RESEARCH PAPER

A North Star Vision: Results from a Deliberative Dialogue to Identify Policy Strategies to Improve Value in Healthcare

Vision à long terme : résultats d'un dialogue délibératif visant à identifier des stratégies politiques pour améliorer la valeur des soins de santé

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Abstract

We hosted a deliberative dialogue with citizens (n = 3), policy researchers (n = 3), government decision makers (n = 3) and health system leaders (n = 3) to identify evidence-informed policy options to improve the value of Canadian healthcare. The analysis resulted in three themes: (1) the need for a vision to guide reforms, (2) community-based care and (3) community-engaged care. Results suggest the need for a new paradigm: community-focused health systems. Such a paradigm could serve as a North Star guiding healthcare transformation, improving value by aligning citizen and healthcare system goals, prioritizing spending on services that address the social determinants of health and improving quality and equity.

Résumé

Nous avons organisé un dialogue délibératif avec des citoyens (n = 3), des chercheurs en politiques (n = 3), des décideurs gouvernementaux (n = 3) et des dirigeants du système de santé (n = 3) afin d'identifier des options politiques fondées sur les données probantes pour améliorer la valeur de soins de santé au Canada. L'analyse a abouti à trois thèmes : (1) la nécessité d'une vision pour guider les réformes, (2) les soins communautaires et (3) les soins engagés dans la communauté. Les résultats font voir la nécessité d'un nouveau paradigme : des systèmes de santé axés sur la communauté. Un tel paradigme pourrait servir de guide pour transformer les soins de santé, pour améliorer la valeur en alignant les objectifs des citoyens et du système de santé, pour accorder la priorité aux dépenses consacrées aux services qui traitent des déterminants sociaux de la santé et, finalement, pour favoriser la qualité et l'équité des soins.

Introduction

The Canadian healthcare system ranks second to last in overall performance among 11 comparable nations across five domains (i.e., access to care, care process, administrative efficiency, equity and healthcare outcomes) (Schneider et al. 2021). Notably, Canada also ranks second to last in performance compared with spending (Schneider et al. 2021).

Improving the value of healthcare involves improving quality, equity, health outcomes and patient and provider experiences while simultaneously containing or reducing healthcare costs (Conrad et al. 2016; Porter 2010). Since the establishment of Medicare, there has been no shortage of policy proposals to improve these key dimensions of health and healthcare (Advisory Council on the Implementation of National Pharmacare 2019; Romanow 2002; Lalonde 1974; Government of Canada 1997), yet there has been limited change (Lazar et al. 2013).

Healthcare reforms often succeed as a result of timing or context changes, such as fiscal or perceived crises or actions taken by new governments (Lazar et al. 2013), and when patients and providers are engaged in the policy process (Culyer and Lomas 2006; Usher et al. 2021). The COVID-19 pandemic has been an unprecedented crisis. It has exposed and deepened health, race and gender inequities; crystalized new challenges (e.g., access to virtual healthcare, mental healthcare, long-term care [LTC] and provider burnout) that require immediate action; and opened the window for healthcare reform (Béland and Marier 2020; Dozois and Mental Health Research Canada 2021; Haworth-Brockman and Betker 2020; Moroni et al. 2020; Ndumbe-Eyoh et al. 2021; PHAC 2021; The Conference Board of Canada 2020; Wake et al. 2020; Wang et al. 2020; Webster 2020). In an effort to build a more sustainable future for Canada's health systems at this critical moment, the Centre for Health Policy at the O'Brien Institute for Public Health launched a Health System Sustainability Initiative (https://obrieniph.ucalgary.ca/centre/health-policy/health-policy-initiatives/the-health-system-sustainability-initiative). The initiative is guided by the Quadruple Aim (improving population health, value, patient experiences and provider experience) (Bodenheimer and Sinsky 2014) and equity. The goal of this initiative is to design evidence-informed health policy options to improve health system sustainability in Canada by improving performance while maintaining or reducing costs. We brought citizens, policy researchers, government decision makers and health system leaders together to participate in a deliberative dialogue at a Health Policy Forum to identify policy options to improve the value of Canadian healthcare.

Methods

Participants

Twelve individuals representing health policy researchers (n = 3), citizen groups (n = 3), governmental decision makers (n = 3) and health system leaders (n = 3) participated in the dialogue. The group included five women and six men from six provinces and two territories. The participants had expertise in patient and citizen engagement, digital health, healthcare

administration, rural healthcare, social work, healthcare funding and payment, evidence-informed policy development and implementation and primary care, as well as access, quality, safety and equity. All the participants had experience with health and/or social policy, including designing, implementing or evaluating public health and healthcare policies at different levels of the health system. The participants were divided into three discussion groups, each containing a representative from the four stakeholder groups.

Deliberative dialogue

A one-day deliberative dialogue was held on June 27, 2022, at the University of Calgary in Calgary, AB. A deliberative dialogue is a group process informed by research evidence that leads to recommendations reflecting both the knowledge, experience and values of individual participants and the consensus that emerges after reflecting on evidence and others' perspectives (Boyko et al. 2014; Culyer and Lomas 2006). The aim of the dialogue was for the participants to develop evidence-informed recommendations that address health policy priorities that have the potential to improve value for money and have historically been challenging to overcome. The dialogue was led by three facilitators and included research presentations and a series of small- and large-group discussions.

RESEARCH EVIDENCE

Participants considered evidence from three research studies. The first presentation addressed Canadians' perspectives on potential reform to the healthcare system (Parsons Leigh et al. 2023). This interview-based study reported results from interviews with public citizens, healthcare leaders, academics and political decision makers on the structure of the healthcare system, healthcare processes and strategies to improve short- and long-term population health outcomes. The second presentation provided results on two knowledge syntheses of international health system reform, including a literature review on the history of reforms in Organisation for Economic Cooperation and Development countries that identified drivers of reform (Farkas et al. 2023) and a concept analysis to develop a model of successful health system reforms (Minion et al. 2023). The third presentation reported findings from interviews with members of federal health advisory groups since the 1990s, as well as interviews with implementers of the group's recommendations (Quinn et al. 2023). Implications for implementation strategies based on barriers and facilitators identified in the sociopolitical context, characteristics of recommendations and collaborations (e.g., stakeholder engagement) of the National Forum on Health, the Romanow Commission and the Advisory Council on the Implementation of National Pharmacare were discussed.

We undertook these three studies to present participants with data to inform the deliberative dialogue. Our intention was that these studies would identify effective health reform strategies and targets in Canada and similar countries, identify barriers and facilitators of reform implementation in Canada and identify stakeholders' needs emerging from the COVID-19 pandemic.

FACILITATION

Three sequential small-group discussions addressed the following: (1) defining a vision for the future to identify opportunities for improvements within the healthcare system, (2) defining priorities for change and corresponding goals and outcomes for reform and (3) identifying barriers that have historically made it challenging to address these priority areas and drafting policy recommendations to achieve identified goals. Each facilitator was partnered with a note-taker who took detailed notes and recorded the group's conversation on prepared templates. The note-takers were instructed to capture the discussion on the templates in a visible, accurate and comprehensive way. The first discussion preceded the research presentations, while the second and third discussions followed the presentations. During the second discussion, facilitators reviewed key findings from the presentation on Canadians' priorities for reform and invited participants to suggest their priority areas. The group was asked to narrow down their list to two priorities through consensus and then identify goals and outcomes for each priority area. In the third discussion, facilitators prompted participants to integrate information from the presentations relating to their identified priority areas and discuss barriers and strategies to achieve their proposed goals. After each small-group discussion, one forum participant (not a facilitator) from each table reported to the rest of the forum on their table's discussion using the prepared templates. Afterward, a large-group dialogue (with all 12 panellists) was facilitated by a moderator.

Analysis

Two authors (AEQ and RD) conducted a reflexive thematic analysis (Braun and Clarke 2006, 2019; Byrne 2022) underpinned by a relativist ontological and subjectivist epistemological stance. Reflexive thematic analysis is a theoretically flexible type of thematic analysis to identify patterns of meaning that are not concerned with coding reliability or structured codebooks. It involves a process of data familiarization, data coding and theme development and revision. Themes, created from both codes and researchers' active engagement with data, are the output of the analysis.

Proceedings were audio recorded, transcribed, de-identified and imported into NVivo 12 software (QSR International). AEQ and RD participated in the deliberative dialogue and independently reviewed the transcripts to develop an initial list of codes. Both the authors discussed the initial codes and agreed upon a first-draft codebook. They both independently coded the transcripts, iteratively refining the codebook as necessary. Both of them also discussed the evolving codebook and initial themes. Coding was predominantly inductive. We utilized questions asked during the dialogue to guide coding. The PROGRESS tool (O'Neill et al. 2014) was used to guide coding related to characteristics typically associated with discrimination and disparities to ensure that an equity-focused lens was adopted. As themes were defined, themes and subthemes were revised and recoded. During the analysis process, AEQ and RD maintained open communication about their interpretation and positionality to challenge their assumptions of the dialogue and to ensure that participants'

experiences were reflected in the results. All quotations that appear in the Results section are from the deliberative dialogue. Quotations are not attributed to specific individuals as they reflect group discussions resulting from the facilitation process.

This study was approved by the University of Calgary Conjoint Health Research Ethics Board (REB22-0491).

Results

A vision to guide us from the healthcare system of today to the healthcare system of the future

The participants identified five priority areas for reform to improve our current healthcare system. These priorities emphasized community-based care models and the leadership and structural changes needed to support these models: (1) develop leadership and vision, (2) restructure coverage and funding, (3) reimagine primary care, (4) improve LTC and (5) advance equitable and community-based care. A summary of potential policy strategies and views on how action in these areas could improve value is presented in Table 1 (available at longwoods.com/content/27089).

The need for a guiding vision for the healthcare system that all stakeholders could understand and work toward was raised repeatedly. This vision could serve as a North Star, to galvanize needed reforms identified repeatedly by Canadian policy experts and to guide future reforms and evaluations of delivery processes and outcomes. The Quadruple Aim was proposed by some participants as a North Star.

> When we talked about what we'd like to look at for healthcare in the future, we felt we already know a lot of this, but that we need to really articulate it. And that the vision could be a North Star [that] we could make our decisions against.

There was discussion of the need for leadership from the federal government, provincial and territorial governments and municipalities to achieve reform. Roles for each of these levels of government were apparent as the group discussed the need for expansion of medicare-covered services (e.g., LTC, mental health and substance use services), care management, publicly delivered community-based care, new payment models that motivate desired healthcare processes and outcomes and community engagement at all levels of the health system.

Conversations about how to support these needed changes were complex, including discussion of capital and human resources, growth of healthcare spending and the performance of the system compared with what is spent. Some participants stated that the current system was not sustainable due to poor infrastructure and a lack of resources. Others described the system as *too* sustainable as there is a continuous inflow of money from governments with limited requirements or expectations. Participants proposed either increasing taxes or utilizing current funding more efficiently or effectively to fund potential reforms. Other sources of

revenue were not discussed. Participants discussed the importance and challenge of estimating the impact of proposed reforms, including the need to be transparent about winners and losers resulting from new funding and payment models, as well as the need to develop mitigation strategies to address anticipated budget impacts.

Community-based care in the healthcare system of the future

The necessary delivery system reforms that were discussed shared common threads of improving equitable access to care and being located in the community as opposed to institutional settings. Community-based care or "care closer to home" could include primary care, home-based care (as opposed to hospital-based care and LTC facilities) and public health interventions, such as developing housing connected to community health centres. By focusing on "care closer to home," one group explained:

> I think the outcome we would like to see is better quality of life for everybody, particularly those who are older and have high healthcare needs.

Primary care was identified as a key component of the healthcare system that needed reform to improve system-wide value for money due to insufficient investments, access issues and outdated models of care characterized by fee-for-service payments and private care delivery by individual or small-group providers. Participants highlighted that access to primary care providers remains a long-standing challenge. One group described their vision for a reimagined model as "respectful, responsive care that is accountable and directly reflective of a defined community's needs." A strategy proposed to be reflective of a defined community's needs was establishing publicly funded primary care delivery sites that serve a designated catchment area alongside existing private facilities.

LTC was also highlighted as an area that requires reform in order to increase the long-term quality of life of older adults and to decrease institutional stays and alternative levels of care days in hospital. Increased home-based care services was suggested as the primary strategy. One group suggested that new LTC facilities should no longer be built or, alternatively, municipalities could lead the delivery of new care models for older people.

> Pay attention to the life trajectory and care for older people. And that's deliberately chosen vocabulary because it's not just about better clinical care for the elderly. It's about the total trajectory based on a philosophy that drives it, which is that this is about a system that cares about older people and believes in enabling their capacities to pursue high quality of life.

Many individual and social characteristics, such as place of residence, age, gender, occupation, language and socio-economic status, were discussed as being associated with disparities in health opportunities and outcomes. These factors were typically viewed as barriers to

accessing care. Community-based care could increase access to prevention and treatment services because it would be closer to patients' homes. However, there are also risks that a focus on home care could increase caregiver burden, which would likely affect women more than men.

Community-engaged care in the healthcare system of the future

Equitable, community-based care was described as reflecting and responding to the needs and voices of the community. Thus, engaging patients and citizens in health systems was perceived as essential to implement community-based care and to overcome historic barriers to healthcare reform. The historic barriers identified were (1) lack of a guiding vision, (2) the intertwining of politics and policy, (3) lack of transparency and accountability, (4) limited public information and knowledge, (5) lack of community voice and (6) inadequate funding and infrastructure. Each barrier is defined and corresponding strategies for change are presented in Table 2 (available at longwoods.com/content/27089).

Participants discussed both broad principles of reform and specific strategies related to community engagement. Two principles of reform discussed were universality and trust. The concept of universality reflected the need to strive for a system with a high level of equity and accountability where all Canadians are included, regardless of need, age and socio-economic or other circumstances. Participants described the importance of trust between patients and healthcare workers, as well as trust among healthcare workers in future reforms. Many of the implementation strategies described by participants involved "a shift in some decision making and control toward community that might start to address those structural considerations of power and voice within health systems."

There was a substantial focus on strategies to include the community voice across the healthcare system (in policy development, administration and delivery) in order to empower citizens. This would require including patients and citizens in non-tokenistic roles in governance committees and other decision-making bodies across the system to increase their influence. There was also discussion of "conversations" with patients and citizens as vehicles for specific performance improvements, as well as to generate a narrative to inspire increased community advocacy. "Safe spaces" in the healthcare system would be necessary to have these conversations. Increasing community engagement would also require educating the public to reduce misinformation and misunderstanding about the healthcare system, particularly regarding funding and payment models, government priorities and roles and the vision for healthcare. Furthermore, increasing the transparency and accountability of the government and delivery systems could also play an important role in communicating with patients and citizens regarding health system performance.

Discussion

A deliberative dialogue of cross-national citizens, researchers, delivery system leaders and decision makers was held to identify evidence-informed priorities and strategies for

healthcare reforms that improve value for money. Based on our interpretation of the priorities and strategies discussed, we identified three themes: (1) the need for a vision to guide us from the healthcare system of today to the healthcare system of the future, (2) a future system of community-based care and (3) a future system of community-engaged care. A future healthcare system focused on community-based care would emphasize primary care, care for older adults in the home, home-based hospital care and public health services. Strategies to overcome historic barriers to create a healthcare system focused on community-based care predominantly involved a shift in decision making and control away from payers and providers toward communities through community engagement and government and delivery system transparency and accountability. These reforms can improve value by aligning citizen and healthcare system goals, prioritizing spending on services that address the social determinants of health and improving quality and equity.

The need for a guiding vision, a North Star, for healthcare administration, management, funding and delivery system reform was a dominant point of discussion. The concepts of community-based care and community-engaged care point to a vision of community-focused health systems that could serve as the North Star. Participants also indicated that the Quadruple Aim could serve as a North Star, just as the Triple Aim originally intended (Berwick et al. 2008). Furthermore, equity was identified as an important component of future reforms. Taken together, community-focused health systems could serve as a North Star vision representing where we hope to get, while the Quintuple Aim (improving population health, value, patient experiences, provider experience and equity [Nundy et al. 2022]) could represent pillars of that vision. These pillars would signify what we hope to achieve within community-focused health systems.

A community-focused health system would include three key features: (1) co-led and co-designed by community members alongside healthcare payers and providers, (2) focused on primary and community-based care and (3) built upon supportive funding and delivery mechanisms. Similar concepts have been proposed in Canada for decades. However, little progress has been made. Federal health advisory groups have prioritized citizen engagement (Advisory Council on the Implementation of National Pharmacare 2019; Romanow 2002; Government of Canada 1997), including calls to shape the healthcare system "around health needs of individual patients, their families and communities" (Romanow 2002: 50). Because of the COVID-19 pandemic – an unprecedented crisis – there may currently be a window of opportunity to introduce community-focused solutions as a new paradigm for reform.

There is evidence from Canada that community-based care that emphasizes primary care can improve health system performance. A systematic review of primary care reforms in Alberta, Ontario and Quebec found that team-based care and disease management reforms were associated with improved utilization and health outcomes (Carter et al. 2016). Payment reforms were associated with changes in the utilization of services but not necessarily quality improvement (Carter et al. 2016). The concepts of primary care health teams and alternative payment models have been advancing in Canada, with renewed calls as access to primary care

has been even more challenging since the COVID-19 pandemic (Kiran 2022). Coalitions of physicians and patient and citizen partners could lead the development of alternative delivery and payment models in order to overcome historic barriers to reform. Alternatively, regional health authorities could advocate for the ability to directly contract with physicians.

A big challenge for Canada would be developing and implementing performance evaluation frameworks to ensure that new community-based care delivery and payment models were contributing to improved value (Fletcher et al. 2021) and meaningfully engaging the public (Abelson et al. 2016). Participants suggested that provincial/territorial governments could be responsible for managing providers similar to private health plans in the US or, alternatively, that providers or professional societies could monitor their performance. Another option could be developing new governance structures for primary care in parallel to regional health authorities that support empowerment and accountability for population-based primary care. In a community-focused health system, public reporting of performance would be critical to foster trust with patients and citizens.

The main findings from our deliberative process echo many of the themes developed by authors in the recent *HealthcarePapers* series on value from healthcare –particularly stakeholder engagement, population health, measuring what matters to patients and alternative funding and payment models that support new models of care delivery (Logan and Sutherland 2020; Mathies 2020; Strumpf 2020; Sutherland 2020a, 2020b; Wodchis and Reid 2020). Our work also echoes much of the broader policy conversation that has called for significant attention to LTC, primary care and community-based care (Dass et al. 2022; Key and Lewis 2018; Kiran et al. 2020; Lee et al. 2021; McKay et al. 2022; O'Neill et al. 2020; Pulok and Hajizadeh 2022; Usher and Denis 2022; Wilson et al. 2022). However, our work extends the current body of literature by focusing on the healthcare system writ broad as opposed to individual aspects of it and considers high-level reform. Our work also integrated multiple stakeholders across the system, which has not been done at a macro-system level since the Romanow Commission (Romanow 2002).

There are limitations to this analysis. The deliberative dialogue and reflexive analysis process reflect the interpretations of individual participants and individual researchers. Thus, the results may be influenced by the participant recruitment process, specific questions asked during the meeting and the knowledge and experience of the researchers. Other participants and questions may have offered alternative ideas for reform options and strategies.

Conclusion

Collectively, the results of the deliberative dialogue address the need for a new paradigm: community-focused health systems. Such a paradigm could serve as a North Star to guide healthcare transformation, providing both a vision for value-based Canadian healthcare and a path to achieve it. A community-focused health system would include three key features: (1) co-led and co-designed by community members alongside healthcare payers and providers, (2) focused on primary and community-based care and (3) built upon supportive funding and

delivery mechanisms. While questions of governance would still need to be answered by co-leaders, empowering Canadians to be more actively engaged in healthcare could improve the value of care by aligning citizen and system goals.

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