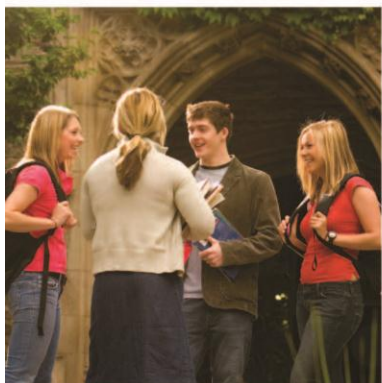


DIALOGUE
SUMMARY



MEASURING HEALTH
SYSTEM EFFICIENCY IN
CANADA



7 NOVEMBER 2011

EVIDENCE >> INSIGHT >> ACTION

**Dialogue Summary:
Measuring Health System Efficiency in Canada**

7 November 2011

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Conflict of interest

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SUMMARY OF THE DIALOGUE

Most dialogue participants saw great value in an effort to measure health system efficiency in Canada, arguing that it could be used as a: 1) complement to service-, program- and institution-based efforts (i.e., micro-level work) to identify opportunities for efficiency gains; 2) spur to intra- and inter-provincial/territorial discussion and learning about the benchmarks to which health systems should aspire and about ‘system drivers’; and 3) corrective to many international comparisons that treat Canada’s health system as a single, monolithic system and not as a set of distinct provincial and territorial health systems, each with sub-sets of semi-autonomous health regions. Most dialogue participants generally agreed with the issue brief’s description of the challenges encountered in health system efficiency measurement, including: 1) conflicting views about the objective of the health system; 2) conflicting views about and cross-provincial variation in the boundaries of the system; and 3) data challenges in and methodological disagreements about health system efficiency measurement.

The majority of dialogue participants supported an iterative process of developing a measure (and later measures) of health system efficiency, and in the near term: 1) prioritizing the enhancement of health system performance as the objective (and hence output measures such as potential years of life lost); 2) prioritizing healthcare expenditures (i.e., dollars spent) as the principal input; and 3) delegating decisions about particular methods or approaches to data collection to technical experts who should be mindful of a number of principles, namely that a) methods must be appropriate across all regions, b) data collection at the regional level, which is where the key gaps exist, must not ‘take away from service delivery,’ and c) the process of iteratively developing health system efficiency measures and demonstrating their potential uses should not be slowed down or stopped while waiting for the ‘perfect data’ to be collected.

Most dialogue participants supported the idea that the Canadian Institute for Health Information would accelerate its work on health system efficiency measurement informed by the inputs received through the dialogue. In so doing they reiterated their call for adopting an iterative approach and then building on lessons learned. Several dialogue participants also supported the 10-year vision for developing many models in order to stimulate public discourse about the many different aspects of health system efficiency. A number of dialogue participants noted that a lot of work would be needed in order to provide concrete examples of the types of issues that could be addressed by health system efficiency measurement, and the types of implications that could follow from broader discussions about health system efficiency findings.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE ISSUE

Most dialogue participants saw great value in an effort to measure health system efficiency in Canada, arguing that it could be used as a:

- 1) complement to service-, program- and institution-based efforts (i.e., micro-level work) to identify opportunities for efficiency gains (e.g., by adopting the ‘lean’ practices being used in some health systems);
- 2) spur to intra- and inter-provincial/territorial discussion and learning about the benchmarks to which health systems should aspire (even if the processes they adopt to achieve these benchmarks look very different), and about ‘system drivers’ (e.g., proportion of funds spent on primary healthcare, high-volume users of healthcare, end-of-life care or overhead; remuneration mechanism used in primary healthcare; price differentials; and geography), both overall (e.g., is there a level of spending beyond which little is gained) and in specific regions (e.g., rural and remote regions); and
- 3) corrective to many international comparisons that treat Canada’s health system as a single, monolithic system and not as a set of distinct provincial and territorial health systems and then as sub-sets of health regions within these systems.

Another dialogue participant noted that stakeholders have been asking for health system efficiency measurement for some time now.

Several dialogue participants cautioned against efforts to measure health system efficiency that would be used in:

- 1) funding decisions at the national or provincial/territorial level (at least without making this an explicit objective of the effort from the very beginning); and
- 2) ranking provinces and regions in ways that lead to a ‘shooting down’ of the measurement effort by those who rank low (which could mean either providing confidential reports to those in leadership positions in provincial and territorial health systems, or preparing them for the resulting media coverage, as was done in preparation for the release of data about standardized mortality ratios).

A small number of dialogue participants questioned the need for measuring health system efficiency at the national level. One dialogue participant attributed a personal sense of skepticism to years of observing that policymakers rarely used evaluations, which led this dialogue participant to

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in Canada (in this case, the challenges encountered in health system efficiency measurement);
- 2) it focused on different features of the issue;
- 3) it focused on three elements of an approach to addressing the policy issue (in this case, three elements of a model of health system efficiency);
- 4) it was informed by a pre-circulated issue brief that mobilized both global and local research evidence about the issue, three elements of an approach to addressing the issue, and key implementation considerations (in this case, considerations related to developing and using a model of health system efficiency);
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the issue and possible elements of an approach to addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders, and researchers;
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed”; and
- 10) it did not aim for consensus.

Participants’ views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary and the video interviews with dialogue participants.

suggest that the same would happen with a measure of health system efficiency. In response to this statement, one dialogue participant argued that most politicians want to do the right thing and they need help to do so, and another argued that even if politicians don't use evaluations those working under them and those seeking to influence them do use evaluations. A second dialogue participant argued that what politicians really want is a measure of consumer confidence, not a measure of health system efficiency. In challenging this, a dialogue participant argued that a measure of health system efficiency would have great political currency. A third dialogue participant advocated for quality measures as the next biggest priority (and ahead of health system efficiency measures as a priority). A fourth dialogue participant suggested that true efficiency gains are far more likely to come at the micro-level, meaning at the service and program level where very specific questions can be asked about what is the best model of service or program delivery, and how can those not using this model be supported to do so at the individual, organizational and system level. This individual argued that system-wide efficiency gains are more likely to be built up from micro-level efficiency gains than to emerge from macro-level measurement. However, one dialogue participant noted that health quality councils don't exist in all provinces and territories so the focused pursuit of micro-level efficiency gains isn't happening everywhere now. Another dialogue participant argued that the challenge of aggregating micro-level assessments is such that we could never have conversations at the provincial/territorial and national levels about how our systems are doing unless we complement these micro-level assessments with the type of macro-level assessment being discussed at the dialogue.

Having participated in or listened to the macro- versus micro-level discussion, most dialogue participants argued strongly for having both types of measures. As one dialogue participant argued, a macro-level health system efficiency measure will 'not be the only tool in the kit bag,' but it needs to be one of them. This dialogue participant noted the importance of asking questions like 'why does British Columbia have good statistics [i.e., health outcome indicators] but low [health system] expenditures?' A second dialogue participant argued there is a need both for public discourse stimulated by a macro-level efficiency measure (which will inform high-level political decisions about broad directions for health systems and which will promote reflection among health system leaders about whether and possibly where changes are needed 'on the delivery side') and a professional discourse informed by a range of micro-level efficiency measures (which will inform service-, program- and institution-level decisions). A third dialogue participant noted that with health systems consuming such a high proportion of provincial/territorial budgets, the search for efficiency is a high priority and both types of discourse will be needed to ensure that there are resources left for other sectors. A fourth dialogue participant pointed out that many health system leaders and teams visit health systems outside the country simply because we lack the measures that would allow them to identify (the parts of) high-performing Canadian health systems where important lessons can be learned.

One dialogue participant questioned whether the focus should be on quality (not efficiency), noting that one can be doing things efficiently, but not necessarily the right things, and if the focus is efficiency whether the focus should be primary healthcare, hospital care, nursing home care, home care, community care or something else. Another dialogue participant clarified that: 1) quality can be seen as a component of most models of health system efficiency (as is the case here), as a focus for a complementary set of indicators or as a broader construct within which efficiency is nested; and 2) the issue brief and dialogue are focused on the efficiency of the entire health system and not its constituent parts.

Most dialogue participants generally agreed with the issue brief's description of the challenges encountered in health system efficiency measurement, including:

- 1) conflicting views about the objective of the health system;
- 2) conflicting views about and cross-provincial variation in the boundaries of the system; and
- 3) data challenges in and methodological disagreements about health system efficiency measurement.

Dialogue participants' views about the best way to address these challenges are the focus of the next section.

DELIBERATION ABOUT ELEMENTS OF A MODEL OF HEALTH SYSTEM EFFICIENCY

Dialogue participants discussed each of the key elements of a model of health system efficiency in turn:

- what is the objective of the health system?
- what are the boundaries for the health system?
- what are the appropriate methods and needed data?

Element 1 - Establish a clear objective for the health system

All but one dialogue participant agreed that it would be important to prioritize the enhancing of health system performance as the objective (and hence output measures such as potential years of life lost) in any iterative process of developing a measure (and later measures) of health system efficiency. As one dialogue participant said, ‘we need to tackle performance first’ (which another participant defined as how well we respond to healthcare needs). A second dialogue participant noted that, while we can have endless debates about whether we’re in the healthcare delivery business or the health business, in the end Canada’s health systems are judged by citizens largely on the extent to which they provide timely access to effective treatments. A third dialogue participant noted that a focus on health system performance also aligns with provincial and territorial ministries of health increasingly seeing themselves as stewards of their respective health systems, so there is a natural audience for an efficiency measure focused on health system performance. Drawing on the issue brief’s contents, several dialogue participants observed that establishing health system performance as the objective would permit a focus on diagnoses specifically amenable to healthcare and would accommodate individuals who establish their expectations for the system after diagnosis. One dialogue participant cautioned the group about using the language of diagnosis because it implies that preventive services don’t contribute to achieving this objective. Several dialogue participants also noted that the measure typically used for this objective – potential years of life lost – focuses on mortality only and not on both mortality and disability, however, this shortcoming did not dissuade them from prioritizing performance as the first focus of an effort to measure health system efficiency.

Recognizing the value in having multiple health system efficiency measures in order to address different types of issues, a number of dialogue participants agreed that a complementary focus on maximizing average population health as the objective (and hence disability-adjusted life expectancy as the output measure) could be helpful after progress was achieved in using health system performance as the prioritized objective. One dialogue participant argued for maximizing average population health as the objective, and this individual, while recognizing that a measure of such an objective would appear to attribute all mortality and disability to a failure of the health system, argued that this type of measure would ‘drive discussion to broader’ issues, such as the determinants of health. A second dialogue participant argued that a combination of maximizing average population health and reducing inequalities would be ideal in that it would promote broader public discussion about the need to focus ‘upstream’ on the social determinants of health, and stimulate more cross-ministry and cross-government activities. However, this individual noted that we’ve been ‘at the determinants of health for a while and people get used to the language, but the data doesn’t seem to move the system.’ This individual also noted that we’re not in an ideal world given the state of the economy (and with even European health systems in trouble) so we need to, at least for now, prioritize health system performance. A third dialogue participant noted that ‘sub-questions, such as ‘how much do high-volume users contribute to inefficiencies?’ would appropriately direct attention to housing and other social determinants of health (i.e., to factors outside the health system that contribute to high-volume use).

Element 2 - Establish clear boundaries for the health system

Most dialogue participants agreed that healthcare expenditures (i.e., dollars spent) should be the principal input. One dialogue participant noted that choosing healthcare expenditures as the input would promote debate about questions such as whether Canadians want the aggressive forms of treatment in the last three months of life that account for such a high proportion of total healthcare expenditures. A second dialogue participant commented that using healthcare expenditures allowed for greater flexibility and more of a future-oriented perspective, because new types of healthcare providers or new configurations of healthcare providers could appear on the scene and easily be captured through expenditures. A number of dialogue participants argued for a broad interpretation of which types of healthcare expenditures would be included. For example, several dialogue participants emphasized the importance of including expenditures related to disease prevention and health promotion, while one dialogue participant argued for including the opportunity costs associated with caregivers' time (although another dialogue participant noted that caregivers' time is not a factor within the control of health system decision-makers).

One dialogue participant argued against using healthcare expenditures as the principal input because expenditures don't provide the specificity needed to assist health system leaders to make decisions about which capital and labour inputs they need more or less of. This individual noted that it was the more fine-grained information used in the education sector that spurred much-needed conversations in that sector. Two dialogue participants accepted the idea of using healthcare expenditures, but introduced additional considerations. One noted that if a decision were made to go with capital and labour inputs then more attention would need to be given to technological inputs. A second worried that going with healthcare expenditures could create challenges in data comparability (e.g., community care agencies would be counted as part of the health system in Quebec, but possibly not in other jurisdictions) and public messaging (e.g., physicians' salaries are not within the control of decision-makers at the regional level and are difficult to adjust at the provincial and territorial level). A third dialogue participant noted the complexity that is introduced by inter-jurisdictional transfers of patients (e.g., from rural and remote areas to other regions or provinces and territories).

Dialogue participants found it challenging to establish the environmental constraints under which the system must work (i.e., the factors outside the control of health system decision-makers). For example, one dialogue participant asked whether the proportion of new immigrants should be counted as either a 'non-controllable' characteristic of citizens being served or a characteristic of the external environment (while another dialogue participant asked the same question about a social deprivation index, although data for such an index is not currently collected in Canada). A second dialogue participant asked whether the quality of roads at different points in the year should be counted as a characteristic of the external environment given the impacts that road quality has on healthcare utilization. A third dialogue participant argued that the quality of resources used (e.g., capital stock, including hospitals) is within the control of health system decision-makers over time, just not in the short term, although a fourth dialogue participant noted that the quality of resources used can be within the control of provincial and territorial governments more than within the control of regional health authorities.

One dialogue participant wondered whether controlling statistically in an efficiency measure for some of these factors (such as the proportion of the population that has First Nations status) actually 'throws the problem away' insofar as efficiency is 'what's left over' once you control for the many factors that a system should respond to even if it can't control them per se (e.g., socioeconomic status and geography). However, this individual also included factors such as health behaviours and illness severity (i.e., case mix) among the citizens being served, and deliberate choices about which services to offer and which best practices to adopt, all of which is (as one dialogue participant noted) arguably within the control of health system decision-makers (and hence should not be 'controlled for').

Element 3 - Select appropriate methods and collect appropriate data for measuring efficiency

Dialogue participants did not argue strongly for or against particular methods or approaches to data collection, choosing instead to emphasize a number of principles: 1) methods must be appropriate across all regions (e.g., rural and remote regions may not have large enough populations to make reasonable inferences and these inferences will be complicated by inter-jurisdictional transfers of patients); 2) data collection at the regional level, which is where the key gaps exist, must not ‘take away from service delivery’ (as one dialogue participant said, we sometimes ‘spend lots of money to get data that aren’t usable’); and 3) the process of iteratively developing health system efficiency measures and demonstrating their potential uses should not be slowed down or stopped while waiting for the ‘perfect data’ to be collected. Several dialogue participants noted that they appreciate the specification of the data gaps in the issue brief because this can focus future efforts to address data gaps.

Only a few dialogue participants commented on the two approaches to estimating an optimal level of performance. Most of their suggestions involved trying out different approaches over time rather than selecting a single approach and, regardless of which approach is used at a given time, explaining clearly its strengths and limitations as was done in the issue brief. One dialogue participant noted that most health quality councils are focused on identifying a maximum or optimal level of performance (as opposed to the average relationship between inputs and outputs), albeit at the micro-level and not the macro-level, and hence would have a natural affinity with methods that also identified a maximum or optimal level of performance. A second dialogue participant noted that regardless of which approach is selected, it will ‘create the illusion that [we] understand the black box’ in which healthcare expenditures are translated into impacts on the health of Canadians.

Several dialogue participants noted that some of the data gaps will be easier to fill in some provinces and territories than in others, that some types of data are unlikely to be available even at the provincial and territorial level (e.g., expenditure data for drugs and for nursing homes and residential care facilities because much of these expenditures takes place within the private sector where it can be difficult or impossible to obtain data), and that some types of data are available at the provincial and territorial level, the municipal level or both (as with public health expenditure data in Ontario) but not at the regional level (although in the case of provinces like Alberta and Prince Edward Island there is now effectively just one region covering the entire province, and in other provinces it may be possible to impute expenditures at the regional level using geo-coding and other methods). Regarding the last point, one dialogue participant noted that sometimes provincial and territorial data comes from the regional level, but that additional efforts would be required to obtain the additional data that was shared between levels. This individual also noted that in some circumstances the decision-making actually happens at the provincial and territorial level so that obtaining or imputing regional data in these circumstances would not make sense. Another dialogue participant noted that it would be a shame if the province of Quebec were unwilling to share their data because it would mean that other provinces would not be stimulated by a health system efficiency measure to learn from Quebec’s experiences. A third dialogue participant noted that better and better data would be available as electronic health records are increasingly adopted and interconnected. A fourth dialogue participant argued for including as a fourteenth jurisdiction the Canadian federal government’s health systems focused on armed services and First Nations populations, however, another participant argued that this is not a comparable ‘system’ for a wide variety of reasons and will introduce complications and add little value.

One dialogue participant noted that it would be ideal if efficiency could be measured at the level of regions that share key characteristics rather than only at the provincial and territorial level. This individual gave the example of rural and remote regions, which might share more similarities across provinces and territories than with the other regions in the same province or territory. A second dialogue participant suggested that it would also be ideal if efficiency could be measured longitudinally as well, in order to permit assessments of whether the system is growing more efficient over time or not. A third dialogue participant noted that the 2014 health accord negotiations might be an opportunity to build in accountabilities for data sharing.

Considering the full array of model elements

Having discussed all model elements, the majority of dialogue participants remained very comfortable with an iterative process of developing a measure (and later measures) of health system efficiency, and in the near term: 1) prioritizing the enhancement of health system performance as the objective (and hence potential years of life lost as the output measure); 2) prioritizing healthcare expenditures (i.e., dollars spent) as the principal input; and 3) delegating decisions about particular methods or approaches to data collection to technical experts who should be mindful of a number of principles that emerged during the discussion.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

One dialogue participant began the deliberation about implementation considerations related to developing and using a model of health system efficiency by arguing that Canada ‘needs a model sooner rather than later to demonstrate capacity’ to do the three things listed in the first section of the dialogue summary, namely to: 1) complement service-, program- and institution-based efforts (i.e., micro-level work) to identify opportunities for efficiency gains; 2) spur intra- and inter-provincial discussion and learning about the benchmarks to which health systems should aspire and about “system drivers”; and 3) act as a corrective to many international comparisons that treat Canada’s health system as a single, monolithic system and not as a set of distinct provincial and territorial health systems and then as sub-sets of health regions within these systems. The same individual said that this is a ‘10-year project or dream and it won’t be accomplished in 18 months’, but neither will it be accomplished if we don’t start now and keep pushing for iterative enhancements, including new approaches, better data, the ‘cascade of tools’ that will flow from it, and thoughtful uses of the results. The participant also argued that politicians will continue to push for greater efficiency and that this effort can help to ensure that the responses to this pressure are as rigorous as possible. A second dialogue participant agreed, pointing out that Canada needs some efficiency measures and a targeted effort to engage ministers of health using these measures in the short term and, that refinements can come later in the form of special studies. A third dialogue participant said that the real value would come with the special studies that address the ‘drivers’ of health system efficiency, which could help with the big-picture questions that politicians ask, such as ‘where resources should be allocated’ (e.g., more on primary healthcare and less on high-volume users of healthcare or on end-of-life care) and ‘where the anticipated returns on investment are being achieved.’

A number of dialogue participants echoed these calls for adopting an iterative approach, by which they meant selecting a single objective, a small number of indicators related to inputs and environmental constraints, existing data and an understandable model to begin the process and then building on lessons learned. Several dialogue participants also supported the 10-year vision for developing many models in order to stimulate public discourse about the many different aspects of health system efficiency. One dialogue participant noted that measuring efficiency is ‘à la mode’ and that any Canadian effort should be ‘in front but not too far in front’ in order to avoid ‘getting shut down on the first try and then finding it difficult to bring it back.’

One dialogue participant argued for engaging provincial governments (or the single health authorities in provinces like Alberta and Prince Edward Island) in the development of a model of health system efficiency, and in how it could best be used within their respective health systems, and then leaving it to these provincial bodies to engage regional health authorities within their jurisdiction. A second dialogue participant advocated for engaging citizens and healthcare providers (not just provincial authorities) in developing and supporting the use of a health system efficiency measure. A third dialogue participant strongly endorsed the use of health system efficiency measurement as a ‘gateway to a broader discussion.’ A fourth dialogue participant strongly endorsed the idea of engaging clinical leaders sooner rather than later in the process in order to begin discussions about how efficiency can become part of their conversations.

Dialogue participants were divided over whether the national wait times initiative is a good example to emulate or a bad example to avoid. On the positive side, several dialogue participants noted that the initiative had high-level political buy-in, gave the public a sense of how provincial and territorial health systems are performing, and achieved measurable improvements in some domains of health system performance. On the negative side, two dialogue participants noted that the initiative had sometimes led to ‘perverse responses’ and one noted that the initiative hadn’t effectively engaged patients in a broader public discussion.

A number of dialogue participants noted that a lot of work would be needed in order to provide concrete examples of the types of issues that could be addressed by health system efficiency measurement and the types of implications that could follow from broader discussions about health system efficiency findings. Dialogue participants returned to previous discussions about the benchmarks to which health systems should aspire, and especially to the ‘system drivers’ that were described earlier in the dialogue summary. One example of a system driver – the proportion of funds spent on end-of-life care – was the focus of a great deal of discussion because of how helpful it was argued to be if Canadians had a broader discussion about how they wanted to be treated at the end of their life. As one dialogue participant said, this is ‘not about them getting an intervention but about normalizing dying outside of a medical model’ (i.e., outside of a hospital and with a focus on the person and their family and not the medical care). A second dialogue participant noted that this type of conversation could over time bring about a change in culture. A third dialogue participant introduced additional issues that health system efficiency measurement could provoke discussion about, including who determines what is a ‘waste of resources’ (patients or providers), how can more focus be given to self-management and to patients’ and families’ roles, and how can the elderly be treated in locations other than emergency rooms and hospitals in order to avoid making them ‘more elderly.’ A fourth dialogue participant, who remained skeptical about the need for the effort and concerned about the resources that would go into it and the limitations of what would come out of it, argued for focusing on an issue like chronic disease management initially to test out the helpfulness of the approach. However, several dialogue participants countered that the unique value added was the focus on ‘whole system efficiency’ and not the efficiency of very specific parts of the system

DELIBERATION ABOUT NEXT STEPS FOR EFFICIENCY MEASUREMENT IN CANADA

Most dialogue participants supported the idea that the Canadian Institute for Health Information would accelerate its work on health system efficiency measurement informed by the inputs received through the dialogue. They noted that CIHI had (or could get access to) the data, and had (or could get access to) the senior decision-makers who would need to be prepared each time findings were about to be released, as well as that this mandate complemented the mandate of other organizations, such as the Health Council of Canada at the national level and health quality councils at the provincial level in at least some provinces. A number of dialogue participants emphasized that there is value in the effort ‘only insofar as [decision-makers] use it to meet their mandates’ and strongly recommended that CIHI think through how to support the use of health system efficiency measures while it is developing the measures. As one dialogue participant said, be ready to say ‘here’s how you use the data... and how to have [provincial/territorial or regional] conversations about next steps.’ A second dialogue participant noted that if CIHI can’t make these types of statements, and perhaps even to go farther by making recommendations about what these next steps could be, then CIHI should consider partnering with an organization that could.