



ASSESSING INITIATIVES TO TRANSFORM HEALTHCARE SYSTEMS: LESSONS FOR THE CANADIAN HEALTHCARE SYSTEM

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TABLE OF CONTENTS

KEY MESSAGES	i
EXECUTIVE SUMMARY.....	ii
INTRODUCTION: FRAMING THE PROBLEM OF HEALTHCARE SYSTEM TRANSFORMATION	1
APPROACHES TO EVIDENCE SOURCES AND INTEGRATION	2
1. ASSESSMENT OF CHANGES WITHIN THE CANADIAN HEALTHCARE SYSTEM FOLLOWING THE HEALTH ACCORD (2003): WHERE AND WHEN HAS CHANGE OCCURRED IN THE SYSTEM?	2
1.1 Changes in the Canadian healthcare system.....	2
1.1.1 Primary healthcare.....	3
1.1.2 Home care.....	4
1.1.3 Long-term care.....	4
1.1.4 Mental health	5
1.1.4 Management of chronic diseases.....	5
1.1.6 Structural changes.....	6
1.1.7 Quality and safety.....	6
1.2 LESSONS FROM CHANGE IN CANADA.....	7
1.3 LEARNING FROM THE CHANGES TO DATE.....	8
1.4 LEARNING FROM OTHER OECD COUNTRIES.....	8
1.5 CONCLUDING REMARKS ON A DECADE OF CHANGE	10
II - Themes for healthcare system transformation.....	11
Theme 1: Strategic Realignment efforts	11
Theme 2: Organizations as the engine for delivery and change.....	13
Theme 3: Professional cultures (shaping professional cultures to shape the industry).....	15
Theme 4: Creating an enabling environment that supports improvements	17
Theme 5: Patient engagement: the making of countervailing power.....	20
Theme 6: The evidence-informed movement: the making of countervailing power	21
CONCLUDING REMARKS.....	23
REFERENCES	26

KEY MESSAGES

- ▶ One key element of any transformative strategy is a clear picture of what needs to be changed. Canada needs an integrated vision and approach to achieve healthcare system transformation.
- ▶ Healthcare systems tend to reproduce their dominant logic (in Canada it means that more and more resources are invested in specialized care) and consequently neglect other areas where major care deficits persist.
- ▶ Without vigorous human resources policies that favour a new mix of skills, including new professional roles and innovative models of inter-professional teams, current care deficits will not be alleviated.
- ▶ Human resources don't work in a vacuum. An enabling environment and organizations that support professional and clinical practices can have a significant impact on the provision and quality of care and services.
- ▶ New organizations and governance models are essential elements of a large-scale improvement strategy. Initiatives to renew primary healthcare in Canada in the last ten years clearly illustrate that an inherent tension in transformation is how to challenge healthcare professionals and stakeholders to adopt new ways of thinking and working while keeping them fully engaged in the transformation process.
- ▶ Renewal of delivery organizations requires strong leadership from and close connection between the management and clinical worlds. It is essential to recruit and train individuals to effectively bridge these two worlds.
- ▶ Professionals and organizations can make important progress at the local level. However, to support improvement and spread good practices, better communication and mutual learning between the policy and delivery levels are needed.
- ▶ Debates among providers, organizations and the government too often focus on the level of financial resources and incentives available to achieve improvements in the healthcare system. While financial resources and economic incentives can play a role in orienting the provision of care and services, strategies to develop a commitment to better care seem more promising.
- ▶ In order to realign the system to meet evolving health needs, initiatives that support patient engagement and citizen participation, as well as the use of evidence to inform change, are crucial. Both types of levers are potentially powerful instruments to channel organizational and professional strategies toward improvement.

EXECUTIVE SUMMARY

This paper suggests that money alone cannot improve healthcare. A clear vision and a coherent set of strategies are required to transform the system and achieve better alignment between the care offered and the care the population needs today (primary healthcare, more effective management of chronic diseases, mental health, etc.).

Canada has invested significant financial resources and energy (including numerous federal and provincial commissions) in efforts to make the healthcare system more responsive to evolving needs. Nonetheless, there is general consensus that Canada's healthcare systems have been too slow to adapt. A 2008 report by the Health Council of Canada concludes that since the 2003 Health Accord there have been improvements in access to care in some clinical priority areas, such as hip and knee replacement and cataract surgery. However, it also identifies a number of areas where "progress on the accord commitments is not a cause for celebration" (HCC, 2008:34). These areas include drug coverage and safe and appropriate prescribing; home care; aboriginal health; primary healthcare; the healthcare workforce; electronic health records and information technology; and accountability.

The Council's conclusions raise questions about how governments can further support change and on which policy options and instruments they should rely. Our analysis identified six themes that are crucial for an integrated and systemic approach to healthcare transformation.

Strategic realignment: No significant changes will occur without a serious attempt to realign the system to meet patient needs and evolving demands. Such realignment requires concerted efforts across sub-sectors of healthcare systems. At the delivery level, it implies large-scale organizational development initiatives to implement new models and processes of care. It is important to recognize that reforms which aim to strengthen primary healthcare and implement more effective chronic disease management and population health interventions will inevitably challenge the predominant logic of the current system.

Organizations as the engine for delivery and change: Organizational capacity is an essential ingredient in improving healthcare delivery. Increased reliance on team-based organizations and networks is an indication of growing recognition that more effective organizations can deliver better care. Organizational transformation is highly demanding. When implementing new organizational arrangements such as networks and inter-professional teams, it is essential to closely and deliberately manage the change process. Diverse organizational forms are needed to meet evolving and shifting demands.

Professional cultures: Transformation requires new professional roles and the engagement of the medical profession. Various options have been considered to stimulate changes in professional culture, with most attention being paid to the medical profession. Economic levers are not sufficient to get the commitment of professionals to improve care and services and lead change initiatives. More attention should be paid to the development of new professional roles in the healthcare system such as nurse practitioners, patient navigators and health assistants. The development of professional roles that link clinical and managerial functions may be part of the solution. Individuals would need to be trained and recruited to fulfill those roles.

Creating an enabling environment: Achieving improvements requires effective governance, well-defined and appropriate goals and targets, effective reporting mechanisms and well-designed financial (for example, hospital funding, pay for performance) and non-financial incentives. However, system transformation also requires policies that stimulate engagement of professionals, along with acquisition of new competencies and skills by both healthcare managers and providers. In addition, funding-renewal and incentive mechanisms need to be coupled with the capacity to monitor and adjust these policy instruments.

Patient engagement: Care is more than the encounter between a health professional and a patient; it is also a function of organizational context and system policies. Patient engagement and public participation should be a hallmark of good governance in healthcare, and strategies should be designed to make these happen. Patients can be involved in the design of services and citizens can participate in policy decisions if healthcare systems and organizations develop deliberate strategies to support such involvement. Recent experiences with expert patients and citizen councils, such as the Citizens' Council of the U.K.'s National Institute for Health and Clinical Excellence, support the notion that patient and citizen involvement can be nurtured. Finally, the promotion of self-care can be a strategy to reinforce the role of patients in decisions about the delivery of health services.

Evidence-informed policy-and decision-making: Evaluation of the effectiveness of initiatives to improve care is crucial for healthcare system transformation. Since the early 1990s, many efforts have been made to produce evidence in priority areas, to find new ways of packaging evidence (such as through knowledge syntheses) and to disseminate evidence more effectively to practitioners and decision-makers. Today, there is a need to design strategies to enhance organizational capacity to integrate evidence into practice, as well as better coordination among research-based evidence, policy-making and politics.

This paper suggests avenues that governments can take to support the transformation of the healthcare system to provide better care and services. The recommendations are based on a very basic principle: constant re-organization of the system will not deliver better care. Structural changes have often been implemented without a clear rationale and with potentially detrimental effects on the system. The political context is a major factor in healthcare system transformation. While we strongly advocate for major efforts, investments and transformative initiatives at the delivery level, we also underscore the need for innovations and experiments that will increase communications between the research community, policy-makers and the political sphere. We also recommend the development of strategies to better involve professionals in leading transformation and improvement initiatives, while recognizing that transformation implies direct challenges to professional power and monopolies.

INTRODUCTION: FRAMING THE PROBLEM OF HEALTHCARE SYSTEM TRANSFORMATION

Healthcare represents an important share of public spending in Canadian provinces and territories. The evolution of costs and demands for healthcare, particularly at a time of slow economic growth, is a major preoccupation. In Canada, as in many Organisation for Economic Cooperation and Development (OECD) member countries, the healthcare system is at the core of political life and commands significant policy attention. The media also devote significant attention to healthcare system issues and contribute, in part, to public perceptions of the system's functioning and performance. Patients and citizens also have high expectations with regard to healthcare, placing increased pressures on the system to respond adequately and in a timely way.

This paper suggests that money alone cannot buy sufficient and desirable changes for improvement in healthcare. A better fit between the care offered and the care the population needs (primary healthcare, more effective management of chronic diseases, mental health, etc.) can be achieved through a broad and coherent set of strategies to significantly transform the system.

When speaking of healthcare system transformation, we mean changes in the perception that agents have of their roles, practices and activities as well as in the structure of the system.¹ A transformation occurs when changes in the mindset of key actors occur in tandem with changes in the architecture of the system. From a policy perspective, significant changes within the system will only occur if there are changes in the governing coalition and policy framework used to approach problems and solutions.² Despite significant investments of financial resources and energy in Canada (including numerous federal and provincial commissions) to better adapt the healthcare system to demographic changes, changing pattern of disease (e.g. increased prevalence of chronic diseases), increased capacity of interventions and the evolving socio-economic context, there is a general consensus that the Canadian healthcare system has been too slow in making the necessary adaptations.³ This observation raises questions about how governments can further support change and on which policy options and instruments they should rely.

Annual spending on healthcare in Canada is approximately \$191 billion. The federal government spent approximately \$31.4 billion on healthcare in 2009–10. This figure includes spending by 11 federal organizations. The Canada Health Transfer is the primary federal transfer of healthcare funds to provinces and territories. In 2009–10, the transfer reached \$24.8 billion, representing 79% of the federal spending on health.

Healthcare is primarily a provincial responsibility. The provinces design and manage their healthcare systems within the context of the principles laid out in the *Canada Health Act* (1984). The Health Accord (2003) and the 10-Year Plan to Strengthen Healthcare in Canada (2004) represented a shift in the approach to healthcare reform, with greater focus on accountability and system improvement. The Health Council of Canada was created in 2004 to monitor progress in Canadian healthcare systems within the framework of the 2003 Health Accord. This Accord expires in December 2013. It is in this context that this policy paper on healthcare system transformation has been commissioned. Three main questions guide the preparation of this paper:

- ▶ Where and when has change occurred in the Canadian healthcare system since the 2003 health accord? (section I of the paper)
- ▶ What were the barriers to transformation? (section I of the paper)
- ▶ What lessons can be learned from these experiences in the context of the international experience with healthcare reforms and healthcare system transformation? (section II of the paper)

After a brief explanation of methodology, section I summarizes the changes that have taken place since 2003 in Canada's healthcare systems and then examines the major issues facing healthcare systems and identifies areas where improvement is needed. This assessment provides insights into the challenge of healthcare system transformation, which create a framework for section II. Section II explores six themes that are crucial for healthcare system transformation. These themes provide an integrative approach to transformation and are the basis of key policy messages to support healthcare system transformation. In the conclusion of the paper, we discuss critical challenges that Canadian healthcare systems will face as they attempt to adapt to evolving demands and expectations. These challenges should be debated and addressed in a much more decisive way than has been done in the past.

Approaches to evidence sources and integration

The theme of healthcare system transformation is very broad. The evidence regarding transformation of complex systems comes from a wide variety of sources, including scientific publications, grey literature and expert opinions. In this paper, to identify needs for transformation and improvement (care deficit) in the Canadian healthcare system, we mainly used reports produced since 2003 by governmental agencies (provincial and federal) that are mandated to monitor or assess the evolution of healthcare systems in their jurisdictions. We identified these reports through websites of provincial governments and federal government departments and agencies such as the Health Council of Canada (HCC) and the Canadian Institute for Health Information (CIHI). To provide a broader context for the challenges faced by the Canadian healthcare system, we relied on recent reports published by the OECD on healthcare system performance and on websites of different think tanks, such as the European Observatory on Health Systems and Policies, The King's Fund and The Nuffield Trust. We also searched main health policy journals (*Health Affairs*, *Milbank Quarterly*, *Journal of Health Policy*, *Politics and Law*) for key papers on healthcare system transformation.

To identify the six themes that represent pathways for healthcare system transformation, we organized a working session on healthcare system transformation with three U.K. experts in the field of health policy and management. We then searched for works (major health policy journals, government and think-tank websites) that support the development of each of the themes and the formulation of key messages for policy-makers.

1 ASSESSMENT OF CHANGES WITHIN THE CANADIAN HEALTHCARE SYSTEM FOLLOWING THE HEALTH ACCORD (2003): WHERE AND WHEN HAS CHANGE OCCURRED IN THE SYSTEM?

The objectives of this section are to identify the main areas where change has occurred and the principle levers that were used to produce change, and the key lessons for the development of strategies to support healthcare system transformation.

1.1 Changes in the Canadian healthcare system

The Health Council of Canada (HCC), in its 2008 report on healthcare renewal in Canada, concludes that there have been improvements in access to care due to major investments that boosted the volume of services delivered and better management of waiting lists within the system. Improvements in access to care in some clinical priority areas, such as hip and knee replacement and cataract surgery, have been

observed and provinces have agreed on standards for wait times. A recent report by the Canadian Institute for Health Information (CIHI)⁴ on wait times also finds improvements for specific procedures, but notes variations among provinces in their attainment of standards for wait times in priority areas.

The HCC report identifies a number of areas where “progress on the accord commitments is not a cause for celebration” (HCC, 2008:34). Among these areas are drug coverage and safe and appropriate prescribing; home care; aboriginal health; primary healthcare; healthcare workforce; electronic health records and information technology; and accountability. While provinces made significant efforts in some of these areas, the report underscores the need to accelerate change. Based on the HCC’s list of areas for improvement and other reports on various aspects of the Canadian healthcare system, we focus our analysis on primary healthcare, home care and community-based care for mental health patients, chronic disease management, long-term care, structural changes, and quality and safety. Issues related to the healthcare workforce are central to each of these areas. We do not focus on aboriginal health, as we feel this topic deserves an analysis of its own based on a much broader framework than a focus on healthcare system transformation. Similarly, major gaps between expectations and achievements in the area of electronic health records and information technology also deserve a full report. However, the latter issues will arise when we discuss the need to transform models of care delivery in various sectors.

This section provides a high-level assessment of changes in key areas related to the transformation of the Canadian healthcare system. The focus is mainly on the identification of key areas for current and future transformation. It cannot, of necessity, do justice to the many initiatives or innovations at the local level that push the system in the right direction.

1.1.1 Primary healthcare

Primary healthcare (PHC) is a revelatory case of the challenges involved in bringing about changes in Canada’s healthcare systems. Significant efforts have been made in recent years by various provinces to reorganize and improve PHC in Canada.

In the 2010 Commonwealth Fund International Health Policy Survey,⁵ 86% of Canadian adults report having a regular source of care. The proportion varies from a low of 81% in Alberta to a high of 92% in the Atlantic provinces. According to this survey, 45% of Canadians are able to get an appointment the same or next day for immediate needs, while 33% wait six or more days before accessing a doctor or nurse when sick or needing care. According to a 2008 survey, 51% of PHC practices in Canada provide eight or more of the eleven listed services for comprehensive care.⁶ Nearly one-third – 31% – of Canadians has access to more than one provider, meaning professionals other than their family doctor.

A recent analysis of PHC reforms in Canada⁷ reveals that provinces mainly use two levers to bring about change: quality and performance-based programs, and the design and implementation of new organizational models such as family health teams in Ontario and family medical groups in Quebec. Looking at PHC reform in Canada, the authors conclude that reforms in PHC are primarily led by government and more marginally by the medical professions, and that physicians are considered partners in these reforms, while other professionals are less involved. Some initiatives, such as Access Improvement Measures in Alberta (2009), have resulted in improvements in access to family medicine. However, variations in improvement across provinces remain.⁸

Overall, due to promising initiatives in many provinces, the development of strong PHC organizations based on inter-professional teams has progressed in recent years. For example, Ontario has made significant progress at the system level with the expansion of Community Health Centres and the

implementation of family health teams. The number of family physicians working in inter-professional teams has increased from less than 200 in 2002 to more than 2,100 in 2010, with 18% of Ontario's family physicians now working in inter-professional teams. In Quebec, 216 family medical groups (groupes de médecine de famille – GMF) have been established as of September 2010.⁹

While this progress is significant, recent reports suggest that the implementation of inter-professional teams across the system is still a challenge.^{10,11} Various obstacles to change can be identified from the experience of PHC reforms in Canada, including:

- ▼ the difficulty of investing new resources in or reallocating existing resources to this sector;
- ▼ the availability of new professionals such as nurse practitioners;
- ▼ the difficulty of implementing new professional roles within current organizational arrangements; and
- ▼ the need to strengthen and better support the leadership role of the medical and other health professions in the renewal of PHC.

Change has occurred but not at a sufficient pace¹² and this affects our ability to respond properly to the needs of patients with chronic diseases and long-term conditions, who can especially gain from well-developed inter-professional teams at this level of care and who are responsible for 80% of PHC visits.^{13,14}

1.1.2 Home care

It is difficult to assess access to and quality of home care from existing data. Some promising initiatives in Nova Scotia and B.C. seem to have improved access to home care in those provinces.^{15,16} Data on access to alternate levels of care¹⁷ suggest that patients with needs may be discharged from hospitals without proper support at home. The study by Williams, Lum, Deber et al.¹⁸ on care within the community for older persons in Ontario reveals that a significant proportion of patients in residential care could be cared for in the community. In addition, inappropriate coverage of services outside hospitals may add to the difficulty of delivering proper care at home or within the community.

Current trends seem to focus on providing home care for higher-need clients and short-term home care to people discharged from hospital. There seems to be less of an emphasis on low- to medium-need clients and the preventive aspects of home care. Clearly there is a need to further develop home care and care in the community as an alternative to residential care.

1.1.3 Long-term care

A recent report by CIHI¹⁹ on alternate-level-of-care estimates for the period 2007–2008 reveals that 14% of hospital days in Canada are for persons in need of a different level of care. Timely access to long-term or residential care is still a major issue, despite efforts to improve access in many provinces. In addition, many patients are discharged to home with the expectation that they may eventually need residential care. Overall, on-time access to long-term residential care is still an issue for many patients. The quality and safety of care delivered in these organizations are also of concern.

1.1.4 *Mental health*

The Canadian healthcare system demonstrates a major care deficit in the mental health sector. In its 2009–2010²⁰ report, the Mental Health Commission of Canada (MHCC) underscores that only one-third of people facing mental health issues receive appropriate care. The report also estimates that about 50% of homeless people suffer from mental illness and notes a particular difficulty in developing community-based care to respond to their needs, despite promising initiatives such as the Home First project for the aboriginal population in Winnipeg. Children and youth with mental health problems are also not receiving the care they need.²¹ It is estimated that only one out of six children and young people will be adequately diagnosed and served. This is highly problematic considering that it is estimated that up to 70% of mental health problems can be solved if proper care is provided. To respond to these challenges, the MHCC developed a framework for a mental health strategy in Canada oriented around seven goals:²²

- ▶ People of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being.
- ▶ Mental health is promoted, and mental health problems and illnesses are prevented wherever possible.
- ▶ The mental health system responds to the diverse needs of all people in Canada.
- ▶ The role of families in promoting well-being and providing care is recognized, and their needs are supported.
- ▶ People have equitable and timely access to appropriate and effective programs, treatments, services and supports, which are seamlessly integrated around their needs.
- ▶ Actions are informed by the best evidence based on multiple sources of knowledge, outcomes are measured, and research is advanced.
- ▶ People living with mental health problems and illnesses are fully included as valued members of society.

Overall, despite some promising initiatives, major care deficits persist for the mental health sector.

1.1.4 *Management of chronic diseases*

Chronic diseases represent a major challenge for the Canadian healthcare system. Based on a Commonwealth Fund study,²³ Canada as a nation ranks last in the implementation of chronic disease patient management. While progress has been made for specific pathologies like diabetes and asthma, only 33% of Canadians, compared to 61% of Americans, have a written plan for the treatment of their chronic conditions. It is estimated that chronic diseases represent two-thirds of healthcare costs in the U.S.²⁴ A recent report by the Canadian Academy of Health Sciences (CAHS) identifies major gaps between current functioning of the healthcare system and the needs of patients with chronic diseases.²⁵ The report underscores among other things the need to better align funding mechanisms and remuneration of providers; reinforce quality and performance management across the system; and develop a culture of life-long learning among providers to deliver optimal care for chronic patients. There is a need to develop a more active and organized response for the management of chronic diseases in Canada.

1.1.6 *Structural changes*

In addition to attempts to improve care in various sectors, important structural changes have been implemented in various provinces. For example, Alberta abolished its regional health authorities in 2008 and created a single body to manage the system, while Ontario created the Local Health Integration Networks (LHINs) in 2006, providing an intermediate agency between the central government and local organizations for healthcare planning and resource allocation. Quebec created the Centre de santé et de services sociaux (CSSS), an organization that merges primary and secondary care organizations in 95 local territories.²⁶

The Quebec Ministry of Health and Social Services has conducted an evaluation based on eight case studies of local health networks (Gouvernement du Québec, May 2010).²⁷ This evaluation is concerned with two issues: the development of the legal entity (the CSSS) in charge of the local health networks, and the integration of care and services within these networks. The results of the evaluation suggest that the broader policy environment plays both an enabling and limiting role in the development of the CSSS. Between 2006 and 2010, most of the eight CSSSs evolved in a coherent whole and are now in a position to contribute to the integration of care and service in their territory. In most of the cases, positive developments are observed in the creation of partnerships between the CSSS and other providers within their territory. The CSSSs expected more input from the Regional Health Authorities (RHAs) for the implementation of coordination mechanisms such as clinical information across providers. There are three main challenges to increased integration: the low level of physicians' involvement, the competitive behaviours among healthcare providers and the NGOs' fear of losing their autonomy. Data on accessibility and continuity of care suggest that local health networks have improved the follow-up for patients with chronic diseases and increased the reliance on primary care for patients usually seen by specialists. Difficulties persist in the coordination of primary care with other levels of care.

A report prepared for the Ontario Ministry of Health and Long-Term Care (MOHLTC) about the initial phase of implementation of the 14 LHINs²⁸ concludes that they have succeeded in creating a unique model of local government for healthcare. The report suggests that the LHINs are in a position to perform four key functions related to the organization of the local healthcare system: planning, community engagement, funding and integration activities. Recommendations were made to further develop the LHINs as a governance body, including the clarification of roles and decision-making responsibilities between the MOHLTC and local authorities.

These significant structural changes have passed their initial stage of implementation. More studies are needed in the future to assess the contribution of these structural changes to integration of care and services. We were not able to identify studies on the de-regionalization of the healthcare system in Alberta.

1.1.7 *Quality and safety*

Since the publication of the Canadian adverse events study in 2004, more attention is being paid to quality and safety of care. The study reveals the frequent occurrence of adverse events (7.5% of hospital admissions) and identifies that a significant percentage of these (36%) are preventable.²⁹ Various institutions have been created since 2004 to support improvements in the quality and safety of care and in the performance of the healthcare system, including quality councils in British Columbia, Alberta, Saskatchewan and Ontario, the Commissaire à la santé et au bien-être au Québec and the Canadian Patient Safety Institute at the federal level. These institutions have the potential, through their expertise and the tools they develop, to contribute to a realignment of healthcare reforms toward clear improvement objectives.

Various provincial reports produced since 2003 suggest that provinces have clearly recognized the need to develop more appropriate care and services, particularly in the areas of chronic disease management, palliative care, home care and long-term care.³⁰⁻⁴⁴ These reports identify promising initiatives but also suggest that the Canadian healthcare system is still struggling to provide an adequate response to patients with complex and long-term conditions.^{45,46}

1.2 Lessons from change in Canada

Having assessed changes to the healthcare system in Canada since 2003, it is important to look at the main levers for change that were used during this period. Adapted from the work of Lazar⁴⁷ on healthcare reforms in Canada, three main types of levers were used to various degrees across the different provinces since 2003:

Financial levers: These include the use of financial resources to support the attainment of pre-defined targets or to support improvements in specific areas such as home care or safety of care; changes in methods of funding providers, hospitals and other facilities to change behaviours and encourage specific activities; and investments in general practice, such as coverage of the cost of nursing personnel or new programs.

Governance levers: These include the creation of new institutions such as quality councils; development of measures and standards; use of benchmarks and reporting systems; changes in the devolution of authority such as the creation or abolition of RHAs or the creation of a single health board; and restructuring, for example merging organizations with different missions, such as primary healthcare and long-term care.

Legislative levers: Legislation can be considered as a subset of governance levers. It has significant importance in healthcare reforms where governments can, through legislation, have major impacts on healthcare systems. As an example, governments can impose major structural changes or “new” mandates such as safety of care on health organizations.

Delivery arrangements: These include creating new provider entities such as Quebec’s family medical groups (groupes de médecine de famille – GMF) or primary healthcare networks; implementing healthcare teams; developing new care models such as the Advanced Chronic Care Model; and using new contractual arrangements with private providers. New delivery arrangements often imply the implementation of new financial incentives or funding mechanisms, such as providing additional funding for registering more vulnerable population in family medical groups.

Since 2003, significant efforts have been deployed to improve access to care in the provinces. By increasing the level of funding (financial and governance levers) around clinical priority areas, provinces have been able to increase the volume of services and have an impact on access. Attaching new money to volume targets has been an important lever to better respond to demand for specific procedures. Other levers have been used less frequently, including attempts to renew models of organization (delivery arrangements) in PHC. New models of care (chronic disease models) have also been promoted. Legislation has been used to bring about significant changes in the structure of the system, including the creation of new institutions like quality councils, and to impose “new” mandates on organizations, such as Bill 113 in Quebec, which established a structure for safety of care in hospitals and the Excellent Care for All Act in Ontario.

1.3 Learning from the changes to date

Our interpretation of the changes implemented during this period is that the injection of additional funding contributes to improved access for services that are part of the acute-care and hospital-care sectors of the healthcare system. These services are valuable when performed according to proper clinical standards and need to be accessible. However, healthcare systems in Canada find it much more difficult to achieve significant or large-scale changes within domains that once were seen as outside the core business of the healthcare system but were identified in the 2003 Health Accord, such as primary healthcare, home care, chronic disease management and mental health, despite significant and/or growing needs in these areas. Setting improvement targets/objectives in these areas may help focus the attention of policy-makers and providers, but targets do not yet appear sufficient to create significant changes and improvements across the system as a whole. As we will see in section II, realigning the system to overcome care deficits in these areas depends on an integrative approach that deals simultaneously and deliberately with the governance, organizational and professional dimensions of change.

A recent analysis of the implementation of need-based funding in various provinces underscores the limits of a piecemeal approach to healthcare system transformation:

The new dollars into the system did not, as some had hoped, “buy change” (Romanow, 2002:44), but rather were absorbed into the existing hospital and physician-centric system that had been the hallmark of Canadian medicare since the 1960s (McIntosh, Ducie, Burka-Charles & al., 2010:59⁴⁸).

Preliminary results from the Cross-Provincial Comparative Project⁴⁹ suggest that, despite some major shocks (major restructuring, significant budgetary constraints), these reforms aim mainly to improve the “existing healthcare model rather than replacing it” (Lazar, 2009: 10). Two additional observations from this study need to be underscored. First, more changes were achieved when they did not affect physician autonomy and remuneration, which suggests that new levers may have to be identified and used to stimulate greater physician engagement. Second, research-based evidence played a role in the implementation of change in areas with substantial technical content, such as wait-times management, suggesting that there is probably room to further increase the use of research-based evidence to guide policies and decisions in the healthcare system. Linking these two points, the increased use of research-based evidence will depend also on the design of appropriate strategies to promote evidence use among professionals and the medical profession (see next section).

Overall, the Canadian healthcare system demonstrates an ability to bring about circumscribed changes in specific areas with specific investments. It faces major challenges when the goal is to realign its system to better respond to the evolving needs of the population.

1.4 Learning from other OECD countries

Attempts to renew the Canadian healthcare system in the last decade somewhat parallel efforts in other systems. Developed countries appear to face similar challenges, including: the need to strengthen and broaden primary healthcare to respond to evolving and emerging needs; prevention of and care for chronic diseases (increased standardization and coordination of care); assuring timely access to care; growing attention to the quality and safety agenda; preoccupation with the management of drugs (e.g. the New Zealand pharmaceutical program) and with productivity and efficiency; and aspirations for greater diversity of providers and greater patient choice.⁵⁰⁻⁶² While areas of preoccupation may be similar,

the strategies used to achieve improvement may be different, at least in terms of emphasis or intensity. Attempts to renew and expand PHC play a major role in the U.K., while the renewal of incentives for hospitals and other providers seems a major preoccupation for many European countries, and may have been experienced in a less convincing way in Canada.

The search for more effective governance models and new delivery arrangements permeates debates around healthcare reforms. As an example, structural changes like the LHINs in Ontario and the emphasis on the development of local health networks in Quebec resonate with attention paid to networks in other jurisdictions.⁶³ One main feature of healthcare system transformation is the constant search for a balance between stability and change; the renewal of organizational arrangements is seen as a way to make improvements without “big-bang” reforms. In addition, a common challenge for many systems is how to ensure that new money does not serve mainly to pay a higher price for care and services or to increase the wages of professionals and personnel across the system. Another challenge is to promote better alignment between care and recognized standards of excellence. Human resources are also seen as a major issue for healthcare system change and improvement. The problem is not defined solely in terms of sufficiency or availability of resources, but also in terms of competency development and inter-professional collaboration. It is recognized that, without proper measurement and without organizational changes, gains in productivity and quality and safety of care will be very difficult to achieve. Overall, healthcare systems seem to face a kind of paradox of effectiveness, where investments and success in the acute-care sector risk undermining the capacity of the overall system to overcome care deficits in other sectors.

The assessment of changes in the Canadian healthcare system is reflected in a recent report on the performance of the U.K. healthcare system.⁶⁴ While the U.K. system has made tremendous progress in the last ten years in improving healthcare delivery, the report concludes that the shifting of care from the hospital to the home or community has been much more difficult to implement. It also suggests that the potential of any policy instrument to bring about change cannot be assessed independently of the additional resources invested in the system. The King’s Fund report underscores that general practitioners react overall positively to new incentives like pay for performance (P4P) and that some gains were achieved for the management of chronic diseases. However, it also notes that about half of the new investments have been absorbed in wages or prices of services. The report refers to the positive role played by institutions such as the U.K.’s National Institute for Clinical Excellence (NICE) in reducing practice variations and assuring more evidence-informed treatments.

While significant changes need to be brought to the fabric of the Canadian healthcare system, recent OECD papers^{65,66} suggest that there is not much appetite now for so-called “big-bang” reform. Empirical analysis of institutional features of different healthcare systems and their performance shows no clear evidence of countries that outperformed others in all dimensions. In its report on “Health Systems: Efficiency and Institutions,” the OECD suggests developing strategies to increase the coherence of policy in healthcare systems rather than trying to dramatically change their fundamental elements. Such a proposition is aligned with the literature on high-performing healthcare⁶⁷ organizations, which indicates that incremental management of change and design of strategies for continuous improvement appear to be key.

While incremental reform through the use of well-designed policy instruments is probably less disruptive and more in tune with the “natural” pace of change in healthcare systems, it can also leave almost intact the architecture of the system and the distribution of power that are at the basis of a need for change.⁶⁸ This dilemma will surface from time to time in our discussions of the different themes for healthcare system transformation. Another important challenge in healthcare reform is the almost autonomous

dynamic of politics and political cycles that may significantly disrupt the pace and course of change. As some authors suggest, one of the main issues in contemporary health reform is the fact that politics often trump policy.⁶⁹

Our assessment of recent change in the Canadian healthcare system also suggests that the performance of healthcare systems cannot be evaluated solely by aggregating the performance of sub-sectors. The OECD report⁷⁰ underscores that high performance in the in-patient sector (for example) can be offset by inefficiencies in other areas (e.g. home care, chronic disease management) or insufficient coordination across sub-sectors. It suggests that any approach to healthcare system transformation will have to take an integrative approach and deal with interdependence across various sectors of the overall healthcare system. The problem of alignment across the different levels of governance within the system should also not be underestimated and probably cannot be resolved simply by increasing the communication of information such as benchmarks within a given system. Finally, when designing levers for change, attention must be paid to the reduction of practice variations and inappropriate care.⁷¹

1.5 Concluding remarks on a decade of change

Our assessment of change within the Canadian healthcare system underscores that healthcare system transformation is highly constrained by the fundamental architecture of a system in terms of past investments and the positioning of various providers (see for example analysis by Tuohy).⁷² This argument is not new but needs to be kept in mind when we discuss the challenges in developing effective levers for change.

It is possible to identify barriers to change within the Canadian healthcare system from the material presented in this section. The “buy change” approach that is often used is definitely not sufficient to achieve significant and coherent transformation across the system. The allocation of resources across the system tends to reflect the architecture of the system and reformers have not tackled with sufficient determination the care deficits in various sectors. In addition to the issue of resource allocation, more attention should be paid to the development of delivery models and professional skills and competencies that are aligned with policy goals to reduce care deficits.

Based on the Canadian experience and a comparative analysis of OECD countries, we make the following propositions regarding the dynamic of healthcare system transformation:

- ▶ Changing the structure of a system, and producing a greater volume of care and services within the core business of the system, is relatively straightforward to achieve.
- ▶ Realigning the system and changing the location and emphasis of care (e.g. primary healthcare, frail elderly, chronic diseases, mental health) to better respond to evolving demands is necessary, but much more challenging.
- ▶ The healthcare system is based on a series of equilibriums across institutions, organizations and providers or professional groups, which make radical shifts very difficult to achieve.
- ▶ Levers for change should try to reconcile the need for radical change within care delivery with the incremental pace of change that is part of the fundamental dynamic of the system.

Our analysis of the dynamic of change in the Canadian healthcare system is based on observations during a period of reinvestment in the system. It is not clear how this dynamic will evolve in a period of financial constraints.

In section II, we will discuss six themes for healthcare system transformation that show promise in bringing about more significant changes in the Canada’s healthcare systems.

2 THEMES FOR HEALTHCARE SYSTEM TRANSFORMATION

Six themes are discussed in this section. Each of these themes contributes to a systemic or integrative approach to healthcare system transformation. The first theme revisits the requirement to realign the system in order to diversify the type of care (primary healthcare versus in-patient care, episodic versus chronic care) and respond to evolving health needs and demands. The next five themes identify pathways to undertake this realignment. We start with a discussion of the importance of organizations as an asset to implement change, and then examine professional cultures and the need to find a way to transcend professional boundaries and harness their power differently. The review of governance arrangements identifies options to enable change within delivery organizations. The last two themes look at potential sources of input (patient engagement and evidence-informed movement) that may help to realign the system.

Theme 1: Strategic Realignment efforts

MAIN MESSAGES FOR HEALTHCARE SYSTEM TRANSFORMATION

- ▶ Systemic realignment of the healthcare system requires a strategic and integrative vision that delineates key areas for improvement.
- ▶ Investments or reallocation of resources must target areas where care deficits are more important.
- ▶ Strategic orientations of the healthcare system have to systematically incorporate primary and preventive care and population health interventions as core activities.
- ▶ The capacity issues related to realignment require innovations that include different professions and teams, not just the medical profession.

One element that emerges from the previous section is that significant changes will not happen in the healthcare system without changes to the role and importance of its various sub-sectors (in-patient/out-patient services, institutional/community-based care, episodic/chronic care, etc.). Areas of strategic concern for the realignment of Canada's healthcare system are the under-development of primary health-care and care for chronic diseases and long-term conditions, including mental health. Realigning the system implies doing what is currently not done or not done sufficiently, such as prevention of major health problems. Such realignment may lead to better control of healthcare costs, for example, through policies and interventions to reduce the prevalence and incidence of obesity.⁷³ In addition, the capacity of the healthcare system and more broadly of society to improve the health of the population and reduce health inequities should be a concern, particularly considering the level of spending for healthcare. We will now briefly discuss each of these strategic areas (primary healthcare, management of chronic diseases and population health improvement) to define their implications for healthcare system transformation.

Primary healthcare has been at the core of policy discussions related to healthcare system reform for more than 20 years. Evidence suggests that increased access to primary healthcare⁷⁴ and to care delivered by inter-professional teams can improve the condition of patients.^{75,76} Reforming primary healthcare requires significant investments in the organizations that deliver such care,⁷⁷ so strengthening primary healthcare organizations is a strategic consideration.

However, the organization of primary healthcare will only improve if the commitment and participation of organized medicine (bodies such as physician unions and colleges of physicians) is secured.⁷⁸ In addition, more attention has to be paid to the consequences of increased incidence and prevalence of chronic co-morbidity for the organization and development of primary healthcare.^{79,80} The primary healthcare sector also appears to be an ideal laboratory for innovations in the use of health human resources, by going beyond policies that aim to increase the size of the health workforce⁸¹ to incorporating changes in roles and inter-professional relations. Further, while primary healthcare can play a pivotal role in healthcare system renewal, the impact of strengthening primary healthcare organizations is also dependent on the overall features of the healthcare system.^{82,83} The capacity of the healthcare system to relay demands from primary healthcare to other sources of care in a coordinated and concerted way is likely key to realizing maximum benefits from improved primary healthcare.

Rising prevalence and incidence of chronic diseases is a challenge for all OECD countries. Chronic diseases have been defined as conditions which “require a complex response over an extended time period that involves coordinated inputs from a wide range of health professionals and access to essential medicines and monitoring systems, all of which need to be optimally embedded within a system that promotes patient empowerment.”⁸⁴ Healthcare systems are currently designed around an episodic/acute model of care and not for proper response to long-term conditions.⁸⁵ Moreover, models to deliver appropriate care to patients with chronic diseases have been designed to respond to single clinical conditions and not to chronic co-morbidities, which are more and more frequent.⁸⁶ The adoption of models for care delivery that are not necessarily physician-led may be more appropriate for patients with co-morbidities.⁸⁷ Renewing models of care for better management of chronic diseases has multiple human resource and financial (reimbursement, incentives) implications that need to be taken into account.^{88,89,90}

Development of primary healthcare and effective models to respond to the needs of patients with chronic diseases clearly overlap. Community-based care for people facing mental health issues (e.g. moderate to severe depression, anxiety) and more assertive outreach in communities can be performed by existing primary healthcare structures. The reliance on a single lever for change, such as changing the mode of physician payment, will be largely insufficient to implement desirable changes in these sectors. Investment in the development of organizational capacity (teamwork, information systems, electronic medical records, practice guidelines, etc.) is crucial to improve primary healthcare and the delivery of care for chronic diseases.

Another area of concern for realignment of the system relates to interventions to improve the health of the population. A large body of evidence^{91,92} is available regarding the importance of developing interventions to address the fundamental causes of diseases and health conditions. Such interventions go beyond the boundary of the healthcare system. Nonetheless, the healthcare system can contribute to the attainment of population health objectives by developing effective interventions to reduce the risk of chronic diseases and their consequences for individuals and groups. While there is a clear need for policies and interventions that address health inequalities at a more collective and political level,⁹³ it appears that healthcare systems can incorporate effective prevention interventions and collaboration with resources from other sectors.^{94,95}

In addition, works by Wennberg and colleagues^{96,97} have clearly shown variations in treatments provided for similar health conditions that are not dependent on the clinical condition of the patients. The existence of such variations suggests that any efforts to realign the healthcare system will have to consider the potential contribution of new regulations and institutional support that would channel professional and organizational autonomy more effectively.

This brief exploration of key areas at the core of the debate about healthcare system transformation suggests that no significant change will occur without a serious attempt to realign the system to meet patient needs and evolving demands. Such realignment requires concerted efforts across sub-sectors of the healthcare system. At the delivery level, it implies large-scale organizational development initiatives to implement new models and processes of care. In addition, any reforms will have to contemplate or implement changes in the distribution of authority in the system (see for example the recent reforms in Nordic countries⁹⁸ and of primary healthcare in Canada⁹⁹). Besides the reliance on so-called rational policy instruments such as incentives, reforms in the areas of primary healthcare, chronic disease management and population health interventions will necessarily challenge current power structures and the predominant logic of the system. These considerations suggest that one of the main challenges in the transformation of the healthcare system is the problem of policy persistence, where ingrained approaches to health issues and ways of allocating resources limit the ability to innovate and improve care and services. In addition, as suggested in the definition of healthcare system transformation presented in the introduction of this paper, political will among influential professional groups, healthcare organizations and politicians to support the realignment of the system is crucial.

Theme 2: Organizations as the engine for delivery and change

MAIN MESSAGES FOR HEALTHCARE SYSTEM TRANSFORMATION

- ▶ Organizations are key assets in improving and sustaining the quality of care.
- ▶ A variety of organizational forms is needed to meet evolving and shifting demands (e.g. networks and team-based organizations).
- ▶ Benefits of new organizational arrangements depend on the ability to manage multi-faceted change processes (human resources, information, performance management, decision-making, etc.). Policies to address and support managerial development are needed.

Care is delivered through health organizations. Organizational capacities are increasingly seen as an essential ingredient in improving the performance of healthcare systems.^{100,101,102} Organizational capacities are the structure and core competencies of an organization and its capacity to learn from the environment, to change and adapt, to innovate and, ultimately, to improve care. In the healthcare sector, increased reliance on a variety of organizational forms, such as team-based organizations and networks, indicates that policy-makers, managers and providers are paying growing attention to the importance of developing more effective organizations in order to deliver better care. Research on organizations in various sectors suggests that the transformation of organizational forms is key for adaptation and performance.¹⁰³ Growing interest in the renewal of organizations differs from periods of large-scale restructuring that most healthcare systems in OECD member countries have seen in the past. Developing organizational capacities implies much more than changing structures or merging organizations;¹⁰⁴ it implies the alignment of organizational design and functioning with the needs of the patients.¹⁰⁵ In short, form should follow function. While this logic appears evident, many healthcare systems have devoted much energy to implementing solutions that are not clearly linked to improvement and performance objectives. In this

section, we will explore two main trends in the renewal of healthcare organizations: the emergence of networks and team-based organizations. We use these two examples to illustrate the potential of investing in new organizational capacity to improve the delivery of services.

Networks have been promoted and implemented in many healthcare systems to overcome fragmentation across organizations and providers and to better respond to the challenges of taking care of complex and long-term conditions.¹⁰⁶ Unlike vertical bureaucracies, networks are characterized by increased lateral or horizontal patterns of exchange and collaboration, interdependent flows of resources and operations, reciprocal lines of communication and the fluid circulation of knowledge.¹⁰⁷⁻¹¹⁰ In the healthcare sector, the benefits and limitations of more formal (e.g. hierarchical) types of networks as opposed to virtual types of networks have been widely debated.¹¹¹⁻¹²² Some authors refer to “managed networks” as networks that go beyond traditional professional networks and that incorporate in their mission attainment of care and system objectives.¹²³ The local health networks in development in Quebec are examples of “managed networks.” Networks are also seen as vehicles to achieve cross-cutting outcomes. This is particularly important when the effort to improve the patient condition needs to transcend traditional organizational boundaries, such as with the frail elderly or patients with mental illness. Dementia networks¹²⁴ and cancer networks¹²⁵ are examples of arrangements that increase the coordination of organizations in the delivery of care for specific populations to achieve better outcomes.

While the notion of networks refers mainly to coordination, collaboration and improving the process of continuity of care across organizations, team-based work is seen as an important option to improve quality and safety of care from within delivery organizations. Teams can be defined as:

A collection of individuals who are interdependent in their tasks, who share responsibility for outcomes, *who see themselves and who are seen by others* as an intact social entity embedded in one or more larger social systems and who manage their relationships across organizational borders.¹²⁶

Teams present various degrees of inter-professional collaboration, depending on their size, diversity and the health situation of patients. Teamwork can be a source of increased work satisfaction for professionals, is seen as being compatible with professional autonomy and may have positive impact on quality of care.^{127,128} The primary finding from research on team-based organizations is that effective teams rely on appropriate work processes, strong leadership skills, investment in human resources development, clarity of vision and purpose, formalization of responsibilities and mechanisms to share information.^{129,130} We focus the discussion on inter-professional teams because of their potential to accommodate the challenges of delivering proper care and obtaining better clinical results for people facing chronic diseases and for specific vulnerable populations.^{131,132} Inter-professional teams can be effective in reducing current care deficits in many areas.

Team-based work – and more specifically, inter-professional teams – hold great promise for improving the delivery of care. However, teamwork needs to be developed within the context of human resources policies that cut across professional boundaries. The objective is to achieve a more diverse and flexible workforce with more joint responsibilities, with the end goal of increasing the focus on patients and user-needs.¹³³ The interest in team-based work in healthcare should be put in the context of a growing attention to human resources practices (i.e. an emphasis on training, performance management, participation, decentralized decision-making, involvement, teams and employment security) as a lever to get maximum benefits from resources invested in the delivery of care.¹³⁴ It appears that people-management systems that emphasize “high-involvement policies and practices” may positively influence the quality of care (see, for example, works by Baker et al.¹³⁵ on high-performing healthcare organizations).

Teamwork is a common theme in debates on healthcare renewal. However, health teams are not easily implemented on a system-wide scale,¹³⁶ which suggests the need for a deliberate approach to their spread and implementation in appropriate areas of care.

The transformation of organizations is highly demanding.¹³⁷ Consequently, the change process involved in implementing new organizational arrangements must be closely and deliberately managed. Recent research suggests that organizations will succeed in achieving significant transformation if they implement complementary changes and synchronous innovations.^{138,139} Integrated healthcare delivery systems such as Kaiser Permanente^{140,141,142} and the Veterans' Health Administration^{143,144} provide examples of systems that appear to have achieved complementary organizational changes. The development of networks and team-based organizations requires strong leadership and robust management processes. Attention must be paid to the development of new roles, such as case managers and patient navigators, to support new approaches to delivering care.

Theme 3: Professional cultures (shaping professional cultures to shape the industry)

MAIN MESSAGES FOR HEALTHCARE SYSTEM TRANSFORMATION

- ▶ Health professionals need to play a more active role in healthcare system transformation and improvement strategies.
- ▶ Rational or economic levers are not sufficient to get the commitment of professionals to improve care and services and lead change initiatives.
- ▶ More attention should be paid to the development of new professional roles in the healthcare system and not just in terms of the transfer of tasks, such as nurse practitioners, patient navigators and health assistants.

The development of new professional roles and the engagement of the medical professions are at the centre of any debates about healthcare system transformation. Healthcare organizations are knowledge-based organizations characterized by a distribution of expertise and authority.¹⁴⁵ The ability to implement significant transformation within healthcare systems requires the harmonization of various perspectives¹⁴⁶ and professions play a key role in this process. Healthcare organizations, through their professionals, are a reservoir of innovations (technological innovation, innovative clinical practices and new models to deliver care).¹⁴⁷ These organizations are considered both very innovative and very reluctant to implement changes imposed by external sources and pressures. This combination of innovation and inertia has favoured an approach to change that builds upon bottom-up dynamics and top-down pressures. The bottom-up approach essentially rests on the hypothesis that innovation and changes that originate with professionals will be more appropriate and face much less resistance. While this “push” approach to healthcare system transformation is critical in professional organizations, it is also insufficient in light of pervasive problems in the coordination and integration of care and in the quality and safety of care. Professional *laissez-faire* is not an option. The challenge is to find a way to protect professional autonomy while challenging professions to achieve better performance and commitment to transformation.¹⁴⁸

Various options have been considered to stimulate changes in professional culture, with most attention paid to the medical profession. Some authors¹⁴⁹ talk about the emergence of a new professionalism characterized by more interface with the managerial/organizational and policy worlds. A new sub-group

of clinical/managerial hybrids may emerge that usefully links two traditionally very different worlds.¹⁵⁰ Some branded systems like Kaiser Permanente have developed various corporate arrangements that bind physicians more tightly to the system. Research on the integration of care and services and on integrated delivery systems¹⁵¹ have also underscored the importance of physician alignment¹⁵² and physician engagement in the attainment of system objectives. The notion of facilitators¹⁵³ who enable professionals to maintain high-quality practices has become increasingly popular in discussions of healthcare system transformation. While facilitators are often defined in terms of technology like electronic medical records and telehealth, the softer aspect of organizational context, such as norms, patient rights, inter-professional collaboration and team work processes, appears to be a key enabler to help professionals improve their practice.

A recent review by Burns and Muller¹⁵⁴ reveals that the relationship between economic integration (through various types of incentives and reimbursement mechanisms) and clinical integration is complex and largely uncertain. Burns and Muller (2009, 407) suggest that:

Indeed, anecdotal evidence from hospital systems reveals that once physicians achieve income security and stability through employment models, they turn their attention to patient care issues ... Another consistent finding from consulting reports and case studies (substantiated in peer-reviewed research) is that the “hard levers” of economic integration need to be supplemented by the “soft levers” of non-economic integration (2009:414).

From this analysis, one can conclude that economic incentives may have benefits but are only one part of a strategy to support professional commitment for service improvement. This review also suggests that the relationship between economic integration and clinical integration can be mutually reinforcing. Clinical integration may drive economic integration where new organizational forms (see previous theme) open up new options in terms of incentives and non-economic drivers for change.

Finally, the emergence of clinical leaders and physician managers may be an option to stimulate closer linkages among physician practices, professionals in general and organizational or system objectives. The notion of strategic hybrids developed by McGivern et al.¹⁵⁵ and initiatives to train physician leaders (see for example initiatives in the U.K.) may enable bridging these two cultures.

While the focus on the role of professionals in healthcare system transformation is often on physician leadership and engagement, the question of the roles of other professionals and the emergence of new professional roles is also fundamental. The need to increase the supply of nurse practitioners and use them more effectively is now well recognized.^{156,157} In addition, the importance of introducing new roles, such as health assistants and midwives, to support the delivery of care is also recognized. The process of introducing new professional roles has progressed slowly and innovative approaches to renew the healthcare workforce are needed.¹⁵⁸

In addition, managers have to change their focus and pay more attention to the inner workings of their organizations and to the design of environments and processes that can stimulate performance.¹⁵⁹ Growing attention to “lean” processes and cultures may be indicative of a movement in this direction. Professionalization of management to deliver high-quality and appropriate care in an effective way is also considered a main asset for healthcare system transformation.

What we get from this literature is that a model of professionalism that is under-socialized – that is, not committed to the attainment of broader organizational or system objectives – is inappropriate. Strategies to increase the commitment of powerful and/or highly competent professionals to healthcare system improvement have to be implemented at the organizational level. However, such strategies must also be supported by a new deal between organized professions and the state.

Theme 4: Creating an enabling environment that supports improvements

MAIN MESSAGES FOR HEALTHCARE SYSTEM TRANSFORMATION

- ▶ Renewal of funding mechanisms and incentives is crucial to bring about significant changes and improvement.
- ▶ Strong governing/regulatory capacities are needed to monitor and adjust incentives and to benefit from these policy instruments.
- ▶ Incentives should be designed and implemented within the context of a broader set of policy levers, such as non-economic incentives (see previous and subsequent themes).

As with organizations in any sector, the performance of healthcare organizations is highly influenced by their external and regulatory environment. An environment that supports improvement develops around effective governance rules and processes, well-defined and appropriate goals and targets, effective reporting mechanisms and well-designed financial and non-financial incentives (see, for example, in the case of quality and safety, the report by Baker, Denis, Pomey et al.¹⁶⁰).

Governance refers to the means for achieving direction, control and coordination of wholly or partially autonomous individuals or organizational units, on behalf of interests to which they jointly contribute.¹⁶¹ Recent works on governance suggest that boards may develop their skills and take various initiatives to have a positive impact on quality and safety of care. While boards may play an important role in the improvement of care and services, recent works suggest taking a broader approach to governance by paying attention to the regulatory environment in which healthcare organizations evolve.^{162,163} A distinction has been made recently between external governance (the regulatory environment) and local governance (the actions of boards). Under theme four we will focus on some elements of the regulatory environment for effective governance: the definition and setting of targets and reporting strategies, incentives like hospital funding models, pay for performance, and reimbursement of providers.

The healthcare system is increasingly setting targets for delivery organizations to increase levels of accountability and to orient the use of resources toward more effective health services and interventions. The definition of these targets and more broadly of benchmarks is a major issue in and of itself. Systems need to define targets and benchmarks according to priority policy objectives and areas, and not according to data availability or immediate pressures.¹⁶⁵ As an example, targets have been set in many jurisdictions around waiting times, while at the same time favouring additional investments in acute care and less policy attention to growing needs regarding chronic diseases.¹⁶⁶⁻¹⁷¹

Critics of target setting and pay for performance have also often referred to the risk of an over-emphasis on the attainment of non-clinical targets such as cost control or volume of care without considerations for quality.¹⁷² With respect to system and patient needs, in 2004 NICE in the U.K. developed “quality frameworks” that go beyond the setting of targets and aim to improve practice through guidelines and standards. Overall, there may be problems related more to the types of targets defined (i.e. targets defined too narrowly or not aligned with core policy objectives) than to the use of targets themselves. The capacity of a system to define targets for more complex care objectives is probably an issue that needs more attention.

Funding of hospitals has been the object of much scrutiny recently.¹⁷³⁻¹⁷⁵ Hospitals represent an average of 28% of healthcare spending in OECD countries. Historically, the predominant approach to the funding of hospitals has been global budgets, which do not take into account levels and types of activities. Various methods of funding hospitals have been proposed (see Sutherland for a recent review of these approaches¹⁷⁶). Considerable attention is now being paid to the potential of activity-based funding (ABF) to generate efficiency in the delivery of hospital care.^{177, 178} While ABF may achieve greater efficiency, it does not provide incentives to improve coordination and continuity of care across organizations. A mix of funding strategies for hospitals has been proposed by Sutherland,¹⁷⁹ with activity-based funding being combined with global budgets to leave the organization some financial slack to absorb some of the transaction costs associated with the need to better coordinate care and services and manage complex cases. This approach seems to correspond to the one taken by many European countries, where ABF is often combined with global budgets (EO, 2010). Bundled episode-based funding has also been proposed for the funding of hospitals. According to this method, the whole continuum of care for a given patient is under the responsibility of the hospital. While this method of funding appears attractive, particularly given the prevalence of chronic diseases,¹⁸⁰ it requires changes in the regulatory environment that limit its feasibility. For example, hospitals cannot directly pay physicians in private clinics for their involvement in the delivery and coordination of care. The idea behind bundled episode-based funding is interesting, because this approach links very explicitly the responsibility of an organization in terms of care delivery with the level of funding. One may ask, however, if the hospital is the best location to develop this approach to funding.

In recent years, much attention has been paid to pay for performance in the U.K. and U.S. healthcare systems. Pay for performance can be a supplement to funding policies of hospitals or other providers. A recent review of pay for performance in organizations suggests that there is potential to use financial incentives to improve performance in terms of quality of care, public health interventions and care for patients with chronic diseases.^{181,182} Investment of resources in such an incentive system should be balanced with regard to expected changes and the value of these changes for the performance of an organization. For example, pay for performance is not considered a powerful incentive to improve efficiency in the delivery of care.¹⁸³

In addition, it appears that pay for performance may positively affect the composition of the labour force, through the introduction of new professionals or new professional roles in a sector – an often neglected area in the debate around the value of pay for performance. Evidence suggests that, in a situation of high interdependence and need for cooperation, incentives aimed at a group may be a better option than those aimed at an individual. Doran and Rolan¹⁸⁴ have published a recent analysis of the pay-for-performance system for general practitioners in the U.K. They conclude that there was a significant improvement in the first three years of the program and then a ceiling effect in the fourth year. They observe no improvement, but also no deterioration, in non-incentivized conditions like osteoporosis and they also observe some improvement in chronic diseases. However, the latter is due to a set of initiatives that predate pay for performance, which suggests the importance of relying on multiple levers for change.

Werner & Dudley¹⁸⁵ suggest assessing pay-for-performance systems along a set of four dimensions: size of rewards, payment difference between high and low performers, ability to reward improvement in the absence of high performance, and percentage of payment based on performance. There is no place in this report for a technical analysis of the attributes of different pay-for-performance systems and their impact on improvement. It is sufficient to say that any use of financial incentives like pay for performance should take into account system needs and policy objectives and be clear on the nature of the signals that are sent by a given incentive. Proper design and monitoring of any incentives, including pay for

performance, are crucial. Incentive systems like pay for performance need to be constantly monitored and adjusted according to the evolution of goals and scope of programs and policies,¹⁸⁶ including for technical difficulties met in their application (see Robinson et al., 2009¹⁸⁷ for the limits of a pay-for-performance system based on episodes of care in California).

These considerations about the potential and limits of incentives are consistent with recent works on responsive regulation¹⁸⁸ and the importance of constant feedback on the impact of new regulations and incentives. Analysis of the experience with pay for performance of general practitioners in the U.K. and various health plans in the U.S. suggests that expansion of the incentive structure in healthcare systems requires parallel developments in governance capacity, such as information and monitoring.

A vast amount of work has been published on the question of reimbursement mechanisms for providers, all reaching a similar conclusion: no single reimbursement mechanism provides all the necessary incentives to achieve the broad set of policy goals pursued in healthcare.^{189,190} Reliance on a well-designed mix of reimbursement methods is probably a reasonable option. Within the context of this paper and from a policy perspective, while recognizing the potential of mixed-methods of reimbursement, one has to take into account the need to depart from “buy-change” logic where any improvements are in exchange for specific financial gains.

We have focused under this theme on governance, targets and various types of incentives (funding of hospitals, pay for performance) as three core elements that may help to align healthcare delivery with system objectives. Such an evolution in healthcare systems also responds to increased demands for accountability. An environment that supports improvement at the system level cannot depend only on these more formal elements of system design. Policies that stimulate engagement and acquisition of new competencies and skills are essential for system adaptation. The literature on safety of care has underscored the importance of a culture of learning and of a supportive culture to minimize risks, as well as investments in highly reliable processes such as those observed in other industries.^{191,192} An enabling environment uses a series of levers that touch upon the softer side of organizational structure as well as on the harder side, with economic incentives considered to be more on the hard side of the equation (see theme three on this question).

Theme 5: Patient engagement: the making of countervailing power

MAIN MESSAGES FOR HEALTHCARE SYSTEM TRANSFORMATION

- ▶ Patient engagement and public participation should be a hallmark of good governance in healthcare and strategies should be designed to make these happen.
- ▶ Recent experiences with expert patients and citizen councils support the notion that patient and citizen ability to get involved can be nurtured.
- ▶ The promotion of self-care can be a pathway to reinforce the role of patients in decisions regarding their own health and care.

Patient engagement is increasingly seen as a means of catalyzing change in the delivery of healthcare services. One assumption behind this interest in increased patient engagement is that the experience of care by patients is a function of organizational context and system policies and not just of the encounter between a health professional and a patient.¹⁹³ Another assumption behind this aspect of healthcare renewal is that patients want to get involved in the design of the services they receive.¹⁹⁴ For example, a U.K. study by Richards and Coulter¹⁹⁵ found that 32% of primary healthcare patients and 48% of hospital patients said they had not been sufficiently involved. More and more evidence suggests that it is possible to involve patients at a system and/or organizational level, such as NICE in the U.K. and Bates' experiment in the design of care.¹⁹⁶ The issue of patient engagement goes beyond the simple injection of a dose of consumerism and competition in healthcare. It implies considering patients as co-designers and co-producers, with providers, of service improvements.

A report by the Picker Institute¹⁹⁷ in the U.K., an organization dedicated to the development of policies to favour patients' involvement in healthcare, underscores the fact that patients pay more attention to the quality of the communication with health professionals and only a non-representative minority of patients wishes to have a voice in policies and in complex processes of services design.¹⁹⁸ This suggests that deliberate strategies need to be put in place to stimulate such interest from patients and their proxies. Such strategies may also help develop a broader view of governance of healthcare systems closer to a stewardship model,¹⁹⁹ as suggested by the World Health Organization. To stimulate patient engagement, health professionals must be trained and informed about the importance of patient involvement and self-management of care. Recent works on shared decision-making in health suggests that there is greater openness among health professionals to involving patients in treatment decisions.²⁰⁰ One may hypothesize that, as more and more patients become involved in decisions regarding their care, they will become more open to and possibly more skillful at getting involved in design of services. Again, this seems possible as long as healthcare systems attempt to stimulate patient engagement and offer opportunities for patients to be better prepared for this role.

Cromwell,²⁰¹ in a review of strategies for involving patients in the improvement of services, suggests that organizational policies play a key role in making change at this level. Looking at the experience of hospitals that focus on patient-centred care and magnet hospitals, the report suggests that a set of corporate policies can be used to re-inforce patient engagement, including involving patients on key committees, allocating resources for service improvement, training personnel and designing proper physical environments. Overall, it seems that corporate policies play a determining role in this regard.

Another path to ordinary citizen engagement has been explored and tested under the theme of public participation (see Abelson & Gauvin²⁰² for a review of the evaluation of public participation experiments in general). This review suggests that such processes may affect the attributes of the participants (increased levels of interest in, and knowledge of, public issues; improved capacity for future public involvement; increased propensity for social bond formation; and improved trust of fellow citizens). Looking at these attributes, it is logical to assume that the development of deliberative processes will have an educational effect on participants, with the consequence of making them better equipped for further participation in policy process.

As is the case in other sectors, as demonstrated by the literature on patient engagement, healthcare systems can play a definitive role in stimulating propensity and ability to participate in deliberate processes.^{203,204} A recent scoping review by Mitton & colleagues²⁰⁵ also suggests that deliberative processes can be used for priority-setting in healthcare. In addition, public reporting²⁰⁶ is often raised as a potential strategy for increasing the role of the public in the governance of healthcare systems. The benefits obtained by disseminating information to the general public, however, is not clear. There may be a learning curve, where a public exposed to information on providers' performance through public reporting may become more interested in taking an active role in the evolution of their healthcare system.

One of the key lessons from work in this area is that deliberative process and, more broadly, public participation, should be designed according to context; there is no one-size-fits-all recipe. One of the limitations of work on public participation is a limited set of studies on the impact of such participation on the policy process and on policy-making in general. Process benefits seem plausible enough, however, to include public participation as one potential lever for healthcare system transformation. Recent reviews by Bate and colleagues²⁰⁷ (on the use of the social movement concept to engage health professionals in service improvement) also support the idea of mechanisms of involvement that go beyond traditional surveys to obtain citizen opinions. It seems reasonable to look for more day-to-day involvement of patients and citizens, noting that participation will probably not be at the same level for patients/users as for citizens.

Theme 6: The evidence-informed movement: the making of countervailing power

MAIN MESSAGES FOR HEALTHCARE SYSTEM TRANSFORMATION

- ▶ A policy, institutional and organizational architecture is needed to support evidence production, dissemination and application.
- ▶ Professional leadership is key to the spread and use of evidence.
- ▶ Many approaches to knowledge use are legitimate and policies and organizations should not strive only for instrumental use.
- ▶ Strategies to maintain a tighter connection between the research community, health policy-makers, politicians and ministers should be identified and experiments launched.
- ▶ Because of the importance of the contextualization of knowledge, comparative analysis and sharing of experiences across jurisdictions, organizational and professional boundaries are critical for knowledge use.

Evidence-informed policy- and decision-making have been a hallmark of efforts^{208,209} to support changes in healthcare systems for the past 15 years.²¹⁰ Issues regarding implementation of interventions and remaining uncertainties regarding their effectiveness imply that evaluation of major initiatives to improve care is crucial for healthcare system transformation (see, for example, the Strategy for Patient-oriented Research of the Canadian Institutes of Health Research – CIHR). The use of evidence to support high-quality practices may eliminate a large proportion of inappropriate and/or ineffective procedures and have a significant impact on the cost of care and, ultimately, on its quality and safety. This trend, inspired by earlier developments in evidence-based medicine,²¹¹ has stimulated a series of developments at the policy and managerial level that enable access to research-based evidence, including the reliance on new professional roles such as knowledge brokers; the development of tools to support knowledge use;²¹² new organizational arrangements like knowledge-based networks;^{213,214,215} new institutions such as NICE in the U.K., Sax Institute in Australia, and the Canadian Health Services Research Foundation (CHSRF) in Canada; and efforts in various jurisdictions to institutionalize evaluation in decision-making processes.^{216,217} The rationale behind these initiatives is that knowledge utilization in policy and healthcare management will not happen at a sufficient level without deliberate strategies and investments.

Moreover, research on strategies to modify the behaviours of healthcare professionals has underscored the importance of initiatives that target the policy and organizational context.²¹⁸ The type of knowledge use that is pursued through these different initiatives is also a matter of concern.^{219,220} In the policy and management arenas, the notion of a non-instrumental use of knowledge-based evidence, based on the circulation of ideas around complex problems with no clear, unique and/or technical solutions, has become more and more common. Actors in organizations or in policy arenas have to make sense out of research in a given context to find reasonable and feasible options for application.^{221,222}

A recent publication on the evidence-based movement in healthcare²²³ suggests that any attempt to use evidence in healthcare should deal with the following elements: agreement on what counts as evidence; accumulation of knowledge that has meaning for the clinical, managerial and policy areas; active dissemination to spread evidence across a given field; and strategies to promote integration of evidence into practice. It is clear that, since the early 1990s, many efforts have been made to produce a body of evidence in priority areas; find new ways of packaging evidence, such as syntheses; disseminate evidence more effectively; and make it accessible to broader audiences of practitioners and decision-makers. The concern now is more on the side of designing appropriate and effective strategies to push integration of evidence into practices. One of the options has been to develop a model of “integrated knowledge translation” such as that adopted by CIHR, where co-production of evidence or at least co-interpretation of research findings is seen as a way to promote practice changes.²²⁴

Such a preoccupation for increased uptake in practice has promoted a growing body of work on organizational capacity for knowledge use.²²⁵ Three dimensions need attention here. First, healthcare organizations can develop capacity in terms of infrastructure to make evidence accessible to practitioners in their day-to-day operations, such as electronic platforms. Second, practitioners need occasions to put evidence in context and work on a trial basis to adapt evidence to their own practice – an approach that departs from a prescriptive approach to knowledge use. Third, organizations can maximize knowledge use by relying on the mobilization and production – preferably in a collaborative manner with key stakeholders – of knowledge such as performance and quality indicators and guidelines for priority settings. The enrichment of the organizational context is thus a key element in the promotion of knowledge use and requires investments and managerial approaches that depart significantly from the current situation in many healthcare organizations. Clinical leadership in favour of evidence use is also an important piece of the puzzle for more informed decision-making in healthcare.²²⁶

The approach to the use of research-based evidence in healthcare has thus become more nuanced over time and now accords more attention to the social dimensions of knowledge use. A recent empirical study shows the complexity of such processes, such as the social and cognitive boundaries that limit the circulation and acceptance of knowledge across professional boundaries.²²⁷ While professionals have traditionally been seen as drivers for innovation, their strong identification with a group (their peers) and their immersion in a specialized body of knowledge may impede the application of innovations that go beyond their professional boundaries, such as teamwork and inter-professional collaboration. Interventions to stimulate knowledge use within practice settings will have to be developed within the context of the evolution of professional cultures and the development of new professional roles (see previous themes).

While our focus up to now has been on the clinical and managerial/organizational level, the policy and political arenas present specific issues that need to be taken into account in order to stimulate knowledge use. In his now classic paper on “evidence-based government,” Davies suggests that some prerequisites need to be met to influence policy formulation at the government level. The scientific quality of the work by policy groups and their ability to respond to political demands with innovative methodologies appear to be essential elements. Training of personnel at the ministerial level and exchanges between think tanks and research and development organizations in the field of policy and management can also support the use of evidence in the policy context. That being said, the presence or absence of a policy window (a set of circumstances that increases the likelihood of successful policy change)²²⁸ will play a role in the ability of a government to act on evidence.

At the risk of being too simplistic, works on “evidence-based government” converge with works on organizational determinants of knowledge use by underscoring the importance of developing capacity and connecting with priority areas for decision-makers – in this case, politicians. While this is important, a key issue that remains is the connection between policy expertise and politicians²²⁹ and the role of lobbyists in shaping policy.²³⁰

CONCLUDING REMARKS

This paper looks at the efforts to transform the Canadian healthcare system since the 2003 Health Accord and identifies strategies to induce and support transformation in the future. Following the Health Accord, new investments were made in priority areas and greater attention was paid to reporting on healthcare systems improvement and performance. Our paper suggests that investments are only one piece of the improvement equation in a healthcare system.

Going back to our initial questions, changes during this period have occurred mainly to relieve pressure on priority services and to reduce wait times. Changes were more limited in other priority areas that depart from acute care services, which constitute the dominant logic of healthcare system. Our analysis found that barriers to change are related to the difficulty of reallocating resources across sectors or allocating resources in areas characterized by major care deficits. Constant and immediate pressures to provide and deliver more acute and specialized care limit our ability to change.

Looking at the experience of different healthcare systems, we identify a set of themes for an integrative strategy for change and improvement. If money is not enough and cannot buy sufficient change, healthcare systems have to rely on a more diverse set of options to achieve improvement. Each theme addresses a strategic area on which a system could focus to develop an approach to transformation. These themes work in synergy and should be addressed in a coordinated and coherent manner.

This set of themes does not by itself provide a magic recipe to deal with the political economy of implementing significant changes for improvement at the system level. However, they provide a basis to explore and generate innovative and challenging strategies to counteract the natural tendency of a healthcare system to reproduce its own logic with respect to allocation and use of resources. This tendency seriously limits our ability to convert new investments into significant improvements.

One key element of any transformative strategy is a clear picture of what needs to be changed. We propose that a major issue for the healthcare system is realignment: we must provide the care and services that are most needed given demographic evolution and shifting patterns of disease toward chronic and long-term conditions, including mental health, while maintaining the capacity to respond to demands for acute care. We have identified six themes to support a shift of the system in that direction. Each theme raises issues regarding the dynamic of healthcare systems and defines options for action. A set of key messages can be extracted from these different themes:

- ▶ Healthcare systems tend to reproduce their dominant logic (e.g. more and more resources in specialized care) and consequently neglect other areas where major care deficits persist.
- ▶ Human resources issues cut across each theme. It is essential to develop human resources and new professional roles to better respond to health needs. Without vigorous human resources policies that favour a new mix of skills, new professional roles, and innovative models of organizing work in inter-professional teams, the system will not be able to respond to current and future challenges. The tendency to reproduce the usual ways of doing and organizing, which we earlier called policy persistence, will not be resolved if not sufficiently challenged.
- ▶ Human resources don't work in a vacuum. The creation of organizations and enabling environments to better support professional and clinical practices can have a significant impact on the provision and quality of care and services.
- ▶ Better organizations and governance models are essential elements of large-scale improvement strategies. This means challenging professional cultures and the way professions use their influence. Initiatives to renew primary care in Canada in the last ten years illustrate very clearly the difficulty of cooperating with, while at the same time challenging, highly influential professional groups, specifically the medical profession.
- ▶ Renewal of delivery organizations requires strong leadership from, and closer links between, the management and clinical worlds. Recruitment and training of individuals to effectively bridge these two worlds are essential.
- ▶ Professionals and organizations can achieve a great deal at the local level to transform the healthcare system. However, more exchanges and mutual learning between the policy and the delivery levels are needed to support improvement and spread good practices.
- ▶ Debates among providers, organizations and the government too often focus on the level of resources available to achieve improvements in the healthcare system. While economic incentives play a role in orienting the provision of care and services, strategies to develop a commitment to better care seem more promising.
- ▶ To realign the system, initiatives to support patient engagement and citizen participation as well as the use of evidence to inform change are crucial. Both types of levers are potentially very powerful instruments to channel organizational and professional strategies toward improvement.

These key messages suggest avenues that governments can take to support the transformation of the healthcare system. They are built upon a very basic principle: constant reorganization of the system will not help deliver better care. While local organizations and providers' groups can make a major contribution to improvement, the healthcare system can be destabilized by government actions. Structural changes have often been used to bring about changes without a clear rationale and with potentially detrimental effects on the system. These messages also underscore the need to take more seriously the influence of the political context on the opportunity and ability to transform the healthcare system.

While we strongly advocate for major efforts, investments and transformative initiatives at the delivery level, we also emphasize the need for innovations and experiments that will increase communications among the research community, policy-makers and the political sphere. The scope of the current review does not cover such exploration. We also advocate the development, in cooperation with professional associations, of strategies to better involve professionals in leading transformation and improvement initiatives. Reformers need to recognize that greater involvement of professionals in improvement strategies will entail direct challenge to professional power and monopoly.

An inherent tension in transformation is how to challenge healthcare professionals and stakeholders to adopt new ways of thinking and working while keeping them fully engaged in the transformation process. Based on past experiences with introducing change to the Canadian healthcare system, a more integrative and systemic approach (which implies more connections between the worlds of politics, policy, organizations and professionals) to transformation is required. The pursuit of a more global approach to change should not constrain the design and implementation of changes and innovations at the delivery level.

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