



International
Hospital
Federation

World Hospitals and Health Services

The Official Journal of the International Hospital Federation

Canadian success stories on health and social care

- | Application of a coordinated-type integration model for vulnerable older people in Québec (Canada): the PRISMA project
- | Pathways to transformation in publicly-funded health systems: Experience in Canada's provinces
- | Managing the Myths of Health Care
- | Preparing the Ground for Transformation: A Case Study of the MUHC's Experience
- | General Overview for Long-Term Care Centers in the Province of Quebec
- | Whither Canadian Hospitals: Aligning Authorities and Accountabilities
- | Population health management A Canadian Perspective on the Future of Health Systems
- | Empowering Nurses in Canada to Deliver Better Care, Better Health and Better Value
- | The Evolution of general practice in Canada: a reflection on retirement
- | The Montreal 2017 Executive Hospital Study Tour: Learning from Others

Abstracts: Français, Español, 中文

Download the Acrobat
Reader app for better viewing



iOS Version
Android Version

HEALTHCARE MANAGEMENT & LEADERSHIP COMPETENCY ASSESSMENT PLATFORM



*Promoting enhancement of leadership and managing competencies
in healthcare organizations*

WHAT IS THERE FOR ME?

**Assess your
management
and leadership
skills**

**Benchmark your
current level of
competencies**

**Promote your
personal and
professional
growth**



WHO CAN JOIN

The online platform is open to any healthcare professional in a management position



HOW IT WORKS

A globally accessible online tool, free of cost



LANGUAGE

The platform is available in different languages



RULES

Confidentiality, security & protection of information consistent with Swiss regulation and laws

Register to assess your management and leadership skills
<http://healthmanagementcompetency.org>

WHAT RESULTS WILL I GET?

Personalized report measuring potential improvement between your professional needs and your current status in management and leadership

Access to resources to support your continuous professional development

Compare to your peers within your position, your country, as well as peers around the world



Contents volume 53 number 4

03 Editorial

Canadian success stories on health and social care

- 05 Application of a coordinated-type integration model for vulnerable older people in Québec (Canada): the PRISMA project
Réjean Hébert
- 11 Pathways to transformation in publicly-funded health systems: Experience in Canada's provinces
Jean-Louis Denis and Susan Usher
- 15 Managing the Myths of Health Care
Henry Mintzberg
- 18 Preparing the Ground for Transformation: A Case Study of the MUHC's Experience
Judith Horrell and Normand Rinfret
- 21 General Overview for Long-Term Care Centers in the Province of Quebec
Paul Arbec
- 24 Whither Canadian Hospitals: Aligning Authorities and Accountabilities
Bill Tholl and Paul-Émile Cloutier
- 28 Population health management A Canadian Perspective on the Future of Health Systems
Brian N. Jobse, Owen Adams and Isra Levy
- 34 Empowering Nurses in Canada to Deliver Better Care, Better Health and Better Value
Carolyn E. Pullen
- 37 The Evolution of general practice in Canada: a reflection on retirement
John Edworthy
- 40 The Montreal 2017 Executive Hospital Study Tour: Learning from Others
Alexander S. Preker, Hortenzia Beciu and Eric De Roodenbeke

Reference

- 44 Language abstracts
- 49 IHF events calendar

Editorial Staff

Executive Editor: Eric de Roodenbeke, PhD
Desk Editor: Marianne Corazon E. Bacani

External Advisory Board

Alexander S Preker Chair of the Advisory Board, Health Investment & Financing Corporation
Charles Evans, International Health Services Group
Juan Pablo Uribe, Fundación Santa Fe de Bogotá
Mark Pearson, Head of Health Division (OECD)

Editorial Committee

Enis Baris, World Bank
Dov Chernichosky, Ben-Gurion University
Bernard Couttelenc, Performa Institute
Nigel Edwards, Nuffield Trust
KeeTaig Jung, Kyung Hee University
Harry McConnell, Griffith University School of Medicine
Louis Rubino, California State University Northridge

Editorial Office

Route de Loëx 151 1233 Bernex (GE),
SWITZERLAND

For advertising enquiries contact our Communications
Manager at subscriptions@ihf-fih.org

Subscription Office

International Hospital Federation
Route de Loëx 151
1233 Bernex (GE), SWITZERLAND
Telephone: +41 (022) 850 9420
Fax: +44 (022) 757 1016

ISSN: 0512-3135

Published by Nexo Corporation
for the International Hospital Federation

Via Camillo Bozza 14, 06073 Corciano (Pg) - ITALY
Telephone: +39 075 69 79 255
Fax: +39 075 96 91 073
Internet: www.nexocorp.com

Subscription

World Hospitals and Health Services is published quarterly. The annual subscription to non-members for 2017 costs CHF 270 or US\$280 or €250. All subscribers automatically receive a hard copy of the journal, please provide the following information to subscriptions@ihf-fih.org:
-First and Last name of the end user
-e-mail address of the end user
NO CHECK ACCEPTED FOR SUBSCRIPTIONS

World Hospitals and Health Services is listed in Hospital Literature Index, the single most comprehensive index to English language articles on healthcare policy, planning and administration. The index is produced by the American Hospital Association in co-operation with the National Library of Medicine. Articles published in *World Hospitals and Health Services* are selectively indexed in Health Care Literature Information Network.

The International Hospital Federation (IHF) is an independent non-political and not for profit membership organization promoting better Health for all through well managed and efficient health care facilities delivering safe and high quality to all those that need it. The opinions expressed in this journal are not necessarily those of the International Hospital Federation or Nexo Corporation.

IHF Governing Council members' profiles can be accessed through the following link:
http://www.ihf-fih.org/governing_council

IHF Newsletter is available in <http://bit.ly/IHF-Newsletters>

THE NEW HEALTHCARE SUPPLY CHAIN IS COLLABORATIVE AND INTEGRATED



Planning



Analytics



Hospital
Purchases



Standardization
of Material
Description



Logistics



Diagnosis



Strategic
Sourcing



Supplier
Services



Bionexo is the largest marketplace for healthcare in Latin America. Pioneer and market leader, it operates in Brazil, Argentina, Colombia, Mexico and Spain offering digital solutions for purchasing, sales and process management in healthcare.

Lessons Learned from Canada



ERIC DE ROODENBEKE
CEO
INTERNATIONAL HOSPITAL FEDERATION
BERNEX, GE, SWITZERLAND



ALEXANDER S. PREKER
PRESIDENT AND CEO
HEALTH INVESTMENT & FINANCING CORPORATION
NEW YORK, NY, USA

In this special issue of the World Hospitals and Health Services Journal (WHHJ) of the International Hospital Federation (IHF) we will review some of the key lessons learned from a Hospital Executive Study Tour to Montreal and Ottawa, Canada.

From June 27th to July 1st 2016, the International Hospital Federation (IHF) and Health Investment & Financing hosted a Hospital Executive Study Tour in Montreal, Province of Quebec and Ottawa, Ontario Province, Canada. The objective of the Hospital Executive Study Tour was to allow participants to learn how the Canadian hospital sector addresses some of the key challenges and solutions in order to transform the way hospital care is delivered in the 21st Century. The Montreal Study Tour was part of a series of premier events offered by the IHF. The Study Tour was a collaborative effort among Canadian partner organizations in both Montreal and Ottawa, who hosted various events to enable an exchange of ideas, knowledge, experiences and best practices in the delivery of healthcare services, and in the leadership and management of their organizations.

The Study Tour included visits to leading Canadian policy makers, hospital managers and decision makers, researchers, entrepreneurs, community leaders, and health financing experts. In Montreal, the Executive Study Tour, included visits to the following groups:

- Department of Management, Evaluation and Health Policy, School of Public Health, University of Montreal
- Leadership program in Health Care Management, Desautels Faculty of Management, McGill University
- Integrated University Center for Health and Social Services
- McGill University Hospital Center
- Montreal University Institute of Geriatrics; and
- Arbec Health Group

In Ottawa, the Executive Study Tour included meetings with Health Canada; HealthCareCAN, Canadian Medical Association; Canadian Nurses Association; Accreditation Canada; Canadian Institute of Health Information (CIHI) and Elizabeth Bruyère Hospital leadership.

The participants in the Study Tour included executives and leaders from Albania, Australia, Brazil, Canada, France, India, Spain, Switzerland and the USA.

The Montreal 2017 Executive Hospital Study Tour provided

participants with a fascinating overview of the Quebec, Ontario and Canadian health care system.

During recent debates on health care reform in the US, the Canadian system has been variously lauded and vilified as either one of the best or worst models that should either be emulated or avoided at all cost. The study tour, the articles in this issue of the World Hospitals and Health Services Journal and other recent reviews of the Canadian health care system shed light on this dichotomy in opinions. Not surprisingly, as the contributing authors to this issue of the journal highlight, the truth lies somewhere between these extremes. The Canadian health care system is an amazing health care system that provide access to quality health services to everyone, at a reasonable cost. No one is excluded. However, like all other health systems in the world there are important trade-offs between quality, cost, access, efficiency, effectiveness and patient satisfaction.

Health care expenditure in Canada is among the highest among OECD countries with their own universal health care system. However, some studies suggest that high spending levels do not translate into equally high health outcomes, financial protection or positive patient experiences.

Therefore the Montreal 2017 Hospital Executive study tour provided participants with a fascinating overview of health care in Canada and lessons learned – both positive and negative – that could be useful to other countries.

For a complete and more detailed description of the study tour, you may download a copy of the complete report from the study tour at the following website: (<https://www.ihf-fih.org/activities?type=training§ion=study-tour>).

The IHF remains committed to providing its members with a rich exposure to the health care systems of other countries. From June 10th-14th 2018, a visit to Jerusalem, Haifa and Tel Aviv has been scheduled, to examine the Israeli health care system. This upcoming Hospital Executive Study Tour will focus on the explosion in innovative technologies, discoveries in life science and new delivery systems that Israel has become so well known for in recent years. For more information about this upcoming event and to benefit from the special Early Bird rate please register at the following link. <https://www.eventbrite.com/e/israel-2018-hospital-executive-study-tour-tickets-36955751648>

*Technology makes it possible...
People make it happen.*

HEALTH INFRASTRUCTURE DEVELOPMENT MADE EASY

EOH has always specialised in being able to craft effective and efficient solutions for the sectors and industries it serves, and the healthcare sector is no different.

Our exposure to almost all facets of health infrastructure development and management has led to the development of the Hospital in a Box concept, which aims to simplify and expedite the process of developing and managing any health facility globally.

Our service package is offered on a turnkey or modular basis, depending on our clients' needs, with expert, centralised programme and process management employed for each project.

Our expert team consists of business analysts, consulting engineers, quantity surveyors, medical doctors, registered nurses, attorneys, accountants, system engineers, software developers, database managers, facility managers and facility network managers.

| KEY BUSINESS AREAS | INDUSTRY VERTICALS | | | | | | | | | | |
|------------------------------|--------------------|--------------------|--------|---------------|-------------------------|--------|--------|--------|-------|------------------|--------------------|
| | Financial Services | Telecommunications | Retail | Manufacturing | Transport and Logistics | Mining | Health | Energy | Water | Local Government | Central Government |
| Industry Consulting | • | • | • | • | • | • | • | • | • | • | • |
| Applications | • | • | • | • | • | • | • | • | • | • | • |
| IT Management | • | • | • | • | • | • | • | • | • | • | • |
| IT Outsourcing | • | • | • | • | • | • | • | • | • | • | • |
| Industrial Technologies | • | • | • | • | • | • | • | • | • | • | • |
| Business Process Outsourcing | • | • | • | • | • | • | • | • | • | • | • |

Application of a coordinated-type integration model for vulnerable older people in Québec (Canada): the PRISMA project



RÉJEAN HÉBERT, MD MPHIL
DEAN
SCHOOL OF PUBLIC HEALTH,
UNIVERSITÉ DE MONTRÉAL
MONTREAL (QC), CANADA

ABSTRACT: PRISMA is a coordinated-type model of Integrated Service Delivery for vulnerable elderly people. The PRISMA model includes the following components to enhance integration: 1) a formal mechanism to manage co-operation between decision-makers and managers of all services and organizations, 2) the use of a single-entry point, 3) a case management process, 4) individualized Service Plans, 5) a unique assessment tool with a case-mix system, and 6) a computerized system for communicating between institutions and professionals.

The PRISMA model was experimentally implemented in three areas (urban, rural, with or without a local hospital) in Quebec, Canada, and research was carried out using both qualitative and quantitative data to evaluate its process and impact. A significant impact of the prevalence and incidence of functional decline, satisfaction with services and empowerment was observed. There was a reduction in the number of Emergency Room visits and hospitalisations. The overall cost was not higher in the experimental group, even when implementation cost was included.

The PRISMA model was then implemented throughout the province of Quebec from 2005 to 2015. Budget constraints and concomitant reforms (merging of institutions) slowed down implementation. Many lessons were learned from this implementation: case managers should be formally trained and accredited, and structural integration by merging does not necessarily foster functional integration. The PRISMA model is a good illustration of the effective transfer of research findings to a national programme, within the context of evidence-informed public policy.

This text is a short version of a book chapter previously published:

Hébert R. Canada: Application of a Coordinated-Type Integration Model for Vulnerable Older People in Québec: The PRISMA Project. In Amelung V, Stein V, Goodwin N, Balicer R, Nolte E & Suter (eds), Springer: Cham (Switzerland), 2017.

Introduction

The population of Canada and Québec is aging rapidly. In 2014, 17% of Québec's population (1.4 million people) was over 65 years old. Since the baby boom in the fifties, particularly in the French-speaking Québec population, it is expected that the elderly will make up over 25% of the population by 2031 (Azeredo & Payeur, 2015). Despite the integration of health and social services, delivering services to a growing and vulnerable elderly population remained a challenge. Prior to 2003, many public organizations (hospitals, nursing homes, rehabilitation centres, CLSCs), together with social economy and voluntary agencies, delivered care without coordination. Multiple assessments, delays, redundant services, gaps in services and multiple providers created inefficiencies, compromised service quality and increased costs, probably unduly so. There was a pressing need to integrate those services (Hébert 2010).

PRISMA (Program of Research to Integrate Services for the Maintenance of Autonomy) was designed to better fit the Canadian health care system than full-integration models developed in the USA. PRISMA is a coordinated-type integration model developed by a steering committee

including policy-makers at the provincial and regional levels, health care managers, clinicians and researchers. The coordination level of integration was originally suggested by Leutz (1999), as one of three types of integration (in addition to liaison and full integration), but at that time no model had been developed for its operationalisation. Unlike fully integrated systems, this model includes all public, private and voluntary health and social service organizations involved in caring for elderly people in a given area. Each organization maintains its own structure but agrees to participate under an umbrella system and to adapt its operations and resources to agreed requirements and processes. At this level, the integrated service delivery system is not merely perched in the health care and social services system (like fully integrated models); it is embedded within it.

Description of the PRISMA model

The PRISMA model consists of six components: 1) coordination between decision-makers and managers at the regional and local levels, 2) single entry point, 3) case management, 4) individualized service plans, 5)

single assessment instrument, coupled with a case-mix management system, and 6) computerized clinical chart.

Coordination between institutions is at the core of the PRISMA model. Coordination must be established at every level of organizations. Firstly, at the strategic level (governance), a Joint Governing Board (JGB) is created, involving all health care and social services organizations and community agencies (public, private and voluntary), the decision-makers who agree on policies, orientations and the allocation of resources to the integrated system. Secondly, at the tactical level (management), a service coordination committee, mandated by the JGB and comprising public and community service representatives together with elderly people, monitors the service coordination mechanism and facilitates adaptation of the service continuum. Finally, at the operational level (clinical), a multidisciplinary team of practitioners surrounding the case manager evaluates patients' needs and delivers required care and services.

The **single entry point** is the mechanism for accessing the services of all health care institutions and community organizations in the area for a frail senior with complex needs. It serves as a unique portal that older people, family caregivers and professionals can access by phone or written referral. A link is established with the Health Information Line available 24/7 to the general public in Québec. Callers are screened using a brief 7-item questionnaire (PRISMA-7) (Raïche et al. 2008) that has shown good levels of sensitivity and specificity in identifying older people with significant disabilities. PRISMA-7 is also used by health professionals in physicians' offices, emergency rooms, and flu shot clinics to screen older people. A detailed assessment of disabilities is then undertaken for positively screened individuals and those deemed eligible for integrated service delivery are referred to a case manager. The eligibility criteria are: to be over 65 years old and present significant disabilities as defined by a SMAF score of over 15 or an Iso-SMAF Profile of over 4: see Box 1).

Box 1: Functional Autonomy Measurement System: SMAF (Système de mesure de l'autonomie fonctionnelle)

The SMAF (Hébert et al. 1988; Hébert et al. 2001; McDowell, 2006) measures functional ability in five areas:

- activities of daily living (ADL) [7 items]
- mobility [6 items]
- communication [3 items]
- mental functions [5 items]
- instrumental activities of daily living (IADL) [8 items].

For each item, the disability is scored on a 5-point scale:

- 0 : independent
- -0.5 : with difficulty
- -1: needs supervision
- -2: needs help

■ -3: dependent

The resources available to compensate for the disability are evaluated and a handicap score is calculated. The stability of the resources is also assessed. A disability score (out of -87) can be calculated, together with sub-scores for each dimension.

A case-mix classification system based on the SMAF has been developed (Dubuc et al. 2006). Fourteen Iso-SMAF profiles were generated using cluster analysis techniques in order to define groups that are homogeneous with regard to their profile.

- Profiles 1 to 3: slight disabilities in instrumental activities of daily living only.
- Profiles 4, 6 and 9: moderate disabilities predominantly in motor functions
- Profiles 5, 7, 8 and 10: moderate disabilities predominantly in mental functions
- Profiles 11 to 14: severe disabilities (those people are usually cared for in nursing homes).

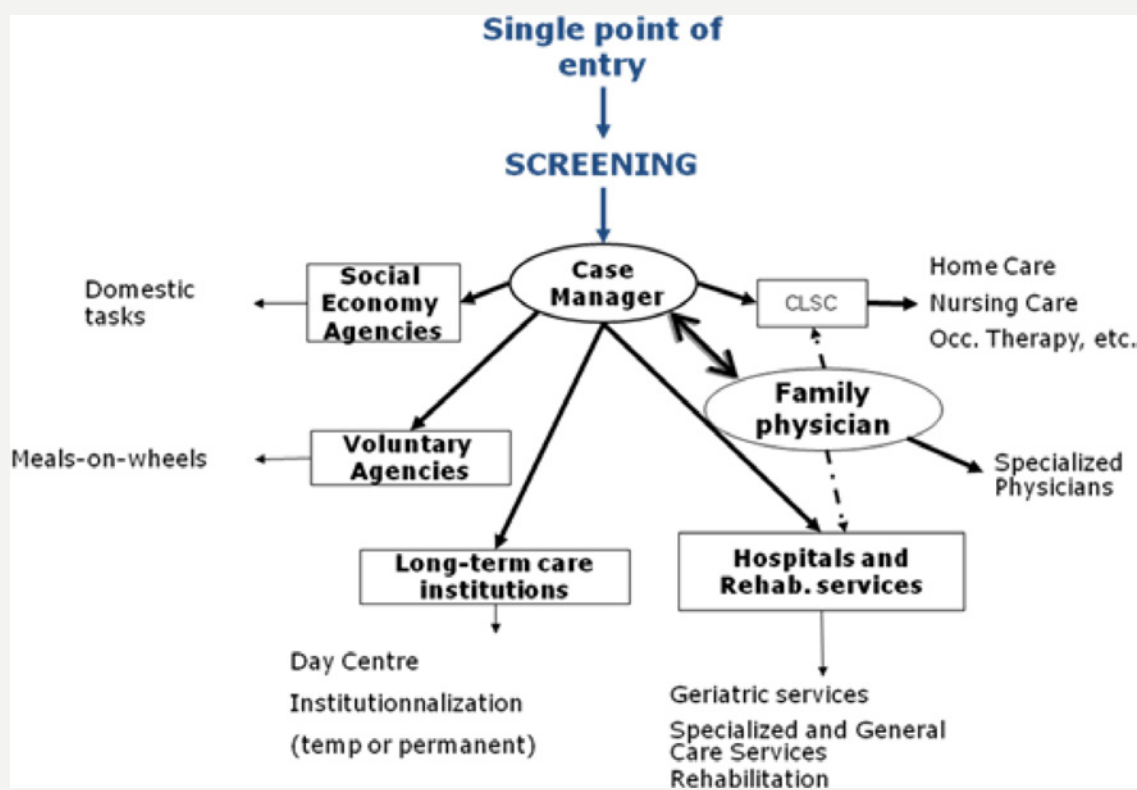
The Iso-SMAF profiles are used to establish eligibility criteria for different services and to calculate the organizations' required budget, based on the disabilities of their patient groups (Tousignant et al. 2003; Tousignant et al. 2007).

Source: Hébert R., 2017. "Canada: Application of a Coordinated-Type Integration Model for Vulnerable Older People in Québec: The PRISMA Project." In *Handbook Integrated Care*, ed. Amelung V, Stein V, Goodwin N, Balicer R, Nolte E & Suter, 499-510. Springer: Cham (Switzerland)

The **Case Manager** (CM) model included in PRISMA draws directly from those described as Clinical CM (Scharlach et al. 2001), Neighborhood Team (Eggert et al. 1990), or Basic CM (Phillips et al. 1988). The case manager is responsible for conducting a thorough assessment of the patient's needs, planning the required services, arranging patient access to these services, organizing and coordinating support, directing the multidisciplinary team of practitioners involved in the case, advocating for, monitoring and reassessing the patient. The CM is legitimated by the JGB for working in all institutions and services. The CM can be a nurse, social worker or other health professional, and should be specifically trained. An ideal caseload is around 40 patients per CM. Figure 1 summarizes the flow of patients through the coordinated PRISMA model.

The **Individualized Service Plan** (ISP) results from the patient's overall assessment and summarizes the prescribed services and target objectives (Somme et al. 2009). The ISP is led by the CM and is established at a meeting of the multidisciplinary team including all the main practitioners involved in caring for the older person. The ISP should be confirmed with the patient and informal caregivers, so that they are empowered in the decision-

FIGURE 1: FLOW OF PATIENTS THROUGH THE COORDINATED PRISMA MODEL (REPRODUCED WITH PERMISSION FROM THE JOURNAL OF INTEGRATED CARE – EMERALD GROUP)



Source: Hébert R., 2017. "Canada: Application of a Coordinated-Type Integration Model for Vulnerable Older People in Québec: The PRISMA Project." In *Handbook Integrated Care*, ed. Amelung V, Stein V, Goodwin N, Balicer R, Nolte E & Suter, 499-510. Springer: Cham (Switzerland)

making process.

The **single assessment instrument** is used to evaluate the needs of clients in all organizations and by all professionals working in home care organizations or in hospitals and institutions. The instrument implemented in the PRISMA model is the SMAF (French acronym for Functional Autonomy Measurement System), a 29-item scale developed according to the WHO classification of disabilities (see Box 1) (Hébert et al. 1988; Hébert et al. 2001).

Finally, the PRISMA model includes a **Computerized Clinical Chart (CCC)** to facilitate communication between organizations and professionals. This shareable clinical chart, specific to the care of elderly people, uses the Québec Ministry of Health and Social Services Internet network and is interconnected with other clinical electronic records (hospitals, physicians' offices).

Experimental implementation and impact

After pre-testing in the Bois-Francs area which yielded promising results (Tourigny et al. 2004), the PRISMA model was implemented in July 2001 in three regions of the Eastern Townships in the province of Québec (one urban and two rural). The PRISMA model was subject to rigorous

evaluation, including an implementation study that sought to monitor the degree and the process of implementation, and an outcome study, using a population-based quasi-experimental design.

The implementation evaluation study was carried out using an embedded multiple case method (Yin 1994), with each region being a case. Detailed results from these studies can be found elsewhere (Hébert, Tourigny and Gagnon 2005; Hébert et al. 2008; Hébert, Tourigny and Raïche 2008; Milette et al. 2005). A method was developed for monitoring the degree of implementation, based on specific indicators for each of the six elements of the PRISMA model (Hébert and Veil 2004). The indicators were weighted according to their importance, and the different elements of the model were also weighted to obtain a score out of 100. Overall, a 70% degree of implementation was achieved after two years, the a priori threshold set for defining a significant degree of implementation. After four years, an 85% implementation rate was achieved in Sherbrooke, 78% in Granit and 69% in Coaticook (Hébert et al. 2008).

To evaluate the impact of the PRISMA model on health, satisfaction, empowerment and services utilization by frail elderly people, a population-based, quasi-experimental

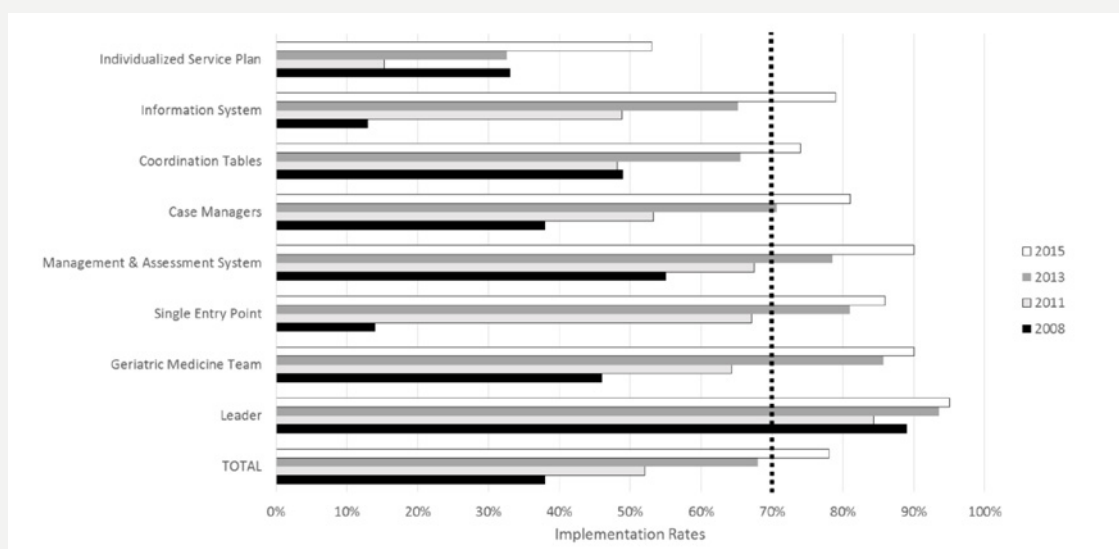
study was conducted on the three experimental and three comparison areas. 1501 persons identified as at risk for functional decline were recruited (728 experimental, 773 comparison) from a random selection of people over the age of 75 years. Over four years, participants were measured for disabilities (SMAF), unmet needs, satisfaction with services and empowerment. Information on utilization of health and social services was collected via bi-monthly telephone questionnaires (Hébert et al. 2010).

Over the last two years (with an implementation rate of over 70%), a 6% reduction of functional decline was recorded (62 fewer cases per 1000 individuals) in the experimental group ($p<0.05$). In the fourth year of the study, the annual incidence of functional decline dropped by 14% in the experimental group (137 cases per 1000; $p<0.001$), while the prevalence of unmet needs in the comparison region was nearly double the prevalence observed in the experimental region ($p<0.001$). Satisfaction and empowerment were significantly higher in the experimental group ($p<0.001$). With reference to health services utilization, fewer visits to emergency rooms ($p<0.001$) and hospitalizations ($p=0.11$) were observed than expected in the experimental cohort (Hébert et al. 2010). Using growth-curve analysis, Dubuc et al. (2011) showed that the needs of elderly people living in the area where PRISMA was implemented, were better met over time. An economic analysis comparing the cost of care in the experimental group, including the cost of the PRISMA component, to the comparison group, showed that the costs were similar. This means that the PRISMA model was more efficient than usual care¹.

Dissemination and replication

During the study in 2003, the Québec Minister of Health was convinced that the model would be successful (even before the results were formally published), and decided to undertake major health care reform, merging the different public organizations involved in caring for elderly people within a local area (hospitals, nursing homes and CLSCs) in the CSSSs (Health and Social Services Centres) (Levine 2007). This structural integration was seen by the Minister as providing strong support for improving the coordination of services. However, as demonstrated in other contexts, structural integration does not necessarily foster functional integration (Demers 2013). The reverse was actually observed in Québec over the first four years of the reform. According to the Québec Ministry of Health, the implementation rate of the PRISMA model, based on the same indicators developed in the experiment, was only on average 38% in 2008, although wider roll-out of the PRISMA model was included in the Ministry's 2005-2010 action plan (Gouvernement du Québec 2005). It was noted that the newly created CSSSs (health and social service centres) struggled to implement the strategic planning process and the reorganization of services. The roll-out of the PRISMA model was slowed considerably and even stopped momentarily in many regions because: firstly, the CSSSs' different programs continued to work in silos and, second, this new big organization in the system (the CSSS) no longer prioritized coordination committees and collaboration with voluntary agencies, social economy enterprises and private providers also involved in delivering services for frail elderly people (INSPQ, 2014).

FIGURE 2. IMPLEMENTATION RATES OF THE PRISMA MODEL IN QUÉBEC, CANADA FROM 2008 TO 2015



Source: Hébert R., 2017. "Canada: Application of a Coordinated-Type Integration Model for Vulnerable Older People in Québec: The PRISMA Project." In *Handbook Integrated Care*, ed. Amelung V, Stein V, Goodwin N, Balicer R, Nolte E & Suter, 499-510. Springer: Cham (Switzerland)

¹ All the publications on the PRISMA model and experiments, in both French and English are available on the following website: <http://www.prisma-qc.ca/cgi-cs/cs.waframe.index?lang=2>

This natural experiment showed that it is not always desirable or necessary to structurally integrate different providers into a common organization in order to implement a functional integration model like PRISMA. Nevertheless, after 10 years, implementation levels of the PRISMA model reached 70% across the province, in 2014 (Figure 2). Implementation of the computerized clinical chart, the sixth element of the PRISMA model, was delayed because the Ministry wanted to develop new, more powerful Web-based software. This allowed for the utilization of the management tool (Iso-SMAF Profiles) and completed the implementation of the fifth element of the PRISMA model. In 2014, a module to support the elaboration of the Individualized Service Plan and the allocation of services was added to the software, boosting implementation of this element.

In 2015, a new structural reform was implemented in Québec, merging all the public institutions in a region, this time including rehabilitation and youth centres. These new *Integrated Health and Social Services Centres* (CISSSs) also replaced the regional authorities. Although improving integrated services was one of the reasons which motivated this reform, this new structural integration will likely have negative impacts on functional integration, as was the case in the 2003 reform.

The experience of the PRISMA model influenced integrated care models beyond Quebec. In France, for example, where the comparatively high number of actors involved in funding and delivering care to older people was seen to be a challenge for coordination, the PRISMA model was adapted in three experimental implementations (Somme et al. 2008). Following this experiment, the model was applied to people with dementia in the so-called MAIA model of care (*Maison pour l'autonomie et l'intégration des malades d'Alzheimer*), as part of the 2008-2012 Alzheimer Plan (République française 2008). In 2013, the MAIA model was extended to cover all frail elderly people, and over 350 MAIA homes were set up across France. The acronym MAIA was then used for *Méthode d'Action pour l'Intégration des services d'aide et de soin dans le champ de l'Autonomie*. The PRISMA model is also being implemented in several areas in Spain.

The PRISMA model has been adapted to other populations. In Québec, it is being applied for young patients with mental and physical disabilities. It could be used to meet the needs of patients with mental health problems.

Conclusion

The PRISMA model can be seen to be a good illustration of an effective transfer of scientific knowledge to public policy. The continuous presence, right from the beginning, of representatives from the Ministry of Health and Social Services and regional authorities on the PRISMA steering committee, was one of the factors that led to this success.

Institutionalization of an innovation is a challenge, and there is a real risk of the system returning to its previous state unless sustainable change is embraced. Although the

PRISMA model is not very prescriptive and elements of its model can be adapted to the local context, it should be acknowledged that it is being implemented within complex organizations and networks in which self-regulation mechanisms are preventing any significant change (Begun 2003).

In PRISMA, a necessary seventh component was not included in the model: financing, which is usually a component of all integrated models (Kodner 2006). This was not possible since the Québec health care system is a universal, publicly funded, Beveridge-type system. Long-term care is included in the overall funding of health and social services. This arrangement makes it impossible to prioritize long-term care and home care, especially during a period of budget restrictions since with global funding, hospital care drives most of the budget. In the new CISSSs (and more so in the CISSSs) most of the funding is directed to hospitals and nursing homes, which leaves home care programs with insufficient funds to really make a difference in the way care is provided to frail elderly people with multiple care needs. Improving the efficacy of the PRISMA model and case managers' actions would require a specific funding scheme for long-term care modelled on the public long-time care insurance programs which are in place in many European and Asian countries (DaRoit and LeBihan 2010; Ikegami 2007). Such a financial incentive could give the case manager real power to obtain the necessary services from providers. Québec and Canada will have to move towards this type of funding scheme, coupled with the integration of services, in order to cope with the rapid aging of the population (Hébert 2011). Unfortunately, an attempt to implement an autonomy insurance plan in Québec was stopped for political reasons in 2014 (Hébert 2016).

The PRISMA model shows that it is feasible and efficacious to improve integration functionally without -- or in spite of -- structural integration and merging of organizations. Innovation implementation should be closely monitored and adequate resources should be allocated to support the implementation and training for professionals and managers. Funding is a key issue in integration, and budget incentives and mechanisms should be adapted to the integration model. The most difficult challenge is institutionalising innovation, given the complexity of health care systems.

Biography

Réjean Hébert is now Dean of the School of Public Health of the Université de Montréal and Professor at the Department of Health Management, Evaluation and Policy. He was the founding Scientific Director of the Institute of Aging of the Canadian Institutes of Health Research. From September 2012 to April 2014, he was Minister of Health and Social Sciences of the Québec Province, Canada.

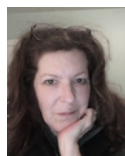
References

- Azeredo, A.C. and F.F. Payeur 2015. Vieillesse démographique au Québec: comparaison avec les pays de l'OCDE. *Données statistiques en bref*, 19(3): 1-10.
- Begun, J.W. 2003. Health care organizations as complex adaptive systems. In Mick S.M. and M. Wyttenbach (eds). *Advances in Health Care Organization Theory*. San Francisco: Jossey-Bass, pp 253-288.
- DaRoit, B., and B. LeBihan. 2010. Similar and yet so different: cash-for-care in six European countries' long-term care policies. *Milbank Quarterly*, 88(3): 286-309.
- Demers L. 2013. Mergers and integrated care: the Quebec experience. *International Journal of Integrated Care*, Jan-Mar, URN:NBN:NL:UI:10-1-114229.
- Dubuc, N., R. Hébert, J. Desrosiers, M. Buteau, and L. Trottier. 2006. Disability-based classification system for older people in integrated long-term care services: the Iso-SMAF profiles. *Archives of Gerontology and Geriatrics*, 42: 191-206.
- Dubuc, N., M.F. Dubois, R.N. Gueye, M. Raïche, and R. Hébert. 2011. Meeting the Home Care Needs of Disabled Older Persons Living in the Community: Do Integrated Services Delivery Make a Difference? *BMC Geriatrics*, 11:67 (<http://www.biomedcentral.com/1471-2/11/67>).
- Eggert, G.M., B. Friedman, and J.G. Zimmer. 1990. Models of intensive case management. *Journal of Gerontological Social Work*, 15(3): 75-101.
- Gouvernement du Québec, 2005. Un défi de solidarité: Les services aux aînés en perte d'autonomie. Plan d'action 2005-2010. Québec.
- Hébert, R., R. Carrier, and A. Bilodeau. 1988. The functional autonomy measurement system (SMAF): Description and validation of an instrument for the measurement of handicaps. *Age and Ageing*, 17: 293-302.
- Hébert, R., J. Guilbault, J. Desrosiers, and N. Dubuc. 2001. The functional autonomy measurement system (SMAF): A clinical-based instrument for measuring disabilities and handicaps in older people. *Geriatrics Today – Journal of Canadian Geriatrics Society*, September: 141-147.
- Hébert, R., and A. Veil. 2004. Monitoring the degree of implementation of an Integrated Delivery System. *International Journal of Integrated Care*, 4: e1-11.
- Hébert, R., A. Tourigny, and M. Gagnon. 2005. Integrated service delivery to ensure persons' functional autonomy. *St-Hyacinthe: Edisem*, 323 p.
- Hébert, R., A. Tourigny, and M. Raïche. 2008. Integration of services for disabled people: Research leading to action. *St-Hyacinthe: Edisem*, 542 p.
- Hébert, R., M.F. Dubois, N. Dubuc, M. Tousignant, M. Raïche, and A. Veil. 2008. Evaluation of the Implementation of PRISMA, a Coordination-Type Integrated Service Delivery System for Frail Older People in Quebec. *Journal of Integrated Care*, 16(6): 4-14.
- Hébert, R., M. Raïche, M.F. Dubois, N.R. Gueye, N. Dubuc, M. Tousignant, and the PRISMA Group. 2010. Impact of PRISMA, a coordination-type integrated service delivery system for frail older people in Quebec (Canada): A quasi-experimental study. *Journal of Gerontology - Series B Social Sciences*, 65 B: 107-118.
- Hébert, R. 2010. Home Care: From Adequate Funding to Integration of Services. *HealthcarePapers*, 10(1): 58-69.
- Hébert, R. 2011. Public Long-Term Care Insurance: A way to ensure sustainable continuity of care for frail older people. *HealthcarePapers*, 11(1): 69-75.
- Hébert, R. 2016. Still-born Autonomy Insurance Plan in Quebec: Example of a Public Long-term Care Insurance System in Canada. *HealthcarePapers* (in press).
- Ikegami, N. 2007. Rationale, design and sustainability of long-term care insurance in Japan – in retrospect. *Social Policy and Society*, 6(3): 423-434.
- INSPQ, 2014. Synthèse des connaissances sur les conditions de mise en œuvre des réseaux de services intégrés aux personnes âgées. Québec : Institut national de santé publique du Québec.
- Kodner, D.L. 2006. Whole-system approaches to health and social care partnerships for the frail elderly: an exploration of North American models and lessons. *Health & Social Care in the Community*, 14: 384-390.
- Levine, D. 2007. The reform of health and social services in Quebec. *Healthcare Papers*, 8 (special issue):46-54.
- Leutz, W.N. 1999. Five laws for integrating medical and social services: Lessons from the United States and the United Kingdom. *Milbank Quarterly*, 77: 77-110.
- McDowell I. 2006. *Measuring Health: A guide to rating scales and Questionnaires*. Oxford University Press: New York.
- Milette, L., R. Hébert, and A. Veil. 2005. Early perceptions of family physicians regarding the introduction of integrated service delivery networks for older people. *Canadian Family Physician Journal*, 51: 1104-1105.
- Phillips, B.R., P. Kemper, and R.A. Applebaum. 1988. The evaluation of the national long term care demonstration. - Chap. 4 – Case management under channeling. *Health Services Research*, 23(1): 67-81.
- Raïche, M., R. Hébert, and M.F. Dubois. 2008. PRISMA-7: A case-finding tool to identify older adults with moderate to severe disabilities. *Archives of Gerontology and Geriatrics*, 47(1): 9-18.
- République française 2008. Quality labelling throughout the country for "single points of contact", the "Maisons pour l'Autonomie et l'Intégration des malades Alzheimer" (MAIA). <http://www.plan-alzheimer.gouv.fr/measure-no4.html>
- Scharlach, A.E., N. Giunta, and K. Mills-Dick. 2001. Case management in long-term care integration: an overview of current programs and evaluations. Paper written for California Center for Long-Term Care Integration, 84 p.
- Somme, D., H. Trouvé, Y. Couturier, S. Carrier, D. Gagnon, B. Lavallart, R. Hébert, C. Cretin, and O. Saint-Jean. 2008. Prisma France: Implementation program of an innovation in health and services system for disabled people. Adaptation of a case-management based integration model. *Revue d'épidémiologie et de santé publique*, 56: 54-62.
- Somme, D., L. Bonin, P. Lebel, R. Hébert, and F. Blanchard. 2009. Development of an individualized service plan tool and rules for case management in Québec. *Care Management Journals*, 10(3): 89-99.
- Tourigny, A., P. Durand, L. Bonin, R. Hébert, and L. Rochette. 2004. Quasi-experimental Study of the Effectiveness of an Integrated Service Delivery Network for the Frail Elderly. *Canadian Journal on Aging*, 23: 231-246.
- Tousignant, M., N. Dubuc, R. Hébert, R., and C. Coulombe. 2007. Home-care programmes for older adults with disabilities in Canada: How can we assess the adequacy of services provided compared with the needs of users? *Health & Social Care in the Community*, 15: 1-7.
- Tousignant, M., R. Hébert, N. Dubuc, F. Simoneau, and L. Dieleman. 2003. Application of a case-mix classification based on the functional autonomy of the residents for funding long-term care facilities. *Age and Ageing*, 32: 60-66.
- Yin, R.K. 1994. Case study research: Design and methods. *Applied Social Research Methods Series*, vol. 5. Thousand Oaks, CA: Sage Publications.

Pathways to transformation in publicly-funded health systems: Experience in Canada's provinces



JEAN-LOUIS DENIS
FULL PROFESSOR OF HEALTH POLICY AND
MANAGEMENT
SCHOOL OF PUBLIC HEALTH,
UNIVERSITÉ DE MONTRÉAL
MONTREAL, CANADA



SUSAN USHER, MA (POL. ECON.), PHD(C)
DOCTORAL STUDENT
ÉCOLE NATIONALE D'ADMINISTRATION
PUBLIQUE
MONTREAL, CANADA

ABSTRACT: Canadian provinces have undertaken repeated health system reforms to better respond to changing needs arising from an aging population and high prevalence of chronic disease. As in other countries, large-scale system reform is considered necessary to meet these challenges. While structural changes, such as hospital closures and the creation of regional health authorities, prevailed in the 1990s, more recent reforms are employing other levers of change. This paper examines three themes that appear in reforms undertaken in different Canadian provinces over the past decade: the cultivation of alternate bases of mobilization to bring about improvement; a quest for increased capacity in governance; and efforts to engage clinical leaders, and notably physicians, in large-scale improvement.

Introduction

Reforms of healthcare systems are on the political agenda in all OECD countries and include a wide range of policies aimed at improving healthcare delivery systems, optimizing the use of resources and advancing population health. System reform can be defined as deliberate changes to the structures and processes of organizations with the objective of getting them (in some sense) to run better (Pollitt and Bouckaert, 2011, 2).

Governments make “ongoing efforts to increase their decision-making leverage over financial and/or clinical aspects of health system.” They look for what “... mix of structural and non-structural tools is most likely to produce the types of organizational and behavioural change that national governments are steering to create” (Jakubowski and Saltman, 2013: 3).

Recent studies show that healthcare reforms are increasingly likely to focus on system-wide change rather than piecemeal interventions in order to respond to complex policy issues presented by an aging population, increased incidence of chronic disease, and resource constraints (OECD, 2016; Reeves et al., 2014; Greer et al., 2016). Large-scale system reform is considered necessary given that the prevalent organizational (e.g. hospital level) focus of service improvement is too narrow to meet these challenges (Gauld et al., 2012; Hunter, 2015; McDaid et al., 2015). However, political and structural inertia and resistance (McQueen et al., 2012; Coeira, 2011) can make it difficult for policy actors to achieve meaningful system-level change (Best et al., 2012). As well, reforms are not just

rational solutions to obvious problems (Davies, 2004; Howlett, 2009; Kingdon 1995), but are embedded in a specific political and constitutional context and must contend with the vested interests shaped by this context (Pollitt and Bouckaert 2011).

Canada is no exception to this system focus, undertaking repeated reforms conditioned by predominant political ideologies in response to pressing contingencies. Since 2010, health spending growth has been slower than or close to growth in the overall economy. Consequently, the health-to-GDP ratio has declined to an estimated 11.1% in 2016, down from its peak of 11.6% in 2010 (CIHI, 2016). While better cost control may help to assure sustainability, the system must also deliver effective and appropriate care (Maynard, 2013; Lewis, 2015). In 2014, Canada placed tenth out of 11 countries in the Commonwealth Fund ranking of health system performance, highlighting the pressing need for improvement. Analysis of the evolution of Canadian health systems in the last 15 years suggests that substantive change remains elusive or slow (Health Council of Canada, 2008, 2013; Schoen and Osborn, 2010; Nasmith et al., 2010; Mental Health Commission of Canada, 2009; Denis, et al., 2011; Lewis, 2015).

In this paper, we describe and reflect on recent attempts by provincial governments in Canada to reform their health systems. The Canadian system is based on a decentralized (federal) state structure and a majoritarian type of executive government at both federal and provincial levels. Provinces lead healthcare policy design and delivery, within the context of the federal

Canada Health Act (1984). This structure means we cannot speak of reforms in a Canadian healthcare system, but rather of reforms in the different provinces and territories. In this paper, we examine three themes that arise in recent reforms: 1) a move, in some provinces, away from large-scale structural reforms towards the cultivation of alternate bases of mobilisation; 2) a persistent search for increased capacity in governance; and 3) a growing preoccupation with eliciting the contribution of clinical leaders in large-scale improvement. While these are certainly not the only themes to emerge from analysis of reforms, we feel that they illustrate important trends in Canada.

I - Disenchantment with structural reforms and the search for alternate bases of mobilisation:

During the 1990s, a conjunction of factors — new ambulatory care technologies, increasing healthcare costs and recognition that healthcare *per se* plays a limited role in improving population health — triggered moves to consolidate and restrict system capacities in terms of hospital beds and physician workforce (Sinclair et al., 2005). Major reorganizations can be painful and destabilizing for organizations and providers. While the focus on structural changes may be seen as a *passage oblige* during that period, policy-makers in many provinces have since become more interested in other, non-structural, strategies to bring about improvements.

The trend towards Collaborative Quality Improvement (CQI) approaches such as Lean is evident in many jurisdictions. Saskatchewan, a small province (population 1,158,339) embarked on a major policy experiment between 2008 and 2016, focusing on large-scale development of Lean capabilities across the system to improve the quality, safety and efficiency of care. Even in Québec, well-known for its inclination towards structural reforms, government supported the dissemination of Lean approaches between 2011 and 2015 (Touchette 2014). Ontario, Canada's largest province, has promoted quality improvement as a way to bring about large-scale change, creating Health Quality Ontario in 2011 to generate a focus on accountability and high-quality care, and passing legislation such as the Excellent Care for All Act (ECFAA) in 2010 (Chan 2012) and the Patients' First Act in 2016 that make improvement of care and patient experience a system priority.

It is too early to assess the impact of these efforts, or even the extent to which new approaches have been embedded in the system fabric. For example, political controversies in Saskatchewan have restrained further government promotion of the Lean experiment (MacIntosh 2016) and, in Ontario, challenges in executing a "coherent" and systemic approach to quality improvement persist (Sibbald 2013). Other provinces, such as Manitoba and British Columbia, have historically been less prone to undertaking major structural changes; while they have not embarked on the type of system-wide drive seen in Ontario and Saskatchewan, they likewise display growing emphasis on quality improvement capacities. Looking at recent health reforms in Canadian provinces, we see a growing but uneven movement away from structural changes and towards alternative approaches to improving system performance. Structural changes may become an option of last resort, or may

be used to concretize and formalize changes in practice that have already taken place.

II - Persistent search for increased capacity in governance

Structural reforms entail a reorganization of governance to redefine who is responsible for making decisions and allocating resources in the system. Canadian efforts in the 1990s to install regional governance structures have been studied extensively (Lomas 2001; Barker 2017; Denis 2004, 2011); nine of the 10 provinces — Ontario being the one holdout — created regional health authorities (RHAs) that were meant to meet a wide range of objectives (Lewis and Kouri, 2004). In most provinces, a two-tier model of governance was instituted, where RHAs absorbed healthcare delivery organizations and local governing boards. Exceptionally, Québec maintained a three-tier governance structure until the most recent reforms in 2015. Despite their widespread adoption, regional governance structures have proven unstable over time. In 2008, Alberta became the first province to abolish their RHAs and create a single central governance body, Alberta Health Services, to oversee the health system. Other provinces have followed suit: 2015 saw the institution of a single Nova Scotia Health Authority and the creation of 26 regional integrated health systems in Quebec to replace the three-tier governance system; in 2017, Saskatchewan adopted policy to abolish RHAs in favour of a single governance structure. Such developments suggest a drive by provincial governments to increase their control over the system through some form of centralization that involves a degree of structural change. This represents a major shift away from previous ideology that viewed the decentralization of system governance to local or regional bodies as a way to consider local needs and situations in the planning of services and allocation of resources. The trend towards centralized governance is motivated predominantly by concern for increased accountability and control (Gray 2014; Reeleder 2008; OHQC 2008). It also addresses longstanding preoccupations with assuring governance in regions serving relatively small populations, where capacities are thinly distributed across. Ontario is once again bucking the trend, with the Patients First Act of 2016 calling for some form of consolidation of Local Health Integration Networks (LHINs) to reinforce regional governance, though without dissolving governance structures at local (hospital) level.

III – A growing preoccupation with eliciting the contribution of the medical profession and clinical leaders in large-scale improvement

A parallel trend, which may be seen as an epiphenomenon in the search for alternate levers of mobilisation, is the increasing government attention to the role of clinical leaders in health system improvement (Denis and Usher, 2016). While all health professionals have a key role to play, in Canada the autonomy and status of physicians distinguish them from other health professions. Increasing efforts to engage them are evident in a number of provinces. Governments in Ontario and Québec have provided financial and other incentives for private-practice physicians to form Family Health Teams (FHT) and Family Medicine Groups (FMG), respectively (Born and Laupacis 2012;

Vérificateur générale du Québec 2015). In both provinces, government provides support for the incorporation of other health professionals into these teams, as well as subsidies for information technology. Ontario has seen improvements in people's access to family physicians, but the continued expansion of FHTs was stalled due to their high cost (Marchildon and Hutchison, 2016). In Québec, access to primary care remains an issue and government has threatened to introduce coercive legislation to increase patient loads of family physicians.

British Columbia's government has taken a more collaborative approach, embarking on a major policy initiative (the Facilities Engagement Initiative) negotiated with the physicians' association (Doctors of BC) to promote physician engagement within public healthcare organizations; both sides are investing significant resources in the effort (Specialist Services Committee 2017). In Alberta, Strategic Clinical Networks (SCNs) engage physicians and other health professionals in spreading best practices and building partnerships across the care continuum. Fourteen SCNs in different clinical areas have been established since 2012, and data on outcomes and practice variations play a key role in getting clinicians involved (Dick 2017). The Alberta experiment has attracted interest in other provinces, and may forecast a growing trend toward the reinforcement of clinical governance as a way to improve health systems in Canada. More broadly, the experience in various provinces suggests that participation of the medical profession is a crucial ingredient of reform, but also that engaging physicians is challenging.

Discussion and conclusion:

This paper describes recent trends in government attempts to improve and reform health systems across Canada. It does not provide a thorough account of reforms nor assess their results. Our aim is to identify changing approaches to reform as governments and policy-makers in Canada seek to better respond to changing health needs within current constraints. The experience in a number of provinces suggests that governments are moving from structural reforms towards alternate levers of change; however, they face challenges in sustaining change and improvement in a consistent and coherent way over time to produce systemic impact.

Designing and stabilizing governance structures that can serve to mobilize these alternate strategies remains a major challenge: they need to be equipped to promote and support the development of clinical governance at a scale that can bring about significant improvement. Clinical leaders from various professions, and especially the medical profession, will have to find a place in these governance arrangements and become accountable for reaching improvement objectives. The role of patients and citizens in shaping the health system and more actively participating in the delivery of care is receiving increasing attention, however their contribution to the transformation and improvement agenda needs to be more clearly defined (Best 2012; Conklin 2012; Carman 2013; Chessie 2009; Detsky 2013; Fooks 2015; Gauvin 2009). Finally, provincial health systems are well aware of the importance of driving health care and systems with solid data at every stage, from the clinical encounter to the macro level of health policy decision-making. Connecting the

data with the decisions politicians make about health system reform is a constant challenge that may limit the scale and scope of change.

Biographies

Jean-Louis Denis is Full Professor of Health Policy and Management at the School of Public Health, Université de Montréal, and visiting professor at the Department of Management, King's College London. He holds the Canada Research Chair (Tier I) on health system design and adaptation. His current research looks at healthcare reforms and health system transformation, medical compensation, professional leadership and clinical governance.

Susan Usher, MA (Pol. Econ.), PhD(c) is a doctoral student at the École nationale d'administration publique, focusing on patient and citizen engagement as a lever of transformation in health systems. She is Director of the Health Innovation Forum, collaborating with the McGill University Health Centre to explore policy challenges arising in healthcare organizations.

References

- Barker, Paul and John Church. 2017. "Revisiting Health Regionalization in Canada." *International Journal of Health Services* 47: 333-351.
- Best, Allan, Trisha Greenhalgh, Steven Lewis, et al. 2012. "Large-System Transformation in Health Care: A Realist Review." *The Milbank Quarterly*, 90(3): 421-456.
- Born, Karen and Andreas Laupacis. 2012. "Are Ontario's primary care models delivering on their promises?" *Healthy Debate*, March 29, 2012. <http://healthydebate.ca/2012/03/topic/community-long-term-care/comparing-primary-care-models>
- Canadian Institute for Health Information (CIHI). 2016. *National Health Expenditure Trends, 1975 to 2016*. https://secure.cihi.ca/free_products/NHEx-Trends-Narrative-Report_2016_EN.pdf
- Chan, Ben. "Transforming healthcare in Ontario through integration, evidence, and building capacity for improvement." In *Healthcare Management Forum* 25(4): 191-193.
- Chessie, Kelly. 2009. "Health System Regionalization in Canada's Provincial and Territorial Health Systems: Do Citizen Governance Boards Represent, Engage, and Empower?" *International Journal of Health Services*. 39 (4):705-24.
- Coeira, E. 2011. "Why System Inertia Makes Health Reform So Difficult." *British Medical Journal*. 342.
- Conklin, Annalijn, Zoë Morris, and Ellen Nolte. 2012. "What Is the Evidence Base for Public Involvement in Health-Care Policy?: Results of a Systematic Scoping Review." *Health Expectations* 18 (2):153-65.
- Davies, P. 2004. *Is Evidence-Based Policy Possible?* The Jerry Lee Lecture, Campbell Collaboration Colloquium, Washington.
- Denis, Jean-Louis. 2011. "Les agences régionales de santé : au-delà des logiques fondatrices, une nouvelle capacité d'action ? : Commentaire." *Sciences sociales et santé* 29(1): 29.

Denis, Jean-Louis, Damien Contandriopoulos, Marie-Dominique Beaulieu. 2004. "Regionalization in Canada: a promising heritage to build on." *Healthcare Papers* 5(1):40-5.

Denis, Jean-Louis, Huw TO Davies, Ewan Ferlie and Louise Fitzgerald. 2011. "Assessing Initiatives to Transform Healthcare Systems: Lessons for the Canadian Healthcare System." Ottawa: Canadian Health Services Research Foundation. Ottawa. http://www.chsrf.ca/Libraries/Commissioned_Research_Reports/JLD_REPORT.sflb.ashx

Denis, Jean-Louis, and Susan Usher. 2017. "Governance Must Dive into Organizations to Make a Real Difference: Comment on" Governance, Government, and the Search for New Provider Models". *International Journal of Health Policy and Management* 6(1): 49.

Detsky, Jay, and Randi Zlotnik Shaul. 2013. "Incentives to increase patient satisfaction: Are we doing more harm than good?" *Canadian Medical Association Journal* 185(14): 1199-1200.

Dick, Donald. 2017. "Strategic Clinical Networks in Alberta: What's Required for Success?" Presentation at the 2017 Conference of the MUHC-ISAI, Montreal, October 27, 2017. <http://www.healthinnovationforum.org>.

Fooks, Cathy, and Stephanie Hylmar. 2015. "Are LHINs influencing the patient experience in Ontario?" *Healthcare Management Forum* 28(6).

Gauld, Robin, Robert Blank, Jako Burgers, et al. 2012. "The World Health Report 2008 – Primary Healthcare: How Wide Is the Gap between Its Agenda and Implementation in 12 High-Income Health Systems?" *Healthcare Policy* 7(3): 38.

Gauvin, François-Pierre, Élisabeth Martin, Pierre-Gerlier Forest and Julia Abelson. 2009. L'expérience citoyenne dans la gouvernance du système de santé et de services sociaux au Québec. *Santé, Société et Solidarité* 8(2):45-50.

Gray, Carolyn Steele, et al. 2014. "Seeking Accountability: Multi-Service Accountability Agreements (MSAAs) in Ontario's Community Support Sector." *Health Reform Observer – Observatoire des Réformes de Santé* 2.1.

Ontario Health Quality Council (OHQC). 2008. "White paper: Accountability agreements in Ontario's Health System July 2008. http://www.hqontario.ca/Portals/0/modals/qi/en/processmap_pdfs/resources_links/accountability_agreements_in_ontario-july_31_2008.pdf

Greer, Scott L, Matthias Wismar, Josep Figueras, and Nikolay Vasev. 2016 "Policy lessons for health governance." *Strengthening Health System Governance*:105.

Health Council of Canada. 2008. *Rekindling reform. Health Care Renewal in Canada 2003-2008*. Toronto: Health Council of Canada. healthcouncilcanada.ca.

Health Council of Canada. 2013. *Better health, better care, better value for all: Refocusing health care reform in Canada*. Toronto, ON: Health Council of Canada. healthcouncilcanada.ca.

Howlett, Michael. 2009. "Policy analytical capacity and evidence-based policy-making: Lessons from Canada." *Canadian Public Administration* 52(2): 153-175.

Hunter, David J. 2015. "Role of politics in understanding complex, messy health systems: an essay." *British Medical Journal* March 9;350:h1214. 350 doi: <https://doi.org/10.1136/bmj.h1214>

Jakubowski, Elke, and Richard B Saltman. 2013. "The Changing National Role in Health System Governance." *European Observatory on Health Systems and Policies*, Observatory Study Series No. 29

Kingdon, John. 1995. "Agendas, alternatives, and public policies."

Boston: Little Brown.

Lewis, Steven. and Denise Kouri. 2004. "Regionalization: making sense of the Canadian experience." *Healthcare Papers*, 5: 12–31.

Lewis, Steven. 2015. "A System in Name Only - Access, Variation, and Reform in Canada's Provinces." *New England Journal of Medicine* 5:372(6):497-500.

Lomas, Jonathan. 2001. "Past concerns and future roles for regional health boards." *Canadian Medical Association Journal* 164(3): 356–357.

MacIntosh, Tom. 2016. "Rolling-out Lean in the Saskatchewan Health Care System: Politics Derailing Policy." *Health Reform Observer* 4(1).

Marchildon, Gregory and Brian Hutchison. 2016. "Primary care in Ontario, Canada: New proposals after 15 years of reform." *Health Policy*: 732-738.

Maynard, Alan. 2013. "Health Care Rationing: Doing It Better in Public and Private Health Care Systems." *Journal of Health Politics, Policy and Law*, 38(6), 1103-1127.

McQueen, David, Matthias Wismar, Vivian Lin, et al. 2012. "Inter-sectoral Governance for Health in All Policies: Structures, Actions and Experiences." Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Mental Health Commission of Canada. *Annual Report 2009-2010*. 2009, 32 p.

Nasmith, Louise, Penny Ballem, Baxter R, et al. 2010. "Transforming care for Canadians with chronic health conditions: Put people first, expect the best, manage for results." Ottawa, ON: Canadian Academy of Health Sciences.

OECD 2016. *Health at a Glance: State of health in the EU Cycle*. <http://www.oecd.org/health/health-at-a-glance-europe-23056088.htm>

Pollitt, Christopher and Geert Bouckaert. 2011. *Public Management Reform: A comparative analysis-new public management, governance, and the Neo-Weberian state*. Oxford University Press.

Reeleder, David, Vivek Goel, Peter A Singer and Douglas K Martin. 2008. "Accountability agreements in Ontario hospitals: are they fair?" *Journal of Public Administration Research and Theory* 18(1), 161-175.

Reeves, Aaron, Martin McKee and David Stuckler. 2014. "Economic suicides in the great recession in Europe and North America." *The British Journal of Psychiatry* 205(3): 246-247.

Schoen Cathy, Robin Osborn, Michelle M Doty, et al. 2007. "Toward higher-performance health systems: adults' health care experiences in seven countries." *Health Affairs* (Millwood) 26:w717-w734.

Sibbald, Shannon L, Charmaine McPherson and Anita Kothari. 2013. "Ontario primary care reform and quality improvement activities: an environmental scan." *BMC Health Services Research* 13:209

Sinclair, Duncan, Marc Rochon and Peggy Leatt. 2005. *Riding the Third Rail: The Story of Ontario's Health Services Restructuring Commission, 1996–2000*. Montreal: Institute for Research on Public Policy.

Specialist Services Committee, BC. "Supporting Facility Engagement". <http://www.sscbc.ca/physician-engagement/supporting-facility-based-physicians>

Touchette, Laurie. 2014. "Le lean santé gagne du terrain au Québec." Pôle Santé, January 13. <http://www.hec.ca/projet-quebecor/2013-2014/le-lean-sante-gagne-du-terrain-au-quebec.html>

Vérificateur général du Québec. 2015. "Groupes de médecine de famille et cliniques-réseau. Services de première ligne dans le réseau de la santé et des services sociaux." Rapport de vérification de l'optimisation des ressources, Chapter 5.

Managing the Myths of Health Care



HENRY MINTZBERG

CLEGHORN PROFESSOR OF MANAGEMENT STUDIES
MCGILL UNIVERSITY, MONTREAL (QC), CANADA

ABSTRACT: This article presents a summary of my book published in 2017, entitled “Managing the Myths of Health Care”, in three parts: I. The myths of health care, II. Reorganizing health care, and III. Reframing health care. Two additional notes are included, one about managing with and without soul, the other about a forum for developing health care managers with soul.

I. The Myths of Health Care

All over the world, people rail on about the failings of their health care. Yet we are living longer, thanks to the many advances in its treatments. In other words, where it focuses its attention, health care is succeeding, not failing, sometimes astonishingly. But it is doing so expensively, and we don't want to pay for it. So the administrators of our health care, in governments and insurance companies alike, have been intervening to fix it, mostly by cutting costs. And here is where we find a good deal of the failure.

Is management, therefore, the problem? Many health care professionals believe so. But health care cannot function without management. It just needs to function without a form of management that has become too common. (See the note below entitled “The Epidemic of Managing Without Soul”.)

We can call it remote-control management, because it is detached from the operations yet determined to control them. It works badly even in business, from where it has come. In health care, it reorganizes relentlessly, measures like mad, promotes a heroic form of leadership, favors competition where there is the need for cooperation, and pretends that this *calling* should be managed like a business. The more of all this we get, the more dysfunctional health care becomes.

Box 1: The Epidemic of Managing without Soul

A tale of two nurses

We run a rather unusual International Masters Program for Health Leadership (imhl.org), described at the end of this article, for people in mid-career. When we asked the incoming participants in one class to share stories about their experiences, an obstetrician told about the time as a resident when he was shuttling between the

wards of several hospitals. He and his colleagues “loved working” in one of them. It was a “happy” place, thanks to a head nurse who cared. She was understanding, respectful of everyone, a champion of collaboration between doctors and nurses. The place had soul.

Then she retired, and was replaced by someone in nursing with a masters degree in management. Without “any conversation . . . she started questioning everything.” She was strict with the nurses, for example arriving early to check who came late. Where there used to be chatting and laughing at the start of shifts, “it became normal for us to see one nurse crying” because of some comment by the new manager.

Morale plummeted, and soon that spread to the physicians: “It took 2-3 months to destroy that amazing family. . . We used to compete to go to that hospital; [later] we didn't want to go there anymore.” Yet “the higher authority didn't intervene or maybe was not aware” of what was going on.

The Management Epidemic

How often have you heard such a story, or experienced one? In the work that I do—studying management and organizations—I hear them often. And no few are about CEOs in business. Managing without soul has become an epidemic in society—in health care alongside business. Many managers these days seem to specialize in killing cultures, at the expense of human engagement.

Leadership programs too often leave people with a distorted impression of management: detached, generic, technocratic. This is bad enough—numbers, numbers. numbers. The worst of it is also mean-spirited, by bullying people and playing them off against each other. One person, pushed around for years by

a nasty boss, said: “It’s the little things that wear you down.”

These managers focus on themselves. In health care, you can sometimes tell them by comments about “my department” and “my hospital,” as if it is theirs because they manage it. And when they get to the “top” of some health care organization, they prefer to be called “CEO,” as if they are managing a business. They are not. They are managing a calling. Health care needs to purge itself of this business vocabulary.

Source: Mintzberg, Henry, 2017. *Managing the Myths of Health Care*. San Francisco: Berrett-Koehler

II. Organizing Health Care

To get past these myths, we need to consider how we organize in general and for health care in particular. In general, we differentiate work into component parts and then integrate these parts into unified wholes. In health care, however, there tends to be a lot more differentiating than integrating, and this has encouraged all sorts of excessive separations: “consulting” physicians who barely talk with each other; a preoccupation with evidence at the expense of experience; the researching of cures for diseases while failing to investigate their causes; persons reduced to patients and communities reduced to populations. And in the administration of health care, there are those walls and floors that separate managers from each other and from the professionals.

Behind all this lies a particular form of organizing that dominates the delivery of health care services. To understand it, turn on its head much of what you know about conventional organizing. For example, here strategy and leadership do not so much descend from some metaphorical “top” as emerge from the base, especially through venturing to create new services and users; bigger is not inevitably better; and many of the most successful institutions are often neither private nor public.

This *professional* form of organizing is the source of health care’s great strength as well as its debilitating weakness. In the administration, as in the operations, it categorizes whatever it can, in order to apply standardized practices whose results can be measured. When the categories fit, this works wonderfully well. The physician diagnoses appendicitis and operates; the government or insurance company ticks the appropriate box and pays. But what happens when the fit fails? For example, who treats the patient who falls between the categories, say, with some form of autoimmune illness that medicine has yet to prototype, or across the categories, as is often the case in geriatrics? Or how about the patient who fits the category but is ignored as a person, and so does not respond adequately to the treatment? Even more damaging can be the misfit between managers and professionals, as they pass each other like ships in the night, the managers in their descending hierarchies of authority, the professionals in their ascending hierarchies of status.

III. Reframing Health Care

Hence, to achieve the necessary integration, so that health care can function more like the system it is thought to be, we need to reframe it in all kinds of ways. Its management can be reframed as engagement rather than detachment—or, if you like, as caring more than curing. (See the note at the end about what we have been doing to develop this kind of managing in health care.) And this management has to be distributed beyond just those people called managers. Thus strategies, rather than being seen as emanating immaculately conceived from that “top”, can be considered to emerge from the base, as professionals in the operations learn their way to new forms of care and cure.

The organization of health care can be reframed by encouraging collaboration to transcend competition, culture to transcend control, and what can be called “communityship” to transcend leadership. More broadly, the raging battles over public sector versus private sector health care can be reframed with the recognition that much of the best of our professional services are delivered by community institutions, in another sector altogether, which is known as “civil society” but can better be called the *plural* sector. Overall, care, cure, control, and community have to collaborate, within health care institutions and across them, to deliver quantity, quality, and equality concurrently.

To Conclude

We can hardly turn our backs on the great advances that have been made in health care. But we do need to manage them better, and not just by people called managers. It may be fashionable these days to imitate the management of big business, but much of this is off track—no model at all.

The management of health care has to become less distant and opaque, more engaging and collaborative. There is too much managing on high as an escape from managing on the ground. And in the professional services, there is too much resistance to collaboration—with the managers and across the specialties.

In our lives, homes, clinics, institutions, communities, countries, and the world, we need more fortified care, more connected cure, more nuanced controls, and more engaged communities.

Box 2: A Forum for Developing Health Care Managers with Soul

Trying to create a manager in a classroom for business, let alone health care, encourages hubris. Removed from practice, such classrooms graduate people who believe they have been trained to manage everything in general, whereas in fact they have learned to manage nothing in particular.

Too many of these people get into senior management positions, pushed along by their credentials and sometime that “old boys” network of fellow alumni. There, too many of them depend on tools and techniques, fads and clichés. When they talk about “thinking outside the

box,” this suggests that they do not. When they promote strategic planning, they discourage strategic learning. They especially appreciate measuring, because, after all, what else can you do when you don’t understand what’s going on (to quote a senior civil servant in the U.K.)?

Rooting Management Education and Development

How about getting out of the office, to find out what is going on. Better still, try a program that encourages managers to learn from their own experience. That is what a group of us at McGill University championed: the creation of another kind of management education, to **engage managers beyond administration** (standing for emba, but not an Executive Masters of Business Administration!).

The first version, starting in 1996, was for business (International Masters Program for Managers, impm.org), the second from 2006 for health care (International Masters for Health Leadership, imhl.org), for people from all aspects of the field, all over the world. The participants are highly experienced (average age: in their 40s), combining face-to-face modules with learning back on the job.

Designing to Engage

The fundamental idea is that managers learn best by reflecting on their own experience and sharing their insights with each other. Theory alone, and cases about other people’s experience, just don’t suffice. Hence these programs are for people in practice who come into the classroom for five modules of 10–11 days each spread over a year and a half, interspersed with various other activities on the job.

These five modules are built around, not business functions (finance, marketing, etc.), but managerial mindsets: the reflective mindset (managing self), the analytical mindset (managing organizations), the worldly mindset (managing context), the collaborative mindset (managing relationships), and the action mindset (managing change). We want people to come to these programs to *do* a better job, not just *get* a better job. And so, while we offer lectures, exercises, and so on, as in other programs, half the class time is turned over to the participants, on *their* agendas. They sit at round tables in a flat classroom—no need to “break out”: they can go into workshops at a moment’s notice.

These tables, and the whole class, become communities of learning in their own right. Here the participants reflect on the ideas, connect them to their experience, share their insights with each other, and consider how to carry all this back to their own workplaces. While the participants of the business program are understandably there to improve their managerial practice and better their own organizations, most of those in the health care program are also determinedly there for the sake of better health care itself—as a calling. Various other activities are designed in the same spirit, to use the work of these busy people rather than to *make* more work for them. To take two especially popular activities, in the *managerial exchanges* they pair

up to spend the better part of a week at each other’s workplaces—to live in another manager’s world. (Thus, a senior civil servant for health in Iceland exchanged visits with the head of the ambulance service in Qatar.) And in *friendly consulting*, held in several of the modules, each participant brings an issue of central concern into a workshop to receive the advice of several sympathetic colleagues.

It has been said to “never send a changed person back to an unchanged organization.” But management development programs almost always do. So the participants in our programs are encouraged to create IMPact *teams* of colleagues back at work, through whom they can carry their learning to others for consequential changes.

A Forum Forward

We think of the IMHL as a forum for the improvement of health care worldwide. The field of health care has no shortage of meetings and conferences. But almost all focus on specific issues, such as health insurance or HIV/AIDS treatments. Imagine, instead, 35 experienced people from a dozen or more countries at all stages of development, who are working in hospitals, government agencies, community health clinics, international agencies, and so on. They meet intensively for eleven days, five times, over a year and a half, to consider thoughtful ways to change health care. The energy in such a classroom with so many of the participants devoted to the calling of health care is extraordinary.

Source: Mintzberg, Henry, 2017. *Managing the Myths of Health Care*. San Francisco: Berrett-Koehler

Biography

Henry Mintzberg is Cleghorn Professor of Management Studies at McGill University in Montreal. He is the author of 19 books and many commentaries, including a regular TWOG (TWEEt 2 bLOG, @mintzberg141 to Mintzberg.org/blog) about management and more. He spends his public life dealing with organizations and his private life escaping from them—in a canoe, on a bicycle, up mountains, and atop skates. (See mintzberg.org.)

References

- Mintzberg, Henry, 2017 *Managing the Myths of Health Care*. San Francisco: Berrett-Koehler
- Mintzberg, Henry, 2013 *Simply Managing*. San Francisco: Berrett-Koehler
- Mintzberg, Henry, 1989 *Mintzberg on Management*. New York: Free Press
- Mintzberg, Henry, 1994 *The Rise and Fall of Strategic Planning*. New York: Free Press
- Mintzberg, Henry, 2006 *Managers not MBA*, San Francisco: Berrett-Koehler

Preparing the Ground for Transformation: A Case Study of the MUHC's Experience



JUDITH HORRELL, M. MNGT
SENIOR STRATEGIC ADVISOR
EXECUTIVE OFFICE, MCGILL UNIVERSITY
HEALTH CENTRE (MUHC)
MONTREAL (QC), CANADA



NORMAND RINFRET, CRIA
FORMER DIRECTOR GENERAL AND CEO
MCGILL UNIVERSITY HEALTH CENTRE
(MUHC)
MONTREAL (QC), CANADA

ABSTRACT: In 2015, the McGill University Health Centre (MUHC), a leading academic health centre located in Montréal, Québec, Canada, inaugurated a CAN\$1.3-billion health complex (Glen site) after a planning, authorization, design, finance, building and activation process that spanned nearly two decades. The MUHC was compelled to leverage the transformative project to innovate and share the new information it acquired. Consequently, this turbulent period yielded a considerable body of knowledge. This article draws on the MUHC's experience and is anchored in literature. It addresses the topics of complex change, innovation and performance improvements in health care. In particular, it aims to provide organizations, which may be planning or are already engaged in a transformative project, such as the one undertaken by the MUHC, with evidence as to why it is beneficial to dedicate resources to support transformation, notably for the transition period. The article concludes with a summary of lessons learned and a possible avenue of additional study.

Background

In 1997, the Montreal General Hospital, Royal Victoria Hospital, Montreal Children's Hospital, Montreal Chest Institute, and Montreal Neurological Hospital (teaching hospitals affiliated with McGill University's Faculty of Medicine) merged to create a legal entity called the McGill University Health Centre (MUHC). The Research Institute of the MUHC was formed as part of this merger to facilitate investigator-initiated and discovery-driven healthcare research along the entire spectrum of investigative activities. Concurrently, a planning office was opened to set in motion a transformative project for the consolidation of sites and construction of state-of-the-art facilities. Staffed by personnel with a variety of expertise, it would oversee the many phases of project planning, including the project's clinical, functional and technical plan, architecture and engineering specifications, etc.

By 2008, the MUHC was immersed in the complexity of its redevelopment project, which had grown to include the Lachine Hospital and Camille-Lefebvre Pavilion (a community hospital and long-term-care centre), following the signing of an integration agreement. As turbulence increased at every level of the organization, so too did the volume of questions and challenges. The redevelopment project would be amalgamating six hospital sites into four sites, with one entirely new facility (the Glen site that houses the Royal

Victoria Hospital, Montreal Children's Hospital, Montreal Chest Institute, Cedars Cancer Centre and Research Institute of the MUHC), which meant merging clinical and operational teams with different modes of functioning (Richer, Marchionni, Tremblay-Lavoie, and Aubry, 2013). Senior management was concerned about achieving a successful transformation given that over 10,000 healthcare professionals and staff needed to be mobilized to maximize the envisioned performance improvements.

Therefore, the MUHC consulted extensively on the latest designs of healthcare centres, on challenges and opportunities intrinsic to transformative projects, and on best-in-class clinical, research, education and administrative practices. Teams involved themselves in exchanges with stakeholders in North America, Europe, the United Kingdom and Australia. Representatives of visited academic health centres told the MUHC that, in hindsight, they should have invested more resources into supporting the integration of teams who would be called upon to work together in the new structure and environment. Senior management at the MUHC took this information to heart and decided to explore how best to provide that support.

The merits of a project office surfaced from a literature review (Lavoie-Tremblay, Richer, Aubry, Biron et al, 2013; Aubry, Hobbs and Thuillier, 2008). Therefore in 2008, the MUHC created its Transition Support Office (TSO). The TSO

was led by a director and staffed with a dedicated support team of knowledge brokers, evidence specialists, project and change managers, as well as experts in evaluation, process review and communication. The TSO used evidence and its previous experience in guiding over 100 major institutional projects to create a structure for its efforts, including the evaluation of project results and performance, project and change management, and knowledge management.

The TSO proved invaluable. Myriad complex practice, team- and process-related projects were implemented and led to measurable performance improvements (Lavoie-Tremblay, Richer, Aubry, Biron et al, 2013). The TSO's advance work and the mobilization of teams also supported the activation of the MUHC's Glen site, Quebec's first LEED® Gold-certified healthcare complex, valued at \$CAN 1.3 billion, and the flawless execution of the biggest hospital move at the time in Canada's history.

Grooming an Organization's Capacity to Adapt

Nearly two decades would go by before the MUHC's Glen site would rise from the soil. It wasn't for a lack of desire or trying: the MUHC's internal stakeholders understood the direction they wanted to take and persevered. External stakeholders also understood that there was a valid need to modernize infrastructures for academic medicine. However, like an ecosystem with interdependencies, Canada's health system's mutability is controlled by many drivers, not least of which is the provincial government. These interdependencies can impinge on a healthcare organization's progress and, according to McCann and Selsky, magnify the complexity of a turbulent environment (2012). For example, from the conception of the MUHC's redevelopment project to the 2015 inauguration, seven different premiers succeeded each other in office. An organization's capacity to adapt to complex change thus becomes critical.

The MUHC was required to adapt the parameters of its redevelopment project due to cyclical disruptions, whereas multiple delays in the project's groundbreaking date forced the organization to anticipate, and adapt to, the volatility of the healthcare landscape. Regionally, this landscape was shaped by technological and research advances, an ageing population, healthcare reforms, economic pressures, new best practices, and a local shift towards an increasingly networked patient-care pathway — elements of which are sure to resonate with institutions regardless of their geographic location.

To stay true to itself and its pioneering history, the MUHC was required to manage possibility and expectation against available resources. Zolli and Healy (2012) suggest that resisting displacement from core purpose while increasing the scope of alternatives you are prepared to embrace, if push does come to shove, will in fact allow your organization to adapt to disruption and volatility. Therefore, the TSO developed a strategy for project management around practice, people and process using the principles of evidence-informed decision-making, appreciative inquiry and LEAN health care (Richer, Marchionni, Lavoie-Tremblay

and Aubry, 2013). Practice-related projects invited groups to harmonize the way the MUHC functioned across all sites, by considering the evidence in relation to the context and implementation circumstances. Involving directly affected people in decision-making decreased resistance, by increasing acceptability. Consolidation-related projects invited groups who would work together in the future to reproduce what the organization does best by using existing knowledge and using innovatively that body of evidence. Process-related projects invited in-depth analyses of work processes to explore areas of waste and propose innovative ways of functioning that would improve performance. The TSO managed over 100 such projects, contributing to the MUHC's preparedness to work together at the Glen site and supporting the adaptability of teams.

An Innovative Framework for Harnessing the Potential of Turbulence

Zolli and Healy (2012) remind us that encouraging adaptation brings us to a different way of being in the world; it's what makes individuals and organizations resilient, which goes hand in hand with agility and mastering turbulence (McCann and Selsky, 2012). This aspect prevailed in the MUHC workplace climate throughout the transition period, right up to its transformation at the Glen site. Furthermore, if we accept the notion that organizations resist change less than is actually perceived, as advanced by Senge, Kleiner, Roberts, Ross et al (1999), we must also accept that individuals are prepared to put ideas into action whenever they understand the value of the change. However, Senge et al also suggest that frustration occurs if they lack control over their job. Indeed, in complex change, it is worth considering, as Richer, Dawes and Marchionni (2013) note, Nonaka's conclusion that the key to unlocking knowledge is to create a sense of identity amongst teams and within the organization and then to leverage this generated commitment. In this regard, the TSO's efforts were tantamount to knowledge generation and innovation. Its research exposed the fact that the MUHC would have to navigate between push and pull, depending on the groups and/or departments and/or clinical missions involved in changes required to complete the transformation.

Therefore, harnessing the potential of push and pull or turbulence became a major TSO objective. The TSO partnered with the Quality, Evaluation, Performance and Ethics department to establish a theoretical framework for evaluating each project and its own productivity. Adopting a common, theoretical performance evaluation framework ensured consistency across the organization; promoted integration by charting a course for measuring performance, using indicators that were valued by the organization; and facilitated teams' use of the organization's data systems. In fact, teams acknowledged that the TSO's performance evaluation experts encouraged the emergence of a performance measurement culture (Biron, Vézina, St-Hilaire, Lavoie-Tremblay and Richer, 2012; Lavoie-Tremblay, Richer, Aubry, Biron et al, 2013).

Logically, when people see positive results from performance

measurement, we can expect diminished resistance in the implementation of change. This is why choosing to create new knowledge by investing in the TSO was very beneficial. By producing research on the function and outcomes of a TSO and publishing its findings, the TSO not only closed the knowledge gap it found during the organization's early consultation process vis-à-vis the value of a TSO, but it also improved performance and fostered innovations that were implemented at the Glen site and across the organization. The emergent culture was also a positive step towards making the organization more agile.

Conclusion

Pulitzer award-winning author Jared M. Diamond (2005, 2011) suggests that the past offers us a rich database from which we learn and make decisions that will allow us to thrive or fail. The MUHC's redevelopment experience confirms this theory, but it also underscores that the past doesn't always provide the data organizations need to drive performance improvement, innovation and transformation. Moreover, transformation may begin with purposeful decision-making, but its progress will inevitably be impinged by the interdependencies of internal and external disruptions, both short-lived and protracted. In these situations, a resilient and agile organization will be better positioned to adapt. By evaluating the transition period within the context of the disruptions, the organization can capitalize on turbulence, improve performance and generate innovations. This in turn makes the effort required to implement subsequent changes more acceptable to teams that may have had a tendency to resist in the past. Finally, evaluating the productivity and outcomes of an organization's own structures, such as a TSO, creates added value. It is an excellent means for preparing the ground for transformation, notably because it enriches an organization's adaptability, thus preparing it to manage complex change in the future.

It is worth noting that the MUHC did not evaluate the experience of 'being in the midst of change' throughout the transition period. There is merit in studying this topic, in view of the sheer complexity of change. Making sense of the change process as a 'way of being', from the perspectives of individuals, teams and organizations, might create a stronger narrative, with reference to uncertainties associated with change in health care and on how organizations might yield more powerful outcomes. After all, it has been argued that organizational success is dependent on people's reflections on past experiences, while intuiting and embodying emergent futures (Shaw, 2002; Scharmer, 2000). Therefore, our experience of change mirrors what lies beneath, above or behind our experience. The mere act of discussing this might change the conversation about organizational transformation.

Biographies

Judith Horrell is a senior strategic advisor in the Executive Office of the McGill University Health Centre (MUHC) and a graduate of McGill University's International Masters for

Health Leadership program.

Normand Rinfret's career in health care has spanned four decades. He oversaw the transition, activation and inauguration of the Glen site as past president and executive director of the MUHC.

References

- Biron, A.D.; Vézina, M.; St-Hilaire, C.; Lavoie-Tremblay, M.; Richer, M.-C. 2012. *Role of Performance Measurement in a Major Redevelopment Project: The Case of the McGill University Health Centre Transition Support Office*. *Healthcare Quarterly*, 15 (1) 34-40
- Diamond, Jared M. 2005, 2011. *Collapse, How Societies Choose to Fail or Succeed*. New York, NY: Penguin Group
- Hobbs, B; Aubry, M.; Thuillier, D. 2008. *The Project Management Office as an Organisational Innovation*. *International Journal of Project Management*. 26 (5): 547-555
- Lavoie-Tremblay, M.; Richer, M.-C.; Aubry, M.; Biron, A.; Vézina, M.; Boulay-Bolduc, M.; Lefebvre, P.; St-Marie, M.; Cyr, G.; Denis, J.-L. 2013. *An Innovative Strategy in Organizational Transformation: Creating and Implementing a Transition Support Office Within a University Health Centre*. Report of the Canadian Foundation for Healthcare Improvement. Ottawa, ON: www.cfhi-cfss.ca
- Lavoie-Tremblay, M.; Bonneville-Roussy, A.; Richer, M.-C.; Aubry, M.; Vézina, M.; Deme, M. 2012. *Project Management Office in Health Care. A Key Strategy to Support Evidence-based Practice Change*. *The Health Care Manager*, 31(2): 154-165
- McCann, J. E. and Selsky, J.W. 2012. *Mastering Turbulence, The Essential Capabilities of Agile and Resilient Individuals, Teams, and Organizations*. San Francisco, CA: Jossey-Bass
- Richer, M.-C.; Dawes, M.; Marchionni, C. 2013. *Bringing Knowledge to Action in the Context of a Major Organizational Transition*. *The Health Care Manager*, 32 (1): 4-12
- Richer, M.-C.; Marchionni, C.; Lavoie-Tremblay, M.; Aubry, M. 2013. *The Project Management Office: Transforming Health Care in the Context of a Hospital Redevelopment*. *Healthcare Management Forum*. Forum Gestion des soins de santé, Fall/Automne 151-156
- Senge, P.; Kleiner, A.; Roberts, C.; Ross, R.; Roth, G.; Smith, B. 1999. *The Dance of Change, The Challenges of Sustaining Momentum in Learning Organizations*. New York, NY: Doubleday
- Shaw, P. 2002. *Changing Conversations in Organizations: A Complexity Approach to Change*. New York, NY: Routledge
- Zolli, A. and Healy, A. M. 2012. *Resilience, Why Things Bounce Back*. New York, NY: Free Press

General Overview for Long-Term Care Centers in the Province of Quebec



PAUL ARBEC

CEO
ARBEC HEALTH GROUP
TERREBONNE (QC), CANADA

ABSTRACT: This article covers the three major reforms that have affected and influenced developments in the long-term care sector. Various statistics are discussed to provide readers with a basic knowledge of services offered to seniors in Quebec, as well as the demographic that they cover.

Introduction

It is my pleasure to share my observations regarding the long-term care services offered in the Province of Quebec. My text will also cover different reforms in the healthcare sector, pertinent to long-term care services in the Province.

The privately run Arbec Health Group has been operating long-term care and assisted living facilities for over 50 years. I am the group's third generation CEO and much like my father, I have grown up in the private health environment, passionate about offering quality care services to the elderly.

I studied Administration at the University of Concordia and obtained a post BA diploma at the University of Sherbrooke, specifically in the sector of long-term and residential services for seniors.

We presently own and manage 15 different facilities which provide care for over 1,250 seniors and employ 1,300 doctors, professionals, nursing and assistance care and administrative staff members.

Our services cover the full spectrum of care and assistance for the elderly: from quality residential accommodation to rehabilitative and long-term nursing

and medical care.

Aside from our residential care, our clientele is composed primarily of patients with aging-related cognitive deficiencies and dementia, often also affected by secondary physical health problems.

Three Reforms which have had a strong effect on Long-Term Care in Quebec

Before 1992, most public operated long-term care centers were managed by distinct establishments and were therefore more autonomous in their management as well as their development.

In 1992, the Health Reform Act integrated all public long-term care services with local community health organizations (CLSC). This process was a natural transition and resulted in more effectiveness and efficiency.

In 2005, the community health organizations and long-term care centers integrated one step further with local territorial health services, including acute care beds, long-term beds and all community health services, including homecare.

Yet another reform was implemented in 2015, this time integrating all health services offered for a given

administrative region, including all three previously mentioned spheres, with rehabilitative care, mental healthcare, youth protection services and intellectual deficiencies services. The number of Health centers decreased from 182 to 34 establishments.

These new integrated health administration entities can reach up to 15,000 employees and manage billion dollar budgets. Needless to say, long-term care centers have lost their voice and funding over the years, opening up a market for private enterprise to fill the void.

Long-Term and Elderly Services in Quebec

Let us start by examining the following statistics:

- For the first time in the history of Canada, the number of seniors will exceed the number of children.¹
- 2.4 million Canadians over the age of 65 will need support and continuous healthcare.¹
- By 2046 this number will reach 3.3 million.¹
- The cost of services allocated for senior care will pass from 28.3 billion dollars in 2011 to 177.3 in 2046.¹
- In Quebec, the population over the age of 65 will reach 1.7 million people in 2021, constituting 20.5% of the total population. By 2061 the elderly will grow to 28.5% of the total population.²

Throughout the Province, there are approximately 45,500 long-term beds in operation. This breaks down into 33,350 beds operated by the Public Sector and almost 12,000 beds (6,800 private subsidized, approximately 3,350 private non-subsidized and approximately 1,500 clandestine establishments), owned and operated by the Private Sector, with multiple types of contract agreements and financing by the public healthcare system.³

There is also an intermediary level of 13,000 additional light-care beds, owned and managed by the Private Sector with Government funding. This mode of developing light care is becoming increasingly popular throughout the Province.⁴

With an ever increasing number of citizens over the age of 65, the number of beds has not increased proportionally to the new demands. The private market has reacted and seized the opportunity, offering over 120,000 rental units⁵ with a wide array of care and assistance levels that have emerged over the past 20 years.

These assisted living homes range from entirely

autonomous clients to end-of-life and palliative care. Many organizations offer the possibility to evolve through a continuum of care which includes end-of-life care.

With almost one third of the Government-managed long-term facilities in a dilapidated state, the Public Sector has trouble simply keeping up with their relocation and renovation projects, so the Private Sector is picking up the slack.

The latter has proven to be more agile and responsive to the real needs of seniors over the past two decades. Projects under private administration deliver on time, respect budget requirements, while guaranteeing expected levels of quality care and satisfaction. Furthermore, the period spanning from private project conception to the end of construction is 18 months, compared to 5 to 7 years required by the Public Sector.

The different types of contracts between the Public and private sectors vary from one region of the Province to another and include an array of variations and levels of care. Part of this diversity is a result of aiming to respond to the necessary needs of a given population in a given territory.

Many social economy programs, cooperatives and non-profit organizations also offer homecare and long-term care services. This somewhat new approach is becoming increasingly popular. They also manage contracts with the Public Sector.

Over the last 20 years, Government funding for long-term care has decreased considerably. Few new beds are opened by the Public Health Sector and when they are, it is often with private cooperation.

It is unfair to say that the Public Sector is not doing their part any more. It seems more like their part is gradually evolving into a more passive role of governance and regulation in long-term care, rather than an active care model in development for the future. Many financial injections have been made for elderly services in public establishments, however increasing needs and the poor state of buildings is beginning to take its toll.

The response has been very clear from the private entrepreneurial approach to elderly care and assistance, and has proven to be a model that the population accepts and appreciates.

The Public Sector treats the aging population with a silo approach, which starts with homecare. When homecare reaches its limits, clients are referred to intermediary resources, then to a long-term nursing care center, for non-autonomous seniors requiring end-of-life or palliative care. They often stay in transition centers awaiting their first choice.

From a client experience perspective, the state of affairs is far from simple. The Public System is not easy to navigate and requires our seniors to be relocated several times during their evolution in the continuum of care.

1 Source: L'Alliance canadienne pour des soins de santé durables (ACSSD) of The Conference Board of Canada, La durabilité du système de santé, un enjeu clé face au vieillissement de la population. http://www.conferenceboard.ca/press/newsrelease/17-05-15/La_durabilit%C3%A9_du_syst%C3%A8me_de_sant%C3%A9_un_enjeu_cl%C3%A9_face_au_vieillessement_de_la_population_canadienne.aspx?AspxAutoDetectCookieSupport=1

2 Source: Famille Québec, Les personnes âgées de 65 ans et plus : données populationnelles. <https://www.mfa.gouv.qc.ca/fr/aines/chiffres-aines/Pages/personnes-agees-65-plus-donnees.aspx>

3 Source : Le Devoir Newspaper, Les CHSLD à bout de souffle, Etienne Plamondon Emond, May 20th, 2017

4 Source : Association des ressources intermédiaires d'hébergement du Québec (ARIHQ). <https://www.arihq.com/membres-ri-et-avantages/portrait-au-quebec/>

5 Source: Rapport sur le marché des résidents de personnes âgées, Publication JLR, mai 2017.

The negative effects on clientele have been documented: it is a traumatic experience for a dementia patient to relocate, with new staff and a new environment.

The 120,000 units for private residential and assisted living facilities accommodate 18.4% of the over 75 year old population^{6 7}. In order to maintain this penetration rate, which is amongst the highest in North America, 100,000 new units will have to be built over the next 15 years, just to keep up with the aging population⁸.

Quebecers love the assisted living community feeling!

Many criticise the fact that once an elderly person enters an assisted living center, the care and attention they receive actually contributes to their decrease in autonomy, as they no longer take care of themselves. The market has made strong improvements on this level, and most quality centers are conscious of the necessity of encouraging their residents to be both physically and socially active. This, coupled with a proper nutrition program and medication management, has proven to be quite effective in improving the quality of life of seniors in Quebec for their golden years.

With waiting times increasing for homecare and almost 3,000 people⁹ awaiting admission into a long-term care center across the Province, it is clear that the Private Sector is inevitably obliged to be the development of the future.

There are many advantages for investors and entrepreneurs with the aging population in Quebec. However, there are also some constraints:

- Construction norms have evolved according to high demand in this sector. This results in promoters building larger complexes due to higher construction costs, in order to achieve the same returns on their investment.
- Constant market pressure is forcing many centers to age with their clients and offer levels of care which may prove to be beyond their capacities, indeed many have succeeded very well in doing so.
- Five different business groups own over 50% of the 120,000 assisted living¹⁰ units.
- Full employment levels in Quebec means that hiring is difficult, primarily for assistance care orderlies.
- Many small residences, with just 10 to 50 residents, are finding it difficult to keep up with construction regulation adjustments.

Conclusion

Despite market challenges, investors are very active and

have flourished across the Province, investments are on the rise and occupation rates are high. We are presently occupied at 100%.

Our family has been managing centers for the elderly with varying degrees of care levels over three generations. We still enjoy what we do and take our job very seriously. It is an immensely gratifying vocation and investment.

We have grown from 125 to over 1,200 residents in the last 15 years. We are proud of and intend to continue this growth.

Our company values of respect, confidence, commitment, rigor, cooperation and pride guide our decisions and have proven to be effective over the years. The Arbec Health Group was singled out as one of the examples to follow for partnerships with the Government by the HEC University of Montreal.

We have a passion for seniors and a curiosity for all of the services available to them. After all, they deserve it!

Biography

Paul Arbec has been CEO of the Arbec Health Group since 1999. With over 30 years of experience in housing services for seniors, he has occupied several operational and managerial functions and has developed an expertise in caring for seniors. Highly committed to the community, Paul Arbec is a recognized visionary in the health sector for the Province of Quebec.

References

JLR, 2017. *Rapport sur le marché des résidents de personnes âgées*, JLR Publication, Canada. Available at :

https://solutions.jlr.ca/hubfs/Etudes_et_rapports/2017-05-ResidencesPersonnesAgees.pdf?t=1495743124377&utm_campaign=%C3%89tude%20-%20sp%C3%A9cial&utm_source=hs_automation&utm_medium=email&utm_content=52296266&_hsenc=p2ANqtz-8slvMExpD2p1Z0_14neb6mclgP8a9p5sPMXKINuNeMdlDlbnPmnsB22WyOhYAwYsaIH1I5zCukXudN_lmRaVQOp_fcfcHzupq2tDMINzsoveeDqZw&hsmi=52296266

Société Canadienne d'hypothèques et de logement (SCHL). 2016. *Rapport sur les résidences pour personnes âgées 2016*. Seniors' Housing Report, Canada. Available at: https://www.cmhc-schl.gc.ca/odpub/esub/65989/65989_2016_A01.pdf

6 Source: Regroupement québécois des résidences pour aînés, Rapport sur les résidences pour personnes âgées 2016, SCHL.

7 Source: <https://www.rqra.qc.ca/salle-de-presse/statistiques>

8 Source: Rapport sur le marché des résidents de personnes âgées, Publication JLR, mai 2017.

9 Source: Article from Journal de Montréal, Fermeture de 400 lits dans des chambres en CHSLD, Héroïse Archambault, May 23, 2017 and Ministère de la Santé et des Services sociaux du Québec (MSSS), 14 avril 2017. <http://www.journaldemontreal.com/2017/05/22/fermeture-de-400-lits-dans-des-chambres-en-chsld> and <http://www.msss.gouv.qc.ca/>

10 Source: Rapport sur le marché des résidents de personnes âgées, Publication JLR, mai 2017.

Whither Canadian Hospitals: Aligning Authorities and Accountabilities



BILL THOLL M.A., ICD.D
SENIOR CONSULTANT IN HEALTH POLICY AND
LEADERSHIP DEVELOPMENT
THOLL HEALTH LEADERSHIP CONSULTING
OTTAWA (ON), CANADA



PAUL-ÉMILE CLOUTIER M.POL.SC., M.H.A
PRESIDENT AND CEO
HEALTHCARECAN
OTTAWA (ON), CANADA

SUMMARY: The Canadian healthcare system, not unlike many around the world, is undergoing tremendous change. Nowhere have these changes been more dramatic than in what used to be known in Canada as the “hospital sector”. The world-wide symbol of the blue “H” can still be seen in over 1000 communities and different highways across Canada. However, over the past decade, as legal entities, hospitals have been deemed to no longer exist in all provinces save one, our largest province: Ontario. Elsewhere, an increasingly broad range of hospital and community-based services are administered through Regional Health Authorities or RHAs. This short piece attempts to provide a high-level description of the nature of these changes as well as the economic, technological and political forces behind them, and briefly assess the implications for the national voice of “hospitals”.

Taking Stock: Canada has a universal, publicly financed health insurance system with virtually all medical services and about 90 percent of all hospital services paid for by the public purse. Since the 1950s and 1960s, all Canadians are covered and according to some of the most meaningful metrics, Canada’s healthcare system continues to serve Canadians reasonably well in terms of access to essential or acute care services¹. Canada also seems to be “bending the cost curve” in terms of public sector healthcare spending (see below) and compares well when it comes to administrative efficiency and “care processes”².

That said, according to the Organization for Economic Cooperation and Development³ and the Commonwealth Fund⁴, Canada continues to lag behind many of our comparator countries in terms of overall value for money. For example, we continue to rank in the top tercile in terms of per capita spending, while occupying the bottom tercile in terms of key performance indicators such as wait times and access to primary care. While we do well in terms of overall life expectancy, we continue to fall further behind in terms of infant and maternal mortality. There is also growing public and political concern in Canada over health

status disparities among and between Canada’s indigenous peoples⁵.

Responsibility for the financing and delivery of healthcare in Canada rests primarily with the ten provinces and three territories. The federal government provides substantial annual cash transfers to the provinces and territories in return for compliance with criteria and conditions set out under the Canada Health Act (1984)⁶. In brief, the conditions are: *Reasonable access* (without point-of-services charges) to a *comprehensive* range of insured hospital and medical services, on a *publicly administered* basis, with *portability of benefits* when moving or travelling within Canada, with *universal population coverage*.

Over the last few years and over the past five years in particular, hospital sector governance has changed markedly. By 2017, every province in the country except Ontario has put in place Regional Health Authorities (RHAs) that span a much broader range of services than traditional in-patient and outpatient hospital services. RHAs have been formed with delegated authorities and embrace accountabilities for a wide range of services (i.e. more of a “population health” mandate), reporting to arms-length, largely appointed Boards of Directors, as opposed to elected Boards. Most physician services are still settled on a fee-for-service basis (approximately 70%) and tend to operate outside the locus of accountability of the RHAs.

1 See most recent Canada Health Act Annual Report to Parliament: <https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2015-2016.html>

2 Commonwealth Fund “Mirror, Mirror” 2017 <http://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-international-comparisons-2017>

3 OECD, June 2017. See link accessed Oct 5, 2017: http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_STAT

4 Commonwealth Fund (2017), Op. Cit. Across Canada, Ontario and British Columbia rank in top tercile, while provinces in eastern Canada rank at or near the bottom.

5 HealthCareCAN link: <http://www.healthcarecan.ca/resources/issue-briefs/>

6 See Canada Health Act Annual Report to Parliament: <https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2015-2016.html>

Table 1: De-regionalization and Centralization of Canada's Healthcare System

| Province/Territory | Regional entities | Brief Description |
|---------------------------|-------------------|--|
| British Columbia | 7 | Regionalized (2001): Five geographic Regional Health Authorities (RHAs); One Provincial Health Service Authority responsible for speciality services (e.g. cancer care); and First Nations Health Authority (2013). |
| Alberta (AHS) | 1 | Re-regionalized (2008): Single, province-wide Alberta Health Services with 5 operational zones (2011); AHS created out of 9 geographic regional entities. |
| Saskatchewan | 1 | De-regionalized (2017): Single, province-wide authority created by consolidating 11 geographic RHAs; retained province-wide specialized and shared services responsibility. |
| Manitoba | 5 | Regionalized (2012): With recent consolidation of clinical services within Winnipeg RHA and strengthening of province-wide responsibility for speciality services and shared services ⁷ . |
| Ontario | 14 | Decentralized (2004): Elected Hospital Boards continue to exist, but increased responsibilities and authorities have recently been vested with 15 Local Health Integration Networks (LHINs) by subsuming Community Care Access Centres (CCACs). |
| Quebec | 18 | Regionalized (2015): Two-tiered regionalized structure, with 18 Regions working through/with 34 integrated health and social service institutions ⁸ . |
| New Brunswick | 2 | De-regionalize (2008): Eight geographic RHAs were amalgamated into two: Vitalité to coordinate services the francophone population and Horizon to service the needs of the rest of the province. Province-wide clinical and information services are provided through a province wide agency known as "Facilicorp NB". |
| Nova Scotia | 1 | De-regionalized (2015): The Nova Scotia Health Authority (NSHA) was the result of the merger of nine RHAs. Like Alberta, there are operational "zones" or areas supported by province-wide shared services. |
| Prince Edward Island | 1 | De-regionalized (2010): Health PEI is the single authority with responsibility for province-wide coordination of services. This crown corporation was created by merging five RHAs |
| Newfoundland and Labrador | 4 | Regionalized (2003): The province continues to rely on one large RHA operating out of St. John's to coordinate specialty series province-wide, with three geographic specific RHAs to provide local services. |
| Yukon Territory | - | Centralized: Yukon does not have a regional health authority. It has three hospitals run by the Yukon Hospital Corporation. |
| Northwest Territories | 1 | De-regionalized (2015): One Health Authority has been established, a Territorial Board of Management replacing eight authorities. |
| Nunavut Territory | - | Centralized, with responsibility resting with the Department of Health and Social Services. |

⁷ Manitoba is undergoing further "sweeping reforms" in terms of centralizing specialty care services province-wide. See this link for most recent description: <http://www.cbc.ca/news/canada/manitoba/winnipeg-health-care-closures-1.4308163>

⁸ See following link describing health regions across Québec: <http://www.msss.gouv.qc.ca/en/reseau/regions.php>

Furthermore, many geographic-specific health authorities have been recently consolidated to provide for a better alignment of authorities and accountabilities at provincial level, to achieve better coordinated and integrated hospital and community-based care. Not unlike several other countries in Europe (e.g. Norway, Denmark, Sweden, Finland) and the UK, Canada has struggled to realize the full potential of regionalized systems and has recently re-centralized or de-regionalized provincial/territorial systems. Delivering high quality care in a cost effective manner in rural and remote areas remains very problematic in Canada⁹.

The current governance arrangements for each province and territory are summarized above (see Table One)¹⁰.

As Barker and Church (2016)¹¹ point out, this process of regionalization followed by de-regionalization and consolidation has been driven by several factors. These include:

1. Citizen engagement or community participation: In the early years, regionalization was explained or couched in terms of

⁹ Importantly, in most jurisdictions, private, not-for-profit hospitals under the auspices of religious organizations are not part of these new province-wide authorities.

¹⁰ This table draws heavily on two recent reports on trends to concentrate or de-regionalize governance of Canada's healthcare systems. See: Barker and Church (2016). Revisiting Health Regionalization in Canada: More Bark than Bite? International Journal of Health Services; and Bergevin et. al. (2016): Toward the Triple Aim of Better Health, Better Care and Better Value for Canadians: transforming regions into high performing health systems, Canadian Foundation for Healthcare Improvement.

¹¹ Barker, P. and J. Church (2016) Op. Cit.

"putting patients first" or "closer to home". For both economies of scale and political accountability reasons, recently there has been increased attention to the improved alignment of authorities and accountabilities, on a province-wide basis.

2. Service delivery and integration: The over-riding policy objective in 2017 is improving overall continuity of care under the banner of a "population health" approach. Province-wide Health Authorities (HAs) across Canada have responsibilities, from traditional "downstream" programs (in-patient/acute and outpatient care services), long term care and home/community services through to "upstream" programs, such as public health and health promotion.
3. Community-based Care and Cost containment: While mitigating cost increases has tended to be downplayed, we have in fact seen a "bending of the cost curve" when it comes to overall public-sector healthcare spending in Canada¹². Since 2010, the rate of growth in per capita health spending has barely kept pace with the rates of inflation and population growth combined. While hospitals still account for the largest share of overall spending (29.5%), this slice of the pie has decreased by about 25% since the 1990s, remaining stable since the early 2000s. It is experiencing its lowest rate

¹² See the recent report from the Canadian Institute of Health Information: https://www.cihi.ca/sites/default/files/document/nhex-trends-narrative-report_2016_en.pdf

of growth since the late 1990s, reflecting the restraints of provincial and Territorial budgets.

Other factors driving the need for reform include technology and demography. For example, the advent of *Dr. Google* has created a new, more informed and demanding pool of patients. Conjoint decision-making is increasingly the norm. While the costs of many technologies are increasing, they have also helped hospitals cope with increased demands, through fixed resources (e.g. drug reconciliations, digital radiology and better discharge planning).

In terms of demography, while Canada still has a relatively young population, it is aging rapidly. For the first time, Canadian seniors (65+) now outnumber those under the age of 15. As the baby boomers grow older, hospitals need to improve the integration of home and institutional care, informal and formal care, offering patients better assistance in navigating the system. More resources and attention are now being directed to chronic, long term care while streamlining acute care hospital services¹³.

Demographics is also taking a toll on the health workforce, with estimates as high as 50% of hospital workers retiring by 2030. As Dickson and Tholl (2016)¹⁴ found, one of the biggest challenges is a growing leadership gap, partly due to the aging workforce:

"The challenge of creating large-scale change requires levels of systems thinking, strategic thinking, relationship development and self-leadership that supersede the current capacity of many formal leaders".

This echoes earlier findings by the Health Council of Canada, that leadership is the most important enabling factor in successful health reforms, and by the Council of the Federation, which found that "present leadership" was essential in terms of effectively scaling and spreading healthcare innovations across Canada¹⁵.

Looking ahead. Given the significant changes in regionalization and a renewed focus on the economics of healthcare services, the world-wide symbol of the blue "H" and its role across the continuum of care is being redefined across Canada.

There are at least three recent policy initiatives at the national level that have yet to play out in Canada's healthcare system. The *first* is the recent agreement between the federal government and the provinces/territories, under the banner of a new health accord¹⁶. The new 10-year agreement provides for an additional \$11 billion and signals a more activist federal health agenda¹⁷. This is over and above annual increases under the Canada Health Transfer (\$38 Billion/year), which will continue to grow at a minimum of three percent per annum, or the three-year moving average of GDP (whichever is greater). These additional amounts are targeted on two shared high priorities for the Canadian healthcare system: mental health (\$5 billion over 10 years) and home care (\$6 billion over 10 years). These are two areas where Canada has traditionally lagged behind other industrialized countries. Current federal/provincial/territorial discussions revolve around reaching agreement on the metrics of success in investing in these two

strategic areas.

The *second* federal initiative is aimed at reducing the health gap between and among Canada's Indigenous peoples. The federal government remains constitutionally responsible for providing for the health and social service needs of Canada's First Nations, Inuit and Metis. This is a segment of our population that is recording the fastest rate of population growth. Sadly, the life expectancy of this segment of our population is approximately ten years shorter than the average Canadian, while infant and maternal mortality rates are 3-5 times higher than the Canadian average. In the last federal budget, an unprecedented commitment of \$825 million over five years was allocated to start working differently with Indigenous leaders. Another unprecedented move consists of the federal government's split of the former department of Indigenous and Northern Affairs into two departments, with the former Minister of Health now serving as the new Minister of Indigenous Services¹⁸. The intent here is to work with the indigenous leaders to improve federal health and social support services integration, under arrangements that provide for increased autonomy and clearer lines of "by first nations, for first nations" authority and accountability¹⁹.

Finally, the new federal Minister of Health, The Honourable Ginette Petitpas Taylor, announced in October 2017 an *External Review of Federally Funded Pan-Canadian Health Organizations*²⁰. This review has been expected for some time and covers all eight such organizations that have evolved over the past twenty years²¹. Its premise is that improving the responsiveness and sustainability of Canada's healthcare system requires *strong national leadership* and greater pan-Canadian collaboration. The overall mandate of the review is to "ensure the role and structure of the Pan-Canadian Health Organizations is optimized to maximize the reach and impact of federal investments in these (eight) organizations."

Conclusions. Canada's health system is undergoing unprecedented changes in terms of governance structures and administrative processes. What do these changes mean for Canadian "hospitals", health authorities and other institutional care providers? The de-regionalization of provincial/territorial health systems is still ongoing, but it has already resulted in significant governance changes, locally and nationally. There is an increased preoccupation over the improved alignment of authorities and accountabilities in the system. Most provinces have concentrated authorities and accountabilities under health authorities, under the auspices of appointed Boards. Operational responsibilities are increasingly being vested with "zones". Hospital services are increasingly being provided on an outpatient basis, with a focus on decreasing lengths of stay. There is also a country-wide focus on reducing the number of Alternate Level of Care (ALC) Patients, with increased investments in integrated homecare programs.

Nationally, these changes are what helped trigger the merger of two longstanding national organizations as the voice of hospitals to merge to create HealthCareCAN in 2014²². Our traditional advocacy

13 Government of Canada (2017) News Release: Government of Canada implements new legislative changes to the Citizenship Act

14 Dickson, G and Bill Tholl (2014) Cross Case Analysis Final Report: Canadian Health Leadership Network: <http://chlnet.ca/wp-content/uploads/PHSI-Cross-Case-Analysis-Report-2014.pdf>

15 Council of the Federation (2012) From Innovation to Action: First Report of the Health Care Innovation Working Group. 28 p.

16 See: New 2017 Health Agreement https://www.canada.ca/en/health-canada/news/2017/08/canada_and_manitobareachagreementontargetedhealthfunding.html

17 This follows a period going back to 2006 where the previous federal government took a more laissez faire approach to health policy, deferring to provincial program administration with little or no accountability for federal funding increases that were locked in at 6% growth per year.

18 See August 2017 announcement: <http://pm.gc.ca/eng/news/2017/08/28/statement-prime-minister-canada-changes-ministry>

19 The former Minister of INAC (The Honourable Carolyn Bennett) will now form a new ministry responsible for Crown-Indigenous Relations and Northern Affairs

20 Health Canada: See Link: <https://www.canada.ca/en/health-canada/programs/external-advisory-body-pan-canadian-health-organizations.html>

21 They are: Canadian Institute of Health Information; Canadian Patient Safety Institute; Mental Health Commission of Canada; Canadian Foundation for Healthcare Improvement; Canadian Partnership Against Cancer; Canadian Centre on Substance Use and Addiction; Canadian Agency for Drugs and Technologies in Health; and Canada Health Infoway.

22 HealthCareCAN is the result of a merger between the former Canadian Healthcare Association (CHA) and the Association of Canadian Academic HealthCare Organizations (ACAHO). For a detailed description of the merger and the mandate of HealthCareCAN see: see HCC website at www.healthcarecan.ca.

and representation roles have evolved. More attention has come to focus on what the federal government can or should do directly at a pan-Canadian level, to help provinces and territories respond to demographic, economic and technological pressures on the health system. More advocacy is also now focused on the federal government's direct responsibilities in areas such as health information, infrastructure, public health and safety, health research and indigenous health. More attention is now focussed on helping HealthCareCAN members lead change and provide required professional training and development opportunities for staff through *CHA Learning*.

In an ongoing effort to demonstrate value and make a concrete difference, HealthCareCAN has developed a new, more representative governance structure and a new strategic plan that repositions itself as the *one voice* of the institutional community across Canada, speaking out on shared issues and concerns. Given our limited resources, this has also meant reaching out to other national organizations to form issue-specific and (often) time-limited coalitions to address issues such as antimicrobial resistance, the opioid crisis and cybersecurity: issues that know no provincial/territorial boundaries.

Many of our priority issues, such as cybersecurity and antimicrobial resistance, transcend international boundaries, underscoring the importance of continuing to work with the International Hospital Federation and our sister organizations such as the American Hospital Association. We welcome this ongoing dialogue and the sharing of information and strategies to deal with the evolving role of hospitals around the globe.

Biographies

Bill Tholl currently serves as senior consultant in health policy and leadership development. Until July 2017 he served as the Founding President and CEO of HealthCareCAN: the voice of Canada's health care organizations and hospitals. Prior to his appointment in March 2014, Bill served as Founding Executive Director of the Canadian Health Leadership Network (2009-2014); CEO and Secretary General, Canadian Medical Association (2001-2008), and CEO of the Heart and Stroke Foundation of Canada (1995-2001).

The Globe and Mail has described Bill as "Medicare's Mr. Fix-it". He is a sought-after speaker, being billed recently by CHLNet as a "leader of leaders" on the Canadian health scene.

He holds a graduate degree in health economics (from University of Manitoba) and has written on many topics, most recently as the lead author of "Twenty Tips for Surviving and Thriving in the Association World" (CSAE 2010) and is co-author of "Bringing Leadership to Life in Health" (Springer, January 2014). He is the recipient of numerous national awards and is a Certified Corporate Director (ICD.D).

Born and raised in Saskatchewan, Bill and his wife, Paula, live in Ottawa and have three children and three grandchildren.

Paul-Émile Cloutier was appointed President and CEO of HealthCareCAN, on June 12, 2017.

Before coming to HealthCareCAN, Paul-Émile Cloutier was Vice-President of Advocacy and External Relations of Genome Canada, where he was responsible for managing government and stakeholder relations, communications, events and sponsorships.

Prior to that, he spent 11 years at the Canadian Medical Association, initially as Assistant Secretary General, and then as

CEO and Secretary General responsible for strategic planning, stakeholder relations and alliances, as well as overseeing the policy direction of the Association.

Mr. Cloutier also worked as a senior executive at VIA Rail Canada and for the Ontario Minister of Intergovernmental Affairs. He has held a number of policy and strategic direction positions in the federal departments of Immigration Canada, External Relations and International Development, and Indigenous and Northern Affairs, where he honed an excellent understanding of the federal-provincial dynamic.

A Montreal native, Mr. Cloutier is fully bilingual and holds two master's degrees (Health Administration and Political Science) and two bachelor degrees (Social Sciences and Political Science) from the University of Ottawa, where he has also been a lecturer in Political Science.

Over the years, Paul-Émile has been an active member in the community and served on a number of Boards, including his current role on the Kemptville District Hospital Board.

References

1. Government of Canada. 2017. *Canada Health Act Annual Report to Parliament*, by Health Canada. Annual report, Ottawa.
2. Commonwealth Fund. 2017. *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care*, by Eric C. Schneider, Dana O. Sarnak, David Squires, Arnav Shah, and Michelle M. Doty. Report, Washington, D.C.
3. Organization for Economic Cooperation, June 2017. See link accessed Oct 5, 2017: http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_STAT
4. Kitts, Jennifer and Alike Lafontaine, 2016. "Truth and Reconciliation Commission of Canada: Health Related Recommendations." Issue brief. HealthCareCAN link: <http://www.healthcarecan.ca/resources/issue-briefs/>
5. Barker, Paul.M. and John Church, 2016. "Revisiting Health Regionalization in Canada: More Bark than Bite?" *International Journal of Health Services*, 47 (2): 333-351.
6. Dickson, Graham and Bill Tholl (2014) *Partnerships for Health System Improvement Leadership and Health System Redesign: Cross-Case Analysis (Final Report)*. Canadian Institutes of Health Research, Canada.
7. Health Council of Canada. 2013. *Better Health, Better Care, Better Value for All: Refocusing Health Care Reform in Canada*, Report, Canada.
8. Canadian Foundation for Healthcare Improvement. 2016. *Toward the Triple Aim of Better Health, Better Care and Better Value for Canadians: transforming regions into high performing health systems*, by Yves Bergevin et al. Study, Canada
9. Canadian Institute for Health Information. 2017. *National Health Expenditure Trends, 1975 to 2016*. Report, Canada.
10. Council of the Federation, 2012. *From Innovation to Action*, First Report of the Health Care Innovation Working Group, Canada.
11. Government of Canada, 2017. *New 2017 Health Agreement*. News release. https://www.canada.ca/en/health-canada/news/2017/08/canada_and_manitobareachagreementontargetedhealthfunding.html

Population health management

A Canadian Perspective on the Future of Health Systems



BRIAN N. JOBSE, PHD
MEDICAL SCIENTIST AND HEALTH POLICY
ANALYST
CANADIAN MEDICAL ASSOCIATION
OTTAWA (ON), CANADA



OWEN ADAMS, PHD
CHIEF POLICY ADVISOR
CANADIAN MEDICAL ASSOCIATION
OTTAWA (ON), CANADA



ISRA LEVY, MBBCH, MSC, FRCPC, FACPM
VICE-PRESIDENT OF MEDICAL AFFAIRS AND
INNOVATION
CANADIAN BLOOD SERVICES
OTTAWA (ON), CANADA

ABSTRACT: Internationally, two trends in healthcare are becoming increasingly well established. One is the growing recognition that healthcare is just one determinant of health status. Prevention and health promotion have a large role to play by affecting the social determinants of health and the sectors that represent them. The second trend is experimentation with approaches to systems funding that increasingly aim to share risk and benefits between funders and providers. Together, these trends form the impetus for what is becoming known as population health management (PHM). Canada has been a pioneer in developing the concepts, but international experience suggests that it has been a laggard in their implementation. In moving forward, critical success factors for Canada include health information management, multisectoral collaboration, and clinical leadership.

*This paper was previously published in the Canadian Journal of Physician Leadership 2014;4(1):8-15

KEY WORDS: determinants of health, healthcare system funding, health information management, multisectoral collaboration, clinical leadership, system integration.

A Canadian perspective

A large majority of Canadians continue to see healthcare improvement as a primary concern for government. Escalating costs, at least partly attributable to an aging population and a greater burden of chronic disease, demonstrate the need for change, but policymakers struggle to introduce effective innovation. Where should we turn to for inspiration? The healthcare system is obviously an important input with regard to individual health, but the 2009 Canadian Senate Subcommittee on Population Health Final Report highlights that 75% of health is attributable to other determinants. Long before this report, Canadians were playing a large role in the development of this line of social inquiry, yet the implementation of public health measures and the integration of these concepts into healthcare has been limited.

Understanding and accepting the social determinants of health in a society is an area in which Canadians have had an important impact, in terms of the development of population health models. Key to this work is acceptance of the 1946 World Health Organization constitutional statement that “Health is a state of complete physical, mental and social well-being and not

merely the absence of disease or infirmity.”

The record of the Canadian perspective and input begins with the Lalonde Report of 1974 entitled “A new perspective on the health of Canadians,” which described the factors of health as human biology, lifestyle, the organization of healthcare, and the social and physical environments in which people live. The upstream determinants of health and health promotion impacting tools for these determinants, were central themes.

The Epp Report of 1986, entitled “Achieving health for all,” continued in this vein by highlighting preventable disease, stress and chronic conditions as major challenges to health. This report also emphasized the importance of social support from both government and community, as well as coordinated healthy public policy.

The influence of the Lalonde and Epp reports is palpable in World Organisation documents, including the 1986 Ottawa Charter for Health Promotion and the 2010 Adelaide Statement on Health in all Policies.

Further elaboration on the Lalonde framework was provided in 1990. In “Producing health, consuming healthcare,” Evans and Stoddart advanced the Lalonde model to describe the interaction between social, environmental, and biological elements of health, their relation to general health and ultimately, the overall well-being of an individual. The authors effectively positioned healthcare alongside associated costs, within the

social feedback cycles that describe our society.

If Canadians were at the forefront in building these foundational ideas, why haven't they been implemented more effectively in the decades since? Although the Public Health Agency of Canada currently provides a framework for a population health management (PHM)-style approach, there is little evidence of an implementation strategy. Increased provincial reliance on regional health authorities is an example of the shift towards the management of geographically defined populations, a stance that reflects a core consideration of PHM approaches. However, there seems to be little acknowledgement of PHM as an option in Canadian health systems. A universal access-based system should surely favour the adoption of methods to impact health social determinants, so why is PHM currently a foreign concept, best exemplified south of the border?

The second is sharing risk between the funder and provider by agreeing to share savings or losses, depending on whether care is provided at a return or loss, with regard to some predetermined benchmark (e.g., growth rate in the previous year's costs).

Integrated delivery systems

Integrated delivery systems typify risk-sharing behaviour and have evolved over the last few decades. A number of US healthcare providers neatly illustrate this model; perhaps the best example is Kaiser Permanente, which boasts operating revenues and a served population not dissimilar to those of the Ontario Ministry of Health and Long-Term Care. This healthcare provider was founded on the experience that charging individuals a flat yearly rate for healthcare services reduces financial barriers to care and leads to increased use of health interventions, limiting the scope and cost of long-term morbidities. Population health information thus became a great commodity in a competitive market, as resource development could be directed toward limiting upstream negative determinants.

Associated providers, generally led by physicians, are incentivized by capitated budgets and shared savings arrangements, to create efficiency and reinforce population well-being. In turn, this encourages continued service use as a result of greater user satisfaction. This model also encourages the rapid integration of new technologies and concepts to improve efficiency and user experience. Today, the assorted entities that make up the Kaiser Permanente

(working cooperatively) have created a single integrated electronic record system, with online access for users. As such, population health data are readily available to inform best practices, identify problems, and shape tailored solutions.

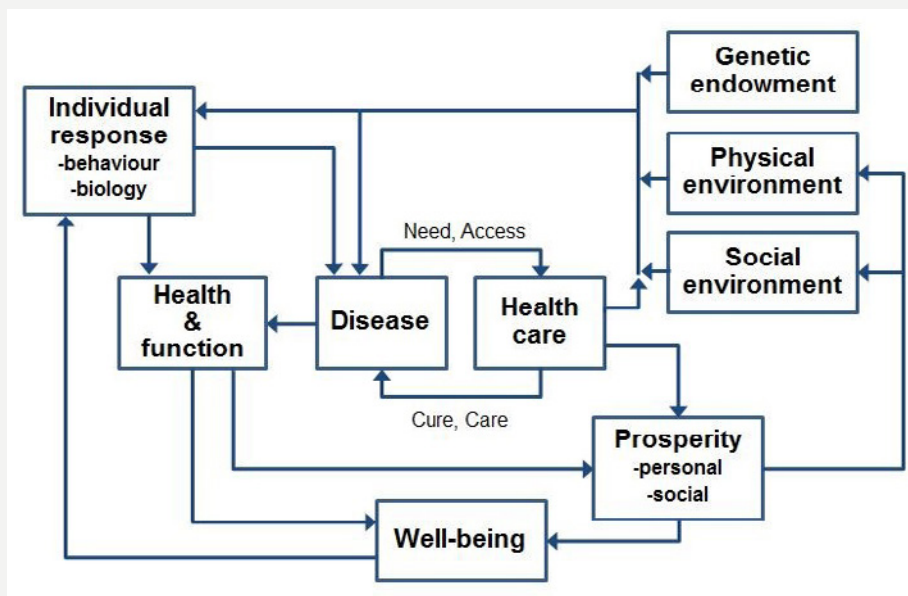
Glossary

Public health – “Public health is the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society.” (Acheson, 1988)

Population health – “The health outcomes of a group of individuals, including the distribution of such outcomes within the group.” (Kindig and Stoddart, 2003) (Generally taken to refer to a geographic population.)

Population health management – The application of population health concepts and measurements in reference to specific patient populations. (Kindig, 2015)

FIGURE 1. THE EVANS-STODDART POPULATION HEALTH FRAMEWORK.



Source: Adapted from Evans and Stoddart (Figures 1 and 5).

Defining population health management

PHM can be narrowly interpreted as the use of patient-level socioeconomic and geographic data to direct health resources and assess key population-level outcome indicators, such as life expectancy. Ideally, PHM is a strategy whereby population health status is improved by accounting for multiple determinants. Again, the current healthcare system is an important but relatively small contributor to life-long health.

As an approach to health system integration and improvement, PHM is arguably the contemporary extension of population health concepts that were shaped in Canada, but are rapidly being adopted elsewhere, especially in the United States

Risk sharing

There are two dimensions to provider risk sharing. The first is managing risk by contracting, to provide all necessary care for an individual, at a fixed rate of payment for a specified time.

Population health approach – An approach “that aims to improve the health of the entire population and to reduce health inequities among population groups.” (Public Health Agency of Canada, 2012)

Social determinants of health – The conditions in which people are born, grow up, live, work, and age, and the systems put in place to deal with illness. (Commission on the Social Determinants of Health, 2008)

Emergence of accountable care organizations

The Triple Aim framework, developed by Berwick, Nolan, and Whittington with the Institute for Healthcare Improvement (IHI) in 2008, succinctly describes the core concepts of PHM as they relate to service providers: improving the experience and quality of care, improving the health of populations, and reducing the per capita cost of healthcare. The proliferation of accountable care organizations (ACOs) in the US also falls into this time frame, following the *Patient Protection and Affordable Care Act* of 2010, which proved to be a major driver for PHM implementation. This legislation established a shared savings plan for the Medicare program, rewarding ACOs that are able to lower their growth in healthcare costs while meeting specified quality standards. ACOs can accept either one-sided (shared savings) or two-sided (shared savings or losses) risk-sharing models.

Overall, ACOs have experienced early success in improving quality of care and most of the original participant organizations have opted to continue under ACO frameworks. It should also be noted that the track record for cost savings is much less conclusive. Several of the obvious issues may not apply to the Canadian context, but it is becoming clear that appropriate incentivization for various aspects of healthcare provision are necessary to engender success. There is growing international interest in ACOs. For example, the English National Health Service has put forward an incentive framework for ACOs in new care models.

It is also becoming apparent that physician and clinical leadership have a very large role to play in the success of PHM approaches to healthcare. Physician involvement in redesigning health systems and overcoming resistance to change, both financial and procedural, is undoubtedly an important facet of the successful transition to a new paradigm. As evidenced by ACOs, the growing trend of risk sharing between funders and care providers is likely key to creating momentum towards the goal of healthcare improvement.

Limited Canadian exploration

Of relevance to this discussion are the projects supported by the Canadian Foundation for Healthcare Improvement indicating, in a similar fashion to the comparable examples south of the border, that switching to PHM is a complex realignment that requires concerted and sustained efforts along multiple social trajectories. Various other Canadian ventures into PHM approaches to solving various societal health concerns are detailed in a 2014 report from the Canadian Institute for Health Information. However, there is currently no large-scale (provincial) example of a fully integrated PHM-oriented healthcare network in Canada.

Critical factors for implementation

Instead of the generally accepted view that the healthcare system is the main mode of disease and illness treatment, the PHM paradigm integrates healthcare as one (albeit a pivotal) of several determinants of individual well-being and population health outcomes. As such, PHM frameworks require healthcare systems to engage with individuals and their communities, work with governments and population health agencies to intersect emerging issues, and develop multidisciplinary and inter-sectoral collaborations to provide higher care standards. The PHM approach acknowledges that relevant and timely information is critical to decision-making and therefore requires the measurement of outcomes at the population level, irrespective of population size.

Interest in PHM continues to develop, as evidenced by a broadening body of Canadian academic literature revolving around the social determinants of health and aimed at policymakers. The chaotic state of the diverse terminology and confusion regarding roles and responsibilities requires delineation of what is likely necessary to achieve successful implementation in a large-scale context, such as within an entire provincial healthcare system. Therefore the three following concepts are critical in determining the successful establishment of PHM in Canada. Similar to the IHI's Triple Aim, all three facets are contingent on one another, helping to explain why progress in this area has been slow, devoid of a concerted effort by policymakers, population health agencies, and the medical community.

Information management

Health data is integral to care delivery, research, and policymaking. Electronic health records are currently in varying states of implementation across Canada and despite steady progress in adoption, there is limited records integration across healthcare environments.

A single, compulsory set of standards for all health-related services allows any provider to quickly understand patients' history and needs and communicate treatment options and other lifestyle recommendations more effectively. With regard to population health, an integrated health records system allows for the necessary research to assess population outcomes, appropriately uses of limited resources, and stakeholder mobilisation.

Patient engagement is also served by the accessibility of a system-wide electronic platform. Not only can this platform serve as an educational repository and a source of public health information, but it can also enable the online provision of services, especially where access to appropriate expertise is an issue. Citizen engagement in the healthcare system should not be underestimated, as it has the potential to affect change in a broader, societal sense. Information management is a key factor in this endeavour, empowering patients by enabling greater access to necessary tools and understanding for them to have an impact on health.

Multisectoral collaboration

In a broader, societal sense, cooperation between governments, public health agencies, the health system, and many other stakeholders is necessary to facilitate any PHM-style approach. Collaboration with social services and education sectors are evident connections, but other sectors that could

affect long-term health trends include agriculture, transportation, and land use, to name but a few. Governments should aim to facilitate knowledge-sharing between all levels and districts, especially between public health and health sectors.

The 2009 final report of the Senate Subcommittee on Population Health positions the necessary outlook as a “whole-of-government” approach, with direct involvement of the Prime Minister in a Cabinet committee overseeing participation of various departments and agencies encompassing education, finance, employment, health, and the environment. The framework for incentivization of PHM approaches will also be an evolving issue to be negotiated among healthcare professionals, stakeholders, and policymakers. Medical leadership will be vital to this process, as the funding formulas for various services and regions will require different solutions that speak to both the professional performance of healthcare providers and the implementation of public-health-derived measures of success.

From the standpoint of cooperation within and between health sectors, PHM methodology requires an individualized, patient-focused standard that aims to address health concerns through integrative needs assessment and delivery. As such, the onus is on primary care to ensure that individuals receive support, resources and referrals to a broader range of services than is traditionally available.

This, in turn, relies on cooperation outside the primary care setting to ensure integrated delivery. Outreach and collaboration require local relationship building to successfully affect upstream determinants of health, thereby reducing costs related to chronic and complex diseases.

Examples of this kind of outreach are becoming more common, with work by Minnesota-based HealthPartners standing out as an early effort to create sustained partnerships between healthcare, education, non-profits, and government, by adopting a community business model.

Clinical leadership

A critical point in the development of PHM is that medical practitioners need a greater voice in their areas of expertise and that those areas represent a dynamic, shifting landscape of problems, needs and solutions. “Chief population health officer” is an emerging position in the US, in response to the proficiency essential for designing and implementing population health strategies. This position is often integrated into clinical executive bodies and is likely vital to creating an environment that facilitates sustained progress.

From a ground-level standpoint however, clinicians are ultimately in the best position to make changes reflecting both increased quality of patient care and efficiency within their practices. The current CanMEDS competency framework from the Royal College of Physicians and Surgeons of Canada addresses many concepts required for undertaking this endeavour. Within the Leader role, the stewardship of healthcare resources is a key competency engagement. Within the Health Advocate role, an enabling competency indicates that physicians should improve clinical practice by applying a process of continuous quality improvement to disease prevention, health promotion, and health surveillance activities.

The need for clinical leadership also extends beyond particular

areas of expertise and into the broader policymaking environment. There is no doubt that the experience and drive exists for this venture in the Canadian context. Enabling leadership on both provincial and national stages is primarily an issue of building appropriate venues and opportunities to allow the medical community to truly take part in the restructuring of healthcare systems. Unifying the profession behind shared values of conduct as well as a modern ethical framework is a first step towards providing the landscape for clinical leadership. As new and old medical associations take on greater roles in health advocacy, members will need to be more willing to participate in forums establishing direction and policy positions.

Implications for physicians

Without the ability to prioritize patient health and population health concurrently, real positive progress within the Canadian health system will continue to be elusive. Dynamic situations, such as the modern health system, require communication, a willingness to implement new ideas, disruptive innovation, and the perspective that no one framework is infinitely applicable. Consensus and commitment to a strategic direction will ultimately shape the effectuality of implementation.

The foregoing suggests three key implications for physicians and medical organizations in engaging in PHM approaches. First, physicians can get involved in reform and transformation initiatives. Second, physicians can play a key role in establishing intersectoral collaboration and partnerships, both through their workplaces and through the medical associations to which they belong. Finally, physicians need to facilitate the development of timely, population-based data systems integrating individual clinical records, indicators of the social determinants of health, and information from other parts of the health and social services delivery system.

Conclusion

Canada has been a leader in the development of the population health perspective, raising awareness on the impact of lifestyle on well-being as well as the multiple determinants of health. There is a growing interest in PHM for all of the previously described reasons. Examples and comparisons required to conceptualize an approach of this style in the Canadian context have been detailed, and the framework for application within the Canadian health system continues to develop. It is also noteworthy that Accreditation Canada has introduced standards for population health and wellness.

In realigning the delivery of healthcare, emphasis on improvement in health outcomes may be what is needed in Canada, as both the driving impetus for change and the evaluation tool to make change possible. However incentivization is conceived, the US experience would suggest that a focus on outcomes, with risk-benefit sharing of costs, will be necessary to decrease the rates of preventable disease and health system use, ultimately reducing costs and increasing prosperity. Health really does matter for the well-being of society and the economic outlook of the future, however, to improve the health of Canadians beyond what has been achieved to date, there is a need to look past today's work in managing costs, with a shift towards the long-term benefits of understanding true population health status outcomes.

Biographies

Brian Jobse, PhD, is a biomedical scientist and health policy analyst, working with the Canadian Medical Association while pursuing a master's degree in public policy at Carleton University, Ottawa.

Isra Levy is a medical epidemiologist with experience in population health assessment and health system planning. He is currently the Medical Officer of Health in the City of Ottawa and was formerly the Director of Health Programs at the Canadian Medical Association and Medical Officer of Health in Ottawa.

Owen Adams is Chief Policy Advisor at the Canadian Medical Association (CMA), based in Ottawa, Ontario. Since joining the CMA in 1990 he has contributed to the association's research and policy development in areas such as physician human resources, health system financing and health reform.

References

Acheson D. 1988. *Public health in England: the Report of the Committee of Inquiry into the Future Development of the Public Health Function*. London: Her Majesty's Stationery Office.

Accreditation Canada. 2017. *Population health and wellness*. Ottawa.

Berwick D, T Nolan and J Whittington. "The Triple Aim: Care, Health, and Cost." *Health Affairs (Millwood)* 27 (3): 759-69.

Blackstone E. and J. Fuhr Jr. 2016. "The Economics of Medicare Accountable Care Organizations." *American Health and Drug Benefits* 9 (1): 11-9.

Buckley J., A. Bernard, E. Gruenewoldt, C. Bensimon C and J. Blackmer. 2017. "Medical Professionalism and Physician Leadership: the Time for Action is Now." *Canadian Journal of Physician Leadership* 3 (5): 85-90. <https://tinyurl.com/mp3pd12>.

Canada, The Standing Senate Committee on Social Affairs, Science and Technology. 2009. *Healthy, Productive Canada: a Determinant of Health Approach*, by Wilbert Joseph Keon and Lucie Pépin. Final Report of Senate Subcommittee on Population Health, Ottawa.

Canada Health Infoway. 2016. *A Conversation About Digital Health: Annual Report 2015-2016*. Toronto.

Chang F. and N. Gupta. 2015. "Progress in Electronic Medical Record Adoption in Canada." *Canadian Family Physician* 61 (12): 1076-84.

Centers for Medicare & Medicaid Services. 2016. "Accountable Care Organizations: What Providers Need to Know." Baltimore, MD.

Commission on the Social Determinants of Health. 2008. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva: World Health Organization.

Cohen D, T. Huynh, A. Sebold, J. Harvey, C. Neudorf, A. Brown. 2014. "The Population Health Approach: a Qualitative Study of Conceptual and Operational Definitions for Leaders in Canadian Healthcare." *SAGE Open Medicine*. 2:2050312114522618

Colla C., V. Lewis, S. Shortell and E. Fisher. 2014. "First National Survey of ACOs Finds that Physicians are Playing Strong Leadership and Ownership Roles." *Health Affairs (Millwood)* 33 (6): 964-71.

Epp J. 1986. *Achieving Health for All: a Framework for Health Promotion*. Ottawa: Health and Welfare Canada.

Evans R. and Stoddart G. 1990. "Producing Health, Consuming Healthcare." *Social Science & Medicine* 31 (12): 1347-63.

Farmanova E., C. Kirvan, J. Verma, G. Mukerji, N. Akunov, K.

Phillips et al. 2016. "Triple Aim in Canada: Developing Capacity to Lead to Better Health, Care and Cost." In *International Journal for Quality in Healthcare* 28 (6), ed. Frank J., L. Snell and L. Sherbino J, 830-837. ISQua

CANMEDS 2015 *Physician Competency Framework*. Ottawa: Royal College of Physicians and Surgeons of Canada.

Huynh T. 2014. *Population Health and Healthcare: Exploring a Population Health Approach in Health System Planning and Decision-Making*. Ottawa: Canadian Institute for Health Information.

Huynh T., G. Baker, A. Bierman, D. Klein, D. Rudoler, G. Sharpe et al. 2014. *Exploring Accountable Care in Canada: Integrating Financial and Quality Incentives for Physicians and Hospitals*. Ottawa: Canadian Foundation for Healthcare Improvement.

Ipsos Canada. 2017. "Priorities, Values, and Leadership: Canadian Public Opinion." Toronto.

Isham G., D. Zimmerman, D. Kindig, G. Hornseth. 2013. "HealthPartners Adopts Community Business Model to Deepen Focus on Nonclinical Factors of Health Outcomes." *Health Affairs (Millwood)* 32 (8): 1446-52.

Kindig D. 2015. "What are we talking about when we talk about population health?" Bethesda, Md.: Health Affairs Blog. <https://tinyurl.com/y8p3zn5t>.

Kindig D. and G. Stoddart. 2003. "What is population health?" *American Journal of Public Health* 93 (3): 380-3.

Lalonde M. 1974. *A New Perspective on the Health of Canadians: a Working Document*. Ottawa: Government of Canada.

Law M., A. Kapur and N. Collishaw. 2004. *Health Promotion in Canada, 1974-2004: Lessons Learned*. Ottawa: Canadian Medical Association.

Lucyk K. and L. McLaren. 2017 "Taking Stock of the Social Determinants of Health: a Scoping Review." *PLoS One* 12 (5): e0177306.

Neudorf C. 2012. "Integrating a Population Health Approach into Healthcare Service Delivery and Decision Making." *Healthc Manage Forum* 25 (3): 155-9.

NHS England. 2017. *The Incentives Framework for ACOs*. Supporting document, England

Punke H. 2014. "Health System C-suiters, Meet the Chief Population Health Officer." *Becker's Hospital Review* March. 14. Available: <https://tinyurl.com/y725upek>

Public Health Agency of Canada. 2012. "What is the population health approach?". Ottawa. <https://tinyurl.com/y7s2cwux>.

Townsend M. 2014. *Learning from Kaiser Permanente: Integrated Systems and Healthcare Improvement in Canada*. Ottawa: Canadian Foundation for Healthcare Improvement. Report.

Van Aerde J. and G. Dickson. 2017. "Accepting our Responsibility: a Blueprint for Physician Leadership in Transforming Canada's Healthcare System (white paper)." Ottawa: Canadian Society of Physician Leaders.

Wise A. 2017. *A Health Outcomes Fund for Canada: How Paying for Outcomes Could Improve Health and Deliver Better Value for Money*. Toronto: MaRS Centre for Impact Investing.

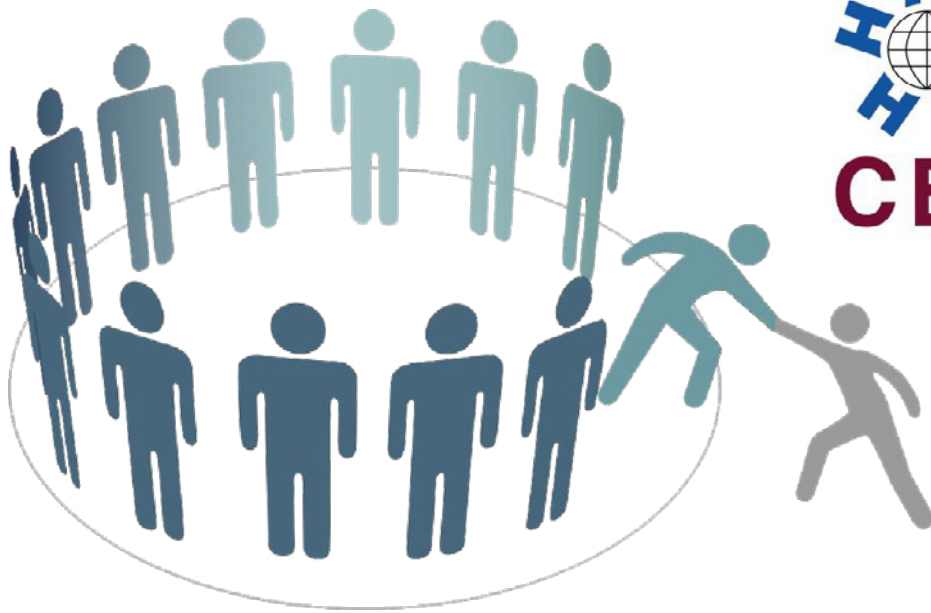
World Health Organization. 1946. "Preamble to the Constitution of WHO as Adopted by the International Health Conference, New York, 19-22 June, 1946". Geneva.

World Health Organization. 1986. *Ottawa Charter for Health Promotion*. Geneva.

World Health Organization and Government of South Australia. 2010. *Adelaide Statement on Health in All Policies*. Geneva.

Correspondence to: owen.adams@cma.ca

This article has been peer reviewed.



JOIN AN EXCLUSIVE NETWORK OF CEOs OF HEALTHCARE ORGANISATIONS

A world-class opportunity for leadership development, peer interaction and information exchange

What will you get?

Participation to **Global Collaboratives** on relevant and **challenging topics**, including webinars and white papers

Share your knowledge and good practices **with your peers** across the world

Unique **networking opportunities** with world-renowned **healthcare leaders**

CONTACT US NOW

To join the IHF CEO Circle contact the IHF Secretariat (ihf.secretariat@ihf-fih.org or +41 (0) 22 850 94 20).
For further information, visit us at the IHF Website (<https://www.ihf-fih.org/activities?type=ceo-circle>)

Empowering Nurses in Canada to Deliver Better Care, Better Health and Better Value



CAROLYN E. PULLEN RN, PHD
CHIEF, PROGRAMS AND POLICY
CANADIAN NURSES ASSOCIATION
OTTAWA (ON), CANADA

ABSTRACT: The Canadian population is aging and the prevalence of chronic disease and health and social inequities is on the rise. While the challenges posed to our health and health delivery systems are formidable, Canada has excellent resources that can be tapped to support system-level change. Our large, highly-educated and skilled nursing workforce is part of the solution to bringing about system transformation and achieving better care, better health and better value for our public healthcare investments. Through a range of efforts by stakeholders at all levels, nurses are increasingly empowered to contribute to health system improvements. Recent examples include enabling prescribing by registered nurses, promoting advanced nursing practice, and modernizing federal legislation to enable nurses to practice to full scope.

Introduction.

Population health in Canada can be characterized as experiencing aging of the population, an increase in the prevalence of chronic disease, and a range of persistent health and social inequities. These and other factors are driving health expenditures steadily upward (Canadian Institute for Health Information (CIHI), 2017). As the proportion of our healthcare funding that flows to hospitals, drugs and doctors edges toward unsustainable, we know we must do more to shift direction toward prevention, primary care and integrated care.

While our challenges are formidable, Canada has excellent resources that can be tapped to support system-level change. Our highly-educated and skilled nursing workforce is part of the solution. The largest health workforce in Canada, in 2016 there were 421,093 regulated nurses, consisting of 298,743 registered nurses and nurse practitioners, 116,491 licensed practical nurses and 5,859 registered psychiatric nurses eligible to practise (CIHI, 2017a). As discussed in detail in a call to action from a 2012 National Expert Commission (Canadian Nurses Association, 2012), optimizing the role of nurses is a key to health system transformation and achieving better care, better health and better healthcare value (Institute for Healthcare Improvement, 2013).

Through collaboration between stakeholders including the national and provincial nursing associations, regulators, schools of nursing, governments, employers, unions and nurse leaders, many strides have been taken to enable the nursing profession to expand impact. Recent examples of transformational change include enabling prescribing by registered nurses, promoting advanced nursing practice, and modernizing federal legislation to enable nurses to practice to full scope.

Registered Nurse Prescribing in Canada

Canada's aging population and a surge in chronic disease

contribute to growing wait times for access to primary care. Recognizing that some unnecessary barriers to timely access to primary care and management of chronic disease could be addressed through RN prescribing for common medications and routine tests, Canada began to explore this potential. Along with innovative health service redesign, RN prescribing can offer more client-centred, efficient, personalised care and improve care coordination (Ball, 2009; Bhanbhro et. al., 2011).

In Canada, among nursing bodies and policy makers, the conversation about the potential for RN prescribing began in earnest in 2009 as the international literature on the subject began to build. In light of research evidence indicating RN prescribing can improve access to care and medication compliance, in 2012, the National Expert Commission report (CNA, 2012) voiced RN prescribing as a promising policy direction, calling for an expanded scope of practice for RNs in Canada. By 2013, a range of tools on RN prescribing had been developed and released (CNA, 2013, 2014).

Despite clear potential benefits, there are legal and political considerations related to RN prescribing. Without doubt, it is imperative for eligible RNs to have the education, skills and supports to perform this advanced function. Further, implementing this form of advanced practice is challenging due to Canada's complex federated governance model where provinces and territories are responsible for delivering health care, and frequently regulatory and funding policies differ across jurisdictions. There is also a threat to the traditional distribution of power in healthcare whereby physicians have historically been the sole prescribers and, in some cases, have opposed prescribing by other health professionals.

In consideration of the opportunities and barriers, with the aim of advancing RN prescribing in Canada, Canadian Nurses Association released the *National Nursing Framework on Registered Nurse Prescribing* (CNA, 2015) to promote consistency, credibility and public engagement to inform changes in policy and regulation as RN

prescribing progresses in Canada. This work references domestic experiences and the experiences of countries where RN prescribing has led to improvements in care (Jones, Edwards & While, 2011).

Today, RN prescribing is gaining momentum across Canada with legislation in place in three provinces, and with RN prescribing according to specified protocols either in place or under discussion in the balance of the provinces and territories (CNA, 2016).

Advanced Nursing Practice

Advanced nursing practice (ANP)¹ is correlated with improved health status, functional status, quality of life, and satisfaction with care. It can improve cost-effectiveness of care delivery and increase nurse job satisfaction and retention (Kaasalainen et. al., 2010). In Canada, national nursing bodies have championed scale and spread of advanced nursing practice through Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) roles.

Through concerted effort to promote ANP, and despite various economic and political barriers, steady progress has been made in developing and growing ANP roles. The convincing body of research showing measurable benefits of ANP has encouraged nurses to pursue advanced practice, and health service delivery organizations to create formal roles. As of 2017, NP numbers in Canada reached 4,832 (CIHI, 2017a). CNS data are not reported nationally, however as a proxy, more than 17,300 registered nurses have specialty certification in Canada in 2017 (CIHI), a standard usually maintained by those in CNS roles. These numbers of nurses in advanced practice continue to climb across Canada as awareness about the effectiveness and positive impact of ANP on patient outcomes and health system modernization gain traction among health system leaders.

Resources such as reports, recommendations, evaluations and action plans related to ANP have been compiled by a number of groups including the CNA. The CNA website offers recent key resources including *The Canadian Nurse Practitioner Initiative: A 10-Year Retrospective* (CNA, 2016) and position statements on the roles of both the *Clinical Nurse Specialist and the Nurse Practitioner* (CNA, 2017).

Of interest to readers may be a key moment in the advancement of NP practice in Canada that occurred in 2017. Critical pieces of federal health legislation (Acts, policies, protocols) predate the protection of the NP title in Canada. As such, despite being educated, regulated and licensed to perform comprehensive primary care functions, NPs are not listed as eligible providers in dozens of pieces of federal legislation. As such, NPs have been unable to perform various primary care functions such as completing patient assessments for eligibility for various government health benefits.

A wide-sweeping federal-level advocacy campaign to modernize the relevant legislation to include NPs led to a watershed moment for ANP in Canada. The campaign, which was led by national nursing groups including the CNA and the Nurse Practitioner Association of Canada, involved engagement with federal-level parliamentarians, senior bureaucrats, and health professional groups to describe the problem and specify necessary changes required in federal

legislation. In June 2017, Bill C-44 (Government of Canada, 2017), the federal Budget Implementation Act, took an omnibus approach to modernizing the affected legislation, listing NPs as eligible providers to perform numerous types of health assessments and authorize various health and social benefits. This evolution in policy has opened the doors for the Provinces and Territories to similarly modernize legislation within their jurisdictions, which will further empower NPs to practice to their full scope and provide more comprehensive care to Canadians.

Medical Assistance in Dying

The 2015 Supreme Court of Canada decision in *Carter v. Canada* (Attorney General) and the passing of *Bill C-14, An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying)* (Government of Canada, 2016) signalled unprecedented changes in legal and social policy for choice on end-of-life decisions in Canada, and one cannot overstate the ethical, legal, social, cultural, and political aspects of this issue.

When this issue was launched into the public policy domain, national nursing organizations took a lead role in federal-level policy discussions to ensure Canadians seeking to exercise their charter rights around end of life choices had access to care. It was also critical to ensure nurses would be protected from prosecution under the Criminal Code, recognizing that nursing care in almost every setting may require nurses to engage in end of life discussions with patients and families, and this could not be framed as a criminal act.

The concerns of nurses were brought forward to federal legislators. In submissions and presentations to the House of Commons and Senate Special Joint Committee on Physician Assisted Dying, the need for a national, person-centred regime that would prevent “the eligibility and process for accessing assistance in dying [to] vary greatly from one province or territory to another” (Canada. Parliament, 2016) was emphasized. Nurses advocated at the federal level for universal access to palliative care; protection for all nurses under the Criminal Code for engaging in discussions with patients on end of life decisions; educational, professional development and counselling supports for healthcare providers participating in assisted dying; and mechanisms for nurses to conscientiously object to participating in assisted dying. A key consideration was the fact that, in rural and remote communities across Canada, NPs are the primary care providers for more than 3 million Canadians and therefore needed to be explicitly included in the legislation as providers of assistance in dying. Not doing so would create a barrier to access for patients under NP care. In addition, nursing stakeholders sought a change in title for the proposed legislation from “Physician-Assisted Dying” to a title that reflected the team-based approach to care and the reality that care providers other than physicians often have the most direct contact with patients at the end of life.

It was heartening that the federal parliamentary Special Joint Committee recommended that the expression “medical assistance in dying” (MAID) replace “physician-assisted death”, that the Criminal Code allow MAID to be provided by physicians *and/or* NPs, and that healthcare professionals, including all nurses, who assist those delivering MAID be protected from prosecution under the Criminal Code.

In the end, *Bill C-14*, made it possible for eligible persons to receive MAID in Canada and provided safeguards for vulnerable populations.

¹ Advanced nursing practice is an umbrella term describing an advanced level of clinical nursing practice that maximizes the use of graduate educational preparation, in-depth nursing knowledge and expertise in meeting the health needs of individuals, families, groups, communities and populations. It involves analyzing and synthesizing knowledge; understanding, interpreting and applying nursing theory and research; and developing and advancing nursing knowledge and the profession as a whole.” (CNA, 2007).

The law also established safeguards and protections for nurses and other healthcare professionals who provide MAID, in accordance with the law, as well as for persons who assist them.

In support of a smooth role-out of the new regime, the national professional association, CNA, developed a *National Nursing Framework on Medical Assistance in Dying in Canada* (CNA, 2017b) which was released in January 2017. Subsequently, additional educational resources and supports relevant to all nurses have been released.

Moving Forward

Demographic shifts and the threats to population health are not problems unique to Canada. Neither are some of the strategies we have embraced to make our health systems better serve the health needs of Canadians. In launching initiatives to expand nursing scope of practice, such as RN prescribing and advanced practice roles, we have learned from other jurisdictions and have much to contribute to the national and global conversation as others study and follow our examples.

Untapped potential still exists in Canada to further empower the nursing profession to deliver better care, better health and better value. It is imperative to continue to move forward on ground already gained. It is also important to ensure the nursing profession overall, comprised of several regulated nursing disciplines, works toward improved coordination and collaboration that allows all nurses and other health professionals to work to their full scope of practice. For nursing, this means continuing to develop roles in preventative care, chronic disease management and management of episodic illnesses and ways of integrating health promotion and care planning across the boundaries of health and social services. This will be facilitated by developing integrated models for health and social services, modernizing health services funding models, advancing interprofessional collaboration and engaging authentically with patients to understand the evolving health needs of Canadians.

Biography

Dr. Pullen is passionate about advancing the health of Canadians through a strong nursing profession and healthy public policy. As Chief of Programs and Policy for the Canadian Nurses Association, Carolyn oversees strategic programs and services to bring the nursing voice to national discussions on interprofessional practice, integration and health system transformation. Past roles include providing leadership in research, policy and knowledge translation for national not for profits including the Heart and Stroke Foundation, the Canadian Cardiovascular Society, the Canadian Institute for Health Information and Accreditation Canada. Carolyn received her bachelor of science in nursing from Queen's University. Her doctorate is from the University of Ottawa where her research focused on mechanisms to mobilize health research evidence into practice.

References

- Ball, J. 2009. Implementing nurse prescribing. *An updated review of current practice internationally*. Geneva, Switzerland: International Council of Nurses.
- Bhanbhro, S., Drennan, V. M., Grant, R., & Harris, R. 2011. "Assessing the contribution of prescribing in primary care by nurses and professionals allied to medicine: A systematic review of literature." *BMC Health Services Research* 11: 1-10.
- Kaasalainen, S., Martin-Misener, R., Kilpatrick, K., Harbman, P., Bryant-Lukosius, D., Donald, F. Carter, N. & DiCenso, A. 2010. "A Historical Overview of the Development of Advanced Practice Nursing Roles in Canada." *Nursing Leadership* 23 (Special Issue): December 2010: 35-60.
- Canadian Institute for Health Information (CIHI). 2017. *National health expenditure trends*. https://www.cihi.ca/sites/default/files/document/nhex-trends-key-findings_2016_en.pdf
- CIHI 2017a. Regulated Nurses, 2016. Ottawa, ON. https://secure.cihi.ca/free_products/Nursing_Report_2016_en.pdf
- Canadian Nurses Association. 2007. *Position statement: Advanced nursing practice*. https://www.cna-aaic.ca/~media/cna/page-content/pdf-en/ps60_advanced_nursing_practice_2007_e.pdf?la=en
- CNA 2012. A nursing call to action: *The health of our nation, the future of our health system*. Ottawa, ON: Author. https://www.cna-aaic.ca/~media/cna/files/en/nec_report_e.pdf?la=en
- CNA 2013. *Enhancing RN scope of practice to include autonomous prescribing* [Backgrounder]. Ottawa, ON: Author. Unpublished.
- CNA 2014. *Registered nurse (RN) prescribing: A literature review*. Ottawa, ON: Author. Unpublished.
- CNA 2015. *Framework for registered nurse prescribing in Canada*. https://www.cna-aaic.ca/~media/cna/page-content/pdf-en/cna-rn-prescribing-framework_e.pdf?la=en
- CNA 2016. *The Canadian nurse practitioner initiative: A 10-year retrospective*. Ottawa, ON: Author. <https://cna-aaic.ca/~media/cna/page-content/pdf-en/canadian-nurse-practitioner-initiative-a-10-year-retrospective.pdf?la=en>
- CNA 2016. "RN Prescribing Scan by Provincial and Territorial Jurisdiction." Ottawa, ON: Author. Unpublished.
- CNA 2017. "National Nursing Framework on Medical Assistance in Dying in Canada." Ottawa, ON: Author. <https://www.cna-aaic.ca/~media/cna/page-content/pdf-en/cna-national-nursing-framework-on-maid.pdf>
- CNA 2017a. "CNA position statements." Ottawa, ON: Author. <https://cna-aaic.ca/en/advocacy/policy-support-tools/cna-position-statements>
- Carter v. Canada (Attorney General), 2015 SCC 5.
- CNA 2016. Bill C-14: *An act to amend the Criminal Code and to make related amendments to other acts (medical assistance in dying)*, S.C. 2016, c. 3. Ottawa, ON: House of Commons, Government of Canada.
- CNA 2017. Bill C-44: *An Act to implement certain provisions of the budget tabled in Parliament on March 22, 2017 and other measures*. Ottawa, ON: House of Commons, Government of Canada.
- Institute for Healthcare Improvement. 2013. *IHI Triple Aim initiative*. <http://www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx>
- Jones, K., Edwards, M., & While, A. 2011. "Nurse prescribing roles in acute care: An evaluative case study." *Journal of Advanced Nursing* 67: 117-126.

The Evolution of general practice in Canada: a reflection on retirement



JOHN EDWORTHY
SITE DIRECTOR
VANCOUVER FRASER FAMILY PRACTICE
RESIDENCY PROGRAM
NEW WESTMINSTER (BC), CANADA

ABSTRACT: Primary care is a key determinant of the health of our population. Family physicians are central to the delivery of primary care in Canada. The perceived value of the generalist in the delivery of medical care has varied since the birth of general practice in the 19th century. I have seen the perceived value of the generalist, relative to the specialist physician, improve, particularly as “full scope” family physicians have become a scarce commodity in recent years. Even with improved support for family doctors and a marked increase in the number of graduating family physicians there remains a significant shortage of family doctors across Canada. I believe much of this problem is due to many graduating family physicians choosing to focus their practice within family medicine and give up on being a generalist who addresses the Principles of Family Practice as outlined by the Canadian College of Family Physicians.

Introduction

I am a family physician in Coquitlam, a suburban community near Vancouver, British Columbia, Canada. I have recently retired from clinical practice, after 39 years. I have been involved in the post graduate education of family physician residents for 20 years and have been a Site director, supervising the training of 34 family practice residents for the last 10 years.

Retirement gives me the opportunity to reflect on general practice/family practice and how it has evolved over my professional career and historically. How does a family doctor best serve the health of his or her community, what is the most cost effective role for family doctors and what forms of practice are most rewarding and sustainable for young family physicians? I continue my role as an educator and wonder how residents will be practicing 20, 30 and 40 years from now. What knowledge and skills will they need to be most effective and what roles will be expected of them? Looking back over the years I see pendulum swings regarding the role of the generalist primary care provider.

Exposition

I think it is generally accepted that good primary care is a key determinant of the health of individuals and communities. Although many people in my community choose to seek their primary care from other primary

care providers such as nurse practitioners, naturopathic physicians, homeopathic physicians and chiropractors, I think that general practitioners/family physicians continue to be the primary care provider for most people in Canada. The role and scope of practice of family physicians will be an important influence on the health of our community for the foreseeable future.

The health care system in Canada offers all Canadians access to health care in hospitals and from doctors. In order to see a specialist (if the specialist is to receive specialist fees) Canadians must first see a family physician and be referred. Other health care needs such as dentistry, psychology (counselling) physiotherapy and pharmaceuticals are not funded by the government plan and must be paid personally or with private insurance plans. The family physician acts as the “backstop” for the system. Family physicians see patients and do their best with problems that might be better managed by others who the patient cannot afford to see. We must be aware of the cost of medication if we want patients to be adherent. The limited nature of the Canadian health care system relies on family doctors to be there for a wide variety of problems and remain a “general practitioner”. For many years family doctors, as individuals or in group practices, have tended to work independently of other health care professionals. I think that new funding models, which include family doctors

in a health care team of other health care professionals and which include funding of other basic health care needs such as dentistry and physiotherapy, will become the norm in the future.

In his textbook on family medicine (1), Ian McWhinney, a founder of family practice in Canada, outlines the birth of “general practice” in the 19th century in America. In Europe, before the invention of the general practitioner, multiple care givers, including physicians for consultations, surgeons for lancing of abscesses, apothecaries and herbalists for medication and mid-wives for assisting child birth were available to the population. The sparse and scattered population in America needed a health care provider who could “do it all” and the general practitioner was born as an amalgamation of these many practitioners. The general practitioner was highly valued for his (almost all GPs were men) ability to do surgery, prescribe drugs, deliver babies or do whatever else was required.

After graduation from medical school in 1977, I completed a one year internship which I thought, at the time, prepared me well to be a general practitioner. My training was bio-medical based and was designed to create the general practitioner of the previous 50 years. During my one year of internship I learned surgical procedures and delivered over 100 babies. I felt I could recognize and treat disease.

After a few years of practice, doing locums, I moved to Alberta, where my wife had matched for her internship. Two years of post-graduate training was required to practice in Alberta and so I could not be licensed with my one year of internship. I decided to register with the Calgary Family Practice Program and completed a second year of “family practice”. I began to appreciate the new Principles of Family Practice developed by the Canadian College of Family Physicians.

The Principles were distilled from Dr. McWhinney’s book and are:

1. The family physician is a skilled physician
2. The Doctor patient relationship is central to the role of the family physician
3. The family physician is community based
4. The family physician is a resource to a defined population.

This changed my attitude toward what a family physician should be and created my belief of the “ideal family doctor” which guided my future practice and influenced my attitude to teaching. My previous sense of worth was based on what I knew and what I could do, how good a diagnostician I was and how skilled I was at procedures. This was all addressed in the first principle of family medicine, a family physician is a skilled clinician. The other principles focused on my ongoing “relationship” with patients, not just my medical skills. To be a good family doctor I had to “FIFE” my patients, recognizing their Feelings, Ideas, Function and Expectations.

I carried my new outlook forward. In particular, I encouraged my resident trainees to recognize the importance of the principles of family medicine to direct their future

choices of work. My attitude valued the generalist who established a strong longitudinal relationship with his/her patients. Although I avoided saying so, I was disappointed when my graduates chose a more limited practice.

General practice was born and grew during the second half of the 19th Century. By the beginning of the 20th century new inventions and innovations were changing the nature of medical care. Diagnostic imaging, effective anesthesia, new drugs and treatments led to the growth of specialties within medicine. Over the first half of the 20th Century the role of specialists grew and the stature of the general practitioner lessened. When I was in medical school, in the 1970s, it was a common attitude, especially among specialist physicians, that physicians doing general practice were those who couldn’t manage a speciality. The pendulum had swung from specialty to general practice and back to specialties. From the 1970s to the 21st century, under the influence of a strong College of Family Physicians and acceptance of family practice into university medical school academia and administration, the influence and perceived value of primary care/family practice again increased. More medical students applied for family practice training and financial compensation for family practice improved. The pendulum swung to general practice. Now I see the pendulum swinging back again. Many of my graduates, who graduate as fully trained family physicians, enter “focused practice”. They limit their practice to areas such as women’s health, sports medicine, obstetrics, hospitalist work, or even primary care dermatology. There are many reasons for this swing including economics and ease of practice but an important factor, I feel, is the general feeling of the value of being a generalist.

This concerned me. Although each of these focussed practices offers skilled and meaningful service, they are not the generalist family practice that address the principles of family medicine that I believed in.

But, are the principles that Ian McWhinney outlined the best definition of family medicine today? Many physicians in more rural communities still offer all the services I felt defined family practice. Are people in these rural communities better served? Is it better for my patients to have me for their deliveries, to excise their skin lesions and be there for counselling or are they better served by individuals who have focussed skills in each of these areas. The principles of family medicine value continuous, “cradle to grave” care. How important is continuity relative to increased, focussed, knowledge and skills. Where will the pendulum swing in the next 30 years?

I have become aware of the constant evolution of the delivery of medical care over the years. This is likely driven by many factors including population growth, economics and technology. It is a challenge as an educator and a long term practitioner to know what the best balance between generalist and “specialist” or focused practice is.

There is a shortage of family doctors in British Columbia and Canada. In spite of the Provincial government and Provincial medical associations making finding a family

doctor for every BC citizen a priority over the last 15 years, tens of thousands of people in BC still do not have a family doctor. Payment schedules for family doctors have been improved to make ongoing community care of patients more attractive. Under government directive, the University of BC has doubled the number of graduates in family practice over the past ten years. In spite of this, the shortage remains. When I began my practice in 1981 it was common for a starting family doctor to pay half a year's income for a practice, which was primarily for the patient slate or "good will". Today a retiring family doctor must struggle to find a replacement at all and feels fortunate to have someone assume his or her practice without any consideration of compensation. Knowing that it will be difficult for patients to find a new family physician, retiring physicians search hard for replacements to avoid "abandoning" their patients. The percentage of medical school graduates entering family medicine is at all-time highs as graduates know they can work wherever they choose and to the degree that they choose. I found a replacement for my practice from the UK as a Canadian graduate was not available.

The actual shortage is of family doctors who work in the community and who identify as the most responsible physician for a defined slate of patients. There are a number of reasons that this shortage persists. I believe that the tendency of many graduates to "specialize" within family practice is an important cause. Every family practice graduate who chooses a focussed practice, such as a hospitalist, palliative care physician or addictions specialist is another graduate who, does not meet the principle of family medicine of being "a resource to a defined population". The shortage is caused, at least in part, by a swing of the pendulum towards specialization within the practice of family medicine.

For many years doctors were accused of being "workaholics", working long hours and neglecting other aspects of their life. Medical schools have recognized this. In our Program we teach our residents that, as a professional, finding a good "work/life balance" is important to their long term success and happiness in family medicine. This usually meant more time devoted to their family lives and less to work. Balance is important but I have stopped using the work/life balance term which, to me implies that everything in "life" with the family is positive and everything related to work is negative. I prefer work/life integration, where the physician finds the positive features of life within and outside of work. New physicians do fewer hours than their predecessors, which is likely good. In rural settings physicians still do a "full scope" of family practice but urban practice have become primarily office based. Although at times disruptive, I found delivering babies, assisting at my patients surgeries, following my patients into nursing homes, making home visits and teaching added spice to practice and was positive for my "work/life integration". New graduates are likely healthier than their predecessors but their fewer hours and more restricted duties, do contribute to the shortage of family physicians. I wonder if

the pendulum has also swung in this area.

Conclusion

Family practice is a wonderful and fulfilling profession. As a Site director for a training program I am given the privilege of giving a graduation chat to my graduates each year. In this talk I encourage residents to remember the positive features of family practice/primary care and not become jaded with the politics, administrative frustrations and logistics of the day. The shortage of family doctors and the lack of monetary value of my practice is a reflection of the politics and administration of medicine in Canada today. How will primary care be delivered in the future? What will be the role of family physicians be relative to other primary care practitioners? What do we need to teach our trainees? Will our computers and artificial intelligence completely change our role?

The way primary care is delivered will continue to evolve. I enjoyed my many years of family practice and the way that medical care was delivered. I appreciate that family physicians graduating now enter a different environment and will likely practice differently. They will need to recognize how to best contribute to primary care in their community and find happiness and fulfillment in their profession.

Biography

Dr. Edworthy has practiced family medicine in Coquitlam and Port Coquitlam, BC for 35 years. He is the Site Director for the Vancouver Fraser Family Practice residency Program in New Westminster and has held several positions with the UBC Department of family medicine for 20 years.

Reference

1. Ian R. McWhinney. 1997. A Textbook of Family Medicine. 2nd ed. New York Oxford: Oxford University Press.

The Montreal 2017 Executive Hospital Study Tour: Learning from Others



ALEXANDER S. PREKER
PRESIDENT AND CEO
HEALTH INVESTMENT & FINANCING CORPORATION
NEW YORK, NY, USA



HORTENZIA BECIU
DIRECTOR FOR THE MIDDLE EAST AND AFRICA
JOHNS HOPKINS MEDICINE INTERNATIONAL
BALTIMORE, MD, USA



ERIC DE ROODENBEKE
CEO
INTERNATIONAL HOSPITAL FEDERATION
BERNEX, GE, SWITZERLAND

ABSTRACT: From June 27th to July 1st 2016, the International Hospital Federation (IHF) and Health investment & Financing hosted a Hospital Executive Study Tour in Montreal, Province of Quebec and Ottawa, Ontario Province, Canada. The objective of the Hospital Executive Study Tour was to allow participants to learn how the Canadian hospital sector addresses some of the key challenges and solutions, in order to transform the way hospital care is delivered in the 21st Century. The Montreal Study Tour was part of a series of premier events offered by the IHF. This Study Tour was a collaborative effort among Canadian partner organizations in both Montreal and Ottawa who hosted various events to enable the exchange of ideas, knowledge, experiences and best practices in the delivery of healthcare services, and in the leadership and management of their organizations.

The Montreal 2017 Executive Hospital Study Tour provided participants with a fascinating overview of the Quebec, Ontario and Canadian healthcare system.

During recent debates on healthcare reform in the US, the Canadian system has been variously lauded and vilified as either one of the best or worst models that should either be emulated or avoided at all cost. The study tour, the articles in this issue of the World Hospitals and Health Services Journal and other recent reviews of the Canadian healthcare system shed light on this dichotomy in opinions.

Healthcare in Canada is delivered through a publicly funded healthcare system, administrated on a provincial or territorial basis, informally called Medicare, which is free at the point-of-use for services provided under the Canada Health Act of 1984. As stated within the Canadian legal framework, the design and delivery of healthcare to most Canadians is the responsibility of the provincial and territorial governments. However, the federal government makes a significant annual financial contribution to

the provinces and territories, to help offset the costs associated with that responsibility¹.

Since the latter part of the 1980s, the Canadian healthcare system has continued to evolve, intent on alleviating the financial pressure on government funds while supporting the universality of the system public-private partnerships models emerged early on. The Canadian Healthcare System provided for physician visits and hospital care, while other aspects were either financed privately or under a mixed model. Therefore, starting with what was already a mixed public-private partnership, recent reforms have not significantly altered this approach to both funding and healthcare delivery. The public character of tax funding, coupled with the public/non-governmental/private character of the service delivery system has prevailed, despite periodic constitutional challenges.²

³ Private health insurance is present on the market, playing a somewhat limited role (as a market share), covering services that are not available under the public mandate, such as vision, home care, rehabilitation, outpatient drug expenses, private rooms in

public hospitals.

In 2002, the Royal Commission on the Future of Healthcare in Canada, also known as the Romanow Report, led by Roy Romanow, issued comprehensive recommendations on ways to preserve the long-term sustainability of Canada's healthcare system.⁴ The proposed changes were outlined in the Commission's Final Report: "Building on Values: The Future of Healthcare in Canada" which was tabled in the House of Commons on 28th November 2002.⁵

The Report led to an important agreement in September 2004, whereby the Government of Canada agreed to strengthen ongoing federal support provided to provinces, through the Canada Health Transfer Act (CHT). While it was up to the provinces how they allocated funds, the CHT required that the aims should also focus on the maintenance and/or increase of population access and system universality. A separate financial commitment was made during the 2003 Health Agreement, specifically targeting waiting times for certain procedures¹.

The latter did not alter the underlying fundamental principles of the Canadian healthcare system set forth in the Canada Health Act 1984, led by Health Minister Monique Bégin, which replaced the earlier Hospital Insurance and Diagnostic Services Act and the Medical Care Act.

The Royal Commission continued to discourage co-payments and user fees for physician and hospital services. It required the federal government to deduct (dollar-for-dollar) the value of all extra billing and user fees, from a given provincial government's share of Established Programs Financing. Established Programs Financing (EPF) was set up in 1977 and is considered to be Canada's first-ever modern transfer mechanism between the federal government and provinces¹. Private profit-making hospitals were excluded from public funding arrangements, thus restricting the growth of such hospitals in Canada, however municipal and non-profit-making hospitals were allowed to access funding, leading to a proliferation of this segment within the hospital sector. It also meant that with the exception of mental health hospitals, the hospital sector in Canada has remained small.

In addition to the CHT, in 2003 the federal government also created the Health Reform Fund (HRF), designed to assist provinces in implementing primary healthcare reform, short-term acute home care and catastrophic prescription drug coverage.

Overall, for the past 40 years, the Canadian healthcare system has remained remarkably resistant to erosion of the basic principles established under the Canada Health Act of 1985.⁶ As of 2017, the Federal Government continues to co-finance provincial and territorial programs, providing that the provinces and territories adhere to the original five principles of the Canada Health Act: 1) public administration; 2) comprehensive coverage; 3) universal; 4) portable across provinces; and 5) accessible (i.e., without user fees).⁷

After a period of fiscal restraint under the Conservative Prime Minister Stephen Harper, Justin Trudeau, leader of the Liberal Party, was voted into office on November 4th 2015, ushering in a new era of more favorable Federal fiscal support for healthcare in the Canadian provinces.

Today, in terms of mobilized financial resources, cost, and public affordability, and in the wake of an initial period of stable spending

following the introduction of universal access, healthcare spending in Canada, like in all other OECD countries, has increased over time at a rate slightly above the OECD average, albeit much lower than in the USA. Age-adjusted total expenditure on health in 2012 amounted to 10.6 percent of GDP. Health Expenditure per capita in Canada has remained within the range of 10-11 percent of GDP over the past decade, varying slightly from year to year.⁸

As a result, healthcare expenditure in Canada is among the highest in OECD countries who have their own universal healthcare system. It is the 3rd highest in terms of age-adjusted expenditure per GDP, and 5th highest in expenditure per capita.⁹

Nevertheless, among the OECD countries, Canada ranks 10th for life expectancy, 9th for healthy-age life expectancy, 25th for infant mortality, 18th for perinatal mortality and 8th for mortality amenable to healthcare. In these terms, health outcomes in Canada across a large range of variables remain in the top OECD tertile for some, and in the bottom tertile on infant mortality and perinatal mortality.

At aggregate level, health status is not strongly correlated with the financing of healthcare, such as health insurance or healthcare interventions. It presents a stronger correlation with socio-economic and other non-medical factors.

Although no direct attribution to universal healthcare should be implied from these findings, that is of course precisely what advocates and critics of the Canadian healthcare have done. Just like in the USA, where poor performance of the American healthcare system is often attributed to the fragmented health insurance system, so too in Canada, both the good and the bad are attributed to the universal, single payer system of healthcare financing.

Despite these shortcomings in comparison, the Montreal 2017 Hospital Executive study tour provides participants with a fascinating overview of healthcare in Canada and lessons learned – both positive and negative – that could be useful to other countries.

Facilities Visited and Executives Participating in the Study Tour

The Study Tour included visits to leading Canadian policy makers, hospital managers and decision makers, researchers, entrepreneurs, community leaders, and health financing experts. In Montreal, the Executive Study Tour, included visits to the following groups:

- Department of Management, Evaluation and Health Policy, School of Public Health, University of Montreal
- Leadership program in Healthcare Management, Desautels Faculty of Management, McGill University
- Integrated University Center for Health and Social Services
- McGill University Hospital Center
- Montreal University Institute of Geriatrics; and
- Arbec Health Group

In Ottawa, the Executive Study Tour, included meetings with Health Canada; HealthCareCAN, Canadian Medical Association; Canadian Nurses Association; Accreditation Canada; Canadian Institute of Health Information (CIHI) and Elizabeth Bruyère Hospital leadership.

The participants in the Study Tour included executives and leaders from Albania, Australia, Brazil, Canada, France, India,

Spain, Switzerland and the USA.

For a complete and detailed description of the study tour, you may download a copy of the full report on the study tour at the following website: (<https://www.ihf-fih.org/activities?type=training§ion=study-tour>).

Biographies

Mr. Alexander S. Preker is President and CEO of the Health Investment & Financing Corporation and a member of the board of several of the companies in which the group has invested. He is a Founding Member of the New York Chapter of the Keiretsu Forum and an LLP with Keiretsu Capital. Mr. Preker is one of the Commissioners for the Global Commission on Pollution, Health and Development, a Member of the Board of the USA HealthCare Alliance, and the Chair of the External Advisory Committee for the World Hospitals and Health Services Journal of the International Hospital Federation. He is the Editor-in-Chief for the World Scientific Series on Health Investment and Financing. He is an Executive Scholar and Adjunct Professor at Columbia University, New York University and Icahn School of Medicine at Mt. Sinai.

Hortenzia Beciu is director for the Middle East and Africa at Johns Hopkins Medicine International. She provides direction and oversight in project management, research and analysis, and she participates in Johns Hopkins Medicine International strategic planning. Dr. Beciu has extensive experience in the health sector, working with governments, development partners and various health industry groups (hospital sector, pharmaceuticals, medical technology and information technology). Before joining the Johns Hopkins team, she worked at the World Bank and International Finance. Prior to her work at the World Bank, she worked with the Pan American Health Organization and the Institute for Health Services Management in Romania. She holds a medical degree from the Carol Davila University of Medicine and Pharmacy in Romania and a master's degree in global health from the George Washington University.

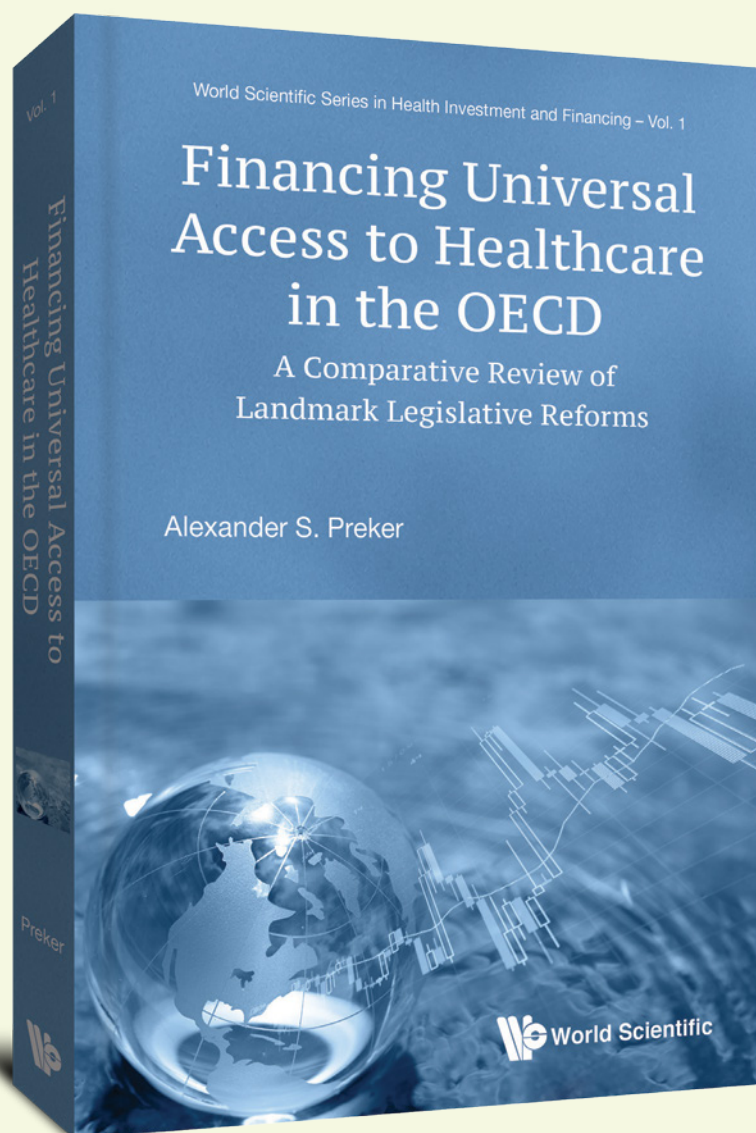
Eric de Roodenbeke assumed the position of Chief Executive Officer of the International Hospital Federation in June 2008. Between July 2007 and May 2008 he was Senior Health Specialist at the World Health Organization (WHO) for the Global Health Workforce Alliance (GHWA), during which time he was involved in support country action programs aiming to develop a response to the HRH crisis and create strategies for regional networks in support of HRH development. He was the focal point for follow-up actions in Francophone countries. Dr. de Roodenbeke holds a Ph.D. in health economics - University of Paris 1, Sorbonne (France); a Hospital Administration Diploma from ENSP Rennes (France); and a Diploma in Public Health from the University of Nancy (France).

References

1. Canadian Parliament. 2004. *The Canada Health Transfer (CHT) and Other Federal Health Transfer*. By Michael Holden and Stephen Laurent. Topical Information for Parliamentarians, Canada. At <https://lop.parl.ca/Content/LOP/ResearchPublications/tips/tip99-e.htm>
2. G.P. Marchildon. Canada: *Health System Review, Health Systems in Transition*, 2013; 15(1): 1 – 179. Ed. Anna Sagan. http://www.euro.who.int/__data/assets/pdf_file/0009/80568/E87954.pdf. Accessed July 25, 2017.
3. S. Dhillon, "Constitutional challenge against Canada's health-care system begins," *The Globe and Mail* Published Tuesday, Sep. 06, 2016. <https://www.theglobeandmail.com/news/british-columbia/medicare-on-trial-as-private-vancouver-clinic-challenges-coverage-rules/article31720282/>. Accessed May 28, 2017
4. Government of Canada. 2002. *Royal Commission on the Future of Healthcare in Canada*. Ottawa <http://www.hc-sc.gc.ca/hcs-sss/com/fed/romanow/index-eng.php>. Accessed May 28, 2017.
5. Government of Canada. 2002. *Building on Values: The Future of Healthcare in Canada*. Report, Ottawa. <http://publications.gc.ca/site/eng/237274/publication.html>. Accessed May 28, 2017.
6. Government of Canada. 1984. *The Canada Health Act 1984*. Ottawa. <https://lop.parl.ca/content/lop/researchpublications/944-e.htm>. Accessed May 28, 2017.
7. USA, The Commonwealth Fund. 2015. *The Canadian Healthcare System*, 2015, by S. Allin and D. Rudoler. Report, New York, p.21-30. http://www.commonwealthfund.org/~media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf?la=en. Accessed May 28, 2017.
8. World Health Organization (WHO). 2015. *National Health Accounts*. Geneva: WHO.
9. Canada, Fraser Institute. 2016. *Comparing Performance of Universal Healthcare Countries*, by B. Barua, I. Timmermans, I. Nason, and N. Esmail. Report, Vancouver, p. 9 and p. 35. <https://www.fraserinstitute.org/sites/default/files/comparing-performance-of-universal-health-care-countries-2016.pdf>. Accessed July 17, 2010

25% OFF
code **WSFUAH25**

FINANCING UNIVERSAL ACCESS TO HEALTHCARE IN THE OECD



This book provides a comparative review of financing universal access to healthcare in the Organisation for Economic Co-operation and Development (OECD) countries.

The recent expansion of health insurance coverage in the USA under the Affordable Health Care Act, and current threats to reverse the benefits of this reform, have once again focused the world's attention on the difficult challenges faced by other countries trying to provide better access to healthcare to their population at an affordable cost.

Amidst this universal challenge, this book is a pioneer in providing a comprehensive synthesis for policy makers on the experiences of countries that have successfully introduced such reforms.

This book is designed as a learning tool for students and user guide for policymakers, including case material and an instructors' manual as well as sample exam questions. The data analysis of the cost of universal healthcare presented in the book is unique and has not been published before.

| | |
|--|----------------------|
| 450pp | February 2018 |
| 9789813227163 (hardback) | US\$138 £121 |
| 9789813227194 (ebook for individuals) | US\$110 £97 |

Get **25% OFF** with the code **WSFUAH25** for purchases on www.worldscientific.com
Valid till **1 February 2018**.

About the Author

Alexander S Preker is a globally recognized expert on health systems development and health policy reform. He has been an advisor to the Ministers of Health and senior policy makers in countries throughout the world on capital investment in the health sector, health financing, health insurance, public-private

partnerships and the political process of healthcare reform.

Currently, Professor Preker is an Executive Scholar and Adjunct Associate Professor at Columbia University, New York University and the Icahn School of Medicine at Mt. Sinai in New York.

Canadian success stories on health and social care Volume 53 Number 4

Résumés en Français

Application d'un modèle d'intégration de type coordonné pour les personnes âgées vulnérables au Québec (Canada) : le projet PRISMA

PRISMA est un modèle de type coordonné de prestation intégrée de services pour les personnes âgées vulnérables. Le modèle PRISMA comprend les éléments suivants pour améliorer l'intégration : 1) un mécanisme formel pour gérer la coopération entre les décideurs et les gestionnaires de tous les services et organisations, 2) l'utilisation d'un guichet unique, 3) un processus de gestion des cas, 4) des forfaits individualisés, 5) un outil d'évaluation unique avec un système de case-mix, 6) un système informatisé de communication entre les institutions et les professionnels.

Le modèle PRISMA a été expérimentalement mis en œuvre dans trois zones (villes, campagnes, avec ou sans hôpital de proximité) au Québec, au Canada, et des études ont été réalisées en utilisant des données qualitatives et quantitatives pour évaluer le processus et son impact. Un impact significatif de la prévalence et de l'incidence du déclin fonctionnel, de la satisfaction à l'égard des services et de l'autonomisation a été observé. Il y a eu une réduction du nombre de visites aux salles d'urgence et d'hospitalisations. Le coût global n'était pas plus élevé dans le groupe expérimental, même lorsque le coût de mise en œuvre était inclus.

Le modèle PRISMA a ensuite été mis en place dans toute la province de Québec de 2005 à 2015. Les contraintes budgétaires et les réformes concomitantes (fusion des institutions) ont ralenti la mise en œuvre. De nombreuses leçons ont été tirées de cette mise en œuvre : les personnes chargées des dossiers devraient être formellement formées et accréditées, et l'intégration structurelle par la fusion ne favorise pas nécessairement l'intégration fonctionnelle. Le modèle PRISMA est une bonne illustration du transfert efficace des résultats de la recherche à un programme national, dans le contexte d'une politique publique fondée sur des données probantes.

Pistes de transformation dans les systèmes de santé publics : Expérience dans des provinces du Canada

Les provinces canadiennes ont entrepris des réformes répétées du système de santé pour mieux répondre aux besoins changeants découlant du vieillissement de la population et de la forte prévalence des maladies chroniques. Comme dans d'autres pays, une réforme du système à grande échelle est jugée nécessaire pour relever ces défis. Alors que les changements structurels, tels que la fermeture des hôpitaux et la création des autorités sanitaires régionales, ont prévalu dans les années 1990, des réformes plus récentes utilisent d'autres leviers de changement. Cet article examine trois thèmes qui apparaissent dans les réformes entreprises dans différentes provinces canadiennes au cours de la dernière décennie : la culture de bases de mobilisation alternatives pour apporter des améliorations ; la

recherche d'une capacité accrue en matière de gouvernance ; et des efforts pour engager les leaders cliniques, et notamment les médecins, dans l'amélioration à grande échelle.

Gérer les mythes du système de santé

Cet article présente un résumé de mon livre publié en 2017, intitulé «Gérer les mythes du système de santé», en trois parties : I. Les mythes de la santé, II. Réorganiser les soins de santé et III. Recadrer les soins de santé. Deux notes supplémentaires sont incluses, l'une sur la gestion avec et sans âme, l'autre sur un forum pour développer les gestionnaires de soins de santé avec âme.

Préparer le terrain pour la transformation : Une étude de cas sur l'expérience du CHUM

En 2015, le Centre hospitalier universitaire McGill (CHUM), un important centre hospitalier universitaire situé à Montréal (Québec), a inauguré un complexe hospitalier de 1,3 milliard de dollars CAN (site Glen) après une phase de planification, d'autorisation, de conception, de financement, de construction et d'activation qui a duré près de deux décennies. Le CHUM a été contraint de tirer parti du projet de transformation pour innover et partager les nouvelles informations qu'il a acquises. Par conséquent, cette période turbulente a fourni un ensemble considérable de connaissances. Cet article s'appuie sur l'expérience du CHUM et est ancré dans la littérature. Il aborde les thèmes du changement complexe, de l'innovation et de l'amélioration des performances dans le système de santé. Il vise notamment à fournir aux organismes qui planifient ou sont déjà engagés dans un projet de transformation, similaire à celui entrepris par le CHUM, des éléments démontrant pourquoi il est avantageux de consacrer des ressources pour soutenir la transformation, notamment pendant la période de transition. L'article se termine par un récapitulatif des leçons apprises et le recours éventuel à des études supplémentaires.

Aperçu général des centres de soins de longue durée dans la province de Québec

Cet article couvre les trois principales réformes qui ont touché et influencé l'évolution du secteur des soins de longue durée.

Différentes statistiques sont examinées afin de fournir aux lecteurs une connaissance de base des services proposés aux personnes âgées au Québec, ainsi que de la démographie qu'elles couvrent.

Où sont les hôpitaux canadiens : Aligner autorités et responsabilités.

Le système de santé canadien, comme de nombreux autres dans le monde, subit d'énormes changements. Nulle part ces changements n'ont été plus spectaculaires que dans ce qu'on appelait au Canada le «secteur hospitalier». Le symbole mondial

du «H» bleu peut encore être vu dans plus de 1000 collectivités et différentes autoroutes à travers le Canada. Cependant, au cours de la dernière décennie, en tant qu'entités juridiques, on a jugé que les hôpitaux n'existaient plus dans toutes les provinces sauf une, notre plus grande province : l'Ontario. Ailleurs, une gamme de plus en plus étendue de services hospitaliers et communautaires est gérée par les autorités régionales de la santé ou RHA. Ce bref article essaie de fournir une description de haut niveau de la nature de ces changements ainsi que les forces économiques, technologiques et politiques qui les sous-tendent, et d'évaluer brièvement les implications pour les «hôpitaux» au niveau national.

Gestion de la santé des populations

Une perspective canadienne sur l'avenir des systèmes de santé

Sur le plan international, deux tendances dans les soins de santé font peu à peu leur apparition. La première est la reconnaissance croissante du fait que les soins de santé ne sont qu'un déterminant de l'état de santé. La prévention et la promotion de la santé ont un rôle important à jouer en influant sur les déterminants sociaux de la santé et les secteurs qui les représentent. La deuxième tendance est l'expérimentation d'approches de financement des systèmes qui visent de plus en plus à partager les risques et les avantages entre bailleurs de fonds et fournisseurs. Ensemble, ces tendances sont à l'origine de ce qu'on appelle la gestion de la santé des populations (GSP). Le Canada a été un pionnier dans le développement de ces concepts, mais l'expérience internationale suggère qu'il a été à la traîne dans leur mise en œuvre. Pour aller de l'avant, les facteurs clés de succès pour le Canada comprennent la gestion de l'information sur la santé, la collaboration multisectorielle et le leadership clinique.

Rendre autonome les infirmières au Canada pour offrir de meilleurs soins, une meilleure santé et une plus grande valeur

La population canadienne vieillit et la prévalence des maladies chroniques et des inégalités sociales et sanitaires augmente. Bien que les défis posés à nos systèmes de santé soient énormes, le Canada dispose d'excellentes ressources qui peuvent être utilisées pour soutenir la transformation du système. Notre main-d'œuvre infirmière nombreuse, très bien formée et qualifiée fait partie de la solution visant à transformer le système et à obtenir de meilleurs soins, une meilleure santé et une plus grande valeur pour nos investissements dans la santé publique. Grâce à une gamme d'efforts déployés par les intervenants à tous les niveaux, les infirmières sont de plus en plus les moyens de contribuer à l'amélioration du système de santé. Parmi les exemples récents, citons la facilitation de la prescription par des infirmières autorisées, la promotion de la pratique infirmière avancée et la modernisation de la législation fédérale pour permettre aux infirmières de pratiquer pleinement leur profession.

L'évolution de la médecine générale au Canada : une réflexion sur la retraite

Les soins primaires sont un déterminant clé de la santé de notre population. Les médecins de famille jouent un rôle central dans la prestation de soins primaires au Canada. La valeur perçue du généraliste dans la prestation des soins médicaux a varié depuis la naissance de la médecine générale au XIX^e siècle. J'ai constaté la valeur ajoutée perçue du généraliste par rapport au médecin spécialiste s'améliorer, d'autant plus que les médecins de famille «à part entière» sont devenus une denrée

rare au cours des dernières années. Même avec un meilleur soutien pour les médecins de famille et une augmentation marquée du nombre de médecins généralistes diplômés, une pénurie importante de ces derniers persiste au Canada. Je crois qu'une grande partie de ce problème est attribuable au fait que de nombreux médecins de famille diplômés choisissent de se concentrer sur la médecine familiale et abandonnent le métier de généraliste qui suit les principes de la médecine familiale tels que définis par le Collège canadien des médecins de famille.

Visites d'étude des hôpitaux de 2017

Apprendre des autres

Du 27 juin au 1^{er} juillet 2016, la Fédération internationale des hôpitaux (IHF) et Health investment & Financing ont organisé des visites d'étude dans des hôpitaux à Montréal, dans la province de Québec et à Ottawa, dans la province de l'Ontario, au Canada. L'objectif de ces visites était de permettre aux participants d'apprendre comment le secteur hospitalier canadien aborde certain(e)s des principaux défis et solutions, afin de transformer la façon dont les soins hospitaliers sont dispensés au XXI^e siècle. Les visites effectuées à Montréal faisaient partie d'une série d'événements de premier ordre proposés par l'IHF. Ces visites étaient le fruit d'une collaboration entre des organisations partenaires canadiennes à Montréal et à Ottawa qui organisaient différents événements pour échanger des idées, des connaissances, des expériences et des pratiques exemplaires dans la prestation de services de santé et le leadership et la gestion de leurs organisations.

Canadian success stories on health and social care Volume 53 Number 4

Resumen en Español

Tramitación de un modelo de integración coordinado para las personas ancianas vulnerables en Quebec (Canadá): el proyecto PRISMA

PRISMA es un modelo de tipo coordinado de suministro de Servicio Integral para las personas ancianas vulnerables. El modelo PRISMA incluye los siguientes componentes para mejorar la integración: 1) un mecanismo formal para gestionar la cooperación entre gestores y directivos de todos los servicio y organizaciones, 2) el uso de un punto de entrada único, 3) un proceso de gestión del caso, 4) Planes de Asistencia Personalizados, 5) una sola herramienta de evaluación con un sistema de casuísticas y 6) un sistema computarizado para la comunicación entre instituciones y profesionales.

El modelo PRISMA fue experimentado en tres áreas (urbana, rural, con y sin hospital local) en Quebec, Canadá y la investigación se llevó a cabo utilizando datos tanto cualitativos como cuantitativos para evaluar sus procesos y su impacto. Se comprobó un impacto significativo en la prevalencia y la incidencia del deterioro funcional y en la satisfacción por los servicios y su potenciación. Se redujeron la concurrencia a la Sala de Urgencias y las hospitalizaciones. El costo general no fue mayor en el grupo experimental, si bien estaba incluido el costo de implementación.

El modelo PRISMA se implementó en toda la provincia de Quebec de 2005 a 2015. Las limitaciones presupuestarias y consiguientes reformas (fusión de instituciones) ralentizaron la implementación. Se aprendieron muchas lecciones de esta implementación: fueron formalmente formados y acreditados los administradores de casos y la integración estructural mediante fusión no promovió necesariamente la integración funcional. El modelo PRISMA es un buen ejemplo de la transferencia efectiva de los resultados de la investigación a un programa nacional, dentro de un contexto de política estatal basada en datos empíricos.

Vías de transformación en sistemas sanitarios con recursos públicos: Experiencia en provincias de Canadá

Las provincias canadienses han emprendido repetidas reformas del sistema sanitario para mejorar la respuesta a las necesidades cambiantes que surgen de una población que envejece y con un elevado predominio de enfermedades crónicas. Como en otros países, la reforma del sistema a gran escala se considera necesaria para enfrentar estos desafíos. Con cambios estructurales, como cierres de hospitales y la creación de autoridades sanitarias regionales, predominando en los años 90, reformas más recientes están destinándose a otros niveles de cambio. Este estudio examina tres temas que aparecen en las reformas emprendidas en las diferentes provincias canadienses en la última década: la promoción de bases alternativas de movilización para ofrecer mejoras, una búsqueda para aumentar la capacidad de gestionar y esfuerzos para contratar

clínicos líderes y especialmente médicos, genera mejoras a gran escala.

Gestión de los mitos en la Asistencia Sanitaria

Este artículo presenta un resumen en tres partes de mi libro publicado en 2017, titulado *Managing the Myths of Health Care* (La gestión de los mitos en la Asistencia Sanitaria). I. Los mitos en la Asistencia Sanitaria II. Reorganización de la asistencia sanitaria y III. Reformulación de la asistencia sanitaria. Se incluyen dos notas adicionales, una relativa a la gestión con y sin alma, la otra relativa a un foro para desarrollar directores de asistencia sanitaria con alma.

Preparando el Terreno para la Transformación: Un Estudio monográfico de la Experiencia de MUHC

En 2015, el McGill University Health Centre (MUHC), un centro sanitario académico líder ubicado en Montreal, Quebec, Canadá, inauguró un complejo de 1.3-billones de dólares canadienses (Glen site) después de un proceso de planificación, autorización, diseño, financiación construcción y activación que abarcó casi dos décadas. El MUHC fue obligado a impulsar el proyecto transformador para innovar y compartir la nueva información desarrollada. Como consecuencia, este período turbulento produjo una considerable mole de conocimientos. Este artículo ilustra la experiencia del MUHC y está basado en la literatura. Orienta los tópicos hacia cambios complejos, innovación y mejoras del rendimiento en la asistencia sanitaria. En especial, para aquellas organizaciones que quizás estén planeando o ya se hayan implicado en un proyecto de transformación como aquel emprendido por el MUHC, les aporta pruebas sobre por qué es beneficioso dedicar recursos a sostener la transformación especialmente durante el período de transición. El artículo concluye con un resumen de las lecciones aprendidas y una vía posible de estudios adicionales.

Descripción general de los centros de asistencia a largo plazo en la Provincia de Quebec

Este artículo trata sobre las tres mayores reformas que han afectado e influenciado el desarrollo en el sector de asistencia a largo plazo.

Se discuten diferentes estadísticas para ofrecer a los lectores un conocimiento básico sobre los servicios brindados a los ancianos en Quebec, así como la población que cubren.

Hacia dónde se encaminan los Hospitales Canadienses: Ajustando Atribuciones y Responsabilidades.

El sistema sanitario canadiense, a diferencia de muchos otros en el mundo, está siendo sometido a una enorme reforma. En ningún lugar estas reformas han sido más dramáticas que en aquel que se conoce en Canadá como el "hospital sec-

tor". El símbolo mundial de la "H" azul puede verse en más de 1000 comunidades y autopistas a lo largo y ancho de Canadá. En cualquier caso, en el último decenio, como entidades legales se ha considerado que los hospitales no existen en todas las provincias a excepción de la más grande: Ontario. Por otra parte, una amplia y creciente gama de hospitales y servicios basados en la comunidad son administrados mediante las Autoridades Sanitarias Regionales o RHAs. Este breve texto intenta ofrecer una descripción precisa de la naturaleza de estas reformas así como de las fuerzas económicas, tecnológicas y políticas detrás de ellas, y evaluar resumidamente las implicaciones para la voz nacional de los "hospitales".

Gestión de la salud de la población

Una Perspectiva Canadiense en el Futuro de los Sistemas Sanitarios

A nivel Internacional han comenzado a consolidarse cada vez más dos tendencias en materia de asistencia. Una es el creciente reconocimiento que la asistencia sanitaria es un determinante del estatus de salud. La difusión de la sanidad y la prevención juegan un papel importante ya que influyen en los determinantes sociales de la sanidad y en los sectores que la representan. La segunda tendencia es la experimentación con propuestas de sistemas financiados que apunten cada vez más a compartir el riesgo y los beneficios entre patrocinadores y proveedores. Ambas tendencias forman el impulso que comienza a ser conocido como gestión sanitaria poblacional (PHM). Canadá ha sido pionero en el desarrollo de estos conceptos, pero la experiencia internacional sugiere que se ha quedado rezagado en la implementación. Para seguir avanzando, los factores de éxito críticos para Canadá incluyen la gestión de la información sanitaria, la colaboración multisectorial y el liderazgo clínico.

Enfermeros motivados en Canadá para brindar Mejor Asistencia, Mejor Sanidad y Mejor Valor.

La población canadiense está envejeciendo y predominan las enfermedades crónicas a la vez que las desigualdades sociales y sanitarias están creciendo. Mientras los desafíos orientados en nuestra salud y los sistemas sanitarios son formidables, Canadá cuenta con excelentes recursos que pueden aprovecharse para sostener el cambio de nivel del sistema. Nuestro gran personal de enfermería, altamente cualificado y preparado, es parte de la solución a ofrecer en relación con la transformación del sistema y la adquisición de mejor asistencia, mejor sanidad y mejor valor para nuestras inversiones asistenciales estatales. A través de una serie de esfuerzos de los agentes de todos los niveles, los enfermeros están cada vez más capacitados para contribuir al mejoramiento del sistema sanitario. Ejemplos recientes incluyen la prescripción habilitada para enfermeros registrados, promoviendo el ejercicio avanzado de la enfermería y modernizando la legislación federal sobre la habilitación de los enfermeros para practicar en todos los aspectos.

La evolución de la medicina generalista en Canadá: una reflexión en retirada

La asistencia primaria es una clave determinante de la sanidad de nuestra población. Los médicos de familia son fundamentales para suministrar la asistencia primaria en Canadá. La importancia que se atribuye al médico generalista en el suministro de la atención médica ha variado desde el nacimiento de la práctica general en el siglo XIX. He visto que la importancia

que se atribuye al médico generalista con respecto a los médicos especialistas ha aumentado, especialmente a medida que los médicos de familia de «alcance completo» se han ido volviendo un bien escaso en los últimos años. A pesar del apoyo creciente hacia los médicos de familia y al marcado incremento del número de médicos de familia graduados, sigue habiendo una significativa escasez de médicos de familia en Canadá. Creo que en gran parte este problema se deba a que muchos de los médicos de familia graduados eligen centrar su práctica en la medicina familiar y renuncia a convertirse en generalista, basándose en los valores de la Práctica en la Familia como lo ha destacado el Colegio Canadiense de Médicos de Familia.

Visita de Estudio de las Direcciones de Hospitales de Montreal en 2017: Aprendiendo de los demás

Entre el 27 de junio al 1° de julio de 2016, la International Hospital Federation (IHF) y el Health investment & Financing acogieron una Visita de Estudio de Directivos Hospitalarios en Montreal, en la Provincia de Quebec y en Ottawa, en la Provincia de Ontario, Canadá. El objetivo de la Visita de Estudio de Directivos Hospitalarios fue permitir a los participantes conocer cómo el sector hospitalario canadiense aborda algunos de los principales desafíos y sus soluciones para transformar el modo en el cual se realiza la asistencia hospitalaria en el siglo XXI. La Visita de Estudio a Montreal formó parte de una serie de eventos principales ofrecidos por el IHF. Esta Visita de Estudio fue un esfuerzo de colaboración entre organizaciones asociadas canadienses tanto en Montreal como en Ottawa que albergaron varios eventos para permitir el intercambio de ideas, conocimientos, experiencias y prácticas recomendadas para el suministro de servicios de asistencia sanitaria y el liderazgo y gestión de sus organizaciones.

Canadian success stories on health and social care Volume 53 Number 4

中文摘要

为魁北克省（加拿大）的脆弱老年人实施联动型一体化模式：PRISMA项目

PRISMA是一种为弱势老年人提供一体化服务的联动模式。PRISMA模式有如下的加强一体化的组件：1）一个对所有服务和机构的决策者与管理者之间的合作进行管理的正式机制；2）使用单一入口点；3）病例管理过程；4）个性化的服务方案；5）独特的评估工具，带有病例组合系统；以及6）机构和专业人员之间进行通信的计算机化系统。

PRISMA模式在加拿大魁北克的三个地区（既有城市也有农村的，有的有当地医院，有的没有）进行了试验性实施，并使用定性和定量数据进行了研究，以评估其过程和影响。实施过程中观察到，该模式对机能衰退的患病率和发病率、服务满意度和病患赋权有着重大影响。急诊病人和住院病人的数量都有所减少。即使将实施成本加上，实验组的整体费用也并未上升。

随后从2005年至2015年，在魁北克全省实施了PRISMA模式。预算的限制条件以及伴随而来的改革（机构合并）拖慢了实施进度。在实施过程中，学到了不少经验：病例管理人员应经过正式的培训和认证；通过合并进行的结构整合并不一定能促进功能整合。PRISMA模式很好地展示了如何在以证据为基础的公共政策范围内有效地将研究成果转化至国家计划中。

公共出资的卫生系统的转型途径：加拿大各省的经验

加拿大各省多次进行卫生系统改革，以更好地应对人口老龄化和慢性病发病率高所带来的不断变化的需求。和其他国家一样，为了迎接这些挑战，必须进行大规模的体制改革。20世纪90年代盛行的是结构性变革，例如医院关门和建立区域卫生机构等，而最近的改革采用的是其他变革手段。本文考察了过去十年在加拿大不同省份进行的改革中出现的三大主题：培养替代动员基础以实现改进；寻求提高治理能力；努力让临床领导者参与大规模改善，尤其是内科医生。

管理医疗神话

这篇文章总结了我为2017年出版的新书《管理医疗神话》，文章分三部分：一、医疗神话；二、重组医疗；三、重塑医疗。另外还有两条注意事项，一个是关于有无灵魂的管理，另一个是关于一个培养有灵魂的医疗管理者的论坛。

准备转型的基础：以MUHC经验进行案例研究

2015年，位于加拿大魁北克省蒙特利尔的领先的学术健康中心——麦吉尔大学健康中心（MUHC），为一座价值13亿加元的健康综合大楼（Glen场地）举行了揭幕仪式，此前该大楼经历了长达近二十年的规划、批准、设计、融资、建设和启动程序。MUHC被迫利用转型项目来进行创新并分享所获得的新信息。因此，这个动荡的时期产生了相当多的知识。本文借鉴了MUHC的经验，并以文献为基础。文章探讨的主题包括医疗保健中的复杂变化、创新和绩效改善。特别是，它旨在为正在计划或正在参与转型项目（如MUHC所开展的项目）的组织提供证据，以证明为什么投入资源支持转型中有益的，尤其是在转型期。文章最后总结了经验教训以及开展额外研究的可能途径。

魁北克省长期护理中心概况

本文讨论的是影响长期护理行业发展的三大改革。

文中讨论了各种统计数据，让读者对魁北克省老年人服务情况以及此类服务所覆盖的人口统计数据有基本的了解。

更洁白的加拿大医院：调整权限和责任。

加拿大的医疗体系，与世界上许多国家的医疗体系一样，正在发生巨大的变化。但任何地方的变化，都比不上曾在加拿大被称为“医院部门”所经历的变化更为戏剧化。在加拿大各地的1000多个社区和不同的高速公路上，仍然可以看到蓝色“H”的世界性标志。但是，在过去十年中，医院已不再作为法人实体存在于各省，除了我们最大的一个省——安大略省。在其他地方，越来越多的医院和社区服务机构接受地区卫生当局或RHA的管理。这篇短文试图对这些变化的性质以及背后的经济、技术和政治力量进行高层次的描述，并简要评估“医院”这一国民声音的含义。

人口健康管理

加拿大对卫生系统未来的展望

在国际上，医疗保健的两大趋势正在日益完善。一个趋势是，人们越来越认识到医疗保健只是健康状况的一个决定因素。预防和促进健康的工作可发挥重要的作用，主要通过对健康相关的社会决定因素和健康相关的领域施加影响。第二大趋势是，有渠道获得系统资金的试验，其目的越来越倾向于让资助者和提供者分担风险和分享利益。总的来说，这两大趋势共同构成了“人口健康管理”（PHM）的推动力。加拿大一直是建立概念的先驱，但国际经验表明，加拿大在实施方面落后了。在前进过程中，加拿大的关键成功因素包括健康信息管理、多部门合作和临床领导。

让加拿大的护士有能力提供更好的护理、更好的健康和更高的价值

加拿大人口老龄化，且慢性病发病率以及健康和社会不平等现象正在增长。虽然我们的健康和卫生服务体系所面临的挑战是艰巨的，但加拿大拥有优质资源，可用来支持系统级的变化。我们的护理人员队伍庞大、受过高等教育且技能熟练，他们是解决方案的一部分，可实现系统转型，并为我们的公共医疗投资实现更好的护理、更好的健康和更高的价值。通过各级利益相关方的努力，护士越来越有能力为卫生系统的改善做出贡献。最近的例子包括允许注册护士开处方、促进高级护理执业、使联邦立法现代化以便护士能够全面执业。

加拿大全科医疗的演变：对退休的反思

基层医疗是我们人口健康的一个关键决定因素。家庭医生是加拿大提供基层医疗服务的核心。自19世纪全科医疗的诞生以来，人们对于全科医生在医疗服务方面的价值的认知有所变化。本人发现，相对于专科医师而言，全科医生的认知价值有所提高，特别是在近年来“全方位”的家庭医生已成为稀缺的商品的背景下。即使加大了对家庭医生的支持力度，毕业离校的家庭医生数量也有显著增加，加拿大各地的家庭医生仍然严重短缺。我认为，这个问题很大程度上是由于许多毕业的家庭医生选择把他们的执业重点放在家庭医学上，并放弃成为全科医生，而后者按照加拿大家庭医生学会规定的家庭执业原则执业。

2017年蒙特利尔行政人员医院考察团：

向他人学习

2016年6月27日至7月1日，国际医院联合会（IHF）和卫生投融资部门在加拿大魁北克省蒙特利尔市和安大略省渥太华市开展了医院行政人员考察。医院行政人员考察的目的是让参与者了解加拿大医院如何解决一些关键挑战并执行解决方案，以改变21世纪医院护理的服务方式。蒙特利尔考察是国际医院联合会组织的一系列重要活动的组成部分。这次考察之旅是位于蒙特利尔和渥太华的多加拿大合作组织共同努力的结果，他们主办了各种活动，以交流医疗保健服务过程的相关理念、知识、经验和最佳实践，考察活动由这些组织进行领导并管理。

IHF events calendar

2018

IHF

42st World Hospital Congress

October 9-11, Brisbane, Australia

<http://event.icebergevents.com.au/whc2018>

For more information, contact 2018congress@ihf-fih.org

2019

IHF

43rd World Hospital Congress

November, Muscat, Oman

For more information, contact patricia.mencias@ihf-fih.org

2018

MEMBERS

BRAZIL

CISS – International Congress on Healthcare Services

Hospitalar Fair and Forum

May 23 – 24, Expo Center Norte – São Paulo

<http://www.hospitalar.com/en/>

CANADA

Canadian Summit on Healthcare Cyber Security

HealthcareCAN

February 22, Toronto

<http://www.healthcarecan.ca/2017/11/22/canadian-summit-on-healthcare-cyber-security/>

COLOMBIA

VI Feria Internacional de la Salud, Meditech 2018

Asociación Colombiana de Hospitales y Clínicas y Corferias

July 3-6, Bogotá, Colombia

<https://feriameditech.com/>

XIII Congreso Internacional de Hospitales y Clínicas

Asociación Colombiana de Hospitales y Clínicas

July 4-5, Auditorio Corferias, Bogotá, Colombia

<http://achc.org.co/congreso-internacional-de-hospitales-y-clinicas/>

Entrega V Galardón Nacional Hospital Seguro

Asociación Colombiana de Hospitales y Clínicas

July 5, Bogotá, Colombia

<http://achc.org.co/galardon-nacional-hospital-seguro/>

FRANCE

Paris Healthcare Week 2018

French Hospital Federation

May 29 – 31, Paris Expo – Porte de Versailles, Paris

<http://www.parishealthcareweek.com/>

HONG KONG

Hospital Authority Convention 2018

The Hospital Authority, Hong Kong SAR

May 7-8, Hong Kong Convention and Exhibition Centre

www.ha.org.hk/haconvention/hac2018

www.ha.org.hk/haconvention/hac2017

JAPAN

68th Congress of Japan Hospital Association

Japan Hospital Association

June 28-29, Ishikawa prefecture, Japan

<http://www.hospital.or.jp/gakkai.html>

NORWAY

Leader Conference 2018

Norwegian Hospital & Health Service Association (NSH)

February 8-9, Oslo Congress Center, Oslo

<http://www.nsh.no/lederkonferansen-2018-paamelding-er-aapen-med-early-bird-priser.5976637-372304.html>

UNITED ARAB EMIRATES

Dubai Health Forum 2018

Dubai Health Authority

January 15-16, Madinat Jumeirah, Dubai

<http://dubaihealthforum.org/>

USA

Rural Healthcare Leadership Conference

American Hospital Association

February 4-9, Arizona Grand Resort & SPA, Phoenix, AZ

<http://www.healthforum-edu.com/rural/index.dhtml>

For further details contact the: IHF Partnerships and Project, International Hospital Federation, 151 Route de Loëx, 1233 Bernex, Switzerland; E-Mail: info@ihf-fih.org or visit the IHF website: <https://www.ihf-fih.org>

2018

IHF BRISBANE

42nd World Hospital Congress

10-12 OCTOBER 2018 BRISBANE AUSTRALIA



Join us Down Under in 2018!

Australian Healthcare & Hospitals Association (AHHA) is pleased to invite you to join us in Australia for the 42nd IHF World Hospital Congress to be held on 10-12 October 2018.

Join health leaders from around the world to discuss how healthcare needs to evolve to meet 21st century demands. Globally health systems are in transition. Impacts of new technology, changing demographics and disease profiles, funding pressures, new models of care and more are driving transformation. So how at this critical point do we harness the benefits and overcome the obstacles?

The 42nd IHF World Hospital Congress will inspire you with the journey to date and the opportunities for the future to come.

Important Dates

Call for abstracts closes
15 January 2018

Notification to authors
15 March 2018

Earlybird registration closes
30 June 2018

World Hospital Congress
10-12 October 2018

www.hospitalcongress2018.com

Presented by



Host Partner

Clinical
Excellence
Division



Platinum Sponsor

