Remarks for IRPP Book Launch

August 18, 2005
University Club, Toronto
Duncan Sinclair

No Canadian public policy issue claims as much attention as health care. Funding, opportunity cost, maintenance, expansion, access frustrations – the list is a long one. It is daunting too because keen public interest and the media spotlight lights up every issue. Canadians worry that 'Medicare' won't be there when they need it. It is no wonder that making changes to health care is said to be the political equivalent of touching the subway's electrified third rail. It's a killer!

To begin, I will take a minute to thank our publisher, Hugh Segal and his colleagues at the Institute for Research on Public Policy. We are privileged to share publicly our experiences at the helm of Ontario's one-time principal change agent in health care. I am sure the IRPP shares our hope that *Riding the Third Rail* will contribute important lessons to creation of the new, stronger public policy framework we **must** have to meet the challenges of the 21st century in Canada and beyond. If we can pick up the pace to achieving the goal of a genuine **system** of health and health care services, all that hard work will have been worth it.

What did the Commission teach us?

An early lesson was how 'sticky' the *status quo* in health care really is. Those entrenched interests are in deep; change is not easy or come without turmoil.

But we also learned that change **is** possible – the mould **can** be broken and the pieces put back together in ways that represent net gain to just about everybody involved, especially health care's beneficiaries – Ontario's people, communities and populations.

We learned two things about our so-called system that have to be changed – **fast**:

- First, it is not a system. Its components – hospitals, physicians, home care, long-term care, pharmacies … all the services people need to maintain and restore their good health – work far too independently of one another. They are hardly connected, much less integrated.
- Second, health care revolves around its providers, not the people and populations whose health we are trying to optimize.

Another really scary lesson was that most decisions in health care – policy decisions, management decisions, clinical decisions – are, at best, poorly informed; at worst they are uniformed. The way we record, organize, store, share, analyze, distribute, protect, and use information on the myriad interactions between providers and consumers of health care services – in sum our capacity for health information management – is feeble, way behind the times, especially given modern technology. We are trying to run an enterprise that consumed, last year, $130 billion Canada-wide, on the basis of an information system that the owner of an ordinary corner store would consider seriously deficient. Good people are working hard to rectify the situation but there's a long way yet to go.

On the positive side, we showed that the Commission, an independent organization, could do things that the government and its bureaucracy could not do. But happily for democracy, being at arms length did not absolve the government of political accountability for the Commission's actions. As it turned out, that accountability wore well; another lesson being that the voting public is far more receptive of change – of decisive leadership generally – than are its leaders.

With the vital *proviso* that those affected must be well informed of the goal in mind, we learned that making change, like taking a dose of salts, is best done quickly. Rectifying mistakes is a lot easier (and less expensive) than chasing on and on after that ever-receding, perfect implementation plan.

Most important was the need for leadership, both at the centre – where, basically, the Commission played the role of the system's governance for four years – and locally at the work face. First the Commission set out its vision of what a **real** health services system would look like and do for the people of Ontario in the early 21st century. Then, at least for hospitals, it decided **what** should be done with them to fit that vision. As for **how to do it**, we learned early on that that was best decided by people on the ground who knew what would work in their communities and what wouldn't. In the absence of these two conditions nothing much of any consequence will get done:

- crisp, well-understood policy direction from above in accordance with a clear vision of the desired outcome and
- local leadership on the ground empowered with sufficient flexibility to tailor implementation of those directions to local circumstances. One size will not fit all!

What's happening in health care today – and what's not?

As you will discover from reading the last chapters of *Riding the Third Rail*, we are up-beat about what's happening in Ontario and nationally with respect to transforming health care's notorious silos into a genuine system. Michael Decter[1] once quoted Tommy Douglas as saying in 1982:

> "*When we began to plan Medicare, we pointed out that it would be in two phases. The first … would be to remove the financial barrier between those giving the service and those receiving it. The second phase would be to reorganize and revamp the delivery system – and, of course, that's the big item. It's the big thing we haven't done yet.*"

Reorganizing and revamping the delivery of health care services into a genuine system – that's what the Health Services Restructuring Commission was all about from 1996 to its sunset in 2000. It was what Quebec's Clair Commission, Saskatchewan's Fyke Commission, and Alberta's Mazankowski Council were all about – and, more recently, the Senate Committee chaired by Michael Kirby and Marjorie LeBreton, and Roy Romanow's Commission on the Future of Health Care in Canada. There is no shortage of well thought-out advice on the revamping.

Happily good things **are** happening:

- on health information management for example;

[1] Decter, Michael B. 1994. Healing Medicare. McGilligan Books, Toronto, p.14

- changing to a team-based model of primary care;
- focusing on outcomes and accountability through the Health Council of Canada and Ontario's Quality Council.

It is gratifying to see being implemented, however late and slowly, those policy recommendations fundamental to system-building on which the Commission worked so hard. Most importantly, with the devolution of management responsibilities to LHINs and RHAs, governments are slowly re-awakening to the desperate need for **governance** of the putative system. **Leadership** is key!

But the pace of progress is dangerously slow! Our optimism is tempered by the concern that erosion among Canadians of the solidarity principle may outpace our getting on with the "big thing we haven't done yet". Waiting and others of Medicare's well-publicized problems are leading too many people to think about buying preferential access to diagnostic, surgical and other services. Some conclude that it's not possible to make publicly-insured health care sufficiently productive to meet their needs.

The Commissioners and staff members who lived this story of Ontario's Health Services Restructuring Commission participated in a bold policy experiment to move health care's mountain. We showed that it **can** be moved; that stickiness **can** be overcome – and relatively quickly. That's at the heart of our story.

The primary challenge now is for governments to pick up the challenge of governing, to grasp the nettle and implement a new public policy framework to integrate health care's silos into a system, a coherent whole. It is not necessarily a financial challenge, although change is never cheap. Nor is it a management challenge; leave that to folks at the work face. The challenge is for resolute, decisive leadership – the **governance** – necessary to accelerate work in progress to create a real **system** that guarantees timely access to affordable, high-quality health and health care services to all who need them.

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Mark Rochon

Good afternoon everyone! We appreciate your interest and support of this endeavour.

This is the first time, since the wind-up of the HSRC, that Duncan and I have had the opportunity to speak at the same meeting and I must say that this gathering is very different from those of the days of the commission. I had to remind myself that while Duncan and I were going to be speaking at the same event, there was no need for me to wear my commission game face. And, none of you seem to bear the pained, tense expressions of those we met with at the time of the HSRC.

I wish to begin today by acknowledging Duncan's unfailing leadership and commitment not only to the production of Riding the Third Rail but more importantly to the work of the Health Services Restructuring Commission. Peggy Leatt and I were the paid help but Duncan and his colleague commissioners were motivated by the highest ideals of citizenship. They shared and contributed their many talents and time because they wanted to make a difference in the provision of health services and they wanted to prove that necessary change could occur.

When I was invited by Duncan to join the HSRC as its CEO there were many reasons why I accepted but none more significant than the opportunity to work with Duncan who brought to his volunteer post an extraordinary sense of purpose, determination and integrity. It was indeed a pleasure.

The idea to write our version of what went on during the life of the commission and lessons for the future was rooted in a responsibility we felt to review and stimulate consideration and debate about this extraordinary experiment in public policy and execution.

Why were we needed? Why was an "arm-length" body with authority normally exercised by cabinet created?

I believe that the answers begin with something Duncan said in his comments that "the status quo was rather sticky". I agree that many organizations were committed to the maintenance of the status quo but the stickiness was not consistent across all aspects of the health system. When I think about the circumstances that led to the need for change through a vehicle like the HSRC three major elements come to mind - all with varying amounts of stickiness.

First, the tremendous improvements in technology, the least sticky of the three. Innovations such as minimally invasive surgery or new pharma therapy led to a tremendous reduction in the need for traditional hospital services provided largely in in-patient beds. Changes in technology and therapeutics at the level of the patient were, more often than not, embraced enthusiastically by individual providers and organizations. These improvements in technology combined with early versions of reporting on relative hospital performance, served to stimulate the improved economy of hospitals. Expensive inpatient hospital beds were substituted by better and often less costly alternatives.

Secondly and related to these improvements in technology came reductions, in real terms, of government spending on hospitals. Reductions in government spending on hospitals were initially accommodated by technological innovation, new medications, some home care but, for the most part did not result in reductions in service. Beds were reduced but services were maintained. Hospitals changed the way services were provided to meet economic realities with new technology largely filling the gap. There was a limit, though, to how much organizations could achieve in improvements on their own. With continued financial stress, hospitals were put in a position of reducing services, as a consequence of an absence of shared or governance in common across a range of providers or clear expectations from the "payer" over what the "suppliers", read hospitals, were to provide. This circumstance led an understanding among some hospital leadership of the need to deal with the number of providers, operating at less than optimal levels. Related to this reduction in operating capacity was the need to invest capital resources in aging building stock badly in need of capital replenishment.

The third factor related to the newly elected government of the day. Faced, when taking office, with an annual operating deficit of $10 billion and the need to curb if not reduce spending the government determined that it needed to find a way to make some difficult decisions about its single largest expense category – health care and within health care – hospitals. It also realized the challenges of making difficult decisions involving the potential closure or amalgamation of hospitals within the politically charged environment of government. It decided that it needed a mechanism to insulate these decisions, as much as possible, from politics. It recognized that even with the establishment of an arms length body to make decisions that it could not, it would wear every decision made by this organization.

What did we learn? What would we advise?

The two major debating points concerning health care in Canada, often confused in public debate are questions of finance (who pays for what services) and service delivery (how are services organized and who delivers them).

I think it is reasonable to contend that questions of financing or payment; what services are in or out of publicly covered basket of services are clearly within the realm of direct government decision making and policy. These are matters that ought to be the clear responsibility of governments to consider and determine.

On the other hand, I believe that we learned that matters about delivery, can be handled at arm-length from government. We learned that important decisions can be made, at arms-length in the public interest and in a fashion that provides for the ongoing evolution and improvement of health services. This experiment in delegation ought to be seen as evidence that questions of service delivery and improved system performance can be made by organizations, hopefully as close to populations served as possible and as insulated from politics as possible providing that three essential elements are in place:

1. Clear articulation about the end-game. Arms-length agencies are the means not the end. Government's must be clear about what an improved health system will mean for citizens in terms of health system performance, integration and hopefully, the health of the population. It is a

reasonable expectation that governments must plainly state what they believe the vision is so that all citizens and players know what the expected outcomes are.

2. There needs to be clear delegation of authority. Agencies at arms-length from government must know what they are accountable for and must have the necessary levers to achieve their intended objectives. The establishment of LHINs in Ontario, for example, is moving us in the direction of local accountability for system integration. In order for LHINs to be successful they must have the necessary authority and freedom to achieve their intended directions and have their decisions stick.

The third element is clarity about the length of the arm. How much freedom should arms-length agencies have? As much as is necessary. If improving the health system is also about changing the rules of the game, there ought to be few if any conversations between providers and government ministries about local health system matters. The action must be between local integration bodies and providers. This means that local agencies must have the authority to make decisions involving providers with the confidence that those decisions will not be undermined by end-runs to government.

Linked to these three conditions is the reality that change in health services takes time with horizons that extend beyond the term of any one government. It is important that the end-game and the structural means to achieve it are sufficiently "cemented-in" so that momentum is not curtailed or direction abruptly changed by the political calendar.

Thank you for your interest and support of this work. It has truly been an honour to have been part of it.

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Kellie Leitch

Thank you very much Hugh for that kind introduction. I am delighted to be here today to participate in this panel discussion on the recently published text "Riding the Third Rail, the Story of Ontario's Health Services Restructuring Committee" authored by fellow panelists Dr's Duncan Sinclair, Mark Rochon, and Peggy Leatt.

As was mentioned in the introduction I am a paediatric orthopaedic surgeon and am currently the Chair/Chief of Paediatric Surgery at the Schulich School of Medicine at the University of Western Ontario. I must say before beginning that I am in awe of those that have authored this text. There is a reason that I am a surgeon, it is because I was unable to speak or write the English language in a compelling manner. In fact, I spend most of my days addressing only two people in an operating room, one of which is asleep and the other, the anaesthetist, who wishes he was asleep.

I have had the experience of living the story of the Health Services Restructuring Commission here in Ontario. From 1994 thru to 2001, I was an orthopaedic surgery resident at the University of Toronto. Throughout that time I was both being educated and educating younger colleagues in many of the hospitals that were affected by the Commission. More recently, in my capacity as a paediatric orthopaedic surgeon at the Children's Hospital of Western Ontario, I have been living the reality of the changes instigated and now being implemented due to the Commission.

I think it is important to set the context of the Commission, as the other panelists have done eloquently in their text, of what the Health Care climate was like in 1995. And it was, as my weather man would say, "not the sunniest days ahead". At that time the Ontario Government found itself in a position of substantial deficit and debt. My general impression from listening to patients and their families, and this is only my personal opinion, was that the public was concerned about whether health services would be provided to them in the future at the same level they had experienced in the past. The system was at its capacity – the patients and stakeholders were aware of the critical financial circumstances– and they knew change was going to occur due to the financial realities of the day – no matter what. They just didn't know what those changes would be.

Among the primary Health care stakeholders there were several commonly held ideas on what changes were required. These included a need for an integrated system, primary care reform, regionalization and that the "bed blocker problem" had to be tackled. Let me explain what I mean by this. There is a "domino affect" in the Emergency Departments. One can imagine that when a patient is seen in the Emergency Department they then need to be admitted to hospital. However a patient cannot be admitted to hospital if there is no bed to put them in – and that bed is being occupied someone with a chronic problem. In many cases, the individual taking up that acute care bed was someone that was waiting for a bed in a long term care facility. But there weren't enough long term care beds available, thus backing up the rest of the system and creating the "bed blocker" problem.

It was this environment I entered into as a junior resident at the University of Toronto. And it was in this environment I had to work, and be educated, as an orthopaedic surgeon, and quite frankly as a junior administrator, in an effort to deal with patients placed under my care on the orthopaedic service.

My experience with the Health Services Restructuring Committee was exceptionally indirect. I was one of the direct recipients of the decisions taken by the Commission and then expected to be one of the Implementers. At no time was I briefed about what changes were being implemented. My understanding throughout the Commission's timeframe was that there were significant deficits, both capital and operational within the system. Everyone recognized this, but more importantly, there was a substantive lack of communication and preparation provided to those individuals that would be actually implementing these changes that were required. Now that is not to say that the Ontario Health Services Restructuring Committee did not try to communicate with the health care professionals involved in the administration of this gigantic task. I am confident they did. But there was a need for repetitive messaging to these implementers that was required and did not necessarily reach them through their hospital organizations. For example, I had the unfortunate role of being the Chief Orthopedics Resident at St. Michael's Hospital when it was being "amalgamated" with the Wellesley Hospital. At no time was I informed of when the actual closure of the Wellesley would take place. I was one among the army of health care "privates and sergeants" in the Toronto system – a system in which there was significant confusion as to what exactly was going to happen and when that would happen. There were great hopes and expectations set with respect to capital investments, new long term care facilities, and the development of new tools in order to service our patients in a more efficient and effective manner. However, it was (and in a number of communities still is) exceptionally unclear as to the time frame for the HSRC recommendations to be implemented, where they would be implemented, and who would be doing the implementing. I must say from personal experience that this was a classic example of what I have seen far too often in the health care system over the last ten years, a case where the silos of the system don't communicate with each other, or at least not in an effective manner. Every administrator at my various teaching hospitals I'm sure knew every detail of the implementation plan, but none of the residents did – and we were providing much of the care – we were being asked by our patients what was about to happen and couldn't answer their questions.

As I mentioned before, I spent a fair amount of time on the front line dealing with the pressures that existed in the system. As a junior and then chief resident, I found many of the hours of my day taken up with what I would call "creative bed management". Days that I would spend shifting patients from one ward to another, and pushing for them to be sent to a long term care facility to avoid the blocking of beds I mentioned earlier. In fact, as chief resident it sometimes gave me great delight that I was taking up 7 beds on the medicine floor and keeping beds free on the orthopaedic floor so that my staff could get their cases done in the operating room that day. However, those days were few and far between. On a far more typical day, I found myself scrambling to exit patients from hospital due to pressure from administration, so that we would not have surgical cases cancelled in the operating room for people that had been on waiting lists for greater than 18 months.

These challenges of bed management only became more difficult in the late 1990's, during the time of the hospital closures being implemented by the Health Services Restructuring Commission. As hospitals in Toronto were amalgamated, closed or resources re-assigned, even fewer resources

were available in the system due to the disruption – which created inefficiencies. In addition, as the authors noted, there were not enough long-term care, rehabilitation or community care services available. This left "front-line" workers scrambling in order to meet the expectations of senior staff in the system.

I must say that my personal experience was that it substantially enhanced my administrative skills. However, the purpose of my orthopaedic education was to make me a better orthopaedic surgeon, not a better manager and on several days of my residency training I found myself managing bed issues to make sure the patients would make it to the operating room, as opposed to standing in the operating room learning the surgical procedures I was to be doing in the future. This detractor from medical education was substantive and I believe that there is not a single resident educated in Toronto hospitals undergoing restructuring, and in fairness, that had experienced the restraints prior to the implementation of the Commissions recommendations, that did not feel this way.

In addition to my experience as a resident, I have been currently living through the ongoing "Implementation" of the HSRC's recommendations as a staff member at the Children's Hospital of Western Ontario, in London, Ontario. Throughout the 1980's and 90's, and in particular during the Health Services Restructuring Commission, London underwent substantive change. As was noted in this text, London was already ahead of the curve in trying the amalgamate it's services prior to the Commission.

London is a unique place. It is the Mayo Clinic of Canada. We just don't set in a cornfield, we sit in a tobacco field. For health services in Southwestern Ontario it is one stop shopping. Unlike in metropolitan Toronto where community hospitals are available to download patient cases, Southwestern Ontario has only one place for individuals to go to for tertiary and quadriary care and in particular for paediatric services. London has been implementing changes for restructuring since before the Commission, and unfortunately, this implementation continues to this day.
The advantages of being ahead of the curve on restructuring meant that London has had an opportunity to be at the forefront of advocating for specific services. However, expectations have been set at our institution that have not been met. Expectations such as an additional 100 beds for acute patient care that the Government of Ontario has not met. These expectations substantially inhibit the morale of our staff and cause increasing challenges in our daily operations.

I believe that the work of the Commission, and this text illustrating it, are extremely important. They set the direction for driving change into health services in the country – change that continues to be desperately needed.

However, as the authors of the text note, there is a need for leadership and for a champion of change in the system. It would be negligent for me not to comment that these institutions are driven by nurses, physicians and the people that actually provide care directly to the patients. In my opinion in order to drive some of those essential changes recommended by the Ontario HSRC, Kirby, Mazankowski, and Romanow – a champion is requited - either at a Provincial or National level - who is a hands on health care provider. Someone who has had to live in the system who knows what it takes to implement within the system. Someone who has unfortunately had to do the "bed space domino program" in an effort to accommodate cases so that they could accomplish their job that day. These individuals understand the system intimately and can drive change, and more importantly motivate other professionals within it to drive change. In Canada, we are lucky to

have a number of qualified individuals who meet this criteria. David Naylor who was mentioned in the text as well as Allan Hudson are two that come to mind in the Province of Ontario. But we need more of them. We have a responsibility to educate young health care professionals – physicians, nurses, allied health professionals - to have that degree of motivation, skill and leadership to drive change within the system.

As outlined by the Commission, there continues to be a need in Ontario's health care system for substantial investment and information technology and health services integration. In addition, we need to take better advantage of new technologies including tele-health and other electronic media to strengthen health prevention and management.

These initiatives require strong, passionate leaders to drive the change agenda with municipal, provincial and national governments, the health care community and most importantly, with Canadians. It is only by identifying and developing young professionals currently in the system and providing them with the tools required to develop and integrated health system that we will be able to ensure the best possible health care for all Canadians.
It is about courage; the courage for us not only to identify the issues and areas for improvement, but to also take the necessary steps top fixing our system. The government must address the issues as outlined by the HRSC, and in order for real change to occur, we must do the strategy, not just talk about it.

Thank you