Notes from the Editors

THE HEALTH COUNCIL of Canada (2013) recently published a report on the state of Canada's healthcare system since the federal, provincial and territorial governments signed the *First Ministers' Accord on Health Care Renewal* (in 2003) and the *10-Year Plan to Strengthen Health Care* (in 2004). The news is, mostly, not good. Despite the vast quantities of money spent, Canada still lacks a "high-performing" health system:

> Overall, the decade saw few notable improvements on measures of patient care and health outcomes, and Canada's performance compared to other high-income countries is disappointing. Some pressing issues have been addressed including wait times, primary health care reform, drug coverage, and physicians' use of electronic health records. But none of these changes have transformed Canada's health system into a high-performing one, and health disparities and inequities continue to persist across the country. Furthermore, the health system has not kept pace with the evolving needs of Canadians (Health Council of Canada 2013: 4).

This reference to "needs" as something to which the health system should be responsive tallies with Gail Tomblin Murphy and Adrian MacKenzie's lead essay in this issue of *HealthcarePapers*. It is incumbent on healthcare planners to research and take into consideration "the health needs of Canadians" – also referred to as "population health needs" – when redesigning care models and pathways. The all-important factor here

is "evidence": will planners continue to use, as Tomblin Murphy and MacKenzie (2013) claim, historical levels-of-service data as well as political factors, or will they draw on "actual" information about healthcare needs?

While they do not focus their contribution to this debate exclusively on health human resources (HHR), staffing is one of Tomblin Murphy and MacKenzie's main concerns. Citing extensive support for "needs-based approaches to HHR planning" from governments across Canada as well as professional bodies, Tomblin Murphy and MacKenzie document in their article two programs from Nova Scotia and British Columbia that have existed long enough to shed valuable light on some of the logistics and outcomes associated with needs-based planning.

The Model of Care Initiative (MOCINS) in Nova Scotia, which began in March 2008, was intended "to achieve health system sustainability in the face of the growing HHR challenge" provincially, nationally and internationally. This collaborative care model for acute care in-patient services is marked by several concerns, including aligning the care delivery system with Nova Scotians' health needs, ensuring providers work to their full scopes of practice, supporting inter-professional teamwork and revising critical processes, modes of communication and use of technology. Evaluation of MOCINS has revealed significant gains for patients – such as shorter lengths of stay and fewer repeat admissions – and staff – such as positive feelings about the "team climate."

The second case study explored in the lead paper is the Care Delivery Model

Redesign (CDMR), developed in 2007 by the Vancouver Island Health Authority. This initiative is focused on responding to patients' care needs on the basis of current evidence. Tomblin Murphy and MacKenzie describe how CDMR is now leading to the development a new staffing model that takes the needs of "typical in-patient populations" as its "starting point," as well as how that model will support staff members to work to their full scopes of practice.

Nothing less than "comprehensive needs-based healthcare planning is required to improve the performance of Canada's healthcare system," Tomblin Murphy and MacKenzie conclude. But our lead authors' surveys of MOCINS and CDMR revealed that, even in such scenarios, significant barriers must be overcome. These include limited resources, pre-existing staff shortages, competing priorities for participants, resistance to change and insufficient communication. One of the most important takeaway messages in their article is that both MOCINS and CDMR have proved the indispensability of rigorous monitoring and evaluation.

Commentaries

The six commentaries in this issue begin with thoughts from Steven Lewis, who argues that "contemporary healthcare is a sobering spectacle"; indeed, the same adjective might be applied to his provocative response (2013). On Lewis's account, Tomblin Murphy and MacKenzie have written not about population health needs, but about "better meeting the care needs of those in the system." And Lewis's beef is with that very system, one that is characterized by "deeply entrenched patterns and entitlements" that put the brakes on meaningful change. Lewis paints a disturbing picture of a system driven by professional (e.g., physician) territorialization and "irrationality." To do a better job for

patients, he says, we need to worry less about numbers and more about "matching what practitioners learn to what people need."

It is interesting to read C. Ruth Wilson's commentary immediately after Lewis's. A past president of the College of Family Physicians of Canada, Wilson (2013) softens somewhat the image of physicians, representing them as team players in improving Canada's health system as well as individuals who are often buffeted about by policy directions not of their own devising. An important coalescence between Lewis and Wilson in their shared sense that local initiatives are all well and good for small-scale changes, but nation-wide system transformation will require genuinely nation-wide efforts.

Agreeing with our lead authors that we need to shift our gaze to the "demand" side of healthcare planning, Ivy Lynn Bourgeault laments the lack of investment in providing the resources to collect data (such an interesting contrast to Lewis's less-sanguine view of Canadians' assumptions about the panacea of data collection). And even more than Tomblin Murphy and MacKenzie, Bourgeault (2013) advocates for an end to "uni-professional" approaches to healthcare delivery. Like them, too, she is also a strong proponent of evaluation, not least because it is necessary to show the resources required for change management and upscaling of innovations; an "arm's-length evaluative infrastructure" would serve that purpose well, she concludes.

David Peachey (2013) approaches the lead paper from a unique angle. While he concurs with Tomblin Murphy and MacKenzie that "legacy demand data" are insufficient for HHR planning, he is critical of their terminology and the "propriety" of their case studies. Instead of addressing "population health" needs, Peachey argues, the lead authors' paper "advances the importance of processes and lean management." Readers will likely want to turn to Tomblin Murphy and

MacKenzie's response piece; in the meantime, however, there is much to be absorbed from Peachey's account of population health assessment and its relation to workforce planning.

Canadian health-system planners are nearly always willing to learn from experiences in other countries, and Karen Bloor and Alan Maynard's thoughts from the United Kingdom (UK) will be welcome to many – especially as our colleagues across the Pond are similarly grappling with skill mix, data collection and several other familiar issues (2013). Resonating with some of Lewis's insights, Bloor and Maynard contend that fixed staff:patient ratios are unable to deal with the fluid changes that affect our healthcare systems. I was also particularly interested in the authors' call to distinguish among "need," "demand" and "utilization," and many readers will likely agree that one of the shortcomings of MOCINS and CRMS was the design of the evaluations used to understand their impact – particularly, as Bloor and Maynard point out, their absence of cost data. Genuine learning can come about only when our evaluations are well designed and funded adequately.

The final commentary in this issue is by Robert J. Sokol, who also brings to bear the perspective of someone outside Canada. A self-described American "contrarian," Sokol orients his reflections to "the rapidly changing expansion of need" arising from the baby-boom demographic wave (2013). Not unlike Bloor and Maynard, Sokol is interested in following the money: "healthcare value" measured, at least to a large extent, in dollars spent. The most fascinating part of Sokol's commentary, however, is his account of a major patient-admission change at his local women's hospital that went badly awry when imposed from above by "corporate" but that succeeded when it was cooperatively developed and owned from within by multiple workforce stakeholders.

The HHR Horizon

We sincerely thank Tomblin Murphy and MacKenzie for developing such a thought-provoking lead essay, as well as the commentators who so thoroughly mined its rich seams. We have a long way to go in terms of ensuring our HHR deployments meet patients' needs, but there is definitely hope on the horizon. Consider, for instance, the recent *Staff-Mix Decision-making Framework for Quality Nursing Care* (2013) developed cooperatively by the Canadian Nurses Association, the Canadian Council for Practical Nurse Regulators and the Registered Psychiatric Nurses of Canada. And I am also reminded of the fact that, while the Health Council of Canada report with which I began this editorial noted that the promise of the 2002 and 2003 health accords has not been realized, increases in the supply, mix and scope of practice of health professionals have indeed contributed to capacity building in Canada's health system over the last decade (2013: 26). Beneficial change might be slow, but with the right resources and approaches, it is possible.

The Editors

References

Bloor, K. and A. Maynard. 2013. "Using Evidence to Meet Population Healthcare Needs: A UK Perspective." *Healthcare Papers* 13(2): 43–46. doi:10.12927/hcpap.2013.23526.

Bourgeault, I.L. 2013. "The Importance of Evaluating New Models of Care to Better Meet Patient Needs." *Healthcare Papers* 13(2): 33–36. doi:10.12927/hcpap.2013.23524.

Canadian Nurses Association, Canadian Council for Practical Nurse Regulators, & Registered Psychiatric Nurses of Canada. 2013. *Staff-Mix Decision-making Framework for Quality Nursing Care*. Ottawa: Canadian Nurses Association. Retrieved September 26, 2013 <http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Staff_Mix_Framework_2012_e.pdf>.

Health Council of Canada. 2013. *Better Health, Better Care, Better Value for All: Refocusing Health Care Reform in Canada*. Toronto: Author.

Lewis, S. 2013. "Is the Deck Stacked against Fundamental Health Human Resources Redesign in Canada?" *Healthcare Papers* 13(2): 24–28. doi:10.12927/hcpap.2013.23522

Peachey, D.K. 2013. "Using Evidence to Meet Population Healthcare Needs: Successes and Challenges." *Healthcare Papers* 13(2): 37–42. doi:10.12927/hcpap.2013.23525.

Sokol, R.J. 2013. "More for Less - If Only We Could Get Them to Do It!" *Healthcare Papers* 13(2): 47–51. doi:10.12927/hcpap.2013.23527.

Tomblin Murphy, G. and A. MacKenzie. 2013. "Using Evidence to Meet Population Healthcare Needs: Successes and Challenges." *Healthcare Papers* 13(2): 10–22. doi:10.12927/hcpap.2013.23521.

Wilson, C.R. 2013. "Policy and Evidence in Canadian Health Human Resources Planning." *Healthcare Papers* 13(2): 29–32. doi:10.12927/hcpap.2013.23523.