

Notes from the Editor-in-Chief

A FEW YEARS ago, G. Ross Baker and five colleagues published a series of case studies under the title *High Performing Healthcare Systems: Delivering Quality by Design* (2008). Their goal was to investigate a handful of international and Canadian healthcare systems in order to learn about the leadership strategies, organizational processes and investments that had earned those systems the adjective “high performing.”

In their introduction to that collection, the researchers held out the Toyota Motor Corporation as an exemplar of the successful quest for quality. Alas, they mused, “there is no Toyota in healthcare: no one system clearly outdistances its competitors in virtually all its products and services” (23). Within a year, however, Baker et al. must have reflected a bit uneasily over their comparison: by late 2009, a series of quality-control lapses had forced Toyota into a series of embarrassing and costly product recalls involving mechanical, electrical and software failures.

From this little narrative I take away a lesson not only of time’s mostly inscrutable (and unavoidable) ironic power, but also about the difficulty both of defining and engineering quality with absolute certainty and long-term stability. And yet, it is into this complicated wilderness that our lead authors – Terence Sullivan, Frederick D. Ashbury, Jason Pun, Barbara Pitts, Nina Stipich and Jasmine Neeson – bravely stride and, in so doing, offer many valuable angles from which to view the subject.

As guides on their journey, Sullivan and his co-authors relied on extensive information gathered through interviews with 53 health leaders from across Canada. These interviews

were aimed at gaining “critical issues and perspectives” about three broad topics:

- Performance improvement and quality activities
- Challenges in the adoption and implementation of quality improvement
- Opportunities to strengthen the quality agenda at the individual, institutional, provincial and national levels.

Most readers will not be surprised to encounter the challenges about which Sullivan et al. heard. These include leadership that lacks a defined focus on quality, absence of a standardized approach across quality improvement initiatives, limited physician engagement, few physician champions and scarcity of human and financial capacity/resources. More optimistically, the researchers discovered “the existence of pockets of leadership” at the individual, organizational and agency levels.

While I wish that Sullivan et al. had spent more time describing the actual fabric, threads, and patterns of those pockets, I take their point that Canada’s healthcare system must develop ways to transfer knowledge from those successes “into measured behavioural and practice change.” At base, the authors learned, such knowledge transfer will require “consistent and strategic approaches” predicated on “the need to adopt a culture of quality” (a requirement cited by all their interviewees). Such a culture, the authors observe, entails continuous learning and improvement; it can, they claim, be achieved through investments that improve operational capacity, by aligning program and institution quality goals and through measuring and reporting.

Sullivan et al. conclude by advocating for a “performance agenda” and a “national agenda.” The latter, they say, must be “based on a coalition of the willing.” Perhaps it is too much to ask in a single essay, but the authors do not clarify who – individuals or organizations – would comprise such a coalition. It is all very good to call for new agendas and coalitions, but I am left feeling a bit dazed by the prospect of who or what body would take “responsibility” (a key word in their title) for contriving and managing such an entity in a country where the healthcare mosaic is so politically diverse.

At least part of my hesitation seems to be shared by Owen Adams who, in his commentary on the lead paper, observes that developing, agreeing on and using common indicators and reporting frameworks is a gigantic undertaking. Despite endorsement at various levels of government, the enterprise (other than with wait times) has never really gotten off the ground. As Adams notes, the last 15 or so years have seen lots of initiatives – for example, provincial quality councils and patient charters – that are likely steps in the right direction. But setting and sustaining a truly pan-Canadian “culture of quality” is on a wholly other order of magnitude.

In an effort to diagnose (partially) the lack of coordination in the national quality agenda, Wendy Nicklin and Gail Williams add the salient point that movement towards the creation of such an agenda will be supported by acknowledging “the interwoven relationship between quality and efficiency”; in their view, “an unrelenting focus on quality and efficiency ultimately results in positive change.” I was most struck by their observation that one of the strongest inhibiting factors afflicting the quality agenda is the proliferation of bodies to which healthcare organizations must submit data. Reporting is essential, but when does it become inefficient

through rampant duplication?

Our third commentary is by a leader of the calibre Sullivan et al. interviewed. Janet Davidson, the president and chief executive officer (CEO) of Trillium Health Centre, begins by stating that quality must be made “everyone’s business,” not just the purview of “evangelical leaders.” Largely addressing organizational-level quality, Davidson takes a sceptical view of large-scale “structures” such as provincial or national quality councils, a point that seems to be at odds with many of her peers across the country and several of her fellow commentators in this issue.

The next two commentaries add further dimensions unexplored by Sullivan et al. First, taking a more theoretical approach, W. Ward Flemons, Thomas Feasby and Bruce Wright suggest that the critical shortcoming in Canada is the lack of recognition that quality and safety are “system” properties and not confined to the competencies of individual care providers. The “disruptive change” for which they argue entails educating future physicians, other providers and managers about how to navigate the complex health systems in which they will one day work. Sullivan et al. are stuck, they say, at the “macrosystem level”; for real cultural change to occur, however, educators must also address the “meso” and “micro” levels in undergraduate and postgraduate healthcare education, including a strong leadership-training component.

Sharon Goodwin and Ariella Lang, meanwhile, view quality through the lens of the home and community-care sector, a practice-setting lacking amongst the leaders Sullivan et al. canvassed. How, for instance, do we deal with the quality issues attendant on the stress, fatigue, financial burdens and lack of training among informal caregivers who perform complex medical tasks in the home? Eighty percent of care in the home is delivered by family members: where do account-

ability and responsibility figure in those scenarios? I see great promise in Goodwin and Lang's contention that "exceptional client experience" might be the necessary "link" among quality, safety and efficiency and not, I would add, just in the home-care setting. In this regard, I detect a partial overlap with Arlene Bierman's contention that the leaders interviewed by Sullivan et al. missed the "perspective of front line providers, patients and the communities that they serve"; engaging these people and groups is, she says, critical. As well, Bierman was concerned that a number of leaders felt the lack of a clear definition of quality inhibited progress; this, she contends, is "a massive failure of knowledge translation." I was heartened, finally, by Bierman's contention that "upstream" public policy focused on health promotion ought to be part of the quality mix.

Hugh MacLeod – another major Canadian leader – devotes a good part of his commentary to exploring the implications of his striking contention that Canada does not actually have a healthcare "system" in the sense of "services that have been designed to work together to create an intentional outcome." As a result, how can the leaders interviewed by Sullivan et al. rationally expect to reform, transform, redesign and, in particular, align something that is more rhetoric than reality? MacLeod concludes by describing four "leverage" points for system redesign: front-line service providers, leadership and management, governance and government context (i.e., public servants and elected officials).

The last two commentaries in this issue address the lead paper from two distinct professional vantage points. Offering perspectives derived from the nursing profession, Rachel Bard and Mary-Anne Robinson echo the sentiments of a number of other commentators in wondering how the leaders Sullivan et al. interviewed seem rather out of touch with

quality-improvement developments occurring over the last 10-20 years. In addition, just as Goodwin and Lang were disturbed by the absence of home-care leaders from Sullivan et al.'s interviews, Bard and Robinson lament the lead authors' erasure of regulators from professional bodies, a group they believe is vital, in particular, to priority-setting and education. I would enjoy one day listening to a conversation on the matter of "efficiency" among Nicklin/Williams, Davidson and Bard/Robinson. I do not think it would lead to fisticuffs; rather, such a debate by these leaders who occupy such varied roles would, I believe, lead to intriguing nuances on how align, measure and balance quality and cost.

From views arising from the nursing profession, we move on to the concerns of a physician. Like nearly every other commentator, Dan Horvat wonders how, given the immense investments and efforts already made, so many quality-related problems still persist. One of Horvat's main points is that the "disconnect" between medical practitioners and healthcare administrators is a fundamental barrier to progress. Drawing on his own experiences, Horvat laments the difficulty physicians (and other distinct groups who comprise a "patchwork of cultures") have of sharing on-the-ground information with decision-makers. Looking beyond Canada for examples of quality-improvement success, Horvat concludes that Canada requires a "bigger tent." Under the canvas he envisions diverse professionals collaborating on plans and decisions, an approach that is superior to conventional performance management because it "promotes shared responsibility and accountability."

As I consider all the views presented in this issue of *Healthcare Papers*, I return to an observation made by Adalsteinn Brown when he was an assistant deputy minister in Ontario's Ministry of Health and Long-Term Care: "high quality is more the result of a

culture that pursues quality than of any single investment or policy” (Baker et al. 2008: 10). The sagacity of Brown’s words echoes in the findings presented by Sullivan and his fellow researchers, and in the commentaries that joust with the aspirations and complexities that surround the (possibly eternal) quality quest.

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Reference

Baker, G.R., A. MacIntosh-Murray, C. Porcellato, L. Dionne, K. Stelmacovich and K. Born. 2008. “Learning from High-Performing Systems: Quality by Design.” *High Performing Healthcare Systems: Quality by Design*. 11–26. Toronto: Longwoods Publishing.

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