Healing Healthcare in Canada: A Shared Agenda for Healthcare Quality and Sustainability

ABSTRACT

Sullivan et al. make a compelling argument that a “coalition of the willing” must seize the nettle and create a national agenda and the capacity for quality leadership in Canadian healthcare. While there is reason to believe that Canada could benefit from such an agenda, there is also evidence that, if done incorrectly, such an agenda could be expensive and counterproductive. To increase the likelihood that a national quality agenda will contribute to the creation of a sustainable and effective healthcare system, it will be important to understand potential pitfalls and to incorporate approaches that have enabled leading organizations to achieve success. It will be key to create a shared vision of healthcare that focuses on the health needs of our population and engages stakeholders broadly.

Sullivan et al. (2011) have sought input from a selection of healthcare leaders across the country to assist with clarifying current thinking regarding the quality agenda in Canada and how a national strategy might be of benefit. They conclude by challenging us to form a “coalition of the willing” to “get over our giant inferiority complex and seize the nettle of building a national agenda and the capacity for quality leadership in Canada.”
As a physician with a long-standing interest in improving the quality and sustainability of healthcare, I am supportive of a quality agenda at all levels and agree with the assertions made in the article that it will take many working together to make this happen. Not addressing this issue effectively will both impact the quality of health services that Canadians receive and the funding available for other priorities and also threaten to make Canadians feel like people of a can’t-do nation.

The lead article covers a wide range of issues related to such an agenda, including three drivers of change: “(1) a move to person-centred models of care delivery in which individual needs and expectations for participation in health are given primacy; (2) the need to contain and reduce costs in healthcare delivery, duplication of services and process inefficiencies; and (3) the need to improve patient safety.” Also included are impediments such as an embedded culture, a lack of definition of quality, insufficient engagement of boards and physicians and concerns regarding measurement. The importance of leadership is identified. In order for a national agenda to be successful, exploring these issues further and considering potential pitfalls will be beneficial.

**Potential Pitfalls**

Concerns regarding the quality and sustainability of health services persist, despite many investments and efforts over the years. Further, many jurisdictions have struggled with similar concerns and have also been disappointed with their attempts at change. As efforts internationally in recent years have had a similar focus to that supported by the lead article’s authors, considering such experiences is instructive. A jurisdiction mentioned in the article that invested heavily in a bold national strategy to become more patient centred and achieve measurable targets through a variety of means is England’s National Health Service (NHS). Between 1999 and 2000, that centrally run health service was able to achieve many improvement targets, especially those related to wait times. Unfortunately, the NHS also more than doubled its budget (Jim Easton, presentation June, 2009). Its strategy contributed significantly to the current need for an austerity budget. Targets that had been reached have been scrapped due to a lack of sustainability. NHS has now embraced a radically different policy approach, the results of which will not be known for years. The UK example is dramatic but serves to point out that a bold national agenda focused on quality does not necessarily result in the desired outcomes. Such experiments suggest that a more nuanced quality agenda will be required for success.

**Engaging a Broader Stakeholder Group**

It is interesting to note that the immense policy shift occurring in England’s NHS is being driven from the political level and involves putting the vast majority of resources under the direction of general practitioners. The logic, as I understand it, is that empowering those more directly engaged with addressing the needs of patients is more likely to lead to the population’s needs being met. Further, by tying budgetary accountability to the same people, it is more likely this will be achieved in a fiscally responsible manner.

I can certainly relate to this logic. Early in my career as family physician, I noted clear trends that were negatively impacting the
quality and sustainability of health services. There were some primary care initiatives in the province (British Columbia) at the time, but they were so proscriptive and the government of the day was so clearly anti-physician that few physicians, me included, were interested in engaging. The anti-physician sentiment carried into negotiations and, due to lack of trust and relationship, there was little scope for negotiation beyond dollars and cents. The resulting physician master agreement provided a substantial increase in physician income and a concomitant decrease in physician morale and system functionality. This is an example of the increased cost and decreased function that plays out in many ways across our country. I suspect that there are numerous stories that can be told by clinicians, users of the system and others regarding their perception of system waste and dysfunction. Obtaining such insights and empowering change are critical to sustainable improvement.

The “Culture” of Healthcare in Canada

The lead paper contends that the culture of healthcare in Canada needs to shift and embrace a focus on quality and sustainability. Understanding the current cultural issues ingrained in our healthcare system should assist with increasing the clarity regarding what will be required to make this shift.

My early experiences in healthcare caused me to become concerned about having a long career within a system that was becoming increasingly dysfunctional. In an effort to contribute to solutions, I became involved in a variety of activities, initially in the governance of a regional health authority. Through this role, I came into contact with board members from across British Columbia, senior administrators and ministry staff as well as a physician and academic leaders. I came to realize that issues and trends that seemed obvious were not understood by many in healthcare. Further, there was no clear path for sharing this information in ways that were constructive. I am not alone in this observation. Most physicians experience such a disconnection. As is evidenced by the membership survey published in the fall 2009 newsletter of the Canadian Society of Physician Executives, even physicians who are committed to substantive leadership roles within our system share this experience. The survey reveals that the top three challenges for their membership are (1) being effective in the leadership role, (2) making an impact on decision-makers and (3) being included in key organizational decisions.

Canada is not alone with such disconnections. Brent James of Utah-based Intermountain Healthcare, a well-recognized leader of health system improvement, describes the medical and healthcare administrative communities as “fundamentally joined structures with fundamentally separate objectives” (Personal communication, June 2009). Significant disconnections between such major components of the healthcare system are, in my estimation, at the root of the structural and cultural issues that impede progress. Sullivan et al.’s paper also references disconnections in healthcare when it mentions such things as physician autonomy and when it describes boards as being too focused on finances and strategy. My diverse activities in healthcare, including medical administration and academia, have helped me to see that disconnections do extend beyond the administrative and medical communities. Healthcare is made up of many groups, each with its own culture, that do not connect with each other as well as they need to. Doug Eby, of Southcentral Foundation, who consults widely internationally, describes healthcare as a “non system” (Personal communication, June 2009). Perhaps the best way to consider the culture of healthcare in Canada is a patchwork
of cultures that are only loosely related. Those of us who are, or have been, immersed in the culture of healthcare have experienced the atmosphere of mistrust and the lack of shared vision present in many settings. It is reminiscent of what the late BC author Peter Frost (2003) described as a “toxic” work environment.

**A Quality Culture**

The quality agenda has the potential to create a bigger tent under which the many cultures that exist within healthcare in Canada can come together to co-create a more effective and sustainable healthcare system. My academic focus has been on understanding how the organizations viewed by the international community as being the most effective, from quality and sustainability perspectives, have used a quality agenda to achieve success. It is clear that, despite significant contextual differences, such organizations share many traits (Horvat 2011). For such organizations, quality improvement provides an approach that brings people with different roles together in a respectful and supported fashion to consider how resources can be used most effectively to address the health needs of the population being served. Clinicians and those responsible for significant infrastructure work together to identify priority areas. With the support of those with expertise in such areas as quality improvement, data analysis and finances and with input from patients, relevant best practices in clinical and non-clinical realms, appropriate measures and suitable Plan-Do-Study-Act (PDSA) cycles to trial changes are identified. Trials are made, results measured and, if effective and sustainable approaches are found, efforts are made to spread such best practices. This results in a reduction in clinical variation. Such systems use peer mechanisms and sometimes incentives or disincentives to motivate people to embrace change and work together effectively. Barriers to improvement are removed. The sense of collaboration increases somewhat as people have the opportunity to work together, across disciplines, to achieve shared goals. This approach promotes shared responsibility and accountability and appears more successful than the potentially judgment-laden approach of performance management.

> “People came into healthcare to serve; how do I make it easier for them to do it right?”

The approach to leadership that has led to shifts in organizational culture toward quality and has resulted in more effective and efficient health services is more service oriented than the leadership style one typically finds. Observations on leadership by Brent James include noting, “People came into healthcare to serve; how do I make it easier for them to do it right?” and, “The role of leadership is to build infrastructure” (Personal communication, June 2009). This supportive and empowering style of leadership, coupled with the creation of shared priorities and approaches, results in quality being embraced broadly by people working in healthcare and leads to the development of leadership throughout the system. This is a key feature of highly effective healthcare systems that are able to support sustainable improvement in many areas at once.

While the landscape in Canada has many similarities to those of other countries, we do have our unique features as well. The different mandates and cultures of the federal versus provincial governments make it highly unlikely that a directive federal agenda will be embraced. There are, however, benefits to this. As demonstrated, a centralized approach,
if incorrect, can cause significant difficulties. Further, successful approaches have been much more supportive than directive methods. A federal approach will more likely succeed through a “coalition of the willing,” composed of organizations and “individuals who have an ability and determination to change practice and improve care,” working together to construct a shared quality agenda.

**Conclusion**

An increased focus on quality and sustainability is required for the Canadian healthcare system. By avoiding the common pitfalls that we and others have experienced, by broadening the engagement and by constructing a shared agenda for improvement, we will be doing a great service to Canadians.

Healthcare in Canada is in the public domain and so, by necessity, is a political matter. Ultimately, successful change will require political support. As there are few politicians who have an understanding of the nuances of our healthcare system and the activities that will lead to successful improvement, it is unlikely that political leadership will be grasping nettles anytime soon. It is up to the many of us who are more directly engaged within the system – as clinicians, administrators, researchers, educators etc – to grasp this nettle and deliver a shared vision of what our healthcare system can be. Such a shared vision will be more easily embraced by those at the political level and will therefore make progress more likely to occur.

This is an exciting time in healthcare. Let’s make it work for Canadians.

**References**


