

# Canadian Chief Executive Officers' Prescription for Higher Quality: More Clinical Engagement, Shared Accountability and Capacity Development

Mark J. Dobrow, Jasmine Neeson and Terrence Sullivan

**Q**uality of Healthcare in Canada: A Chartbook, published by the Canadian Health Services Research Foundation (CHSRF) in 2010, showed that when compared with other developed countries, Canada ranks in the middle of the pack with respect to healthcare quality. How we can best achieve higher-quality care is a much-debated issue in Canada and in most modern healthcare systems – and there are many conflicting views.

The historical guild of professionalism through self-regulating professional colleges remains intact, especially for issues of poor conduct or criminal behaviour. However, there is widespread evidence of errors of commission (e.g., wrong-sided surgery or medication error) and omission (e.g., under-managed care or infection caused by an absence of hand hygiene) and unacceptable variation in quality of care (CHSRF 2011). So beyond the regulatory bodies, important new organizational, managerial and legislative imperatives are emerging to improve quality. With the emergence of “accountable care organizations” in the United States and new legislation in several Canadian provinces promising greater attention to performance measurement and reporting, there is increasing movement toward enhancing accountability structures and mechanisms as a means of achieving higher-quality care.

To promote further examination of accountability for quality, CHSRF, in partnership with the Association of Canadian Academic Healthcare Organizations, the Canadian Institute for Health Information and the Canadian Medical Association, chose Leadership Accountability in Canadian Healthcare: Creating the Momentum to Improve Quality as the theme of the fifth annual CEO Forum in Montreal on February 16, 2011. Over 150 leaders from various sectors of Canada's healthcare system were in attendance at the forum. As part of the program, a polling exercise was conducted to gain participants' perspectives on quality and to promote discussion.

## Respondent Characteristics

Respondents came from a range of settings, including health service provider organizations, governmental and non-govern-

mental organizations, professional regulatory groups and quality agencies, and included some clinical leaders and health services researchers. Two thirds of respondents were older than 50 years, and the gender split was roughly equal. All regions of the country were represented (although two thirds were from either Ontario or Quebec).

## Results

We were able to analyze responses to the polling questions by the general respondent characteristics. For the most part, the findings were consistent, so we report only the overall results below.

**While less than 40% of respondents indicated that clinicians are currently the most accountable for quality, more than 60% indicated that clinicians should be most accountable.**

## Which Leaders Are Accountable for Quality, Who Ought to Be and Where Are the Gaps?

Several questions probed potential gaps between observed practices and normative perspectives. For example, participants were asked who currently has and who ideally should have the greatest impact on the quality of healthcare services (Figure 1). Clinicians were clearly perceived to have the greatest impact currently, which was consistent with normative perceptions. Notably, respondents also suggested that patients currently have limited impact on the quality of healthcare services but did not indicate this as a key area for improvement. This seems to conflict with the commonly held position that increasing focus on preventing disease and educating patients on the appropriateness of care could position patients to contribute more actively and effectively to a shared decision-making process that would have a positive impact on the quality of care they receive.

Clinicians were again the top choice for who is and who should be most accountable for the quality of healthcare services.

However, while less than 40% of respondents indicated that clinicians are currently the most accountable for quality, more than 60% indicated that clinicians should be most accountable (Figure 2). In contrast, respondents indicated that healthcare administrators/managers and public payers take on more accountability for quality than they ought to.

With respect to where quality improvement capacity/capability is strongest and most needed, respondents indicated that such capacity is currently strongest at the organizational

level but is most needed at the clinical practice level (Figure 3). This highlights a major challenge: aligning clinicians' aspiration for quality practice with organizational missions and payer expectations related to performance. Furthermore, respondents indicated that quality improvement leadership is currently strongest at the senior management level, but suggested that greater leadership is needed from physicians, middle management and governing boards (Figure 4).

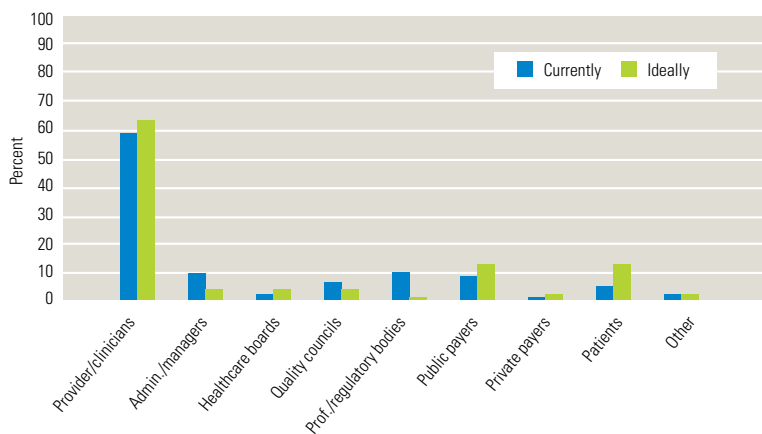
Another series of questions probed what could be done to advance quality improvement efforts. While over 96% of respondents indicated that improving the quality of healthcare services is a top priority, only a small minority (less than 10%) felt that recent investments have had a significant impact on the quality of healthcare services. Almost 90% of respondents indicated that more resources should be allocated (or re-allocated) to quality improvement activities. In particular, respondents felt that investments should focus on developing capacity through training and mentoring (versus quality improvement programs or research).

When asked where their future investments would likely be directed, respondents' top choice was international quality improvement consultants (e.g., Institute for Healthcare Improvement). There was no clear second option among a mix of other agencies and organizations noted, and no clear Canadian focal point. Respondents indicated that non-Canadian quality improvement investments were driven by greater breadth and depth of quality improvement expertise/knowledge, and that there is a lack of Canadian options. More than two thirds of respondents agreed that there would be added value in establishing a Canadian centre to develop a pan-Canadian quality improvement approach. Of those, the majority (58%) indicated that some form of a new national organization/effort is required, while 26% would prefer to build upon existing provincial organizations.

**What Was Learned?**

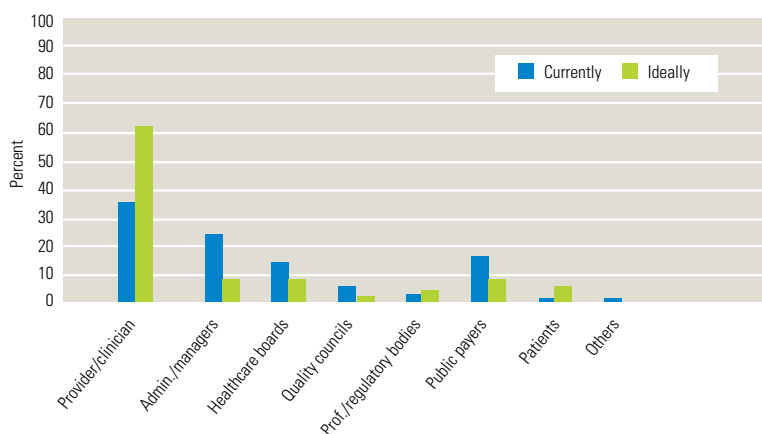
It became clear that achieving the right alignment between accountability structures and mechanisms is a crucial strategy for improving quality. Given the inherent complexity of modern healthcare systems,

**FIGURE 1.**  
**Who has and who should have the greatest impact on quality improvement?**



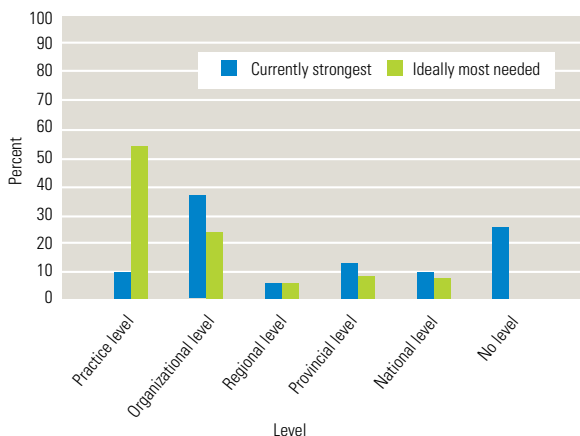
Admin. = administration; prof. = professional.

**FIGURE 2.**  
**Who is and who should be most accountable for the quality of health services?**

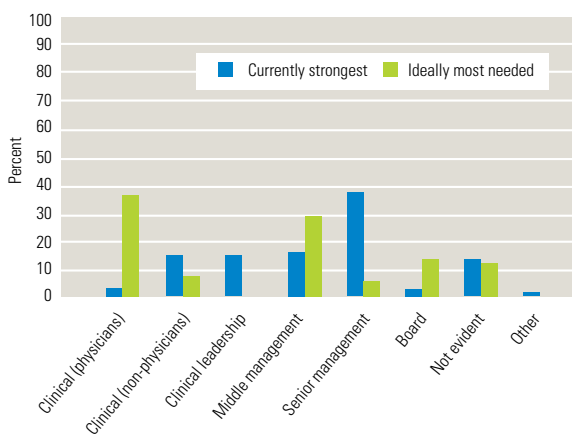


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**FIGURE 3.**  
Where is quality improvement capacity the strongest or most needed?



**FIGURE 4.**  
At what level is quality improvement leadership strongest or most needed?



accountability is as difficult to characterize as it is to execute. We may all agree that clinicians can and must embrace quality, but unless roles and responsibilities, performance information and incentives are aligned to support desired behaviours and activities, progress will remain slow. Self-regulating clinicians work in a range of organizational contexts (they may or may not be directly working for a healthcare organization). However, they increasingly face organizational quality goals that have

little to do with their compensation or employment (Shortell et al. 2000). When payers enter the fray with talk of “bending the cost curve” to constrain costs while advancing quality, the professions sometimes react with suspicion. A healthy debate is emerging both in the United States and Canada regarding the value of blended models of payment for physician services as a way to alter the relationship between physicians and healthcare organizations and facilitate quality improvement (Kocher and Sahni 2011; Léger 2011).

**When asked where** their future investments would likely be directed, respondents’ top choice was international quality improvement consultants.

While shared quality objectives are attainable, shared accountability for quality is considerably more challenging. Clinicians (and physicians in particular) need to take on a greater role in terms of accountability for quality. The recent focus on quality improvement by senior management is promising, but it is essential to advance this focus at the board level and among middle management in order to encourage a more pervasive culture of accountability for quality. Discussions at the CEO Forum emphasized the need to develop an environment of shared values, increased monitoring and reporting of performance data, and greater engagement in quality improvement, spanning from patients to policy makers (CHSRF 2011). There were clear indications that while Canadian healthcare leaders still look to international quality improvement expertise for guidance, there is a desire to develop Canadian capacity at national and provincial levels to support quality improvement within our healthcare service delivery organizations, agencies and professions. Perhaps creating such capacity should be an item on the agenda of future discussions related to the possible renewal of the current Health Accord in 2014.

For more information on the annual CEO Forum, visit [www.chsrf.ca](http://www.chsrf.ca). **HQ**

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