



# THE Watchdog

In a candid interview with *Canadian Healthcare Manager*, the head of the new Ontario Health Quality Council, Ray Hession, says the government could be doing more to provide equal access to health services.

BY MARJO JOHNE

Ray Hession was sitting in the top seat of Ottawa Hospital's board of governors when the Ontario government tapped him on the shoulder and asked him to lead a new agency called Ontario Health Quality Council (OHQC). Though funded by the province, the agency is an independent watchdog whose job is to examine the state of Ontario's healthcare system—and identify ways to make it better. Shortly after the OHQC released its first report in April, Hession spoke to *Canadian Healthcare Manager* about the challenges facing the new organization and, most importantly, the challenges of healthcare delivery in Ontario.

**Q** The OHQC's mandate is to report on Ontario's healthcare system and identify ways to make it better. How do you plan to carry out this mandate?

**RH:** Therein lies—as we used to say when money was more valuable—the \$64,000 question. We set out in this first report, which I characterize as “foundational,” a list of nine attributes of a high-performing health system. We will report on the system's progress on those attributes each year. But defining those attributes is one thing—achieving wide adoption of them is another. To measure against these attributes calls for the provincial government to set policy objectives. As it is, only one of the attributes is enjoying an element of policy-objective specification—and that's the wait times.

**Q** Your report identifies many areas that need improvement,



Ray Hession

**but in the end you seem to focus more on the need to invest in eHealth. Why?**

**RH:** The paucity of relevant information in Ontario's health system is the biggest single barrier to driving up improvement in health quality. It's very difficult to formulate policy objectives without good data—good

clinical data, in particular. We also won't find the real evidence-based best practices and bottlenecks in our systems that create issues such as wait times or differential access to health, unless we find the evidence.

Most of the data we deal with is a derivative of the administrative transactions that go into the Ontario Health Insurance Plan (OHIP)—so it's administrative data. More doctors are moving into alternative pay plans that don't call for billing for each incidence of service delivery... so the resource that people have relied on [for data] for so long—OHIP—is actually diminishing in terms of competence. It isn't getting better—it's getting worse.

**Q** What's standing in the way of eHealth in Ontario?

**RH:** The problems are manifest and they start with the decision to do it. The federal government created Canada Health Infoway in 2002, and through that vehicle began funding the development of eHealth capability in the country. At that time, it was discerned that there was a \$10-billion problem. Up to this year, nearly \$1.2 billion has been invested by Infoway, so we're woefully under-investing. In building eHealth capability in Canada, you need a very well-specified set of outcomes—specifically, the architecture of the electronic health records and the infrastructure to implement it. Who is the archi-

tect? Who decides what the architecture and infrastructure look like? As investments are made, everybody is working to deliver those outcomes. It's hard to find the answer. I would say at the moment Canada Health Infoway is the acting architect, but it does not have the adequate authority.

**Q How did the healthcare community react to your report?**

**RH:** They've been saying "thanks for getting it out there, we agree." I'm getting e-mails, and the early signs are encouraging amongst [healthcare providers] across the province. The province has a whole gaggle of very successful delivery models, and as we say in our report, apart from the adoption of research outcomes issue, we have an issue with the adoption of these very capable service delivery models. They're there and we ask, "why aren't they being adopted in a wider way? Why aren't things in that context changing more quickly?"

**Q Can you give an example of these successful service delivery models?**

**RH:** In the broad area of primary care, the move to the so-called family-health-team model is a central strategy—one which we heartily endorse and embrace. There are a number of examples that demonstrate the characteristics of how it all works. First, you have doctors, nurses, dietitians and other healthcare professionals working as a team. Second, they set up lines of communications with specialists, such as neurologists, psychiatrists and the like. So the family doctors have the ability—while doing diagnoses of patients—to contact the specialists and discuss likely problems and treatments. So it cuts down dramatically on access issues. The whole testing world—be it lab testing or forms of diagnostic imaging—can also be better managed in an integrated team-based model.

**Q Outside of the healthcare community, how are you perceived by the public?**

**RH:** When we appeared in the media recently, just as we delivered our report, I could see and feel the skepticism. In fact, it was verbalized: "Are we toadies of the provincial government?" I can tell you—not at all. The provincial government, from the premier on down, has been enormously careful about the integrity of our mandate. It has been very encouraging.

**Q Did any of the findings in your report surprise you?**

**RH:** I'd say *disappointed* is a better word. The degree of disparity, the inequities in the system are troubling. Why aren't certain social, economic and geographically dispersed groups getting what you and I would agree are the benefits of a universal health system? We don't know. We thought things had progressed more. **CHM**

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*Marjo Johnne is a frequent contributor to Canadian Healthcare Manager.*