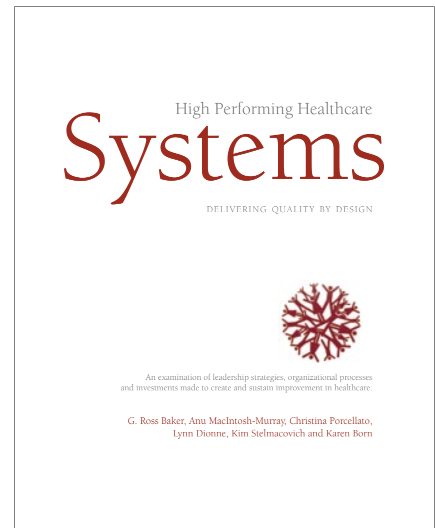
High Performing Healthcare Systems

DELIVERING QUALITY BY DESIGN

Afterword



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Afterword

Reading these stories about high-performing health systems should make Canadians uncomfortable. From a small county in Sweden to a large, Canadian-style dispersed system in the United States; from a focus on primary healthcare to the pursuit of excellence in acute care; from implementing tools and techniques to the development of system-wide cultures – these narratives describe achievements to which Canada aspires but rarely achieves.

Our inability to make things right despite huge investments in healthcare is no longer a private failure. Chris Ham from the University of Birmingham, an astute international healthcare system observer, tells a revealing story. As the architects of the UK's National Health System (NHS) transformation charted their course at the beginning of this century, they looked, Ham recounts, elsewhere for inspiration and cautionary tales. The worst possible outcome, they concluded, would be to increase spending from 6% to 10% of GDP and end up looking like Canada. By this they meant it would be a travesty to spend so much and achieve so little.

Damn them for their prescience. In 1997 total Canadian healthcare spending was $79 billion. Ten years later the tab had reached $160 billion. Yet that decade of spending

increases far above the rate of inflation did not fundamentally improve performance. In addition, public confidence has not been fully restored, and international rankings on measures such as public satisfaction and value for money, however controversial, do not flatter Canada. We support dozens of demonstration projects but rarely generalize proven success. We learn a lot *about* others' successes – everyone seems to know about the prerequisites for high performance and regiments of Canadian front-line workers, managers, board members and government officials have visited the UK, Intermountain Healthcare, Virginia Mason and their cousins. They all sing lustily from the Institute for Healthcare Improvement (IHI) hymnal. Whether we learn from them is another matter.

Why this apparent contradiction: on the one hand we are willing and able to learn, seem to want to change, sign up in droves to improve safety, succeed on a small scale, but on the other, we can't seem to close the deal system-wide? As careful comparative health systems analysts remind us, context is everything. What works in Sweden might not work here. So what is it about our context that holds us back? Are we in the end a learning-disabled nation, frozen by tradition, paralyzed by the power of vested interests, as complacent as Canadian hockey prior to the wake-up call of the 1972 summit series with the Soviets?

Peculiarly Canadian challenges

Our expensive mediocrity is not entirely an accident. Canada faces challenges that are less daunting elsewhere. They are not insurmountable, but we ignore them at our peril. Among the most prominent:

Mon pays, ce n'est pas un pays …

Yes, the state of federalism holds us back. It is no secret that federal–provincial relations are at a low ebb. Canadians reliably support the involvement of both levels of government in policy-making and direction, yet their governments do not share this view. Ottawa's role is to be a cash cow (see the accords of 2000, 2003 and 2004). With a guarantee of billions of new dollars coming down the pipeline for years to come, the predictable result is increased expectations for higher pay and plans to add capacity. The unintended (but inevitable) consequence is that our new money mainly buys the status quo while other countries' buys change. (We should have gone to the UK for counselling.)

Clinical autonomy rules

It is quite possible that clinical autonomy is more firmly entrenched in Canada than anywhere else. We know about and accept huge variations in practice with equanimity. Most physicians feel little attachment to health regions or larger systems, and medicine remains primarily a cottage industry. Autonomous judgment is a hallmark of professionalism and, properly applied, it is a fundamental building block of excellence. But

autonomy without accountability is a recipe for huge variations in practice and an invitation to plunder public resources. It also makes managing wait times and achieving real equity of access extraordinarily difficult.

Perverse incentives breed cynicism

Everyone familiar with Canadian healthcare knows the following:

- It is more lucrative to practise bad medicine than good medicine, particularly in family practice. See 80 basically healthy patients a day for five minutes and you'll prosper. See 20 complex frail elderly patients and apply all of your learning and wisdom and you'll make a modest income at best. Medical associations by and large determine which specialities will make how much money and which practice patterns will be most lucrative – yet another example of a healthcare system designed to get the results we observe. Governments need to find ways to eliminate these perverse incentives.
- Governments send mixed signals about whether they wish to fund volumes or excellence and prudent use of resources. Their rhetoric supports needing and using less healthcare, but their behaviour rewards volumes. It is hard to take seriously their population health and prevention messages when they hold the system accountable for activity but not outcomes. Governments must commit to a population- and needs-based approach, and find ways to reward ingenuity that improves access and quality with less volume.
- Many professionals are woefully underused. Nurse practitioners are probably the best-studied occupational group in human history. Three dozen randomized controlled trials have confirmed that they can deliver a wide swath of effective primary care services. Lured by every imaginable form of incentive, family doctors still largely will not go to or stay in rural and remote Canada. Yet the juxtaposition of these two firmly established realities has not led to the obvious transformation. The guilds are powerful and it is instructive to observe how medicine has managed to change the focus to physicians' assistants (i.e., a hierarchical, doctor-controlled approach) from an expanded nurse practitioner model (i.e., collaborative and egalitarian approach). All health human resources stakeholders need to rethink the whole approach to education, credentialing and the division of labour.

Success notwithstanding

The barriers to improvement are real, but there are solutions – even in Canada. Most do not require wholesale rebuilding. They often rest merely on the removal of a few important barriers to improvement and on policies that encourage the behaviours to which we aspire.

Beyond pretend-management

Eight provinces have health regions, and Ontario has Local Health Integration Networks (LHINs). In theory, these structures have been established to decentralize authority, encourage experimentation and innovation, and set creativity free. Yet health ministries cannot resist looking over (even sitting on) the shoulders of health regions and LHINs, wading into mini-crises and generally letting the public know that they, and not the local authorities, are in charge when the going gets tough (and even when it doesn't). If ministries were brilliant micro-managers, with policies and incentives aligned, one might forgive them for their meddlesome and demoralizing hubris. Moreover, there is a lot of pretend-governance and pseudo-management. Costs are still heavily driven by independent and largely autonomous physician contractors. There is sufficient confusion about who really makes decisions to allow clever players several options for getting what they want. These are the elephants in the room, leaving scant room to pursue a truly needs-based, efficient and effective public interest mandate. The solution is to let organizations manage within sensible accountability frameworks and expand the concept of management into the domain in which it is needed most: clinical service.

Embrace the information revolution

When it comes to comprehensive, real-time health information, Canada exhibits all of the characteristics of a country that doesn't want to know and doesn't want to tell. Those responsible for the health information and information technology (IT) agenda have said over and over that it may take 10 times as much money as we have thus far been prepared to invest to produce real-time performance information accessible to providers, the public, managers and policy-makers. Every high-performing health system story has electronic, standardized, widely used information at its centre. The next frontier is the office-based electronic medical record, which has to be standardized, interoperable, linkable and useful at multiple levels. Otherwise, we will end up with less analytical power than we had a decade ago.

Learn from the best – including ourselves

The key object lessons from the inspiring stories in this collection of case studies are:

1. Policy and leadership matter. Success cannot be optional. Accountability must be clear. Performance improvement is a serious business that requires steely commitment and a refusal to tolerate persistent failure.
2. Policy without tools is ineffective; tools without policy are highly limited.
3. It may take a village but it doesn't have to take a generation. Transformation is never complete, and in some areas progress can take a long time. But some transformations have been rapid – notably, at Veterans Affairs (VA) and in some aspects of the UK's healthcare system. Always aim for fast, even if sometimes slow is all you can get.

4. Integrating key providers fully into the system and engaging them in goal-setting and performance improvement are essential to success. Fostering a culture of cooperation and participation requires a dedicated strategy, resources and policy framework. In Canada, there are several competing cultures at play: hierarchical vs. egalitarian; primary care focused vs. intensive specialized care; a population focus vs. a patient focus. Creating a unified approach to system improvement will not come about by osmosis. Great organizations invest a lot in building common cultures; healthcare must as well.
5. Let people experiment, fail, regroup and improve. Let them organize their own work. Once they have embraced the culture of performance, the need to instruct, cajole, persuade and intervene vanishes.
6. Be wary of narrow targets and paying for isolated successes. Incentives are important, but they must be carefully calibrated, and there is always the risk of unintended consequences. Healthcare is a public service with powerful ethical underpinnings. The greatest international successes seem to have abandoned flirtation with market concepts and pseudo-competition; instead, they have focused on cultural change supported by tools, relationships and a powerful sense of common purpose.
7. Successful transformers are fundamentally dissatisfied with the status quo. Canadians are slow to see the flames on the platform even when we feel the heat. Let's get constructively agitated and apply the resulting energy and sense of urgency to getting better. Every delay means that people will suffer needlessly.
8. Learn from Canadian success stories. There is hardly a species of excellence that cannot be found in Canada. From the Ontario provincial Cardiac Care Network to the Group Health Centre in Sault Ste. Marie to the Alberta Bone and Joint Institute, there have been triumphs of access and quality. Making excellence mandatory is the next step. That's what high-performing healthcare systems do, and that's what Canada ought to do.

Steven Lewis
President, Access Consulting Ltd., Saskatoon
Adjunct Professor of Health Policy,
University of Calgary and Simon Fraser University