Bridging Policy and Politics" (Drummond 2015) suggests that the healthcare reform debate should look at the conditions that supported bold policy reforms in other areas, including deficit reduction, free trade, value-added sales taxes, public pensions, and others. In each of those cases, governments acted boldly despite considerable opposition from the public and legislatures. Certain common conditions can be found, or in many cases were created, with each of these major reforms. They are:

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

In the strategy for healthcare reform set out here, we will be addressing how to complete the creation of favourable conditions for reform, and then how to move forward in the political space opened.

The paper is structured in accordance with a sensible sequence for policy reform in any area, outlined below in Figure 1:

Figure 1 – Sequence for Policy Reform

Before launching into the substance, it is first necessary to situate proposals in the context of reforms undertaken, to identify the governments that constitute the target audience, and to address how to engage stakeholders in reform processes.

1. Now published in *Toward a Healthcare Strategy for Canadians*, A. S. Carson, J. Dixon, and K. R. Nossal (eds.) (Montreal and Kingston: McGill-Queen's University Press, 2015), 237–54.

RECOGNIZING REFORMS UNDERWAY

No jurisdiction in Canada is starting healthcare reform from scratch. Most provinces and territories would, with justification, argue they are in the midst of health policy reform or even that reform is a continuum. So it is necessary to define what changes in strategy are in order.

The most basic distinction between what is called for in this paper and existing processes is the need to emphasize system-wide strategies. Healthcare consists of many pieces, often operating as silos. A central tenet of most reform proposals is to make the pieces work better together to improve health outcomes at the same or at lower costs. System-wide strategies change the nature of the reform process considerably, most notably by involving stakeholders, including the public, more directly. We argue that this requires governments to be clearer and more transparent in their reform intentions, and to work more closely with stakeholders than would be required under piecemeal change.

WHAT GOVERNMENT IS BEING ADDRESSED?

Participants of the first two Queen's Health Policy Change conferences revealed a strong preference for a national focus on health policy reform. That has some attractive features, such as supporting portability of care across provinces and territories, lowering costs through economies, and creating comparable standards for all Canadians. However, at the moment, the federal government does not seem inclined to play a large role in healthcare, and provinces to date have only dealt collectively with healthcare in selective areas. In part, that may be due to reflection on previous federal-provincial accords, where the federal government provided funding, but the provinces did not give a detailed account of improvements in return for the money. This speaks to a classic challenge in terms of one level of government providing funding for policies and programs that are in the jurisdiction of another. The muddled lines of accountability can compromise the transparency and efficiency of how the funds are used. So it seems likely that most of the health policy reforms that will be implemented over the next few years will be driven by provinces and territories acting without federal leadership or even involvement. Such an approach may still yield common factors across the country over time as success in one jurisdiction is modelled in others.

In general, the strategy for health policy reform set out in this paper is targeted at a specific province or territory. However, there are at least four aspects of reform where a broader, and pan-Canadian or national, perspective might be particularly applicable.

First, attendees at the inaugural Queen's Health Policy Change conference set their top priority for reform as a "national pharmacare program" for Canada. This has been debated in Canada for decades with no progress. However, provinces have recently been working together on obtaining better pharmaceutical prices than can be accessed by provinces acting individually. As well, the federal minister of health recently asked Ontario to lead discussions about national pharmacare. At a minimum, a pan-Canadian approach could be strengthened to obtain better pharmaceutical prices.

Second, better care for the rapidly growing number of elderly Canadians is a high priority for reform. This too could have national elements or at least feature a number of provinces working together. For example, governments in Canada could set out common standards of care for the elderly that each jurisdiction could work toward.

Third, the federal government could play a lead role in healthcare innovation. This could flow from the Advisory Panel on Healthcare Innovation chaired by Dr. David Naylor and due to report in May 2015 on the five most promising areas of innovation in Canada, and five ways that the federal government could support such innovation. This could lead to pan-Canadian improvements, particularly if the federal government established an innovation fund and if the ideas were supported by all provinces.

Finally, there is a need for better health information. There would be economic and portability advantages to developing this nationally.

For the purposes of this paper, efforts to establish national pharmacare and eldercare programs will be encouraged, but will not be assumed. Instead, the focus in these and other areas will be on individual provinces and territories. In contrast, much of the focus on improved information will be at the national level, building upon institutions already in place.

National or pan-Canadian elements of healthcare could result from two opposing strategies. One could be a top-down approach, where the federal or provincial and territorial governments act together to set standards to be adopted within their respective jurisdictions. This seems unlikely over the next few years, other than in selected areas such as pharmaceutical pricing. A second could be more of a bottom-up approach, whereby best practices from one province or territory are emulated by others. This seems the more likely course at this time in Canada. Its strength would be bolstered by improved capacity of health information, and in particular the capacity to compare health outcomes and the efficiency of healthcare across provinces and territories. This would help identify best practices that could be adopted by others. It would also highlight jurisdictions that lag in the quality and efficiency of healthcare delivery. Individual provinces could and should look for such best practices, but an enhanced pan-Canadian capacity is also advised.

ENGAGING STAKEHOLDERS AND THE PUBLIC

Some aspects of healthcare reform might have limited impact or even interest for the public or large groups of stakeholders. Governments can and should proceed with little fanfare in such cases. However, almost anything that involves system-wide reform will come to the attention of stakeholders, and that attention may come in the form of concern. If not managed properly, that concern may lead to governments backing down on reforms. The better course is to involve stakeholders, including the public, from the outset.

Healthcare reforms over the next ten years will likely be formed in an environment of ongoing fiscal constraint. Few if any jurisdictions will attempt to or succeed in lowering the level of health costs, but most will be striving to slow down cost growth relative to revenues. This fiscal environment will preclude governments from injecting new funding that might "buy" support from those working in the health sector. Instead, workers in the sector may perceive that they could potentially lose something. So in addition to public wariness over change in healthcare, internal stakeholders may feel defensive and hence resist change. This is another reason to work closely with the healthcare workforce in the reform process and to ensure that to the greatest extent possible cost constraint results from efficiency gains rather than austerity measures.

We believe health policy reform in any Canadian jurisdiction should be anchored by a public document that accurately sets out the problem, the objective(s), steps in the reform, and how progress will be measured. Such policy statements were used to support other major Canadian public policy initiatives. The Conservative government telegraphed much of its economic agenda in 1984 with the release of *A New Direction for Canada: An Agenda for Economic Renewal*. Similarly, ten years later, the Liberal government laid out its economic and fiscal plans in the so-called Purple and Grey Books. These documents conditioned the public to upcoming changes, drew stakeholders into reform processes, and provided a common script to bureaucrats and politicians in discussing change.

Despite the reforms underway in various provinces, no jurisdiction has yet communicated such a grand vision for health to the public and the healthcare sector's stakeholders. Presenting the larger picture for reform permits everyone to see how the pieces of change are to fit together to achieve a better outcome. Challenges in particular areas of reform should then become more manageable.

Stakeholders should be involved in a consultation exercise leading up to and following a public report on healthcare reform. This has been facilitated by the involvement of many stakeholder groups in recent years in publishing position papers on aspects of healthcare reform. Table 1 and Appendix A set out a selection of recent policy position papers by major healthcare stakeholder groups. It must be noted that the majority of stakeholder reports by national organizations are aimed at national reforms. So here we have a disjoint. The policy capacity of stakeholder groups tends to be at the national association level, whereas the thrust of policy change of late, and in the foreseeable future, will be at the provincial level. This has created an unfortunate disconnect between the stakeholders and policy development. Various stakeholder groups will need to make more of an effort to address their policy recommendations to the provinces.

	Canadian Medical Association (CMA)	Canadian Nurses Association (CNA)	CMA & CNA	British Columbia Medical Association	New Brunswick Medical Society	Health Action Lobby	Health Council of Canada	Council of the Federation	Canadian Physiotherapy Association	Canadian Academy of Health Sciences	Canadian Health Services Research Foundation
Access	✔	✔	✔	✔	✔	✔					
Choice	✔				✔		✔	✔	✔	✔	✔
Clinical Autonomy	✔				✔						
Accountability			✔					✔	✔	✔	✔
Patient-centred care	✔	✔	✔	✔	✔		✔			✔	✔
Continuum of care	✔	✔					✔			✔	
Quality	✔	✔	✔	✔	✔						
Sustainability	✔	✔	✔	✔	✔		✔				
Efficiency	✔			✔	✔						
Effectiveness	✔			✔							
Equity	✔	✔	✔								
National Leadership		✔				✔	✔	✔	✔	✔	
Triple Aim (Better Health, Better Care, Better Value)	✔	✔	✔			✔	✔	✔		✔	

Table 1. Policy Position Papers by Canadian Healthcare Stakeholders

Interactions with stakeholders during a reform process need not be acrimonious. Recent policy papers from such organizations as the Canadian Medical Association (CMA) and the Canadian Nurses Association (CNA) have been very much in line with the recommendations heard during the Queen's Health Policy Change Conference Series and are reflected in this paper. This is not to say all would be smooth sailing. Attempts to address scope of practice, for example, could be highly contentious. It is noteworthy that in the collaborative efforts of the CMA and CNA they choose to leave this controversial area aside. But all the major stakeholder groups support the general thrust of a high quality, efficient, integrated, accessible, and equitable health system focused on individuals and families. Further, there are examples of collaborative input from stakeholders in previous reform exercises, including ten health professional organizations working together under the Primary Health Care Transition Fund (HCTF) in the early 2000s to enhance interdisciplinary collaboration in primary healthcare.

It would be advantageous for each jurisdiction to have a fairly independent review of its healthcare as part of the process leading to such a public document. That provides the government with a reading of stakeholder perspectives and allows various reform ideas to be floated without the government having to take ownership and becoming defensive if there is controversy. Such reviews also condition the public and stakeholders to the notion of reform. Table 2 and Appendix B set out which provinces have had such reviews completed during the past four years. Many provinces have had recent external reviews of important segments of healthcare in recent years, but only Ontario and New Brunswick have had system-wide reviews. The other provinces should contemplate doing likewise quite soon.

THE STARTING POINT FOR HEALTHCARE REFORM: DEFINING THE PROBLEM

Communication with the public should start with a better definition of the problem, in that the fiscal element is broadened by references to mediocre health outcomes and care and inefficiency. To the degree that the Canadian public is aware of problems with healthcare in the country, attention is likely on just two facets – rising costs and long wait times, especially for specialists. For those who contemplate efficiency, they are likely struck by the frequent necessity of going to hospitals when other sites of care (e.g., community health centres) have lower costs and higher client satisfaction.

When governments incurred large deficits in the late 2000s, they put enormous emphasis on how healthcare costs were rising faster than revenues. By now, numerous studies have pointed out how healthcare will continue to consume larger portions of revenues and hence threaten the sustainability of other programs or require ever-rising tax rates, which have likely caught the public's attention. So the "fiscal problem" has some traction.

However, we argue that policy reform based solely on fiscal matters will not be successful and will likely be met with public suspicion. There will be no support for reforms interpreted to solely drive down costs and save money, as Canadians will interpret cost cutting to healthcare as putting their health at risk.

In contrast to the fiscal dimension, there is little public awareness of the quality of Canadian healthcare and the efficiency with which it is delivered. These data

	BC	AB	SK	MB	ON	QC	NB	NS	NL	PEI
Healthcare System			2008		2012	2001	2012/13	2007		2008
Healthcare Governance		2013		2008						
Healthcare Funding						2013				
Hospital Care	2011									
Emergency Care	2014			2013				2010		
Ambulatory Care									2013	
Cancer Care	2013									
Long-Term Care					2012					
Rural Healthcare		2015								

Table 2. Independent Reviews of Provinces' Healthcare

We now return to the recommended elements of a public document to launch broader healthcare reforms, those being: defining the problem, describing the objectives, determining steps in reform, and then outlining how to monitor and measure progress.

are not available to make strong, sweeping statements about the quality of Canadians' health and how their healthcare compares to that of other countries, in part because the results vary widely by particular ailments. However, as documented in several background papers to the first two Queen's Health Policy Change conferences (see Carson et al. 2015), a general assessment is that Canadians' health and the quality of their overall healthcare is about

average, in comparison to other developed economies. Yet in terms of dollars spent per capita or as a ratio of Gross Domestic Product, Canada, with some provincial variation, is part of a small group of countries that have one of the most expensive healthcare systems; it comes after the United States, which truly is in a universe of its own and should not, as is the norm in Canada, be used as a comparator (OECD 2010).

Putting the two sides of the equation, outcomes and costs, together, means that Canada has inefficient healthcare. As noted in an OECD presentation to the second conference, Canada spends 30 percent more public funding on health than would be required under an "efficient system" (based upon a hybrid of the best features across OECD countries) (Srivastava 2014).

Affordability of healthcare will be a third facet of concern to a portion of the Canadian public. Most Canadians are conditioned to believe we have a public healthcare system so affordability is not an issue. But that is only true of primary care. Overall, according to CIHI's report, *National Expenditure Trends, 1975 to 2014*, private spending accounts for 30 percent of health-related costs in Canada. This is considerably higher than the average of developed countries. Private spending accounts for more than half of drug costs and more than 90 percent of non-primary, non-pharmaceutical costs, and that includes many aspects of mental health, one of the fastest growing areas of healthcare spending (CIHI 2014). Private insurance, both commercial and not-for-profit, is maturing to address private health costs. In 2012, a bit more than 40 percent of private healthcare costs were covered by private insurance, up from just over 29 percent in 1988 (CIHI 2014). Sixty percent of private drug costs are covered by private insurance and a similar coverage ratio applies in dental. Private insurance coverage is only 26 percent of private costs in vision care (CIHI 2014). Given the extensive public coverage in primary care and the availability to some people of private insurance for pharmaceuticals and other aspects of non-primary care, the affordability issue is not generalized for the whole population but rather acute for certain demographics, mainly for those who do not have access to employer-sponsored insurance plans.

Public acceptance and even support for healthcare reforms will be more likely once the public is aware that Canada, and their particular province, delivers mediocre healthcare at a high and, other than during brief periods of restraint, rapidly rising cost, and that a significant number of Canadians face affordability barriers to accessing appropriate care.

DESCRIBING THE OBJECTIVES OF HEALTHCARE REFORM

A public document setting out a reform process must address, but not unduly dwell on, the necessity of containing healthcare cost growth. That would frame

the issue in a negative fashion for the public. So an accurate description of the problems should transition into clear objectives to demonstrate that with a more efficient approach better health outcomes are feasible.

The objectives of healthcare reform should be a high level of health, superior results from healthcare interventions in terms of measured health improvement, and patient and family satisfaction, all delivered in an efficient manner that is accessible and affordable for all Canadians. In a public discussion paper these objectives can be described in an absolute sense and relative to other jurisdictions (where better outcomes that are realistic can be cited).

THE STEPS IN HEALTHCARE REFORM

All the major steps in healthcare reform should be set out in a public document from the particular province or territory. But all are not equal in importance or in approach. Some steps will involve the public directly and these must be communicated and proceeded with carefully with extensive public consultation. Other steps will be contentious with particular healthcare stakeholders. Yet others are more internal matters that will be less visible to the public.

a) Enhancing the Role of External Agencies

A first major decision to be made in the reform process is the division of roles between government and an independent body appointed by the government. We have argued that all governments should use an independent body to provide an assessment of the provision of healthcare along with recommendations, all informed by extensive consultations with stakeholders. There is an option to go further and have some of the reforms implemented by an external body such as the Ontario Health Services Restructuring Commission (1996–2000), chaired by Dr. Duncan Sinclair. This option can relieve some of the political pressure, although ultimately all stakeholders will hold the relevant government accountable.

A second major decision is on how to organize the management of healthcare. At the first Queen's Health Policy Change conference, participants attached a high priority to moving responsibility away from the political realm. With Ontario being the last in 2005, all provinces have devolved important parts of healthcare administration to arm's length agencies. The agencies typically have their own boards, but the province tends to appoint or at least nominate board members. The structure is there for the agencies to have a fair degree of independence, but the length of the arm, be it short or long, is influenced by practice as much as design. There has been a great deal of change in the structure of these agencies, particularly over the number of entities in a province. In recent years there has been a trend toward consolidation into fewer

regional agencies. However, on March 18, 2015, the Government of Alberta announced its intent to introduce eight to ten "operational districts" within the highly centralized Alberta Health Authority (Alberta 2015a).

Table 3 and Appendix C provide a summary of the diverse management structures of healthcare across the provinces.

	BC	AB	SK	MB	ON	QC	NB	NS	NL	PEI
Provincial Health Authority	✔									
Local Health Integration Networks					✔					
Health Networks							✔			
Regional Health Authorities	✔		✔	✔					✔	
Single Health Authority								✔*		✔
Operational Health Districts		✔*								
Health and Social Service Agencies						✔				
First Nations Health Authority	✔									

* To be completed in 2015

Table 3. Administrative Management Structure of Healthcare in the Provinces

b) Big Decisions Are Required On Pharmacare and Seniors' Care

Of all the steps in reform recommended during the Queen's Health Policy Change Conference Series and by others, the two that would impact the public the most are a new pharmaceutical program and a different approach to seniors' care.

i) Options for Pharmacare

The attendees of the first Queen's conference revealed their preference for a national program that would extend coverage to all Canadians and replace the current piecemeal provincial plans and the bits and pieces of private insurance that exist. A federally designed and funded pharmacare program would inevitably create inefficiencies because most of the levers for controlling the use of pharmaceuticals are in the hands of the provinces and their agents. It would also raise tricky issues of federal-provincial transfers. A federally funded program would not only transfer money from people paying private insurers to paying the public insurer, but it would save billions of dollars to the provinces as well. Would the federal government then want a transfer of tax points back to them in return?

Given the division of responsibilities and budgeting for healthcare, it is inevitable that the provinces would need to be intimately involved in any national pharmacare program. That would clearly require a great deal of discussion at all levels of government, all the more so because there are important distinctions across existing provincial pharmaceutical policies, which could create challenges and even opposition to adopting a new, common scheme across the country. This necessary dialogue can be made easier by moving beyond the current mindset that a pharmacare program has to be either federally- or provincially-driven. It can and should be both. A pharmacare program in Canada could be modelled after the Canadian Pension Plan where the federal and provincial governments are joint custodians. Employees and employers make contributions to the Canada Pension Plan, and to a large extent this would likely be the structure of a pharmacare program as well. So that is another potential parallel. At any rate, the latest dialogue on a national program has just begun. Keeping in mind that such a scheme has been discussed in Canada for decades, no one should hold their breath waiting for it to happen. Yet the case for major reform in pharmaceuticals in Canada is compelling.

Relative to other countries, pharmaceuticals are expensive in Canada and until recently the costs were rising rapidly. In 2011, Canadians spent an average of $701 dollars on pharmaceuticals, second highest within the OECD and well above the OECD average of $483(U.S. dollar at PPP) (OECD 2013). From the early 1990s until 2010, pharmaceuticals were one of the fastest growing cost components of healthcare in Canada. According to CIHI (2012, vii), drug costs increased slightly less than 0.1 percent in 2012. However, this may be due in part to temporary factors – such as fewer new drugs coming to market, some major ones coming off patent protection, and recent provincial moves to lower generic drug prices – and should not necessarily be taken as a sign that the cost curve has been permanently dampened. On the cost side, pharmaceuticals are consistent with overall healthcare in that Canada has a more expensive system compared to almost all other developed countries, except the United States.

At least in terms of primary care, Canadians can offer that the relatively high cost comes with good access, however the same cannot be said in the case of pharmaceuticals. Statistics Canada's Canadian Community Health Survey of

2007 indicated that almost 10 percent of Canadians do not take pharmaceuticals as directed due to cost considerations. Common factors for those unable to afford prescribed medication include poor health, low income, and lack of access to a private insurance plan. Of the families without insurance, 26.5 percent were not able to afford the drugs as prescribed (Statistics Canada 2007). As some provinces cover drug costs for people on social assistance, the affordability issue is particularly acute for the low-income and working poor who do not have access to an employer-sponsored insurance plan. Indeed, in absolute level terms, the highest spending on prescription drugs occurs with the second lowest income quintile (CMA 2014a). There can still be affordability issues in families with some form of insurance as co-payments can be high.

There is great variation in provincial pharmaceutical plans. At the aggregate level, provincial plans pay 41.6 percent of drug costs, but this varies from a low of 23.9 percent in New Brunswick to 47.6 percent in Saskatchewan (CIHI 2012). Some provinces base coverage largely on income while others use age (as in seniors). Low-income residents on social assistance are typically covered, but in several provinces there is weak coverage, or relatively high co-payments for the working poor. Quebec has a unique model in that people who do not have private insurance are obliged, at a cost, to take public coverage.

A 2013 Commonwealth Fund General Public Survey found 8 percent of Canadians did not fill a prescription or skipped a dose in the last ten months because of cost. This compares to only 2 percent in the United Kingdom. There was considerable variation across provinces, although at around 5 percent even the best Canadian performers, namely Saskatchewan and Quebec, are still not close to the UK. The affordability challenge was particularly acute in New Brunswick and Ontario with avoidance rates above 10 percent (Busby and Peddle 2014).

The overall approach to pharmaceuticals in Canada gets low marks for efficiency. At the aggregate level this is obvious from the high cost relative to other countries, which co-exists with poor access and affordability for low-income people. The fragmentation of the system has compromised purchasing power in getting better prices for brand and generic drugs, although recent initiatives are helping somewhat on that front. The multiple payers in the system raise administrative costs. And evidence exists that co-payments reduce optimal use of pharmaceuticals (see for example, Tang, Ghali, and Manns 2014).

A great deal could be gained through a national pharmacare program, as called for by many Canadian commissions, task forces, and studies as well as participants at the first Queen's Health Policy Change conference. A fairly standard rationale for the lack of government drive to establish national pharmacare is the public cost. But a number of studies question whether there would be a significant net cost compared to the status quo. A public pharmacare system would lower costs through more efficient administration, greater ability to direct lower-cost pharmaceutical use, and lower prices through

the benefits of greater bargaining power. To be netted against these gains are the costs the public sector would have to pick up from current private sector spending. First, it should be clear that this is largely a perception issue. Taxes or some sort of taxpayer contribution might need to rise to cover this transfer of expenditure, but from the individual's perspective this is simply a transfer of a payment from a private insurer to the public sector. Second, the net increase in public spending may not be that large once the economies are accounted for. In an article for the Canadian Centre for Policy Alternatives, Marc-Andre Gagnon (2010) argued that total costs would be reduced $10.7 billion per year under a public system. Morgan et al. (2015) calculate that total spending on pharmaceuticals would be $7.3 billion per year lower under a public program and this would decompose as $8.2 billion in savings to the private sector and a net incremental public sector cost of around $1 billion per year – all figures from the central tendency estimates.

The Canadian Life and Health Insurance Association (CLHIA) disputes the very large estimates of cost savings from converting to a public pharmaceutical plan (Swedlove 2014). They argue, among other things, that the estimates rely upon CIHI data on existing (partial) public administration that are not fully inclusive. Therefore, the CLHIA believes that the extrapolation to a cost estimate under a fully public system is substantially under estimated.

In light of a pan-Canadian dialogue on a national pharmacare program, it is troubling that there are such disparate views on the likely financial consequences. As support for that dialogue, a credible, independent body should be charged with examining the existing cost estimates and rendering a view on the differences and likely cost implications of a public system. In the absence of this, it is very difficult to assess the pros and cons of going in this direction.

A round of talks with the provinces and the federal government is being launched on a national pharmacare program. Such an objective is worthy of support, but provinces may not wish to count on a positive outcome given Canada's long-suffering efforts aimed at such a national program.

In the meantime, there are many steps that can be taken, some nationally and some within provinces. From a financial perspective, the claimed benefits of sweeping pharmaceuticals into public coverage, as with primary health, are lower drug prices, greater facility to control costs through what drugs are used and how, and lower administration costs. Some gains can certainly be made on the first two fronts without going the whole way to a public pharmacare program.

First, the Patented Medicine Prices Review Board could be strengthened. It now compares prices in Canada with seven countries that have comparatively high drug prices. It could shift the countries in the base, and it could extend its purview to generic drugs. This may be particularly important with the

enactment of the Comprehensive Economic and Trade Agreement between Canada and the European Union. A great deal of attention has been paid to the prospect of higher brand drug prices in Canada due to the imposition of Europe's longer patent protection period. Less attention has been paid to the lower generic drug prices in much of Europe.

Second, the provinces could continue strengthening their efforts under the pan-Canadian Pharmaceutical Alliance (pCPA) to establish an opt-in system to "bulk buy" pharmaceuticals, meaning that lower base prices for both brand name and generic drugs would be established. If prices negotiated by the pCPA are not disclosed, it may be difficult for private insurers to benefit from the strides made by the public bodies. However, there should be a way to allow private insurers to benefit from price discounts negotiated by governments.

Third, there are a number of things that could be done to improve the effectiveness and efficiency of pharmaceutical use. Better data and analysis on the effectiveness of medication would help if the findings were shared with physicians and pharmacists. Provinces could tighten systems to monitor prescription use by individuals. As people can get prescriptions through different doctors and pharmacies they often end up with too many medications, some of which may essentially just be countering the effects of others. As in the case of British Columbia, greater latitude on therapeutic substitutes could also improve cost and efficiency.

Steps can also be taken within current structures to improve affordability. Some provinces are already addressing this to a considerable degree. A concern is Alberta, Ontario, Nova Scotia, and Prince Edward Island, where provincial plans remain age-based rather than income-based other than to cover recipients of social welfare, or in some cases where drug costs exceed a certain percentage of family income. A minimalist reform in this area could be for these provinces to shift to an income-based plan, as already exists elsewhere in Canada. This would require some political work with seniors who would lose the automatic subsidies they now enjoy, but low-income seniors would still be covered, as would the working poor who are now left to shoulder the full burden if they do not have a private plan. Going one step forward would be to consider the Quebec model with mandatory public coverage, at a cost, for those not in a private insurance plan. Premiums could be based on income, with care taken not to create steep marginal effective tax rates as income rises. In provinces with co-payments that may be creating affordability issues, a tighter link could be made to income and/or the medical value of the pharmaceutical. In general, the most likely reform model for improved affordability will be public coverage based on income with a deductible and co-payments that do not unduly impinge upon prescribed drug use. But lest it be thought that adopting a Quebec-style program is a simple answer for some other provinces, it must be pointed out that in March 2015 Quebec's Health and Welfare Commissioner reported that the prescription rate is too high in Quebec, drugs covered by the plan are not reviewed sufficiently often, insufficient efforts are made to use less

expensive drugs, and too much is paid for pharmaceuticals in Quebec relative to the rest of Canada and other countries. The report is a sobering reminder that pharmaceutical policy needs to move on many fronts if it is to be fiscally sustainable and equitable to access.

ii) Options for Improving Seniors' Care

As with healthcare in general, seniors' care features widespread problems of cost, inefficiency, access, and poor satisfaction of the elderly and their caregivers. Under the current system, the cost of long-term care services will roughly triple in constant dollars over the next forty years. Public costs are estimated to rise from $24 billion to $71 billion (inflation-adjusted dollars) while private costs are expected to rise even faster from $44 billion to $116 billion (Blomqvist and Busby 2014). A survey commissioned by the Canadian Medical Association in August 2014, *National Report on Health Care: Seniors Health Issues and the Impact of an Ageing Population*, revealed that only half of the respondents agree they can afford or will be able to afford to pay for the extra healthcare services that are not covered by medicare or their health insurance. In response to a slightly different question, 70 percent expressed concern about having enough money for uninsured services. The stress involved in seniors' care also comes through in the CMA survey, where 60 percent of respondents who participate in providing care report experiencing a high level of stress because of this.

There are quite a few parallels between pharmacare and seniors' care. Neither is close to being fully covered by public sector plans. Private sector plans, usually through an employer, have filled part of the vacuum. But gaps remain for some people, typically those in the low to middle income range without access to a comprehensive employer-sponsored insurance plan. In the 2014 CMA survey on seniors' healthcare, 40 percent of respondents said they were very concerned about having enough money for a long stay in a long-term care facility or a long period of nursing care at home, and another 34 percent indicated they were somewhat concerned. Greatest concern is found among those close to retirement. So access and affordability of seniors' care are serious issues for a substantial portion of Canada's population.

Governments, whether federal or provincial, could move to sweep seniors' care more fully into the public sphere of healthcare such that it is paid for through general tax revenues. Or the financing could be done through a more comprehensive system of co-payments. Alternatively, a new program could be introduced to encourage and facilitate individual savings accounts targeted at care in the later years of life. The latter two seem more likely given the significant tax increases that would be required under the first possibility and the widespread existence of private insurance plans. However, before delving more intensively into funding, it is advisable to address the uncertainty of costs people will face in their later years and the inefficiency of current seniors' care.

The most likely scenario for funding seniors' care is that governments, whether it be a provincial or a federal-provincial scheme, will cover some basic level and individuals and their families will be responsible for anything above that. A major problem with such a scenario is that there is tremendous uncertainty over what the individual and family will be responsible for. In a perfect world, people would have a good idea of how much of a nest egg they need to accumulate before hitting the older, frailer years. But few have such insight because the present system is not transparent on cost and future directions are uncertain. It is not surprising then that the cost of home care or long-term care is not explicitly factored into people's lifetime savings plan. A high priority should be to change this approach. Most likely, the realistic amounts people will need to accumulate by age 65 or so are much higher than most are now contemplating. In the absence of such clarity, it is hard to imagine that any new savings vehicle tied to seniors' care could be successful.

We should also first ensure that the money for seniors' care is being used efficiently before settling on a path to raise more funding. Present systems are certainly not efficient. Dr. Chris Simpson, President of the CMA, refers to the system as "warehousing our seniors in hospitals" (2015). He points to the 15 percent of acute care hospital beds in Canada occupied by patients who do not need and are not receiving acute care and observes almost all of them are seniors. The hospitals are not equipped to deal with their chronic care needs and in the meantime these patients are "deconditioned, they fall, and they suffer hospital-acquired infections." In a study for the Ontario Government in 2011, *Caring for Our Aging Population and Addressing Alternate Level of Care*, Dr. David Walker describes how the situation begins with emergency rooms far too often being the point of entry for an elderly person into healthcare. Once in the hospital the elderly often languish without receiving the treatment and rehabilitation they need. Discharge procedures are often inefficient in that the elderly are not directed to the care that would maximize their prospects of returning to an independent life. Long-term care facilities do not tend to include a capacity to, in the words of Dr. Walker, "assess and restore." Simpson estimates the cost of a hospital bed at $1,000 per day compared to $130 for long-term care and $55 for home care. The potential savings from shifting from hospitals to long-term care and home care are estimated by the CMA at $2.3 billion a year.

An objective of a better seniors' care system is of course a more sustainable financial situation. That would involve extracting a dividend from making care more efficient. And it would require identifying and securing a source of funds for the increase in costs due to the sharply rising number of elderly. There are many options to consider for how to cover the inevitable rise in the cost of seniors' care. Private savings could play a larger role. That could happen through greater promotion of existing vehicles such as RRSPs, TFSAs, and reverse mortgages, or it could occur through the creation of a new savings vehicle, such as Medical Savings Accounts, modelled after the TFSA, but for the explicit use of funding long-term care. Alternatively, there could be more formal reliance on private insurance, such as through a system where individuals contribute to a

risk pool and draw from that pool on the basis of the evaluation of their needs by a multidisciplinary assessment team. Another option that combines private insurance with public support is a voucher system whereby governments provide means-tested subsidies (vouchers) and individuals are left to cover the rest of the costs. Or the public sector could take on most or all of the cost, funded either through general revenues or a new contribution plan along the lines of Employment Insurance and the Canada Pension Plan.

The discussion on future funding should begin in earnest, but at the same time there are many other aspects of seniors' care that need immediate attention. We must start by looking at seniors' care from the perspective of elders themselves. Dr. Duncan Sinclair, former Vice Principal (Health Sciences) and Dean of Queen's Faculty of Medicine, spoke from a personal perspective in remarks to the Tech Value Net (TVN) Conference on Improving Care for the Frail Elderly in February 2015. Dr. Sinclair acted as an eloquent spokesperson for everyone when he said his wants and needs when he becomes frail, dependent, and in need of on-going care are continued dignity, staying in his home, avoidance of pain and suffering, and not being a burden to others. Current arrangements are not suitable to deliver on these fronts for many seniors.

An instinctive reaction to projections of sharply rising numbers of elderly people is to build more long-term care facilities. But that goes against the grain of care efficiency and the aspirations enunciated by Dr. Sinclair and likely felt by the majority of people. The Queen's Health Policy Conference Series has heard compelling arguments that the Danish model, which prohibited building more long-term care facilities and instead focused on improving home-based care, is a better course for Canada. Not only is this a lower-cost option, but it also results in higher satisfaction of the elderly and their families. Provinces would need to increase their resources for home care and the attendant co-ordination required in order to move in this direction. In part, this funding could and should come from money now being given to hospitals, as the number of seniors in hospitals should be reduced. In most provinces, other steps required would include: increasing programs to provide house calls by nurse practitioners; enhancing integration of community care and service providers and hospitals; promoting renovation tax credits for homes; and establishing standards for personal care workers.

Many changes would be required to provide better quality and more efficient care for the elderly. The starting point would be to move the focal point from the emergency wards of hospitals to community care settings. There, a better capacity could be built to assess the needs of the elderly and design appropriate care strategies, with an emphasis on supporting the person in their home. Primary care providers would need to be much more involved in the diagnosis and rehabilitation plans. And long-term care facilities would need to devote a good portion of their resources to ensuring that a number of their clientele do not become permanent residents.

To address seniors' care it is critical to ask who should take the lead. The CMA calls for a "national seniors' healthcare strategy" and this was backed up by 95 percent of the respondents in their 2014 survey. Ninety-one percent of those respondents agreed that the strategy should find ways to "keep elderly patients living at home for as long as possible and not in hospitals or long-term care facilities." It is encouraging that there is an alignment of the aspirations of people with the analysis of efficiency of care. The CMA has been less clear on why the strategy needs to be national and what exactly that means. However, it is clear they mean for the federal government to take a prominent role. A natural reason for a broad initiative is that similar situations appear across the country, so common approaches would be sensible. But that does not mean the drive must necessarily be from the federal government or even "national" as opposed to "pan-Canadian." As with other aspects of healthcare, a national approach has the advantage of providing consistent standards of care across the country. Some political cover would be offered to individual jurisdictions if all or at least many moved in a similar fashion at the same time. Any new savings vehicle would be facilitated if operated through the national tax system. As with most other aspects of healthcare, reform of seniors' care could at least start at the provincial level, whether by an individual province or more than one operating together. Progress need not be stymied if a national approach is not forthcoming over the next few years.

One strategy for moving toward what might ultimately be a national seniors' care system is for governments across Canada to begin discussing standards of care to which each of them could aspire. Even if the standards were common, they might get there in different ways and at different paces. As often happens in Canada, a study for a particular province has applicability across the country. In this regard, all provinces should look at the study done for Ontario in 2012 by Dr. Samir Sinha, *Living Longer, Living Well*. The report revolves around five principles for seniors' care: equity, access, choice, value, and quality. These principles would likely be agreed to by all jurisdictions. Dr. Sinha went on to make specific recommendations that are on occasion somewhat specific to Ontario, but that for the most part apply, perhaps with a few tweaks, to other provinces. For example, he addressed the promotion of health and wellness, improved funding for house calls to reduce the incidence of seniors going to and staying in hospitals, enhanced home and community care services, and improved flows to and from long and short stay care facilities, among many other areas (Sinha 2012, 11–15).

c) Steps to Increase Efficiency

Several provinces are already implementing steps to drive up efficiency of healthcare and this effort should be continued. Examples include moving away from cost-plus budgeting of hospitals to basing financing on performance; shifting some portion of physician compensation away from a per service fee to a salary model; greater differentiation across institutions that reflects

their relative efficiency in particular areas; and more and better use of health information and records. The structural changes need to be complemented by clearer objectives and measurement against those objectives. For example, Ontario and other provinces have moved more care to healthcare clinics. In theory this makes sense as it moves care aware from higher-cost hospitals while still allowing economies across caregivers. But expected outcomes were not clearly set for the clinics and outcomes have been only weakly recorded, so it has been difficult to measure their efficiency.

d) Organization Changes to Increase Quality and Efficiency

The second priority revealed by participants at the first Queen's Health Policy Change conference was better integrated care across the sectors – hospital, community, primary care, specialty, homecare, social welfare, and so on. In general, less emphasis should be placed on hospitals as the epicentre of care. They have high costs, increase the risk of infection, and generally result in lower patient satisfaction. Several provinces have expanded the use of healthcare clinics. In Ontario, there has been an expansion of nurse-led clinics and these have recorded lower costs and higher levels of patient satisfaction.

Considerable savings would likely be realized in every province and territory through paying more attention and better coordinating the care of the small portion of the population accounting for a very large share of costs. For example, in Ontario, about 1 percent of the population accounts for 49 percent of hospital and home care costs, and 10 percent of the population accounts for 95 percent of such costs (Drummond 2012, Ch. 5). The costs will always be sharply skewed because some people are very sick and require expensive care while the majority enjoys good health. But a good portion of the high cost of the minority results from weak co-ordination of their care. Indeed, until recently, little was known about this group. Patients with congestive heart failure might be dismissed from hospital without notice to their physician or community nurse. A timely visit by that nurse, which is often not feasible due to lack of notice, might prevent an expensive and dissatisfying return to hospital.

Stronger standards for medical approaches and conducts of practice would improve the quality and efficiency of care. In some areas these are strong now, such as in certain areas of cancer, but in general there is little guidance provided to physicians and other caregivers.

e) Scope of Practice

In a verbal submission to the Commission on the Reform of Ontario's Public Services, the Ontario Nurses' Association has argued that 70 percent of what physicians do can be completed by nurses. This finding has also been supported

by an extensive body of research, which has found that nurses and physician assistants can handle up to 70 to 80 percent of the care that primary care physicians typically provide (Scheffler 2008). To a degree, the efficiency gains associated with this are being garnered by nurse-led clinics. One could argue that a more efficient allocation of care across stakeholders would involve more than shifting roles between physicians and nurses. This would obviously be a contentious area of reform within stakeholder groups who may perceive change as a threat to their incomes. Thus, close consultation with stakeholders would be required. An option to be explored is the extent to which responsibility for scope of practice could be shifted to the local or hospital level. Informal discussions among hospital administrators during the second Queen's Health Policy Change conference led to suggestions that very large reductions in budget, with no loss and possible improvements to quality, could result if there were greater local autonomy in human resource management.

f) Human Resources Planning

Human resource planning in healthcare is largely the responsibility of the provinces and territories, either directly or through their faculties of medicine. The shortages of some specialists, and hence the long wait times, can be laid at the doorstep of this planning process and interaction with other elements of public policy such as compensation. For example, the shortage of gerontologists has long been known and will get worse with the ageing of the population. This is not likely unrelated to gerontology being one of the lowest paid fields within medicine. Closer attention needs to be paid to demographic and technological changes (for example, fewer physicians in certain areas such as cataract surgery, radiology, cardiac surgery, and so on are now required), and this insight must be used to change the inflows into medical schools and alter compensation schemes to provide the required incentives.

The C.D. Howe Institute, in "Doctors without Hospitals: What to do about Specialists Who Can't Find Work" (Blomqvist, Busby, Jacobs, and Falk 2015), adds another human resources reason to consider in terms of giving more authority to hospitals for budgeting. They argue that hospitals should pay for specialists' services and that this should include negotiating pay and access to hospitals' facilities. The case is made that this would better match available specialists with hospital capacity.

g) Full Circle to The Ultimate Goal – Promoting and Maintaining Good Health

In the long run, improving health outcomes at a sustainable, affordable cost to society will require the promotion and maintenance of good health, and not just efficiency gains in biomedical care. Most provinces are active in public education campaigns on the negative health effects of smoking and alcohol

abuse, there have been some provincial and federal "participation" initiatives, and some jurisdictions dabble in student nutrition program initiatives. But, in general, Canada's healthcare system is inadequate to tackle public health challenges and must be improved. This should extend to long-run perspectives on who is most likely to get sick and under what conditions. In doing so, greater attention would be paid to the conditions that lead to such poor health outcomes for the most vulnerable and marginalized Canadians, including indigenous and racialized people, immigrants and newcomers, women, children, and the low-income and working poor. A more holistic approach may well determine that the best way of lowering future healthcare costs is to invest in the education of high-risk youth, or in more affordable housing for low-income families.

More specific things can be done on the health promotion side as well. For example, it is probably not a coincidence that Canada has one of the highest rates in the developed world of hospitalization of adults with Type II diabetes, and one of the lowest incidences of people with diabetes or at risk of diabetes taking the recommended, regular blood tests. A tighter link between health promotion and healthcare would not permit this. It seems ironic and perverse that our cars tell us how many kilometres until the next oil change but we have no equivalent for our bodies.

Much of the problem with promoting and maintaining good health comes down to the objectives and compensation models for healthcare providers. As the objectives are largely around healthcare interventions rather than promoting good health and as much of the compensation is based on fees for these interventions, it is not surprising that the focus is largely on addressing health problems after they have struck rather than promoting good health in the first place.

A good part of the thrust on health promotion could include an important role for the federal government. One fairly easy step would be to coordinate the work being done in this area by the provincial health research councils or institutes in Alberta, Ontario, Saskatchewan, Quebec, Manitoba, British Columbia, New Brunswick, Newfoundland and Labrador, and Nova Scotia.

MEASURING OUTCOMES

Public policy often sets out lofty objectives but does not track their realization. This must not be the case with healthcare. Currently, health data focuses on outputs and especially inputs, but not on the outcomes of general health and healthcare interventions. If outcomes are more effectively tracked, this could result in better evaluations of the value-added aspect of healthcare interventions. Moreover, the measurement of outcomes should reflect the

perspective of patients and their families, not just as to their medical outcome, but also their satisfaction with treatment and associated processes.

One fairly easy step would be to help coordinate or at least compile the work being done. Better data would facilitate analysis of quality and efficiency of care and enable identification of best (and worst) practices. One of the most powerful ways to improve the quality of healthcare across Canada will be a facility to compare and contrast results across provinces and territories, other countries, and even across institutions. Several institutions already exist in Canada to do this. So the thrust for better measurement should begin at the national (but not necessarily federal) level, as opposed to many of the other steps in this report that are targeted more at provinces and territories. It would be desirable to have a few degrees of freedom from political input for the data collectors, disseminators, and analyzers.

At the aggregate or more "macro" level, we have the Canadian Institute of Health Information (CIHI). Recently it has ventured more into cross-jurisdictional comparisons and this should be furthered. Infoway's work should be continued on a national electronic health record system and there should be a comprehensive evaluation to ensure that there is value added and, if not, how practices should be amended. Further, the Canadian Foundation for Healthcare Improvement (CFHI) highlights best practices across the country. Through continuation of the CFHI's work or through another agency, this analytical capacity should be strengthened and expanded.

In recent years, massive amounts of electronic health records have been created across Canada at great expense, but an astonishingly low level of health information exchanges across organizations and care settings is still featured. For example, only 12 percent of primary care physicians are "notified electronically of patients' interactions with hospitals or send [or] receive electronic referrals for specialist appointments" (Protti 2015, 1). Moreover, "fewer than three in ten primary care physicians have electronic access to clinical data about a patient who has been seen by a different health organization" (Protti 2015, 1). This all adds up to one of the poorest levels of health information exchange across organizations and care settings among developed countries. To the degree that the inefficiency and mediocre quality of healthcare in Canada relates to the difficulty in bringing the various silos of care together, electronic health records have so far failed to deliver on their promise. A new era must be launched to ensure connectivity of records, and as with all public policy challenges, this should start with an analysis of what is going wrong.

With a focus on healthcare interventions as opposed to health outcomes more generally, and with most physicians still being compensated on a fee-for-service basis, it is not surprising there has been so little progress in connecting electronic health records across organizations and care settings. Too few of the players involved have an incentive to devote the necessary time, as connectivity is neither explicitly in their objectives nor reflected in their compensation. As

with other challenges in health, then, success in connectivity with electronic health records will require a shift toward targeting the health of people rather than just the results of health interventions, and as part of that shift in objective, the relevant stakeholders should be incentivized to spend the time required in building these information bases to best serve people's overall health.

ALL TOGETHER NOW

There are many strands to needed healthcare reform, but they can and should be held together through a public document that accurately sets out the problems, objectives, and steps to reform, and then determines how to regularly measure and report progress. Nothing in what is recommended above seems heroic relative to the kinds of reform that have been implemented in other areas – or indeed even compared to what has already been done in healthcare in Canada. It just takes a few more steps to create the winning conditions to get the public and stakeholders onside and then a comprehensive strategic plan. At the moment, it seems change will most likely occur at the provincial or territorial level, but these individual jurisdictions will likely quickly emulate success observed elsewhere. A national approach is wise in some areas, in particular for building upon some of the information infrastructure already in place. There should be an effort to create national standards for seniors' care and pharmaceuticals. Provinces could work toward the standards in their own ways and at their own paces. In time there might be greater comparability of healthcare across the country. Further, there might even be programs like a national pharmaceutical plan or national seniors' care. But these can be gradual evolutions and do not need to be starting points because they could also be stumbling points.

Many of the conditions needed for successful provincial healthcare reform have been established within the last few years, with the Queen's Health Policy Change Conference Series playing a crucial role. Moving forward, provinces, either acting alone or together, can put the remaining pieces in place and act now to create positive change for our healthcare system.

Summary of Recommendations

General Strategy

R1.	The piecemeal reforms of healthcare across the country should broaden to system-wide change.
R2.	National leadership and design in healthcare reform are welcome, but provinces can choose to act together.
R3.	Each province should commission an external review of its healthcare system that closely involves stakeholders, including the public.
R4.	Each province should anchor its healthcare strategy in a public document that accurately explains the problems, the objective(s), the steps in reform, and how progress will be monitored and measured.
R5.	Key stakeholder groups should engage more directly with provinces on healthcare reform.

Steps in Healthcare Reform

R6.	Provinces should consider a greater role for an arm's length agency, both in healthcare administration and in implementing reforms.
R7.	While discussions are being launched on a national pharmaceutical program, provinces should focus (individually and where feasible together) on more affordable drug prices (with a federal role here as well), better access/affordability through reforms of public support systems, and tighter protocols and monitoring of the use and effectiveness of pharmaceuticals.
R8.	To better inform the dialogue on a national pharmacare program, a credible, independent body should be charged with examining the differing views of the cost implications of public administration.
R9.	Governments should facilitate discussions on national standards of seniors' care, with an aim to improve efficiency and quality of seniors' care through reducing hospital use, expanding home care, and ensuring flow into and out of long-term care.
R10.	Recent efforts to improve the efficiency of healthcare delivery should be continued, including moving further away from cost-plus budgeting for hospitals and fee-for-service for doctors and making greater and better use of electronic health records.
R11.	Provinces should focus on better coordination of care across the various sites of care and pay greater attention to coordinating the care of the small portion of the population that accounts for much of total healthcare spending.
R12.	Provinces should examine potential efficiency gains and cost savings through scope of practice changes, including giving hospitals a greater voice in the delineation of duties.
R13.	Provinces and medical schools should put more emphasis on human resources planning in light of demographic and technological changes, and strive for a better match of the supply of healthcare providers with patient demand.
R14.	The emphasis should shift from healthcare to health promotion with more effective means of promoting the latter along with appropriate shifts in the incentives to healthcare providers to do so.

Measuring Outcomes

R15.	Existing pan-Canadian institutions such as CIHI, CFHI, and Canada Health Infoway can lead in generating better data and analysis on health outcomes and the results of healthcare interventions, including comparisons across institutions and provinces.
R16.	Incentive systems need to be further changed to give healthcare providers the motivation to focus on health outcomes and to better use electronic health records in that pursuit.

Appendix A. Policy Position Papers by Healthcare Stakeholders

Year	Stakeholder Group & Report	Reference
2010	**Canadian Medical Association:** **Health Care Transformation in Canada – Change that Works, Care that Leads**	http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD10-05.PDF

The CMA has created an extensive framework for healthcare transformation, listing the actions needed for change under five main pillars. A copy of this transformation framework is included below:

1. Building a culture of patient-centred care;
   a. Key action: Create a Charter for Patient-Centred Care
2. Incentives for enhancing access and improving quality of care;
   a. Key action: Change incentives to enhance timely access
   b. Key action: Change incentives to support quality care
3. Enhancing patient access along the continuum of care;
   a. Key action: Universal access to prescription drugs
   b. Key action: Continuing care outside acute care facilities
4. Helping providers help patients;
   a. Key action: Ensure Canada has an adequate supply of health human resources
   b. Key action: Improve adoption of health information technologies
5. Building accountability/responsibility at all levels;
   a. Key action: Build system accountability
   b. Key action: Build system stewardship.

The CMA has made fourteen recommendations to achieve these objectives:

1. Gain government and public support for the CMA's Charter for Patient-Centred Care.
2. Improve timely access to facility-based care by implementing partial activity-based funding for hospitals.
3. Implement appropriate pay-for-performance systems to encourage quality of care at both the clinician and facility levels.
4. Establish an approach to comprehensive prescription drug coverage to ensure that all Canadians have access to medically necessary drug therapies.
5. Begin construction immediately on additional long-term care facilities.
6. Create national standards for continuing care provision in terms of eligibility criteria, care delivery, and accommodation expenses.
7. Develop options to facilitate pre-funding long-term care needs.
8. Initiate a national dialogue on the Canada Health Act in relation to the continuum of care.
9. Explore ways to support informal caregivers and long-term care patients.
10. Develop a long-term health human resources plan through a national body
11. Accelerate the adoption of Health Information Technology (HIT) in Canada.
12. Accelerate the introduction of e-prescribing in Canada.
13. Require public reporting on the performance of the system, including outcomes.
14. Establish an arm's-length mechanism to monitor the financing of healthcare programs at the federal and provincial/territorial levels and assess comparability of coverage.

Year	Stakeholder Group & Report	Reference
2012	**Canadian Nurses' Association:** **A Nursing Call to Action: The Health of Our Nation, the Future of Our Health System**	https://www.cna-aiic.ca/~/media/cna/files/en/nec_report_e.pdf

In May 2011, the Canadian Nursing Association established an independent National Expert Commission to evaluate the most efficient, effective, and sustainable ways to meet the changing and pressing health needs of Canadians in the 21st century.

The Commission made a number of recommendations, including:

- Addressing the social determinants of health.
- Improving access to primary healthcare for vulnerable populations (immigrant and refugees, Aboriginal, low-income populations).
- Reinforcing the shift to team-based medical care and changing the way healthcare professionals are educated.
- Bringing pharmacare under medicare.
- Enhancing federal funding to develop a national home care and palliative care program.
- Integration across the continuum of care, and increasing public financing across the continuum of care.
- Improving selection of indicators and data that more effectively measures progress of healthcare systems.
- Utilizing technology to improve access to care (e.g., Skype, telemedicine, email).
- Safer, higher quality of care.

The Commission found that nurses are underemployed and underutilized outside of acute and long-term care settings. In 2010, public sector healthcare nurses worked a total of 20,627,800 hours of overtime. Hospital over capacity is a key contributor to over utilization of the existing nursing workforce and it is having a negative impact on patients, families, and health outcomes.

Year	Stakeholder Group & Report	Reference
2011	**Canadian Medical Association & Canadian Nurses' Association:** **Principles to Guide Health Care Transformation in Canada**	https://www.cna-aiic.ca/~/media/cna/files/en/guiding_principles_hc_e.pdf

This brief report outlines the principles that the CMA and CNA came up with together to guide healthcare transformation in Canada. The goal of this report is to have these principles guide discussions at the provincial/territorial and federal levels, leading to the signing of a new healthcare accord between the governments. The principles are summarized as follows:

- **Patient-centred:** Patient must be at the centre of healthcare, with seamless access to a continuum of care; services must be based on need, not ability to pay; and health professionals must treat patients with respect and dignity.
- **Quality:** Canadians deserve quality services that are appropriate for patient needs, respect individual choice, and are delivered in a manner that is timely, safe, effective, and according to the most currently available scientific knowledge.
- **Health promotion and illness prevention:** The health system must support Canadians in the prevention of illness and the enhancement of their well-being, with attention paid to the social determinants of health.
- **Equitable:** The healthcare system has a duty to Canadians to provide and advocate for equitable access to quality care and commonly adopted policies to address the social determinants of health.
- **Sustainable:** Sustainable healthcare requires universal access to quality health services that are adequately resourced and delivered across the board in a timely and cost-effective manner.
- **Accountable:** The public, patients, families, providers, and funders all have a responsibility for ensuring the system is effective and accountable.

In addition to the principles developed by the CMA and the CNA, the action plan should continuously build on the five principles of the Canada Health Act to guide the transformation of Canada's healthcare system toward one that is publicly funded, sustainable, and adequately resourced, and provides universal access to quality care.

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Year	Stakeholder Group & Report	Reference
2013	**British Columbia Medical Association:** **Charting the Course: Designing British Columbia's Health Care System** **for the Next 25 Years**	https://www.doctorsofbc.ca/sites/default/files/charting_the_course_final.pdf

In a written submission to the standing committee on health in 2013, the British Columbia Medical Association (BCMA) authored a report entitled *Charting the Course: Designing British Columbia's Health Care System for the Next 25 Years*, which examined the policy measures the province must pursue to build a healthcare system that will serve the aging population and address the rising incidence of chronic diseases.

This report made six recommendations to the Ministry of Health in British Columbia:

1. Continue to implement and expand patient-centered funding.
2. Pursue and implement public health strategies, which address chronic illnesses such as obesity, mental health, and chronic diseases of the circulatory system.
3. Invest in health capital infrastructure and community based programs.
4. Coordinate physician workforce planning, both federally and with other provincial governments.
5. Pursue better efficiencies in terms of cost and supply of medications.
6. Introduce evidence-based wait time benchmarks for the timely delivery of health care services.

Year	Stakeholder Group & Report	Reference
2014	**New Brunswick Medical Society:** **Fixing New Brunswick's Healthcare System**	http://www.nbms.nb.ca/assets/Care-First/NBMSPolicyENG.pdf

The New Brunswick Medical Society has published a submission to government, entitled *Fixing New Brunswick's Health Care System*. This review focused on the following areas of reform in New Brunswick's healthcare system: primary care, electronic medical records, better care for seniors, aligning peoples and processes more effectively, and creating inter-professional healthcare teams.

Year	Stakeholder Group & Report	Reference
2014	**Health Action Lobby (HEAL):** **The Canadian Way: Accelerating Innovation and Improving Health Performance**	http://www.healthactionlobby.ca/images/stories/publications/2014/HEAL_TheCanadianWay_EN_NoEmbargo.pdf

The Health Action Lobby represents more than 650,000 healthcare providers and consumers of healthcare. This consensus statement was created to identify the various ways the federal government can play a role in improving the health and healthcare of Canadians.

The statement focuses on six main issues:

- Improved collaboration between the federal government and the provinces and territories.
- A performance framework that is consistent with the Triple Aim approach to guide improvements and innovation in health systems and healthcare delivery.
- A commitment to stable and reliable transfer payments to go towards healthcare in the provinces and territories.
- Collaboration with healthcare providers to ensure the delivery of health promotion and illness prevention initiatives are evidence-based and cost effective.
- Strategic federal investments related to Canada's aging population, access to prescription drugs, and the spread of on-the-ground health innovations.
- The development of a common set of national health system performance indicators.

The statement calls on the federal government to participate in the Council of Federation's Health Innovation Working group, and for combined, time-limited strategic funds to spur system improvements, including a "National Health Innovation Fund focused on primary care, health human resources and mental health and addictions, as well as a Community-Based Health Infrastructure Fund" to help the provinces and territories accelerate the building of much needed long-term care facilities.

As part of the statement, HEAL advocates for the federal government to contribute 25 percent annually to healthcare funding in Canada. The present federal share of health system funding is estimated to be 23 percent this year and will drop to 13.3 percent by 2037 if no changes are made.

Finally, the statement proposes a new vision statement for healthcare: "to advance the health and health care of Canadians, working collaboratively with the provinces and territories, health-care providers and the public to ensure the promotion and delivery of appropriate, integrated, cost-effective, and accessible health services and supports."

Year	Stakeholder Group & Report	Reference
2013	Health Council of Canada: Better Health, Better Care, Better Value for All: Refocusing Health Care Reform	https://www.cahspr.ca/web/uploads/conference/2014-02-14_Better_Health_Better_Care_Better_Value_For_All.pdf

This report looks back on the last decade of healthcare reform, and finds that changes made to healthcare have not kept pace with the evolving needs of Canadians:

- Progress on wait times for key procedures cited in the Health Accords have stalled.
- Primary healthcare services lag behind other countries.
- Home care services do not address long-term needs.
- Prescription drug costs remain beyond the means of many Canadians.
- Health disparities and inequities continue to persist across the country.

The Health Council builds off the Triple Aim framework and proposes that better health, better care, and better value for all can be achieved through sustained support of five key enablers: (i) leadership at both the policy and delivery level; (ii) linking health system change to policies and legislation; (iii) capacity building through increasing resources and the effectiveness and efficiency of existing resources; (iv) innovation and spread; and (v) measurement and reporting.

The report concludes that enablers were not aligned to support the above system goals of better health, better care, and better value for all. The healthcare system can be improved in the following ways:

- Patient engagement (e.g., active participation in their care);
- Individual contributions of health care providers (e.g., nursing care);
- Management processes at the organizational level (e.g., operationalizing a hospital surgical checklist); and
- Strategic planning and policy decisions at the regional health authority level (e.g., implementing integrated service plans) and health ministry levels (e.g., implementing a provincial disease strategy).

Year	Stakeholder Group & Report	Reference
2012	**Council of the Federation:** **From Innovation to Action: The First Report of the Health Care** **Innovation Working Group**	http://www.pmprovincesterritoires.ca/phocadownload/ publications/health_innovation_report-e-web.pdf

In July 2012, the HCIWG released its report: *From Innovation to Action*. As discussed in the report, the HCIWG's work is guided by the Premiers' view that innovation needs to be the cornerstone of improved healthcare for Canadians. This report focuses on three priority areas: clinical practice guidelines that are consistent across provinces, team-based healthcare delivery, and health human resources. Additionally, the report considers how to create opportunities for the provinces and territories to work together to improve health outcomes.

The report lists twelve recommendations for improvement across the three focus areas identified above:

- Clinical practices:
    - Adopt clinical guidelines on heart disease and foot ulcers.
    - Work with clinical communities and health offices with the objective of developing within six months provincial and territorial-specific deployment strategies.
    - Report back within 24 months with an update on implementation.
    - Encourage national health provides to promote the adoption of clinical practice guidelines.
    - Identify other leading practices in clinical practice guidelines that could be shared among provinces and territories.
- Team based models of care:
    - Working group identified best practices of team based care in provinces and territories across Canada (for example collaborative emergency centres in Nova Scotia).
    - Define options for a platform for ensuring the ongoing identification and dissemination of information on innovative models.
- Health human resources:
    - Adopt guiding principles for health human resource management.
    - Work with ministers to create a health human resource website to better facilitate communication of information about health human resource labour markets across provinces and territories.
- Generic drugs:
    - Identify three to five generic drugs to include in a provincial/territorial Competitive Value Price Initiative.
    - Initiate a national competitive bidding process that would result in lower prices by April 1, 2013.
- Advancing the work:
    - Monitor the progress made on the initiatives contained in this report.

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Year	Stakeholder Group & Report	Reference
2014	**Canadian Physiotherapy Association:** **Submission to the Advisory Panel on Health Care Innovation**	http://www.physiotherapy.ca/getmedia/b954618b-3c9e-4eb7-a42e-32d7223e5499/2014-12-08_Federal_Advisory_Panel_on_Healthcare_Innovation.pdf.aspx

This policy position paper focuses on innovative models that feature the role of physiotherapy in improving patient flow and maximizing system resources for better health outcomes.

CPA calls on the federal government to lead in three specific ways:

1. Support direct access to healthcare providers in the public and private systems through mechanisms that prohibit third party payer requirements for physician referral. This may be achieved through changes within federal departments responsible for health services.
2. Invest in health services research and design to bridge the gap between demonstrated success in pilot projects to system-wide implementation and reform.
3. Dedicated funding for community-based well-being and injury prevention initiatives to target aging populations appropriately. The new federal funding model does not account for the fiscal disparities of provinces with older populations. A targeted investment program would allow provincial health savings from prevention-based care to be reinvested into continuing innovation and health services improvement that meets the needs of an older population.

Year	Stakeholder Group & Report	Reference
2014	**Canadian Academy of Health Sciences:** **Optimizing Scopes of Practice: New Models of Care for a New Health System**	http://www.cahs-acss.ca/wp-content/uploads/2014/05/Optimizing-Scopes-of-Practice_-Executive-Summary_E.pdf

This report acknowledges that Canada's health system has been difficult to change because of enshrined legislative, regulatory, and financial schemes. The Assessment directly addresses the optimal scope of practice of healthcare providers through an examination of these barriers to change, and calls for a system-wide transformation that builds upon ongoing quality improvement initiatives to better meet patient, community, and population needs.

This report identifies the misalignment of Health Human Resources capacities with the need to provide healthcare services relevant to population demands as the current problem with Canada's healthcare system. In response to the challenge of providing high-quality and accessible care, the scopes of practice of some healthcare professionals, such as pharmacists and nurse practitioners, have been extended and new professions and roles, such as pharmacy technicians and health navigators, have been developed in several jurisdictions across Canada. In some cases, however, these roles have been introduced without full articulation of how they will be integrated into existing service delivery models or how they will impact the scopes of practice of existing health professions.

A new healthcare strategy for Canada must focus on the patient, be flexible and accountable, and will ensure that the right provider gives the best care in the most appropriate location. Further recommendations:

- The federal government to provide national leadership to support collaborative care models and the evolution of this scope of practice
- An infrastructure that provides arm's length evidence and evaluation of the health workforce with both HHR planning and deployment through optimal scopes of practice as its mandate
- Research funds earmarked to address gaps in the literature on HHR planning
- Provincial governments should take the lead on funding, financing, and remuneration that would enable collaborative models of care that align with patient outcomes

Year	Stakeholder Group & Report	Reference
2011	**Canadian Health Services Research Foundation:** **Assessing Initiatives to Transform Healthcare Systems: Lessons for the Canadian Health Care System**	http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/JLD_REPORT.pdf?sfvrsn=0

This report recognizes that a clear vision and strategy is required to better align between the care offered and the care the population needs in Canada. The report looks at different healthcare systems and comes up with six different themes to address strategic areas in healthcare.

An analysis of the current health system in Canada shows that there are six areas in need of reform:

- **Strategic alignment:** The healthcare system must be realigned to meet patient needs and demands. Large reforms at the system level and implementing more effective chronic disease management and population health interventions can help to achieve this objective.
- **Organizations as the engine for delivery and change:** Through encouraging more inter-professional teams to deliver healthcare, this can transform organizational behaviour to meet evolving and shifting demands in the population. However, organizational change can be challenging and it is essential for reforms to be closely and deliberately managed during the change process.
- **Professional cultures:** Transformation of the healthcare system also requires new professional roles and the engagement of the medical profession. The report recommends that more attention be paid to nurse practitioners, patient navigators, and health assistants in delivering healthcare. Other suggestions include the development of new professional roles that link clinical and managerial functions.
- **Creating an enabling environment:** Achieving improvements also requires effective governance, well-defined and appropriate goals and targets, effective reporting mechanisms, and well-designed financial (for example, hospital funding, pay for performance) and non-financial incentives.
- **Patient engagement:** Patient care takes place not only between physician and patient, but also as a function of organizational context and system policies; therefore, patients must be included in policy decisions and the design of health services.
- **Evidence informed policy and decision making:** Strategies must enhance healthcare organizational capacity to integrate evidence into practice, as well as better coordination among research-based evidence, policy-making, and politics. Structural changes to healthcare systems are constantly being implemented without improved patient outcomes. There is a need for innovations and experiments that will increase communications between the research community, policy-makers, and the political sphere. Professionals should take on a more significant role in transforming Canada's health system.

Appendix B. Independent Review of Provinces' Healthcare

British Columbia

A comprehensive external review of British Columbia's healthcare system has not been conducted; however, there have been several external reviews of different healthcare sectors.

UBC Health Services and Policy Research has conducted external reviews of patient experiences in different sectors of B.C's healthcare system. In 2011/12, they focused on acute inpatient hospital care in British Columbia (Murray 2012), and in the most recent 2012/13 report, they examined patient experiences with outpatient cancer care (Black, Mooney, and Peterson 2014).

Alberta

In April 2013, the Government of Alberta organized a task force that was responsible for interviewing individuals in leadership positions on how to improve the healthcare governance system. The main finding of this research was to make Alberta Health work more effectively by clarifying roles and responsibilities, developing a partnering culture, and building the capacity of all individuals to deal with the challenges the system will face in the future. The task force made ten recommendations which focused on three key themes:

1. All parties must be clear about their roles and responsibilities and be committed to achieving excellence in their execution, including having the Minister and the Alberta Health Services Board adopt a procedure for the recruitment and selection of new board members that is competency-based, nonpartisan, and transparent.
2. Alberta Health works with the Alberta Health Services to achieve targets set out in the health plan.
3. Albertans require the full engagement of physicians in order to benefit from the effectiveness and quality outcomes that the health system should deliver (Alberta 2013).

The Ministry of Health in Alberta recently conducted a comprehensive review of rural health in the province to better understand the concerns and challenges of Albertans living in rural and remote communities. The final report was released in March 2015. Fifty-six recommendations were made which focused on six main themes: greater community engagement; team-based primary healthcare services; addressing EMS dispatch issues; retention of healthcare professionals; enhancing utilization of existing healthcare facilities; and acknowledging the role of healthcare facilities and services in the economic viability of rural communities (Alberta 2015b).

Saskatchewan

In November 2008, the Minister of Health launched the independent Patient First Review of the Saskatchewan health system, entitled *For Patients' Sake* (Dagnone 2009).

The review comprised two distinct streams of research: an examination of the patient experience across the full continuum of healthcare services and the administration of healthcare in regional health authorities (health regions), the Saskatchewan Cancer Agency, and the Saskatchewan Association of Health Organizations (SAHO).

Similar to the Alberta report, Saskatchewan's external health review recommended that no major changes be made to the existing regional healthcare governance model. The report made sixteen recommendations which fell under three broad themes:

1. **"Patient First" must be embedded as a core value in healthcare:** the best interests of patients and families must be the primary driver of policy decisions, collective agreements, priority setting and resource allocation decisions, and the operation of workplaces.
2. **Healthcare in Saskatchewan needs to function as a cohesive system:** there is a lack of coordination and standardization within the health system's administrative and leadership structures.
3. **Frontline providers must be empowered to deliver patient- and family-centred care:** effective leadership and improved system performance are critical to supporting a family- and patient-centred care model..

Manitoba

The province of Manitoba has not had a comprehensive external health review. However, in 2008 an independent task force was convened to conduct a governance review of Regional Health Authorities across the province (Manitoba 2008).

In March 2013, a large-scale review of Manitoba's emergency medical services system was completed. This report recommended closing eighteen low-volume EMS stations and upgrading others, as well as setting a province-wide standard for ambulance wait times (Toews).

Ontario

The 2012 *Commission on the Reform of Ontario's Public Services* made over 100 recommendations on improving the efficiency of the healthcare system in Ontario. Some of the key recommendations include:

- Giving Local Health Integration Networks (LHIN) more responsibility over funding and integration.
- Diverting patients who do not need acute care in hospitals to family doctors, clinics, and nursing homes.
- Increasing university nursing programs and using nurse practitioners more effectively.
- Expanding the role of pharmacists to permit them to give routine injections, inhalations, and immunization.
- Creating an online system for prescription refills, test results, and appointment scheduling.
- Linking the Ontario Drug Benefit program, currently for seniors and social assistance recipients, directly to income (Drummond 2012).

In the 2011 report *Caring for our Aging Population and Addressing Alternate Level of Care*, Dr. Walker made thirty-two recommendations to the Ontario government for improving the care of alternate level of care patients in the province, including:

- **Primary Care:** Primary care providers identify seniors for early risk of frailty and help seniors manage other health challenges.
- **Community Care Continuum:** Additional and sustained resources are provided to integrate, coordinate, and enhance Community Care Access Centres (CCACs), Community Support Service (CSS) agencies, and assisted living arrangements.
- **Cross-System Responsiveness to Special Needs Populations:** Integrated care for populations with special needs across the care continuum.
- **Assess and Restore:** Enhance "Assess and Restore" programs, which are interventions for short-term rehabilitative and restorative care treatments for seniors and other people who have experienced a reversible loss of their functional ability and who risk losing their independence.
- **Role of Acute Care Hospitals in Seniors' Care:** Hospitals must become more effective in optimizing this capacity, while applying best practices as related to discharge planning.
- **Specialized and Differentiated Long-Term Care Capacity:** Increase capacity for cyclical, restorative, transitional, and respite care programs for seniors, while maintaining permanent placement programs for seniors with more complex needs.
- **System Enablers:** Strengthen governance and accountability of LHINs. LHINs must be responsible for meeting targets and objectives and aligning incentives with desired outcomes. Additionally, a comprehensive needs-based service planning and forecasting model is necessary to inform decision-making on the type and number of beds and services to be funded in each community.

In 2012, Dr. Samir Sinha released the *Living Longer, Living Well* report to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a seniors strategy for Ontario. The report outlined five principles for a seniors' strategy (equity, access, choice, value, and quality) and proposed a number of key recommendations to improve seniors care in Ontario, including:

- **Promoting Health and Wellness:** Increase the availability of accessible exercise, falls prevention, and health promotion classes across the province.
- **Strengthen Primary Care for Older Ontarians:** Ensure that its development of Quality Improvement Plans in Primary Care and Health Links supports a core focus around the care of older Ontarians, and maintain and improve funding to support the number of house calls made by physicians.
- **Enhance the Provision of Home and Community Care Services:** Increase home and community service funding by 4 percent, support LHINs, CCACs, and CSSs to formalize a Standardized Collaborative Care Model, and encourage the development of more assisted living and supportive housing units as alternatives to long-term care homes.
- **Improve Acute Care for Elders:** Promote the development of senior friendly hospitals, explore the development of community paramedicine programs, and support the development and launch of the successful Hospital at Home model in Ontario.
- **Enhancing Ontario's Long-Term Care Home Environments:** Develop new LTC home-based service models, and improve flow to and from LTC home long stay and short stay services by reviewing the existing application and transfer processes and policies.

- **Addressing the Specialized Care Needs of Older Ontarians:** Leverage the success of the Behavioural Supports Ontario (BSO) Initiative and support the LHINs in broadening palliative care.
- **Medications and Older Ontarians:** Conduct full review of the MedsCheck Program, reform the Ontario Drug Benefit Program, and develop best practice guidelines and knowledge transfer mechanisms to improve prescribing practices.
- **Caring for Caregivers:** Improve the awareness of services and supports available to unpaid caregivers with improved single points of access, promote the awareness of tax credits for unpaid caregiving, and encourage the standardization of services and supports offered through the Alzheimer Society's First Link program and fully support the implementation of this program in every LHIN across Ontario.
- **Addressing Ageism and Elder Abuse:** Raise public awareness about the abuse and neglect of older adults, provide training for front-line staff, and co-ordinate community services to better assist victims of elder abuse in communities across the province.
- **Addressing Needs of Older Aboriginal Peoples in Ontario:** Aboriginal peoples start to deal with chronic illnesses and geriatric issues at younger ages than other populations and have more challenges finding culturally appropriate care – a separate Seniors Strategy must be designed for Aboriginal peoples to accommodate their unique needs and circumstances.
- **Supporting the Development of Elder Friendly Communities:** Enable older Ontarians to adapt their homes to meet their needs. Further enhance the development and availability of non-profit, safe, dignified, and consumer-oriented transportation systems for older Ontarians.
- **System Enablers:** Provide more financial support to PSWs, finalize the Alternate Funding Plan to support geriatricians, and require that health, social, and community service providers streamline their assessment and referral processes.

Quebec

In 2001, the Clair Commission proposed thirty-six recommendations to improve Quebec's healthcare services. Included among those recommendations are a number of innovative suggestions, such as:

- The reorganization of the delivery of primary health-care services by encouraging the formation of group family practices made up of 6–10 physicians that would provide care to a roster of patients 24 hours a day, 7 days a week; and
- The creation of a dedicated "loss of autonomy" insurance fund financed by taxpayers that would be used to pay for an expansion of homecare and institutional services to the growing number of elderly persons (Chodos 2001).

In 2013, an advisory committee was convened to look at how to implement patient-focused funding in Quebec. At the end of its work, the panel submitted its report to the government on the implementation of patient-focused funding in the health sector. This report reflects the unanimous conclusions of the members of the expert group (Quebec 2014).

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New Brunswick

In the spring of 2012, the Government of New Brunswick created the Office of Health System Renewal (OHSR), with a two-year mandate to encourage and assist health system partners and the NB health system to improve its performance.

The OHSR found that the NB healthcare system was not aligned, integrated, citizen-centred, innovative, affordable, or sustainable. Based on this analysis, the OHSR recommended that the goal should be to achieve a per capita public healthcare cost equal to the Canadian average by the 2016 fiscal year; according to the OHSR, this represents a total annual reduction in healthcare spending of approximately $250M by 2017.

In order to achieve this, the OHSR developed an eight-point action plan that includes benchmarking NB healthcare expenditures against Canadian provinces and identifying and implementing best practices.

The OHSR also focused on the following priorities:

- An organizational review, leading to management efficiencies within the healthcare system.
- Monitoring the regional health authorities' progress in implementing the cost per weighted case initiative.
- A review of shared services, including participation in a feasibility study of integrating FacilicorpNB operations with the new Department of Government Services.
- Identification and implementation of health innovations and best practices most promising to health renewal in New Brunswick.
- Monitoring and accountability of health renewal results (New Brunswick 2013).

Nova Scotia

The last comprehensive external review of the health system took place in 2007. The report provides over 100 recommendations, under the following themes:

- Renew emphasis on primary and continuing care, including shifting everything other than acute care out of acute care hospitals.
- Improve access to alternate levels of care and create care options in private homes, and dedicate facilities geared to long-term and chronic healthcare conditions.
- Review the scope of practice of nursing and other non-physician professionals to find innovative means to provide services.
- Review and assess technology-oriented services (e.g., computerized patient records) (Campbell 2007).

In September 2009, the Nova Scotia government appointed Dr. John Ross as its provincial advisor on emergency care. Dr. Ross's report, *The Patient Journey Through Emergency Care in Nova Scotia*, contained twenty-six recommendations to improve emergency care in the province. As a follow-up to his report, Dr. John Ross also developed minimum care standards for emergency care in November 2010. In response to Dr. Ross's recommendations, *Better Care Sooner: The Plan to Improve Emergency Care* was released in December 2010 by the Department of Health and Wellness. Adoption and implementation of the Emergency Care (EC) Standards is one of the action items in the plan. The purpose of the provincial EC Standards is to provide consistency and high quality care in the emergency care system in Nova Scotia (Nova Scotia 2014).

Prince Edward Island

The last comprehensive external health review in PEI took place in 2008. *An Integrated Health System Review in PEI. A Call to Action: A Plan for Change* made recommendations for all sectors of PEI's healthcare system, but found that the most serious gaps observed in the health system were in primary care. The recommendations included changes to governance and management, and the operating framework.

Newfoundland and Labrador

A comprehensive external review of Newfoundland and Labrador's regional healthcare system has not been conducted.

On March 12th, 2015, Newfoundland and Labrador's largest health authority released the results of an external review that gave several recommendations to improve its pathology laboratory. The review was conducted by the Ontario-based University Health Network (UHN), and recommends hiring a medical director, establishing a training program for pathology assistants, setting up a new reporting procedure, and conducting a workload analysis (UHN 2015).

A program review in 2013 was conducted on the ambulance program in Newfoundland and Labrador. The report made ten recommendations to improve the ambulance care system in Newfoundland and Labrador, including improving accountability, building a medical dispatch centre, and enacting EMS legislation to govern ambulance services in the province.

Appendix C. Administrative Management Structure of Healthcare in the Provinces

British Columbia	http://www.health.gov.bc.ca/socsec/roles.html

In 2002, the BC government reduced the network of regional authorities to create the current system of five regional health authorities and one provincial authority. British Columbia's five regional health authorities are responsible for governing, planning, and delivering healthcare services within their geographical regions. More specifically, the RHAs are responsible for identifying population health needs, planning appropriate programs and services, ensuring programs and services are properly funded and managed, and collecting data and tracking performance objectives. The Provincial Health Services Authority (PHS) oversees the work of the RHAs and governs and manages their performance. Additionally, the PHS works with the five RHAs to coordinate and deliver highly specialized services, including cardiac care and transplants. British Columbia has a separate health authority for First Nations peoples, which is responsible for planning and delivering First Nations health services and programs.

Alberta	http://www.albertahealthservices.ca/204.asp

In 2008, ten RHAs and three health agencies in Alberta were amalgamated into one authority (Alberta Health Services). Currently, the AHS is the largest single health authority in Canada and delivers medical care through 400 facilities throughout the province. The AHS was established to improve access, quality, and sustainability of healthcare services. Since its inception, the AHS has been organized so as to separate acute hospital facilities from small hospitals and community services, which are organized into five separate zones. The AHS reports to a board of directors, appointed by the Minister of Health and Wellness. Under the AHS, there are twelve Health Advisory Councils who are charged with fostering community engagement.

On March 18th, 2015, it was announced that Alberta Health Services would establish eight to ten "operational districts" within the AHS. The new AHS operational districts, to be implemented by July 1, will be responsible for delivering local health services and meeting performance objectives. Under the new model, each operational district will have more authority on how money is spent on services, facility repairs, and staff recruitment. They will receive advice from new 10–15 member Local Advisory Committees.

Saskatchewan	http://www.health.gov.sk.ca/health-system

Since 2002, Saskatchewan's twelve RHAs and Cancer Agencies have provided health services either directly or through healthcare organizations. The RHAs scope of responsibilities include: hospitals, health centres, wellness centres, social centres, emergency response services, supportive care, home care, community health services, mental health service, and rehabilitation services. Boards and chairs of the RHAs are appointed by order-in-council. Saskatchewan is the first jurisdiction in Canada to apply a lean approach to patient care; more than 700 lean projects have been launched across Saskatchewan, with the goal of improving patient outcomes.

Manitoba	http://www.gov.mb.ca/health/rha/

The Regional Health Authorities of Manitoba are mandated to promote and provide patient-centred, integrated province-wide sustainable solutions to healthcare services and programs. Manitoba's five RHAs are composed of healthcare providers who coordinate, manage, deliver funds to, and evaluate healthcare and health promotion in their region. All RHAs receive funding from the provincial government and are governed by a board of directors. In the spring of 2012, the provincial government reduced the number of RHAs in Manitoba from eleven to five. Through the merger process, 81 board member positions were eliminated. The amalgamation is intended to realize $10 million in savings over three years.

Ontario	http://www.lhins.on.ca/
Ontario was the last province in Canada to devolve healthcare to regional decision making. In 2005, Local Health Integration Networks (LHINs) were created as the health system designer and manager in Ontario. LHINs are charged with building and funding regional systems of integrated care and aligning health systems with the Ministry of Health's priorities and local needs. Responsibilities of the LHINs do not include the delivery of healthcare services. The LHINs delegate the delivery of healthcare services to Health Services Provider Boards. Currently, there are fourteen LHINs across Ontario, with an average of 900,000 persons per LHIN.	

Quebec	http://www.msss.gouv.qc.ca/en/reseau/services.php
Quebec's healthcare system is divided into three levels: provincial, regional, and local. At the provincial level, the Ministry of Health and Social Services manages the health and social services system. It is responsible for overall organization and allocates budgetary resources. At the regional level, eighteen health and social services agencies (ASSS) are charged with regional planning, resource management, and budget allocation to institutions in each region of the province. Below the ASSS are local health and social services networks (there are 94), certain hospitals, children and youth protection centres, long-term care centres, and rehab centres. Health and social services networks (CSSS) provide services directly to citizens and follow-up on the care they receive.	

Nova Scotia	http://novascotia.ca/dhw/about/DHA.asp
Currently, Nova Scotia's healthcare services are delivered by nine district health authorities (DHA) and the IWK Health Centre. These health authorities are responsible for all hospitals, community health services, mental health services, and public health programs in their districts. However, on April 1, 2015, the province of Nova Scotia will amalgamate these nine DHAs into a unified provincial authority. The purpose of amalgamation is to enhance patient care and safety, streamline administration, and provide more timely and consistent access to care. Under this new structure, nine vice presidents will report to the President/CEO, with one position shared with the IWK. In addition, there will be two executive directors in each zone, one for medical leadership and one for operational leadership.	

New Brunswick	http://www2.gnb.ca/content/gnb/en/departments/health.html
In 2008, New Brunswick reformed its healthcare system from eight Regional Health Authorities to two health networks, in order to improve integration, consistency, and the effectiveness of the healthcare system. Since then, the New Brunswick Health Council has been responsible for oversight and accountability of the two health networks in the province (Horizon Health Network and Vitalite Health Network). Similar to RHAs across Canada, New Brunswick's health networks are responsible for delivering heathcare services and programs. The health networks are governed by a seventeen-member board of governors, appointed by the Lieutenant Governor, on the recommendation of the Minister of Health. The health networks receive support services, including supply chain, clinical engineering, information technology and telecommunications, and laundry and linen services, from FacilicorpNB, a public sector agency created by the New Brunswick government in 2008.	

Newfoundland and Labrador	http://www.health.gov.nl.ca/health/
Currently, healthcare services and programs in Newfoundland and Labrador are delivered through four Regional Health Authorities (RHAs). The RHAs are charged with the delivery, administration, and assessment of health and community services in a specified area. Each RHA delivers similar services across Newfoundland and Labrador, but are structured differently, using different divisions for lines of business. The programs and services delivered through RHAs cover the full spectrum of hospital and community services, including Acute Care Hospital Services, Long-Term Care Services, and Community-Based Services. The RHAs are governed by a CEO and a voluntary board of trustees, who are appointed by the Minister of Health.	

Prince Edward Island	http://www.healthpei.ca/

In 1993, PEI created the first five regional health authorities in Canada. However, the RHA model was not effective for PEI because it required a large administrative structure for a small population. These boards were dissolved in 2005, with responsibility transferred to the Department of Health. The system changed once again in July 2010, with the government transferring power from the Department of Health and Wellness (renamed) to Health PEI, an arm's length crown corporation. Currently, Health PEI is governed by a board of directors, which ensures that the approved programs are delivered in accordance with the Ministry of Health's priorities. Health PEI's organizational structure is arranged into seven divisions that cover the full spectrum of healthcare services. Each year, the Quality and Safety Council evaluates Health PEIs programs and services on the basis of a balanced scorecard system that measures achievement against numerous Key Performance Indicators.

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