

## ***Reflections on Leadership in Health Care***

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***FOR LEADERS, BY LEADERS***  
**DINNER**

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I want to thank the Canadian Health Leadership Network for the initiative they have shown in creating the Network. There is no major public policy area in Canada in which strong leadership is more urgently required. Hence the work of the Network is critically important.

Six months ago, Preston Manning spoke to this group and concluded his presentation with two key points:

- There is no basic disagreement in Canada about the facts of the health care system as it exists today;
- Any discussion of potential changes to the health care system never involves an unemotional discussion of the proposed changes. Instead, the discussion immediately becomes one of principle which usually rules out any meaningful change to the system.

I agree with Preston on both these points and will return to them near the end of my remarks.

Let me turn first to the issue of leadership in general and then specifically to leadership in healthcare.

Many people have written on leadership. The writer who most reflects my own views is Michael Hyatt, the CEO of a major U.S. publishing company. Hyatt says that authentic leaders have five characteristics:

- **Insight.** They are able to look at complex situations, gain clarity and determine a course of action.
- **Initiative.** They are willing to go first. They do not sit on the sidelines. They don't ask others to do what they are unwilling to do themselves. Instead they lead by example.
- **Influence.** Not just influence because of their position or power over others. But real influence. They are able to get people to willingly follow their ideas.
- **Impact.** They are able to create real and lasting change. Authentic leaders make a real difference on the ground.
- **Integrity.** Not every leader with the first four criteria is benevolent. Hitler, Stalin, and Mao Zedong all had insight, initiative, influence and impact, yet their actions did not reflect the highest human values.

Hyatt describes weak leaders, or non authentic leaders, as having three common characteristics.

- **Hesitating to take definitive action.** Things are never quite ready. Just a few more weeks or months or years and they will be ready to take action. But that day never comes.
- **Complaining about a lack of resources.** All that is needed to make change is more people or more money. If only they were available, the problem would be solved.
- **Refusing to take responsibility.** The responsibility for solving the problem is always someone else's in the minds of weak leaders. They live by the max in that politics is the art of shifting the blame.

Let us examine these components of authentic leaders and weak leaders in the context of the health care system.

There are many people who have had insight about what needs to be done to make the system more efficient (and hence cost less for the current level of service) and more effective (patient outcomes of the system improve).

While details vary from writer to writer, there are several common themes among initially all of the proposed reforms:

- Competition in service delivery is required to increase service efficiency, particularly for high volume, relatively simple procedures (e.g. cataracts, operations on joints).
- Incentives for service providers need to change (e.g. roster or capitation for family physicians; service or activity based funding for hospitals).
- Even greater emphasis on primary care both as the gatekeeper of the system and as the promoters of healthy living.
- Improved regulation of all parts of the health care system, both public and private, is required.
- System needs to be reoriented so it focuses on patient outputs not money inputs, and on being patient-centered not service provider-centered.
- Essential health care services need to be publicly funded for those who cannot afford to buy insurance or pay out of their own pocket. These services include, at least, essential drugs, homecare and mental health services.

All of these changes are consistent with the Canada Health Act, including requiring people who can afford it to pay for part of the cost of services which may be free to those with lower incomes.

In short, there is a broad consensus on what needs to be done. There is no consensus at all on how to do it. We are not short of insight, but we are desperately short on the willingness to turn the insight into action.

Initiative is slowly appearing in some provincial governments. Forced by budget requirements and not constrained by rigid ideological positions, some provincial governments (e.g. British Columbia, Saskatchewan) are making some changes in the way services are delivered and service procedures are reimbursed.

Saskatchewan is to be congratulated for the way it used a Patient First Review as the foundation for transformational change. This Review looked at the health care system from the perspective of the public, patients and families and made recommendations on that basis. As a result, leaders within the health care system regard themselves as being driven by views of the public rather than needing to find ways to bring them along.

Influence, and power, is what provincial governments have. While they can impose their will on the population, and will do so if they have to, they should make a reasonable effort to bring their population along with them.

This is usually easier to do than governments initially expect. This is because the public is way ahead of politicians in understanding that the system must change. As long as health care services are available to everyone, the public will accept virtually any changes that hold the promise of

improved service (such as reduced waiting times) while maintaining the principles of Medicare. (I will say more on those principles in a moment).

As I commented a moment ago, Premier Wall of Saskatchewan is proving this right now. He has developed his plan for change by focusing on the needs of the public, patients and families. The result is that changes to both the efficiency and effectiveness of the health care system are being made with the full support of the public. It is noteworthy that these changes are being made in Saskatchewan - the birthplace of Medicare and the home of the so-called Friends of Medicare.

**Impact** can also be achieved by provincial governments and is being achieved, although in too few provinces and too few changes.

The **integrity** criteria is also satisfied, in any view, if the changes satisfy the fundamental objective of Medicare, as put forward by Tommy Douglas. This objective essentially says that no one should suffer undue financial hardship as a result of getting sick.

There are people who claim Tommy Douglas had many more objectives for Medicare than he really had. For example, they claim that Douglas said that all health care services had to be publicly delivered; that is, delivered in publicly owned institutions. That is simply not true. At the time Medicare began, Saskatchewan had privately owned service facilities and they continued even after Medicare came into effect in the province.

These same people also claim that Tommy Douglas said that health care services should be free to everyone. That this is completely untrue is illustrated by the following quote from Douglas: “There is a psychological value in having every individual make some individual contribution (to health care costs)” and that “even if we could finance (Medicare) without a per capita tax, I personally would advise against it”.

Therefore, I return to my definition of the objective of Medicare: no one should suffer undue financial hardship (or lose the family farm) as a result of getting sick.

You will have noticed that in my description of authentic leaders, I have only mentioned provincial governments. I did not mention the federal government or the leaders of any group of service providers, including all the health care professions. The reasons for not mentioning any service providers can be seen by reference to the characteristics of weak leaders I described earlier.

Leaders of service provider organizations are very hesitant to take definitive action. They float ideas and suggest changes which almost always do not impact their members. They virtually never propose specific changes, if these changes would affect their members.

Consider, for example, the complete lack of progress on modernizing scope of practice rules, or the resistance to changing the relativity of the fee schedule among medical specialists to reflect increases in productivity because of improved technologies (cataract operations being an excellent example). The provincial medical associations recognize that to do so would set specialist against specialist, and thus break the unity among the members of their association. This they are, understandably, reluctant to do.

This is exactly what is happening currently in Ontario with the fee schedule which the government has imposed with its impact on ophthalmologists, cardiologists and radiologists. In my opinion, this change would never have been achieved with the support of the Ontario Medical Association. The government had no choice but to impose it. Moreover, as an example, given the enormous improvement in productivity in cataract operations – from a couple of hours to fifteen minutes - since the fee schedule was first set in 1967, it is entirely reasonable that some of the benefit of that increased productivity should accrue to the payor of the system. The benefit should not go entirely to the service provider.

All parts of the health care system complain about a lack of resources. Their rhetoric suggests that if only a lot more money were thrown at the problem, everything would be fine. In so doing, they ignore the point I made earlier about the need to make the system more efficient. Most importantly, in complaining about a lack of resources they never mention the need for increased competition in service delivery or changing the incentives for service procedures in order to change behavior or making scope of practice rules less restrictive than they are now.

Finally, all parts of the health care system refuse to take responsibility for fixing it. They wait for others to propose change and then criticize the change if they think it affects them or requires them to behave differently.

This is why I doubt that all the system changes which are required can be achieved with the support of the health professions. I think, however, that they can, and will, be achieved with the support of the public, just as Saskatchewan is now doing.

It is important to keep in mind that Medicare began in spite of the opposition of the medical profession. Regrettably, it may well require that changing the system may also have to be done without the support of the profession.

In summary, I think that the leadership provided by service providers has been weak. I understand why that is the case – the internal politics of the organizations they represent virtually prevent service provider organizations from being at the forefront of the system change. I stress this point because it has a significant impact on a proposal I will make at the end of my remarks.

You will recall that I did not mention the federal government in my list of authentic health care leaders. The reason is that I do not believe that the federal government has a role to play – other than, a financial role – in system reform.

There is a major federal role in ensuring reasonable equity in the level of healthcare services across the country. Indeed, the equalization principle of the Charter of Rights obligates the federal government to ensure that all parts of the country have reasonably comparable levels of public services. But, in my opinion, the federal government has no role in how the system is operated.

Consider, for example, what role the federal government could play in making the system more efficient and effective. If the federal government, which is the 5<sup>th</sup> largest purchaser and provider of healthcare services in the country, could be helpful, why has it not made the areas where it is responsible for providing health care services (e.g. First Nations on reserves and inmates of federal penitentiaries) more efficient and effective? That they have not done so, is illustrated by the fact that these populations have the worst health outcomes of any demographic segments in the

country. So why would anyone listen to federal proposals on ways to improve health care services on the ground, or ways to make the system more efficient and effective?

In addition, many other required changes, such as scope of practice rules, are not subject to federal jurisdiction.

Moreover, the history of health care in Canada has been that once health care becomes a major public issue, the federal government does one of two things. It either delegates the issue to a third party, such as Roy Romanow, or it throws money at the problem without demanding system change in return, such as in the 2004 Health Accord. In either case very little, if any, meaningful change is accomplished.

Finally, remember that all health system changes in Canada have always begun at the provincial level. In my view, that is not about to change. If governmental leadership is to come, it will have to come from provincial governments. This is why I am encouraged by the interprovincial Health Care Innovation Working Group. I believe that under the leadership of Premier Wall and Premier Ghiz this Working Group will develop meaningful proposals for change, which will be adopted nationally, in the next few years.

But why, given budgetary pressure on provincial governments – pressure which has been with us for the last several years - has the start of change only begun in the last year or two? I believe that there are two reasons which are closely interrelated:

- First, the public's complete misunderstanding of what the Canada Health Act says or doesn't say. Since the Act was passed in 1984, Canadians have been led to believe that the Canada Health Act (because of its public administration criterion) prohibits the private profit delivery of health care services. This is not true. The public administration criterion means that a provincial health insurance program must be run by a public institution and cannot be contracted out to a private health insurance company.
- Second, Canadians have also been led to believe that the universality criteria of the Canada Health Act means universally free to all Canadians. This is also not true. The universality criteria means that health care services must be available - or universally accessible - to all Canadians and hence, by inference, that money cannot be a barrier to an individual getting service.
- While this clearly means that service must be free to those who cannot afford to pay for it, it does not rule out a means test, or income test, on how much money, if any, a person should have to pay for healthcare services. In my view, this observation is critical when considering how to make the health care system financially sustainable for the long term.
- Little progress has been made on health care reform because many Canadian leaders, including a vast majority of the nation's politicians use the two untruths about the Canada Health Act, which I just described, to discredit any significant proposed change to the way services are delivered and health is financed.

This usually takes the form of claiming that the proposed change will lead to an American style health care system and that profit taking in health care is immoral. Roy Romanow's words "health care is not a business, it is a moral enterprise."

This, of course, ignores the fact that, the new primary care clinics across the country are shareholder owned private businesses which earn profits. Apparently it is acceptable for shareholders who are doctors to earn a profit but not shareholders in other forms of private healthcare businesses (unless, of course, they are dentists, physiotherapists, pharmaceutical companies, or medical device manufacturers, or diagnostic labs and so on). These examples illustrate the absurdity of the moral enterprise argument.

As long as there is this kind of immediate reaction to any meaningful change – and there will be – as long as anyone proposing meaningful change is shouted down, meaningful change is not possible unless a mechanism is found to go over the heads of the health care establishment, and most politicians and interest groups, directly to the Canadian people and bring them at least reasonably onside with the proposed changes. This will make it politically safe for provincial governments to make the changes which are required. This is precisely what Premier Wall has done so well in Saskatchewan and why, in my opinion, Saskatchewan has the best health care system in Canada.

As Dr. Philippe Couillard, the former Minister of Health in Quebec recently described it: “what is needed is a safe gap between the right and left ideologies in which provincial politicians can act.” What is needed he said is a “space for open dialogue and action”.

What could a mechanism which goes over the heads of the health care establishment look like? How can the “safe gap” be created?

In his speech to this group last December, Preston Manning called for the creation of an eminent person’s “Health Care Fact Committee”. This Committee would explain to Canadians the true facts about the Canadian model of health care and what the Canada Health Act actually says. It would also try to get all players in the health care system to agree on a common set of facts.

At almost exactly the same time last December, Brian Mulroney and I, in an op-ed piece in the *Globe and Mail*, called for “a national adult discussion that will allow us to arrive at a common goal: finding new ways to increase funding (to the health care system) while preserving the fundamental principles Canadians cherish”. Mulroney and I focused on funding because increased revenues will be needed to finance the system, even after the required efficiency changes are made. In our view, even a more efficient system, funded as it is now, is financially not sustainable.

Mulroney and I said that there are only two ways to do this. “Either Canadians pay increased income or sales tax to governments, which would then put the money into health care, or (Canadians) could contribute an income based levy directly to the health care system”.

This question then is how does an eminent person’s panel get created? How does a national adult discussion get started? Who sets the terms of reference and chooses the members?

It cannot be any government because the issue would immediately become partisan.

It cannot be any service provider organization. As I explained earlier, history has shown that service provider organizations do not have the ability to look at changes which might not be in their members self interest.

It would be difficult for a purely business organization to lead a national debate as it would be seen to have too much of a privatization bias. This would rule out organizations like the Canadian Council of Chief Executives.

This leaves organizations like the Canadian Health Leadership Network, or possibly more broad based business and labour organizations, such as the Conference Board of Canada.

I believe that funding could be relatively easily obtained from a consortium of Canadian foundations, or possibly even the federal government.

What needs to be done is clear – what is lacking is an organization willing to stand up and support authentic leadership on health care reform in Canada. All of us in this room need to work hard to find, or create, such an organization quickly.

Thank you.