Session III: Issues in the Delivery of Health Care: Health Human Resources and Regionalization

Peter Glynn (Queen's University)

Let me first go through the papers in turn, very briefly, and then make some other comments. The first paper on health human resources really wasn't a paper on health human resources at all. Dominik Wranik's paper is really about the failings of our health care system. Indeed, I refuse to use the word *system* for what we now have. It is in no way, shape or form a system. Systems demand interconnectedness; they demand some rationality. One would be hard pressed to find either one of those in what we do in many parts of this country. The issues and challenges facing health care delivery are well known. All of these recommendations on human resource issues have been made for over 30 years. Nobody has done anything about it. Maybe someday, somebody will pay attention to them, but only if we have determined political leadership. The paper really provides a very cogent comment, about the failings of health service provision in this country.

Margaret Denton very nicely demonstrates that everything is connected to everything else. If you change health service provision in one place, you can seriously mess up the health care of people down the line. We so often don't understand that everything in health care is connected to everything else, and that you need to model the connectedness. The paper also demonstrates quite profoundly our fundamental ignorance of the role of home care in an integrated system of care. There is also fundamental ignorance in the bizarre notion that emergency transportation is a municipal transportation issue. The economists in the audience know that that had to do with balancing the issue of paying lower local education taxes in Ontario and had nothing to do with a coherent health policy. What was lost in the notion of managed competition was that keeping people in their home, looking after them better, maintaining their independence actually reduces the total cost of their involvement in the system. A superb example of dealing with one piece of health care in isolation.

Lori Curtis' paper talks about the issue of variation in health care and how do we make sure that people get what they need? This also relates to Therese Stukel's issue of how do we make sure that they *don't* get what they *don't* need?

Stukel's whole presentation demonstrates the power of data and the power of planning. Some of the successes in Ontario involve the distribution of primary-care physicians, and some of the maldistributions involve, for example, cardiologists. I think one of the things to look at here is the number of interventional cardiologists versus non-interventional cardiologists.

The other interesting thing is a comparison of how many physicians you really need – i.e., in more of a managed-care world – in comparison with U.S. HMOs. This comes right back to Wranik's paper, which said if we allowed people to practise what they are able to, you can actually get by with substantially fewer physicians. And so the two papers are connected. Therese Stukel might even want to show data on "other providers" within U.S. HMOs versus "other providers" in the Canadian system.

As to my own comments, I think these presentations have proven over and over again that nobody's really in charge of all the "pieces" of the provision of health care. It certainly isn't the minister of health, either federally or provincially, otherwise we wouldn't be where we are today. Our dilemma is that *everybody* is in charge. You have all of these silos and micro-silos, all with folks who think they're in charge of their tiny little piece. And they do their best on their tiny little piece. Their connectedness is irrelevant because they're not rewarded for connecting. They're rewarded for

balancing the budget – home care is a good example – providing the most service at the least cost. They are not rewarded for connecting all the pieces together.

Another thing that we seem to fail to remember is that in Ontario, we have well over a $30 billion business that has had no clear accountabilities for the functioning of the total "system". I'll give you just a short list:

– The degree of variation in quality and quantity. Nobody would allow that to go on in their company because the failure rate of their products at 20 percent – they couldn't stand the litigation, let alone anything else. We allow that to happen in the health care sector.

– The variation in resource allocation. I think all the papers have demonstrated that.

– The lack of standardization. For example, we allow highly paid, highly educated, highly skilled people to do things that much lower-paid, lower-skilled, lower-educated people could do. Indeed, we reward them for doing that. This makes no sense.

– We don't have a focused or concerted HR strategy. The issue of the turnover in the home care folks is a superb example of this. No business could tolerate that kind of turnover. Not only do we allow this to happen, we actually create the conditions for it to happen.

– There is no interconnectedness in information systems. This is Dr. Duncan Sinclair's favourite topic. Not only don't we have this; what we do have can't talk to each other.

– There is no real-time data available. Every modern business has real-time data in which to manage. Wait times are probably the best example of this. How can you manage access if you don't know who's supposed to be accessing and what their needs are?

– We have a wide variation in management skills and competencies, ranging from none of the above to very highly skilled and very highly competent. Again, no business would allow that kind of variation to take place.

– There are no clear decision-making strategies.

– There is no detailed cost information, and we're running a $30 billion enterprise in this province.

One of the things that Ontario is going into is the LHINs. Ontario's going into this initiative in a different way from other provinces in that we've decided, for very practical reasons, to maintain all of the current corporations. What will be interesting is whether all those corporations will allow the LHINs to be in charge. There is going to be one big struggle because most providers, whether they're individual physicians or hospital corporations or others, have no interest in anybody else being in charge. We keep forgetting that health care is about patients, not providers. And we're really good at talking about vertical and horizontal integration around providers, etc. But I have said elsewhere could we talk about patients for a minute, please? We should not forget about them.

We are captured by our history. And our history is one of individuals – whether that's individual physicians, individual nurses, or individual hospitals – providing care individually. We need a profound disruption to change that. We are stuck in those organizations and their politics, and the power relationships, that we can't readily get out of them. But there is some hope here.