Invited Essay

On Leaving Canada – Reminisces, Remonstrations and Recommendations

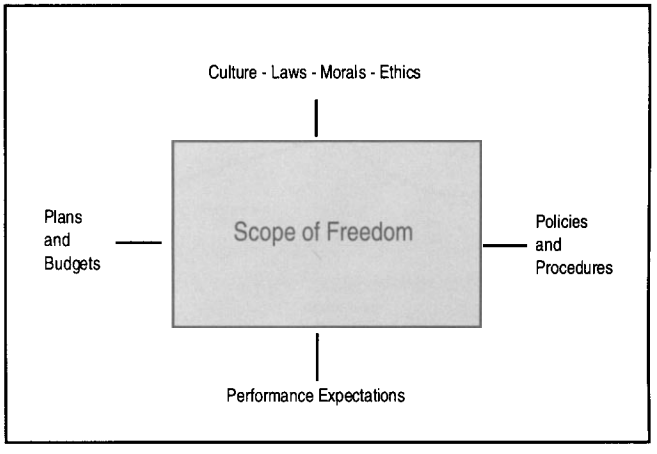
by Peter H. Ellis, CHE

As I come to the end of my 21-year stay in Canada, I wanted to reflect on my time here, assess what I have learned during that time and articulate my fears and aspirations about the future of health care in this rapidly changing environment.

In 1974, I came to Canada from the United Kingdom, disillusioned with its system and the environment in the country at that time. England's national health service had, since 1948, been government owned and operated; however, until 1974 there had been some local hospital autonomy as each group of hospitals was governed through an appointed board that had some degree of latitude. This was particularly true of teaching hospitals where each board of trustees was accountable directly to the Ministry of Health. In 1974, a regionalized model was introduced which, in addition to the existing regional health authorities, created two further layers; that of area health authorities and district health authorities. Thus, the providers were separated from the payer and the government by three layers. Much of this change was initiated to purportedly improve the planning and integration of services; however, the bureaucracy grew exponentially and every detailed aspect of hospital operation became the subject of central fiats. Thus, the ability to meet the needs of one's clients was totally subjugated by the need to defer to the next higher level of the bureaucracy. Similarly, the system and process of management were also prescribed to the extent that local innovation was near impossible. The results were the creation of a system that was atrophied and remote from its customers.

On arriving in Canada, I was impressed with the scope of opportunity and flexibility presented to the provider agencies while maintaining a single payer system. This ensured equity of access to services regardless of the ability to pay and attempted to balance

Figure 1: "Unit President's" Concept



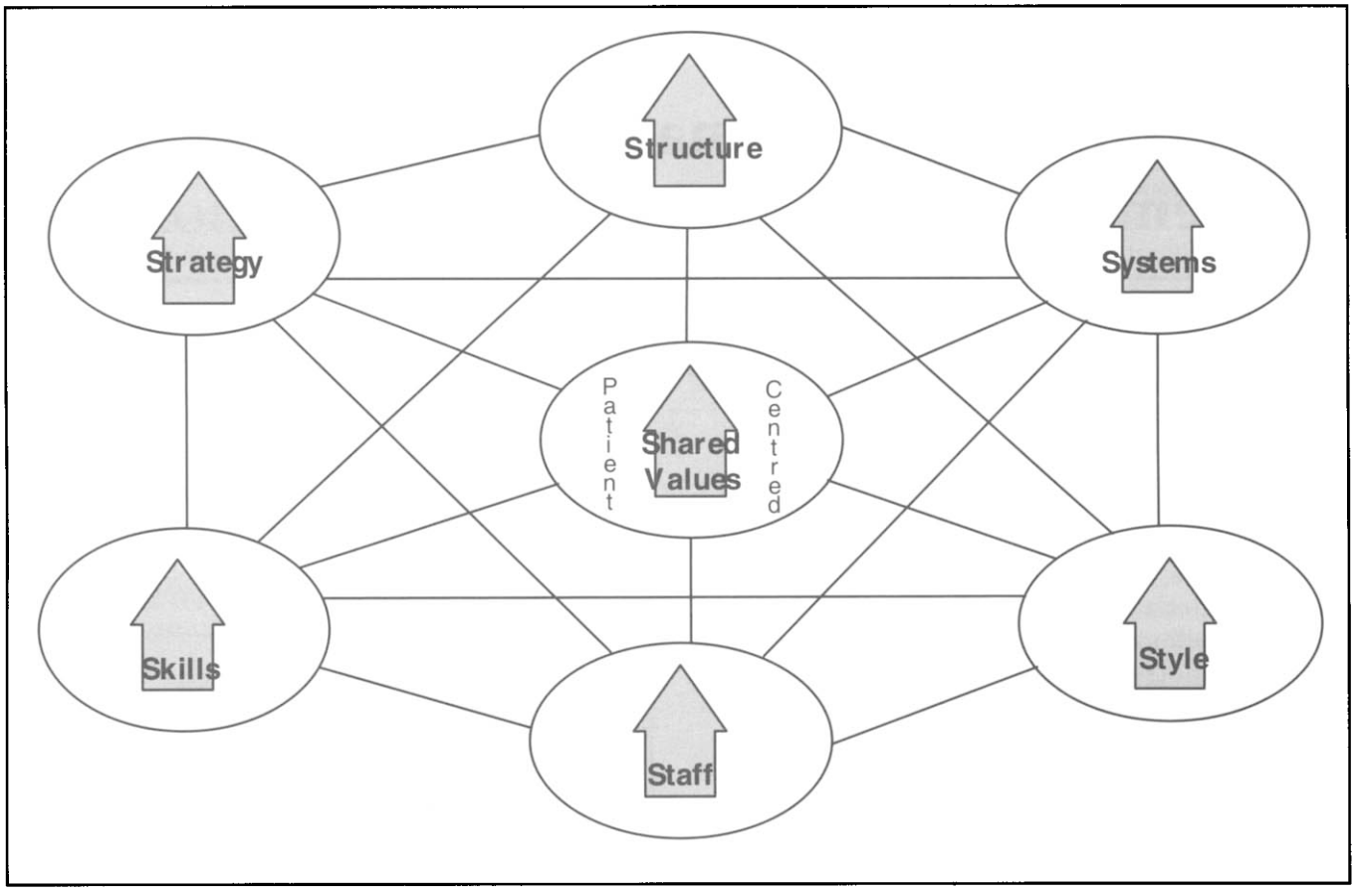
the concept of a national health service with autonomous providers free to demonstrate flexibility and innovation.

As the environment has changed over the years, the existing system has been tested. We are now faced with two major challenges: how do we ensure that the delivery part of the system continues to have autonomous high-performance organizations, and how do we achieve a broader systems approach to effectively coordinate and integrate the component parts into "a health care system?" While this may at first seem to be a paradox, the two concepts are not totally contradictory, and an important first step is recognizing that each has differing values, needs, incentives, skills and organizational requirements. I have chosen to address these as two separate parts in this paper.

Creating high-performance delivery enterprises

Over the years there are moments while reading or during a presentation when you realize that something you had been struggling with that seemed to be intuitively correct now has a basis in a documented

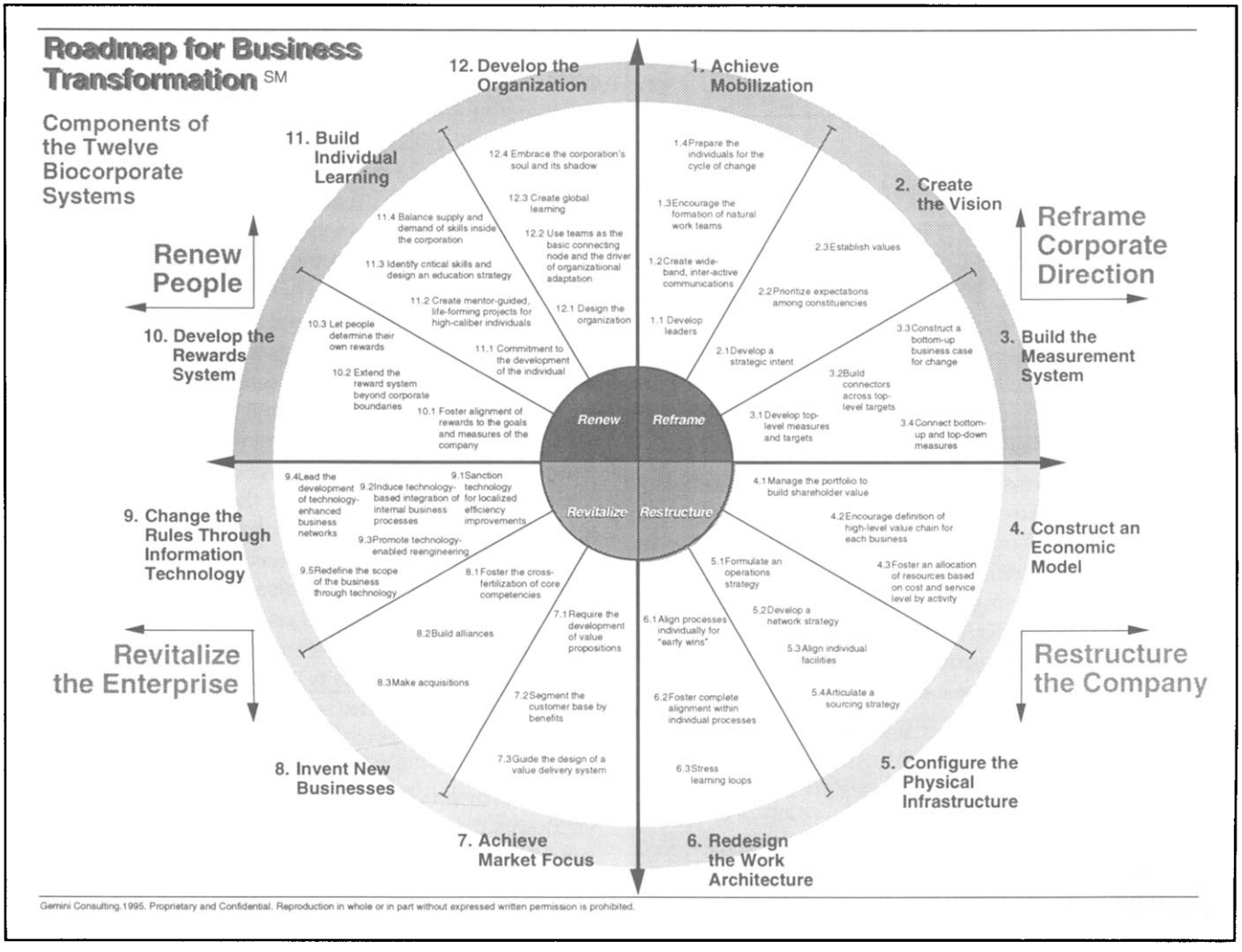
Figure 2: Key Components of an Organization Aligned Around Shared Values



theory. This has happened to me on several occasions during the last few years, and collectively and accumulatively these thoughts have become the fundamental principles guiding my strategies and direction. The first of these "Pauline" experiences that I recall was in 1987 when I attended the president's association course for CEOs and was introduced to the American Management Association's concept of "unit presidents." This concept identified that individuals and organizations operate more effectively when they are given an extensive area of freedom. This area of freedom is bounded by a framework established by some higher authority that ensures that the overall direction fits within the larger goals and aspirations of the whole organization. Figure 1 shows this concept in a visual form. The challenge before me in my role as CEO was how did I create an appropriate area of freedom for Sunnybrook in the health care system within which it could operate flexibly, creatively and innovatively. Similarly, how did I within Sunnybrook provide individuals, departments and divisions with their own areas of freedom to maximize their potential, always ensuring that this was moving us toward our common strategies and objectives (see "Purchasers vs Providers," *Healthcare Management Forum*, Spring 1993). The immense motivational impact of giving organizations and people sufficient freedom and space in which to do their own thing to achieve some broader objectives is one to which I have strongly subscribed.

The second concept as articulated by Tom Peters and others is that of focusing on one's customers and aligning business processes around them. This is interpreted in a health care sense as a patient-centred focus. The extension of the "customer-centred organization" into a health care environment was a challenging one. Academic hospitals in particular have traditionally been driven by professional structures and values. This approach provided a theoretical framework to achieve the major and radical restructuring and reengineering that we knew had to take place if we were to attempt to meet and hopefully exceed our customers' expectations. This focus in our case extended to how we organized our strategy, organized our information systems, developed our organization to ensure accountability for our patients in terms of meeting their particular needs, reengineered our processes, and how we changed our quality improvement processes. This has been discussed in far greater detail in my paper titled "Re-Focusing on Our Patients - A Vision for Excellence" published in *Health Services Management*, June 1994. This was reinforced by a third

Figure 3: Each System Consists of Specific Tasks for Creating a Transformation Path



issue revelation which was articulated by a colleague of mine, Daniel Biederman of the University Basle Hospital (Figure 2).

He articulated that the various key components of an organization need to be aligned around a common set of values. This helped to crystallize my own thinking at Sunnybrook as we were undertaking a wide variety of initiatives which included restructuring, physical redevelopment, an executive information system, pay-for-performance, strategic plan update, quality improvement implementation, cost and expense reduction programs, staff development plans and succession planning. The challenge was to ensure they were aligned to achieve a cohesive overall purpose for the enterprise as a whole.

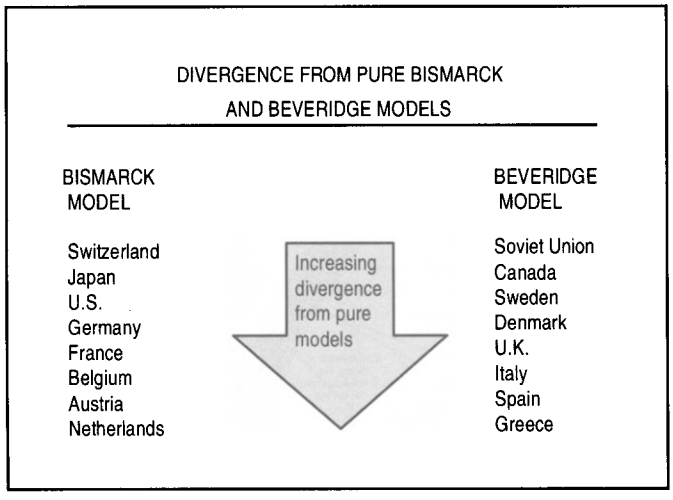
Further important learning for me took place at a recent meeting of academic hospital CEOs in Cambridge, England where we focused on the factors necessary to drive organizations toward improvement and high performance. These were:

- the presence of competitiveness and the underlying ambition within the organization to succeed;
- the presence of risk; thus, survival was at stake and the status quo was not an option. This recognizes that constant change and improvement are vital for the long-term survival of the organization; and
- the organization has the necessary sets of skills and competencies and understands what those skills and competencies are and is able to constantly build, renew and reinvent itself to optimize the use of those competencies.

To believe that health care delivery agencies are immune to those forces because of their social role is attractive rhetoric but is avoiding reality. Competition and risk may be hard to conceive for some in the health care industry but they are compelling forces that should be harnessed to their fullest extent.

My final enlightenment relates in some part to the reason for my move back to the United Kingdom. I am leaving Sunnybrook to join Gemini Consulting. Gemini has an extensive consulting practice in a range of industries, including telecommunications, oil and gas, finance and banking, and the health care industry. It

Figure 4: Divergence from Pure Bismarck and Beveridge Models



assists organizations that go through major transformations and has developed an approach that relates to how organizations operate and therefore how they can be transformed. Gemini likens an organization to a living entity (*Transforming the Organization*, Francis Gouillart and James Kelly, 1995). Its premise is that there are 12 essential components to this living entity, all of which have to be recognized and dealt with in a holistic way as part of any ongoing process of transformation (Figure 3).

The constant need to monitor the effectiveness of these various components, their relationship, their linkages and interactions is crucial to the long-term health and survival of the organization.

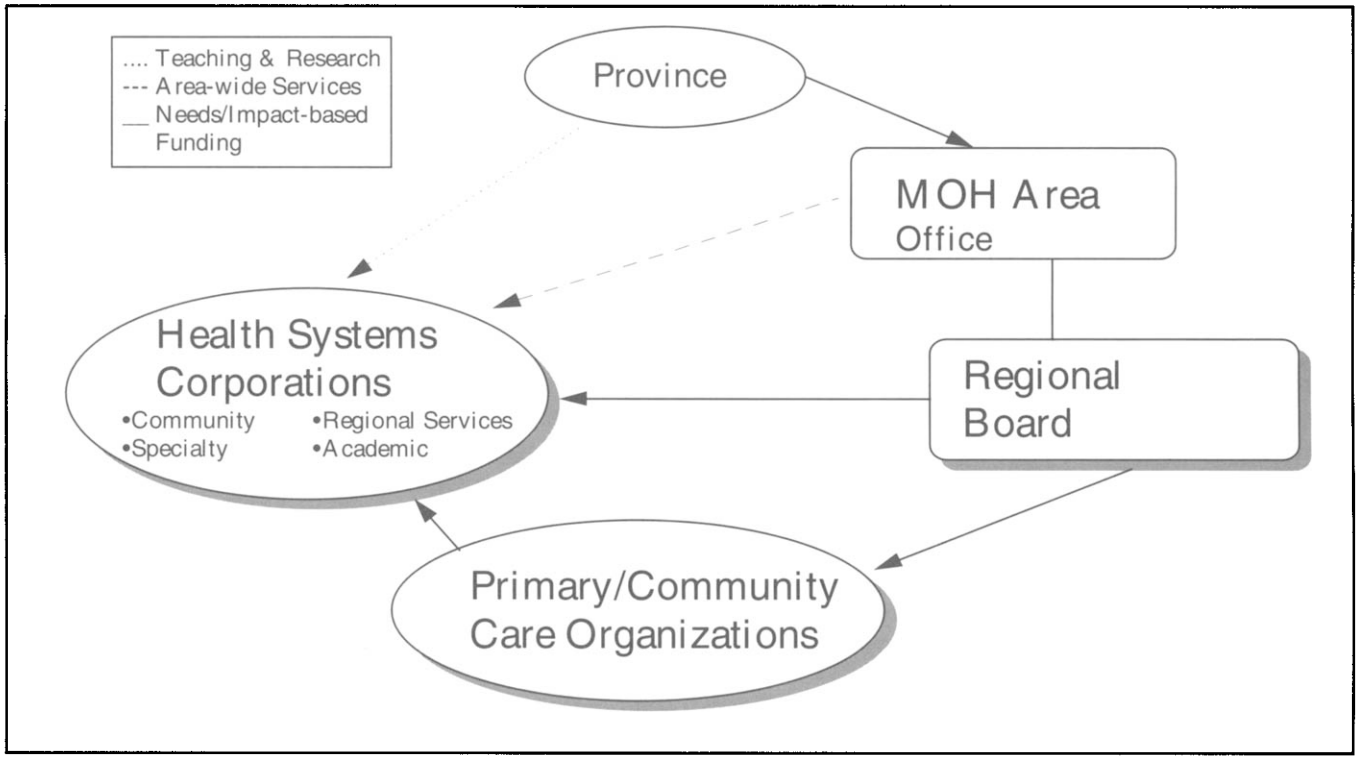
In identifying the above key learnings in my career as a CEO, I do it from the perspective of looking to the future. What I have synthesized from the above relates to the ongoing need to ensure that we have high-performance organizations delivering health care in Ontario and Canada. It requires risk-taking and freedom. It also requires organizations that are not bound by bureaucracies and are nimble enough to adapt and change. My current fears centre around some of the simplistic ways of dealing with the current fiscal crises that I believe in the longer term will hamper the capacity of some of our organizations to truly adapt and change. What I also believe, however, and what I deal with in the next section of this paper is the fact that, as the needs of our clients and customers have changed and while we have been successful in adapting our organizations to meet some of these changes, more extensive system-wide changes are possible within the present structure of health care. I wish to address some of these systemic issues, the challenges they present and the opportunities to still maintain high-performance organizations while liberating us from the current bureaucratic silos in which many of us find ourselves, in large part because of current sectoral funding and strategies.

The broader health care system

Two fundamental philosophies have been identified as underlying the development of health care systems in different jurisdictions. There are those that follow the Bismarck philosophy which looked to health insurance as the way of ensuring health care for its population. The other jurisdictions followed the Beveridge model where the state took a far greater direct role, not only in the funding of health care but in the actual delivery and organization of specific services. Over the years there has been some significant overlap between these various approaches and different countries have shifted in their allegiance to the purity of the model. At a recent meeting held in Cambridge, the schematic in Figure 4 was presented. This was an attempt to demonstrate the relative degree of commitment to the basic principles of the respective models with the countries at the top being those truest to the original philosophy. From this it is interesting to note where Canada lies, which raises an interesting paradox. The *Canada Health Act* requires that there be a publicly administered system of health insurance in each province. This was not a call for provincial governments to deliver the services but to ensure the provision of health services for the population through a publicly administered insurance system. The shift from this original requirement to the intrusion of governments directly into the delivery system is, I believe, fundamental cause of the dilemma and difficulties we find ourselves in today. As a result we are suffering from the effects of that neglect as government has failed or abrogated its use of the many powerful levers that an insurance system offers to modify and motivate behaviour and thereby pursue its health goals and objectives. An example of this is the practice in many provinces of handing over of the total medical professional fees responsibility to a third party for its administration with no means of influencing its use. Similarly, the global funding approach to hospitals has resulted in a similar inability to influence priorities. The second consequence of this is that having forgotten or abandoned their basic role, they have attempted to compensate by micro-managing the delivery system, thus pursuing a supply-side driven strategy to fight their fiscal battles. It is widely acknowledged that government is the least capable to manage services directly and, ironically, it usually leads to added cost in the delivery system.

A sad reflection of the current state of the debate over health care is the media coverage of the recent premier's meeting in St. John's. The reporting focused on the inappropriate role of the private sector in the delivery of health care. That is not and never has been the issue. The private sector always has and always

Figure 5: Funding Relationships (with primary care fundholders)



will have a significant role in the delivery of health care, whether it be through the private ownership of nursing homes, the pharmaceutical and medical device industries, independent practitioners or other opportunities for the private sector to be involved in service delivery. The real issue that seems to have been lost in the hyperbole is the role and appropriateness of private health insurance in a single payer system (i.e., the emergence of a two-tiered system through the provision of alternative insurance). This is where the debate should be focused. This would draw further attention to the extent to which the provinces have abandoned their role as the public administrators of the insurance system. This concern extends itself to the government's funding systems impact on the delivery of health care systems. Because of the block funding of individual health care sectors, strategy is being determined and moulded around the silos within government departments. We have separate votes for the delivery of mental health, long-term care, cancer care, institutional care and "community programs." The reality is that the client needs to move freely between these various silos within the system. The challenge is how do we break down these silos and look at some of the new and exciting vertically integrated models and health care capitation systems that are truly focused on populations and their needs. These challenges have been met in several other jurisdictions, particularly the United States and some European jurisdictions. It is disappointing that because of barriers at the bureaucratic level we seem unable to make use of these opportunities. The opportunities would allow us to harness changes in technology to provide care in settings where it would previously be inconceivable. A recent example was the 6 year process Sunnybrook had to go through to initiate its hospital-in-the-home project. By the time ground guidelines and procedures had been developed the need had been dealt with in another way. This shift and the movement of the location of care is part of the need to have organizations that are flexible enough to move the site of the delivery of care across various settings without being bound by artificial structural and financial barriers between primary care, home care, ambulatory care and traditional in-hospital care. This has to be dealt with if we are to allow the exciting experiments that are being introduced in many other jurisdictions.

A fundamental part of this change relates to the major challenge for the system in many provinces which is to create an organized system of primary care. The potential of using the gatekeeper role of primary care into an integrated model to maintain healthy communities is immense. However, the current disparate system of solo office practitioners in primary care will not allow the necessary clustering and critical mass of population to pursue the innovations that would be achievable through an integrated approach. The opportunity to radically restructure the system and to use the insurance system to provide the financial incentives that reward health rather than sickness

will come only through an organized and appropriately funded primary care system.

As chairman of the Metropolitan Toronto District Health Council's Priority and Planning Committee, I was involved in the proposal for a health care system for Metro Toronto which envisaged competing vertically organized "health care enterprises" with strong primary care gatekeepers (Figure 5).

A further missed opportunity relates to something I alluded to earlier – the role of the private sector. This does not threaten the important tenant of the single payer health insurance system. There are many exciting opportunities to look at new and innovative partnerships with the private sector to deliver care and service. Sunnybrook engaged in a joint venture with Dynacare with the potential of providing high quality laboratory services to a large population in a timely and cost-effective manner. However, this is the tip of the iceberg. The opportunities for innovative joint ventures, networks, and so on, bringing together the skills of the private sector with the values and services of the non-profit sector, can create exciting ways of delivering care and services. Dialysis is a service that would greatly benefit from such an opportunity. Asthma care, diabetic care, in partnership with pharmaceutical companies using their disease-management expertise, present exciting opportunities. Many of the medical technology firms are anxious to be involved in the actual delivery of care and services into individual's homes. Information management is another opportunity. Sunnybrook is part of an exciting project which involves the local cable television company and information system providers and integrates hospitals, community and general practitioners into an accessible integrated information system. This would allow the cable network to be used to ensure that information and assessments can be shared in a timely fashion as patients move through different parts of the system. A concept such as this could truly liberate us to provide care and monitor patients in a totally different manner.

Politically motivated attitudes to the private sector limit the opportunities to find new, cost-effective ways for how we organize and deliver health care. We have to break down these barriers to truly let the inventiveness and the creativeness of the people we have within the system flourish.

The final concept I have strongly identified with is the rationale for the separation into two major parts of this paper — the concept of the purchaser/provider split. ("Purchaser vs. Providers," *Healthcare Management Forum*, Spring 1993). This concept is now being implemented extensively in the United Kingdom, northern Europe, Australia and New Zealand, recognizing the different incentives, roles, skills and structures necessary to plan, fund and monitor the overall system from those required by individual providers to deliver timely and effective services. In addition, this separation allows the factors of competition and risk to be employed to drive quality, effectiveness and to provide the elements of a marketplace and consumer choice in the systems. These options are not possible in large, non-competitive regionalized models which combine the roles of purchasers versus providers and to which many cash-strapped governments have become enamoured because of their potential for offering short-term control of costs.

My concern is that the perceived short-term benefits cloud the long-term consequences. In the United Kingdom, it was 15 years before the 1974 reorganization was recognized as having led to a politicized system that had lost any commitment to its customers. Canadian provinces have an opportunity to move ahead without submitting the system to such unnecessary bureacratization. If they can learn from the experiences in other jurisdictions and root their changes in an unswerving philosophical commitment to the needs of its clients, the Canadian system can regain its position as a recognized leader in ensuring a healthy population and offering exemplary health care service.

Peter H. Ellis, CHE was President and CEO, Sunnybrook Health Science Centre, Toronto. He is now Consultant, Gemini Consulting Limited, London, United Kingdom.