

How Long Can We Enjoy B-Player Status?

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In the recent edition of *Healthcare Papers* (<http://www.longwoods.com/publications/healthcarepapers/22856>, Sutherland and colleagues reflect on their experiences developing a pan-Canadian picture of quality measurement (Sutherland and Leatherman 2010). Their review points out shortcomings, gaps and variations in how we measure and report on the performance of our healthcare system. The picture is not good. It is no better when we consider what the actual data say about the health system performance in Canada. On the basis of this chartbook – which is a useful compendium of quality data from multiple sources – one of us (T.S.) made this case clearly at the Canadian Health Services Research Foundation (CHSRF) CEO Forum in 2010: Canada gets a B grade. In the commentaries that follow, several authors raise – and seem to accept – this B grade.

Are We Really a B Player?

What should we make of this B rating? At the 2010 CEO Forum, one of us (T.S.) reviewed the evidence on our relative performance. The highest rating was a B+, as a chart from the forum (Table 1) shows. So we are B players at best.

TABLE 1.
How does Canada perform? A summary

Quality Dimension	Rating
Access and timeliness	C+
Equity	B
Safety	B
Effectiveness	B+
Capacity	B (incomplete basis for evaluation)
Patient-centredness	B

Sutherland and colleagues worry that this B grade may seem good enough and discourage serious efforts to improve (Sutherland et al. 2012). They note that Canada’s “position as a ‘B-player’ on quality risks encouraging an attitude of complacency, rather than motivating a leadership imperative to strive

for excellence (or for A-player status),” a major concern voiced at the CEO Forum (CHSRF 2010; Sutherland et al. 2012: 15).

It is time to put the B-player status into perspective. In the early 1960s, Canadians lived longer than people in any other nation. According to the chartbook, we are now ninth in the world. And this is one of our better measures. When one reviews the indicators around how well we are preparing for the future – for example, the use of e-health systems – we quickly drop from our B-player status to the back of the class. Perhaps the much-feared complacency is already here. As other countries move forward with major efforts to improve the quality of care and even the overall level of health, we are left holding up exceptions such as Saskatchewan or Cancer Care Ontario. And even in these cases, there are some significant challenges. Despite meaningful improvements in cancer survival in Ontario, mortality is still poor compared with other countries, largely because of years of poor health behaviours. It will take us years to reduce this burden of ill health across our population. Middling performance and an overall poor commitment to improvement put our B-player status into jeopardy.

So we are poised for decline. What can we do about this? This is where the chartbook is particularly damning. Authors across most of the articles in this edition note huge gaps in data availability, variations in what is collected in each province and a profound disconnect between measures that matter to patients and their care and what is actually reported. By way of partial explanation, Sutherland and colleagues note that “healthcare is a provincial/territorial responsibility in Canada and, as a result, the measurement and reporting of healthcare performance have been managed at this level” (2012: 21). But again, the problems go well beyond the level stated. The range of performance on simple and important measures of performance such as mortality and cost per capita vary more within our country than between Canada and some of our peer nations. This means that some Canadians, depending on where they live, cannot expect even B-player performance when they receive care.

And this is where measurement is so important. Although there are always risks associated with measurement, the old adage holds true: you can only manage what you can measure. Without better measurement, we are unlikely to improve. In this edition, Watson (2012) also notes that this measurement becomes a powerful tool for change when it is publicly reported. A consistent approach to measurement and reporting across the country might accelerate this change because we would have comparisons and benchmarks to set what is possible in terms of performance.

It might also help bring sense to our current measurement systems that focus on measurement within an institution or sector, rather than understanding a patient trajectory. Most provinces acknowledge alternative-level-of-care (ALC) or “bed-blocker” patients as a major problem; but the data systems that could be used to measure and manage our way out of this problem are fragmented, with little ability to create a consistent picture of patients as they bounce between the sectors and institutions that characterize our healthcare system. In some provinces, this problem has been so bad that they have built yet another independent system to measure the ALC phenomenon.

When Do We Commit to A-Player Status?

Our B-player status – and the risk of a further slide – will persist until we set improvement goals and link them to measures for our system from coast to coast. The authors across all the articles in that edition of *Healthcare Papers* provide some useful guidance on how to achieve this and ensure improvement. Florizone (2012) and Corbett (2012) write of the importance of linking performance data to improvement strategies and of making improvement (and the necessary data) important to providers and policy makers. Watson (2012) picks up this theme and provides some practical guidance on how to make sure that chartbooks capture the attention of the public, providers and policy makers. Veillard and colleagues (2012) perhaps hit on the most important lever. Half of their recommendations call, essentially, for measures that matter to patients. If we all understood our B-player status, understood why it ends lives earlier, increases the tax burden and leads to unnecessary suffering, perhaps we would do something more.

After the last round of restructuring of our healthcare systems in the early '90s, nurses left the country, doctors were unhappy and our healthcare infrastructure frayed. Access clearly worsened and became a top media story, with patients leaving for the United States and providers calling for a parallel private system to ease pressure on our publicly financed system. Our politicians rightly responded to widely held concerns and invested in improving access. Where these investments were linked to better performance reporting and better organization of care, access improved significantly. Yet we remain quite poor on access relative to our international peers.

It is now time to set goals for better quality, the sorts of measurable and easily understood goals that made access reporting powerful. Before we congratulate ourselves on new committees, new reports and new programs, we should ask, to what end? A much more powerful statement would be to create a committee to improve quality, with goals and measures that would bring Canada back to an A-player status and reduce the disparities that still plague our country. **HQ**

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