



Quarterly Letters

Creating New Conversations

Taken together, the articles by Alan Hudson, “The First 200 Days: Cancer Leadership in Ontario,” and Shamian-Ellen/Leatt, “Emotional Intelligence,” (Eds. note: See *Hospital Quarterly*, Fall 2002) touch on issues of culture, relationships, communications, responsibility, accountability, appreciation, learning, and foundational values. These are never-ending challenges to people who wish to lead organizations.

The observations made in the articles are offered in the spirit of progress – that is, they represent an acknowledgement that a new attitude to leadership and management is required in our dramatically shifting environment and arena of public expectations that affects healthcare in Canada today. There is a growing appetite in public service today for a more decisive and action-oriented form of leadership; but also for a deeper commitment to justice, equality and citizen engagement. In order to survive, leaders must respond to this prevailing public sentiment while focusing unwaveringly on the purpose and reasons for them to be leading in the first place.

The articles also explore the need to create new conversations about what we value, about how healthcare-consumer focused we are, and about the quality of our work life. New conversation leads to new relationships, which are the arena of action for leadership. To quote R. Shortt, “What goes on between people defines what an organization is.” I would add to this and “what it can become.” Creating new conversations through healthy relationships is also a fundamental underpinning of accountability.

In the healthcare sector, with its traditional command-and-control systems, structures and processes, “accountability” is often about “who is to blame?” Real accountability is about keeping agreements and performing jobs in a respectful atmosphere. It is about learning, truth, change and growth. It is not about fear and punishment. We need to learn from our “best mistakes” and continuously improve the system for which we assume stewardship. Accountability is often a misunderstood word. It is regularly confused with the concept of responsibility. To be responsible means to do what one has committed oneself to do, through the simple act of accepting one’s job or position. Accountability, on the other hand, refers to the process of accounting for the achievement of one’s responsibility. It is the process by which one demonstrates fidelity to that obligation or purpose. Leaders must be able to account to others for appropriate exercises of responsibility if they are to retain credibility in their leadership role.

The articles suggest that to be open to large-scale change,

leaders must create literal openings and emptyings that ensure the emergence of a new vision that articulates new-shared values. This opening requires discipline and courage – discipline to resist knee-jerk reactions and courage to separate from old patterns, structures and processes that are no longer useful to the evolving organization. Finally, the articles underscore the need for leaders to ask the right questions at the right time. Framing the question, and timing it in a manner that creates commitment to learning, is vital to an organization’s continual improvement.

– **Hugh MacLeod**

Senior Vice President, Vancouver Coastal Health Authority

The Romanow Commission: An Opportunity Lost

At the conclusion of my presentation to his Commission, Roy Romanow asked me what I thought was most urgently needed in Canadian healthcare. I answered “Leadership!” I explained that, while there are pockets of leadership in individual institutions and programs around the country, overall the system lacks clear vision and leadership. I was therefore pleased to see that Mr. Romanow described the first of his three overarching themes as being the need for “strong leadership and improved governance to keep medicare a national asset.” The term “national asset” reminded me of Brian Mulroney calling our health system “a national trust,” as well as of the debate at the time of repatriation of the Constitution when some voices promoted healthcare as a constitutional right!

My view of the need for a sustainable visionary leadership is illustrated by the turnover in the Ontario Health Ministry since I have been involved in healthcare: Fourteen ministers and 12 deputy ministers, across the political spectrum, over a period of 27 years, averages 1.9 years per minister and 2.25 years per deputy minister, a description of public sector leadership reflected in all other provinces and at the federal level. No private corporation could succeed with such a turnover among its senior executives.

Executive public administrators have to manage three consecutive budget cycles before they can claim to have accomplished any change. Furthermore, they need to be on the job for five consecutive fiscal periods to demonstrate efficacy and sustainability of their decision-making. The nature of the political process, with its election every four to five years, tends to negate such outcome assessment of leadership.

Politicians see “health” as a stepping-stone to higher office. After all, providing oversight of a health ministry budget involves managing what is rapidly becoming half the provincial budget. In many provinces, the ever-expanding nature of its budget has given “health” priority attention in the Premier’s office where most long-term healthcare decisions appear to be approved, if not made. In public administration, the deputy of health position is regarded as the “fall-guy” for a system beyond control. Most persons assuming the position regard it as right of passage to retirement as a healthcare consultant. It is difficult to identify any definitive vision amid these political imbroglios that characterize public health administration in Canada.

The Canadian public desperately needs new visionary healthcare leadership. Unfortunately Mr. Romanow has not provided such visionary leadership. Instead he has relegated the system to its post-World War II origins when Canada was primarily an agricultural country with half the population it has today and when “healthcare” was what doctors did from the contents of their “black bags.”

While public consultation has its place in the democratic process, the question is: can such a ritual provide visionary leadership? A realistic vision of healthcare would describe a system of incentives and options that 31 million modern-day Canadian consumers can relate to. Mr. Romanow’s conclusion that only public employees know how to deliver health services is a reflection of leadership by opinion poll that says, “My people are on the move, I must lead them.”

A more constructive approach would have been the detailing of alternative futures by presenting scenarios that list the pros and cons of high public sector intervention, a mixed private /public collaboration, and a market-driven approach. Being presented with such choices, provincial politicians could better explain to their electorate why they are choosing a specific direction. Instead of providing such leadership, Mr. Romanow chose to present himself as “the defender of the faith.”

New federal/provincial fiscal transfer arrangements are essential if the system is to remain truly Canadian. However, memories of federal health dollars being used to supplement provincial budgets, more in support of re-election than optimizing health services, makes accountability critical to such arrangements. Since provinces were invented largely to create jobs for the boys, accountability must be between Ottawa and the provinces, and not between Ottawa and programs.

The federal government’s National HIV/AIDS Strategy exemplifies centralized intervention in local affairs, often with no coordination among provincial initiatives. The tragedy that was the Canadian Red Cross blood system illustrates gridlock in inter-provincial decision-making to collectively protect Canadians. The failure of all governments to implement a national vaccination policy and infection control strategy to protect Canadians, demonstrates Ottawa’s inadequacy in exercising any authority over provincial health agendas. The combined provincial budgets for pharmacare would pay for a national drug formulary, if only the provinces would relinquish their direct administration over such affairs, as they have been obliged to do for the blood system. Given these examples of federal-provincial collaboration in health, the possibility of the feds involving themselves in grassroots homecare programs is frightening.

Leadership is urgently needed that explains to Canadians that managing health services involves overseeing socio-economic and political forces beyond government’s control. These forces include an increasing proportion of older people living longer and who could enhance their remaining years from timely access to new health technologies and managing the adoption of expensive technologies through collaboration between suppliers and providers.

Mr. Romanow’s call for “evidence” in justifying private delivery systems is indicative of a pseudo-academic/bureaucratic conspiracy consuming his Commission. While it has its

place, “evidence”-based decision-making is more an intellectual exercise than an instrument of health services management. Professors of health administration promote such intellectual endeavors as more efficacious than the ethical business practices that govern the rest of society. With his emphasis on “evidence,” clearly Mr. Romanow was

Ontario Ministers of Health	Term	Deputy Ministers	Term
Hon. Frank Miller	February 1974 – February 1977	Allan Backley	1975–78
Hon. Dennis Timbrell	February 1977–February 1982	Tom Campbell	1978–81
Hon. Larry Grossman	February 1982 – July 1983	Graham Scott	1981–83
Hon. Keith Norton	July 1983 – February 1985	Gerard Raymond	1984–85
Hon. Alan Pope	February 1985 – May 1985	Dr. Allan Dyer	1985–87
Hon. Philip Andrews	May 1985 – June 1985	Dr. Martin Barkin	1987–91
Hon. Murray Elston	June 1985 – October 1987	Michael Decter	1991–93
Hon. Elinor Caplan	October 1987 – October 1990	Margaret Mottershead	1993–97
Hon. Evelyn Gigantes	October 1990 – April 1991	Sandra Lang	1997-99
Hon. Frances Lankin	April 1991 – February 1993	Jeff Lozon	1999-00
Hon. Ruth Grier	February 1993 – June 1995	Daniel Burns	2000-02
Hon. Jim Wilson	June 1995 – October 1997	Phil Hassen	2002 - Present
Hon. Elizabeth Witmer	October 1997 – February 2001		
Hon. Tony Clement	February 2001 – Present		

converted to this mythology.

The rationale for evidence-based justification arises from academic papers that compare Canada's publicly funded health system with the American system. Comparing highly specific aspects of both cultures provides interesting academic analysis. However, the market-driven American health system is totally alien to the Canadian experience. Instead of frightening Canadians with scenarios of hostile American takeovers, it would have been more constructive for Canadians to learn about examples of American information technology applications and accountability infrastructures, attributes that are sorely missing in Canada's public health system.

Only God doesn't need an advisor. Second to God, health ministers receive most of their advice from local provincial academics. Given the challenges facing the health establishment there should be some broadening of their advisory horizon. Within standard ethical business practices, advice from the insurance industry would provide insight about the demographic management of risk, and the medical supply industry could provide insight about making scientific discoveries available to the masses. It is unfortunate Mr. Romanow chose not to, or perhaps lacked the ability to, listen to such counsel.

Mr. Romanow is a retired politician from Canada's ground zero of healthcare – Saskatchewan. Consequently his conclusions are described as pre-destined. Many of us can identify with socialist beliefs. People who have not had such an epiphany cannot appreciate the mark the experience leaves on one's soul. The challenge is accommodating our beliefs with the values of the society and times in which we live. Unfortunately Mr. Romanow chose a value base of post-World War II Canada rather than taking the opportunity to present a vision of healthcare that serves the values of Canada's 31 million modern-day consumers.

– **Tim Lynch**

Health Services Reimbursement Consultant, Info-Lynk Consulting Services, Vancouver. Email: tim@infolynk.ca
www.infolynk.ca/romanow.html

Acknowledgements: The writer wishes to acknowledge critical appraisal provided by Dennis Timbrell, Toronto ON Mark McElwain, Toronto ON, Dr. Alan Thomson, Victoria B.C, and Dr. Robin Hutchinson, Ladysmith B.C.

The CANADIAN INSTITUTE
Health Group

2nd Annual Forum
Implementing Best Practices for Effective
GOVERNANCE
FOR HEALTHCARE
ORGANIZATIONS

Integrating New Standards, New Requirements and New Expectations for Healthcare Boards and Senior Administration

Monday and Tuesday, May 26 and 27, 2003
Optional Post-Conference Workshop — Wednesday, May 28, 2003
Marriott Bloor Yorkville Hotel, 90 Bloor Street East, Toronto

With an outstanding faculty including 11 Hospital Chairs and CEOs

Endorsed by:

Hospital Quarterly

To Register or for More Information Call Toll-Free 1-877-927-7936 or in Toronto 416-927-7936 or visit us Online at www.CanadianInstitute.com

Priority Service Code: 804J03X1