

HEALTHCARE

# POLICY

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## Politiques de Santé

*Health Services, Management and Policy Research  
Services de santé, gestion et recherche de politique*



**Volume 2 + Number 1**

### Under the Radar: Stealth Development of Two-Tier Healthcare in Canada

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### Performance Measurement in Healthcare: Part II – State of the Science Findings by Stage of the Performance Measurement Process

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### From World War to Class War: The Rebound of the Rich

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*Data Matters + Discussion and Debate  
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Health Services, Management and Policy Research  
Services de santé, gestion et recherche de politique



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*Healthcare Policy/Politiques de Santé* seeks to bridge the worlds of research and decision-making by presenting research, analysis and information that speak to both audiences. Accordingly, our manuscript review and editorial processes include researchers and decision-makers.

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*ykoo@longwoods.com*

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#### HOW TO REACH THE EDITORS AND PUBLISHER

Telephone: 416-864-9667 Fax: 416-368-4443

#### ADDRESSES

All mail should go to: Longwoods Publishing Corporation, 260 Adelaide Street East, No. 8, Toronto, Ontario M5A 1N1, Canada

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## Consuming Healthcare: What's in a Word?

Use of the terms “consumer” and “customer” has become widespread in discourse about healthcare among policy makers, managers, academics and advocacy groups. I was reminded of this phenomenon – and inspired to write this editorial – by a recent call by the policy branch of a provincial ministry of health for a “policy theme paper” on “consumer centredness” and “consumer choice.” Reflecting on the gradual, but seemingly relentless, shift from “patient” and “client” to “consumer” or “customer,” I wondered what might underlie this trend, what values and interests might be advanced or challenged (whether inadvertently or by intention) by use of these terms, and the extent to which healthcare users have come to see themselves as consumers of care.

To sample the recent literature, I searched PubMed for editorials, letters and reviews published in the last five years that included the word “consumer” in the title or abstract. As I browsed this material, two distinct strands of meaning were apparent in the use of the term “consumer” – the consumer as empowered, informed, autonomous health decision-maker and the consumer as purchaser of healthcare goods and services. Some authors appeared to have only one strand in mind; others adopted both.

The notion of healthcare users who are informed, empowered and autonomous, engage in self-care, participate in decisions about their health and have the right to receive care that is timely, culturally appropriate and responsive to their values and preferences is hard to quarrel with. What is curious is how these values came to be associated with the term “consumer.” No doubt the linkage is, in part, a reaction to the waning, but still present, paternalism (maternalism?) of medicine and nursing where the term “patient” is most firmly entrenched. Adoption of “consumer” declares a rejection of that traditional feature of the relationship between health professionals and healthcare users. But the term “consumer” carries baggage of its own.

The concept of the empowered and informed healthcare consumer hardly squares with the reality of the marketplace from whence the term was imported. In that sphere, a bewildering array of goods and services are marketed based largely on image rather than information, conveyed through design, packaging and advertising – which Stephen Leacock characterized as “the science of arresting the human intelligence long enough to get money from it” (Leacock 1924). Unlike health professionals, producers, marketers and sellers of goods and services have no ethical imperative to act in the

“customer’s” best interests; their primary allegiance lies elsewhere. In their world, the principle of *caveat emptor* prevails. Characterizing healthcare users as consumers seems completely at odds with Julian Tudor Hart’s inspired concept of patients and healthcare providers as “co-producers of health” (Hart 1992).

How do healthcare users feel about all of this? Based on Canadian and international research (Lloyd et al. 2001; Nair 1998; Deber et al. 2005), they’re not at all enamoured of the consumer label. For example, in a Canadian study of people receiving care in breast cancer, prostate disease, fracture and HIV clinics, more respondents liked the label “patient” than any of the alternatives that were posed (consumer, customer, client, partner or survivor) (Deber et al. 2005). Among those attending the breast, prostate and fracture clinics, 90% moderately or strongly disliked and less than 5% moderately or strongly liked the label “consumer.” People living with HIV/AIDS were slightly more open to being referred to as consumers, with about 12% moderately or strongly liking the label. Imposing an identity on healthcare users that they reject seems like an odd form of empowerment.

The second strand of meaning defines the consumer as an economic actor making choices in a healthcare marketplace. In a typical expression of this concept, George Lundberg, former editor of the *Journal of the American Medical Association*, writes: “Why not let individuals make the purchasing decisions directly, spending their own money, so as to inject free-market components into the otherwise skewed medical marketplace?” (Lundberg 2005). Although both strands of meaning conceptualize healthcare consumers as private actors, this second sense of the term poses a direct challenge to the communitarian view, long dominant in Canada, of healthcare as a collectively financed, social good that is made available based solely on need. What could be more “natural” for healthcare consumers than access to a wide variety of healthcare products and services available for purchase in keeping with one’s tastes and means. Whatever its other effects, characterizing citizens and healthcare users as “consumers” of healthcare seems likely to have a “softening up” effect in aid of efforts to expand private financing options for services currently included in the medicare basket.

Where does this leave us? Those who favour marketization of healthcare will understandably (and with intent) continue to privilege the term “consumer.” For others, continued use of “consumer” to describe healthcare users may support a healthcare agenda that many Canadians reject. Perhaps the time has come to abandon this muddled and misleading terminology. Surely the laudable goals of citizen and patient empowerment can be pursued without recourse to the language of the market.

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BRIAN HUTCHISON, MD, MSC, FCFP  
*Editor-in-chief*

## La consommation des soins de santé : à la recherche du mot juste

Les décideurs, les gestionnaires, les universitaires et les groupes d'intervention tendent de plus en plus à utiliser les termes « consommateur » et « client » quand ils parlent des soins de santé. Un récent appel de communications publié par la Direction des politiques d'un ministère provincial de la Santé demandant des articles portant sur « les politiques » et traitant des « soins axés sur les consommateurs » et des « choix des consommateurs » m'a rappelé ce fait et m'a inspiré à rédiger le présent éditorial. En réfléchissant sur le virage graduel – mais apparemment inexorable – de « patient » et d'« usager » à « consommateur » ou à « client », je me suis demandé ce qui pouvait sous-tendre cette tendance, quelles valeurs et quels enjeux on pouvait promouvoir ou contester (intentionnellement ou par inadvertance) en utilisant ces termes, et dans quelle mesure les usagers des soins de santé étaient venus à se percevoir comme étant des consommateurs de soins.

J'ai effectué un survol de la documentation actuelle en recherchant, dans PubMed, des éditoriaux, des lettres et des critiques publiés au cours des cinq dernières années et où le mot « consommateur » figurait dans le titre ou le résumé. En parcourant les différents articles, deux significations différentes sont devenues apparentes dans l'utilisation du terme « consommateur », à savoir, le consommateur en tant que décideur habilité, informé et autonome en matière de soins de santé, et le consommateur en tant qu'acheteur de biens et de services de santé. Certains auteurs semblent n'avoir qu'une seule signification en tête, tandis que d'autres ont adopté les deux.

Il est difficile de contester la notion d'utilisateurs de soins de santé informés, habilités et autonomes, qui prennent leurs soins en charge, qui participent aux décisions prises au sujet de leur santé et qui sont en droit de recevoir des soins en temps opportun, culturellement appropriés et adaptés à leurs valeurs et à leurs préférences. Ce qui est curieux est la façon dont ces valeurs sont venues à être associées au terme « consommateur ». Sans aucun doute cette association constitue-t-elle, du moins en partie, une réaction au paternalisme (maternalisme?) encore présent – bien qu'en perte de vitesse – de la médecine et des soins infirmiers, où le terme « patient » est profondément enraciné. L'adoption du terme « consommateur » se veut un rejet de cette caractérisation traditionnelle de la relation entre les professionnels et les usagers des soins de santé. Mais le terme « consommateur » possède lui aussi son propre lot de bagages.

Le concept de consommateur habilité et informé en matière de soins de santé cadre bien avec la réalité du marché, d'où le terme a été emprunté. Dans cette sphère, un éventail hallucinant de biens et de services sont commercialisés sur la base de l'image et non de l'information, et sont présentés par l'entremise de la conception, de l'emballage et de la publicité – que Stephen Leacock a défini comme étant « la science de stopper l'intelligence humaine assez longtemps pour en soutirer de l'argent » (Leacock, 1924). Contrairement aux professionnels de la santé, les producteurs, les promoteurs et les vendeurs de biens et services ne sont nullement tenus, sur le plan éthique, d'agir dans les meilleurs intérêts « du consommateur »; leur allégeance première est ailleurs. Dans leur monde, le principe de *caveat emptor* a préséance. Le fait de qualifier les usagers des soins de santé de consommateurs semble aller totalement à l'encontre du concept novateur proposé par Julian Tudor Hart selon lequel les patients et les fournisseurs de soins de santé sont des « coproducteurs de la santé » (Hart, 1992).

Que pensent les usagers des soins de santé de tout cela? Selon des études effectuées au Canada et à l'étranger (Lloyd *et al*, 2001, Nair 1998, Deber *et al*, 2005), ils n'affectionnent pas particulièrement l'étiquette de « consommateurs ». Par exemple, Deber et ses collègues parlent d'une étude canadienne menée auprès de personnes qui recevaient des soins en clinique pour le cancer du sein, des maladies de la prostate, des fractures et le VIH, où plus de répondants préféreraient le mot « patient » à tous les autres termes proposés (consommateur, client, usager, partenaire ou survivant) (Deber *et al*, 2005). Parmi ceux qui se faisaient soigner pour le cancer du sein, des troubles de la prostate ou des fractures, 90 % avaient une aversion modérée à forte pour le mot « consommateur » et moins de 5 % l'aimaient modérément ou beaucoup. Les personnes recevant des soins pour le VIH/SIDA étaient légèrement plus enclines à accepter l'appellation de « consommateurs » : environ 12 % ont dit affectionner modérément ou beaucoup ce vocable. Le fait d'imposer aux usagers des soins de santé une identité qu'ils rejettent me paraît être une étrange forme d'habilitation.

La seconde signification définit le consommateur comme étant un acteur économique qui exerce des choix sur le marché des soins de santé. Dans une expression

typique de ce concept, George Lundberg, ancien rédacteur de la revue de l'*American Medical Association*, écrit : [traduction] « Pourquoi ne pas laisser les gens prendre eux-mêmes leurs propres décisions d'achat et dépenser leur propre argent, et ainsi intégrer des composantes du marché libre dans le marché médical par ailleurs tendancieux? » (Lundberg, 2005). Bien que les deux significations conceptualisent les consommateurs des soins de santé comme étant des acteurs privés, le second sens attribué au terme pose un défi direct au point de vue communautariste – depuis longtemps dominant au Canada – selon lequel les soins de santé sont un bien social financé collectivement et offert uniquement en fonction du besoin. Quoi de plus « naturel » pour les consommateurs de soins de santé que d'avoir accès à un large éventail de produits et services de santé offerts sur le marché et de s'en prévaloir en fonction de leurs goûts et de leurs moyens. Quelles que soient les autres répercussions que cela peut avoir, le fait de coller l'étiquette de « consommateurs » aux usagers des soins de santé semble avoir un effet favorable sur les initiatives visant à élargir les options de financement privé pour les services actuellement couverts par l'assurance-maladie.

Où cela nous mène-t-il? Ceux qui sont en faveur de la commercialisation des soins de santé continueront intentionnellement – et avec raison – de privilégier le terme « consommateur ». Pour d'autres, l'utilisation continue de ce mot pour décrire les usagers des soins de santé peut contribuer à favoriser un programme de soins de santé que beaucoup de Canadiens rejettent. Le temps est peut-être venu d'abandonner cette terminologie confuse et trompeuse. Il y a sûrement moyen de poursuivre l'objectif louable d'habilitation du citoyen et du patient sans recourir au langage du marché.

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# From World War to Class War: The Rebound of the Rich

De guerre mondiale à guerre des classes :  
la remontée des riches

by ROBERT G. EVANS  
*Professor of Economics*  
*University of British Columbia*  
*Vancouver, BC*

## Abstract

Incomes in Canada, as in many other countries, are becoming increasingly unequal. In North America this process has several notable features. First, after 40 years of stability, income has since 1980 been increasingly concentrated in the hands of the top 0.01% of earners. Second, this concentration correlates with an explosion in the relative earnings of corporate CEOs, a sort of “corporate kleptocracy.” Third, the top earners have appropriated most of the productivity gains over this period. The resources and political influence of the super-rich underlie the growing prominence of the “elite” agenda: lower taxes, smaller government and privatization or shrinkage of social programs. The marketing of this agenda may explain much of the nonsense that contaminates health policy debates.

## Résumé

Au Canada, comme dans de nombreux autres pays, on observe de plus en plus de disparités dans les revenus. En Amérique du Nord, ce processus comporte plusieurs caractéristiques importantes. En premier lieu, après 40 ans de stabilité, les revenus sont de plus en plus concentrés entre les mains de 0,01 % de la population active depuis 1980. En deuxième lieu, cette concentration correspond à une explosion des revenus relatifs des PDG des grandes sociétés – une sorte de « kleptocratie des entreprises ». En troisième lieu, les personnes ayant les meilleurs revenus d'emploi se sont accaparé la plupart des gains de productivité pendant cette période. Les ressources et l'influence politique des super-riches sont à la source de la dominance croissante des intérêts de l'« élite », à savoir, des taxes réduites, un gouvernement plus petit et la privatisation ou la réduction des programmes sociaux. La promotion de ces intérêts peut expliquer une bonne partie des balivernes qui contaminent les débats sur les politiques relatives à la santé.

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*Above all things, good policy is to be used, that the treasure and moneys, in a state, be not gathered into few hands ... money is like muck, not good except it be spread.*

– Sir Francis Bacon, Essay XV

**T**HE DISTRIBUTION OF INCOME IN CANADA, AS IN MANY OTHER COUNTRIES, is becoming increasingly unequal. This is not exactly late-breaking news, though the issue seems to have stayed largely below the public radar. Several recent papers, however, have focused in particular on the highest incomes and placed this trend in historical context.

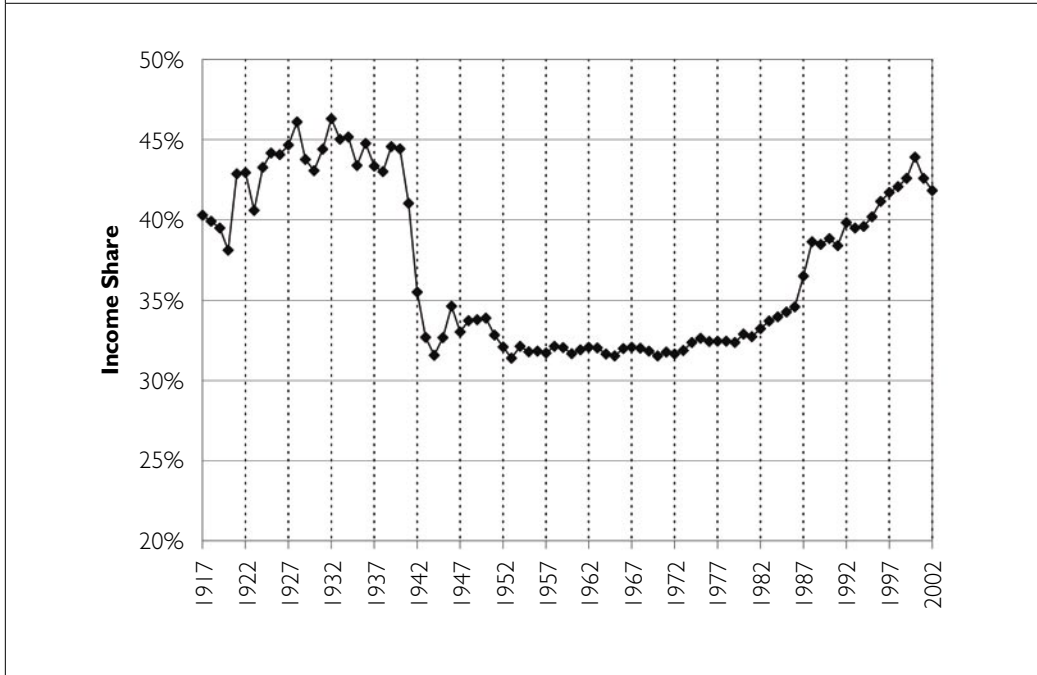
## Forward to the Past

Income in North America is now concentrated in the hands of the very, very wealthy to a degree not seen since before the Second World War. And with greater wealth comes greater political influence; public policy, including health policy, is increasingly driven by the priorities of the wealthy, overriding the concerns of the general population.

Piketty and Saez (2006) examine the concentration of income in the United States over most of the last century, with comparative data for Canada and several other countries. Their graph 1A (Figure 1), drawn from income tax data, tells a remarkable story.

Between 1919 and 1940, the top 10% of American earners accounted for a relatively steady 43%–46% of total incomes. The onset of war, however, brought major increases in corporate taxes and steeply progressive individual taxation. Top earners'

FIGURE 1. Top decile income shares in the United States, 1917–2002



share plummeted to about one-third, and stayed there for the next 40 years. In that era, studying income distribution was likened to watching paint dry, or grass grow.

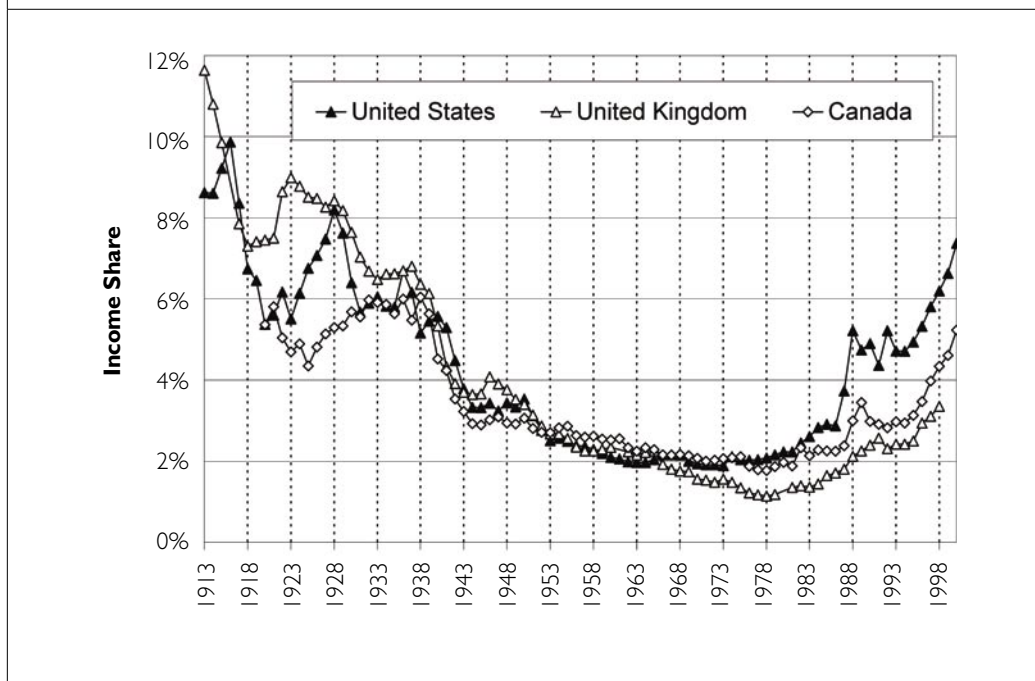
Then came the 1980s, and coincidentally, the elections of Ronald Reagan and Margaret Thatcher. (“You think the income distribution can’t be changed? Watch me!”) Money began to flow back to the long end. Today, the pre-war relationship has largely been re-established.

## The Higher, the Better

Times are very good in the top decile, but the more thinly one “top-slices” the income distribution, the better they get. The top 1% saw their share increase from 8% to 17%. But the gains still farther up are even more extraordinary. The highest-earning ten-thousandth, representing perhaps about 30,000 people, increased their share from 0.5% to nearly 3% of all incomes earned in the United States. Two and a half percentage points may not seem like much, but it was enough to raise these people’s relative incomes by a factor of six, from about 50 times the national average to about 300 times.

As Figure 2 shows, Canada and the United Kingdom have followed the U.S. pattern (*Ibid.*, Figure 3A). Their trends are, as usual, less extreme than in the United States, but over 20 years the top one-thousandth of Canadian earners have more than

FIGURE 2. Top 0.1% income shares in English-speaking countries



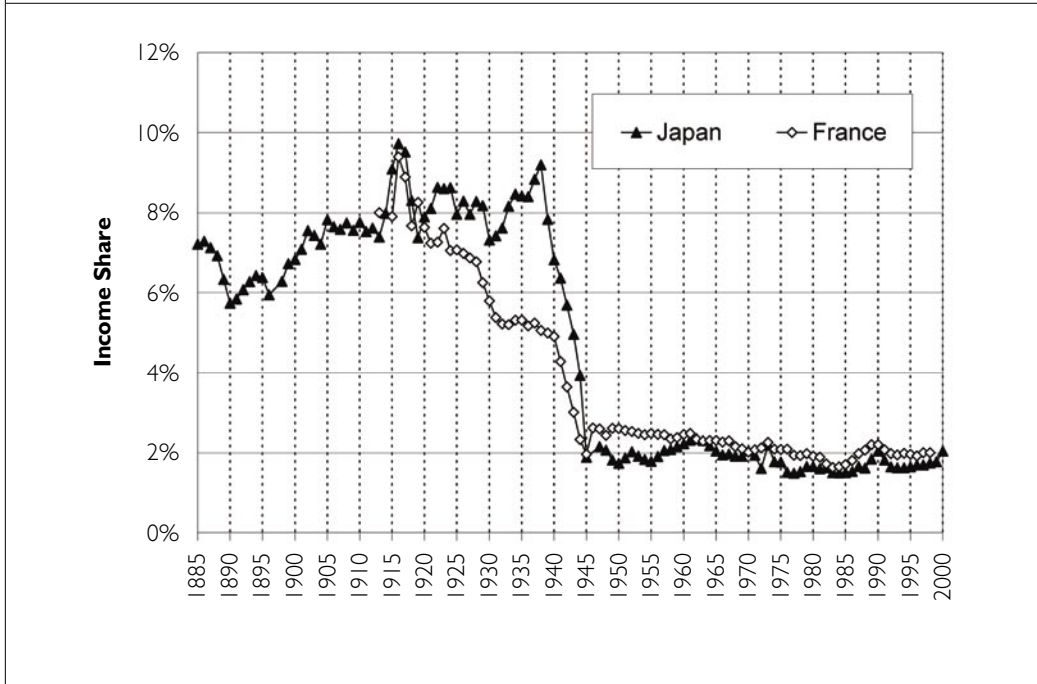
doubled their share, and the top 0.01% – representing about 3,300 people – saw their share rise from 0.5% to 1.8% (Saez and Veall 2004). Yet in France and Japan (Figure 3)(Piketty and Saez, Figure 3B), the pattern is totally different and seems to refute any explanation based on universal economic laws at work in the development of advanced industrial economies. One might want to focus instead on country-specific institutions and policies.

## Dr. Pangloss, Right on Cue

Nevertheless, a common response by economists to increasing economic inequality has been to look for general external factors unrelated to particular institutions or policies. The favourite code phrase is “skill-biased technological progress.”

Continuing technological innovation makes possible ever-increasing productivity and correspondingly ever-increasing incomes – the Holy Grail of Growth. But it just happens – it’s no one’s choice or fault, just part of the structure of the universe – that at present, technical progress is increasing the demand for, and thus the relative incomes of, the highly educated and highly skilled. Incomes are more unequal because, given present technology, individual productivity is more unequal. (What could be fairer than that?)

FIGURE 3. Top 0.1% income shares in France and Japan



So economic growth, which is very good and very important, comes with the side effect of increasing economic inequality, which some people may think is not so good. But it would be very wrong-headed for governments to interfere with the allocation of incomes by the impersonal forces of the market. Imposing more progressive taxation, for example, or expanding income support programs or the provision of public services, or even raising minimum wages or facilitating unionization, would risk lowering the rate of economic growth and would thus be really bad. Such policies would condemn a society to progressively declining (relative) incomes, compared with more economically enlightened countries.

Policy should rather seek to minimize public interventions, regardless of the distributional consequences, in order to encourage even more rapid growth. If increasing inequality is a concern, the proper response is for those losing ground to get more training. Send the children to the Harvard Business School – or even enroll yourself.

## The Corporate Kleptocrats

Not such a bad idea, at that. (But don't expect any public support – see below.) Paralleling the march of inequality across North America has been an extraordi-

nary increase in the compensation of corporate senior executives, and particularly of CEOs. Frydman (2005) presents the results of a long-term study of a sample of major American corporations, many with substantial Canadian operations. Her focus is on testing various economic explanations for this recent increase, but the basic data are interesting enough.

Over the decade of the 1970s, the median total annual compensation (averaged over the three top executives of each of the corporations studied) was \$1.03 million (USD of 2000). This was a slow and unremarkable rise from \$890,000 in the period

1936–1939. But then median executive earnings took off: \$1.53 million in the 1980s, \$2.90 million in the 1990s and \$5.23 million in 2000–2003. The spread within the corporate ranks also widened dramatically; average total compensation among the 90th percentile of corporate executives rose from \$2.06 million in the

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**The ratio of CEO compensation to average production workers' pay, which had averaged 42 to one in 1982, was 10 times higher – 431 to one – in 2004 ...**

1970s to \$22.19 million in 2000–2003. Top earnings rose more than 9% per year, compounded over 27 years!

The rest of the American labour force fared somewhat less well. The ratio of CEO compensation to average production workers' pay, which had averaged 42 to one in 1982, was 10 times higher – 431 to one – in 2004 (Anderson et al. 2005).

These are staggering increases. They correspond to an intriguing observation by Piketty and Saez (2006). The pre-war period was still the era of the *rentier*; the super-rich were sustained primarily by income from investments. But the dramatic resurgence after 1980 was powered by increases in salaries and business earnings – including those of corporate executives. It appears that in the current era, those at the top have found alternative ways of extracting and concentrating wealth from the corporate sector.

But this would imply conscious agency, inconsistent with conventional economic thinking. A more economical approach interprets CEO earnings as just another manifestation of “skill-bias,” in this case skill-biased environmental change. The corporate world has become dramatically more complex and competitive, what with globalization and the Internet and all that, such that the value to a corporation's shareholders of the very best top management – the super-stars – has greatly increased. (But are they all super-stars now?)

The argument rests on faith in the collective intelligence and ability of corporate directors in matching rewards with contributions. Empirical support for this is distinct-

ly dubious; the CEO who took Moore Corporation shares from \$16 to \$3, for example, picked up US\$40 million on his way out the door. And then there is John Roth ...

Economic faith insists, nonetheless, that on average, CEOs must be worth the money, or rational, fully informed boards of directors, wholly dedicated to the enhancement of shareholder value (the PC term for profit), would not offer such whacking great compensation packages. The existence of these idealized boards has been vigorously challenged by Bebchuk and Fried (2004, 2005). "We show that, under current legal arrangements, boards cannot be expected to contract at arm's length with the executives whose pay they set" (Bebchuk and Fried 2005).

Faith or no, however, there is in fact no logical link from the argument that exceptional managerial talent confers a corresponding competitive advantage on the corporation, and the conclusion that a general growth in executive compensation will raise the overall productivity of a society. (Conversely, capping hockey players' salaries will not lower the average quality of play in the NHL.) Nor, more generally, does economic theory provide any *a priori* basis for the proposition that greater inequality is associated with greater economic efficiency. The "equity–efficiency tradeoff" popularized by Arthur Okun (1975) was simply a theoretical blunder, taken up enthusiastically in "pop" economics presumably because of its political attractiveness.

The relationship between inequality and growth is thus an empirical one, and as usual the empirical studies are mixed. It depends upon when, and where, and what else is going on. For what it's worth, we do find that the rate of growth of real national income per head in the English-speaking countries is substantially higher than in France or Japan, at least over the 10- and five-year periods prior to 2003. But it isn't worth very much.

## Where Did All the Productivity Go?

The apparently central issue of inequality and growth turns out to be irrelevant, a red herring. For most of us in North America there hasn't been much growth. The gains have all been captured at the top end.

Between 1976 and 1990, average personal income per capita in Canada (inflation-adjusted) rose only 0.6% per year. From 1990 to 2000 it didn't grow at all (Saez and Veall 2004, 2005). A similar pattern emerges in the United States: "We show that over the entire period 1966–2001, as well as over 1997–2001, ... median real wage and salary income barely grew at all ... because half of the income gains went to the top 10 percent of the income distribution ..." (Dew-Becker and Gordon 2005).

The corporate kleptocrats are making out like bandits, but none of this wealth is trickling down. So even if public policies to mitigate inequality were to threaten the aggregate rate of growth, what have most of us got to lose?

These are heretical thoughts, totally out of synch with the economic *zeitgeist*.

The public agenda has for a number of years been prodded in the opposite direction – “smaller government,” tax cuts, privatization (perhaps starting with P3s), de-regulation, and ever-greater scope for free markets. But who or what is calling forth these *geists*? Surveys suggest that at least in Canada these are not the priorities of the general public, only of the “elites” – and no wonder.

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**The corporate kleptocrats are making out like bandits, but none of this wealth is trickling down. So even if public policies to mitigate inequality were to threaten the aggregate rate of growth, what have most of us got to lose?**

The contrast of priorities was nicely illustrated by Conrad Black’s vitriolic editorial after the federal election of 2000. Canadian governments are engaged in “a process of taking money from people who have earned it and redistributing it to people who haven’t, more or less in exchange for their votes” (Black 2000). Lord Black’s concept of “earned” may be somewhat

idiosyncratic; he is currently under indictment in the United States for fraud and racketeering. But if we strike that word, he is quite correct. Governments, in every country, are primarily and pretty much the only institutions for redistributing income and in-kind benefits down the income spectrum. If voters support that, well, isn’t that how democracies are supposed to work?

## Starving the Welfare State

The counter-strategy for the wealthy is simple enough. Cripple the fiscal capacity of governments through tax cuts, particularly for themselves. After all, if you are stinking rich you don’t need much of a government. The Welfare State wastes money on all sorts of public services you either do not need, or are perfectly capable of buying privately. And to add insult, governments often interfere with your enterprises in the name of some exiguous “public interest.” A Watchman State is quite sufficient.

This agenda is well advanced in the United States. The tax cuts under the Bush administration have created a federal debt that will hobble government for years or decades. And the beneficiaries have indeed been the wealthy. The *New York Times* (Johnston 2006) reports that in 2003, cuts to taxes on investment income transferred an average of \$500,000 each to those with incomes over \$10 million, bringing their average gains from combined Bush tax cuts to just over \$1 million. Of the total revenue forgone, 42% went to those with incomes over \$1 million – 0.1% of all taxpayers.

Canada is very different, so far. The federal government has been running surpluses for years and is (very slowly) reducing the federal debt. But the same pressures are at work. The Alberta “flat tax” and Senator Kirby’s proposed income-linked healthcare premiums both significantly lower the tax burdens of the highest earners, as did the B.C. tax cuts of 2001. The subsequent program cuts required to restore budget balance have been mostly “wealthy-friendly.” Meanwhile, since the mid-1990s the federal and provincial governments have between them forgone through tax cuts a sum now “not unadjacent to” \$60 billion a year. Cumulated over the last decade, these amounts could have made a very big hole in the public debt.

The recent proposals from the Canadian Council of Chief Executives (CCCE) are the most transparent attack on the public sector. Downloading a much greater share of taxation and of responsibility for public programs from the federal to the provincial level is designed to trigger a classic “race to the bottom.” Provincial governments would be under increased pressure to compete more aggressively in cutting taxes and public spending. The casualties would certainly include the *Canada Health Act* and medicare, and probably much of the public support for post-secondary education, but then that’s really rather the point, isn’t it? The principal beneficiaries? – see above under “Corporate Kleptocrats.”

Advocates of this program, including the CCCE, emphasize the importance of international competitiveness and faster economic growth. The *New York Times* report (Johnston 2006) quotes a lobbyist to the effect that investment earnings should not be taxed at all, because they will be saved and invested, creating more jobs and faster growth. (On this logic, government should perhaps introduce a negative tax for investment earnings.) The new capital investments, and the income they generate, would of course all be owned by the same thin top slice of the income distribution who received the tax breaks in the first place.

As every economist knows, however, government surpluses are an alternative and equally effective form of national savings. They flow directly into the bond market as government debt is repaid, and are there available to private investors. But the ownership of this form of savings and investment is not concentrated among the very wealthy, so no one lobbies for bigger surpluses. Indeed, the public commentary in Canada seems quite negative – better, apparently, to promote growth through corporate tax cuts for the wealthy. Curious.

## Money, Myths and Medicine

But what has all this got to do with healthcare policy? The connection, I suggest, is that the attack on the Welfare State, and the erosion of the post-war consensus on the role of government, parallels the dramatic increase in the concentration of wealth. And public systems of healthcare are a centrepiece of the Welfare State. They are a natural

focus for attack on the Willie Sutton Principle – “that’s where the money is” – and smaller government requires a larger role for private finance. Public healthcare also offers, at least outside the United States, less scope for the corporate kleptocracy. But it is also by far the most widely used and strongly supported of any public service. To discredit government, you must discredit public healthcare.

And you must discredit government – as the Dark Lord clearly recognized – if you are to reduce its depredations on the wealth of the upper classes. When he bought

the Southam chain and founded the *National Post*, Black was quite open about his intent to use them as a propaganda vehicle, to shift the centre of gravity of public debate in Canada. Whatever his personal fate, he appears to have succeeded. The torch has now been picked up by the Aspers and CanWest Global. (The *Globe and Mail* and *La*

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**They have their roots in the simple fact that public healthcare systems transfer both resources and access down the income spectrum, from the healthy and wealthy to the unhealthy and unwealthy.**

*Presse*, controlled respectively by the billionaire Thomson and Desmarais families, emphasize their strong commitment to press independence.)

Meanwhile, a string of *soi-disant* “think tanks” has emerged on the model of the highly successful Fraser Institute, privately and well financed, to serve as propaganda outlets for the corporate sector and to undermine confidence in governments. (As always, the original models are American.) It works; behind the notorious *Chaoulli* decision, for example, lie at least 15 years of anti-medicare disinformation, seeping into the ill-informed and inadequately critical minds of the majority court.<sup>1</sup>

Erroneous and often patently absurd claims about healthcare and the “public–private mix” have been around in more or less the same form for many decades. They have their roots in the simple fact that public healthcare systems transfer both resources and access down the income spectrum, from the healthy and wealthy to the unhealthy and unwealthy. Public financing can also limit the transfer of wealth from those who pay for care to those who are paid for it. These effects are ever-fertile sources of well-worn and specious arguments as to why such transfers/limitations are unfair, inefficient and unhealthy.

But why have these myths been promulgated with increasing energy over the last quarter century, becoming embedded, like coproliths, in the media and in political debate? They are no less specious, but the political landscape has changed dramatically. Medicare is now very much on the defensive. The spectacular growth in the incomes

of the super-rich, expanding the resources behind their agenda, may offer at least part of the explanation. If we are back to a pre-war income distribution, how much of our post-war social policies can survive?

#### NOTES

1. "... one of the most unsettling aspects of the *Chaoulli* decision was the misuse, and ignorance, of evidence" (Barer 2005: 217).

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# Under the Radar: Stealth Development of Two-Tier Healthcare in Canada

## Sous l'écran radar : implantation subreptice d'un système de soins de santé à deux vitesses au Canada



by ALAN DAVIDSON, PHD  
*Associate Professor, Health Studies*  
*University of British Columbia Okanagan*  
*Kelowna, BC*

### Abstract

The shocked reaction of commentators to the recent Canadian Supreme Court decision (*Chaoulli v. Quebec*) overturning Quebec's ban on private healthcare insurance is difficult to square with the facts and policy options realistically open to provincial governments. The problem is that rhetoric has centred on preserving a single-tier universal system that has never existed in the form its supporters imagine. Meanwhile, quasi-private agencies and healthcare entrepreneurs have been improvising private care options, either ignored or abetted by governments. Consequently, policy and practice have become increasingly divergent. Supporters of Canadian-style medicare can only hope that the *Chaoulli* decision will force clearer-headed policy re-appraisal. Towards that end, this paper argues that provincial governments ought to focus more on robust regulation of already existing, privately financed healthcare, including the commissioning of care by Workers' Compensation Boards.

## Résumé

La réaction-choc des commentateurs suite à la récente décision de la Cour Suprême (*Chaoulli c. Québec*) invalidant l'interdiction, au Québec, de recourir à des assurances privées pour les soins de santé est difficile à réconcilier avec les faits et les options de politiques qui s'offrent, de façon réaliste, aux gouvernements provinciaux. Le problème est que la rhétorique s'est concentrée sur la préservation d'un système universel à une vitesse qui n'a jamais existé sous la forme que ses défenseurs prétendent. Entre-temps, les agences paraprivées et les chefs d'entreprise oeuvrant dans le domaine de la santé s'affairent à improviser des options en matière de soins privés, sous les regards peu soucieux des gouvernements ou avec l'aide de ceux-ci. On constate donc une divergence croissante entre les politiques et la pratique. Les défenseurs d'un système de soins de santé « à la canadienne » ne peuvent qu'espérer que la décision *Chaoulli* entraînera une réévaluation plus éclairée des politiques. À cet égard, le présent article soutient que les gouvernements provinciaux devraient mettre davantage l'accent sur une réglementation plus musclée des soins de santé privés déjà existants, y compris la prestation de soins par les commissions des accidents du travail.

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## Public Health Insurance in Canada

Following introduction of a provincial hospital insurance program in Saskatchewan, the federal *Hospital Insurance and Diagnostic Services Act* offered financial assistance to provincial programs covering the cost of hospital care. By 1961, all 10 provinces had signed agreements with Ottawa. In 1966 the federal government, again following developments in Saskatchewan, introduced the *Medical Care Act*, which, from July 1, 1968, provided federal funding support to provinces establishing insurance programs to pay the cost of doctors' services. By 1972, all provinces and territories had added medical insurance plans to supplement the hospital ones. The framework left uninsured a class of hospital services, notably, amenity services such as preferred accommodations, and non-medically necessary doctors' services such as adult cosmetic surgery.

The Established Program Financing block funding arrangements, which replaced cost sharing in 1977, helped the federal government to gain control over its health expenditures but did so at the expense of capping provincial revenues from federal sources. Provincial efforts to reduce the rise in their spending through demand-side measures, such as allowing doctors to bill above the public insurance tariff, provoked the *Canada Health Act* in 1984. That Act mandates financial penalties on provinces that impose or permit private charges on insured residents for insured services.

## Initial Conditions: Policy Limits on Private Financing

Controversially, federal funding conditions required coverage of all residents within participating provinces, rendering private cover redundant. Various disincentives to bill privately were also built into provincial healthcare insurance legislation. In Ontario, for example, if a physician wishes to bill at a rate other than the established tariff, he or she is required to “opt out” of the provincial healthcare insurance plan and directly bill all his or her patients. In Quebec, an opted-out (“non-participating”) physician was not only barred from billing the plan directly, but also his or her patients were ineligible to apply for public reimbursement of any part of the fee. In light of these various policy instruments, very few doctors chose to “go private.”

In spite of strong policy disincentives, concern about the possible return of privately funded hospital and medical care led six of Canada’s 10 provinces – British Columbia, Alberta, Manitoba, Ontario, Quebec and Prince Edward Island – to ban private insurance for services that were insured under their provincial plans. Private funding through private insurance policies invoked the spectre of a “second tier of care” – care that can be differentially accessed based not on health needs but rather on ability to pay. Additionally, policy makers at the time believed that a duplicate, privately financed care system running alongside the publicly funded one could drain the public system of resources and political support, a belief recently supported by evidence from Spain (Costa-Font 2005).

## Policy Limits on Universal Public Insurance

The policy window for expanding universal entitlement programs closed over the decade following 1975 because (a) federal tax cuts and economic slowdown drove budgets into deficit (Evans 2005), (b) resistance to federal involvement in areas of provincial jurisdiction grew, notably in Alberta and Quebec and (c) concern over healthcare spending deepened. The planned extension of universal health insurance into such areas as drugs dispensed outside a hospital never happened.

In consequence, some form of private financing, combined with a hodgepodge of provincial programs, is the norm everywhere except for insured hospital and medical services, where private financing virtually disappeared after passage of the *Canada Health Act* (Office of the Auditor General 1999, 2002; Choudry 1996). This situation is uniquely Canadian and has been aptly named “sectoral” financing (Tuohy et al. 2004).

## The Ambiguity of “Medical Necessity”

The criterion for public hospital and medical insurance coverage, “medical necessity,” has not been without difficulties. Under financial pressure and the influence of the evidence-based medicine movement, provincial governments engaged in bound-

ary shifting. First, services of dubious clinical merit, such as neo-natal circumcision, were de-insured. Then, following the *Canadian Task Force Report on Periodic Health Examination* in 1979, provinces began to de-insure or place limits on the frequency of routine medical examinations and impose meaningful constraints on the routine ordering of laboratory tests and imaging (Canadian Task Force 2005). The result was the creation of a small niche market for privately financed health examinations, including privately financed diagnostic imaging services for the worried well. While not of great moment in and of itself, the policy point is significant: boundary setting by provincial insurance authorities establishes not only the limits of public coverage, but also marks the terrain that can be, and increasingly is, occupied by privately financed service providers.

The lengthening in Canada of wait times for elective procedures has proven to be the biggest problem associated with equating “insured service” with “medical necessity.” Privately financed diagnostic and treatment clinics advance the argument that if a three-month wait time is medically acceptable, providing the service sooner cannot, strictly speaking, be “medically necessary” (Day 2005). While plainly trading on an ambiguity, the privately financed diagnostic and treatment clinics exist precisely to provide services more expeditiously than is justified by the evidence-based guidelines informing the publicly funded system. In and of itself, the ambiguity is unimportant because the potential market for expedited service is too small to finance private diagnosis and treatment. But coupled with unused capacity funded from another source, a more serious threat is posed to the universal insurance plan. As this paper will show, another source exists in the form of Workers’ Compensation Boards.

## Private Health Insurance in Canada

An underappreciated fact is Canada’s heavy reliance on private healthcare insurance. In 2002, only four OECD countries depended on private insurance for more than 10% of their total healthcare expenditures. Canada is among them. Only in five countries – Canada, the United States, Switzerland, France and the Netherlands – does more than 60% of the population have private insurance coverage (Colombo 2004). This largely accounts for the fact that Canada’s public share of healthcare expenditure is on the low side at less than 70% (CIHI 2005a).

Currently, less than 50% of the cost of prescription drugs, including those dispensed in hospital, is financed by the public sector; roughly 35% is covered by the private insurance industry (Health Council 2005). With the exception of Quebec, provinces have been reducing drug coverage; the new Quebec drug plan actually shifts coverage from public to private insurance. British Columbia recently increased co-payments and thresholds, and Ontario narrowed eligibility criteria, decreasing the number of beneficiaries by 9%.

As Evans (2002) pointed out, private healthcare insurance in Canada is subsidized. It is expensed as a business cost, but the benefits are tax free in the hands of employees, resulting in an estimated 30% tax expenditure. While important for the profitability of companies offering drug and other non-insured service coverage, subsidization is even more important for duplicate coverage of services wholly or partially paid by universal public plans. Underwriting is only marginally viable without hefty public subsidies, as evidenced by the small market share in the United Kingdom (6%) and the need for massive subsidies in Australia (Davidson 2004b). Removing public supports for private insurance in Canada would go some considerable distance towards ensuring that private corporate insurance will not expand beyond its beach-head in drugs and other non-insured benefits.

## Workers' Compensation Boards and Private Care in Canada

The absence of commercial insurance companies in the Canadian medical and hospital care sectors does not mean that Canada has been without a significant source of private insurance financing for services that would normally be covered by medicare. The arrangements respecting workplace injury preceded medicare and were grand-parented into the policy mix. Workers' Compensation Boards (WCBs), structured under provincial legislation, continued to be responsible for paying for medical care and rehabilitation of injured workers. As quasi-autonomous agencies, WCBs were and remain private healthcare insurance operations funded by premiums paid by employers. The services they cover are, from the perspective of the universal public insurance plan, an amalgam of insured and non-insured ones – medically necessary care, but also drugs dispensed in the community, community-based rehabilitation services, and so on. Technically, WCB coverage is not duplicate insurance coverage comparable to duplicate coverage in Australia, where the same baskets of services may be paid for by either private insurance or public medicare. In the Canadian case, treatment stemming from a workplace accident is exempted from public coverage, defined as an “uninsured service” even though it is medically necessary, because the legal responsibility to pay was legislatively assigned to WCBs.

Workers' Compensation Boards commission services from physicians in private practice, hospitals and private rehabilitation centres such as physiotherapy clinics, paying rates negotiated independently from the provincial healthcare insurance plans. That funding facilitated the expansion of privately funded/privately provisioned care, especially in the areas of diagnostic imaging and rehabilitation.

In the 1990s, in response to growing wait times for elective procedures in the public system, provincial WCBs sought private care providers who would treat injured workers sooner than the publicly funded healthcare system. The shift in WCB funding away from publicly funded hospitals towards privately funded private treatment

centres made these centres financially viable by adding to their traditional revenues from non-insured services such as cosmetic surgery. Falling costs of, and improved technology in, arthroscopic surgery allowed for product line expansion in light of WCB demand and WCBs' willingness to pay premium prices for repairs of joint and ligament injuries. Consequently, there was a proliferation of private treatment centres and an expansion of existing ones.

Once established, diagnostic and treatment centres have the obvious objectives of stabilizing their funding and expanding their market. Those objectives require four strategies. The first is to promote the idea that delays in the public system may cause health to deteriorate. The second is to argue a quality and amenity advantage over public care. The third is to expand the product line by including high-demand items. The fourth is to find means to make the care more affordable for potential private-paying patients, given that the alternatives are entirely free to the user. The first three are evident in the intensive advertising by private treatment centres (False Creek Surgery Centre 2005; Cambie Surgery Centre 2005). The fourth is evident in private care centres' lobbying for, on the one hand, private insurance to cover their services and, on the other, contracts with the health authorities to treat public patients with public funds, putatively to shorten waiting times for all publicly insured patients. As predicted (Deber 2002), once established the Canadian private care providers formed political coalitions to defend and increase their share of funding. Not surprisingly, 14 private treatment centres, the majority from British Columbia and most of them recipients of WCB funding, were intervenors in *Chaoulli v. Quebec*.

British Columbia's WCB makes no apology for its robust support for the expansion of private, specialized facilities offering services for which there are long queues for publicly supported access in public facilities. "To improve rehabilitation and return-to-work timelines for injured workers, the WCB provides expedited medical services to many claimants who would otherwise be subjected to lengthy waiting lists in the public health care system" (WCB 2003: 20). The amounts of money are not trivial. For example, in 2002, British Columbia's WCB reported expenditures on healthcare of over \$237 million (WCB 2003).

WCB funding has not only incubated private treatment centres; it has also expanded private care within public hospitals. British Columbia's health authorities are competing with private treatment facilities for the business, bringing additional resources into the hospitals and, according to WCB managers, expanding capacity, as opposed to shunting aside public patients (LeBourdais 1999). The development is welcomed by cash-strapped health authorities and surgeons who benefit from additional operating room time. De facto, it means a two-tiered healthcare system of expedited privately financed patients and patiently waiting public patients. To date, there is no evidence regarding the effect of the private funding stream on the fate of those publicly supported patients because there has been no effort to find out. But it

would be surprising if hospital managers and health authorities in Canada are doing what their counterparts in Britain and Australia cannot – preventing the privately funded care from adversely affecting access for publicly funded patients (Pollock 2005; Duckett 2005a,b).

## Conclusion

The perception of increased waiting times and decreased quality of service (Blendon 2002) has harmed public support for Canadian medicare. The reality of some extreme waits led the Supreme Court to conclude that the current situation poses an unacceptable threat to security of the person. More is required than the benchmark wait times belatedly delivered by the provinces in December 2005. What is needed is meaningful action on wait times, including much-improved health information management, a transparent system for setting priorities and a democratically accountable approach to the provision of care. Additionally, technical improvements, such as the elimination of “choke points” and the building and staffing of specialized high-volume facilities for eye and joint care, are urgently required. The private assault on the public system can be stopped only if the public system is regarded as worth defending. Provincial health policy must begin to demonstrate that governments are bearing this in mind.

Given the reality in Canada of multiple growth nodes in privately funded care, it is hard not to agree with the majority of the Supreme Court justices. They found the argument that a provincial ban on private health insurance is required to protect Canada’s unique, single-tiered healthcare system to be either cynical or naïve. They were no doubt influenced by the fact that privately financed healthcare, along with privileged access, has grown, not only for WCB clients, but also for corporate executives, politicians – and judges. Moreover, the justices reasoned that protecting publicly funded programs does not require a ban on private insurance because some provinces and some countries have no such ban, yet maintain publicly financed, universal healthcare systems. That is because other policy instruments are available to governments and, from the Court’s perspective, it is up to provincial governments as to whether they will deploy them. An example here is the 2004 *Ontario Healthcare Insurance Act* amendment requiring Ontario doctors to submit all bills for insured services to the public plan (*Health Insurance Act* 1990: 15(1)).

The Supreme Court was correct to conclude that the ban on private insurance is not strictly necessary, although it is plainly helpful, to protect the publicly funded healthcare system. Other, equally effective policies are available for regulating the scope and role of private healthcare in Canada. Those policies include (a) clarifying the boundaries of insured and uninsured services, (b) establishing regulations regarding privately financed services in treatment settings, (c) more closely regulating the billing practices of providers, (d) removing subsidies for private insurance, (e) controlling the com-

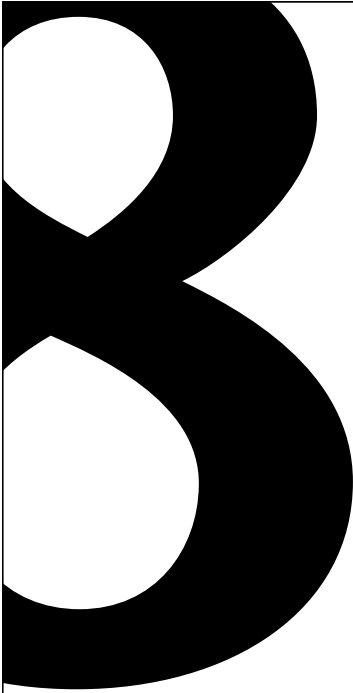
missioning practices of quasi-public agencies such as WCBs and (f) most importantly, improving the responsiveness of, and public confidence in, the publicly financed system.

Correspondence may be directed to: Alan Davidson, PhD, Associate Professor, Health Studies, University of British Columbia Okanagan, 3333 University Way, Kelowna, British Columbia V1V 1V7; tel.: 250-807-9969; email: alan.davidson@ubc.ca.

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# Waits for Surgery Following Hip Fracture

## Temps d'attente pour les chirurgies après une fracture de la hanche



by KIRA LEEB, BA, MA  
*Canadian Institute for Health Information*  
Toronto, ON

KATHLEEN MORRIS, BA, MBA  
*Canadian Institute for Health Information*  
Toronto, ON

LINDA CHOY, CCHRA(C), BCOMM  
*Canadian Institute for Health Information*  
Toronto, ON

TRACY JOHNSON, BSC, MBA  
*Canadian Institute for Health Information*  
Toronto, ON

### Abstract

Almost all hip fracture patients undergo surgery to repair the fracture. Recent research suggests that timely repair is important for good outcomes following surgery. Patients who had surgical repair of a hip fracture in 2003–2004 were identified using hospitalization data collected by the Canadian Institute for Health Information. Time to surgery was calculated from day of admission to day of surgery. The associations of

both patient and system characteristics with waits for surgery were considered. While the majority of patients had surgery on the day of or the day following admission, 29% waited two days or longer for surgery. Wait times were related to patients' age, hospital size, day of admission and whether patients were transferred.

### Résumé

Presque toutes les personnes victimes d'une fracture de la hanche subissent une chirurgie pour réparer la lésion. De récents travaux de recherche suggèrent qu'une intervention en temps opportun est importante pour assurer de bons résultats après la chirurgie. On a repéré les patients qui ont subi une intervention chirurgicale après une fracture de la hanche en 2003/2004 à l'aide des données sur l'hospitalisation compilées par l'Institut canadien d'information sur la santé. On a ensuite calculé le délai entre la date d'admission et celle de la chirurgie. On a aussi tenu compte de l'association entre les caractéristiques des patients et du système et les temps d'attente pour la chirurgie. Tandis que la majorité des patients ont été opérés le jour même de leur admission à l'hôpital ou le lendemain, 29 % ont attendu deux jours ou plus pour se faire opérer. Les temps d'attente variaient selon l'âge des patients, la taille de l'hôpital, le jour de l'admission et si les patients avaient été transférés ou non.

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**A**LMOST ALL HIP FRACTURE PATIENTS UNDERGO SURGERY TO REPAIR THE fracture. Recent studies indicate that rates of surgery for these patients are over 90% (Orosz et al. 2002; Bottle and Aylin 2006). Given the high rates of surgical intervention, outcomes related to delays in surgery following admission to hospital have received attention from researchers. Several studies have focused on outcomes such as rates of post-operative complications, functional recovery and independence, length of hospital stay and in-hospital mortality (Orosz et al. 2002; Orosz et al. 2004; Weller et al. 2005; Bottle and Aylin 2006). While these studies are not entirely conclusive, improved outcomes have been noted following earlier rather than later surgery (Weller et al. 2005; Orosz et al. 2004; Sund and Liski 2005). In December 2005, Canadian health ministers adopted a common goal of hip fracture repair within 48 hours (Ontario Ministry of Health and Long-Term Care 2005).

Waits for surgery following hip fracture can be divided into a variety of segments. For example, a study of hospital admissions for hip fracture to four hospitals in New York found that 17% of patients waited more than 24 hours before going to hospital (Orosz et al. 2002). In Ontario – the only province for which wait times associated with emergency department visits are routinely collected by CIHI – in 2004–2005, hip fracture patients had a median length of stay of four to five hours in the busiest emer-

gency departments prior to being admitted to hospital (CIHI 2006). This paper focuses on a third segment of the wait: waits for surgery following admission to hospital.

## Methods

### Data source and study population

This study relied on hospitalization data from the Canadian Institute for Health Information's Hospital Morbidity Database (HMDB) between April 1, 2003 and March 31, 2004. This patient-specific database contains clinical, demographic and administrative data on acute hospital inpatients from all provinces and territories. The HMDB was used to select patients with a most responsible diagnosis of hip fracture (ICD-10 S72.0, S72.1, S72.2, ICD-9/ICD-9CM 820) and a surgical intervention in the same or contiguous hospitalization (also referred to as the same "episode of care").

Patients were excluded from the analysis if there was no surgical intervention; the institution code was invalid; the health insurance number was invalid; or age was less than 20 or greater than 105. Also excluded from the analyses were patients whose hip fracture occurred in hospital. For those 65 and older, the rate of occurrence of in-hospital hip fracture is approximately one in 1,124 admissions annually (CIHI 2004).

### Data analysis

Wait times for surgery following hip fracture were calculated in days from the date of index admission to the date surgery was performed. The proportion of those who waited two or more days for surgery was compared to the proportion of those who received their surgery either on the day of admission or on the day following their admission.

Because time of procedure is not available in the HMDB, we cannot determine the number of hours a patient waits between admission and surgery. Given the research evidence suggesting that timely surgery is important, we segmented the study population into two groups: those who received their surgery on the day of admission or the next day, and those who waited two days or more after admission. Those included in the "same or next day" group will all have waits of less than 48 hours following admission as an inpatient. A limitation of the study is that some of the patients in the "two days or more" group may also have post-admission waits of less than 48 hours, if they were admitted late in the day and received surgery early on the second day following admission. For this reason, we considered the distribution of waits associated with those who waited two or more days following admission.

Wait times were calculated by age of patient, day of index admission, hospital size and whether patients were transferred to another facility to have surgery following the index admission. Significance tests were performed where appropriate.

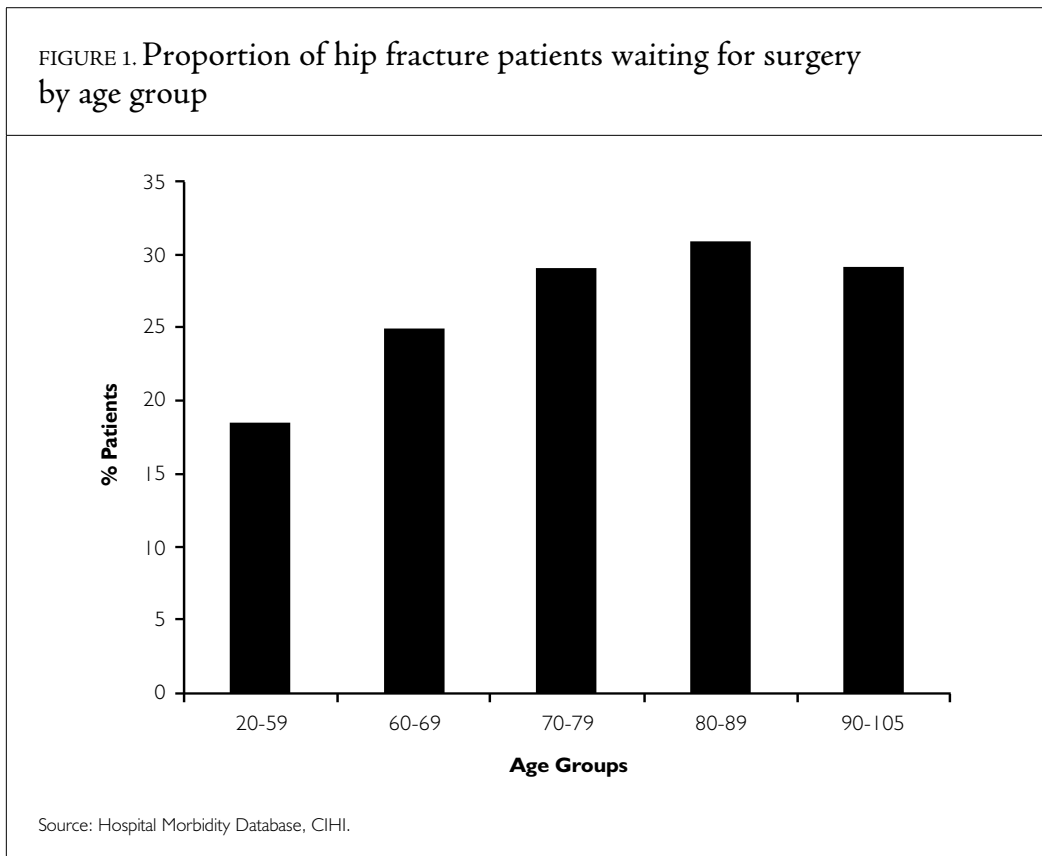
## Results

### Who received surgery?

In 2003–2004, 24,117 patients had surgery following a most responsible diagnosis of hip fracture in Canadian acute care facilities. More than eight out of 10 were 70 years or older. The majority of patients (71%) received surgery either on the day of admission or the following day. However, just over 6,940 people (29%) waited longer for their surgery. While 16% had surgery two days after admission, the remaining 13% waited three days or longer and 3% waited six days or longer. Age was also associated with wait times. Twenty-two percent of patients aged 69 and under waited two days or longer for surgery, whereas of those 70 years and older, 30% waited this long (chi-square,  $p < .0001$ ; Figure 1).

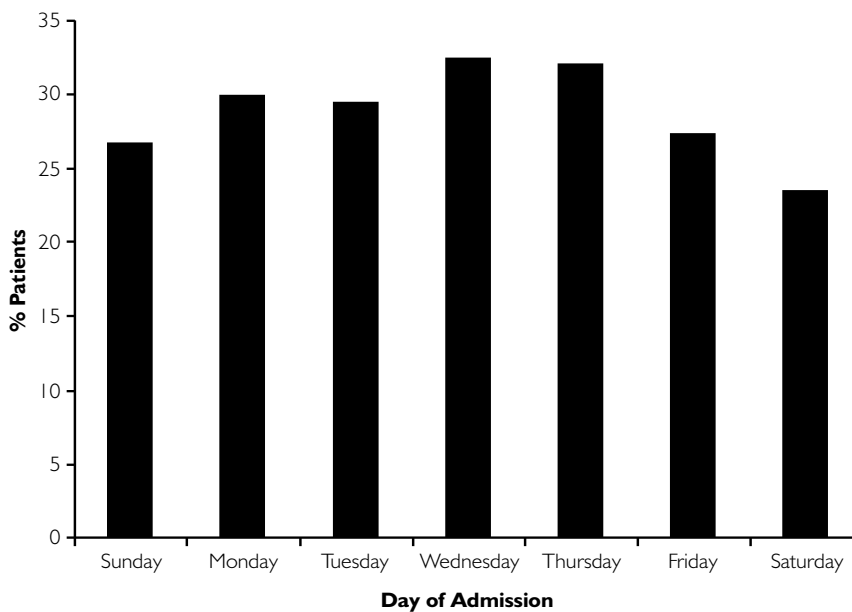
### Waits associated with system characteristics

Both day of admission to hospital and hospital facility size (measured by number of beds) were associated with the percentage of hip fracture patients who waited two



days or more for surgery following their admission. For example, significantly fewer patients admitted to hospital on weekends waited two days or more for surgery (chi-square,  $p < .0001$ ; Figure 2). Hip fracture patients were more likely to have longer waits for surgery in larger hospitals, with teaching facilities having the highest percentage of patients waiting two days or more (chi-square,  $p < .0001$ ; Figure 3).

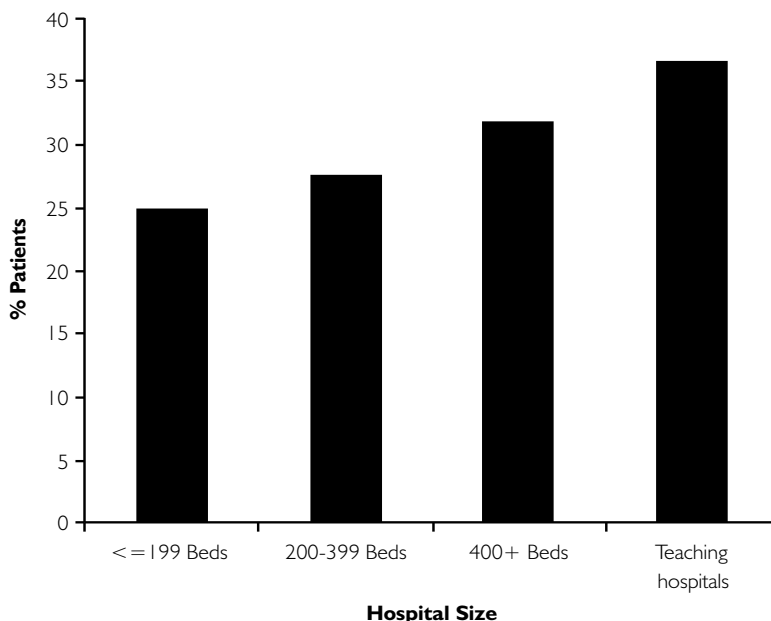
FIGURE 2. Proportion of hip fracture patients waiting for surgery by day of the week, 2003–2004



Source: Hospital Morbidity Database, CIHI.

Surgery to repair hip fractures is almost entirely unplanned. In 2003–2004, close to nine in 10 patients were admitted to hospital through emergency departments. In some cases, the hospital at which the patient first presents may be unable to perform the needed surgical repair or provide other care required. In this situation, some patients may be stabilized in the emergency department and then transferred to another acute care facility (resulting in a single inpatient admission). Other patients may first be admitted to hospital from the emergency department and then transferred to another acute care facility where the surgery is performed (resulting in two inpatient admissions). In 2003–2004, just over 1,350 patients (6% of all patients) fell

FIGURE 3. Proportion of hip fracture patients waiting for surgery by facility size



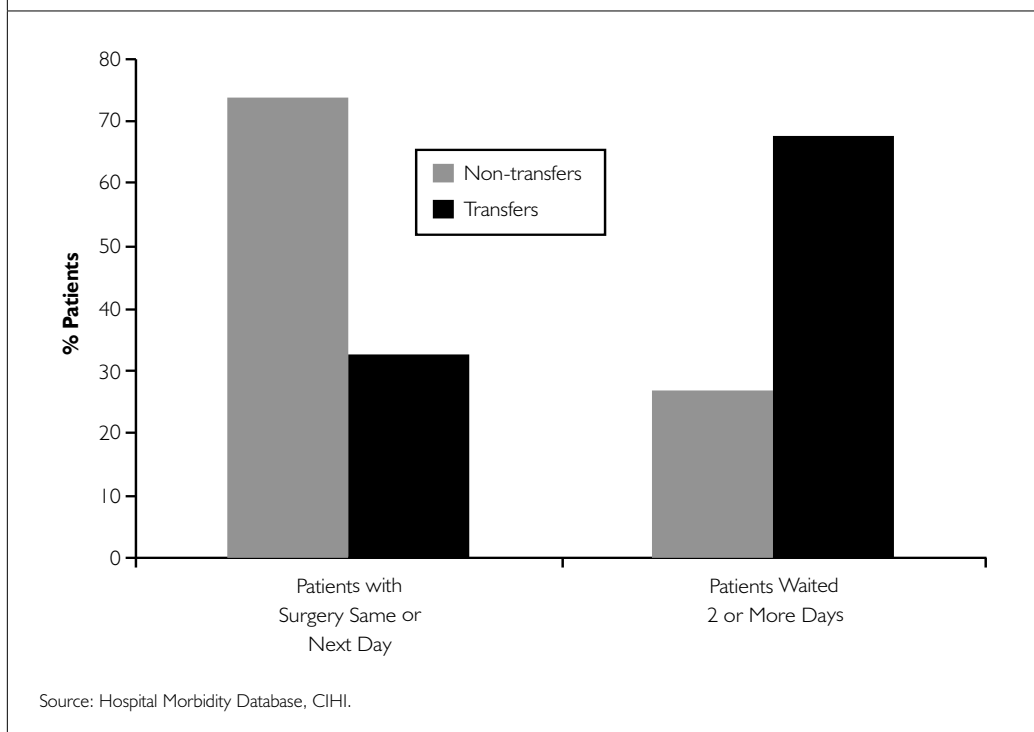
Note: Some institutions from Manitoba and Quebec did not have an assigned peer group; therefore, a total of 5,323 patients were excluded from this analysis by peer group.  
 Source: Hospital Morbidity Database, CIHI.

into this latter category. When waits to surgery for these transferred patients were compared to patients who underwent surgery at the hospital of their initial admission, almost 2.5 times as many patients (67%) waited two days or longer for their surgery than those who had surgery at their initial hospital (27%) (Figure 4).

## Conclusion

While the majority of hip fracture patients received surgery on the day of admission or the day following, close to a third did not (16% on the second day after the admission day and 13% beyond the second day). In this study, older patients were more likely to wait longer. This is consistent with the longer waits for older patients observed in a study of hip fracture patients hospitalized in the United Kingdom, which researchers suggest was related to the increased likelihood of co-morbidities (Bottle and Aylin 2006). Medical stabilization of patients due to associated medical conditions caused the longest delays in surgery in another study (Orosz et al. 2002). With respect to system

FIGURE 4. Waits for hip fracture repair for transferred vs. non-transferred patients



characteristics, size of admitting hospital, day of admission and whether the patient was transferred prior to surgery were all associated with wait times for hip fracture.

This study demonstrates that a significant proportion of patients wait two or more days for surgery. In some studies, delays in surgery have been associated with poorer outcomes. Understanding these and other factors that are associated with longer wait times for surgery following hip fracture can help channel efforts to reduce them and ensure that hip fracture patients are receiving optimal care.

Correspondence may be directed to: Kira Leeb, Senior Project Manager, Health Council of Canada/Conseil canadien de la santé, 90 Eglinton Avenue East, Suite 904, Toronto, Ontario M4P 2Y3; tel: 416-480-7091; email: kleebl@healthcouncilcanada.ca.

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### Call to Authors

Data Matters presents brief, focused papers that report analyses of health administrative or survey data that shed light on significant health services and policy issues. Submissions to Data Matters should be a maximum of 1,500 words, exclusive of tables, figures and references, and should include no more than three tables or figures.

### Appel aux auteurs

« Questions de données » présente de brefs articles portant sur des analyses de données administratives sur la santé ou de données d'enquête et qui font la lumière sur d'importantes questions liées aux services et aux politiques de santé. Les articles soumis à « Questions de données » doivent être d'au plus 1 500 mots, excluant les tableaux, diagrammes et références et ne doivent pas comprendre plus de trois tableaux ou diagrammes.

For more information contact Rebecca Hart, Managing Editor, at [rhart@longwoods.com](mailto:rhart@longwoods.com).

# Linkage and Exchange

## Liens et échange

THE CASE STUDY PRESENTED HERE is drawn from a recent publication from the Canadian Institutes of Health Research: *Evidence in Action, Acting on Evidence* by the CIHR Institute of Health Services and Policy Research. This knowledge translation casebook highlights original submissions from across Canada that focus on lessons learned from both successful, and less than successful, knowledge translation activities. Designed as a means for researchers and decision-makers to share and recognize their experiences, this casebook also demonstrates the impact that research can have in shaping policy, program, and practice changes.

The casebook was published in early 2006. Please visit CIHR's website at [www.cihr-irsc.gc.ca](http://www.cihr-irsc.gc.ca) for more details.

L'ÉTUDE DE CAS PRÉSENTÉE ICI est tirée d'une récente publication des Instituts de recherche en santé du Canada intitulée : *Agir et Réagir Face aux Données Prochantes* produite par l'Institut des services et des politiques de la santé des IRSC. Ce recueil de cas d'application des connaissances contient des résumés de cas envoyés par des auteurs de partout au Canada et illustrant les leçons tirées d'initiatives fructueuses ou non d'application des connaissances. Conçu pour permettre aux chercheurs et aux décideurs de partager et de reconnaître leurs expériences, le recueil démontre aussi les répercussions possibles de la recherche sur la façon dont les changements sont apportés aux politiques, aux programmes et à la pratique.

Le recueil de cas a été publié au début de 2006. Pour plus de détails, consulter le site Web des IRSC à [www.cihr-irsc.gc.ca](http://www.cihr-irsc.gc.ca).

# On the Rock, in a Hard Place: Challenges in Working with Advocacy and Care Provider Groups

Tempête sur le Rocher : les défis de la  
collaboration avec les groupes de défense des  
droits des patients et les prestataires de soins



by MARIA MATHEWS, PHD

*Division of Community Health and Humanities  
Memorial University of Newfoundland  
St. John's, NL*

SHARON BUEHLER, PHD

*Division of Community Health and Humanities  
Memorial University of Newfoundland  
St. John's, NL*

ROY WEST, PHD

*Division of Community Health and Humanities  
Memorial University of Newfoundland  
St. John's, NL*

## Abstract

Researchers from Memorial University of Newfoundland collaborated with a patient advocacy organization and the provincial cancer care provider on a study showing substantial variation in out-of-pocket costs for patients travelling to access cancer treatment. While the partnered research phase of the study proceeded smoothly, the successful dissemination of the findings – and the resulting government and media interest – created pressure for the provincial cancer care provider. This agency distanced itself from the study and ended its role in what has proved to be an otherwise successful partnership.

## Résumé

Des chercheurs de la *Memorial University of Newfoundland* ont collaboré avec un organisme de défense des droits des patients et le fournisseur provincial de soins aux personnes atteintes de cancer à une étude illustrant les différences significatives dans les frais déboursés par les patients qui doivent se déplacer pour obtenir un traitement contre le cancer. Bien que l'étape de la recherche en partenariat se soit déroulée sans heurt, la diffusion des résultats et l'intérêt que ces derniers ont suscité au gouvernement et dans les médias ont constitué une source de pression pour le fournisseur provincial de soins aux patients cancéreux. Ce fournisseur a donc décidé de mettre fin à sa participation à l'étude, et ce, malgré le succès du partenariat sur les autres plans.

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**I**N THE FALL OF 2001, THE CANADIAN CANCER SOCIETY – NEWFOUNDLAND and Labrador Division (CCS), a non-governmental patient advocacy organization, approached us to request a study of out-of-pocket costs for patients who travel to access cancer treatment. Anecdotal evidence suggests that these costs influence the decisions cancer patients make about their care (Maynard 2001). The CCS had previously embarked on advocacy efforts on this issue, but the provincial Department of Health and Community Services had cited the need for more research.

The Canadian Institutes for Health Research (CIHR), the Newfoundland and Labrador Centre for Applied Health Research and the Canadian Breast Cancer Foundation – Atlantic Division funded the study, with data collection beginning in fall 2002. We surveyed 484 cancer patients, interviewed 21 cancer care providers and gathered information about medical travel subsidy programs across Canada.

We found substantial variation in out-of-pocket costs for patients travelling to access cancer care. One in three rural patients (those living more than one hour away from a cancer clinic) paid more than \$200 for travel and lodging during a single trip to an oncologist, with 9% incurring costs of more than \$1,000 per trip. A significantly

larger proportion of rural residents had higher costs than their urban counterparts and said that expenses for travel, drugs, child care and travel time were important considerations in their care decisions (Mathews and Basky 2004). Patients' cost-cutting strategies (including rationing medications, lengthening follow-up times, or choosing inpatient palliative care) may compromise quality of care. We recommended that the restrictive eligibility criteria of the provincial Medical Travel Assistance Program (the subsidy that reimburses patients for medical care-related travel costs) be reviewed, and that cancer care be provided in smaller communities wherever possible.

The primary audiences for our study were the CCS, the Newfoundland Cancer Treatment and Research Foundation (NCTRF, the provincial cancer care provider) and the Department of Health and Community Services. We also wanted to communicate our findings to study participants, politicians, the public, cancer advocates and care providers in Canada and other researchers.

## The KT Initiative

Our knowledge translation (KT) partners were the CCS and the NCTRF. The Department of Health and Community Services declined direct involvement in the study, but asked to be kept informed through ongoing interactions with the CCS and the NCTRF.

As researchers, our goal in engaging in KT activities was to provide rigorous, relevant, evidence-based recommendations that would improve the accessibility and quality of cancer care in the province. The goal of our partners, however, was to advocate for patients with high out-of-pocket costs, and especially to lobby for change to the provincial Medical Travel Assistance Program. These goals required careful definition of the roles of all partners throughout both the research and dissemination phases of the study.

The KT plan for the study included linkage and exchange activities and a multi-pronged dissemination strategy. The goal of our linkage and exchange activities was to identify relevant research questions, inform our partners of our progress, be responsive to changes in the decision-making environment, provide opportunities for our partners to contribute to the interpretation of findings and the development of recommendations and to discuss the roles of all partners throughout the project.

To this end, we held a series of meetings with CCS and NCTRF staff to gain a better understanding of the research problem, the provincial cancer care system and the partners' information needs. We also provided regular updates through email, telephone conversations and in-person presentations. Both partners provided supporting documents and feedback on our research proposals, liaised with government contacts to inform them that the study was underway and updated us on developments relevant to the study. The NCTRF assisted in recruiting study participants. Near the end

of the research phase, we shared preliminary results and recommendations with the CCS and the NCTRF. An NCTRF administrator, with whom we had been closely collaborating, reviewed a near-final draft of the results and recommendations.

During the dissemination phase of the study, the CCS assumed responsibility for organizing the campaign to increase public awareness of the study findings and to lobby politicians and government officials. The NCTRF agreed to disseminate study findings to other cancer care agencies and to organize seminars with its own staff to identify changes in clinical practice. We were responsible for presenting the data (in summary documents and presentations), participating in interviews with the media and meeting secondary dissemination goals, such as debriefing participants, sharing findings with researchers and identifying collaborators for future projects.

In spring 2004, we (the researchers and CCS, in accordance with the roles described above) held a press conference to publicize the study findings; wrote a summary article for the CCS annual report (which was included as a supplement in community newspapers across the province); pursued media coverage; presented study results in non-technical language to community groups and Department of Health and Community Services officials; sent a two-page summary (written in non-technical language and highlighting actionable messages) to all members of the Newfoundland and Labrador House of Assembly and Department of Health and Community Services officials; and held face-to-face meetings with politicians as well as Department of Health and Community Services officials. The summary report was available on request and was posted on the website of the Division of Community Health (Memorial University of Newfoundland).

## Results of the KT Experience

NCTRF initially shared the research findings with other care providers, but distanced itself from the study when the provincial government requested information about its support programs and delivery of care. In its response to government and in letters to local newspapers, NCTRF dismissed the study results and the partnership activities, and suggested that it had already addressed the issue of out-of-pocket costs. One letter to the editor noted that “Dr. Matthews’ [sic] recommendations are neither new nor novel” and “it is important that researchers explore the current situation so that recommendations can be more meaningful and valuable” (Paulse 2004). NCTRF abandoned its plans to disseminate the study results to its staff.

In January 2006, in response to our research and the CCS’s advocacy efforts, the NL Department of Health and Community Services changed the eligibility criteria for the Medical Transportation and Assistance Program. These changes allow more patients to claim travel subsidies when travelling outside their health region for medical care. A \$500 deductible was also removed for residents of Labrador. The CCS is

also planning to build a cancer lodge in direct response to the study's findings. The lodge will provide accommodation at subsidized rates for cancer patients who must travel to and stay in St. John's to have treatment. Our results were also used to support the introduction of tele-oncology programs (the evaluation of which includes an assessment of out-of-pocket travel costs). The nationwide CCS network has brought together collaborators and researchers in other provinces, and we are currently developing studies to examine other issues affecting access to cancer care in Canada.

## Lessons Learned

This experience taught us valuable lessons about KT in practice. Decision-making and knowledge translation occur in a complex, dynamic environment where the partners' interest in, and perspective towards, the research findings, the researchers, and other

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**Decision-making and knowledge translation occur in a complex, dynamic environment where the partners' interest in, and perspective towards, the research findings, the researchers, and other partners continually evolve.**

partners continually evolve. The desire to use evidence in decision-making competes with other organizational and personal motivations, not the least of which are self-preservation and self-promotion. Health system restructuring was looming in the fall of 2004, when it was widely expected that a new regional health authority would assume responsibility for cancer services from the NCTRF (and the NCTRF would no longer

exist as a separate health board). Such an uncertain political climate would naturally motivate any administrator to demonstrate the value of his or her organization, as well as administrative and political skills, to government decision-makers.

The relationship between the CCS and the NCTRF had been difficult prior to this study: both organizations wanted to position themselves as the leader in cancer advocacy issues in the province. The pressure brought upon the NCTRF by the CCS's advocacy activities only heightened this tension. Although organizations may be interested in realizing similar goals, there may be, nonetheless, an unwillingness to sacrifice other interests to do so.

Our experience also highlights the potential vulnerability that KT can create for researchers, particularly junior academics. KT demands a substantial amount of time

that could otherwise be used in activities that are more highly rewarded by promotion and tenure committees. Moreover, no researcher, particularly those early in their careers, can afford to have his or her professional credibility publicly questioned.

## Conclusions and Implications

Despite these challenges, we were able to develop and sustain a positive, mutually beneficial relationship with the CCS. A key element to this achievement has been the appreciation of each other's needs and cultures. The clear division and understanding of roles during the research and dissemination phases of the study allowed researchers to focus on academic activities and the CCS to strengthen its position as an advocate for cancer care. This linkage was further formalized when the principal investigator (MM) was appointed to the CCS board of directors, providing an ongoing forum for us to learn about CCS's research needs, and for the CCS to learn about the potential use of research in its activities.

### ACKNOWLEDGMENTS

We thank Peter Dawe and Dr. John McGuire for their feedback on earlier drafts of this case.

Correspondence may be directed to: Maria Mathews, PhD, Assistant Professor, Health Policy/Health Care Delivery, Division of Community Health & Humanities, Health Sciences Centre, Memorial University of Newfoundland, St. John's, NL A1B 3V6; Tel: (709) 777-7845; Fax: (709) 777-7382; Email: mmathews@mun.ca.

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## Call to Authors

Linkage and Exchange provides a forum for knowledge translation (KT) case studies. Submissions should include an abstract of no more than 100 words, a brief statement of background and context, a description of the KT initiative, a presentation of results (including challenges that arose and how they were addressed) and a discussion of lessons learned, highlighting those that are potentially transferable to other topics and settings. Manuscripts should be a maximum of 2,000 words, excluding the abstract and references.

## Appel aux auteurs

« Liens et échanges » fournit un forum pour des études de cas en application des connaissances (AC). Les articles soumis doivent comporter un résumé d'au plus 100 mots, une brève mise en contexte, une description de l'initiative d'AC, une présentation des résultats (y compris les défis qui se sont présentés et comment ils ont été relevés), ainsi qu'une discussion des leçons apprises, surtout celles qui sont potentiellement transférables à d'autres sujets et à d'autres cadres. Les manuscrits doivent être d'au plus 2 000 mots, excluant le résumé et les références.

For more information contact Rebecca Hart, Managing Editor, at [rhart@longwoods.com](mailto:rhart@longwoods.com).

# Disseminating and Organizing

## Dissémination et organisation

by LESLIE L. ROOS, PHD  
*Manitoba Centre for Health Policy*  
*Faculty of Medicine, University of Manitoba,*  
*Winnipeg, MB*

### Abstract

How do we reach a wide variety of possible readers? This commentary notes various ways in which academic information has been organized on the Web, stressing the usefulness of different formats and approaches. The Social Science Research Network provides a way for publications to become widely known at an early stage. Such Web-based facilities for one-stop searching are needed for academics and policy makers interested in health services, health policy, public health and population health.

### Résumé

Comment atteindre le plus grand nombre de lecteurs potentiels? Ce commentaire relève les diverses méthodes d'organisation de l'information scientifique sur Internet, en mettant l'accent sur l'utilité des approches et des formats différents. Le *Social Science Research Network* offre un service de diffusion précoce des publications. De tels outils intégrés de recherche en ligne sont nécessaires autant pour les chercheurs que les décideurs qui s'intéressent aux services de santé, aux politiques en matière de santé, à la santé publique et à la santé de la population.

**I**N THE 1930S, A RUSSIAN ÉMIGRÉ AT STANFORD UNIVERSITY HAVING DIFFICULTIES in getting participants for his conference complained to my uncle: “You know, Harold, we live in a small, remote province.” To Canadians, such complaints may still have some resonance, but Internet access provides an audience for our work, if we just take appropriate advantage of it.

Of particular importance is the phenomenon of the *long tail*, the “multitude of users with narrow interests and needs that, in aggregate, are in the majority” (Schwartz 2006: 39). Given the low costs of storage and the worldwide reach of the Internet, Canadian researchers would find it worthwhile to post their findings on the Web. The Web permits going beyond Canada to address the dramatically larger worldwide audience at minimal cost. Those of us in small, remote provinces will find an audience if we get our work up and attract notice by other websites; the new economics of knowledge dissemination facilitates finding readers. The more links, sites and formats, the better.

My previous commentaries have noted how networks can be created and enhanced using the Internet. Several different types of communication and dissemination strategies aid in organizing the fire hose of available information:

- 1) those that are basically informative, presenting what an organization is doing and has done. Papers and reports may be listed or included on the site.
- 2) those oriented towards working knowledge (such as the research protocol/glossary/concept dictionary within the Manitoba Centre for Health Policy website). Information initially organized to facilitate the work of a particular centre can be further refined to help a wider audience.
- 3) the simple structure for lectures in PowerPoint used by the Epidemiology Supercourse. PowerPoint slides have an advantage in being both easy to submit and easy to download in parts of the world with only narrow bandwidth capability.
- 4) the fancier sets of slides and notes organized around term-length courses (characteristic of the OpenCourseWare philosophy pioneered at MIT and adapted by the Johns Hopkins School of Public Health).
- 5) those that help students and researchers find published material. Some are free to the user; GoogleScholar (funded by advertising) and PubMed (a service of the National Library of Medicine and the National Institutes of Health in the United States) are among the most popular. Others are funded by subscription (the services provided by the Institute for Scientific Information are generally available through academic libraries).

How do we reach broader audiences? Beyond traditional journals, a variety of publication formats (including Web-based journals) are available. The Epidemiology Supercourse reaches an audience difficult to address by other strategies. Besides helping those who may lack journals and OECD-type incomes, this is a good way to

spread the word! OpenCourseWare can be easily simplified for the Supercourse; those with lots of bandwidth who pick up information there may well wish to link to the more elaborate sites.

How do we locate timely information? The “grey literature” is obviously missing from my simple listing above. Although often present in the websites of particular organizations, it is likely to be hard to find. Literature review projects characteristically list many places to look besides those noted above, but more centralized organization would be helpful. The Social Science Research Network (SSRN) provides a useful example. As described in Wikipedia (a good place to look for terms, even statistical ones), “in economics, and to some degree in law (especially in the field of law and economics), almost all papers will now be published in SSRN before being submitted to an academic journal.” The SSRN eLibrary is made up of both an Abstract Database (with abstracts on almost 124,000 working and forthcoming papers) and an Electronic Paper Collection (about 95,000 downloadable documents). Currently, SSRN is built around 10 networks, each with a director. Business schools are increasingly represented, with networks for research in accounting, entrepreneurship, information systems, measurement and marketing. This facilitates publications becoming “widely known in the academic community at an early stage.”

To the best of my knowledge, there is nothing like this in the fields of health services research, healthcare policy, public health, or population health. Students and researchers (Canadian or otherwise) must now search across conference proceedings and research centre websites to find material. Thirteen Canadian academic health policy research centres have been identified by Mekel and Shortt (2005). A variety of university departments and schools archive papers on community and population health. Some government departments may participate. A facility for “one-stop searching” to find timely materials is desperately needed.

Who will pay for what? The principals of the Social Science Research Network have tried to make copies of papers free or at low cost to users, although some have expressed concern about whether this policy will continue. SSRN’s eLibrary also includes papers from “fee-based partner publications.”

Differences between the paid and free philosophies are highlighted in a chapter (“The Ultimate Pin Factory”) in a new book, *Knowledge and the Wealth of Nations* (Warsh 2006). Of particular relevance is the material on Aplia, founded by the well-known economist Paul Romer. Aplia is designed to sell (and grade!) Web-accessible exercises to the large university market for teachers of elementary and intermediate economics. What good teaching exercises (preferably Web-based) are available for small markets, for readers of *Healthcare Policy*? Are we getting no synergies from the Regional Training Centres? Leadership by research centres and funding agencies is called for.

Correspondence may be directed to: Leslie L. Roos, Manitoba Centre for Health Policy, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba, Rm. 408 – 727 McDermot Avenue, Winnipeg, MB R3E 3P5; tel: 204-789-3773; fax: 204-789-3910; email: Leslie\_Roos@cpe.umanitoba.ca.

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## Call to Authors

The Web has emerged as a common vehicle for knowledge transfer and dissemination. Yet, it's a tool that is relatively new and often in a state of change as new technologies become available. The editors are interested in your organization's experience with Web-based knowledge transfer – what works and what doesn't? And how do you know?

Send your submissions to: Rebecca Hart, Managing Editor, at [rhart@longwoods.com](mailto:rhart@longwoods.com).

## Appel aux auteurs

Dès son apparition, le web s'est imposé comme un instrument à la fois de transfert et de diffusion des connaissances, mais il n'en demeure pas moins un outil relativement nouveau, qui ne cesse d'évoluer au fur et à mesure que de nouvelles technologies voient le jour. Les rédacteurs veulent savoir comment votre organisme vit le transfert des connaissances par le web : ce qui fonctionne, ce qui ne fonctionne pas et comment vous vous en rendez compte?

Veuillez faire parvenir vos réponses à Rebecca Hart, rédactrice en chef à l'adresse : [rhart@longwoods.com](mailto:rhart@longwoods.com).

Performance Measurement in Healthcare:  
Part II – State of the Science Findings  
by Stage of the Performance  
Measurement Process

La mesure du rendement dans les soins de santé :  
Partie II – Résultats de l'examen de l'état  
de la science, par étape du processus de  
mesure du rendement



*by* CAROL E. ADAIR, MSC, PHD  
*Associate Professor, Departments of Community Health Sciences and Psychiatry  
University of Calgary, Calgary, AB*

ELIZABETH SIMPSON, BA, MSC  
*Health Research Consultant  
Red Deer, AB*

ANN L. CASEBEER, MPA, PHD  
*Associate Professor, Department of Community Health Sciences  
Associate Director, Centre for Health and Policy Studies  
University of Calgary, Calgary, AB*

## Performance Measurement in Healthcare: Part II

JUDITH M. BIRDSELL, BSCN, MSC, PHD  
*Principal Consultant, ON Management Ltd.*  
*Adjunct Associate Professor, Haskayne School of Business*  
*University of Calgary, Calgary, AB*

KATHARINE A. HAYDEN, MLIS, MSC, PHD  
*Associate Librarian, Information Resources*  
*University of Calgary, Calgary, AB*

STEVEN LEWIS, BA, MA  
*President, Access Consulting Ltd.*  
*Adjunct Professor, Department of Community Health Sciences*  
*University of Calgary, Calgary, AB*

### Abstract

**Objective:** This paper summarizes findings of a comprehensive, systematic review of the peer-reviewed and grey literature on performance measurement according to each stage of the performance measurement process – conceptualization, selection and development, data collection, and reporting and use. It also outlines implications for practice.

**Methods:** Six hundred sixty-four articles about organizational performance measurement from the health and business literature were reviewed after systematic searches of the literature, multi-rater relevancy ratings, citation checks and expert author nominations. Key themes were extracted and summarized from the most highly rated papers for each performance measurement stage.

**Results:** Despite a virtually universal consensus on the potential benefits of performance measurement, little evidence currently exists to guide practice in healthcare. Issues in conceptualizing systems include strategic alignment and scope. There are debates on the criteria for selecting measures and on the types and quality of measures. Implementation of data collection and analysis systems is complex and costly, and challenges persist in reporting results, preventing unintended effects and putting findings for improvement into action.

**Conclusion:** There is a need for further development and refinement of performance measures and measurement systems, with a particular focus on strategies to ensure that performance measurement leads to healthcare improvement.

## Résumé

**Objectif :** Ce document résume les résultats d'un examen détaillé et systématique de la littérature grise et des publications évaluées par les pairs sur la mesure du rendement pour chaque étape du processus – conceptualisation, sélection et développement, collecte de données, présentation des résultats et utilisation. Il présente aussi des répercussions sur la pratique.

**Méthodes :** Après avoir effectué des recherches systématiques dans la littérature, demandé à des évaluateurs multiples de déterminer la pertinence des documents repérés, vérifié les citations et désigné les auteurs experts, 664 articles sur la mesure du rendement organisationnel provenant de publications des domaines de la santé et des affaires ont été examinés. On a dégagé puis résumé des thèmes clés à partir des documents ayant reçu la plus haute cote pour chaque étape de la mesure du rendement.

**Résultats :** Malgré un consensus quasi universel sur les avantages potentiels de la mesure du rendement, il existe actuellement peu de preuves pour guider la pratique dans les soins de santé. Les problèmes de conceptualisation des systèmes comprennent, entre autres, l'alignement stratégique et la portée. On ne s'entend pas sur les critères à utiliser pour sélectionner les mesures et sur les types et la qualité de ces dernières. La mise en place des systèmes de collecte et d'analyse de données est complexe et coûteuse, et il y a encore des défis à relever dans la présentation des résultats, la prévention des effets non prévus et la transformation des résultats en des mesures concrètes.

**Conclusion :** Il faut développer et peaufiner davantage les mesures du rendement et les systèmes connexes, en mettant un accent particulier sur les stratégies pouvant garantir que la mesure du rendement mènera à des améliorations dans les soins de santé.

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**T**HE PURPOSE OF OUR REVIEW WAS TO SUMMARIZE THE CURRENT BUSINESS and healthcare literature on performance measurement (PM) systems and to make recommendations for research and practice. Details of methods are provided in Part I (*Healthcare Policy*, 1.4). This second paper reports in greater depth on themes and issues extracted from the peer-reviewed and grey literature in relation to stages of the PM process.

## The PM Process

The PM literature lacks consensus on concepts and definitions. However, the PM process is typically described as having approximately four stages (Nadzam and Nelson 1997; Nutley and Smith 1998; Bourne et al. 2000; Ibrahim 2001; Smith and Goddard 2002), although many authors caution that the process is more dynamic and less linear than a simple set of stages implies. The stages are (a) conceptualization, (b)

selection and/or development of measures, (c) data collection and processing and (d) reporting and using results.

## Conceptualization

Two major issues on conceptualization of PM systems are prominent in the literature: aligning with organizational *strategic direction* and determining the appropriate *scope for the system*.

### STRATEGY

There is increasing emphasis on aligning PM activities with the strategic direction of the organization, and a general sentiment in both business and health that such alignment is rare in practice. However, maintaining a strategic focus is acknowledged to be more difficult in healthcare than in business for several reasons.

First, organizational goals are often difficult to operationalize in healthcare because of the complexity of treatments, settings and patient groups (Baker and Pink 1995). Public service organizations have broader goals (including societal goals) and “a more complex pattern of accountability than the corporate financial statement” (Smith 1993: 137). The dual management model (professional and administrative) and the interrelationships among multiple internal and external stakeholders (Kleinpell 1997; Lemieux-Charles et al. 2002), each with its particular interest in setting the PM agenda (Nadzam and Nelson 1997; Collopy 1998), create greater complexity. In health services the policy environment is very fluid (Smith and Goddard 2002), perhaps more so than in business environments.

Second, causal links between service and health outcomes are very difficult to specify for both medical and public health interventions, owing to the limits of evidence in medicine and the reality that healthcare is only one of several predictors of health status (Williams et al. 1992; Handler et al. 2001; Leggat et al. 1998).

Third, “customer” dynamics are less straightforward in healthcare than in the purchase of a commercial product or service (Newhouse 2002). People seek care out of necessity, not desire. The provider often has a local monopoly on a given service, limiting both comparators for judgments about performance and opportunities to seek alternatives (Smith 1993). An important commercial goal is repeat business, while in healthcare it is often viewed as an unfortunate necessity because a definitive cure is unattainable. The consumer is also typically less knowledgeable about the service content than in commercial transactions (Jennings and Staggers 1999) and is often vulnerable by virtue of being ill and possibly afraid when seeking care. These realities complicate the patient satisfaction and perceived care quality domains of PM (Jennings and Staggers 1999). The message about the task of strategic conceptualiza-

tion of a PM system is clear in both sets of literature: “what gets measured gets delivered,” and there are undesirable consequences for organizations, from a strategic point of view, that collect the wrong measures (Voelker et al. 2001).

#### SCOPE

The second major issue in conceptualization of PM systems in both literatures is determining the appropriate system scope. Scope decisions apply to three dimensions: vertical (level of the healthcare organization or system), horizontal (breadth across the continuum of care or business units) and longitudinal (temporal) (Collopy 1998). In business there is a trend towards involving all levels of the organization in a common vision that can be reinforced by the PM system itself (Neely et al. 1995; Epstein and Manzoni 1998; Lockamy 1998; Legnini et al. 2000). “One of the major problems with conventional PM is the ease with which organizational wholes are carved up, and their interactions with their environments cease to be of interest as management functions devise measures (and associated targets) for their own territory. This reductionism is associated with some of the problems identified by managers when they seek to improve performance” (Holloway 2001: 173).

Healthcare PM activities are also highly fragmented, verified by the sheer number of single-level or single-service systems described in the literature. Single-level focus creates debates about the value of one over the other: some charge that the patient level is often not addressed in system-level approaches (e.g., Greenhalgh et al. 1996), while others express the opposite concern (e.g., Barrell 2000). Many call for greater consolidation through overarching goals and greater consensus and coordination (Eddy 1998; Kizer 2001), and increasingly multi-level systems are being conceptualized (e.g., Moscovice et al. 1995; Luttmann 1998; Evans et al. 2001; Handler et al. 2001). Even so, Nutley and Smith (1998: 53) contend that “calls for a top to bottom PM architecture have largely been ignored.” Others caution that the PM for high-level management and accountability differs from that needed for daily operations (McLoughlin et al. 2001; Voelker et al. 2001).

The horizontal scope of systems is also debated. The business literature reports a few companies attempting to establish measures that capture relevant information across company boundaries (such as with supplier networks), but acknowledges this to be very difficult (Fawcett and Cooper 1998). The roots of healthcare PM are clearly in acute care, and hospital-bounded approaches dominate. Separate PM systems are under development and are testing for other components such as public health (Corso et al. 2000; Handler et al. 2001; Kates et al. 2001), but our review found no systems spanning acute and community care. DeRosario (1999: 38) notes that “to catch the next wave of performance change, we need to begin measuring activities that occur between healthcare sectors,” and others concur (Hall 1996; Kizer 2001). A PM sys-

tem should match the service delivery model, and it is likely that broader PM systems will emerge with the trend towards regionalized, integrated health services in many jurisdictions. With respect to the temporal dimension, a few authors suggest that PM systems need to address and measure the process of care over time for an individual (Bishop and Pelletier 2001).

### Measures selection or development

Many authors stress that, according to measurement theory, measures themselves are just a reflection of reality. In addition, the choice of what to measure among the many options is an imprecise process (van Peurse et al. 1995), reflecting a system of values and social goals (Sheldon 1998). Ibrahim (2001: 431) writes that “performance indicators are inherently controversial” because they require a judgment about what constitutes quality.

#### FRAMEWORKS

After general conceptualization, the next task in PM is to select or develop measures. Optimally, a framework ensures balance across strategic improvement areas and guides the measurement process. An ideal framework describes domains (measure groupings) and dimensions (e.g., organizational levels), but most frameworks reviewed are simply a list of indicators and/or domains (e.g., Lied 1999). More complex frameworks also include one or more dimensions such as level of the healthcare system (McEwan and Goldner 2000) or stakeholder perspective (Nadzam and Nelson 1997; Kizer 2001; McIntyre et al. 2001). We found little consistency in the combinations of 21 domains used in 17 major health PM frameworks reviewed (Adair et al. 2003).

We identified eight business frameworks that included both non-financial and financial measures (Lebas 1995; Neely et al. 1995; Kaplan and Norton 1996, 2001; Epstein and Manzoni 1998; Kueng and Krahn 1999; Kueng 2000; Kanji and Moura 2002) – called multi-dimensional or portfolio approaches – that are tabulated in the full report (Adair et al. 2003). Neely et al. (2000) and Kueng (2000) provide noteworthy reviews of business approaches. The most popular framework in business is the Balanced Scorecard (BSC), which has also been applied in healthcare. Some other approaches to the management of quality in the business literature are noteworthy because of their recent diffusion into healthcare and their close relationship with PM. First are the quality award programs, including the Malcolm Baldrige National Quality Award, the European Foundation for Quality Management’s Business Excellence Model (Neely et al. 1995; Kueng and Krahn 1999; DeBaylo 1999) and many spin-off quality award programs. One widely adopted program, Hoshin Kanri, that developed in Japan in the 1960s and has been disseminated widely is noteworthy

for having extensive coverage in the popular press worldwide but virtually none in the western research literature (Tennant and Roberts 2000). The BSC and other portfolio approaches have evolved towards the selection of more forward-looking, strategy-focused measures, but many criticisms of these early-stage approaches persist (Kueng and Krahn 1999; Mooraj et al. 1999; Kueng 2000; Baughan et al. 2002; Brignall 2002; Morgan and Braganza 2002) that parallel the healthcare PM literature.

#### ISSUES IN CHOOSING MEASURES

Several predominant themes relate to measures selection, including the sheer growth in numbers of measures and systems, as well as issues related to the types of measures and their limitations.

In recent years, measures (both indicators and comprehensive instruments) have become so numerous that it would be nearly impossible to catalogue them completely (Nutley and Smith 1998; Sheldon 1998). The national indicator library of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is believed to have more than 1,000 measures, and the database of the Agency for Healthcare Research and Quality (AHRQ) contained more than 1,197 in 53 sets by 1995 (AHRQ 2002). Unless indicators are commonly defined, comparative reporting is difficult, if not impossible. The development of measures databases is a welcome sign that this duplication of effort may be waning (e.g., Jennings and Staggers 1999; Hermann et al. 2000). Collaborative efforts to standardize measures are another promising development (Braun and Zibrat 1996; Leggat et al. 1998).

Guidelines or criteria for indicator selection are numerous in both literatures and, again, there is little consistency across sets. Table 1 lists criteria catalogued and synthesized conceptually from health literature papers that are cited in the full report but are too numerous to cite here (Adair et al. 2003). They represent suggested, rather than tested, criteria. The more recent literature puts greater emphasis on the importance of choosing indicators that are meaningful, strategic and evidence-based.

Financial indicators are still used as part of health PM systems (e.g., cost per weighted case), but as in business, non-financial indicators have taken centre stage. In discussing BSC applications in health, Voelker et al. (2001) claim that a primary focus on financial measures may actually hinder organizational growth and success. In healthcare, financial measures are notoriously difficult to action because most costs are not variable and there is little flexibility in hiring and firing staff (Brookfield 1992). Because of the complex and multifaceted purposes of healthcare, focusing too heavily on financial measures may diminish prospects for overall improvement. Most PM systems in health continue to collect traditional input/output measures such as service utilization (e.g., bed occupancy, surgery facility use, length of stay and numbers of discharges and admissions), despite repeated commentary that they are poor indi-

TABLE 1. **Criteria for performance measures selection**

CRITERION	DESCRIPTION
Evidence-based	There are valid and reliable operational definitions for the measure that have been demonstrated through rigorous research
Strategic	The measure directs attention towards the ultimate change desired
Important	The measure addresses an important or serious health or health services problem (usually defined as health burden or cost) such that there will be sufficient impact from collection and service improvement initiatives
Attributable	Causal links between the measure, service improvements and health outcomes are known
Actionable	The measure addresses a service area that can benefit from improvement
Feasible	Data collection, reporting and follow-through are cost-effective (potential benefits outweigh costs) and there is reasonable technical capacity for collection and analysis, including risk adjustment of compared measures
Relevant and meaningful	The measure is relevant to most stakeholders, including policy makers, managers, clinicians and the public
Understandable	The measure is understandable to a non-technical audience (often just a communication issue)
Balanced	The set of measures is balanced across types of treatments, treatment settings, major health problems, age groups, special populations and levels of the healthcare system. The set is balanced across short- and long-term measures, and balance and appropriateness are considered across process- and outcome-type measures
Responsive	The measure is sensitive to change over time
Robustness	Potential adverse effects of the measure can be mitigated, and vulnerability to gaming is minimal
Non-ambiguous	The measure is clear in terms of which direction for service change is desirable

cators of performance (Mark et al. 1997; Nutley and Smith 1998). Mortality remains the predominant traditional outcome measure, with the distinct disadvantage that it reflects a rare and end-stage event relative to the total volume of healthcare provided. In a Canadian study of existing indicators reported in 2000, Lemieux-Charles et al. (2000: 52) observed that “indicators measuring integration, coordination and continuity of care, as well as responding to population health needs, were rarely used. These types of measures are critical as we redesign our service delivery systems to address population needs.” Klazinga et al. (2001) consider the ultimate performance measures to be those reflecting overall population health.

Similarly, others express concern about “opportunistic systems” that emphasize readily available measures at the expense of newer, more important and meaningful measures (West 1996; Elkan and Robinson 1998; Nutley and Smith 1998; Smith and Goddard 2002). Shaw (1997: 217) characterizes this as the “spectre of convenience” and asks, “should measures be based on existing available data as ad hoc criteria for achievement, or should health service policy targets first be identified and data then captured specifically to measure their achievement?” A dynamic tension exists between the need for locally meaningful and strategic measures and the benefits of selecting and using standardized measures that enable meaningful comparison.

The business literature also underscores the point that the choice about what not to measure is as important as what to measure, since “things that are measured are considered important while the things not measured are generally considered of less importance” (Waggoner et al. 1999: 54). This literature also notes that once collected, measures are rarely deleted, even if they are obsolete (Neely et al. 2000). Given limited resources, each measure chosen represents an opportunity cost.

The component literatures reveal an important parallel debate about process versus outcomes measures (e.g., Evans et al. 2001; Rubin et al. 2001; Mannion and Davies 2002). The business literature uses other terms, e.g., “a debate on whether performance indicators should be focused on procedures (activities) or on results (output)” (Kueng 2000: 77), but the concepts are identical. Despite some arguments that process measures are more practical, most writers consider them complementary to outcomes or results (e.g., Baker 1995), and all should be chosen to fulfill the specific measurement objective (Wynia et al. 1996).

There are widespread concerns about the paucity of validation work. Eddy (1998: 7) describes current measures as “blunt, expensive, incomplete, and distorting.” There is strong consensus that measures must be evidence-based. Gross et al. (2000) evaluated coronary bypass mortality-related indicators across 24 hospitals and concluded that indicator definitions significantly affected computed rates and changed relative standings. “There are no generally agreed-on external criteria for validity of indicators” (Gross et al. 2000: 210).

## Data collection and analysis

Both component literatures strongly note the unanticipated cost and complexity of PM systems. The business literature describes data collection and analysis as “complex, frustrating, difficult, challenging, important, abused and misused” (Lebas 1995: 23). Costs rise because of the high level of technical and managerial expertise required, new information technology and ongoing maintenance. Some also attribute costs (monetary and strategic) to measuring too many different things. “Measuring something makes it important and therefore motivates people. Measuring everything means nothing is important and therefore de-motivates” (Johnston and Fitzgerald 2001: 183). Kueng (2000) identifies success factors in the data collection stage as a parsimonious set of generally accepted indicators, automation and personal involvement of staff and management.

In healthcare, many organizations have lacked the capacity to implement effective systems, and failed attempts are abundant. They generally underestimate the scope and complexity of the infrastructure required to manage healthcare adequately and, by implication, the measurement of its performance (McIntyre et al. 2001). Voelker et al. (2001) and Braun and Zibrat (1996) attribute system failures at this stage to staff and management turnover, technical problems with information systems, budget constraints and competing priorities. Kates et al. (2001) express concern about mandating PM systems in public service organizations without guidance in their implementation and use. Both literatures express concerns about the cost–benefit relation of PM initiatives.

Other issues related to data collection include data sources and quality. Administrative data have long been considered a rich source for PM if properly “mined,” and researchers in particular have produced notable examples of their creative and rigorous use (e.g., Brownell et al. 2001). But many now suggest that the value of secondary data has been overstated, at least as typically formatted (Bishop and Pelletier 2001; McLoughlin et al. 2001). Problems cited include poor reflection of performance, lack of data elements for sensitive diagnosis and risk adjustment, lack of availability and stability of data at smaller levels of aggregation and generally poor quality (Kelman and Smith 2000; Brown 2002). Many writers bemoan the effort devoted to the analysis of retrospective or secondary data at the expense of the collection of more relevant data (Sheldon 1994; Stryer et al. 2000; Voelker et al. 2001). In the more general context of effectiveness research, after 10 years of experience with secondary data, AHRQ’s Patient Outcome Research Team (PORT) investigators are also calling for more prospective and real-time data (Stryer et al. 2000).

Many advocate for routine prospective data collection, fully integrated with clinical practice, that can be used for the delivery of care as well as rolled up for management use (McLoughlin et al. 2001). Concerns remain about the diversion of clinician time from patient care to data recording tasks (Naylor 1999). Ullman et al. (1996: 361) suggest that research-based, standardized measures are “too unwieldy and time

consuming to mesh well with the practice ecology.” Several hybrid approaches are proposed (e.g., Schneider et al. 1999; Brook et al. 2000; Hoelzer et al. 2001), and many commentators still consider the electronic health record, with the appropriate data for PM thoughtfully built in and integrated with more general operational data, to be the best solution in the long run (Aller 1996; Slater 1997).

The literature is replete with concerns about PM data quality. These include issues of missing data, reliability, validity, accuracy, precision, statistical and clinical significance and timeliness (Kleinpell 1997; Mark et al. 1997; Shaw 1997; Collopy 1998; Jencks 2000; Roper and Mays 2000; Pink et al. 2001). McKee and James (1997) provide an excellent review of data quality issues that arise when comparing outcomes data across systems that use different diagnostic and severity adjustment schemes, and report error rates as high as 20% to 40%. Many cite the need for consistent definitions and processes and data quality checks (Shaw 1997; Nutley and Smith 1998) and for the transparent reporting of data collection issues that underlie the reported measures (Pink et al. 2001). Pink et al. (2001) consider expert involvement of both researchers and management as essential.

With respect to methods for analysis, sound statistical methods have long been available but many authors suggest that they usually fall by the wayside in practice (Leggat et al. 1998; Nutley and Smith 1998; Roper and Mays 2000; Smith and Goddard 2002). Adjustment methods are many and varied, and consensus is lacking about the best methods for a given analytic problem (Mant and Hicks 1996; Iezzoni 1997; Shahian et al. 2001; Schneider 2002; Smith and Goddard 2002). Several authors stress that the problem is not so much the methods’ mechanics but the lack of understanding of their limitations and inconsistency in application (Ibrahim 2001; Zaslavsky 2001). An obvious solution is to ensure that adequate analytic expertise is brought to the PM task. Organizational comparisons should disclose all analytic methods and reveal potential sources of bias. As well, a “healthy skepticism about ratings or ranking [should] be maintained” (Schneider 2002: 3). Smith and Goddard (2002) suggest that devising better ways to communicate complex results to non-experts could strengthen the link between research and strategic policy.

## Reporting and use

A first general theme on the topic of reporting PM information is practical advice on effective presentation for various audiences, with the emphasis on evidence-based communications. A more prominent and controversial topic is the growing practice of reporting performance information to external stakeholders via report cards. Several authors provide excellent reviews of the issues and evidence related to public release of performance data (Leatherman and McCarthy 1999; Marshall et al. 2000; Hoey et al. 2002). Barrell (2000: 15) expresses the general sentiment on this matter: “There seem

to be basically two schools of thought: those who believe we can't afford to do it, and those who believe we can't afford not to." In a rare and interesting empirical study that examined organizational response to public disclosure of quality data in the United States, McCormick et al. (2002) demonstrated that in a voluntary system, providers with lower-quality scores were four to six times more likely to withdraw from future disclosure than those with higher scores.

We also found a large literature on the issue of using PM to produce improvement. The business literature clearly advocates a strong link between performance *measurement* and performance *management* (Lebas 1995), including the development of causal models between measures, actions taken and subsequent improvement (Lebas 1995; Neely et al. 1995; Neely 1999) through an organizational change process (Kueng 2000). With respect to alignment of incentives for change, Epstein and Manzoni (1998) cite Kerr's folly (rewarding A while hoping for B) as a common practice in many companies, due to an inability to break out of old patterns of reward and recognition, the lack of an overall system view and focusing on the short term.

The health literature addresses three themes on the application of PM information: its use by organizations as a whole, by individual service providers and, externally, by consumers to make care choices. A second theme is how PM is used for both positive change as well as its unintended or adverse effects. A third is the organizational culture in which PM is embedded.

First, on the issue of "actioning" results, Goddard et al. (2000: 99) observe that "most schemes appear to rely on a vague hope that providers will 'do something' in response to the data." The importance of organizations learning how to link the PM results to actions, rather than having the PM system simply keep records, is restated in many ways (Camp and Tweet 1994; Baker and Pink 1995; Collopy 1998; Voelker et al. 2001). The few studies on organizational (Turpin et al. 1996; Leggat et al. 1998; Lemieux-Charles et al. 2000) or individual provider behavioural change (Jencks 2000; Marshall et al. 2000) in response to organizationwide PM suggest that impact is minimal (Barrell 2000; Legnini et al. 2000; Marshall et al. 2000; Schneider 2002). It is likely that in some settings individual managers and clinical leaders have found effective ways to use and apply performance measurement information, just as in some settings quality improvement has been applied effectively – many examples are provided by the Institute for Healthcare Improvement (2002) – but virtually no rigorous studies have described effective broader-level PM practice and elucidated its features.

The more recent healthcare literature includes descriptions of new mechanisms involving financial incentives for performance at the organizational or individual level. These mechanisms go by a variety of labels, including value-based purchasing, quality-based purchasing, performance-based contracting and pay-for-performance. With respect to alignment of financial incentives at the organizational level, there were many reported instances in US healthcare and some in the United Kingdom. A straight-

forward incentive system that simply provides high performers with extra funds and penalizes low performers is criticized as having the potential to flow funds to services serving regions with less health need, if the contributors to poorer performance are environmental and socio-economic rather than actual differences in care (Elkan and Robinson 1998). In a fairly innovative concept for incentive alignment, Ward (2000) describes a scheme for improving performance in NHS trusts. In this scheme, funding is not allocated according to performance ranking; instead, *greater autonomy and spending latitude* are given to higher-ranking organizations (Ward 2000). While financial incentives may seem like common sense, they continue to be controversial and are largely unproven to date (e.g., Giuffrida et al. 2000).

With respect to the potential for adverse effects, the literature contains many examples of (mostly theoretical) adverse effects, which are summarized in Table 2. Goddard et al. (1998, 2000), Smith (2002) and Smith and Goddard (2002) have drawn from the management control literature and written extensively on unintended effects in the public sector and healthcare. They consider that “some of these dysfunctional consequences are the result of the imperfect or incomplete data on which indicators are based, some are due to how the data are used and interpreted, and some are simply intrinsic to any system of PM” (Goddard et al. 1998: 26).

TABLE 2. Unintended or adverse effects of performance measurement

1. Attention can be focused narrowly on improvement of the measure itself, rather than the underlying process
2. Measures can be selected that divert attention and effort away from more important problems, or measures can be focused on the short term at the expense of longer-term issues
3. Measurement may encourage an attitude of seeking simplistic solutions to complex problems
4. Individual managers can use measurement to serve their own agendas rather than the needs or priorities of the whole organization
5. Measures can be “gamed” or distorted
6. Average performance may be considered sufficient, encouraging complacency and discouraging risk-taking
7. Measures can be used to lay blame rather than find solutions
8. Good results are disseminated while poorer results are suppressed
9. Broader performance expectations or standards can dominate local priorities
10. Unrealistic performance targets can lower morale and engender defeatism

Sources: Smith 2002; Smith and Goddard 2002; Goddard et al. 1998, 1999, 2000; van Peursem et al. 1995; Collopy 1998; Elkan and Robinson 1998; Leggat et al. 1998; Proctor and Campbell 1999; McLoughlin et al. 2001.

A third theme in the health literature is the relatively recent acknowledgment that organizational contextual issues are paramount to effective PM use because of the invariably complex health system environments. Smith (1993: 150) suggests that while PM systems are assumed to be neutral reporting devices, in reality they are “operating in a far messier and less well understood organizational context.” Barnsley et al. (1996), Leggat et al. (1998) and others outline the organizational culture issues in PM. Legnini et al. (2000) provide a very detailed set of recommendations for realigning incentives to encourage positive use of PM information, according to organizational context and stakeholder perspective. Table 3 lists other suggestions. A more comprehensive and holistic approach to PM is being promoted (McKee and Sheldon 1998; Smith 2002), and the emergence of new models may be imminent (Viccars 1998; Campbell et al. 2001).

TABLE 3. Suggested solutions

1. Leadership and commitment of senior managers/decision-makers is essential
2. Take a systems approach, including consideration of organizational, contextual issues
3. Focus on positive personal development, including education, supports for role change and realignment of incentives
4. Maintain a positive, constructive, solution-focused orientation, not a blaming approach
5. Consider performance measures as flags for identification of areas for improvement, rather than absolute measures of performance
6. Commit to PM as a long-term endeavour
7. Resource PM appropriately; ensure that the appropriate technical and managerial expertise and adequate funds are available
8. Foster continuous, open communication with emphasis on interpretation of findings, avoiding simplistic explanations
9. Encourage ownership of PM through collaborative, participatory approaches
10. Consider all stakeholders' perspectives
11. Plan for performance management, not just measurement, i.e., ensure that mechanisms are in place to use results

Sources: Greenhalgh et al. 1996; Mant and Hicks 1996; Turpin et al. 1996; Ford et al. 1997; Collopy 1998; Goddard et al. 1998; Leggat et al. 1998; Nutley and Smith 1998; Bodenheimer 1999; Proctor and Campbell 1999; Gross et al. 2000; Voelker et al. 2001; Weinberg 2001; Zairi and Jarrar 2001; Inamdar et al. 2002; Jarvi et al. 2002; Mannion and Davies 2002.

## Summary and Implications for Practice

The literature reviewed on PM reveals several points of consensus as well as divergence, as summarized in Table 4. Overall, no author advocated abandonment of PM, but most recommended moving forward with more awareness of the pitfalls and mak-

ing informed choices (Smith 1993; van Peurse et al. 1995; Shaw 1997; Eddy 1998; Sennett 1998). Epstein (1995: 4) urges realistic expectations, reminding us not to “let the perfect be the enemy of the good.” Many recommend using PM to create a shift towards a culture of improvement (Proctor and Campbell 1999; Bishop and Pelletier 2001; McLoughlin et al. 2001). In the United States, Braun et al. (1999) and others suggest a national, staged approach including standardized core measures. Berwick (1998) presents an insightful review that challenges current assumptions about health-care performance. Finally, Lied and Sheingold (2001: 394) summarize the current state of practice on PM as follows: “There are real concerns that the act of measurement itself has taken on such a symbolic significance over and above the power of such information to promote beneficial and worthwhile change. We do not yet know how to make such systems deliver on the promises made for them.”

Finally, there are some key structural aspects of healthcare that challenge actionability. The long and strong tradition of professional autonomy, particularly among physicians, focuses philosophically on individuals, not systems. In many jurisdictions, healthcare professionals have contractual (not employee) relationships with service organizations. There are ethical obligations, real or perceived, to provide often heroic and expensive care even where the likelihood of a successful outcome is small. Optimizing performance in such an environment is different from eliminating inefficiencies in a manufacturing process. Clinical care frequently involves trial and error, particularly where cases are intractably difficult or where the science is imprecise, and what one observer would describe as wasteful, another might view as creative and responsive. These caveats suggest that we pay particular attention to the literature that counsels a balanced, nuanced and comprehensive approach to PM and its uses.

## Conclusion

The research literature on PM is expanding daily and the ideas are advancing, but our team has read nothing since completion of the major report that stands out in contradiction with the overall findings presented here. A number of encouraging developments are noted on the policy front in Canada since the review: a recognition of the need for leadership in the federal/provincial/territorial accords on indicator reporting and subsequent comparative national reports, the addition (to Saskatchewan’s Health Quality Council) of three more provincial HQCs (Ontario, Quebec and Alberta) and the establishment of the Canadian Patient Safety Institute. At the same time, the controversial Maclean’s Health Report has come and gone. Much of the current energy is focused on wait times and patient safety. We need to address PM more comprehensively, and work remains as well at the service level – in regions and on the front line. Just as it is no longer acceptable to disseminate clinical treatment without evidence, the stakes are too high to implement healthcare PM without developing the evidence base.

TABLE 4. Points of consensus and divergence in the PM literature

**Consensus**

- Performance can be measured and improved, and performance measurement can be beneficial
- Performance measures should include non-financial measures with a focus on quality, customer needs and, more broadly, stakeholder needs
- There is a need to move towards more meaningful and strategic measures
- There is a need to dedicate sufficient effort at the conceptualization stage, including consideration of the relevance of proposed measures to system change as well as their potential adverse effects
- PM is a complex and technically challenging exercise that needs appropriate expertise, resource allocation, an evidence base and awareness of the pitfalls
- PM system implementation represents significant organizational change, not just the collection and reporting of data
- More emphasis and effort are needed on “actioning” results for improvement

**Divergence**

- The extent to which PM systems should be integrated across all levels of an organization and, specifically, whether measurement of management performance and measurement of clinical performance should be integrated processes
- The degree to which measures should change over time or remain static for historical comparison
- The optimal horizontal scope of measures
- The relative emphasis on process vs. outcome measures
- In the health literature, whether or not patient-level outcomes should be measured routinely by clinicians for all patients vs. using sampling or case-based approaches
- The extent to which performance results should be reported publicly
- The extent to which measures have specific utility for consumers and the general public
- The utility and relevance of administrative data for, in particular, outcomes measurement
- The extent of customization vs. standardization of measures

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Correspondence may be directed to: Carol E. Adair, MSc, PhD, Associate Professor, Depts. of Psychiatry and Community Health Sciences, Room 124, Heritage Medical Research Building, 3330 Hospital Dr. NW, Calgary, Alberta T2N 4N1, Tel: 403-210-8805, Fax: 403-944-3144.

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# Développement d'interfaces entre les services de santé publique et les services cliniques de première ligne à Québec : une étude de cas

## Developing Public Health – Primary Care Interfaces in Quebec: A Case Study



by JALILA JBILOU, MD, MSC

*Département de médecine sociale et préventive  
Université Laval, Laval, Québec.*

DANIEL REINHARZ, MD, PHD

*Associate Professor  
Département de médecine sociale et préventive  
Université Laval, Laval, Québec*

### Résumé

Les services de santé publique ont, entre autres, pour mission de développer des actions susceptibles de diminuer les inégalités en santé des différents groupes de la population. Pour pouvoir rejoindre ces groupes, ils ont à mettre en place des interfaces avec divers acteurs, dont ceux de la première ligne. La présente étude de cas vise

l'identification, au moyen d'une analyse qualitative, des facteurs organisationnels facilitants et des barrières à l'établissement d'une interface entre les services de santé publique et ceux de première ligne dans un territoire de la région de Québec. Les résultats révèlent que les agences de santé publique doivent entreprendre des stratégies ciblées visant à favoriser l'appropriation de nouveaux concepts par les cliniciens tels que la perspective populationnelle, avant de songer aux structures les plus à mêmes de développer et formaliser cette interface.

## **Abstract**

Public health agencies (PH) have various functions. One of them is to develop initiatives that will help decrease health inequalities among different groups in the population. To reach vulnerable groups, PHs must establish interfaces with various players, including primary care clinicians (PCC). Through a qualitative analysis, this case study identifies the organizational factors that either help or hinder the establishment of a functional interface in an area of the Quebec City region. Findings indicate that PHs must first undertake specific strategies to implement a new paradigm (such as the population perspective) among clinicians before introducing structural changes for developing and formalizing PH-PCC interfaces.

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## **Introduction**

L'histoire de la santé publique (SP) et celui de l'organisation des services cliniques de première ligne (SCPL) au Québec sont riches en réformes, législations et politiques publiques. Néanmoins, les structures implantées ont peu formalisé les conditions favorables au développement d'interfaces SP-SCPL. Ces deux secteurs ont, dans une large mesure, évolué parallèlement et séparément sans vraiment saisir les occasions d'influence mutuelle qui s'offraient dans cet environnement de changement organisationnel.

Néanmoins, le rapprochement entre ces deux secteurs a été une préoccupation constante des gestionnaires et il repose sur deux justifications.

Premièrement, un intérêt mutuel d'aller rechercher chez l'autre, ce qui est nécessaire pour mieux répondre à sa mission. C'est ainsi qu'on demande dorénavant aux cliniciens d'étendre leur pratique à des activités qui englobent une expertise détenue par la SP : la prévention et la promotion de la santé (Commission sur l'exercice de la médecine des années 2000 1998), interventions << extra-curatives >> pouvant avoir une influence sur la santé et le bien-être des patients atteints de pathologies complexes comme le diabète (Hawk et Lippman 2000; Visscher et Seidell 2001), les maladies cardiovasculaires (Eastcott 1982; Cameron et al. 2000; Hawk et Lippman 2000;

Glick 2002) ou le cancer (Hawk et Lippman 2000; Adami et al. 2001; Visscher et Seidell 2001; Storm et Olsen 2002). Quant à la SP, elle a besoin de terrain pour pouvoir exercer certaines de ses fonctions essentielles (Lévesque et Bergeron 2003). Donc, une collaboration entre ces deux secteurs est souhaitable autant d'un point de vue clinique et économique, que paradigmatique, surtout dans des systèmes de santé qui privilègent l'intégration comme option pour mieux répondre aux divers besoins en santé de la population (Wright 1995; Grunfeld, Gray et al. 1999; Frumkin 2000; Elster et Callan 2002; Shi et al. 2002).

Deuxièmement, le rapprochement entre SCPL et SP découle de la responsabilité que se reconnaît l'État par rapport à l'amélioration de la santé de sa population. En accord avec les connaissances actuelles, la santé est vue comme résultante de nombreux déterminants, les services cliniques étant un parmi d'autres. Dans cette perspective, la SP, de par sa responsabilité populationnelle, est devenue un secteur légitimé pour mobiliser l'ensemble des ressources susceptibles d'améliorer la santé, tant intra-qu'extra-sectorielles. Le maillage répond donc à un objectif fondamental de l'État.

Or, force est de constater que malgré les intérêts reconnus et les efforts déployés pour les rapprocher, ces deux secteurs continuent à fonctionner largement en silos (Lasker 1997; Brandt et Gardner 2000; Lasker et al. 2001). Le développement d'une interface SP-SCPL reste complexe. De plus, peu dans ce que rapporte la littérature aborde spécifiquement la question de la dynamique des acteurs et des facteurs tant facilitant qu'entravant la mise en place d'un arrimage fonctionnel entre SP et SCPL. Dans ce cadre, l'objectif de ce travail est d'identifier les facteurs organisationnels qui facilitent ou entravent la rédaction d'une proposition d'un plan d'organisation des services de santé en première ligne qui fait explicitement la promotion du développement d'interfaces SP-SCPL dans un territoire de la région de Québec.

## Méthodologie

### Approche conceptuelle

Deux cadres théoriques, testés par d'autres auteurs en analyse organisationnelle (Reinharz 1999; Reinharz et al. 2000; Jbilou 2004), sont repris dans ce travail :

1. Les *archétypes* (Hinings et Greenwood 1988) pour dresser un portrait organisationnel de l'interface SP-SCPL à des moments-clés de l'histoire récente du site étudié. Ce cadre propose deux composantes de l'organisation : la structure organisationnelle (SO) et les schèmes interprétatifs (SI). La SO s'étudie à travers : les rôles et les responsabilités, les mécanismes de décision et les mécanismes de gestion des ressources humaines. Les SI se représentent par : le domaine d'activité

occupé par l'organisation, les principes d'organisation (valeurs et idées qui sous-tendent la perception de comment l'organisation devrait être structurée) et les critères d'évaluation (mécanismes par lesquels une évaluation des activités du groupe est réalisée).

Ce cadre permet de décrire la stabilité des organisations à des moments-clés de leur évolution en positionnant les acteurs ou groupes d'acteurs les uns par rapport aux autres. Cette stabilité est étudiée à travers deux notions : la convergence et la cohérence. La convergence s'interprète au moyen de l'identification des similitudes et/ou différences qui existent entre les divers groupes d'acteurs. Elle s'analyse autant sur le plan de la SO (c'est-à-dire une répartition claire et acceptée des rôles et des ressources entre les différents acteurs face à un objet) que des SI (c'est-à-dire une vision partagée sur les responsabilités de chacun face à un objet). La cohérence s'interprète au moyen de l'identification des similitudes et/ou différences existantes entre SO et SI au sein de chacun des groupes d'acteurs (c'est-à-dire la concordance entre ce que la structure prescrit en ce qui concerne les responsabilités et ce que les croyances et valeurs des acteurs supposent par rapport à un objet). En effet, l'organisation est considérée stable si, pour chacun des groupes d'acteurs, la SO est cohérente avec les SI dominants. Si les schèmes sont amenés à changer, suite à l'acquisition de nouvelles données probantes scientifiques, par exemple, la cohérence s'estompe et l'organisation devient instable. Face à cette instabilité, les acteurs développent des stratégies pour amener l'organisation à évoluer vers une nouvelle configuration organisationnelle plus cohérente avec leurs nouveaux SI; c'est à ce moment qu'émerge une dynamique entre acteurs que nous analyserons au moyen de la théorie des coalitions.

2. La théorie des *coalitions* (Gamson 1961) pour décrire la dynamique qui sous-tend le développement des stratégies collectives des acteurs et pour identifier les leaders. Cette théorie cadre l'étude de la dynamique des acteurs sur trois dimensions : les transactions, les liens et les contrôles. Les transactions regroupent les bénéfices recherchés par les membres de la coalition et les ressources qu'ils y concèdent pour réaliser leurs objectifs. Les transactions s'opèrent selon un principe d'une recherche d'efficacité ou d'un gain supérieur à l'investissement consenti. La coalition permet ainsi l'obtention de bénéfices que l'individu seul ne peut avoir. Les liens sont fondés sur des préférences non utilitaires qui favorisent l'émergence de la coalition. Les liens se constituent autour de la notion d'appartenance qui est perçue par les acteurs et qui peut être idéologique (positionnement politique), corporative (corps professionnel ou syndical) ou même affective (lien d'amitié). Le contrôle est la capacité qu'à un acteur, individuel ou collectif, de conformer une décision de groupe à son propre choix. C'est cette dernière qui permet d'identifier le ou les leaders de la coalition.

Finalement, et afin d'offrir une présentation structurée des conséquences de cette dynamique, nous avons utilisé une grille d'analyse basée sur les trois principales conséquences d'un changement organisationnel : les conséquences symboliques qui sont relatives à l'image véhiculée par la SO proposée, les conséquences substantives qui représentent les propositions concrètes mises de l'avant dans le rapport soumis et les conséquences politiques basées sur la redéfinition des rapports entre les acteurs concernés et leur évolution future (Greenwood et Hinings 1988; Friedberg 1993; Denis et al. 1996).

### Devis et collecte d'information

Une étude de cas a été réalisée au moyen d'une approche qualitative. Elle a porté sur un territoire administratif de la région de Québec.

L'unité d'étude a été une table territoriale de concertation sur l'organisation des services (TTO) dans ce territoire. Les TTO sont issues d'une initiative régionale préconisée par le plan régional de transformation des services de première ligne. D'un point de vue chronologique, cette initiative précède légèrement la réforme que connaît présentement le système de santé québécois. Cependant, elle en partage les assises paradigmatiques, qui sont d'assurer, grâce à une mobilisation de l'ensemble des acteurs de 1<sup>ère</sup> ligne, une meilleure réponse globale aux besoins de la population. Cette initiative visait à organiser, dans chacun des territoires de la région, une meilleure interface entre les services offerts dans les cliniques privées et ceux offerts par le réseau institutionnel, afin de mieux répondre aux besoins non seulement des consommateurs de services, mais également des populations du territoire. Les TTO ont pour mandat de déposer, après un an de travaux, un rapport proposant un modèle d'organisation des services cliniques de première ligne. Au début, seuls les cliniciens participaient aux TTO. Cependant, certaines ont accepté la participation d'autres acteurs tels que la SP, les infirmières et des gestionnaires. La TTO étudiée fait partie de celles dites « mixtes ».

Les personnes ressources ciblées ont été l'ensemble des participants à la TTO du territoire étudié, soit 15 individus. La provenance des répondants est représentative des différents groupes d'acteurs visés par le présent travail. De plus, ces répondants parlent au nom du groupe qu'ils représentent autour de la TTO. Ils ont été contactés par téléphone dans un premier temps. Suite à leur consentement de participer à l'étude, soit un taux de réponse de 100 %, un résumé du projet et les principaux items du questionnaire leur ont été envoyés. Toutefois, la saturation de l'information ayant été obtenue après 12 entrevues, il n'a pas été nécessaire de rencontrer les quatre autres membres. Ainsi, les répondants<sup>1</sup> interviewés sont :

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1 Le masculin a été adopté dans la présentation des répondants pour préserver leur anonymat.

- un clinicien représentant l'Unité de médecine familiale (UMF);
- un médecin-conseil régional représentant la Régie régionale (RRSSS-03);
- un clinicien exerçant en clinique privée et représentant la Direction régionale de médecine générale (DRMG);
- deux planificateurs représentant la Régie régionale (RRSSS-03);
- trois administrateurs et représentants des instances locales;
- deux représentants de la Direction de santé publique de Québec (Équipe organisation des services et évaluation de la DSPQ);
- un professionnel des services infirmiers;
- une personne externe impliquée dans le soutien à l'organisation des services sur le territoire et ayant siégé à la table.

Les informations colligées proviennent des *verbatim* des 12 entrevues et des PV des rencontres de la TTO et les rapports d'activités soumis par certains groupes d'acteurs. Une triangulation a été réalisée avec l'information fournie dans la documentation produite au sein du territoire, de la Direction régionale de la santé publique (DSPQ<sup>2</sup>) et de la Régie régionale des Services de santé et services sociaux de la région 03 (région de Québec) (RRSSS-03) et du rapport final des travaux de la TTO déposé auprès de la RRSSS-03 par la TTO. L'analyse de l'information extraite a été réalisée conformément aux dimensions conceptuelles précisées dans ce qui précède.

## Résultats

Les résultats sont présentés selon une logique chronologique et respectent les dimensions relatives aux cadres conceptuels retenus aux fins de cette étude. Le temps 0, ou archétype 1, représente la période avant l'implantation de la TTO; la période intermédiaire couvre la période d'implantation et de fonctionnement de la TTO; le temps 1, ou archétype 2, est celui du dépôt du rapport final des travaux de la table et finalement une présentation des conséquences.

Temps 0 : Avant l'implantation de la TTO, l'architecture organisationnelle en vigueur sur le territoire offrait un cadre de réalisation formel pour les activités relevant du mandat de chacun des groupes d'acteurs sans égard pour la formalisation des liens entre les deux secteurs. En effet, peu dans ce que décrivent les plans d'organisation des services de la RRSSS-03 était explicite quant aux activités et aux conditions reliées à la réalisation de l'interface SP-SCPL. Seuls les CLSC, dans le cadre de leur mandat de SP, se devaient de développer des activités de collaboration avec la SP. Néanmoins, ces collaborations ne représentaient qu'une faible proportion des activités de première ligne réalisées dans la région.

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2 Dans le texte l'acronyme SP réfère à la DSPQ.

Au sein de cette configuration organisationnelle, presque tous les représentants des groupes d'acteurs interviewés sont satisfaits de l'adéquation entre la SO dans laquelle ils évoluaient et la conception qu'ils avaient de leur rôle par rapport à la perspective populationnelle. Seuls ceux de la SP ressentaient une certaine incohérence entre la configuration organisationnelle et leurs SI. En effet, quoique satisfaits par rapport aux activités dites traditionnelles comme la vaccination, ils déplorent un manque d'engagement des cliniciens dans d'autres activités moins traditionnelles comme la réduction des iniquités. En effet, ils considèrent que la SO dans laquelle la SP s'inscrit offre peu de cadres formels pour le développement de l'interface. Les représentants de la SP étaient en situation de non-convergence avec ceux des autres groupes d'acteurs. Du point de vue organisationnel, les représentants de la SP déplorent le manque de coordination et de structuration des activités visant de manière spécifique l'interface. Du point de vue des SI, ils soulèvent la question de l'absence de responsabilité claire pour la perspective populationnelle et la faible implication des autres acteurs dans l'offre des services dédiés à des sous-groupes populationnels marginaux, tels les itinérants. Ces éléments laissent entrevoir une instabilité organisationnelle par rapport à la question du développement de l'interface SP-SCPL.

L'implantation de la TTO représente dès lors un événement marquant dans l'histoire du territoire. En effet, la TTO est un espace privilégié de concertation et de confrontation car il réunit autour d'une même table des acteurs professionnels et institutionnels d'appartenance diverse. Ce premier regroupement forme une coalition fonctionnelle, vu l'assiduité de la présence des différents acteurs (vérification de la liste de présence sur les PV des rencontres de la TTO). Néanmoins, il faut noter que chacun des acteurs était là avant tout pour défendre ou faire prévaloir les intérêts du groupe qu'il représente et les intégrer au plan d'organisation final.

Les négociations autour de la TTO font appel à une série de transactions, où chacun engage des ressources tout en évaluant les bénéfices potentiels qu'il va en tirer. Les liens individuels et collectifs sont mis à contribution pour rallier les acteurs et aboutir à des compromis parfois avec l'aide des pouvoirs administratifs, hiérarchiques ou corporatifs lorsqu'un consensus ne peut être atteint. Cependant, c'est essentiellement autour de préoccupations se rapportant au partage des tâches concernant la prise en charge des usagers, et non pas de la population, que se situent les débats. C'est un mouvement parallèle qui à ses débuts est extrêmement marginal et discret. Ce mouvement est conduit par les deux représentants de la SP. Ils essaient dans cette mouvance de saisir l'occasion pour susciter un intérêt de la part de tous les membres de la TTO pour l'interface SP-SCPL. Ces acteurs profitent de ce que les cliniciens remettent en question leurs responsabilités et manières de faire, pour les inciter à étendre leur champ de questionnement à des préoccupations d'ordre également populationnel. Par cette approche, la SP vise l'appropriation par les cliniciens de l'idée qu'il leur incombe désormais une responsabilité pour une population et non pas seulement pour une clientèle. Le but recherché par

la SP est l'appropriation par les cliniciens de l'idée qu'une organisation des services cliniques doit tenir compte du besoin d'une interface fonctionnelle SP-SCPL. Naît alors une coalition, formée par la SP et le CLSC, qui stratégiquement s'engagent à travailler non seulement à mettre en avant leurs préoccupations mais aussi à défendre celles des cliniciens, et ce afin de les rallier autour de leurs intérêts d'ordre populationnel. C'est ainsi que graduellement la coalition SP-CLSC acquiert une reconnaissance et une légitimité de la part des cliniciens. Dès lors les représentants de la SP et celui du CLSC prennent le leadership de la rédaction du rapport final de la TTO.

Temps 2 : représente le moment du dépôt du rapport final de la TTO. Ce rapport est le résultat d'un consensus sur le réaménagement structurel à mettre en place, et dans lequel les différents groupes d'acteurs représentés auprès de la TTO se partagent les activités cliniques minimales à offrir à la population. De façon remarquable, la proposition accorde explicitement une place à l'interface SP-SCPL. La proposition soutient le besoin d'associer la SP à l'ensemble des travaux qui se réaliseront à l'avenir et de lui accorder le leadership pour déterminer les populations vulnérables pour lesquelles une attention particulière doit être portée. Même si les cliniciens ne souhaitent pas s'investir dans le développement de l'interface, ils sont devenus plus conscients de l'importance, autant pour leur clientèle que pour la population générale, d'avoir des liens formels et fonctionnels avec la SP. Un changement majeur des valeurs et croyances des cliniciens s'est donc opéré quant à leur responsabilité face au développement de l'interface SP-SCPL. Les travaux de la TTO ont permis une conscientisation des acteurs par rapport à la responsabilité collective vis-à-vis de la population et la nécessité de développer l'interface pour pouvoir mieux y répondre.

Les conséquences substantives du processus entourant les travaux de la TTO sont exprimées à travers la proposition de l'introduction de deux objectifs sur dix du rapport final de la TTO, directement en lien avec la perspective populationnelle. Ces propositions concernent la mise en place d'un continuum de services entre SP, responsable de l'identification des populations vulnérables, et CLSC, responsable de la prise en charge de ces populations. Cependant, on remarque que les démarches entreprises au début du processus par la SP font appel à des principes de collaborations et d'ententes mutuelles entre tous les acteurs, que seul le CLSC intègre de manière explicite et opérationnelle. Les autres acteurs cliniques, quant à eux, ne partagent pas forcément les valeurs véhiculées par la SP et ne s'impliquent pas vraiment dans la formalisation de l'interface SP-SCPL qu'ils jugent être du ressort du CLSC. Néanmoins, le gain majeur pour la SP réside dans le fait que tous les acteurs de la première ligne s'efforcent de fonctionner en réseau et ne rejettent pas le principe d'une première ligne conçue selon une approche populationnelle, plutôt qu'axée sur les clientèles. Les conséquences symboliques sont relatives à l'image que veut véhiculer le territoire, à savoir celle d'un espace où la concertation intersectorielle a réussi. Cette image est d'ailleurs renforcée par le fait que l'ensemble des membres de la TTO décide de la maintenir

même après la fin des travaux. Cette décision est stratégique pour la SP, car cette table offre une occasion pour maintenir l'appropriation de la perspective populationnelle par les cliniciens. Elle est donc un atout pour le développement de l'interface. Les conséquences politiques sont essentiellement la reconnaissance par les cliniciens de la légitimité de la SP pour s'impliquer dans le processus d'organisation des services cliniques de première ligne.

## Discussion et conclusion

Le jeu des acteurs s'interprète principalement au moyen des stratégies qu'ils développent pour faire prévaloir leurs attentes, protéger leurs acquis et maximiser leurs bénéfices. La dynamique qui en résulte est étroitement dépendante de l'atteinte d'un équilibre entre les stratégies pour et celles contre le changement. Sur le territoire à l'étude, la préoccupation pour le développement de l'interface SP-SCPL a été principalement le fait des représentants de la SP. Cet intérêt est à la base des stratégies que développeront ces acteurs au sein de la TTO pour atteindre leur objectif : l'adhésion des acteurs autour de la TTO à la perspective populationnelle et le déclenchement d'initiatives de formalisation de l'interface.

Les représentants de la SP qui se sont tout d'abord assurés de l'adhésion de leur allié sur le terrain, le CLSC, ont développé des stratégies susceptibles d'influencer le cours des événements et la rédaction du rapport final. Dans le contexte étudié, le développement d'une interface SP-SCPL a nécessité la formation d'une coalition qui lui était dédiée spécifiquement. La création de cette coalition a nécessité un leadership organisationnel ayant un réel impact sur l'orientation du processus transformationnel des SCPL. Seule la SP a pu assumer ce leadership et mener cette coalition, car, plus que les autres, elle y voit un intérêt qui correspond à sa raison d'être.

Ces constats viennent confirmer que deux aspects majeurs, à savoir le leadership de la SP et la gestion du changement en première ligne, sont à la base même du développement de l'interface SP-SCPL, éléments rapportés dans la littérature (Lasker 1997; Weiss et al. 2002; Wilson 2002; Ferrari et Rideout 2005). L'ajout que représente notre contribution à l'avancement des connaissances est d'une part la mise à contribution du leadership de la SP dans le façonnement du cours de l'implantation d'un changement organisationnel, ce qui a peu été documenté auparavant. D'autre part, nos constats montrent de manière opérationnelle comment le jeu des acteurs est une composante déterminante de l'évolution d'un changement organisationnel. La particularité de notre étude se cantonne au choix de notre unité d'analyse : une TTO à Québec. Cette modalité de fonctionnement imposée par une initiative régionale a offert aux acteurs du terrain un espace de confrontation et de négociation ayant permis la prise de décisions collectives basées sur le consensus. Consensus ayant entraîné une contribution équitable et des gains équilibrés pour tous les acteurs en présence.

Cette constatation nous permet de conclure que la négociation et la confrontation des acteurs sont un moyen efficace pour l'atteinte d'un consensus organisationnel pour le développement de l'interface mais que les moyens et les stratégies à engager restent encore à développer et que jusqu'à présent peu de conclusions permettent d'offrir des outils valides et efficaces pour atteindre ce consensus.

Au Québec, la réforme actuelle offre une occasion de taille pour le développement de l'interface SP-SCPL. En effet, l'implantation des réseaux locaux de santé (RLS) introduit des changements autant d'un point de vue paradigmatique que structurel et touche autant le système de santé en général que les différents niveaux d'offre de services et les pratiques professionnelles. Les fondements des RLS reposent sur la hiérarchisation des services et la responsabilité populationnelle. Ces deux fondements supposent un système de santé centré sur une première ligne soutenue par une deuxième et une troisième ligne, le tout configuré selon une approche globale de la santé. Ainsi, la première ligne se voit désormais attribuer non seulement des tâches dans la coordination de l'ensemble des services requis pour les clientèles, allant de la prévention à la réadaptation, mais aussi une responsabilité populationnelle. De plus, une situation relativement nouvelle pour tous les acteurs de terrain, celle de la mise en avant de l'imputabilité (sectorielle, organisationnelle et professionnelle) qui découle de la responsabilité populationnelle. Cette imputabilité représente pour la SP une occasion considérable pour formaliser des ententes avec les SCPL, notamment à travers les projets-cliniques. Alors, dans quelle mesure la SP sera-t-elle capable de jouer un rôle clé au sein de cette mouvance organisationnelle afin de développer des interfaces formelles avec les SCPL ?

Veillez adresser toute correspondance à : Jalila Jbilou, Université Laval, Département de médecine sociale et préventive, Pavillon de l'Est, 2180, Chemin Sainte-Foy, Québec, QC, Canada G1V 1S4, Téléphone : (418) 656-2131, poste 4261, Télécopieur : (418) 656-7759, Courriel : fsajjb@hermes.ulaval.ca

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# Priority Setting in the Provincial Health Services Authority: Case Study for the 2005/06 Planning Cycle

## L'établissement des priorités à la Provincial Health Services Authority : étude de cas pour le cycle de planification 2005-2006



by CRAIG MITTON, PHD

*Centre for Healthcare Innovation and Improvement,  
B.C. Research Institute for Children's and Women's Health, Vancouver, BC  
Faculty of Health and Social Development,  
University of British Columbia Okanagan, Kelowna, BC*

JENNIFER MACKENZIE, MBA

*Provincial Health Services Authority of British Columbia  
Vancouver, BC*

LYNDA CRANSTON, MSCN

*Provincial Health Services Authority of British Columbia  
Vancouver, BC*

FLORA TENG, MPH

*Centre for Healthcare Innovation and Improvement,  
B.C. Research Institute for Children's and Women's Health  
Vancouver, BC*

## Abstract

**Introduction:** Building on a survey of key decision-makers within the Provincial Health Services Authority (PHSA) of British Columbia, a process for prioritizing new service options within this organization for the 2005/06 budget cycle was developed and implemented by senior managers and researchers at the University of British Columbia.

**Methods:** A case study approach was taken in which development and implementation of the prioritization process was documented and feedback was obtained from decision-makers to evaluate the activity. Information from the literature was also used to identify areas for improvement.

**Results:** The 13-member Executive Committee of the PHSA conducted the prioritization. Criteria were defined and weighted, and options for new funding were explicitly rated against them. Multi-attribute decision software was used to rank options based on an overall benefit score. Cost-benefit ratios were also derived and program options were further ranked according to decision-makers' "gut-feel." Ranking between the methods was comparable, and each method contributed to the final decisions by the Executive Committee regarding which programs would receive limited new funding.

**Conclusion:** Through a collaborative effort between decision-makers and researchers, the PHSA was able to shift from allocating new resources on the basis of politics and bargaining to an evidence-driven, transparent, defensible process. Lessons learned from the current activity will help inform future priority setting in the PHSA and should provide insight for decision-makers elsewhere.

## Résumé

**Introduction :** À partir d'un sondage mené auprès des principaux décideurs de la *Provincial Health Services Authority* (PHSA) de Colombie-Britannique, des cadres supérieurs et des chercheurs de la *University of British Columbia* ont établi et mis en application une procédure d'établissement des priorités concernant les nouvelles options de service au sein même de l'organisme pour le cycle budgétaire 2005-2006.

**Méthodologie :** Une approche d'étude de cas a permis de consigner les détails de l'élaboration et de la mise en application de la procédure d'établissement des priorités, et la réaction des décideurs a été notée en vue de l'évaluation de l'activité. Des données tirées de la documentation disponible ont aussi servi à l'identification des domaines où des améliorations sont possibles.

**Résultats :** L'exécutif de la PHSA, composé de 13 membres, a procédé à l'établissement des priorités. Les critères ont été définis et pondérés, puis explicitement évalués dans l'optique des nouvelles options de financement. Un logiciel de décision multi-attributs a servi à ordonner les options selon la mesure d'ensemble de leurs bienfaits. Des rapports coûts-avantages ont été établis, et les options de programme ont aussi été classées en fonction de la réaction instinctive des décideurs. Les diverses

méthodes ont produit des classements comparables, et chaque méthode a contribué aux décisions finales de l'exécutif quant aux programmes auxquels accorder un nouveau financement limité.

**Conclusion :** Grâce à un effort de collaboration entre décideurs et chercheurs, la PHSA a réussi à délaissier les méthodes d'allocation des nouvelles ressources fondées sur la politique et la négociation pour adopter une procédure transparente et défendable basée sur la preuve. Les leçons tirées de l'activité en cours pourront influencer l'établissement futur des priorités à la PHSA et offrir de nouvelles perspectives à d'autres décideurs.

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**A**S RESOURCES IN HEALTHCARE ARE LIMITED, SOME MECHANISM IS REQUIRED within health organizations to decide which services to fund and which not to fund (Madden et al. 1995; Ham and Coulter 2001). Recent evidence has shown that decision-makers often do not have an adequate understanding of tools available to assist in such activity (Lomas et al. 1997; Mitton and Donaldson 2002). As a result, they are likely to revert to historical allocation processes (Miller and Vale 2001; Mitton and Prout 2004) whereby a given year's expenditure is largely based on the previous year's allocation, with some adjustments for demographics or the political call of the day. The main criticism of this approach is that there is little chance of getting the most out of limited resources, as costs and benefits of services are not explicitly examined (Birch and Chambers 1993). This paper outlines a formal approach to prioritization applied in 2005 within the Provincial Health Services Authority (PHSA) of British Columbia.

## Context

With its provincial, rather than regional, mandate, the PHSA is distinct from the five other health authorities in British Columbia (Cranston and Powell 2004). As a provider of specialized services, it coordinates the activities of eight provincial agencies: B.C. Cancer Agency, B.C. Centre for Disease Control, B.C. Children's Hospital and Sunny Hill Health Centre for Children, B.C. Provincial Renal Agency, B.C. Transplant Society, B.C. Women's Hospital & Health Centre, Forensic Psychiatric Services Commission, and Riverview Hospital. In addition, the PHSA is responsible for cardiac services and the provincial coordination of emergency and surgical services. In most other provinces, specialized services, such as tertiary children's hospitals, are housed within regional health authorities while disease-oriented institutions, such as those for cancer and mental health, function as stand-alone entities.

Leadership of the PHSA is provided through an Executive Committee com-

prising 13 individuals of both clinical and managerial backgrounds. The Executive Committee is responsible for overall planning for the PHSA, although each agency also has its own leadership team.

In fall 2003, senior decision-makers in the PHSA decided to work towards a formal prioritization process. They contacted researchers from the University of British Columbia early in 2004 to collaborate on the development and implementation of an approach for prioritization of new investments for the 2005/06 budget cycle.

The primary objective of this paper is to report on the most recent prioritization process for new services and programs undertaken within the PHSA. First, we outline several observations from a survey with PHSA decision-makers that was undertaken before the prioritization exercise.

## Survey of Key Decision-Makers

To ensure a better understanding of the organizational context with respect to priority setting and to investigate the possibility of moving towards a more explicit process, a survey was conducted of 25 key PHSA decision-makers in spring 2004. Results were categorized into (a) current organizational practices; (b) strengths and weaknesses of priority-setting activity to date; (c) areas for improvement, particularly in relation to cultural change, stakeholder involvement and fairness of process; and (d) barriers and facilitators in moving forward with an explicit approach to priority setting.

Decision-makers indicated that up until the time of the survey, priority setting had been largely based on the adage, “the squeaky wheel gets the grease”: resources tended to go to whomever “yelled the loudest.” Prioritization was described as an ad hoc process, with resources allocated to satisfy the most people and incur the least opposition. Decision-makers stated that there had not been discussion of re-allocating resources across PHSA agencies owing to an agreement among the agencies when the PHSA was formed.

Decision-makers identified a number of strengths pertaining to priority setting. First, many respondents identified the creation of the Strategic Plan as an organizational strength. The planning process enabled stakeholders to come together and discuss the future directions of the PHSA. The aim of the strategic planning exercise was to establish a unified vision across the agencies. Decision-makers viewed the plan as the first step towards a more “fair, open and transparent” process. Another strength the decision-makers identified was the openness of the PHSA in moving towards an explicit, more formal process of priority setting.

One identified weakness was a lack of structural and cultural integration within the organization. This was attributed to the newness of the PHSA (created in 2002) and related to the challenge, noted above, of re-allocating resources across agencies. In addition, decision-makers said that an organizational “do-it-all” mentality prevailed

rather than an acceptance of the necessity to make overt rationing decisions. A further perceived weakness was that decision-makers were unlikely to release resources from their own program budgets to fund investments elsewhere.

Survey participants noted that the main strategy for improvement was to develop a process that was more transparent and defensible. Further, they identified a need for developing a culture that supports explicit priority setting through education and training in economic principles and prioritization practices. While the PHSA has used stakeholder opinion in setting priorities, decision-makers believed that stakeholder involvement could be broadened. For example, members of the public could be asked for their insights into the criteria on which decision-makers base allocation decisions.

Despite the desire for greater transparency as a whole, decision-makers identified a number of barriers in moving to an explicit priority-setting process: lack of shared vision in the PHSA, lack of priority-setting skills among the management team and lack of decision-maker buy-in for such a move. Conversely, these decision-makers also highlighted several facilitators that could aid in the implementation of an explicit priority-setting process: a strong leadership team, commitment to explicit priority setting, consistent application of the process, demonstrated results and adequate resources for re-allocation across services.

## Methods

Our research activity within the PHSA followed what Martin and Singer (2003) call a “describe–evaluate–improve” strategy for priority setting. The first stage is to describe the process using qualitative methods, as was done with the key decision-maker survey. Following implementation, the process can be evaluated against known frameworks; subsequently, areas for improvement can be identified. The current process was documented through participation in relevant Executive Committee meetings over a 10-month period (May 2004 through February 2005) and then evaluated through discussion with two sets of decision-makers. Information from the literature was also used to identify areas for improvement.

Table 1 outlines the basic steps taken for this process, with the scope (i.e., stage 1) being to prioritize new services and programs. A work plan for the process was developed jointly by a senior decision-maker within the PHSA (JM) and a researcher at the University of British Columbia (CM). The plan was presented to the CEO and Executive Committee in June 2004. The Executive Committee agreed to serve as the advisory panel (see stage 3 in Table 1), while support would be provided by managers and clinicians within each agency.

An initial set of decision-making criteria was generated by JM and CM, based on (a) organizational values as evidenced through various internal planning and strategic documents and (b) knowledge of criteria found in the literature (e.g., Gibson et al.

TABLE 1. Stages in PHSA prioritization process	
GENERIC STAGES*	PHSA ACTION
1) Determine the aim and scope of the priority-setting exercise	Focus on prioritizing new program and service options for 2005/06 budget cycle (corporate services and independent capital proposals not included)
2) Compile a map of current activity and expenditure	Explicit review and compilation of current activity and expenditure map not conducted
3) Form a multi-disciplinary advisory panel	13 member Executive Team of the PHSA, comprised of both clinicians and managers
4) Determine locally relevant decision-making criteria based on decision-maker, board or public input, including review of strategic documents	Initial set of criteria generated based on organizational values and standard criteria from the literature. These were revised by the Executive Team and then were weighted according to relative preference.
5) Advisory panel to identify options for service growth and rank those options with explicit consideration given to decision-making criteria	Program and service options from each agency were presented to the Executive Team. A business case was developed for each option and a scoring sheet was used to rate options against the criteria.
6) Validity checks with additional stakeholders, final decisions to inform budget planning process, and communication of decisions and rationales internally and externally	Finance personnel reviewed business case cost projections; final decisions were made by the Executive Team and results communicated back to the agencies through the Executive Team members.
7) Evaluate the process and make refinements for future years	Informal feedback obtained from two sets of decision-makers and insight drawn from relevant literature; more formal evaluation using qualitative and quantitative methods to be carried out over time

\*Adapted from Mitton and Donaldson (2004)

2005a; Mitton et al. 2003). Definitions of each criterion were drafted and presented to the Executive Committee in June 2004. Through an iterative process involving extensive discussion at Executive Committee meetings over a three-month period, the definitions were formalized (stage 4). This process included ranking a series of mock proposals to gauge the validity of the criteria. Next, the criteria were weighted according to relative preference. Weighting involved each member of the Executive Committee assigning a total of 100 points across each criterion. Points were tallied and averages, not including high and low scores, were calculated. From these averages, a relative percentage weighting of each criterion was derived.

A simple, one-page scoring sheet (see Appendix 1) was developed by JM and CM so that each new program or service proposal could be rated against the criteria in a standardized format. The criteria in the scoring sheet were those that were initially generated as described above, and formally agreed to by the Executive Committee following extensive discussion and iteration. The columns represent a score, between 1 and up to 6, on which each funding proposal was rated (stage 5). The number of levels for each criterion (i.e., 1 to 4, 1 to 5 or 1 to 6) was selected based on the natural intervals for each criterion, as agreed upon by the Executive Committee. In some cases, epidemiologists were consulted in deriving the final set of levels and corresponding definitions. The column farthest to the right provides an indication of whether the assessment was based on evidence or expert opinion.

Based on the expected amount of new resources available from the government for the 2005/06 fiscal year, and to keep the process manageable, the Executive Committee decided that each agency could submit a maximum of two proposals for prioritization. The scoring sheet and corresponding business case were completed for each proposal by the program requesting the funding and submitted by the relevant agency's executive sponsor prior to a one-day decision-making retreat held in January 2005. The business cases included a summary description of the investment option, a clear statement of the objectives and expected outcomes, including assessment of the proposal against each of the pre-defined criteria, risk assessment and cost analysis. During the retreat, a manager or clinician from the particular program area made a 30-minute presentation on each proposal. The Executive Committee then vetted the scoring sheet ratings, and adjustments were made accordingly.

Three further steps were undertaken during the day-long decision-making retreat. First, the service proposal ratings, along with the pre-defined criteria weights, were entered into an off-the-shelf, multi-attribute decision-making software package (VISA 1995), which produced an overall benefit score for each proposal. The software calculated the benefit score based on a simple linear function, with the weight of each criterion multiplied by the score of the proposal against that criterion. Then, these scores were added across all the criteria and entered into Excel for reporting.

Second, the overall benefit score for each proposal was divided by the five-year

projected capital plus operating cost to produce a cost–benefit ratio. These costs were available in the business case for each proposal. As the costs were cardinal and the benefit scores were ordinal, a skewed list of ratios was produced, with the most costly options receiving the lowest cost–benefit scores. Nonetheless, the intention was to produce some information on the relative “value” (i.e., expected benefits for resources spent) of the investment proposals.

Third, a set of blank cards was handed out to each Executive Committee member, who rated his or her top five proposals based on “gut-feel.” These proposals were hand-tallied to produce an additional score, with first-place proposals on each card receiving a “3,” second-place proposals a “2,” third-place proposals a “1” and “0” for those in fourth or fifth place. The multi-attribute benefit score, the derived cost–benefit ratio and the “gut-feel” score were presented to the Executive Committee at the end of the retreat.

Two weeks following the retreat, at a regularly scheduled Executive Committee meeting, the prioritization process was reviewed and the three sets of rankings were re-presented. During the interval between the retreat and the final decision-making meeting, PSHA financial personnel reviewed the costing of each proposal to ensure consistency of reporting and projection of various costs (step 6 in Table 1). Adjustments were made and incorporated into the final cost–benefit ranking. Prior to final decisions, the senior manager leading the process (JM) presented three key observations to the team:

1. There is no “right” or “wrong” ranked list, and of the three methods presented, ultimately each may provide information upon which the team might base its final decisions. Additional factors may also play a role in decision-making, such as providing services to highly specialized populations; or, other criteria that were not fully captured in the scoring sheet might be applied. So long as evidence is provided and decisions are made in an open and transparent manner, in principle it is legitimate to produce a final ranking that differs from any of the three methods used in this process.
2. The “gut-feel” approach does not include process values that the Executive Committee had indicated were important at the outset of the exercise, including transparency, equity and accountability.
3. The overall benefit score on its own does not provide an indication of value for money spent. The cost–benefit ratio is driven largely by cost, as the variation between programs on the benefit score is limited.

Group discussion followed the presentation of results, and a final decision was made by consensus regarding the top three service options. Next, we immediately embarked on further discussion regarding improvement of the process for future years (stage 7 in Table 1). Additional insight was elicited in a separate meeting with a group

## Priority Setting in the Provincial Health Services Authority

**TABLE 2. Ranked results of program and service options by overall benefit score (OBS)**

PROGRAM OPTION	OBS	TOTAL COST (000'S) (OPERATING+CAPITAL)	BENEFIT/ COST*
Alcohol and Drug Treatment	85	12580	6.76
Colorectal Cancer Screening	82	3414	24.02
Prenatal Genetics Screening	81	5120	15.82
Youth Substance Use Program	80	3071	26.05
Environmental Health Centre	76	15919	4.77
Mental Health Networks	75	5913	12.68
Pediatric Nutritional Needs	74	4685	15.80
Pediatric Oncology Network	68	1353	50.26
HPV Co-testing	62	7119	8.71

\*Pediatric Oncology Network, Youth Substance Use Program, Colorectal Cancer Screening and Prenatal Genetics Screening are the top four ranked programs on the basis of the benefit-cost ratio.

of managers from two of the agencies that met regularly to strategize priority-setting activity within their agencies. Key points from these two feedback sessions were recorded. Main themes are reported below.

## Results

In total, nine proposals for funding were put forward by the agencies. Rank order by overall benefit score is presented in Table 2. This table includes the cost–benefit ratio for each program. The “gut-feel” scores are presented in Table 3, with the number in parentheses representing the total score received based on three points for each first-place vote, two points for second place and one point for third.

TABLE 3. Program options ranked by gut-feel scores

PROGRAM OPTION
1. Colorectal cancer screening (31)
2. Provincial youth substance (18)
3. Prenatal genetics (12)
3. HPV co-testing (12)
5. Pediatric nutritional needs (6)
5. Alcohol and Drug Treatment (6)
7. Pediatric Oncology Network (0)
7. Mental Health Networks (0)
7. Environmental Health Centre (0)

In the end, the Executive Committee decided that the top three programs to receive funding, should new resources become available, were: (1) Colorectal Cancer Screening, (2) Prenatal Genetics Screening and (3) Youth Substance Use Program. The remaining, unfunded programs were turned back to the individual agencies for internal re-allocation of resources, should they be deemed of higher priority than existing services within those agencies. In the end, the team made this decision by taking into account the “gut-feel” scores along with the cost of the proposals and the overall benefit score (but not considering the cost–benefit ratios explicitly).

The final ranking corresponds closely with the “gut-feel” rank order scores and, except for the Alcohol and Drug Treatment program, also follows the overall benefit score rank order. The program option with the best “value” based on the cost–benefit ranking (i.e., the Pediatric Oncology Network) did not make the final three ranked options and received zero points on the “gut-feel” scoring.

Following these decisions, the Executive Committee raised a number of important points related to the process. Overall, the process was seen to be fair, and the team appreciated the due diligence undertaken by program managers and clinicians on the business cases and retreat presentations. The managers and clinicians on the Executive Committee felt that there was ample opportunity for dissenting voices to be heard and that the process was open and transparent among senior staff across the agencies. As well, despite some concerns over the criteria, on balance decisions were made with adequate information at hand, with the caveat that evidence and data will always be limited.

In terms of areas for improvement, the main concern was that the “benefit” of some proposals (e.g., the networks) was not fully captured through the defined criteria. However, the team also understood that results from each of the three methods were

simply inputs into the decision-making process, and that no single rating of, for example, a 6 versus a 4 on the benefit score of an individual criterion would have swayed the final ranking decision. A related issue was concern that the team was unable to fully adjudicate the benefit scores presented by program managers at the retreat, and thus the vetting focused more on assessment of individual managers' understanding of the criteria as opposed to a genuine assessment of the program against the given criteria. The team also recognized challenges with the criteria that may have arisen, in part, through the vast and disparate array of PHSA program areas requiring assessment.

Further points arose in discussion with a small group of managers charged with leading priority-setting processes within two of the agencies. These managers clearly felt that the executive-level process should be continued, noting a need for some refinement. Viewed as perhaps most important was the need for even greater standardizing of the process so that all areas of the organization (e.g., human resources, corporate services) were vying for limited resources on an equal footing. As an indication of the cultural shift required, the managers pointed out that some parts of the organization had not used business cases for examining funding options in the past. A new way of thinking about priority setting, brought about through an explicit process with clearly defined criteria, was considered a major advance. It was also noted that project roll-out within the agencies was underway, and that there should be scope at this level not just for prioritizing new programs, but also for re-allocating existing resources between program areas.

Specific recommendations for moving forward included having wider scales for the benefit scoring in order to capture greater variation between options, and outlining the principles of the process in a one-page document for broad circulation to bolster transparency. It was also suggested that the business cases be streamlined so that only relevant information related to the decisions at hand would be included. In addition, the managers suggested that a filter process be examined whereby a proposal would have to achieve a certain level on some criteria in order to qualify for further consideration. The group also indicated that the denominator in the cost-benefit ratio could be adjusted to reflect a cost per case rather than an overall program cost, and a mechanism should be developed to deal with new developments, or new information on existing proposals, as the fiscal year progresses. Finally, while it was recognized that the Board supported the process undertaken by the Executive Committee, this group of middle managers wondered about the political will of sticking with the prioritized ranking when the next crisis – and corresponding media outcry – materializes.

## Discussion

Overall, the PHSA took an important cultural step in moving towards an explicit, transparent method for prioritizing programs competing for limited new resources.

The collaboration between researchers and decision-makers led to a natural laboratory for knowledge exchange whereby the evidence base of the process could be fostered while working within the constraints of real-world complexity and timelines. While the decision-makers viewed the process described here as an improvement over previous processes (inherently political methods, e.g., “the squeaky wheel gets the grease”), improvement and further iteration should nonetheless continue.

A review of key developments in the priority-setting literature provides insight for evaluating the PHSA process and, with the suggestions from the decision-makers reported above, helped identify areas for improvement and refinement. A recent paper by Gibson et al. (2005a), building on initial work by Daniels and Sabin (1998), outlines a number of case studies on priority setting conducted in Canada. Of central importance is the notion of process fairness, which can be assessed against five criteria: whether decisions are made on the basis of reasons (i.e., evidence, principles, values) that fair-minded people can agree upon; whether decisions and rationales are publicly accessible; whether there are opportunities to re-visit and challenge decisions; whether there is a regulatory mechanism to enforce the first three conditions; and whether efforts have been made to ensure broad participation and minimization of power differences. These criteria form a conceptual framework for the evaluation of priority-setting processes (Gibson et al. 2005b).

For example, while relevant criteria were used in the PHSA process and data were collected related to each criterion, the Executive Committee should have developed a clearer rationale in determining the final top three ranked programs. Also, in future years, the PHSA may wish to place more emphasis on effectively communicating the goals, criteria, processes and decisions to internal and external stakeholders, and should develop a consultation process with a broad set of stakeholders when formalizing the criteria. Further, the Executive Committee should develop a formal review process to resolve any disputes that may arise, and form an iterative review process to decide how to address funding requests that arise during the budget cycle. Finally, efforts should be undertaken to evaluate subsequent prioritization processes on a continuing basis.

This work can also be set in the context of previous work that has taken an economic perspective to priority setting (Donaldson 1995; Peacock 1998; Astley 2001; Mitton et al. 2003; Donaldson et al. 2005). The major contribution from this body of work, in relation to the PHSA process, would be to consider the concept of re-allocating resources at the margin. The basic process would involve ranking options for disinvestment alongside proposals for service growth. Once new resources are exhausted, the question becomes whether additional benefit can be derived through shifting or re-allocating resources within the current mix of funding.

In theory, such re-allocation should occur until the cost–benefit ratios across programs are equal (Mitton and Donaldson 2004). In practice, information limitations prevent full assessment of relative benefit, but the principle of marginal analysis

should nonetheless be considered by all organizations endeavouring to set priorities. In resource-rich environments, there may never be an imperative to disinvest from existing programs, but with current fiscal challenges, the “wish list” of most organizations will likely far exceed available resources. Thus, in reality, decision-makers have a built-in incentive to release resources from within (i.e., it’s the only way proposed programs will be funded).

A further extension of the activity undertaken by the PHSA, again drawing on work by health economists, would be to examine alternative methods of benefit scoring. In particular, economic techniques such as discrete choice experiments (DCEs) and willingness to pay have been used with some success to gauge program benefits (Olsen and Donaldson 1998; Farrar et al. 2000). Although academic expertise may be required to apply these methods, the incremental resources to apply a technique like DCE are actually not that great. The first step in such a process is to identify and define the criteria and levels within those criteria. Precedents for applying such an approach within an actual priority-setting process in Canada can be found with the Calgary Health Region (Ryan et al. 2005), although more research is needed to assess whether decision-makers will readily accept and utilize more technical benefit-scoring approaches. Further, commercially available software, based on hierarchical modelling, can help identify the optimal bundle of program choices for the resources available.

As the PHSA moves forward with prioritization of new services, and perhaps ultimately chooses to engage in setting priorities across agencies through re-allocating resources at the margin, several lessons can be highlighted. First, the lasting sustainability of an explicit process will rest on the “credible commitment” of the organization to the process (Jan 2003), along with a willingness by senior decision-makers to be consistent in its application and in their ability to stand up to political pressures once decisions are made. Second, a transparent, evidence-driven process that draws upon a well-defined and well-communicated set of values will in itself contribute to the perception of fairness and thereby foster buy-in across stakeholder groups (Gibson et al. 2005). Third, as decision-makers in the PHSA themselves have indicated, education with internal stakeholders is an important part of gaining cultural acceptance for explicit approaches to priority setting. A related issue is the need for agreement on the role of both the public and physicians (Mitton and Donaldson 2004).

Further specific points can be highlighted from this exercise, such as the need for earlier integration of financial personnel to ensure accuracy in cost projections; due diligence in outlining the systemwide impact of program investments; and the need for more detailed evaluation, both in tracking the outcomes of investment decisions against the defined criteria and in the fairness and utility of the process itself. Both qualitative and quantitative methods, over time, can provide insight into these issues.

As this case study reports on a prioritization process from a single health authority, its generalizability may be limited. As well, the evaluation insights provided by deci-

sion-makers were not formally analyzed, but rather simply documented and reported. Nonetheless, the underlying issue that this study addresses is familiar to every health authority in the country: given limited resources, decision-makers must make choices about which services to fund and which not to fund. The dilemma of resource scarcity is universal, and the organizational context will affect the decisions and processes utilized. Thus, the indicators employed in this study will likely be useful to others embarking on similar work elsewhere. Drawing insight from the literature also helps to round out the opinions presented by our decision-makers.

Finally, what can be made of the issue of having three different rankings from three different scoring methods? In actuality, the rankings were quite close, save two important differences. The Pediatric Oncology Network scored the highest on the cost–benefit ratio, with a relatively low overall benefit score and very low relative cost. If the Executive Committee wanted to maximize value for dollars spent, this would seem the best choice. However, the committee likely did not pursue this option vis-à-vis others, owing to the low benefit score. In fact, the Executive Committee did not use the cost–benefit scores for two reasons: (1) the committee held that prioritization decisions should be based on the benefit of the programs, not the costs, and (2) the cost–benefit ratios as presented were driven by the cost of the program, owing to the manner in which they were calculated. As discussed above, consideration of program size should alleviate this second challenge in future iterations.

Further, the Alcohol and Drug Treatment program received the highest overall benefit score but ranked second lowest on cost–benefit and relatively low on the “gut-feel” score. The high cost of this program for the relative benefit achieved was an obvious factor in the decision to exclude it from the top three ranked options. The take-home message here is that the highest-cost and lowest-benefit options are unlikely to receive funding, a point that was elucidated through the scoring methods used in this exercise.

While some might argue that a formal process is unnecessary owing to the close match between the overall benefit scores and the “gut-feel” ranking, in actuality both this set of decision-makers, as evidenced in the survey results outlined above, and the literature on fair process, also cited above, clearly indicate that a shift towards a more transparent, evidence-based process is warranted. Results from a more formal, evidence-based process can lend credibility to decisions that previously would have been arrived at through less rigorous activity.

## Conclusion

The prioritization process undertaken by the Executive Committee of the PHSA for the 2005/06 planning cycle was by no means perfect. Specific concerns were raised over how well the criteria captured the concept of benefit across such a diverse set of programs, and those outside the process may well question that the final top three

rankings closely reflected the “gut-feel” scores. On the other hand, the process does reflect the real-world complexities faced by a group of senior managers trying to make sense of a wide range of information from multiple sources on a tight timeline.

The literature would suggest greater attention to process fairness, and indeed, an economic perspective would indicate the need to release resources from one area to invest in another, thereby improving the use of resources against the given criteria. Importantly, however, the key is to take things one step at a time. Priority setting as a management process needs to adapt to the context, and change can thus be slow. The process described here is clearly more transparent and more evidence-based than activity carried out previously in the PHSA. In time, with proper evaluation, the PHSA can continue to improve its priority setting, thereby making strides towards getting the most out of the limited resources available.

To view appendix, please visit this url: <http://www.longwoods.com/product.php?productid=18325&cat=449&page=1>

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Correspondence may be directed to: Craig Mitton, PhD, Faculty of Health and Social Development, University of British Columbia Okanagan, 3333 University Way, Kelowna, BC V1V 1V7; tel.: 250-807-8707; fax: 250-805-8505; email: [craig.mitton@ubc.ca](mailto:craig.mitton@ubc.ca).


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# Health Status and Healthcare Use Patterns of Rural, Northern and Urban Manitobans: Is Romanow Right?

État de santé et habitudes de recours  
aux services de soins de santé des Manitobains  
des zones rurales, nordiques et urbaines :  
Romanow a-t-il raison?



by PATRICIA J. MARTENS, PHD

*Manitoba Centre for Health Policy, Department of Community Health Sciences  
University of Manitoba, Winnipeg, MB*

THE NEED TO KNOW TEAM

*A project funded through Canadian Institutes of Health Research (CIHR) from 2001–2006,  
comprising high-level planners from each of Manitoba's non-Winnipeg regional health author-  
ities, Manitoba Health and MCHP researchers*

RANDY FRANSOO, MSC

*Manitoba Centre for Health Policy, Department of Community Health Sciences  
University of Manitoba, Winnipeg, MB*

CHARLES BURCHILL, MSC

*Manitoba Centre for Health Policy, Department of Community Health Sciences  
University of Manitoba, Winnipeg, MB*

ELAINE BURLAND, MSC

*Manitoba Centre for Health Policy, Department of Community Health Sciences  
University of Manitoba, Winnipeg, MB*

## Abstract

**Objective:** To compare health status and healthcare services use of rural, northern and urban Manitobans.

**Method:** Using anonymized administrative claims data derived from the Population Health Research Data Repository housed at the Manitoba Centre for Health Policy, four Manitoba regions were compared – Winnipeg, Brandon, Rural South and North – for 1996/97–2000/01. Indicators include mortality and morbidity, ambulatory physician visit and specialist consultation rates, prevention/screening rates, selected surgery rates (cardiac catheterization, coronary artery bypass graft surgery, hip replacement) and “discretionary” surgery rates (tonsillectomy/adenoidectomy, Caesarean section, hysterectomy). Rates were annualized, directly standardized to the 1996 provincial population, and statistically tested for differences among the regions using Hotelling’s  $T^2$  statistic.

**Results:** Mortality and morbidity are high in the North, but the Rural South is average (except for high rates of injury mortality and stroke). Rural South and North have low ambulatory physician visits and specialist consultation rates, but high hospitalization rates compared to Brandon and Winnipeg. In prevention/screening rates, Rural South is variable and the North is low. For surgery rates, Rural South is variable, North is average, Brandon has below-average surgical rates but high rates of discretionary procedures, and Winnipeg has high surgical rates but low discretionary procedures. Thus, “urban” is not necessarily synonymous with good health and better access to services, nor is “rural” or “remote” synonymous with poor health and inadequate healthcare.

## Résumé

**Objectif :** Comparer l'état de santé et le recours aux services de soins de santé des Manitobains des zones rurales, nordiques et urbaines.

**Méthode :** À l'aide de données administratives anonymisées tirées du *Population Health Research Data Repository* du Manitoba Centre for Health Policy, on a comparé quatre régions du Manitoba, soit celles de Winnipeg, de Brandon, du Sud rural et du Nord, pour la période de 1996-1997 à 2000-2001. Les indicateurs comprennent la mortalité et la morbidité, les taux de visites ambulatoires de médecins et de consulta-

tion de spécialistes, les taux de dépistage et de prévention, ainsi que la fréquence de certaines chirurgies (cathétérisme cardiaque, pontage aortocoronarien, remplacement de hanche) et de chirurgies non urgentes (amygdalectomie/adénoïdectomie, césarienne, hystérectomie). Les taux ont été annualisés, normalisés selon l'âge de la population provinciale en 1996 et testés pour déceler les différences statistiquement significatives avec  $T^2$  de Hotelling.

**Résultats :** Les taux de mortalité et de morbidité sont élevés dans le Nord, mais moyens dans le Sud rural (à l'exception des accidents vasculaires cérébraux et des taux élevés de mortalité imputable aux blessures). Le Sud rural et le Nord présentent des taux faibles de visites ambulatoires de médecins et de consultation de spécialistes, mais des taux d'hospitalisation élevés comparativement à Brandon et à Winnipeg. Quant aux taux de prévention et de dépistage, ils sont variables dans le Sud rural et faibles dans le Nord. Pour ce qui est des taux de chirurgie, ils sont variables dans le Sud rural et moyens dans le Nord; Brandon, par contre, affiche des taux de chirurgie en deçà de la moyenne mais des taux élevés de procédures non urgentes, tandis que Winnipeg présente des taux élevés de chirurgie mais des taux faibles de procédures non urgentes. Ainsi donc, « urbain » n'est pas nécessairement synonyme de bonne santé ou de meilleur accès aux services, pas plus que « rural » ou « région éloignée » n'est synonyme de mauvaise santé ou de soins de santé inadéquats.

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**T**HE ROMANOW REPORT (COMMISSION ON THE FUTURE OF HEALTH CARE 2002: 159), a landmark report on the Canadian healthcare system, states that “people in rural and remote communities have poorer health status than Canadians who live in larger centres. Access to healthcare also is a problem, not only because of distances, but because these communities struggle to attract and keep nurses, doctors and other health care providers.” The purpose of this paper is to examine the truth of this statement. Do people living in rural and northern Manitoba reflect Romanow's picture compared to people living in the two main urban centres of Manitoba, Winnipeg (the capital) and Brandon?

The overall health status of Canadian rural residents has been compared with those who live in urban areas. Statistics Canada (2001) data show that predominantly rural populations fare worse than predominantly urban populations. Life expectancy is lower in rural areas, whereas total mortality, circulatory and cancer-related deaths, and unintentional injury-related deaths are all higher. The Canadian Community Health Survey (CCHS) 2000–2001 also shows poorer self-reported health in rural and remote areas, as well as underservicing of healthcare needs (Mitura and Bollman 2003). These survey data are measuring self-perceived health status and self-reported access to healthcare.

An alternative way to measure both health status and healthcare use is through administrative claims databases. The underlying assumption of equitable healthcare is that it reflects health status: the “less healthy” a regional population, the higher the need for healthcare services. In this study, the concept of overall regional health status is measured by the premature mortality rate (PMR), or age- and sex-adjusted rate of death before the age of 75 years. PMR is considered the best single measure to reflect the health status of a regional population, being highly associated with morbidity and with self-rated health (Carstairs and Morris 1991; Eyles et al. 1991; Eyles and Birch 1993; Reid et al. 2002) as well as with socio-economic risk factors (Martens et al. 2002a). As this association implies that populations with high PMR have poorer health status (i.e., are “less healthy”), one would expect to see higher rates of health services use by these populations under a universal healthcare system.

Researchers have long observed geographical variation in rates of health services use, including surgical procedures (Wennberg et al. 2002; Roos and Roos 1982; Guadagnoli et al. 2001; Gentleman et al. 1996; Birkmeyer et al. 1998). The difficult question then becomes, “what is the right rate?” Gentleman et al. (1996) ranked 39 surgical procedures in order of variation of rates by the degree to which the procedure was deemed “discretionary.” They defined “discretionary” as those procedures that may not be necessary at all, where there is no general agreement about indications (such as hysterectomy for non-malignant conditions of the uterus), or those for which alternative, non-surgical treatments are available. The 13 procedures with the greatest variation were all primarily “discretionary,” whereas those with the lowest variation were primarily “non-discretionary.” Tonsillectomy with adenoidectomy, hysterectomy and Caesarean section surgeries (used in this study) were within the top six in terms of the index of variation. Birkmeyer et al. (1998) also investigated the variation in common surgical rates and rated coronary artery bypass graft surgery and total hip replacement as having “intermediate” variation profiles, noting that these are among the conditions where doctors may disagree about some but not all diagnostic or treatment decisions. In contrast, those procedures having the highest variation reflect areas of substantial disagreement about diagnosis and treatment.

The Manitoba Centre for Health Policy (MCHP), an academic unit of the Department of Community Health Sciences, Faculty of Medicine, University of Manitoba, undertakes health services research based on anonymized administrative claims data used in the universally provided provincial health insurance plan. The results presented in this paper represent findings from research conducted by *The Need to Know* Team. This Team is funded by the Canadian Institutes of Health Research (CIHR) and comprises MCHP researchers, high-level planners from each of the non-Winnipeg regional health authorities (RHAs) of Manitoba and Manitoba Health representatives. One goal of the Team is to create new knowledge of relevance to rural and northern regions through collaborative research projects. The first was an

RHA “indicators atlas” to facilitate RHA planning and decision-making (Martens et al. 2003). For purposes of this paper, selected indicators from this report were compared to determine whether people living in rural and northern Manitoba experience poorer overall health, lower utilization of physicians and hospitals and less access to services than people living in the two main urban centres of Winnipeg and Brandon. In other words, is Romanow “right” in assuming poorer health and lack of services in rural and remote areas of Canada?

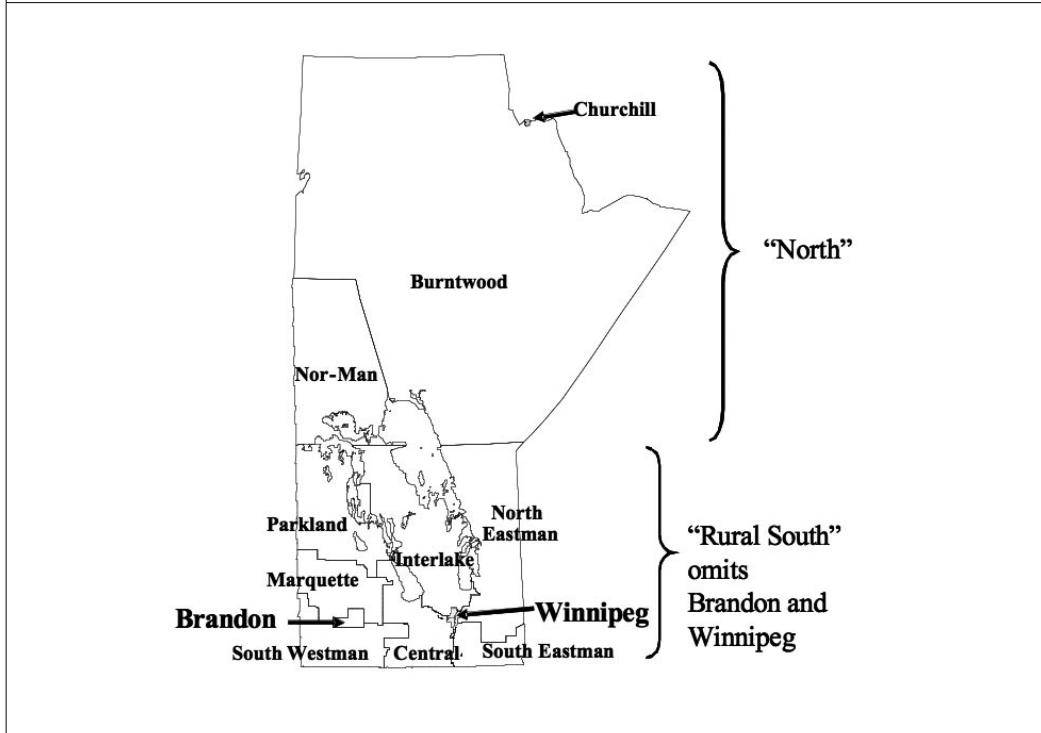
## Methods

### Geographical regions and population counts

This study included the Manitoba health registry population for fiscal years 1995/96–2000/01 ( $n=1,148,699$  in 2000). The 11 non-Winnipeg RHAs each have a Board of Directors overseeing the health services of the region (see Figure 1). Each RHA has remained intact since 1997, with the exception of Marquette and South Westman, which merged to become Assiniboine RHA in 2002. For this paper, rates are reported at the provincial level and by four areas: Winnipeg RHA (population 649,012), Brandon RHA (47,337) and the two aggregate areas called Rural South and North. The Rural South comprises the following RHAs: South Westman (34,029), Central (97,865), South Eastman (54,427), North Eastman (39,369), Interlake (74,944), Marquette (37,515) and Parkland (42,909). The North comprises Nor-Man (25,233), Burntwood (45,051) and Churchill (1,008) RHAs, all regions that are north of 53 degrees latitude.

Various definitions of rural, urban and remote exist in the literature. Many studies comparing health status and healthcare utilization across Canada use the “MIZ” (Metropolitan Area and Census Agglomeration Influence Zones) classification of census metropolitan area and census agglomerations (duPlessis et al. 2002). Although these may facilitate comparison from a different lens, the distribution of such zones in Manitoba has somewhat debatable face validity. Some census subdivisions in rural farming areas within relative proximity to the two urban centres of Winnipeg and Brandon are called “weak” or “no influence.” Other census subdivisions in the northern remote areas of Manitoba show “no influence” close to the city of Thompson, yet “moderate influence” in a large portion of the “wilderness area” of the north. This could potentially skew the data in ways that could dilute the effect of “rural” and “remote” in terms of geographical access to healthcare services. Thus, we are using the RHA divisions outside the two major urban centres of Winnipeg and Brandon to describe geographical locations as either Rural South or North.

FIGURE 1. The twelve RHAs of Manitoba, showing the comparison groups of North, Rural South, plus the two urban centres of Winnipeg and Brandon



### Sources of data for the research

Anonymized individual-level records of all residents of Manitoba (including First Nations peoples) were used for this study and were obtained from the Population Health Research Data Repository housed at MCHP. This Repository contains such databases as medical billing claims, hospital discharge abstracts and vital statistics (mortality) linkable at the individual level. All files are de-identified, with names and addresses removed prior to use by MCHP, but the geographical location and demographic information such as age and sex are available. Ethical approval for the study was obtained from the Health Research Ethics Board of the Faculty of Medicine, and was reviewed by the Health Information Privacy Committee of Manitoba.

### Indicators and statistical tests for comparison

Various indicators were selected to represent regional mortality, morbidity and health-care use (prevention/screening, physician and hospital use, surgical procedure rates).

All rates are population-based, with total service use divided by total regional population, whether people used the service or not. As well, all service use is attributed back to the patients' region of residence, no matter where the service took place. For example, a northern resident hospitalized in Winnipeg would contribute to the "North" hospitalization rate. Rates are age- and sex-adjusted using direct standardization to the provincial population as of December 31, 1996. Rates are "annualized" by averaging over the number of years in the analyses (from one to five years, depending upon the indicator). Standardized rates by region are compared using Hotelling's  $T^2$  statistic (Carriere and Roos 1997), with 99% confidence limits to control for multiple testing. Data management, programming and analyses were performed using SAS<sup>®</sup> software. Each indicator is also graphically compared to the provincial average as a percentage difference.

Age- and sex-adjusted mortality measures were derived from Vital Statistics for calendar years 1996–2000. Total mortality is the number of deaths per thousand; injury mortality is the number of deaths per thousand due to all categories of injury (using the ICD-9-CM coding system). The premature mortality rate (PMR) is the number of deaths per thousand aged 0 through 74. Potential Years of Life Lost (PYLL) is number of years of life "lost" per thousand aged 1 through 74. Life expectancy calculations are based on the methodology reported by Health and Welfare Canada (1992), but this statistic does not yield confidence intervals.

Age- and sex-adjusted morbidity measures include diabetes, stroke, acute myocardial infarction (AMI) and cancer. Measures of morbidity based on administrative claims data depend upon contact with the healthcare system. Thus, lack of access to providers (such as could be experienced in rural or remote settings) could potentially bias the estimate of morbidity and underestimate the prevalence. This bias could be especially problematic for the definition of diabetes, which may be influenced by ambulatory physician visits (see definition below), in areas served by salaried physicians. However, validation of the administrative database definition with self-reports demonstrates a high degree of validity for the diabetes algorithm, even in remote areas and First Nations communities (Lix et al. 2006; Martens et al. 2002b). Most family/general practice ambulatory physician visits in Manitoba are captured in the Repository through fee-for-service billings or through salaried physicians' "shadow billings." As well, virtually all contact with specialists, any contact with hospitals and all mortality rates (derived from Vital Statistics data) are complete for all residents of Manitoba, no matter where they live.

The diabetes treatment prevalence is the percentage of persons aged 20 through 79 years who, over a three-year period (1998/99–2000/01), had a diagnosis of diabetes (ICD-9-CM 250) in two or more physician visits (including specialist visits) or one hospitalization. The rates of AMI and stroke are the number of hospitalizations for AMI or stroke experienced per thousand aged 20+, for the years 1996/97–2000/01. Because an individual may suffer more than one heart attack or stroke, each

is counted as a separate event. Cancer incidence is the number of diagnoses of new cancer cases for 1996 through 2000 (including “in situ” tumours) per thousand residents (using ICD-9-CM codes 140–208, 230–239, excluding 173). Metastases are not included as incident cases, and only new primary cancers are counted. Tumour counts were provided by CancerCare Manitoba from its cancer registry, with statistical analyses by MCHP.

Measures of preventive and screening health services include immunizations (two-year, seven-year, adult influenza), cervical cancer screening tests (Papanicolaou, or “Pap,” tests) and mammography screening rates. The two- and seven-year childhood immunizations are the percentage of two-year-olds (born 1997/98–1998/99) and seven-year-olds (born 1992/93–1993/94) with a complete set of recommended immunizations, for children who have lived in Manitoba the entire period. The adult influenza (“flu”) immunization rate is the age- and sex-adjusted percentage of adults aged 65+ who received a flu shot during 2000/01. The breast cancer screening rate is the age-adjusted percentage of women aged 50–69 who had at least one mammogram in the two-year period 1999/00–2000/01 (as recommended by the Manitoba Breast Screening Program). The cervical cancer screening rate is the age-adjusted percentage of women aged 18–69 having at least one Pap test within a three-year period (1998/99–2000/01).

Hospitalizations and short-stay days are age- and sex-adjusted and are attributed back to the region of residence of the patient no matter where the hospitalization occurred. Hospital separation rates are the total number of inpatient and surgical outpatient hospitalizations per thousand residents. A hospital separation occurs any time a patient leaves because of discharge, transfer, sign-out against medical advice or death. Short-stay hospital days refer to the number of days used per thousand residents for stays less than 30 days. Any patient who stayed in hospital more than 365 days was assigned a length of stay of 365 days, to prevent a few cases from distorting the results.

Ambulatory physician visits include almost all contacts with physicians, excluding only those occurring while a person is an inpatient of a hospital. Visits to both general/family practitioners (GP/FP) and specialists are included. Contacts with fee-for-service physicians are reimbursed through Manitoba Health’s billing system. Salaried physicians are expected to submit “shadow bill” evaluation claims with diagnoses for the visit, but their salary does not depend upon these claims, resulting in possible underreporting. Moreover, nurse practitioner contacts are not recorded in the billing claims. Approximately 85% of salaried physician visits are captured in the claims data, but the percentage of salaried family physicians varies substantially by region: 7% in Winnipeg, 4% in Brandon and 38% in the rest of the province (Katz et al. 2004; Martens et al. 2005).

The specialist consultation rate, defined as the first visit to the consulting physician, is considered the best indicator of access to specialist care (Roos et al. 1999).

Ambulatory consultations occur when a client is referred by one physician to another because of the complexity, obscurity or seriousness of an illness, or because of a request for a second opinion. Most consultations are provided by specialists and are considered complete in the claims data.

Surgical indicators include age- and sex-adjusted rates of cardiac catheterization (1998/99–2000/01) and coronary artery bypass graft surgery (CABGS) as well as total hip replacement surgery (1996/97–2000/01). In Manitoba, these surgeries may be less accessible to those in rural or remote areas because tertiary care services are provided only in Winnipeg. “Discretionary” surgical procedures have been the subject of critical reviews because of potential overuse and wide variation in rates (Brownell 2002; Eldenburg and Waller 2001; Gross et al. 1999). The three “discretionary” procedures reported in this paper are tonsillectomy/adenoidectomy (age- and sex-adjusted rate per thousand aged 0–14 years, 1998/99–2000/01), Caesarean section (age-adjusted percentage of all births delivered by C-section, 1996/97–2000/01) and hysterectomy (age-adjusted rate per thousand women aged 25+, 1996/97–2000/01).

## Results

Table 1 shows rates of the indicators for the Rural South, North, Winnipeg, and Brandon compared to the provincial rate. Figures 2 through 4 show area indicators as percentage differences from the provincial average. Indicator rates for each RHA are available separately online at MCHP’s website ([www.umanitoba.ca/centres/mchp/](http://www.umanitoba.ca/centres/mchp/)) (Martens et al. 2003).

In Figure 3, ambulatory physician visit and specialist consultation rates are lower in the Rural South and the North compared to urban centres. However, one of the most remote RHAs within the North – Churchill – is an anomaly, with higher physician visit rates (5.43 visits per person per year, 99% CI 4.89–6.03) and specialist consultation rates (0.47 visits per person per year, 99% CI 0.39–0.57) than either the Manitoba average or the urban areas (Martens et al. 2003). Less than half (49.4%) of Churchill RHA residents’ visits to specialists in 2000/01 occurred in Winnipeg, in contrast to the two other northern RHAs (Burntwood 82.3%; Nor-Man 90.2%).

Mammography screening and Pap test percentages are shown in Table 1. However, it is also important to note changes over time. Mammography screening rates increased from 47.5% to 67.2% in the Rural South, from 25.8% to 54.7% in the North and from 52.1% to 60.1% in the urban centre of Winnipeg during the period from 1995/96–1996/97 to 1999/00–2000/01. Pap smear rates for cervical cancer screening over the two periods from 1995/96 to 2000/01 showed little change: Rural South (64.4% to 65.2%); North (51.6% to 51.0%); Winnipeg (71.5% to 72.4%); and Brandon (71.0% to 73.9%).

**TABLE 1. Age- and sex-adjusted rates of mortality, morbidity, health services use and selected surgical procedures for Winnipeg, Brandon, Rural South, North compared to the Manitoba average**

	ANNUALIZED RATES (99% CI)				
INDICATOR	RURAL SOUTH	BRANDON	WINNIPEG	NORTH	MANITOBA OVERALL
<b>MORTALITY INDICATORS (1996-2000)</b>					
Premature Mortality Rate (deaths per thousand aged 0-74 years)	3.23 (3.12-3.33)	3.20 (2.91-3.53)	3.27 (3.19-3.35)	4.71* (4.33-5.13)	3.32 (3.26-3.38)
Total mortality (deaths per thousand)	7.97 (7.82-8.12)	7.86 (7.43-8.33)	7.88 (7.76-8.00)	9.94* (9.29-10.63)	7.99 (7.90-8.08)
PYLL males (years lost per thousand age 1-74)	67.2 (63.3-71.4)	59.5 (50.0-70.8)	60.0* (57.3-62.9)	105.0* (93.9-117.6)	65.5 (63.3-67.8)
PYLL females (years lost per thousand age 1-74)	37.3 (34.4-40.4)	32.6 (26.2-40.7)	39.4 (37.2-41.8)	65.8* (56.9-76.0)	40.1 (38.4-41.9)
Injury mortality (deaths per thousand)	0.54* (0.50-0.59)	0.48 (0.37-0.61)	0.41* (0.38-0.44)	0.98* (0.82-1.16)	0.49 (9.47-0.52)
Life expectancy at birth males (years)†	75.9	76.1	76.3	71.7	75.9
Life expectancy at birth females (years)†	81.7	82.0	81.3	77.7	81.3
<b>MORBIDITY INDICATORS</b>					
Cancer (per thousand) 1996-2000	5.46* (5.33-5.60)	6.40* (6.00-6.83)	5.66 (5.55-5.76)	5.17 (4.74-5.64)	5.61 (5.53-5.69)

Table 1 continued

INDICATOR	ANNUALIZED RATES (99% CI)				
	RURAL SOUTH	BRANDON	WINNIPEG	NORTH	MANITOBA OVERALL
Diabetes (%) 1998/99-2000/01	5.43* (5.32-5.54)	5.39 (5.08-5.71)	5.30* (5.18-5.35)	11.10* (10.63-11.52)	5.60 (5.50-5.63)
AMI (per thousand) 1996/97-2000/01	2.30 (2.20-2.40)	2.70* (2.39-3.04)	2.08* (2.01-2.16)	2.90* (2.52-3.33)	2.22 (2.16-2.28)
Stroke (per thousand) 1996/97-2000/01	1.97* (1.88-2.06)	1.60 (1.41-1.90)	1.50* (1.44-1.57)	2.46* (2.10-2.89)	1.71 (1.66-1.77)
<b>PREVENTION AND SCREENING</b>					
2-year-old complete immunizations (% children born 1997/98-1998/99)	70.9 (69.7-72.1)	73.0 (69.5-76.7)	73.7* (72.7-74.6)	55.0* (52.7-57.4)	70.7 (70.0-71.4)
7-year-old complete immunizations (% children born 1992/93-1993/94)	77.0* (75.9-78.2)	77.0* (73.7-80.5)	75.1* (74.6-76.0)	50.2* (47.9-52.6)	73.3 (72.6-73.9)
Adult flu immunizations (%) 2000/01	52.7* (52.3-53.3)	58.9* (57.3-60.4)	56.2* (55.8-56.7)	40.4* (38.3-42.7)	54.7 (54.4-55.0)
Mammography screening (% of women aged 50-69 years) 1999/00-2000/01	67.2* (66.6-67.9)	71.7* (70.0-73.5)	60.1* (59.6-60.6)	54.7* (52.7-56.8)	62.8 (62.4-63.1)
Pap tests (% of women aged 18-69 years) 1998/99-2000/01	65.2* (64.8-65.5)	73.9* (73.0-74.8)	72.4* (72.2-72.6)	51.0* (50.1-51.9)	69.0 (68.9-69.2)

Health Status and Healthcare Use Patterns of Rural, Northern and Urban Manitobans

Table 1 continued

INDICATOR	ANNUALIZED RATES (99% CI)				
	RURAL SOUTH	BRANDON	WINNIPEG	NORTH	MANITOBA OVERALL
<b>PHYSICIAN AND HOSPITAL VISITS</b>					
Ambulatory physician visits (per person) 2000/01	4.29* (4.27-4.31)	5.08* (5.02-5.14)	5.10* (5.08-5.12)	4.45* (4.39-4.52)	4.78 (4.77-4.80)
Specialist consultations (per person) 2000/01	0.231* (0.229-0.234)	0.291* (0.283-0.298)	0.295* (0.293-0.298)	0.236* (0.229-0.243)	0.271 (0.269-0.272)
Hospitalizations (per thousand) 1999/00-2000/01	199.8* (197.7-201.9)	162.4* (157.5-167.4)	141.5* (140.4-142.7)	275.4* (267.0-284.1)	169.1 (168.0-170.2)
Short stay days (per thousand) 1999/00-2000/01	625.6* (614.17-636.6)	569.2* (541.5-598.3)	413.4* (407.1-419.9)	849.4* (807.3-893.6)	513.9 (508.4-519.6)
<b>CARDIAC AND HIP SURGERIES</b>					
Cardiac catheterization (per thousand) 1998/99-2000/01	2.66* (2.54-2.88)	2.18* (1.86-2.54)	3.11* (3.00-3.22)	2.99 (2.57-3.47)	2.91 (2.83-2.99)
CABGS (per thousand) 1996/97-2000/01	0.65* (0.61-0.70)	0.64 (0.52-0.79)	0.76* (0.72-0.80)	0.73 (0.58-0.91)	0.71 (0.68-0.74)
Hip replacement (per thousand) 1996/97-2000/01	0.72 (0.67-0.78)	0.57 (0.45-0.72)	0.71 (0.67-0.95)	0.63 (0.48-0.83)	0.71 (0.68-0.74)

Table 1 continued

INDICATOR	ANNUALIZED RATES (99% CI)				
	RURAL SOUTH	BRANDON	WINNIPEG	NORTH	MANITOBA OVERALL
<b>DISCRETIONARY PROCEDURES</b>					
Hysterectomy (per thousand women aged 25+) 1996/97-2000/01	5.62* (5.38-5.88)	6.07* (5.40-6.81)	4.54* (4.39-4.71)	4.87 (4.29-5.53)	4.96 (4.83-5.09)
Caesarean Section (% births) 1996/97-2000/01	17.0 (16.3-17.8)	19.2 (17.2-21.5)	17.3 (16.8-17.9)	18.2 (16.9-19.7)	17.4 (17.0-17.8)
Tonsillectomy/adenoid-ectomy (per thousand aged 0-14) 1998/99-2000/01	6.03* (5.65-6.44)	8.61* (7.31-10.15)	4.95* (4.67-5.26)	5.52 (4.83-6.30)	5.52 (5.30-5.75)

\* an asterisk indicates that the rate or prevalence is statistically different (either higher or lower) than the Manitoba average (p<.05)

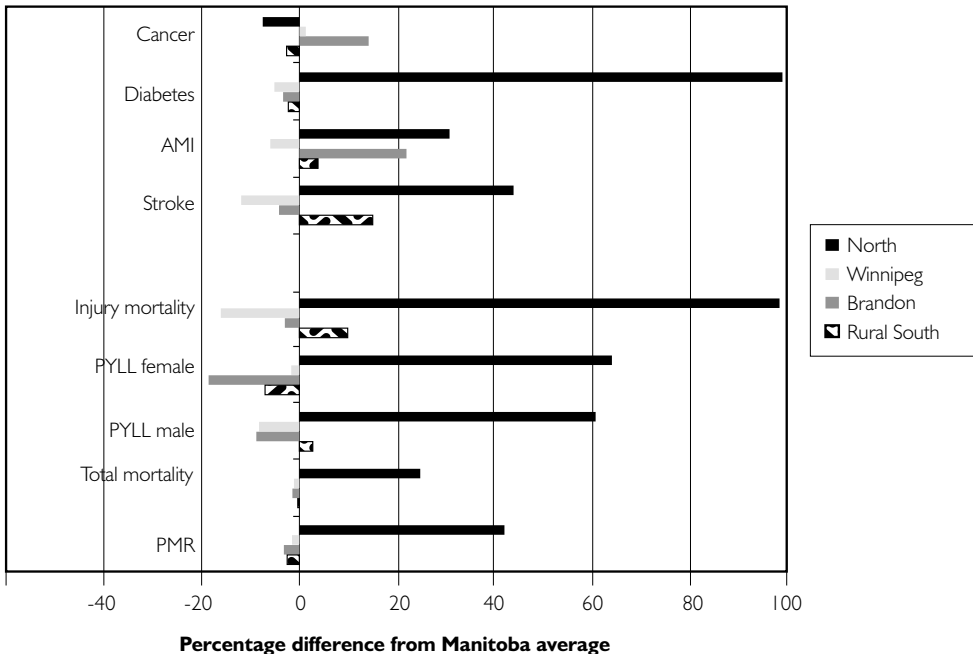
† life expectancy does not have statistical testing associated with it

## Discussion

Use of the healthcare system should be guided by the underlying health status of a regional population – the poorer the health status, the higher one would expect to see the utilization rates of healthcare services. As well, under a universal healthcare system, one would expect to see universal access to whatever procedures are deemed necessary. No matter where a person lives, “necessary” access rates should reflect underlying morbidity.

Comparing the health status of urban, rural and northern Manitobans, the Romanow Report’s generalization of poorer health status for rural and remote Canadians does not necessarily hold true (see Figure 2). In some instances, the Rural South has similar mortality rates (PMR, total mortality, female PYLL), yet lower morbidity (cancer, diabetes) when compared to the urban centre of Winnipeg. On the other hand, Rural South has high injury mortality rates and male PYLL, as well as elevated hospitalization rates for AMI and stroke in comparison to Winnipeg. In

FIGURE 2. Comparison of area rates for mortality and morbidity indicators (North, Winnipeg, Brandon, Rural South) to Manitoba average\*

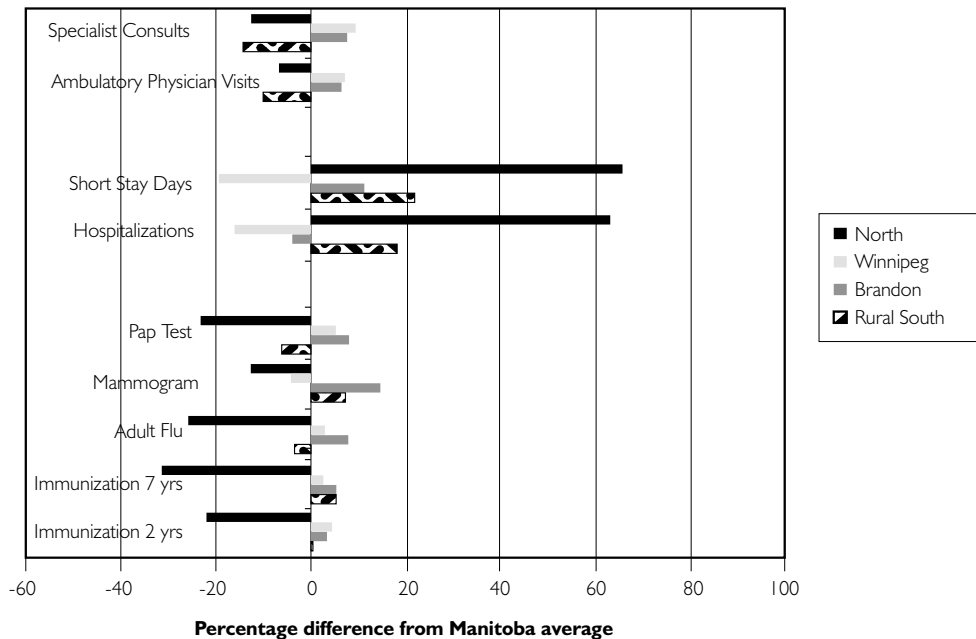


\* The regional rate was divided by the Manitoba rate, multiplied by 100, and subtracted from 100. A difference of 40 means the regional rate was 40% higher than the provincial rate (i.e. 140% of the provincial rate), and -20 means the rate was 100-20, or 80% of the provincial rate.

contrast with the Rural South, the North has dramatically elevated mortality and morbidity rates compared to both urban centres, with the only exception being average cancer rates. Romanow’s comments about poorer health status are valid when concentrating on the most remote areas (i.e., North areas) of Manitoba. One interesting feature is the difference between the two urban centres of Manitoba: although Brandon residents show similar patterns to Winnipeg for most mortality and morbidity measures, they have higher rates of cancer and AMI, but much lower female PYLL. The degree of variation between the two urban centres is just as evident as the variation between Winnipeg and the Rural South.

Do rural and remote people have less access to healthcare services? Ambulatory physician visit and specialist consultation rates are lower in the Rural South and the North compared to urban centres. However, the northern remote RHA of Churchill has higher rates than urban areas, and a much higher proportion of visits to special-

FIGURE 3. Comparison of area rates for health services use indicators (North, Winnipeg, Brandon, Rural South) to Manitoba average\*

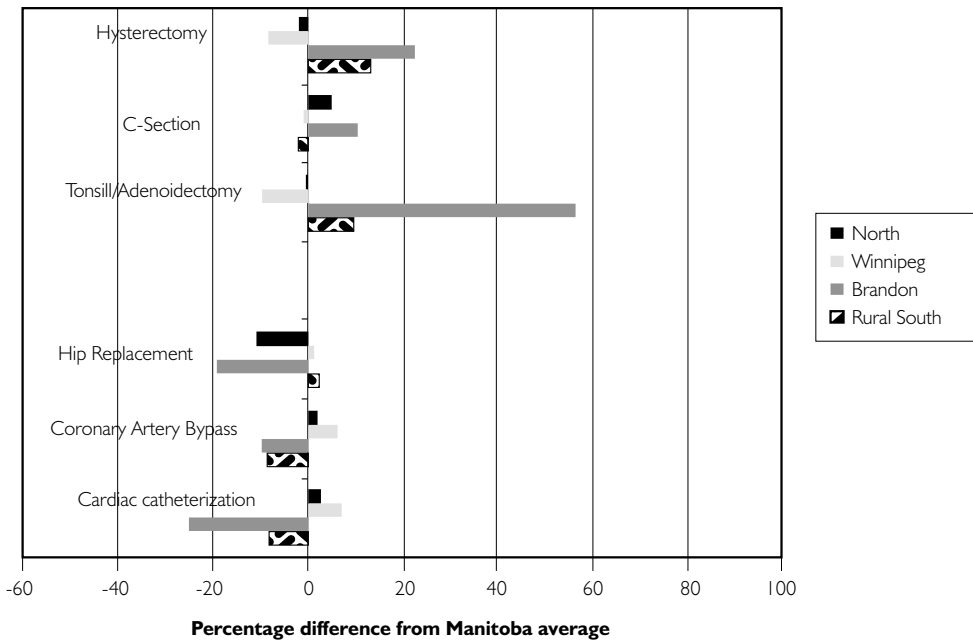


\* The regional rate was divided by the Manitoba rate, multiplied by 100, and subtracted from 100. A difference of 40 means the regional rate was 40% higher than the provincial rate (i.e. 140% of the provincial rate), and -20 means the rate was 100-20, or 80% of the provincial rate.

ists occurring close to home. Churchill physician services (GP/FP and specialists) are provided through contract with the University of Manitoba's J.A. Hildes Northern Medical Unit, where salaried physicians and specialists hired through the unit provide services to very remote communities (both First Nations and others) consistently over the long term. This could be very different from remote communities, where the towns or the RHAs have difficulty hiring and retaining a resident physician for the long term. Different models of care in northern remote areas appear to affect access to services.

Both the Rural South and the North have elevated hospitalizations compared to the urban settings (see Figure 3). This finding may be due in part to concern for people living long distances from medical care (i.e., physicians may err on the side of caution). In the North, the high rate of hospitalization is also appropriate given the underlying morbidity burden. However, previous research has also shown that the hospital beds per capita are high in some parts of the Rural South despite average mortality/morbidity, and this may be another explanation for higher than expected

FIGURE 4. Comparison of area rates for selected surgical and discretionary procedures (North, Winnipeg, Brandon, Rural South) to Manitoba average\*



\* The regional rate was divided by the Manitoba rate, multiplied by 100, and subtracted from 100. A difference of 40 means the regional rate was 40% higher than the provincial rate (i.e. 140% of the provincial rate), and -20 means the rate was 100-20, or 80% of the provincial rate.

hospitalization rates for particular RHAs (Martens et al. 2003; Stewart et al. 2000; Martens et al. 2002c).

Do people in the rural and remote regions of Manitoba have less access to advanced surgeries, as Romanow suggests? Yes and no. Winnipeg experiences high rates of cardiac-related surgeries, but only average rates of hip replacement. Somewhat surprising are the North rates, where cardiac-related surgeries and hip replacement are all similar to the Manitoba average. This may or may not be the “right rate,” given underlying health concerns. High AMI rates in the North suggest the possible need for higher than average cardiac-related surgery rates.

Both the Rural South and Brandon experience lower, or at best, average rates of cardiac and hip procedures compared to Manitoba overall (see Figure 4). In part, this may be due to the overall better health status, but given the high AMI rate in Brandon, one would expect cardiac surgery rates to be high as well. In both the Rural

South and Brandon, discretionary procedure rates (i.e., procedures subject to critical reviews because of potential overuse or disagreement as to indications for surgery) tend to be elevated. In contrast, the cardiac and hip surgery rates tend to be lower than the provincial average. The North has a very different pattern, with average rates of discretionary procedures and cardiac surgery but low hip replacement rates. This finding may be due to access to various types of surgeons and hospitals in different areas of the province. That is, Rural South residents have higher rates of the procedures that can be done in primary and secondary rural hospitals (often by general surgeons), whereas urban residents have higher rates of services done in tertiary hospitals (usually by surgical specialists). The mixed pattern shown for North residents may reflect their more frequent referral to Winnipeg for secondary and tertiary care. More research is needed to understand the complex patterns in the Rural South and North.

Prevention and screening are considered good primary care, and in general, urban dwellers have higher rates. The North, with its high morbidity, shows a troubling pattern of low uptake of prevention and screening programs, which may be due in part to underrecording of these procedures in the health claims data. But it is also due to the fact that services are hard to access by remote dwellers. The Rural South is once again mixed – average to high childhood immunization and mammography, but low adult flu immunization and Pap smears. Notification systems, as well as accessibility, seem to increase the likelihood of rural/remote areas obtaining services. In Manitoba, the Manitoba Immunization Monitoring System is a database of childhood immunizations accessible by all physicians, public health nurses and hospitals to ensure access to records by all healthcare providers. As well, the Manitoba Breast Screening Program has a rural mobile screening unit and notification system for women aged 50–69. The success of this program for the Rural South and the North can be seen in the difference over time, with dramatic changes in mammography screening uptake in the rural and remote areas of the province (from 47.5% to 67.2% in the Rural South, from 25.8% to 54.7% in the North) to bring these rates close to or exceeding the urban rates. In contrast, the lack of a provincial screening program or mobile unit for cervical cancer screening is evident – rates throughout the province have shown very little change over time, and there is a large disparity between urban and rural/remote areas.

Is Romanow right in the case of Manitoba? Yes and no. “Urban” is not necessarily synonymous with superior health and healthcare services, nor is “rural” or “remote” synonymous with inadequate healthcare and poor health. Overwhelmingly, the Romanow view of poorer health status holds true for North residents, but not for residents of the Rural South, where their health status is sometimes better and sometimes worse than their urban counterparts. Distinction needs to be made between “rural” and “remote northern” when statements are made concerning health status.

The Romanow view of poorer access to healthcare is also too broad a generalization. People living in the North have extremely low prevention and screening rates

(even though mammography screening has shown huge increases over time), only slightly lower rates of physician visits (which, if anything, may be undercounted because salaried physician care and nurse practitioner care are undercounted in administrative claims data), very high hospitalization rates, average rates of surgical care and average rates of discretionary surgeries. This is a complex issue – healthcare may be “accessible” by differing degrees for differing services, with prevention/screening healthcare showing major problems, but secondary care such as hospital and surgical access showing reasonable rates. Decision-makers need to use creative approaches to increase accessibility to prevention programs, such as Manitoba’s successful mobile mammography screening units.

Rural South residents show lower rates of contact with physicians and specialists than their urban counterparts, and higher hospitalization rates – in some ways, similar to the North. But the prevention and screening rates for Rural South are quite similar to urban rates (and sometimes better, such as in mammography screening). The real concern lies in cardiac care rates being lower, and discretionary surgery rates higher, than urban rates. Access to care needs to be considered in light of access to appropriate care: does a higher than average discretionary surgery rate indicate too much access to care that is possibly less than optimal? The variation between hip surgery and cardiac surgery is also interesting. It appears as if the Rural South has appropriate access to certain types of specialist surgical care, but lower than appropriate access to other types. This finding could very well indicate problems with referral patterns to certain types of specialists, but needs further research to explore the anomalies. Once again, Romanow’s statement of the lack of access of rural residents needs a qualifier as to the type of healthcare that is being described.

In conclusion, further investigation into different models of care and creative approaches to healthcare services provision may be required in rural and northern areas to ensure equitable access throughout Canada. Rural and northern residents vary in both their health status and access to healthcare services, and overgeneralizations may not be useful in describing their situation.

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Correspondence may be directed to: Dr. Patricia J. Martens, Manitoba Centre for Health Policy, 4th Floor, Room 408, 727 McDermot Ave., Winnipeg, MB R3E 3P5; tel.: 204-789-3791; fax: 204-789-3910; email: Pat\_Martens@cpe.umanitoba.ca.

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