

BENCHMARKING HEALTH CARE IN CANADA

AN OVERVIEW

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INTRODUCTION

The use of comparable health care indicators for clinical, policy, program and research purposes is reasonably extensive in Canada. However, the use of benchmarking, based on best practice or medical evidence, is relatively new.

This presentation provides a brief overview of recent developments giving rise to the growth in the use of both comparable indicators and benchmarking in Canada's health care system.

CONTEXT

In Canada, provinces provide health care services to 97 percent of the population. The federal government contributes less than 25 percent of the cost of provincial services through annual cash transfer payments to the provinces. Provinces are protective of their constitutionally assigned jurisdictions and do not welcome federal intrusions into their areas of responsibility.

Health care data has been traditionally collected by the provinces, Statistics Canada and the Canadian Institute for Health Information (CIHI). CIHI is a federal-provincial agency that is jointly funded and administered with a mandate to be a "source of unbiased, credible and comparable health information."

At the beginning of this decade, a rising sense of urgency to improve the quality and timeliness of health care led the federal government to inject additional funding into the system and in exchange the provinces were to provide increased transparency through comparable indicator reporting.

In 2000, 2003 and 2004, the First Ministers agreed to a series of health care accords that, among other initiatives, greatly increased the number of comparable indicators that were to be reported annually to the Canadian public. In addition, the 2004 accord required the provinces to expand comparable indicator reporting to four surgical areas and to produce evidence based benchmarks for each of these areas by December 2005. There is no legal basis for the accords and the benchmarking initiative. The provinces

are responsible for the design and implementation of the comparable indicators and benchmarks with assistance from the federal government.

THE PROCESS

In the development of the comparable indicators and benchmarks, no rigorous methodology was employed. A functional or collaborative approach was used with the following elements:

- **Organize:** A steering group of Deputy Ministers of Health was formed along with a working group that included Statistics Canada and CIHI officials.
- **Plan:** Clear definitions for comparable indicators were established and the necessary data infrastructure was defined. Similarly, a process for determining benchmark definitions for the four surgical areas was created.
- **Collect Data:** Best practices for data collection infrastructure across the country were examined and shared and implementation began in most provinces. Numerous challenges were encountered. A federal funding agency for health research was contracted to determine the evidenced based surgical benchmarks.
- **Report Progress:** Reports on up to 70 comparable indicators by province were made public in 2002, 2004 and 2006. Additionally, the evidence based benchmarks (8 in total) were published in late 2005. Most data is self-explanatory but inconsistencies remain.
- **Analyze/Refine:** Provinces were also required to produce by December 2007 a public plan on how they were going to achieve the evidence based surgical benchmarks. No province met the deadline. Best surgical practices have been exchanged among the provinces.
- **Adopt Best Practices:** Provinces are currently implementing best surgical practice methodologies and programs. Progress to achieving the benchmarks is being made. Each province has implemented one wait time guarantee relative to one of the benchmarks.
- **Review Progress:** This element has yet to occur.

IMPLEMENTATION

There was some early resistance to the development and publishing of the comparable indicators and benchmarks. Some provinces did not want to be compared to others. Also the cost and difficulty of collecting consistent data was deemed a barrier by some provinces. This resistance was largely overcome due to peer pressure, the public commitments of First Ministers, public pressure and pressure from various health care provider organizations.

Presently, some provincial politicians have lost interest; priorities are shifting elsewhere. The size, complexity and cost of the task were underestimated. CIHI continues to work with the provinces to resolve data collection issues. Public transparency is greater than ever.

Most provinces remain committed to the process as it has enhanced their collaboration and the sharing of best practices in many other related areas.

FUTURE DIRECTIONS

Better upfront planning is needed. Work will continue with CIHI to ensure consistency in data definitions and collection and the sharing of best practices.

A benchmark research agenda is needed. A process to establish the next set of benchmarks including who decides, the order of priority and how the research will be undertaken needs to be established. Provinces need to look outside the health care system to establish certain benchmarks. The involvement of business schools, industrial engineering faculties and other partners is critical to providing robust benchmarks based on clinical evidence or best practice.

Public transparency and collaboration among the provinces have improved. The patient is on the road to recovery.