Impatience and Intergovernmental Relationships in Healthcare

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"Some is not a number and soon is not a time."
– Don Berwick commenting on problems with the typical ways of planning improvements.

William Gardner, Katherine Fierlbeck and Adrian Levy have laid out a bold plan in this issue of *Healthcare Papers* for breaking through the impasse in federal–provincial relations around healthcare. As one of the commentators notes, their plan is elegant. It includes goals, measurement and alignment of incentives for improvement; three common sense elements of management with which it is hard to argue. This plan could revitalize the federal role, stimulate stronger provincial and regional management of healthcare systems and fit well within the current accountability paradigm in Canada that stresses measurement and reporting.

An excellent series of commentaries on the lead paper further flesh out and challenge this plan. Although each of the authors takes a different approach to the arguments made by Gardner, Fierlbeck and Levy, there are some important consistencies across the commentaries. First, all of them agree that we have reached an impasse in federal–provincial relations when it comes to healthcare. The reasons behind this impasse – and even the perceived importance of the impasse – vary across the commentaries but everyone agrees that it is real.

Second, everyone agrees that the Canadian healthcare system could do better. This should not come as a surprise to readers of *Healthcare Papers*, but it is valuable that we have consensus in this area. Perhaps as importantly, there is general agreement across the authors in this issue that some form of stimulus is necessary, whether it be financial incentives or not.

Finally, there is a general theme across the papers that much of what we need to do to improve performance is within our grasp. Zelmer makes the well-supported case that we have pan-Canadian institutions that could fulfill many of the functions laid out by Gardner and colleagues. Forest makes the case

that provinces could step in to the job on their own. Tamblyn argues that we have resources already at hand.

So we have a simple plan, along with some equally or more elegant plans from the commentators, clear agreement that we have a problem, extant institutions that could help and some critical resources necessary for success. This leaves us at the constant question facing health policy observers in Canada: "Why don't we just get on with the job of fixing things?"

Long-time readers of this journal may remember a provocative piece written by Steven Lewis in our sister journal *Healthcare Policy* that closed with the challenge:

> Let's move on to more worthy preoccupations, such as quality improvement, aligning incentives with goals, making excellence mandatory and reducing health (and healthcare) disparities. Canada talks like other countries; now it's time to act like them. Only our refusal to embrace large-scale change that serves the public rather than private interests is unsustainable (Lewis 2007).

Gardner, Fierlbeck and Levy's paper (and the commentaries) are a step in the right direction, as they move beyond some of the tired and blatantly unproductive debates that have dominated discourse in decades past. But we are still left with the question of why we fail to implement effective and large-scale change strategies.

This failure may have many reasons, but one possibility where we should be bullish is goals. We have principles, we have frameworks and we have indicators, but we do not have national goals for our health system, nor do we have comprehensive and compelling sets in most of our provinces. We can draw these goals from any number of inspirations. A recent chart book of quality (Sutherland et al. 2012) published in *Healthcare Papers* laid out any number of important areas where our system fails patients and McIntosh in this issue has even challenged us to think about population health goals. Regardless, in any area of performance, we can find benchmarks within our borders and from other countries that argue we could do better. We also know – again supported by outright common sense – that countries that set targets and goals do better than those that do not (Wismar et al. 2008).

Goals by themselves will not make a better healthcare system, but neither will reporting or incentives. We undoubtedly will need a package of solutions that will be nowhere near – as Bornstein warns – as elegant as we would like. We will need multiple stimuli to make sure we choose the right areas for focus and stay focused. But unless we start, we will never know whether we are finally having the right debates. We need to be able to find ways of taking the options laid out in this issue, building on the resources and opportunities identified in this issue and start building the healthcare system we want. The lead article talks to a new intergovernmental relationship in Canadian healthcare, but we may need a healthy dose of impatience in this relationship if it is to progress and we may need an even greater amount of impatience with ourselves at the provincial level.

Reference

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