Creating Strategic Change In Canadian Healthcare

CONFERENCE WHITE PAPER WORKING DRAFTS

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If Canada had a System-Wide Healthcare Strategy, What Form Could it Take?

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Canada is richly endowed with healthcare strategies. Ten provinces and three territories each have their own strategic frameworks addressing in varying levels of detail and sophistication the delivery of healthcare within their constitutional jurisdictions. In addition, the government of Canada has strategies addressing its management and oversight roles in the federal health insurance legislation as prescribed by the Canada Health Act (1985), as well as its management and regulatory responsibility for consumer and product safety, drugs and health products, food and nutrition, and First Nations, Inuit, and military healthcare.

There is more strategy in the system. At the sub-provincial level, health regions (authorities, integration networks, etc.) have strategies. Canada's more than 700 hospitals each have strategies. Equally, strategies exist within professional associations (such as the Canadian Medical Association, Canadian Nursing Association, and others), pharmaceutical companies, device manufacturers, technology companies, consulting firms, and a myriad of other corporate participants in Canadian healthcare.

Different missions and objectives guide and motivate the participants in this complex system, but to the extent that all can be circumscribed by the World Health Organization's definition of a health system as "all the activities whose primary purpose is to promote, restore, or maintain health" (WHO, 2000, p. 5), the Canadian reality can be characterized as fragmented. Less charitably, Leatt, Pink, and Guerriere refer to it as "a series of disconnected parts," and "a hodge-podge patchwork" (2000, p. 13). That the system has independent or even autonomous parts is not the main problem. Being so unconnected and un-integrated is the main concern. Even if the overall system performed with good outcomes, it would not be because we planned it that way. We could just be lucky, or benefiting from circumstances outside of our control. Further, we would not easily be able to explain why, or predict how well or poorly it would perform in the future.

In satisfaction surveys, Canadians are ambivalent about their system. As a whole they think it is unsustainable (Levert, 2013; Dodge & Dion, 2011; Kirby, 2002), but are generally positive about their own experiences (Health Council of Canada, 2007). As suggested by the Health Council of Canada (2007), perhaps this is because they consider current services to be sufficient but the system overall to be in jeopardy.

Still, more pointed questions show less satisfaction. For instance, in the Commonwealth Fund's (2010) survey of 11 countries,[1] respondents were asked if they became seriously ill, how confident/very confident they were about getting the most effective treatment (including drugs and diagnostic tests). Canadians were in the bottom half. When asked about their overall views of the system, 51% thought fundamental changes were needed. Only the Australians were less satisfied, at 55%.

As will be seen, from the evidence available to us, it is easy to appreciate that our system is not performing well. It may not be performing badly, but it is not doing well compared with other countries. This is especially of concern given how expensive the Canadian system is to operate. Would Canadians be more confident if we had a strategy, a system-wide plan that clarified where we should be headed and how we would get there? Would the system perform more efficiently, effectively, and equitably if we had an overall strategy that knit the disparate pieces together in a way that would allow us to predict and explain the causal relationships among the components of the system? If so, what form would a Canadian healthcare strategy take?

Discussions about Canadian healthcare are heavily influenced by political considerations – commonly cited as a reason for chances involving multiple political jurisdictions being hard to implement.[2] That said, strategy and

1 The Commonwealth Fund (2010) survey comprised 11 OECD countries: Australia, Canada, France Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States.
2 See the excellent study by Lazar et al. (2013).

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governance are concepts at home in management theory and practice. Could a management perspective contribute usefully to the debate about a system-wide Canadian healthcare strategy in a way that could address the political obstacles?

For our purposes, we will take system-wide strategy to be interchangeable with "Canadian strategy," "national strategy," and "pan-Canadian strategy," but not "federal strategy."[3] Based on this, we will address the above questions as follows. First, we will explore how well our system is performing. If it is as strong as it should be, we will have less of a reason for wanting to look beyond the existing Canadian structure than if it is poorly performing. Second, are there are credible calls for a system-wide strategy? If not, and it is only a hypothetical possibility, there will be little urgency for strategic change. Third, what does having a strategy mean, and what form could such a strategy, or strategies, take? It is easy to misconstrue having a system-wide strategy as being equivalent to, or necessarily connected with, a specific form of governance, such as a federal government imposed top-down arrangement. This is not intended here. Fourth, I argue that a good prima facie case exists for a Canadian system-wide strategy. Building on this, I propose that the *balanced scorecard approach* is well suited not only to frame a Canadian strategy, but also to be used as a strategic management tool. Fifth, the scorecard of the newly restructured National Health Service, England, can be fashioned as an illustration of what a Canadian balanced scorecard might look like. This is not to say we should emulate the NHS model, only that it contains certain important features that we might consider adapting for our own purposes. Sixth, I set out two governance models, collaborative governance and corporate governance, and show why the latter has advantages over the former in providing a basis for governance oversight of a Canadian system-wide strategy. Finally, some concluding remarks will draw the discussion points together.

Evaluating Canadian Healthcare

There are many ways of assessing health quality.[4] The Organisation for Economic Cooperation and Development (OECD, 2011) uses 70 indicators in eight categories: health status, non-medical determinants of health, health workforce, health care activity, quality of care, access to care, health expenditures and financing, and long-term care. It is not feasible to evaluate Canada's healthcare system in this depth, so what should we examine for the purposes of lending credibility to the call for at least some form of system-wide strategic framework? As Smith, Mossialos, Papanicolas, and Leatherman (2009, p. 8) point out, the wide array of data used to measure systems are often chosen, not because of their strategic value, but because of their accessibility and convenience of collection. Still, common to most approaches are five general categories: measures of healthcare provided by the system, responsiveness to individuals, financial protection to individuals from the costs of healthcare, productivity of the resources, and equity in terms of access. Smith et al. (2009) also maintain that prioritization is needed in data selection to fit the purposes for which it is being used.

How then should we prioritize? In a recent survey,[5] the Canadian Institute for Health Information (CIHI, 2013a) determined that access, responsiveness, equity, quality, health promotion and disease prevention, and value for money are what Canadians rank as being most important. For our purposes, I propose to consolidate these into three categories: (1) *cost of the system* (value for money); (2) *system performance* (quality, responsiveness, health promotion, and disease prevention); and (3) *access* (access and equity).

We will briefly evaluate these three categories and use this discussion as a step toward answering the question about whether Canada needs an overall healthcare strategy.

Cost of the Canadian System

Canada spends $211 billion on healthcare in an economy of $1.82 trillion (GDP), the 11th largest economy in the world. If Canadian healthcare expenditures represented a fictitious country's economy, that country would be the 46th largest in the world by GDP – between Portugal and Ireland.[6] These health expenditures have been rising steadily in both current and constant 1997 dollars since 1975, as Figure 1 shows. The same is in evidence when calculated as a percentage of GDP (see Figure 2). Although fluctuations have occurred, there seems little reason to think that expenditures to GDP will back down without either a reduction in the former or growth in the latter. The combination of population growth, new medical technologies and techniques, and the expansion of pharmaceuticals to treat illnesses explain continued expenditure growth both in absolute terms and as a percentage of GDP (CIHI, 2013b). These factors are likely to continue into the foreseeable future.

More than a decade ago, the Senate committee headed by Michael Kirby concluded in its report that "rising costs strongly indicate that Canada's publicly funded health care system, as it is currently organized and operated, is not fiscally sustainable given current funding levels" (Kirby, 2002, p. 2). At roughly the same time, the *Romanow Report* (2002) seemed to maintain the reverse, namely that the system was sustainable. The Report said:

> The system is neither unsustainable nor unfixable, but action is required to maintain the right balance between the services that are provided, their effectiveness in

3 A federal strategy is mandated by the Government of Canada.

4 The World Health Organization (2013) uses approximately 80 measures in the following categories of indicators: life expectancy and mortality, cause-specific mortality and morbidity, selected infectious diseases, health service coverage, risk factors, health systems, health expenditure, health inequities, and demographic and socioeconomic statistics. Also, the Canadian Institute for Health Information (CIHI, 2014) measures system performance in terms of access, quality, spending, health promotion, and disease prevention and health outcomes.

5 See Canadian Institute for Health Information (CIHI). (2012). *Engagement Summary Report 2013: Health System Performance Dimensions*. CIHI & Hill and Knowlton Strategies.

6 See World Bank. (2014). *Gross Domestic Product 2012*. Available from http://databank.worldbank.org/data/download/GDP.pdf

> meeting the needs of Canadians, and the resources that we, as Canadians, are prepared to dedicate to sustain the system in the future. (p. 2)

In the end, Kirby and Romanow were not far apart: Kirby said the system is not sustainable *without* remediation; Romanow said the system is sustainable *with* remediation.

Nearly a decade later, Drummond (2011) added an ironic touch by suggesting that Canadians should be careful what they ask for. He said:

> When asked, voters respond that they are prepared to pay higher taxes and consume less of other public services in order to preserve healthcare. But it is not clear they understand how severe this squeeze could become.

The question then becomes, how much tolerance do Canadians have? To date, it appears that the threshold is high.

A key part of the story for our purposes, though, is not just a matter of expenditure increases, but rather it is how much we spend compared to our peer group – the 34 OECD member countries. Measured as a percentage of GDP, Canada ranks 5th highest among 30 of the OECD countries (see Figure 4). In terms of per capita expenditures, Canada is 36% higher than the OECD average, and we rank 6th highest among member countries (see Figure 5). In both percentage of GDP and per capita expenditures, Canada is well below its usual comparator, the United States. However this is still above nearly three quarters of the rest.

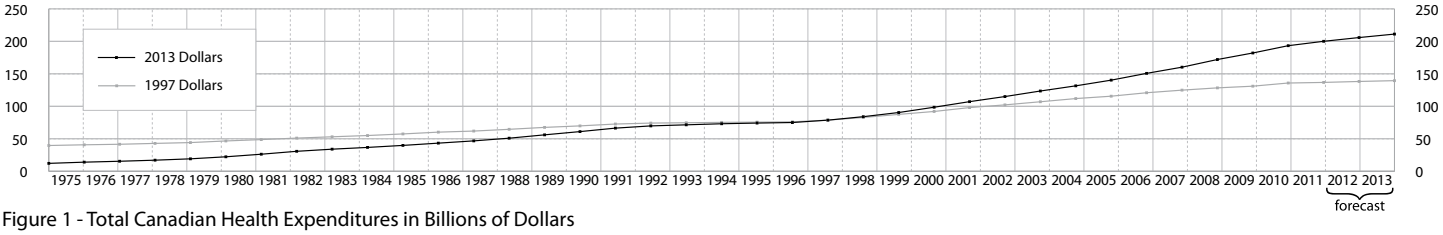

Figure 1 - Total Canadian Health Expenditures in Billions of Dollars

Source: National Health Expenditure Database, Canadian Institute for Health Information.

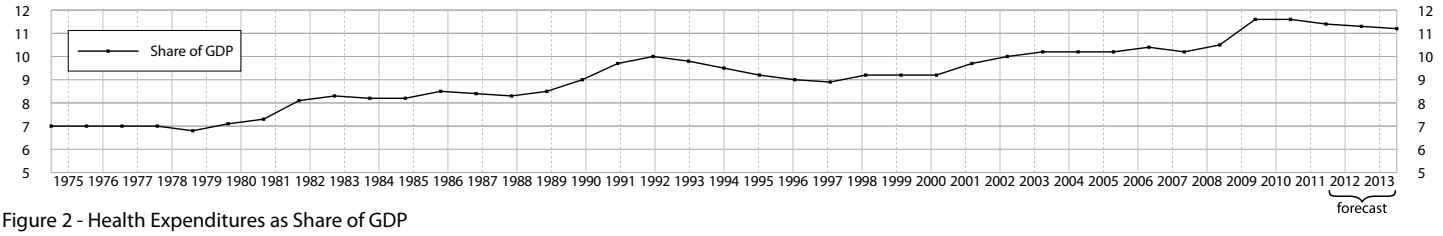

Figure 2 - Health Expenditures as Share of GDP

Source: National Health Expenditure Database, Canadian Institute for Health Information.

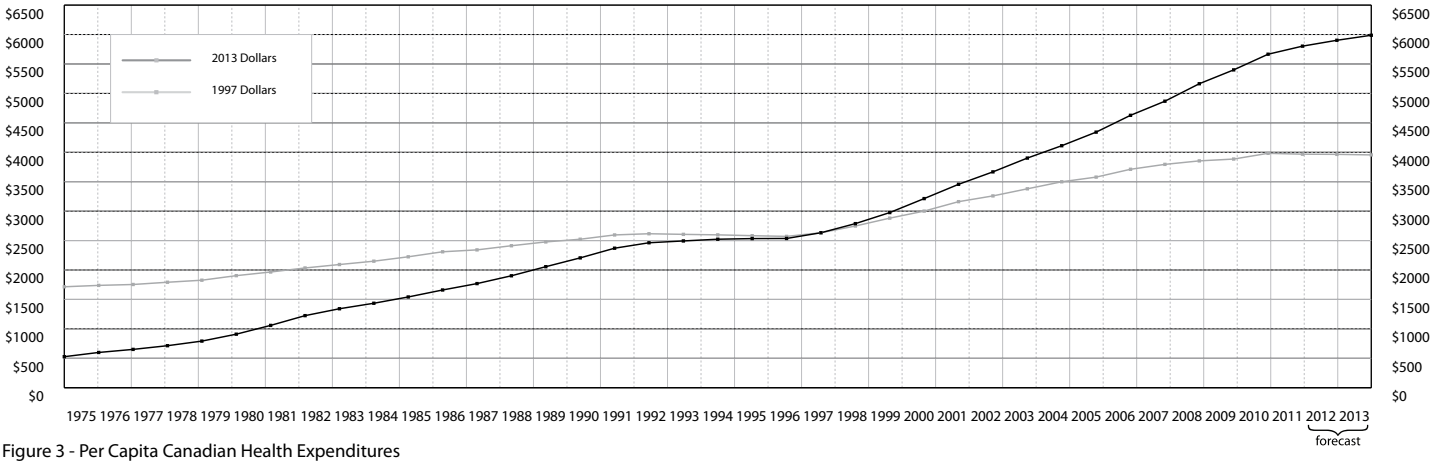

Figure 3 - Per Capita Canadian Health Expenditures

Source: National Health Expenditure Database, Canadian Institute for Health Information.

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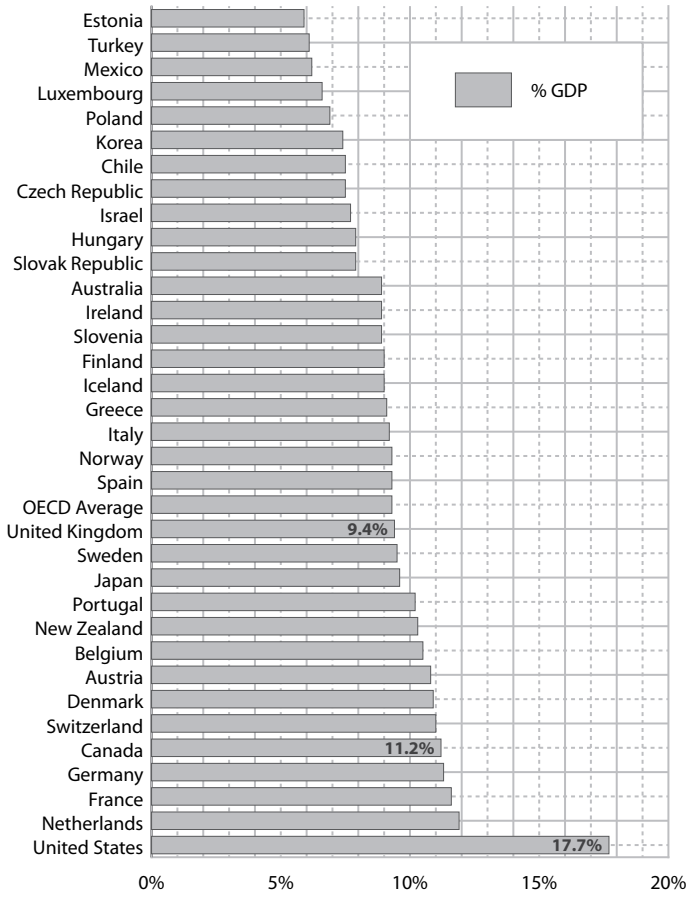

Figure 4 - Healthcare Spending as % of GDP, 2011 (or nearest year)
Source: Organisation for Economic Co-operation and Development (OECD) Health Data, 2012.

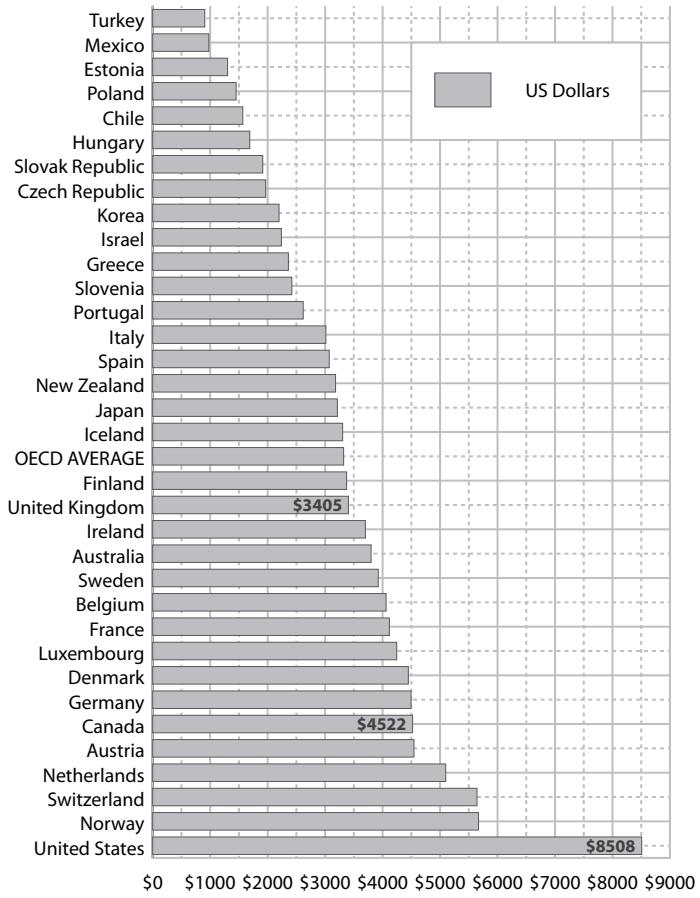

Figure 5 - Per Capita Healthcare Expenditures, 2011 (or nearest year)
Source: OECD Health Data, 2012.

It is useful to note the relative position of the UK, as its system is less expensive than Canada's. The UK ranks 14th in health expenditures as a percent of GDP, and 15th on a per capita basis. This is an interesting comparison with Canada because in the Commonwealth Fund (2010) study referred to earlier, 92% of UK respondents were confident/very confident that they would get most-effective treatment (including drugs and diagnostic tests) if they became seriously ill. Canadians were much less confident at 76%.[7] Canada spends 33% more per capita than the UK, yet the UK respondents are considerably more confident about their quality of care.

We should not conclude from this review that an expensive system is unacceptable in itself, although it is clear that Canadians will need to be prepared to provide the resources to finance it, even if this means accepting diminutions of expenditure on other social programs such as education and social services. Rather, we should ask whether this expensive system is justified. Let us consider the two other evaluation criteria, namely performance and access.

System Performance

There are many ways of measuring performance, but a synoptic view should suffice to make the general point about performance. Figure 6 (CIHI, 2014) shows OECD data in five categories of patient care performance: care in the community, patient experience, cancer care, patient safety, and acute care outcomes. Across a wide range of indicators in each category, Canada is compared against the OECD average.

7 The average confidence level in the 11-country survey was 79.9%. Germany was the median country at 82%, and Australia and Canada were tied at 76%. Only the United States and Sweden were below, at 67% and 70%, respectively.

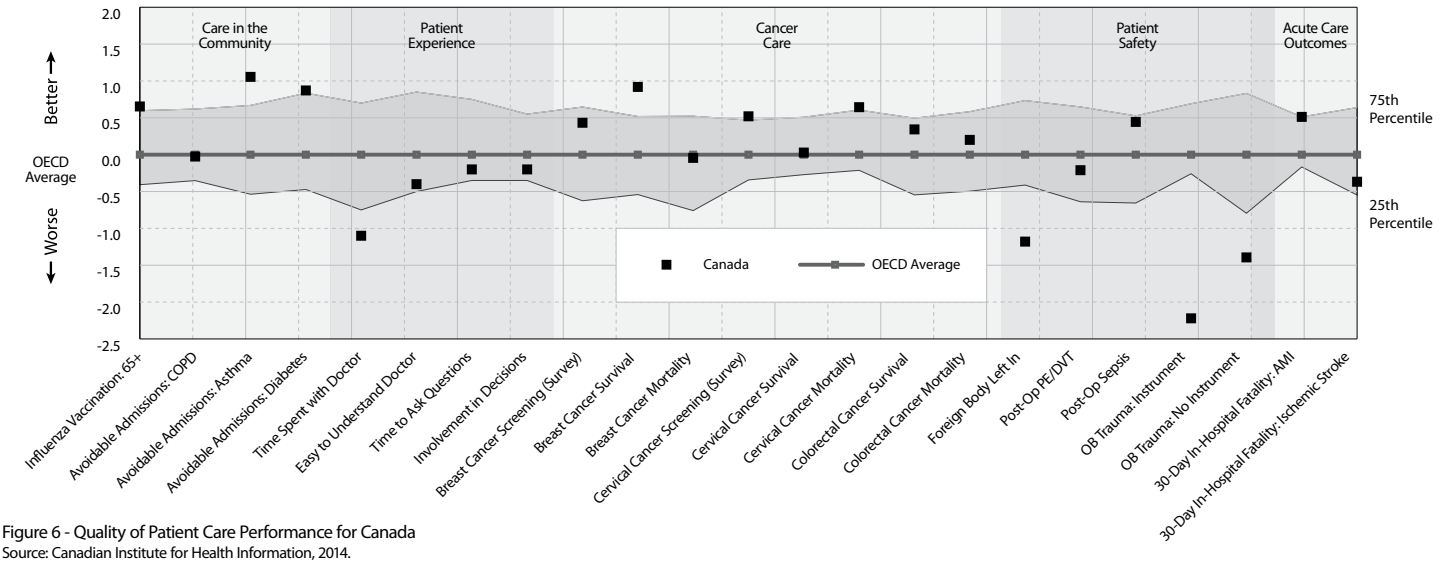

Figure 6 - Quality of Patient Care Performance for Canada
Source: Canadian Institute for Health Information, 2014.

Without going into the detail of the Chart here, it is easy to see that Canada performs at or above the average in community care and cancer care. Each indicator is within the middle 50 percentage points between the 75 and 25 percentiles. In two cases, Canada even performs above that band. However, performance is below the average for patient experience, though still within the middle band, except in one case where it is shown as below the band. Performance in patient safety, though, is considerably worse, with four of the seven indicators falling below the middle band. Finally, the hospital fatality measures in terms of acute care outcomes are split between above and below the OECD average, but both are within the 75/25 band.

The conclusion to be drawn here is not about definitive assessments of system performance. Rather, it is about asking whether our system could perform better. If so, this leads to the further question of whether its performance as a system could be improved by better planning? In other words, if we had a more strategic approach to knitting the pieces of our high cost system together, with a clear focus on patient outcomes, and on how the parts of the system could efficiently and effectively contribute to this effort, would we be better off? Of course, having a comprehensive strategy would not guarantee outcomes, but as we formulated the strategy (or strategies), we would evaluate the causal relations among the components and plan for successful connections between them.

Accessibility

There are two aspects of access to be brought out: wait times and cost to patients. Starting with the former, consider some of the results of the Commonwealth Fund (2010) survey summarized in Table 1.

The Commonwealth Fund 2010 International Health Policy Survey in Eleven Countries
(Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom, United States)

Medical Service Wait Times	Canadian Comparative Performance
Access to doctor or nurse when sick — same or next day appointment	**Worst (tied)**
Access to doctor or nurse when sick — waited six days or more	**Worst**
Difficulty getting after hours care without going to emergency room	**Second worst**
Used emergency room in past two years	**Worst**
Wait time for specialist appointment — less than 4 weeks	**Worst**
Wait time for elective surgery — less than one month	**Second worst**
Wait time for elective surgery — four months or more	**Worst**

Table 1

It is not difficult to see the list of deficiencies. The first three items address basic wait times for seeing a doctor or nurse when sick. Canada performs worst in its

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peer group in patients getting in to see a doctor or nurse the next day, or even within six days. The default option for those unable to get medical attention in the community is to visit the emergency department of a hospital – a very time consuming experience for patients, and expensive for the system. Canadians are the second worst in accessing after hours care without going to the hospital, and worst in terms of needing the hospital for medical attention that likely otherwise could have been dealt with in a physician's office.

Surgical wait times, the following three items, score no better than family practitioner wait times. Canadians wait the longest to see a specialist. And the time it takes for elective surgery is second worst, in that there are wait times of less than one month; wait times taking longer than four months are worst of all.

The second issue relates to accessibility with respect to cost, precisely what the universal health insurance under the auspices of the Canada Health Act (1985) is supposed to address. A recent study (Sanmartin et al., 2014) shows that while healthcare costs have been rising for all Canadian income groups, the burden has been highest for those with lower incomes. This is accounted for by out of pocket spending on prescription drugs and dental care insurance premiums.

Returning to the Commonwealth Fund (2010), we are provided with useful, if sobering, results which show Canada in the bottom four (of 11) in each category. Table 2 summarizes this.

The Commonwealth Fund 2010 International Health Policy Survey in Eleven Countries
(Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom, United States)

Medical Service: Income Accessibility	Canadian Comparative Performance
Answering yes to at least two of: • Did not fill prescription of skilled doses • Had medical problem but did not visit doctor, • Skipped test, treatment or follow-up	**Fourth worst**
Out of pocket medical costs $1000 or more, past year	**Fourth worst**
Serious problems paying or unable to pay medical bills, past year	**Fourth worst (three-way tie)**
Confident will be able to afford needed care	**Third worst**

Table 2

Should we be satisfied with such poor accessibility? Given that we have an expensive system, is there a reason why these impediments to accessibility should be permitted? Could a national strategy address this? Many countries in our peer group do have national strategies. Could this partly explain why they perform better in managing their systems?

The UK, for instance, performs better than Canada in every category of both wait times and income access above. Indeed, it leads all 11 countries in each of the income access categories. By contrast, the US, which does not have a national strategy, is among the three worst in four of the seven wait-time categories and at the bottom in each income accessibility category. That said, since Canada usually compares itself to the US, we should note that the US performs better than Canada in all seven wait-time categories. In terms of income accessibility, Canada ranks better than the US in each category; but lest we be too sanguine, we share with the US the bottom four ranking in all categories.

A final observation from the Commonwealth Fund (2010) study has relevance for accessibility. First, when asked whether they were confident/very confident about receiving the most effective care if sick, Canadians were the third least confident, as indicated above. When the responses were broken out between above and below average income, it would be expected that a country such as Canada, that prides itself on being egalitarian, and that has the Canada Health Act (1985), which seeks to enshrine such values in the universal insurance scheme, would have a very small gap between the two income levels. Yet Canada is the third worst, ahead only of the US and Sweden. Further, when it comes to cost related access problems in the past year by income, it would again be expected that Canada would perform well. However, Canada is also third worst on this indicator (ahead of only the US and Norway).

In summary, it is difficult to see Canada's very expensive system with its rising long-term cost trajectory, as performing at a satisfactory level. So we now address the matter of a system-wide (or national or pan-Canadian) strategy. The first question is, are there currently any demands from key stakeholders for this?

Calls for a System-Wide Strategy

The foundation of any strategy is a common vision and shared goals. From this can be built strategic direction and prioritized courses of action, chosen from among competing alternatives. For decades, national discussions of Canada's healthcare system have called for this. The idea of a Canadian strategy is not something new. As far back as 1964, a Royal Commission on Health Services (Hall Commission) brought forward recommendations for a national health policy and a comprehensive program for healthcare (Hall, 1964/1965). Hall recommended a universal health insurance system for all Canadian provinces based on the existing Saskatchewan model. Hall's recommendations were influential in the creation of the Medical Care Act (1966), although the Act was

not as comprehensive as Hall's proposals.

In 1974, the federal and provincial health ministers endorsed a general framework, later produced in a white paper called, "A New Perspective on the Health of Canadians: A Working Document," by Marc Lalonde, Canada's Minister of National Health and Welfare. He states: "there are national health problems which know no provincial boundaries and which arise from causes imbedded in the social fabric of the nation as a whole" (1974, p. 6). Lalonde goes on to spell out broad objectives, main strategies, and a myriad of proposals, which he says, "constitutes a conceptual framework within which health issues can be analysed in their full perspective and health policy can be developed over the coming years" (p. 73).

The report of the Romanow Commission (Romanov, 2002) entitled, *Building on Values: The Future of Health Care in Canada,* contained 47 recommendations, many of which are parts of what could have been developed into a Canadian national strategic plan. Based on shared values represented by a publicly funded health system and compatible with jurisdictional nature of the Canadian political system in health information, health human resources, health education, research, primary care, immunization, home care, prescription, and many revisions to the Canada Health Act accommodate this. The establishment of the Health Council of Canada to bring collaborative leadership, coordination and common measures, and a performance metric was central to the overall strategy. By combining forces with nationally mandated institutions such as Canada Health Infoway, with its mandate to invest in health technology projects, and the Canadian Institute for Health Information, the vehicle through which national health analysis and reporting could be conducted, a pan-Canadian framework could be established. Romanow (2002, p. xxiii) introduces his report saying:

> Taken together, the 47 recommendations contained in this report serve as a roadmap for a collective journey by Canadians to reform and renew their health care system. They outline actions that must be taken in 10 critical areas, starting by renewing the foundations of medicare and moving beyond our borders to consider Canada's role in improving health around the world.

Reporting at approximately the same time, the Senate Standing Committee Report, *The Health of Canadians: The Federal Role,* Chaired by the Honourable Michael Kirby (2002), covered much of the same ground with a similar starting point, namely that "Canadians want the provinces, the territories and the federal government to work collaboratively in partnership to facilitate health care renewal. Canadians are impatient with blame-laying; they want intergovernmental cooperation and positive results" (Kirby, 2002, p. 6). Kirby provided many recommendations concerning national practices, as did Romanow, but he stopped short of calling for national bodies with clear decision-making mandates for action, and with the legal authority to make change or sanction inaction. For instance, his proposal for system-wide governance ignored advice from academics and others to the Committee about independence and autonomy (Kirby, 2002, pp. 14–16), and instead proposed the National Health Care Council, which would substantially make reports and recommendations to governments (Kirby, 2002, p. 19).

Whatever their merits, Hall, Lalonde, Romanow, and Kirby all affirmed that a vision for Canadian healthcare was crucial, not just for sustainability, but also for achieving the level of healthcare that Canadians deserve. This overriding message taken in the light of the criticisms of sustainability, performance, and access might lead us to wonder if the voices for a national strategic approach have been strong enough.

Of course, not all calls for system-wide strategies are comprehensive. Many are specific to components of the system. For instance, a Federal/Provincial/Territorial Committee (2007) addressing healthcare delivery and health human resources said that "between 60 and 80 cents of every health care dollar in Canada is spent on health human resources (and this does not include the cost of educating health care providers)" (p. 1). The committee went on to recommend "a pan-Canadian framework that will help shape the future of HHR planning and health service delivery… [and that] builds a case for a pan-Canadian collaborative approach to planning...to achieve a more stable and effective health workforce" (p. 2).

In another case, with regard to patient safety, the National Symposium on Quality Improvement (Health Council of Canada, 2013) said:

> we have seen the good results that can come from pan-Canadian approaches in areas such as patient safety and accreditation in this country. We could achieve greater system transformation and improve quality of care if we were to adopt a common quality improvement framework through which we could learn from each other.

This perspective is shared by the Royal College of Physicians and Surgeons (2002), which proposed that we establish "a coordinated, national strategy… to reduce error in medicine, increase patient safety and thus quality of care" (2002, "Preamble"). On a related issue, the Canadian Medical Association conducted a survey (CMA, 2013) showing that "nine in ten Canadians agree having a national health care strategy for seniors would improve the entire health care system" (p. 6).

Outside the medical profession, there are other calls for a Canadian strategy. For instance, the Canadian Life and Health Insurance Association (2013) says that, "the industry believes that Canadians would benefit from the establishment of a common national minimum formulary" (p. 27). Further, with respect to electronic health records (HER), the Auditor General of Canada (2010) commented that, "implementing EHRs is a pan-Canadian initiative that requires the collaboration of the federal government, Canada Health Infoway Inc. (Infoway), provincial and territorial governments, as well as other organizations involved in the delivery of health care" (2010, "Shared Responsibility"). As well, the medical device industry, through its industry association MEDEC (2012),

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in discussing health technology assessment, "recognizes the challenges of decision making in very complex and somewhat silo-based health systems, however, the true value of HTA (Health Technology Assessments) and innovative medical technologies will only be realized through a whole system approach to health care resource management" (MEDEC, 2012, p. 3).

What does all this mean? It shows that within government, industry, professional associations, and others, there are many voices calling for either or both a comprehensive pan-Canadian, system-wide strategy, or sector specific pan-Canadian, system-wide strategies that deal with aspects of Canadian healthcare. It certainly is not necessary to opt for one or the other. A Canadian strategy could be comprised of both comprehensive general strategies and more focused sector-specific strategies.

What the discussion so far does not show is what a Canadian strategy should necessarily contain, either with respect to its scope or the specific content of its recommended objectives, measures, targets, and activities. But it does point to the need for strategy. This is well summed up by the Institute for Public Policy Task Force on Health Policy. In its recommendations to First Ministers (IRPP, 2000), it said: "After nearly a decade of cost cutting, some Canadians have lowered their sights from an excellent healthcare system to one that merely meets minimum standards. This is unfortunate. Canadians should demand and expect excellence, not mediocrity" (p. 6). To this was added the explanatory note,

> the system lacks clear goals and is not sufficiently accountable to the public. While the original principles of the Canada Health Act remain valid, they are no longer sufficient to address the new realities and emerging challenges of health services delivery. Nor do principles substitute for strategic and long-term planning to anticipate the growing pressures on healthcare delivery and the changing healthcare needs of Canadians. (p. 6)

A Canadian System-Wide Strategy

What form could a Canadian system-wide healthcare strategy take? To repeat what was said at the outset, words like "system-wide," "pan-Canadian," or "Canadian" when modifying the word "strategy" are taken herein to be synonyms. And none should be construed as meaning an arrangement in which the federal government usurps the roles of provinces and territories. A Canadian strategy is something that must be acceptable to all, or at least most, provinces and territories as well as the Canadian government.

Next, it is easy to become confused about what is meant by a "strategy," and how it might apply to a national healthcare system. So let us start with some preliminary groundwork leading to a working definition.

Strategy has its roots in military[8] and political[9] contexts. As a management concept, though, it has grown exponentially from the mid 20th century to the present, mainly because of the vast increases in the scale and scope of corporations. It is not difficult to see how the concept of strategy applies to governments and their healthcare systems, because many corporations today have revenues that exceed the GDP of countries. For instance, the largest five companies in the world (Royal Dutch Shell, Wal-Mart Stores, Exxon Mobil, Sinopec Group, and China National Petroleum) have revenues ranging from $482 billion to $409 billion: each larger than the entire economies of countries falling below 27th in the world as measured by GDP. Even the 500th largest company (Ricoh)[10] has annual revenues the size of Trinidad and Tobago, the world's 100th largest economy. And many of the companies on the Fortune 500 list are very complex, having many different lines of business and operating in countries all over the world.

Strategy is discussed in the management literature from many perspectives,[11] such as: (a) patterns of action that can be observed in an organization's decision-making; (b) approaches that an organization takes to positioning itself in the marketplace to gain competitive advantage; (c) philosophical perspectives or images that an organization has of itself; (d) tactics used to compete in the marketplace; and (e) plans that an organization makes to guide decision-making and to achieve its goals.

While strategy can have various meanings, for a healthcare system, strategy needs to be prescriptive, i.e., providing guidance for the future. So (a) will not suffice because it simply describes what is occurring, rather than pointing to what should exist. Definition (b) focuses on competition, so it is better suited to business, or at most the business aspects of healthcare, not the Canadian system overall. Neither (c) nor (d) is sufficient for system-wide, forward-looking guidance, however both could be incorporated into (e), which is the most useful because its focus is planning. Planning the future is the most common meaning associated with strategy, so if we combine (e) with a philosophical approach and tactics, a working definition could be generated. Consider this proposal:

> *A Canadian healthcare strategy is the pattern of decisions that is justified and motivated by goals and principles that embody what we are committed to do in order to promote, restore and maintain the health of Canadians. The pattern of decisions is shaped by specific measurable objectives and activities for achieving desired Canadian health outcomes. The strategy is imbedded in a vision that reflects our aspirations for health based on fundamental Canadian values.*

8 See for instance, Sun Tzu, *The Art of War* (1971; lived 544BCE–496BCE), and Carl von Clausewitz, *On War,* (1968; lived 1780–1831).
9 Niccolo Machiavelli, *The Prince,* (2013; lived 1469–1527).
10 See the CNN listing of Fortune 500 companies, at http://money.cnn.com/magazines/fortune/global500/2013/full_list/?iid=G500_sp_full
11 This reflects H. Mintzberg, "The Strategy Concept: Five P's for Strategy," (1987, pp. 11–24). For a full analysis and critique of the concept of strategy, see H. Mintzberg, B. Ahlstrand and J. Lampel, *Strategy Safari: Your Complete Guide Through the Wilds of Strategic Management,* (2009).

Construed this way, the components of a Canadian healthcare strategy can be set out in Figure 7.

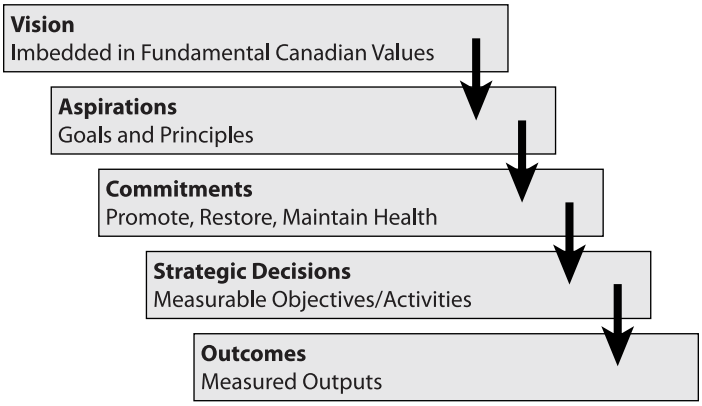

Figure 7 - Components of a Canadian Healthcare Strategy

It might be thought that such a framework could fit only institutions, such as hospitals, and be difficult to stretch out to cover a whole system. I will provide a more concrete system illustration in a moment, but for now keep in mind that system-wide strategies are common in Canadian at the provincial and territorial level. And as an example of a national strategy, the National Health Service in England (NHS England, 2013) has published its strategy in the form of a business plan for 2013–2016, with measurable objectives and targets. Systems can have strategic plans as well as organizations.

A system strategy is really a "strategy-of-strategies" because it incorporates the independent strategies in the various parts of the system. This is common in the corporate sector where some organizations are so large and diverse that they share many characteristics of a national healthcare system.

The next step in understanding the form of a Canadian healthcare strategy is to extend the definition into a structure that shows how the pieces of strategy relate to one another. The "balanced scorecard" (BSC) approach provides a good basis for this.[12] In various forms, it is being used around the globe by governments,[13] regional health authorities, hospitals, and others, as the vast and growing academic and professional literature shows.[14]

The Balanced Scorecard (BSC) Approach

The balanced scorecard (BSC) is not simply a dashboard for categories of decision-making. It is, rather, a strategic management system. Its purpose when applied to healthcare should be to ensure that the focus on patient health is paramount. To ensure good patient outcomes, it is essential that the healthcare delivery system is financially stable, and that management processes and procedures are efficient and effective. As we will see, the BSC approach functions as both guide and monitoring device for decisions and actions. Managers use the BSC to ensure continuous alignment of patient-centred priorities with the aspects of the system that support them.

As Figure 8 shows, the first planning step is to translate visions, aspirations, and commitments into concrete strategies that are measurable. Next, appropriate measures (quantitative or qualitative) need to be established. Then, targets for the planning period using the selected measures are set. Finally, at the end of the period, assessments of outputs are made to determine whether the targets have been met. This leads back into the planning cycle for the next period.

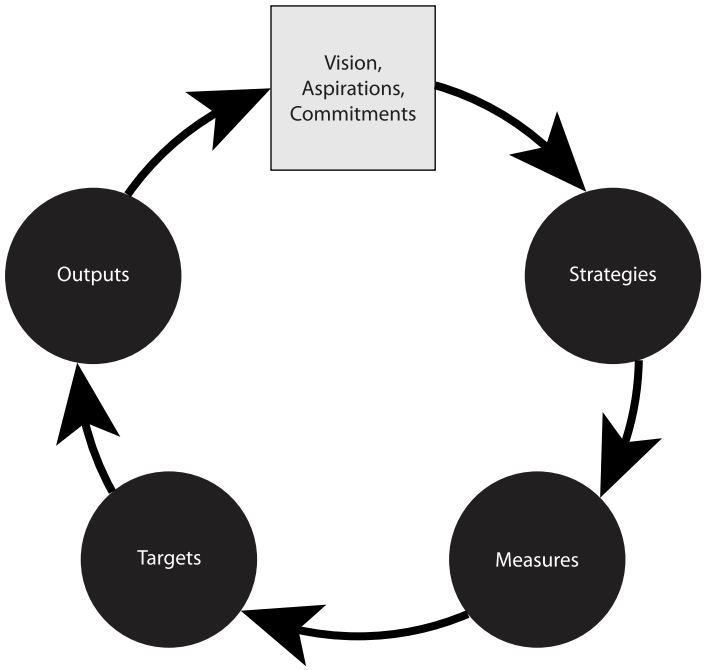

Figure 8

We consider certain essential aspects of the BSC next.

Strategy and Measurable Outputs

The first important feature of the BSC as a strategic framework is the connection that it makes between strategy and measurable outputs. This connection is built into the logic of the BSC approach. Even aspirational goals,

12 R. Kaplan and D. Norton, "The Balanced Scorecard: Translating Strategy into Action," (1996). See also, R. Kaplan, "The Balanced Scorecard for Public-Sector Organizations," (1999), and R. Kaplan, "Overcoming the Barriers to Balanced Scorecard Use in the Public Sector," (2000).
13 See for example the use made of performance metrics by the Alberta Health Service (2014).
14 Among the many studies outlining how and where the balanced scorecard approach is being used in healthcare for strategic and other operational purposes, see: L.C. Yee-Ching, A. Seaman, "Strategy, structure, performance management, and organizational outcome: Application of balanced scorecard in Canadian health care organizations," (2008, pp. 151–180); W.N. Zelman, G.H Pink, and C.B. Matthias, "Use of the balanced scorecard in health care," (2003).

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which are intrinsic to the very nature of healthcare, need to be translated into concrete measurable strategies in the BSC. For example, consider six World Health organization ideals (WHO, 2014): promoting development, fostering health security, strengthening health systems, harnessing research, information and evidence, enhancing partnerships, and improving performance. Each represents a valuable aspiration for the future, and all could remain as goals in the future no matter how far we progress toward them – there is always more to do. But words like "promoting," "fostering," "strengthening," "harnessing," "enhancing," and "improving," whether they are WHO goals or those of a hospital, need to be re-crafted and expressed as achievable and measurable outputs. These outputs are not synonymous with the aspirations. Rather, they are necessary (or at least causally connected with), but not sufficient for meeting the aspirational goals.

As an example, suppose that "fostering health security" in Canada is a goal that is defined as requiring strategies for dealing with pandemic infections such as SARS. We translate this goal into strategies to address quarantine of potential victims, treatment of infected individuals, and health system plans for containment that enable the system to continue operating. In the case of, say, quarantine, we determine that we need quantitative *measures of success* such as a specified number of days to isolate each new case. The next step in translating this strategy is to identify a *target*. Suppose we fix a target that is a range of three to six days. We could measure hospital efficiency rates against this. Further, we could set measures and targets for transmission rates in terms of percentage reductions from past pandemics, e.g., a 50-90% reduction. Once this has been fleshed out in detail, we will have a measurable strategy. It would then be measured when we actually had a SARS outbreak or other pandemic and had to rely on our strategy to address it.

Not all measurement must be strictly quantitative. In some cases, qualitative process measures are more appropriate. For example, returning to the WHO goals, we might interpret "enhancing partnerships" as meaning the development of research relationships between Canada's medical schools and those in the UK. In the early stages of partnering, we might choose a process measure such as conducting a conference among medical school deans from both countries. The *measure* would be the process of setting this up and the *target* could be the date by which the first conference should take place. At some future date, the measures and targets might be expressed in terms of numbers and size of research grants, published papers, conference presentations, etc. But that would be developed in later iterations of the strategy.

Strategic Perspectives

The second component of the BSC framework is the segmentation of strategies. The classic corporate model of the framework treats all strategies that are generated by the vision, objectives, goals, and commitments as either being a, (a) financial perspective, (b) customer perspective, (c) internal-business process perspective, or (d) learning and growth perspective. The classic model holds that a causal relationship exists among these perspectives. That is, financial success is measured by how well the organization's strategies are generating value. This is causally dependent upon how well the organization manages its customers by satisfying their needs, retaining them, and attracting new customers. Customer management is dependent upon focusing on processes that are most important to meeting customer needs and expectations. The internal business systems, or management systems, as we will refer to them, comprise technology, equipment, operating processes and procedures, and entrepreneurship and innovation. In dealing with customers, these systems are ultimately what help to generate the organizational value that is then delivered to the customer. Finally, how well the organization learns, adapts, and innovates is causally related to how well the other categories function. There are three main sources of learning and growth: first are the health human resources, specifically their knowledge, skill, and commitment to organizational goals and most especially to patients; second are the systems that enable healthcare teams to deliver the value to patients; and third are the organizational procedures that align the people and systems to add value.

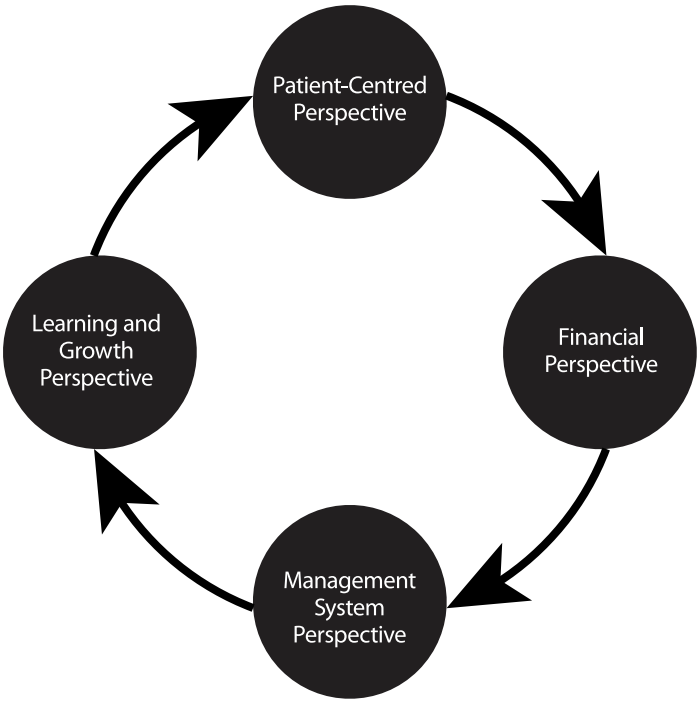

Figure 9 - Four Inter-related Strategic Perspectives

The BSC is a framework for the implementation of strategy. It assumes that the process of establishing vision, objectives, goals, and commitments has taken place. Its main purpose is to establish processes and procedures of organizations, whichever they are, to add value as the strategy is moved to action.

Further, the classic BSC presumes that the highest priority in value extraction is financial in nature. This needs to be amended for healthcare (indeed

most public sector environments) by moving the financial perspective to a supporting role, namely as an enabling condition for adding value to patients, or those requiring care, in order to promote, restore, or maintain health.[15] Placing the priority on patients and those in need by the healthcare BSC process is crucially important. Equally so is the focus on patients that drives both the internal-business process and learning and growth perspectives. Canadian healthcare has long been criticized for placing too much emphasis on what is in the best interests of the doctors or nurses, or on what processes best suit hospital schedules. As Porter and Lee (2013) write: "We must move away from a supply-driven health care organized around what physicians do and toward a patient-centered system organized around what patients need" (p. 50). The BSC shines a light directly on these issues, and it pushes its users to focus on what is best for the patient. The efficiency and effectiveness of the healthcare system have this patient focus as their end, not the practitioners and not governments.

Table 3 presents a schematic outline of the BSC. For Canadian healthcare, strategic objectives would be established on the basis of each of the four perspectives. (While other perspectives might be created it is likely that the existing four will accommodate most strategies.)

Balanced Scorecard Framework					
Perspectives	Strategic Objectives	Measures	Targets	Activities	Outputs/ Outcomes
Patients					
Financial					
Management System					
Learning and Growth					

Table 3 - Balanced Scorecard Framework

The scorecard is used to link the strategic objectives to measures that are appropriate. Targets for the planning period under consideration are set and expressed in terms of the measures that have been selected. The management activities (or sub-strategies, tactics, etc.) are expressed in summary form. The process should then track performance throughout the period and record the outputs of the activities. They are compared against the targets to determine how successful the plans have been. The cycle of re-planning for the next period begins from that point. In the process of assessment, it may be determined that the measures need to be refined or changed, and that targets for the new period need to be retained or changed in light of the experiences of utilizing the plan. Or, it may be that activities need to change, again based on the actual experience during the period.

BSC and Focus and Cause

The BSC approach emphasizes focus. The focus on what is really important to achieving the strategic objectives. Patient strategic objectives related to promoting, restoring, and maintaining health are the highest priority. If the financial perspective is crucial to achieving patient strategies, then so is mapping them to strategic activities and then to measureable outcomes. As we saw earlier, much of the economic sustainability discussion holds it to be central to public policy in its own right. But in terms of a Canadian healthcare strategy, it will need to play a facilitating role as the BSC encourages us to see.

It would be a mistake to conclude that money cures all healthcare problems, and that as much public funding as requested should be provided. The BSC approach clearly requires the causal connection to be a fundamental determinant of investment. Ill-spent support funding could meet the test of focus, but it does not meet causality. This was partly the problem with the implementation of the Romanow Commission's recommendation that funding be increased to bring about change. The commission recommended both focus and causal legitimacy; the implementation met the former but not the latter test.

The business-system perspective requires that we focus directly on those innovative and system management practices and internal system procedures that link to patient objectives. Earlier it was pointed out that more than 70 indicators of health system performance are tracked by OECD, WHO, CIHI, Commonwealth Fund, and others. It is tempting to pick and choose from among them to support evaluations. The BSC approach would see this as a "cart before the horse" problem – using the information we have at hand, rather than determining what information is needed to support the management system evaluation, which in turn is focused on patients. The performance data tells us about the past. Strategy is about the future. What the BSC approach points out is the causal relationship between management systems and patient outcomes, and this relationship should drive our forward-looking requirements for information.

The learning and growth perspective is well suited to deal with the longstanding problem of doctors and hospital schedules and procedures that are self-referential. Schedules and value chains often place the doctors and nurses at the centre. The BSC recognizes the importance of health human resources, but in a strategic management system places them in a supporting role, causally connected to achieving patient outcomes.

15 Even corporations that operate within the 30% private sector portion of Canadian healthcare, namely insurance companies, pharmaceutical manufacturers, drug stores, device manufacturers and distributors, and health sector technology companies, typically state their missions and values in terms of helping people.

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The BSC and Definition of Strategy

The balanced scorecard is a strategic management implementation framework, but it says little about the guidelines for strategy formulation. However, our definition of strategy bridges this gap. It sets out the key building blocks for developing the strategies, which the BSC shows us how to implement.

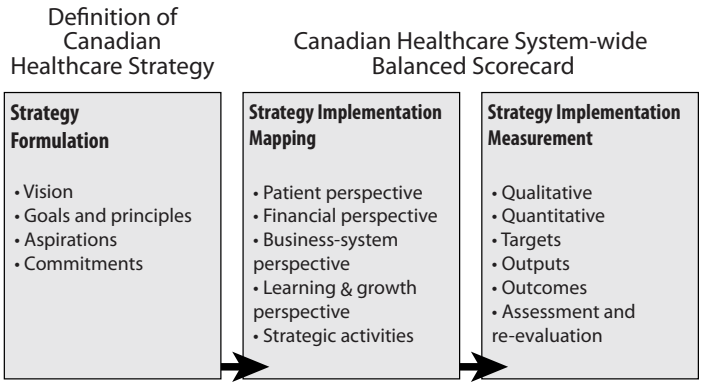

Figure 10

The question arises as to whether the BSC could have application to a health system, or if it should mainly be restricted to smaller parts of the system, e.g., hospitals, community access centres, and private providers. To address this, an illustrative case is the newly restructured National Health Service (NHS England). The NHS has a new business plan, and it takes the form of an 11-point scorecard, which can be expressed in the BSC form. We turn to this now.

An example of the Balanced Scorecard – NHS England

On April 1, 2013, the National Health Service in England launched a massive restructuring. Driven by serious concerns about system-wide failures leading to unnecessary suffering and premature patient mortality, a public enquiry was launched. As a result, the Francis Report (2013) made sweeping recommendations for change that led to an overhaul of the entire system structure.

In the new structure, political responsibility and accountability remain with the Secretary of State for Health, and the national Department of Health provides strategic leadership for health and social services. However, management control of the entire system, along with budget authority, is devolved to the newly created NHS England, which is an arms-length entity that functions independently from government. The NHS thereby becomes the national standalone oversight body for healthcare, but one that is still accountable to the government.

The primary driver of the new structure is patient-centredness. To achieve this structurally, Clinical Commissioning Groups (CCGs) are created at the local level, and are overseen by local governing boards, to plan and design local health services in planned hospital care, urgent and emergency care, rehabilitation services, community services, and services related to mental health and learning disabilities. Their main function is commissioning (purchasing) services from hospitals, social enterprises, charities, and private sector providers. The new system also includes regulatory agencies and entities to gather public input into decision-making.

In this structure, there are three helpful points for our consideration. First, is the adoption at the national level of an 11-point scorecard reflecting core priorities, against which to measure performance system-wide. Second, is that the scorecard places its highest priority on patients by developing mechanisms for feedback from patients and families and direct feedback from NHS staff. The details are spelled out in the planning document, *Putting Patients First: The NHS England Business Plan for 2013-2014-2015/2016* (NHS England, 2013). Third, is the attempt made in the reinvention of the NHS England to *depoliticize* control of the system, while retaining public accountability through the Ministry and Secretary of State for Health.

Let us start with the first and second points, namely the scorecard and its priority. NHS spells out in detail the content and rationale for the scorecard. We could not restate all of that here, but instead are only able to show how the NHS scorecard can be formatted as a BSC. What is shown in Figure 11 below are components of the NHS scorecard arranged into the BSC format. This is not an attempt to describe the NHS strategy per se. It is only to illustrate how a large and complex system-wide scorecard could be used in Canada. We certainly have scorecards at the provincial level; this provides an analogous look at a national BSC. That the complex English system strategy can be set out using a BSC approach should give confidence that Canada might be able to do so as well.

Strategic Perspectives	Strategic Objectives	Measures	Targets	Activities	Outputs/Outcomes
Patient-Centred Perspective	• Satisfied Patients • Motivated Staff • Prevent people from dying prematurely • Enhance quality of life for people with long-term illness • Help people recover from episodes of ill-health or injury • Promote equality and inclusion • NHS Constitution rights and pledges, including delivery of key service standards	• Feedback from patients/ friends/families (scale -100/+100) • (1) "Feedback from patients"); and (2) "Feedback from friends and family of patients, re. staff" • Progress against improvement indicators • Progress improvement indicators • Progress against indicators, potential years of life lost • Progress in reducing identified inequalities on all indicators • Direct commissioning and support and assurance of processes to ensure continued delivery • Measure, access, and publish information on each protected characteristic • Work in partnership with relevant agencies	• Launch customer service platforms by November 2013, full operation by 2015, and publish outcome data by 2015 • 80% CCG funding to support patient participation in decisions • Save £20,000 by 2016 by reducing mortality to best in Europe • NICE guidelines, 30 indicators • Publish a strategy by March 2014	• Medical and nursing directors to provide clinical leadership • Establish nursing compassion in nursing strategy • Emergency care review • Through health and wellbeing boards, develop plans for integrated care • Focus on earlier diagnosis, improved management in community • Improving accute care, mental health • Partnerships for quality • Financial incentives for improvements	TBD
Financial and Economic Perspective	• High quality financial management • Budget monitoring • Financial assurance systems • Manage NHS budgets within tight envelope	• Actual spend within budget	• Total budget of £1,1550 million • Detailed breakdown budget targets (commissioning, technical, directorates)	• Assure CCG and QIPP plans are part of planning process • Monitor CCGs to deliver transformational change • Financial incentives for good financial performance	TBD

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Business System Perspective	• Becoming excellent organization • Ensure staff understands roles • Staff properly supported • Staff well motivated	• 360 degree feedback from local and national partners • Staff survey results, 360 degree feedback	• Telehealth and telecare to 3 million by March 2017 • Online access to primary care offered by 50% of practices by April 2014, 100% by March 2015 • E-referrals service by December 2013, 100% of use by March 2017	• Supporting, developing, assuring commissioning system • Direct commissioning • Emergency preparedness • Strategy, research and innovation for outcomes growth • Clinical and professional leadership • World-class customer service • Developing commissioning support	TBD
Learning and Growth	• Learning by sharing ideas and knowledge, successes and failures • Plan for innovation	• Establish 10-year strategy for NHS • Evaluate medical models • Establish Centre of Excellence • Establish Leadership Academy • Progress on six high impact changes • Procurement of intellectual property • Establish research strategy	• 2014/2014 • 100,000 genome sequences over the next 3 years: cancer, rare diseases, infectious diseases • 2,000 staff to complete by 2014 • 2013/2014 • 2013/2014	• Range of programs throughout 2013-2014 to support diffusion and adoption of innovative practices and ideas • Monitor CCG's financial performance • Contribute to Genomics Strategy	TBD

Figure 11 - Illustrative Summary BSC for the NHS England

The second point is that patients are at the centre of the BSC in England. This affirms a point made earlier here that the BSC approach generally needs a different focus in the public sector than in the private sector, with respect to the primacy of people and service outcomes over financial measures of success. In a Canadian system-wide scorecard, this would be paramount.

The third point is about *depoliticizing* the management of the system. The new structure of the NHS transforms a hierarchical system of centralized control into a more decentralized system of local control through Clinical Commissioning Groups. The CCGs are funded by the NHS, which also provides oversight. Both CCGs and the NHS are imbedded in an environment of regulation (e.g., Monitor and Care Quality Commission) and citizen oversight (e.g., Health Watch and local Health and Wellbeing Boards) to provide further layers of accountability. In this respect, the objective of the new NHS shares much with the notion that Canada could have a system-wide strategy. Canada's starting point is decentralized provincial/territorial control, with limited centralized oversight by the federal government. Health Canada has its specific responsibilities under the Canada Health Act, but it does not exercise system-wide oversight as will the NHS England in its new role. The BSC approach has a chance of meeting the tests of focus on strategy and causal connections among components because oversight is in place. Canada could establish a scorecard. Let us assume that Canada did create a BSC. Who would oversee its application?

The BSC summarized above for the NHS serves to illustrate that something similar is, at least in principle, possible for Canada. As a national system, the NHS England is able to take direction from the Secretary of State for Health and the Ministry of Health in terms of the content of its scorecard. Canada is a federation, so agreement among the provinces and territories would need to be reached with the federal government, both on the need for a system-wide BSC and for a unified approach overall.

Depoliticizing the Management and Governance of a Canadian Balanced Scorecard

Interestingly, both Romanow and Kirby addressed the issue of a system-wide, or national (as distinguished from federal), independent body that would provide analysis, advice, and oversight to the system. Romanow (2002, pp. 53–59) recommended that the Health Council of Canada help achieve "an effective national health care system" (p. 54), by establishing common performance indicators and benchmarks, advising governments, and issuing public reports providing independent evaluations. It was to be an independent body "to drive reform and speed up the modernization of the health care system by 'de-politicizing' and streamlining some aspects of the existing intergovernmental process" (2002, p. 55). However, in reality, the Council had little authority to make change or require compliance from the provinces and territories.

Kirby recommended something similar. He had the opportunity to opt for a depolitized arms-length entity, and received recommendations to this effect. The argument in favour of doing so was the importance of depoliticizing the oversight body, which is an important feature of the new NHS England. Kirby demurred, saying:

> The Committee agrees with the many witnesses who stressed the importance of taking measures to 'depoliticize' the management of the health care system. However the Committee feels that this will be a long-term process, and that it is important to begin with the evaluation function only.

So Kirby opted instead for a much weaker model.[16] Nothing came of it.

For a Canadian system-wide strategy to be successful, not only an independent, but also a depoliticized entity with a broad management authority, is necessary. Whether the NHS England will achieve this over time remains to be seen.

What, then, should we consider for Canada? In terms of the governance of the oversight entity, it is helpful to contrast two governance models. A *council*, as proposed by both Kirby and Romanow, typically follows what could be termed a "collaborative governance model." This model usually comes into existence when a government identifies some policy or program that it wants to oversee in collaboration with other (usually, but not always) non-governmental partners.[17] A council is formed with representation from the collaborators, who provide direction to the entity through a process of discussion and debate leading to consensus. Consensus is the hallmark of collaborative governance. In brief, the collaborative governance model receives its legitimacy from government; processes are collaborative; and collaborators represent the interests of their own groups as well as those of the collaborative entity.[18]

Contrast this with a "corporate governance model." Shareholders (or stakeholders, in the not-for-profit sector) are entitled to the legal and economic property rights of the entity. Shareholders/stakeholders appoint or elect directors to act on their behalf, in order to oversee the managers of the entity to ensure that the managers are acting in the interests of the shareholders/stakeholders. The directors, then, provide the "governance" function. In this model, authority and legitimacy arise from a grassroots level, not from the level of government. The de facto processes that describe how directors typically work with each other and management are consensus-based. But consensus is not a defining feature of the corporate governance model, which is based on formal processes and procedures, namely legal rights, contracts, and voting procedures.

The collaborative governance model fits with the entities supported by Romanow and Kirby. The model provides for independent governance oversight, which is valuable. But it has four main weaknesses. First, it is susceptible to unresolvable disputes, because consensus decision-making relies on informal mechanisms to bring about agreement. If unsuccessful, participants have little recourse other than to withdraw from the collaboration. Second, it is vulnerable to political interference. Governments provide legitimacy to the collaboration, but governments also must meet public accountability requirements. The latter can become so imposing that decision-making authority becomes skewed to the interests of the government collaborator and overwhelms the interests of others. Third, in the collaborative governance model, each collaborator has a divided duty of loyalty, split between the interests of their own organization and those of the collaborative entity. Such conflicts can become unresolvable, leading to impasse and potentially even withdrawal from the collaboration. Fourth, the BSC requires an unrelenting focus on strategy and the delivery of outcomes. This highly managerial approach is not conducive to such a heavy reliance on consensus, even in operational matters.

The advantage of the corporate governance model for our purposes resides in its source of legitimacy. Authority starts with stakeholders (shareholders, in the case of corporations) who are the "owners" of the rights. The definition and content of those rights, along with the goals and objectives of the entity, are set out in the form of legal agreements, such as charters, by-laws, and contractual relationships. Stakeholders, directors, and managers are all bound by those agreements. While consensus is preferred, the law provides direction and procedures for gaining agreement. So mandating a healthcare entity that would oversee and manage a Canadian BSC that was structured more along the lines of a corporate governance model would ensure it had a greater chance of operating at arms-length, and of avoiding, at least, the more debilitating forms

16 Some submissions to the Kirby Committee regarding a national commissioner and council (Canadian Medical Association, 2002, pp. 11–21) recommended a broader mandate for this body, and some proposed an entity that would be not only independent, but protected from day to day politics. The Kirby Committee reviewed a submission to the Rowmanow Commission on this issue: see C. Flood and S. Choudry's, "Strengthening the Foundations: Modernizing the Canada Health Act," (2002).

17 Ontario's new Health Links are examples.

18 For a good analysis and discussion of collaborative governance, see Ansell and Gish (2008).

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of political interference than it would if structured under the collaborative governance model.

Governments should be comfortable with entities using the corporate governance model, since Canadians have many experiences with crown corporations, public-private partnerships, and service contract relationships that use this model.[19] What would be crucially important for governments, in order to ensure they were able to discharge their public accountability mandates for healthcare, would be making sure that the charters, by-laws, and contracts were structured in a way that protected their obligatory roles, while at the same time promoted the benefits of an independent entity.

A Bicameral Governance Structure

The governance structure for a Canadian system-wide strategy must accommodate two basic needs. The first is to establish a management entity that can operate independently of government and be substantially free of political intervention in its normal course of business operations. The second is to enable governments (provincial/territorial and federal) to play their important role in establishing public policy in healthcare, and to fulfill their accountability requirements to their respective electorates. A single entity is unlikely to accommodate both. So the governance structure needs two entities. Let us call the first *Management Company*, and the second, *Governance Council.* Together, they form a bicameral governance structure.

Management Company is described above. It is the manager of the strategy, and its function is to manage the BSC and provide oversight to the strategies contained in it. The BSC is a system-wide strategy with implementation at local levels. While Management Company is the strategy manager, it too has a governance oversight body, namely its board of directors. The theoretical underpinning of this governance is the corporate governance model.

Management Company, on its own, is not sufficient for system-wide governance. A crucial piece is mission, namely the participation of governments. They are, after all, democratically charged with making healthcare policy and being accountable to the electorate for their expenditures and outcomes. These are precisely the policies that become fashioned as the strategic objectives for a system-wide strategy. In turn, these strategies are what the BSC is designed to implement.

The policy making function needs to reside in a second, and senior entity. This is *Governance Council.* Its model is collaborative governance, because its function is to bring the partner governments together to work collaboratively with each other in order to establish policies. Their job is to reach deeply into the foundations of our healthcare strategy – its vision, goals, and commitments – and, from that profound level, establish the strategic objectives that are contained in the BSC. No member government of Governance Council is more senior than others in setting direction. All must agree; they must reach consensus. Failure to do so prevents the strategic objectives of the BSC from being established.

There must be a formal link between Governance Council and Management Company. Governance Council is the senior body, and although it must leave Management Company to do its work without political interference, it nevertheless must retain oversight responsibility. This should be accomplished through Governance Council appointing the board of directors of Management Company.

It is not necessary at this point to address the composition of either Management Company or Governance Council. The functions assigned to each should provide an adequate guide to the qualifications of participants. It is enough for present purposes to recognize that each of the entities is essential to establishing and operating a system-wide Canadian healthcare strategy. Neither is sufficient on its own; both are necessary. Each comes from a different conceptual tradition – Management Company from the management culture of the BSC, and corporate governance in terms of its oversight by a board of directors, and Governance Council from the world of collaborative governance.

This two-entity structure makes it clear that there are two distinct functions that councils such as those recommended by Romanow and Kirby could never have succeeded in fulfilling. Those bodies only had advisory mandates – neither management nor governance. So if a Canadian healthcare strategy is going to be possible, we need to accept the reality that governments will need to work together to form the strategic objectives in the BSC. And they will need to gain assurance that the Management Company will act in their interests, by virtue of the charter, bylaws, and other legal agreements that frame the purpose of the entity, and by confidence in the board of directors they appoint or elect to provide governance oversight of Management Company executives.

Finally, there are two important clarifications. First, the idea of a Management Company to oversee and manage a Canadian BSC is not a way of injecting federal government control. The reverse is true. What is contemplated is a collective vehicle that is "owned" by multiple governments, and perhaps other stakeholders. And Governance Council provides the assurance that the federal government is not acting on its own.

Second, nothing about the BSC approach requires centralized control of all operations. What it does offer is broad coordination based on the shared agreements of collective vision, goals and objectives, and commitments. Local implementation of healthcare would be promoted, not discouraged. Indeed, the NHS England restructuring is attempting to achieve precisely this:

19 Examples include the Canada Pension Plan Investment Board, Export Development Canada, and Canada Post. Each operates independently through its own board governance structure.

to transform a highly centralized command and control system to one that has a national scorecard managed by the NHS England (a version of Management Company), but with decision-making about patient care devolved to local levels (i.e., Clinical Commissioning Groups).

Conclusion

The Canadian healthcare system is an uncoordinated system-of-systems. Thirteen provincial/territorial systems, along with several federal systems, operate independently of one another. They are loosely connected, not with each other, but with the federal government, through limited regulatory regimes addressing such things as drug approvals and funding conditions for universal health insurance for hospitals and doctors. The system is among the most expensive in the world to operate, and its results are middle of the road at best. For decades, there have been calls from national reviews, such as those by Romanow and Kirby, for collaboration among governments to build system-wide strategies. And there continue to be calls for national approaches to pharmacare, health human resources, electronic health records, primary care, seniors' care, integrated care, and much else.

In light of this, I have attempted to make the case that a *managerial perspective* usefully contributes to the Canadian healthcare strategy debate by bringing forward two ideas. The first is to recommend a managerially rigorous approach to healthcare strategy by using the *balanced scorecard approach*. The BSC requires an unwavering focus on strategy when functional and operational decisions are made. It places patients at the centre of concern, and causally links decisions about finances, management systems, and organizational learning and growth to their contribution to patient health outcomes. This approach is based on evidence, analysis, and the achievement of measurable outputs.

Second, is a concept of governance that meets two important needs best achieved in a form of bicameral governance. On the one hand is the management of the BSC. This requires an entity that comes from the tradition of corporate governance. It is an operational entity with an independent board of directors to provide oversight and ensure the alignment of stakeholder (federal and provincial/territorial government) interests and management. On the other, is the council of governments that work from a collaborative governance model. This is the entity that establishes healthcare policies that will lead to the establishment of the BSC. Each entity in the bicameral structure is legitimated by a different governance theory. But both are necessary parts of the Canadian system-wide healthcare strategy framework.

Canada needs a system-wide strategy that is built to suit Canadian needs, not a turnkey model imported from elsewhere. A Canadian strategy should be created from a vision, aspiration, and commitments that we all share. Upon these shared values can be based the Canadian strategies, and the BSC as the framework used to implement and manage them. Further, it is by virtue of agreement among the governments and stakeholders that the BSC can get its legal and moral legitimacy.

Should we turn our attention to the establishment of a Canadian system-wide strategy, or strategy of strategies? If the time is not now, it is hard to see when would be better. Canada has an expensive and underperforming system. Provinces and territories are straining under the economic weight of maintaining it. Calls for a system have been heard for decades in national studies and reports, and many of the key stakeholders are asking for system-wide approaches. Can we afford to allow the opportunity to pass?

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