Toward a comprehensive and integrated assessment of Québec's health and social services system

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The Conseil de la santé et du bien-être (CSBE) was established by law in May 1992. The primary goal of the CSBE is to work toward improving public health and well-being by advising the Minister of Health and Social Services, informing the public about health and social issues, fostering debate and building partnerships. The CSBE's initiatives are centred around these four objectives and geared toward finding the best means to achieve this goal.

The CSBE is composed of 23 members representing users of health and social services, community agencies, actors, researchers and administrators involved in health and social services or in sectors that have an impact on public health and well-being.

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FOREWORD

In February 2003, the *Conseil de la santé et du bien-être* (CSBE) was directed to report on the results achieved by the health and social services system, in accordance with the terms of Canada's Accord on Health Care Renewal. In December 2003, the Québec government tabled Bill 38 before the National Assembly, proposing the appointment of a Health and Well-being Commissioner.

Since then, the CSBE has submitted a brief to the Parliamentary Commission on Social Affairs, recommending a number of amendments to that bill. Furthermore, drawing on its values and experience, the CSBE has produced a series of proposals designed to guide the future Commissioner in fulfilling his or her mandate and responsibilities related to public information, consultation and evaluation.

This publication is part of that process. It proposes an approach that the Commissioner could adopt in conducting a comprehensive and integrated assessment of Québec's health and social services system aimed at sustaining public debate, citizen engagement and decision making in the area of health and well-being.

Hélène Morais
President

EXECUTIVE SUMMARY

The health and social services system is a complex entity. Its multiple dimensions make it a difficult reality to capture, particularly in terms of performance. Given today's results-management context in which not only performance but also transparency and accountability have become imperatives, a real need has arisen for a comprehensive and integrated assessment of this system.

That is why, in response to the mandate entrusted to it in the wake of Canada's 2003 Accord on Health Care Renewal, and in line with the September 2004 First Ministers' Meeting, the *Conseil de la santé et du bien-être* (CSBE) is hereby proposing a comprehensive and integrated framework for assessing the system. This framework was developed in response to the proposed appointment of a Health and Well-being Commissioner who, according to Bill 38, will be mandated to assess the results achieved by Québec's health and social services system.

This publication contains four parts. Part 1 states the aims of the CSBE in considering the requirements for this assessment. Part 2 presents the evaluation model chosen from among many to appraise Québec's system, and then describes it in all of its dimensions. Part 3 presents sample indicators developed by the World Health Organization (WHO), Canada and Québec respectively. Some of these indicators were retained and used in the perspective of putting the framework into operation. Part 4 briefly describes some of the tasks to be accomplished with a view to implementing this performance assessment framework.

To begin, we should mention that the CSBE considers that the goal of public health performance assessment is to inform and sustain ongoing public debate, citizen engagement and decision making. To achieve this goal, the assessment must meet specific requirements. Above all, it must be comprehensive and integrated, which means that it must cover a broad set of system dimensions, while taking into account their interrelationships. It must be tailored to the characteristics of the Québec system, which encompasses health services, social services and public health. It must also allow us to compare the performance of our system with that of other systems across Canada and the world. Such comparisons may shed light on factors liable to affect its performance and improve it. These comparisons may also have a significant impact on how we understand the system's issues and directions and on how we make decisions. Lastly, the assessment process must foster citizens' informed participation and increase accountability within the system.

As it happens, the framework proposed by Champagne et al. (CSBE, 2004c) meets all of these requirements. Although the evaluation models used around the world cover several performance dimensions, most of these models are in fact not as complete. Performance is a complex concept comprising many different dimensions linked to improvements in state of health and well-being, efficiency, production of quality services, resource acquisition, adaptation to needs, public participation, and the maintenance of collective social values such as solidarity, equity, justice, respect and safety. Consequently, we needed to look to a framework that would encompass all these dimensions, along with their interrelationships, as does the one proposed by Champagne et al. This particular framework covers a broad spectrum of dimensions, including the system's *adaptation* to its environment, *achievement of fundamental goals*, *maintenance of social values*, and *production* of health and social services.

To be able to assess these performance dimensions and their many subdimensions, we also need to identify measurement components, or indicators. Organizations such as the World Health Organization (WHO), the Canadian Institute for Health Information (CIHI), Statistics Canada and Québec's *Ministère de la Santé et des Services sociaux* are already in the process of developing indicators to assess health system performance.

Examples of these indicators are presented further on with a view to proposing a framework for assessing the performance of Québec's particular health and social services system. This proposal contains a set of comparable indicators for which Québec data are available and which cover a general rather than a specific reality. However, examination of these comparable indicators clearly reveals that most of those used both here and elsewhere focus more on service *production* and *goal achievement* than on the other dimensions. Despite that, these indicators will still be useful in selecting those required to operationalize Québec's health performance assessment framework.

Our efforts will therefore be directed toward developing indicators for the dimensions of *adaptation* and *maintenance of values* and for their respective subdimensions. With regard to the latter dimension, it will be important to enable citizens to express their views on the values that the system should embrace.

A number of steps remain to be taken before a first health performance assessment report can be produced. The framework proposed here contains guidelines for interpreting selected information and for informing judgments about the system's overall performance. Once these steps are accomplished, we will need to put the framework into operation by setting policy directions, objectives and indicators, to produce an accessible interpretation guide, and to put into place ways and means to facilitate citizen engagement.

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INTRODUCTION

The *Conseil de la santé et du bien-être* (CSBE) is hereby proposing a comprehensive and integrated framework for assessing the performance of Québec's health and social services system with a view to sustaining public debate, citizen engagement and decision making.

This project is part of the mandate entrusted to the CSBE as a result of the February 2003 First Ministers' Accord on Health Care Renewal. In endorsing the agreement reached by First Ministers in September 2004, the Government of Québec commits to forging ahead with Health Care Renewal. The action plan approved by the First Ministers affirms the principle of *ongoing accountability reporting to Canadians on progress achieved* (First Ministers' Meeting Communiqué, 2004 September 15). Under the terms of a specific agreement reached with the federal government, the Government of Québec pledges to report to its citizens on its progress in achieving its health objectives. It plans to use the comparable indicators that were jointly agreed upon with the other provincial governments.

This comprehensive and integrated assessment framework also ensues from the proposed appointment of a Health and Well-being Commissioner who will have the following responsibilities, according to Bill 38:

> With a view to improving the health and well-being of the population, the Commissioner is responsible for assessing the results achieved by the health and social services system taking into account the range of systemic factors that interplay within the system, and for providing the Government and the public with the necessary background for a general understanding of the major issues in the health and social services areas. [Translation]

The health and social services system is a complex entity, as everyone no doubt agrees. As we stated in one of our reports (CSBE, 2004c),

> Health-care systems are under tremendous pressure being exerted by four major concomitant forces: technological advances; proliferation of new knowledge on diseases, their treatments as well as population health determinants; globalization and demographic trends; and the onset of new diseases. The public is concerned. [Translation]

That concern is well founded. The system's shortcomings can have a negative impact on the goals or collective choices that are its very foundation. Difficulty keeping costs under control may threaten its long-term survival. New technologies are being introduced—some of which are very costly—and sometimes without having been sufficiently evaluated. New diseases are arriving on the scene, some within the very walls of our

hospitals. Resources and skills seem at times to be in short demand in health-care facilities for the elderly. Fragmented information about the system, lack of a comprehensive, reliable and transparent knowledge base, the public's increasingly lacklustre involvement in the fundamental choices to be made—all of these are risk factors assailing the system and topics of concern to citizens.

A wealth of data exists on the health and social services system. These data are compared, analyzed and interpreted according to different methodologies and differing interests. How then can we gain a clear overall picture and interpretation of the system's inherent dynamics and outcomes? How can we provide an assessment that is both *differentiated*—one that details the system's various components—and *integrated*—one that provides an overview of the entire system? How can we obtain a comprehensive and integrated comparative analysis of our system? How can we produce an assessment that will result in better reporting and greater accountability? How can we ensure that this assessment will help increase the public's ongoing capacity to influence the system, its goals, services, renewal and growth?

To help the Conseil answer these questions and develop a comprehensive and integrated framework for assessing Québec's health and social services system, we asked experts to shed light on different experiences in health system evaluation and citizen-led evaluation in the world. They produced studies on the question.

The first part of this publication states the aims of the CSBE in considering the various requirements for assessing the system. The second part explains the conceptual model that was chosen from among available ones to appraise Québec's system. It also provides a detailed description of that model in all of its dimensions. For each dimension, model indicators developed by the World Health Organization (WHO), Canada and Québec respectively are presented. Some of them were retained and used in the perspective of operationalizing the framework. The last part offers a brief description of the tasks involved in implementing this health performance assessment framework.

1. PERFORMANCE ASSESSMENT REQUIREMENTS

For the CSBE, any performance assessment designed to inform and stimulate ongoing public debate, citizen engagement and decision making imposes specific requirements. It must be comprehensive and integrated. It must convey the values and the reality of Québec's health and social services system. It must allow us to compare our performance with that of other systems across Canada and the world. And it must foster citizen engagement and increase accountability.

1.1 To produce a comprehensive and integrated system assessment

The first requirement involves producing a comprehensive and integrated assessment of Québec's health services, social services and public health. Comprehensive: because it must encompass the entire system and not be reduced to examining individual service offerings or a component thereof, such as emergency wait times, as it is often tempting to do. Integrated: because the appraisal must take account of the interrelationships that exist among the different performance dimensions and that contribute to how they evolve. While providing a clear picture and understanding of the system's complexity, the assessment must at the same time give us a clear picture and understanding of each of its components.

The assessment approach we adopt must allow us to judge the system's overall performance, while taking into consideration the interrelationships existing among dimensions such as the system's *achievement of fundamental goals*, *production* of health and social services, *adaptation* to its environment and *maintenance of social values*.

1.2 To appraise the reality of health and social services, and of public health

In addition to the need to provide a comprehensive and integrated system evaluation, our assessment approach must be tailored to fit the characteristics of Québec's system, which encompasses health services, social services and public health.

Champagne et al. (CSBE, 2004c) state that the **health services system** includes *all actions that target core social or health problems*. It therefore comprises preventive, palliative, diagnostic and curative services, along with key public health functions (surveillance, health protection and health promotion, disease prevention, health system assessment, and development of public health skills). However, it does not include the social, economic, cultural and demographic conditions affecting people's capacity to live long and healthy lives.

Beaudoin (CSBE, 2004a) defines **social services** as "current services or those foreseen under the *Act respecting health and social services* that are meant to help solve social relation problems, to prevent them from occurring and to meet people's societal needs in order to enhance their wellness through the equitable provision of quality services". [Translation]

The *Québec Public Health Program 2003-2012* defines the **public health** approach as

> acting on the factors that influence health for the benefit of the entire population or specific groups of people. This action is not based on a diagnosis of individuals, but rather on the population as a whole or groups with certain common characteristics. [. . .] Through its objectives, the program strives to change the determinants of health and well-being, enhance health and well-being, and reduce health or psychosocial problems or traumas. [Translation].

Core health services, social services and public health differ in several ways: they deliver different services; they mobilize different areas of expertise; and they have different spheres of action, which may occasionally overlap or compete with one another. Granted, core health services seem to be under the greatest pressure today: the health services sector accounts for the major share of public spending, its services are in greatest demand, and it is the most in need of evaluation. This sector also generates the most data.

Québec's public system differs from those in the rest of Canada in two fundamental ways: (a) its health and social services are administered by a single body, and (b) public health is a large apparatus comprising resources, actors and institutions involved in financing, organizing, carrying out and evaluating actions that target core health and social problems. Its goal is to work toward improving citizens' health and well-being, while respecting values such as solidarity, equity, social justice, equality, freedom, respect, good citizenship, concern for others, and safety.

The health services system is not a hermetic entity. It is part of a vast body embracing (a) a civic and political community that adheres to certain values and that has health and wellness needs; (b) standards, ideologies and social relationships characteristic of Québec society; and (c) a broad spectrum of government policies, organizations, and public and quasi-public institutions. As such, considering our system's social anchors compels us to take both an inside and an outside look at its development.

1.3 To be able to compare Québec's health performance

The assessment process must also allow us to compare the performance of the Québec system with that of other systems across Canada and around the world. As we shall see in Part 2, health system evaluation and comparison is a very widespread phenomenon.

Comparisons are necessary because health system data are rarely meaningful in absolute terms. Comparisons can be carried out through three different theoretical prisms. The

first prism is that of comparisons across time. We compare the value of an indicator between two periods and then examine how it has evolved. This allows us to derive a certain number of findings and to look for the causes underlying the observed differences. The second prism is that of space. We examine the differences recorded for a single indicator in two distinct geographic units in order to measure the gaps between them and to discover their causes. The third prism is normative. It involves quantifiable objectives, a desired ideal. In this case, indicator outcomes serve to illustrate only how near or how far we are from achieving a set standard. The appraisal can be carried out according to any one of these prisms, sometimes even with more than one at the same time (e.g., comparisons across time and space).

Comparisons of health system outcomes may have a significant impact on how we understand our system's issues and directions and on how we make decisions. These comparisons may also shed light on the factors liable both to affect its performance and to improve it.

1.4 To foster citizen engagement and increase accountability

Besides providing a comprehensive and integrated translation of the specific realities of Québec's health and social services and offering a certain level of comparability, the assessment process must foster citizens' informed participation and increase accountability.

This last requirement basically refers to the general goal that the CSBE has defined for the future Commissioner—to contribute, by various means, to protecting and promoting the core values of our collective health and well-being system, chiefly in the form of citizens' common rights, namely, the right to a quality system, the right to be informed and the right to participate. The responsibility for assessing health system outcomes entrusted to the Commissioner is linked to that of informing and consulting citizens in order to encourage enlightened decision making and public debate. (CSBE, 2004f).

Through this assessment, the Commissioner will take all the information available on the health and well-being system and integrate it into a solid, reliable, consistent whole. This information includes citizens' knowledge about the system, whether they are users, payers, practitioners, administrators or staff members. To do so, the Commissioner will first need to recognize that their knowledge is relevant and then take steps to implement different consultation and information-collection strategies, particularly in the form of working groups, public hearings and forums of deliberation. The Commissioner will also need to work in close partnership with the *consultation forum*, a citizens' forum that can help direct and support the work to be done. The intelligence gleaned in this way will allow the Commissioner to collect information about the system's realities and to make judgments that are consistent with the values held by Québec society (CSBE, 2004g).

The knowledge base that the Commissioner will build through this assessment process must help stimulate citizens' active involvement, inform their judgments, trigger debate on the system's issues and future, and ultimately ensure that well-informed collective decisions are made. The Commissioner will also be in a position to help health authorities stay constantly in touch with public knowledge and thus with the values cherished by Québec society, especially by granting a prominent role to public participation (CSBE, 2004g). It is important to remember that in Québec health and well-being are considered to be a public good. That alone turns it into a primary responsibility for health authorities and entails recognizing the public as a particular civic and political community composed of fellow citizens who share a set of standards and values and who subscribe to collective choices (CSBE, 2004e). The way in which responsibility is shared will also be one of the targets of the assessment done by the Commissioner, who will be charged with increasing the system's accountability.

But what exactly is meant by accountability? Dubois and Denis (2001) define it as

> a process that presupposes that the different actors or groups of actors involved in an often complex network of *relationships* remain committed to ensuring that the parties in *authority* undertake to *report* and explain both the results and the *performance* levels achieved through invested efforts. [Translation]

As stated in the CSBE's proposal on participation and consultation (CSBE, 2004b), citizens want decision makers to be more accountable for their actions, and they want these actions to be more transparent and open. Citizen involvement therefore implies a better share of information and power, mutual respect and reciprocity between those in power and the public. This dictates a new way of viewing their relationship, which must be based on trust, openness and feedback. Citizens, for their part, must recognize that although they have rights, they also have responsibilities, and that they themselves must be accountable for their actions to the community and to their government. Citizen engagement can therefore be viewed as a means of promoting and consolidating responsibility both vertically, from the government to the public and vice versa, and horizontally, between citizens (Abelson and Gauvin, 2004; Mackinnon et al., 2003; OECD, 1997).

All these ideas are consistent with the views that emerged from the 1997 National Forum on Health, and that are summarized on Health Canada's Web site: "A better informed public will influence evidence-based decision making. [. . .] More informed and involved users will lead to better health-care decisions and accountability."

By shedding greater light on the system's overall performance, the assessment process will be able to help those in positions of responsibility fulfill their duty to report to the public. Building reliable, consistent, robust and clearly understood knowledge about the system and taking citizens'opinions into account will provide the government with tools to make better informed decisions. In addition, the decisions made by government leaders will gain added legitimacy if citizens play an active part in the Commissioner's work.

Now that we have provided an overview of the concept of accountability, one of the integral requirements of performance assessment, we will describe and explain the conceptual model selected from among several existing ones, along with its particular characteristics.

2. CHOICE OF ASSESSMENT FRAMEWORK

The assessment process, as previously observed, must meet a good number of requirements. As a basis for assessment, the framework proposed here will be shown to meet these requirements through its characteristics and dimensions. This means that it will show a concern to respect the specific characteristics of the Québec system, to produce an assessment that is both comprehensive and integrated, to compare our system with others across Canada and the world, and to include the process of citizen involvement and accountability.

2.1 Choice of conceptual model

Many evaluation models exist in Québec and elsewhere. What are they? Which of them would best serve to appraise the performance of Québec's health and social services system and meet our requirements? The following describes a few available options.

2.1.1 Evaluation models available worldwide

A survey of the different experiences with evaluating health and social services system performance revealed two facts: first, nearly everywhere, factors such as state of health or social problems, service production, user satisfaction and sometimes social determinants are evaluated; second, many of those who have produced indicators have done so without having developed an overall interpretation framework.

Consider the following examples. The health services assessment framework proposed by the Canadian Institute for Health Information (CIHI) includes four major dimensions: state of health, non-medical determinants of health, system performance, and community and health system characteristics. Canada's 2003 Accord on Health Care Renewal contains four indicators: timely access to services, quality of services, sustainability (efficiency, effectiveness) and state of health. The model adopted by the World Health Organization differentiates between a system's goals (state of health, responsiveness to the expectations of the population, fairness of financial contribution) and the functions to attain these goals (administration, financing, service provision, resource generation). The Australian model has three major tiers: state of health, determinants of health, and system performance. The model used by the Organisation for Economic Cooperation and Development (OECD) is centred on health outcomes, responsiveness, fairness and efficiency. The British model includes health improvement, fair access to services, effective delivery of appropriate health care, efficiency, client satisfaction, and health outcomes.

We also took a look at five models for evaluating social services aimed at families, youth, and individuals in long-term care (Alberta, British Columbia [BC], France, Ontario, United Kingdom). Among them, they have the following core dimensions: equity (Alberta, BC); patient/family satisfaction (Alberta, BC, Ontario), continuity of care (BC), effectiveness, efficiency and productivity (Ontario, Alberta, BC, United Kingdom) and adaptation (BC) (CSBE, 2004a).

Although these evaluation models focus on a fair number of performance dimensions, they are incomplete. Given that performance is a complex concept comprising many different dimensions linked, notably, to improvements in state of health and well-being, efficiency, production of quality services, resource acquisition, adaptation to needs, public participation and maintenance of collective values such as solidarity, equity, justice, respect and safety, we should steer toward a framework that would bring together this more complete set of dimensions.

2.1.2 Integrating model developed by Champagne et al.

The CSBE has selected the integrating model for appraising health system performance proposed by Champagne et al. (CSBE, 2004c) and used by André Beaudoin (CSBE, 2004a) for social services. This model proposes the appraisal of four functions of the health and social services system:

1. Its capacity to *achieve its fundamental goals*
2. Its capacity to *produce* services that meet quality criteria or standards
3. Its capacity to *act on its environment* for the purpose of resource acquisition and adaptation
4. Its capacity to fulfill its role as *active mediator of social values*, that is, its ability to adapt the system's functions to fit these values

This integrating model therefore consists of four dimensions:

1. Goal achievement
2. Service production
3. Adaptation to the environment
4. Maintenance and development of values

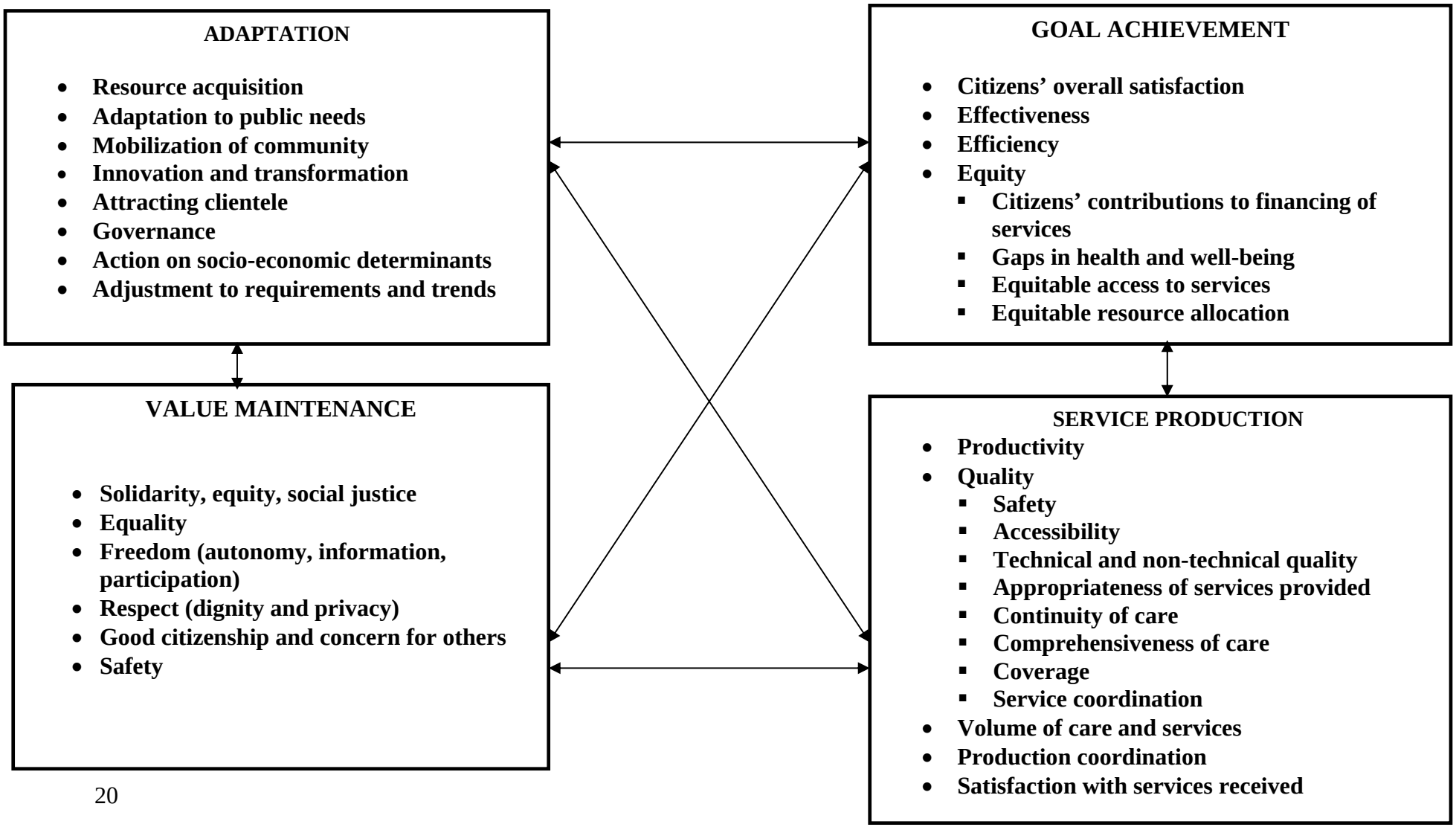
These four dimensions, which are interrelated and which span the entire system, are each comprised a of varying number of subdimensions.[1]

1. For more detailed information on the integrating model developed by Champagne et al., see the publication *Un cadre d'évaluation de la performance des systèmes de services de santé : le modèle EGIPSS*, (CSBE, 2004c).

The Champagne et al. integrating model (CSBE, 2004c) clearly depicts the intrinsic complexity of performance by incorporating a wide variety of dimensions and subdimensions. It is "based on a very general view of the functions that any organization must perform in a given setting" (Sicotte et al., 1998) [Translation]. That is why the CSBE has selected it as the conceptual model for measuring the performance of Quebec's health and social services system. Given that the CSBE wished to respect this model in its entirety in developing this framework, the dimensions and subdimensions selected are, with only a few exceptions, the same as those in the model by Champagne et al.

The following diagram attempts to provide a clear view of the assessment framework developed by the CSBE.

PERFORMANCE ASSESSMENT FRAMEWORK FOR QUEBEC'S HEALTH AND SOCIAL SERVICES SYSTEM



2.2 Framework dimensions and subdimensions

This section provides further detail about the properties of the different aspects covered by the proposed framework. It presents each of the four major dimensions in turn and defines their respective subdimensions. These definitions are also listed in a table found in **Appendix 1**.

2.2.1 Achievement of fundamental goals of the system

The ultimate goal of the system is to maintain and improve citizens' health and well-being. The health and social services system is in fact one of the major measures of social protection adopted by our society to overcome social inequities.

We have retained a few of the system's many objectives for the purpose of this assessment: citizens' overall satisfaction with the system, effectiveness, efficiency and equity.

Citizens' overall satisfaction

Satisfaction refers to how citizens generally rate the overall health and social services system.

Effectiveness

Effectiveness refers to the system's achievement of expected outcomes with respect to improving and maintaining individual and population health, and to the way in which the services contend with health and social problems. Effectiveness corresponds to the *health outcomes and social outcomes attributable to services of the system.*

Efficiency

Efficiency refers to the health and social outcomes achieved as a function of the funds invested in the system.

Equity

Equity corresponds to the value of solidarity and to the collective responsibility to allocate health services equitably (based on need) and to reduce any health inequalities existing among individuals, groups, regions, and so forth.

Equity can be appraised according to citizens' financial contributions to the system, gaps in citizens' health and well-being, access to services, and resource allocation.

2.2.2 Production of health and social services

Production, like the achievement of the system's fundamental goals, occupies a strategic position within the system of health and social services. It is one of the primary dimensions used to assess the system. It is the core of the organization. Production contains subdimensions that are all closely connected to the system's service offerings—they are the concrete elements produced by the system. As a result, this is the dimension that is generally the most visible in society, particularly in the media.

In the proposed framework, *production* is divided into five subdimensions: productivity, quality, volume of care and services, production coordination and citizens' satisfaction with services received. These subdimensions are defined as follows:

Productivity

Productivity corresponds to optimizing service production based on available resources.

Quality

Quality refers to a set of attributes of the process that favour the best possible outcome. It is defined in relation to current knowledge, technology, expectations and social standards. Quality is therefore defined by the way in which the care process matches up with the professional and social standards related to several process dimensions.

Quality includes such attributes as safety, accessibility, technical quality (accuracy, operational competence), non-technical quality (tangible context, respect, courtesy, support, communication), appropriateness of the service rendered, continuity of care, comprehensiveness of care (holistic approach), coverage (range of available services) and service coordination.

Volume of care and services

The volume of care and services delivered by the health and social services system corresponds to the quantity of the various forms of services offered to the Québec public.

Production coordination

Production coordination refers to a set of formal arrangements designed to ensure that the constituent parts of the whole fit together in a logical way. With respect to the production of health and social services, it is an "action intended to harmonize, combine and rationalize the activity of different authorities or departments pursuing identical or similar objectives" (*Le grand dictionnaire terminologique*) [Translation].

The type of coordination referred to here is positioned at a higher level within the process than that defined for the quality subdimension.

Citizens' satisfaction with services received

Satisfaction in this case refers to how people express their appreciation for the specific services they receive from the system. It refers to people's concrete experience within the system and to the various ways in which they interpret and express that experience.

Satisfaction of individuals who have received services is measured on a regular basis. Although it is not direct proof of the quality of the services received, it is nevertheless indicative of the citizen's relationship with the system. It is essential for obtaining a complete evaluation of quality.

2.2.3 Adaptation to the environment

In the context of public management, adaptation refers to "an action that an organization takes to modify a behaviour, a situation or a regulation in response to changes in its environment, new conditions or special circumstances" (*Le grand dictionnaire terminologique)* [Translation].

The system comes up against new realities in its surroundings, which drives it to change its ways of being or doing, in other words, to adapt. These realities will bring actors within the system to question or revise how they:

- acquire resources
- adapt to public needs
- mobilize the community
- innovate and transform the system
- attract clientele
- contribute to good governance
- act on socio-economic determinants
- adjust to other requirements and trends

These aspects which compel the system to adapt are defined more specifically as follows:

Resource acquisition

This subdimension can be measured by the number and type of financial, human and technological resources that are acquired during a given period.

Acquiring and reallocating financial resources are the system's major levers for action and evolution. These functions are conditioned by funding sources and levels, fiscal and economic policies, government and departmental priorities, various criteria for allocating

resource envelopes, professional wage structures, management approaches, service models, private share of funding, and so forth.

The system must also recruit and retain qualified labour. This capacity is shaped by several factors: labour-force planning; the education sector's policy directions; hiring, management and development policies; wage conditions; professional regulations; changing practices and service organisation; labour negotiations and their impact on the other performance dimensions, to name only a few.

Special attention must also be paid to the decision criteria and processes surrounding the choice of new health technologies (e.g., cost, effectiveness, origin) and the system's capacity to adapt to these new technologies. Lastly, an attempt must also be made to understand the factors that determine the different major research priorities and the ties between health-care institutions and research groups and laboratories.

Adaptation to public needs

Adaptation to public needs involves knowing the extent to which the system is adjusting its resources and structure to meet citizens' needs. Assessing this subdimension requires taking into account such factors as the aging population, regional gaps, disadvantaged and at-risk areas, and the issue of gender and ethno-cultural differences.

The system's capacity to adapt to public needs can be examined in relation to the progress it has made in building a strong front line and decentralizing its services to the local level.

Mobilization of community

Community mobilization corresponds to the range and intensity of social capital, support and backing that the system gives to the community. It can be measured by the number of existing community-based initiatives or yet again by the level of citizens' involvement in the system's activities and participative forums.

To understand the system's capacity to mobilize community, we need to examine the respective roles of community actors (non-profit organizations and intermediate care services) and the particular conditions surrounding their activities. It also requires us to find out how much economic weight these actors carry, along with their political and social impact.

Innovation and transformation of the system

The system's capacity to innovate and to transform itself is often associated with its ability to react to new public needs and expectations, to be effective and efficient, and to ensure that its directions and knowledge are assimilated into its decisions and actions. Other commonly recognized sources of innovation include research and the introduction

of new technologies or even simply an open attitude to citizens' growing involvement in decision making. We will need to clearly define the system's capacity for innovation and renewal based on selected values. Innovative capacity is often viewed as a necessary condition for the system's survival.

Attracting clientele

Attracting clientele corresponds to the system's capacity to treat people in a way that will prompt them to use the services again when necessary.

System governance

Governance of a system refers to the way in which its activities are oriented, directed and coordinated. In the *Encyclopédie de l'Agora* (2004), it is stated that

> governance implies guiding and directing. It is a process whereby human organizations, whether private, public or civic, take the helm themselves to govern themselves. Studying governance involves:
>
> - examining the way in which the rights, obligations and powers underpinning an organization are allocated;
> - examining the methods that an organization uses to coordinate its various activities and to ensure that they are internally consistent;
> - exploring the causes triggering organizational dysfunction or the inability to adapt to the environment, resulting in suboptimal performance;
> - establishing benchmarks, developing tools and sharing knowledge to help organizations renew themselves when governance gaps are detected [Translation].

Action on socio-economic determinants

Acting on socio-economic determinants is defined as the role that the system plays in cooperating with the different sectors that have an impact on population health and well-being and that improve the effect that the services system has on them.

Adjustment to other requirements and trends

Adjusting to requirements and trends means adapting to the internal and external environmental forces that influence the system, including all the elements mentioned earlier.

For instance, we could judge how the system is adapting to complementary and alternative medicine by identifying how widely available it is, by positioning it relative to the health and social services system, and by examining any government action taken in its regard, especially in terms of the laws and regulations governing this form of medicine.

Globalization is another force interacting with the system. It introduces new restrictions on governments and opens the door to redefining certain national policies so that they include newly adopted world standards. One of the issues needing investigation is the effect of free-trade agreements, especially the clauses that might force us to question some of the measures contained in our social safety net.

Another matter to look into concerns ongoing policy and normative debates, along with the institutional changes taking place in international health organizations. We will also need to keep an ear open to the debates surrounding the definition of the *right to health*. Such debates are occurring as part of the work being carried out by the World Health Organization and by the United Nations Commission on Human Rights, not to mention UNESCO's discussions on related matters. The need to pay attention to these discussions is justified not only because they might influence Québec government policies but also because citizens' groups could raise these issues in a bid to remind the government of its commitments and to throw them open to public debate.

2.2.4 Maintenance of social values

Maintaining social values is a way of ensuring that the system stays vital and on track. It can be measured from the angle of the system's capacity to embody our values in a way that both facilitates and limits selected dimensions, namely, the system's capacity to achieve its fundamental goals (dimension 1), to produce services (dimension 2), and to act on its environment for the purposes of resource acquisition and adaptation (dimension 3). Values are not identifiable objects. They are symbols, ideals that guide and drive our actions, decisions and plans. A value is a vision on the horizon that goads us into action; it proposes a normative ideal that we strive to achieve or embody through our actions. Evaluating the health and social services system implies that we must first make normative or moral choices. Those choices will in turn lead us to favour a specific interpretation of citizens' collective health and well-being values and rights. To do so, we will need to refer to the shared values that match the societal choices made in tandem with the Québec public and that are the foundation of our health and well-being system.

The CSBE proposes the following classification for these shared values, without forgetting that they must be debated and defined by citizens, particularly during the process of developing an official Declaration on rights and responsibilities in health and well-being (CSBE, 2004d). In our view, **solidarity**, **equity** and **social justice**, which are the cornerstones for the **equitable reallocation of resources** and the **fight against exclusion**, are three essential imperatives, along with **citizens' equality before the system** and the **refusal to countenance any form whatsoever of unjustifiable discrimination**. Freedom is also one of our system's core values, whether in the form of **personal autonomy** in making informed choices about available therapeutic options; **freedom of action** that governments must grant to any citizen wishing to take part in debate and decisions; **freedom of information**, which requires transparency on the part of the system; or **freedom of speech** and the freedom to challenge, which give the right

to lodge complaints. **Respect for the dignity and privacy** of all, including the most vulnerable members of society, **good citizenship** and **concern for others** are other common values that must be respected by the health and well-being system. Lastly, citizens' **safety** and **security** are values that should never be compromised. Consensus must be reached on these manifestly ideal ways of being and doing. System actors must work in close collaboration to find the most efficient way of accomplishing their joint projects.

Organizational climate is another part of *value maintenance.* Glick (1988) defines it as

> [. . .] a broad class of organizational, rather than psychological, variables that describe the organizational context for individuals' actions. These organizational variables include interpersonal practices (the social climate) and the intersubjectively developed meanings that result from organizational sense-making processes.

Organizational climate is driven by the values cited earlier and helps the system maintain these values. It is one of the factors at play in health system performance.

2.3 Guidelines for a comprehensive and integrated interpretation

As we have seen, the dimensions included in this framework cover a large number of performance aspects, which are all closely interconnected. The system's *achievement of goals, maintenance of social values*, *production* and *adaptation* are all woven into a dense web of interrelated dimensions and subdimensions. These interrelationships will need to be clarified in an interpretation guide that will inform the assessment of the system's overall performance and the comparisons made with its counterparts.

Below we provide, for illustrative purposes, a few guidelines for interpreting the *value maintenance* dimension. This illustration, which could set the tone for the interpretation guide to be developed at a later date, demonstrates the comprehensive and integrated nature of this assessment framework, while providing food for thought about how to proceed in assessing this particular dimension.

Maintenance of social values – Model of a comprehensive and integrated assessment

Besides informing the appraisal of the three other core dimensions, the *value maintenance* dimension will serve as a guide in evaluating the results achieved by the different processes implemented by the system to manage ethical issues and organizational climate. Greater still, given that the dimensions are so closely interrelated, the entire dimension set will have a mutual effect on the overall assessment carried out through this framework.

This means that if we wanted to assess the situation regarding the values of solidarity, equity and social justice, fairness in resource reallocation or the fight against exclusion, we could use the results obtained in dimension 1 regarding equity of resource allocation. We would do so by making use of the financial data and other information emerging from consultations with civil society organizations and citizens.[2] This data-collection process could be organized in a way that would stimulate informed public debate on the stakes tied to these values and on the topic of resource allocation.

2. See the publication *Participation et consultation des citoyennes et des citoyens en matière de santé et de bien-être* (CSBE, 2004b).

To assess if the system is treating its citizens on an equal footing, we could rely on comparisons of the service offerings and health and well-being status of the different regions. These comparisons would have already been carried out for the other dimensions, and they could then be thrown open to public debate.

To assess the system's refusal to accept any form of unjustifiable discrimination and its respect for personal autonomy, dignity and privacy, we could use the data (complaints or investigations) issuing from the *Protecteur des usagers* (Health and Social Services Ombudsman) the *Protecteur du citoyen* (Québec Ombudsman), the *Commission des droits de la personne et des droits de la jeunesse*, the *Commission d'accès à l'information* or the commission regulating professional corporations and associations. In addition, we could analyze newspaper articles on these topics or the results of consultations held with citizens, clinical ethics committees, or other committees. We could also evaluate current organizational policies on these issues to judge how clear they are and how they are being applied.

Freedom of action, freedom of information and freedom of speech could be assessed by checking whether their corresponding collective rights are being respected and promoted by the system, that is, the right to participate and the right to information.

To assess the extent to which the system is abiding by the values of good citizenship and concern for others, we could evaluate the codes of ethics, value statements, service statements and rules of conduct formulated by health institutions, networks and agencies. These tools are designed to regulate the conduct of the different actors in the system (e.g., practitioners vs users, practitioners vs staff, staff vs administrators, staff vs users, users vs administrators). Nevertheless, to evaluate what is happening in truth, we would need to listen to the knowledge of citizens and actors of the system (users, practitioners, employees) on these issues. We could also conduct ad hoc consultations to understand how these different policy statements are being applied in daily practice.

To assess the importance that the system attaches to citizens' safety and security, we could evaluate relevant policies developed by organizations, institutions and professional corporations, and compare them with what is happening in reality. We could also compare these policies with the results of qualitative surveys held in private institutions and clinics or through the media.

We have now reviewed all the framework dimensions and their interconnections. Next we will present some model indicators used by the World Health Organization, Canada and Québec respectively to assess health and social services system performance. These examples, which we have classified according to the dimensions in the proposed framework, could guide us in establishing the directions, objectives and indicators for appraising Québec's health and social services system.

3. CHOICE OF PERFORMANCE INDICATORS

The proposed framework, with its different dimensions and subdimensions, is the starting point for appraising the system. Indicators will have to be developed to measure these dimensions and subdimensions of the performance of the health and social services system. Selected on the basis of policy directions and objectives if at all possible, indicators are the final components in the framework.

To ensure better understanding, it is important at the outset, to define certain concept. Assessment is rooted in policy directions, which correspond to what the system is or should be striving to achieve within its different functions. In this case, these functions are translated as the four major framework dimensions: goal achievement, service production, resource acquisition and adaptation, and maintenance of values. Objectives and indicators are closely intertwined with these directions. Objectives may or may not be quantitative and must be achievable within a given time frame.

An indicator is defined as "a meaningful parameter used to measure outcomes, resource utilization, work progress or context. The data that the indicator yields periodically can be quantitative or qualitative" (*Le grand dictionnaire terminologique*) [Translation]. Pierre Voyer (2000) refers to them in these terms:

> An indicator is an element, or a group of elements, of meaningful information, a representative index, a target statistic framed in the context of a measurement need. It is the outcome of data collected about a situation, the observable manifestation of a phenomenon or an aspect tied to an organization's operation. [Translation]

A cause-and-effect relationship must also exist between the objectives and the results obtained through these measurement indicators.

Health performance indicators must be chosen sparingly. An assessment designed to measure the continuous management of an organization's performance will require a greater number of indicators than will one intended for the purpose of public reporting or information gathering. Given the assessment requirements stated in Part 1—to convey the reality of the system, to produce a comprehensive and integrated assessment of the system, to support participation and accountability, and to permit comparisons—the selected indicators should be more global in nature and each indicator should correspond to a framework dimension. They should be limited in number, thirty or so if possible. The choice of indicators will also depend on the availability, reliability and validity of the data sources used.[3]

3. For further details on these criteria, see Champagne et al. (CSBE, 2004c).

In section 3.1, we will take a look at the indicators used by the World Health Organization (WHO), Canada and Québec respectively. These indicators will help us identify those that we could use to appraise Québec's health and social services system. In section 3.2, we propose thirty or so indicators, by way of illustration. Some are associated with policy directions and some, also, with objectives; they correspond to dimensions in the proposed framework and attempt to meet the need for comparability.

3.1 Model indicators: WHO, Canada and Québec

Many indicators are used nationally and internationally to measure the performance of health services for the most part but also of social services. In step with the current world trend driving public administrations to focus on delivering transparent, outcome-based services and on public reporting, Canada and other jurisdictions have devised quite a few indicators. The evaluation models developed by the World Health Organization and by Canada contain indicators that can be particularly meaningful in assessing the performance of Québec's system of health and social services. These indicators deserve consideration as we proceed to determine those for Québec, if only to meet the need for comparability.

3.1.1 World Health Organization

The World Health Organization presents a certain number of health performance indicators in its publication *The world health report 2000*. Champagne et al. (CSBE, 2004c) have classified them within their integrating model. A glance at this classification shows that the majority of WHO indicators cover *goal achievement*, while some others focus on the *production* and *adaptation* dimensions found in that model.

Appendix 2 provides a table listing the WHO indicators as categorized according to the proposal outlined by Champagne et al.

3.1.2 Canada and its provinces

At the federal/provincial/territorial meeting on health held in September 2004, First Ministers and federal representatives agreed on the need to report to Canadians on the progress achieved in providing timely access to quality care and reducing wait times. That meeting, however, was not the only occasion when Canadian health system actors discussed the need for transparency and accountability. A federal/territorial/provincial committee—the Performance Indicators Reporting Committee (PIRC)—had already been involved in a joint initiative to produce comparable indicators for measuring health system performance. In 2002, PIRC pinpointed fourteen indicator areas.

Canada has therefore taken steps, at several levels and on various occasions, to adopt indicators to measure the performance of health and social services nationally, provincially and locally. Indicators were developed and included in the 2003 First

Ministers' Accord on Health Care Renewal (2003 Accord) and also in CIHI's program *Roadmap Initiative . . . Launching the Process* (2000). Examination of both indicator sets shows that they focus primarily on *goal achievement, production* and *adaptation*, as do the WHO indicators. Additionally, there are once again many more indicators covering *goal achievement*, compared with those targeting the other dimensions.

Champagne et al. have also categorized these indicators according to the dimensions in their proposed model. This classification is presented in **Appendix 3**.

3.1.3Québec

At the First Ministers' Meeting on the Future of Health Care (2004), Québec, like the other Canadian provinces and territories, committed to reporting to its citizens on the performance of its health and social services system and to respecting the principle of transparency. Under the specific agreement reached by the different parties at that meeting, Québec will produce its own public report and use the comparable indicators established jointly with the other provinces. Seventy indicators were selected for that purpose. In November 2004, Québec released a report presenting the results for eighteen of the selected indicators (MSSS, 2004).

Some of these indicators, along with a few others issuing from various Québec health and social service organizations, have likewise been categorized according to the proposed model, as shown in **Appendix 4**. These indicators, like those developed by the WHO and Canada, focus more on *goal achievement* and *production* than on *adaptation* or *value maintenance.*

Appendix 5 presents some model policy directions and objectives defined for Québec's health and social services system.

3.2 Model policy directions, objectives and indicators for the assessment of the services system

In considering the indicators proposed by both the WHO and Canada, together with what is already being done in Québec, and bearing in mind the importance of outcome comparability, we have identified certain directions, objectives and indicators that could be used to assess the performance of Québec's services system. These indicators must be chosen on the basis of certain criteria, including:

- the availability of Québec data
- the use of these indicators internationally or nationally (for comparability purposes)
- the aspects covered by the indicator (general rather than specific)

With these criteria in mind, we developed a set of indicators, which we categorized according to the proposed dimensions and which could be used to assess the performance of Québec's health and social services system. These indicators are included in the proposal presented in **Appendix 6**, which also contains model policy directions and objectives.

Goal achievement

- Readmission rate for
  - acute myocardial infarction (AMI): Risk-adjusted rate of unplanned readmission following discharge for acute myocardial infarction (ages 15 to 84) [subdimension: *effectiveness*]
  - pneumonia: Risk-adjusted rate of unplanned readmission following discharge for pneumonia (ages 15 to 84) [subdimension: *effectiveness*]
- 30-day in-hospital mortality rate
  - patients hospitalized for an acute myocardial infarction (AMI): Risk-adjusted rate of all cause in-hospital death occurring within 30 days of first admission to an acute care hospital with a diagnosis of AMI (ages 20 to 105) [subdimension: *effectiveness*]
  - patients hospitalized for stroke: Risk-adjusted rate of all cause in-hospital death occurring within 30 days of first admission to an acute care hospital with a diagnosis of stroke (ages 20 to 105) [subdimension: *effectiveness*]
- 365-day net survival rate for acute myocardial infarction [subdimension: *effectiveness*]
- 180-day net survival rate for stroke [subdimension: *effectiveness*]
- Relative five-year survival rate [subdimension: *effectiveness*]
  - Lung cancer: Age-standardized five-year relative survival rate for lung cancer [subdimension: *effectiveness*]
  - Prostate cancer: Age-standardized five-year relative survival rate for prostate cancer [subdimension: *effectiveness*]
  - Breast cancer: Age-standardized five-year relative survival rate for breast cancer [subdimension: *effectiveness*]
  - Colorectal cancer: Age-standardized five-year relative survival rate for colorectal cancer [subdimension: *effectiveness*]
- Deaths due to medically treatable diseases:
  - Age-standardized rate of death due to bacterial infections in people aged 5 to 64 [subdimension: *effectiveness*]

  - Age-standardized rate of death due to cervical cancer in women aged 15 to 64 [subdimension: *effectiveness*]
  - Age-standardized rate of death due to hypertensive disease in people aged 35 to 64 [subdimension: *effectiveness*]
  - Age-standardized rate of death due to pneumonia and unspecified bronchitis in people aged 5 to 49 [subdimension: *effectiveness*]
- Readmissions for certain conditions:
  - Readmission rate for acute myocardial infarction (AMI) [subdimension: *effectiveness*]
  - Readmission rate for pneumonia [subdimension: *effectiveness*]
  - Readmission rate for gastrointestinal haemorrhage [subdimension: *effectiveness*]
- Recidivism rate of young offenders under supervised probation orders [subdimension: *effectiveness*]
- Permanency planning for children in long-term care [subdimension: *effectiveness*]
- Number of work hours spent on evaluation-orientation (EO) per completed assessment per finalized assessment [subdimension: *efficiency*]
- Number of work hours required per adolescent, excluding hours worked by residential staff [subdimension: *efficiency*]
- Occupancy rate of places registered on the operating permits of residential placement facilities or group homes, under all applicable laws. [subdimension: *efficiency*]
- Expected compared to actual stay: Average number of actual days in acute care hospitals compared to expected length of stay [subdimension: *efficiency*]
- Proportion of health spending in the poorest population quintile in relation to the richest population quintile [subdimension: *equity*]

Production

- Daily cost of community-based activities per offender [subdimension: *productivity*]
- Proportion of child care centres that provide a developmentally appropriate environment for children [subdimension: *productivity*]
- Unit costs of foster care [subdimension: *productivity*]
- Number of children in care awaiting assessment [subdimension: *quality*]
- Difficulty obtaining routine or on-going health services: Proportion of people who reported difficulty obtaining routine or on-going health services [subdimension: *quality*]

- Difficulty obtaining health information or advice: Proportion of people who reported difficulty obtaining health-care information or advice [subdimension: *quality*]
- Difficulty obtaining immediate health care: Proportion of people who needed immediate care for minor health problems [subdimension: *quality*]
- Proportion of people reporting that they have a regular family doctor [subdimension: *quality*]
- Self-reported wait times for surgery [subdimension: *quality*]
- Self-reported wait times for specialist physician visits [subdimension: *quality*]
- Access to home care: Number of home care clients per 100,000 population, all ages (P/T) [subdimension: *quality*]
- Errors and events: Reported medical errors/events (e.g., disease surveillance, adverse drug reactions) [subdimension: *quality*]
- Errors and events: Proportion of child injuries (serious or fatal) sustained between the time the child's safety or development is determined to be at risk and the end of application of measures [subdimension: *quality*]
- Patient satisfaction:
    - Percentage of adult population reporting that they were very or somewhat satisfied with overall health services [subdimension: *satisfaction with services received*)
    - Percentage of adult population reporting that they were very or somewhat satisfied with services received in hospital [subdimension: *satisfaction with services received*]
    - Percentage of adult population reporting that they were very or somewhat satisfied with the community-based services they received [subdimension: *satisfaction with services received*]
    - Percentage of adult population reporting that they are very or somewhat satisfied with family doctor or other physician care received [subdimension: *satisfaction with services received*]

Adaptation

- Age distribution of practising providers by areas of specialty (human resources) [subdimension: *resource acquisition*]
- Number of providers (by specialty) entering and leaving the system each year (human resources) [subdimension: *resource acquisition*]
- Progress on building information systems (information systems) [subdimension: *resource acquisition*]

- Percentage of adults who made an unremunerated contribution to charitable or non-profit organizations, causes, or community development activities, or help through personal initiative to individuals [subdimension: *resource acquisition*]
- Percentage of spending for the five major health problems in relation to needs [subdimension: *resource acquisition*]

Maintenance of values

No examples of indicators associated with the *maintenance of values* were found among those used by Québec, Canada or elsewhere.

The indicators in this proposal, which takes into account the criteria cited earlier, were selected from those illustrated in Appendices 2 to 5. Some may be useable as they are, but they generally need some fine-tuning. In several cases, no objective or indicator has been identified for a given subdimension, which means that objectives will need to be defined and indicators developed. Data sources for the suggested indicators are specified as well as a few indicators used by other provinces or countries. Further data sources will need to be culled from current databases, and new data will even have to be collected.

Our efforts will therefore focus on developing indicators for the dimensions and subdimensions of *adaptation* and *value maintenance*. Although a certain number of *adaptation* indicators exist, they do not cover all the subdimensions. As for the *value maintenance* dimension, it will be important to allow citizens to express their views on the values that should be retained, after which indicators can be developed.

Note that comparability is also a factor in the indicator selection process. To achieve a satisfactory level of comparability, however, we must ensure that all share the same interpretation of each indicator as they refer to them during the assessment process.

Even though several steps still need to be taken in developing new indicators for Québec, our proposal can serve as inspiration for the future choices to be made. Indicators should be selected once policy directions and objectives have been debated and established for the Québec health and social services system.

4. STEPS INVOLVED IN IMPLEMENTING THE ASSESSMENT FRAMEWORK

All the structural components of the proposed framework have now been defined. However, certain steps will need to be taken before the assessment process *per se* can begin. Certain tools and additional processes need in fact to be developed.

System actors, such as health professionals, experts and members of civil society organizations, will be asked to form a committee to deliberate on health performance directions and objectives and to select appropriate indicators. An interpretation guide that clearly explains the selected dimensions and subdimensions must also be produced. In this respect, we must make full use of Québec's existing strengths in evaluation, including citizen evaluation of services. Given that values lie at the root of performance assessment, we will also need to examine this issue and spell out the system's current values. Public participation will be needed at this time and could take the form of a wider consultation.

A considerable amount of work remains to be done before an initial performance assessment report sees the light of day. The proposed framework offers guidelines for interpreting information and for informing judgments about the system's overall performance. Once these various tasks are accomplished, we will need to operationalize the framework by establishing policy directions, objectives and indicators. As can be seen with regard to the model proposed in section 3.2, Québec as well as other Canadian provinces and international organizations have already developed many indicators. There is also a wealth of Québec data available to assess the system. We will have to pinpoint and select a limited number of indicators that relate directly to the directions and objectives that are ultimately adopted. These indicators could be chosen from among those already in use or developed specifically for this purpose. The choices made will allow us to select elements that will be useful in producing an initial assessment report and subsequent reports, given that the core issues surrounding the overall assessment process will have already been debated. Once the directions, objectives and indicators are chosen and several other issues clarified, we will be able to launch the process for assessing the performance of our health and social services system, culminating in the production of our first report.

CONCLUSION

One of the roles played by the health and social services system is never highlighted enough, that is, the preventive function it performs "by instilling, and contributing to, a sense of public trust and confidence" (CSBE, 2004c). The system therefore has a twofold value—what it offers and what it is. Along with education and income security, the health and social services system is a vital part of our social safety net, and no doubt the most important in the eyes of an aging population. It thus contributes to citizens' health and well-being through its service offerings and through its very existence.

The seemingly interminable public debate over the system undermines this trust—hence, the usefulness of producing an assessment of our health and social services system, including public health.

Aimed at enhancing health and well-being, this assessment will provide citizens and the government with the necessary background information to understand the major issues at stake in the area of health and well-being. The assessment approach proposed here will give a voice to citizens, practitioners, administrators and researchers. It will allow us to gain a comprehensive and integrated appreciation of the health and social services system and of public health, by covering all their core functions: goal achievement, service production, adaptation, and maintenance of values. It will also allow us to compare the performance of Québec's system with that of other provincial or national systems, while promoting greater accountability both horizontally and vertically, between citizens and the government.

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APPENDIX 1. DEFINITIONS FOR THE DIMENSIONS IN THE PROPOSED FRAMEWORK

Dimension	Subdimension	Definition
Goal achievement	Citizens' overall satisfaction	Citizens' general satisfaction with the overall system
	Effectiveness	Health outcomes attributable to system services
	Efficiency	Health outcomes as a function of the funds invested
	Equity	Collective responsibility for allocating health services equitably (based on need)/ among individuals, groups, regions, etc.
Production	Productivity	Optimizing production based on available resources
	Quality	Set of process attributes favouring the best possible outcome and defined in relation to current knowledge, technology, expectations and social standards. Quality is therefore defined by the way in which the care process matches up with the professional and social standards related to various process dimensions.
	Volume of care and services	Quantity of the various forms of services provided to citizens
	Production coordination	Set of formal arrangements designed to ensure that the constituent parts of the whole fit together in a logical way for a given purpose
	Citizens' satisfaction with services received	Citizens' level of satisfaction with the specific services received
Adaptation	Resource acquisition	Number and type of human or material resources acquired by an organization (or part thereof) during a given period
	Adaptation to public needs	Extent to which the system's resources and structure are able to adjust to citizens' needs
	Mobilization of community	Range and intensity of the social capital, support and backing that the system can get from the community
	Innovation and transformation	System's capacity to innovate and transform itself
	Attracting clientele	System's capacity to treat people in a way that will generally prompt them to use the services again when necessary
	System governance	Way in which a system directs, guides and coordinates its activities
	Action on socio-economic determinants	Role that the system plays in mobilizing the different sectors that have an impact on citizens' health and well-being
	Adjustment to other requirements and trends	Adapting to the internal and external environmental forces that influence the system (e.g., new technologies, globalization, aging population)
Maintenance of	Consensus on systemic values	Consensus on recognized ideals (ways of being and

Dimension	Subdimension	Definition
values	- Solidarity - Equity - Social justice - Resource reallocation - Citizens' equality (fight against exclusion and refusal to accept discrimination) - Freedom (conscience, action, information and speech) - Respect (dignity and privacy) - Good citizenship - Concern for others - Safety (including protection) - Citizen engagement	doing); set of common benchmarks allowing actors to work together to achieve a joint project
	Organizational climate	"A broad class of organizational, rather than psychological, variables that describe the organizational context for individuals' actions. These organizational variables include interpersonal practices (the social climate) and the intersubjectively developed meanings that result from organizational sense-making processes."(Glick, 1988)

APPENDIX 2. WHO – INDICATORS CLASSIFIED ACCORDING TO FRAMEWORK DIMENSIONS AND SUBDIMENSIONS

Dimension	Subdimension	Indicator	Source
Goal achievement	Citizens' overall satisfaction		
	Effectiveness	Probability of dying under age 5 years (infant mortality) or between ages 15 and 59 years (males and females)	The world health report, 2000 (WHO)
		Life expectancy at birth (males and females)	
		Deaths by cause, sex and mortality stratum	
		Burden of disease in disability-adjusted life years (DALYs) by cause, sex and mortality stratum	
		DALE (disability-adjusted life expectancy) at birth and at age 60	
		Distribution of DALE across individuals	
		Disability-adjusted life expectancy at birth (males and females)	
		Percentage of life span lived with a disability (males and females)	
		Index of equality of child survival	
	Efficiency		
	Equity	Ratio of total household spending on health to its permanent income above subsistence	The world health report, 2000 (WHO)
		Distribution of responsiveness (groups disadvantaged with regard to responsiveness)	
Production	Productivity		
	Quality	Autonomy and confidentiality (respect for persons)	The world health report, 2000 (WHO)
		Prompt attention	
		Access to social support networks during care	
	Volume of care and services		
	Production coordination		
	Satisfaction with services received		
Adaptation	Resource acquisition		
	Adaptation to public needs	Respect for dignity	The world health report, 2000 (WHO)
		Quality of basic amenities	
		Choice of care provider (client orientation)	
	Mobilization of community		
	Innovation and transformation		
Adaptation	Attracting clientele		

Dimension	Subdimension	Indicator	Source
	System governance		
	Action on socio-economic determinants		
	Adaptation to other requirements and trends		
Maintenance of values	Consensus on values		
	Organizational climate		

APPENDIX 3. CANADA – INDICATORS CLASSIFIED ACCORDING TO FRAMEWORK DIMENSIONS AND SUBDIMENSIONS

Dimension	Subdimension	Indicator	Source
Goal achievement	Citizens' overall satisfaction		
	Effectiveness	Pneumonia and influenza hospitalizations	CIHI
		Deaths due to medically treatable diseases, age-standardized rates: - Bacterial infections - Cervical cancer - Hypertensive disease - Pneumonia and unspecified bronchitis	
		Hospitalization rate for ambulatory care sensitive conditions	
		30-day acute myocardial infarction (AMI) in-hospital mortality rates	
		30-day stroke in-hospital mortality rates	
		Readmission rate for acute myocardial infarction	
		Readmission rate for asthma	
		Readmission rate for prostatectomy	
		Readmission rate for hysterectomy	
		Readmission rate for pneumonia	
		Readmission rates for selected conditions	2003 Accord
		Readmission rates for congestive heart failure, gastro-intestinal haemorrhage	
		Mortality rate for cancers	
		Survival rate for cancers	
		Percentage of Canadians engaged in physical activities	
		Percentage of Canadians with recommended body mass index (BMI)	
		Potential years of life lost (PYLL)	
		Disability-free life expectancy (DFLE)	
	Efficiency	May not require hospitalization	CIHI
		Expected compared to actual stay	CIHI
	Equity	Proportion of health spending in the poorest population quintile in relation to the richest population quintile	Saskatchewan
Production	Productivity	Comparisons of productivity measures (value for money)	2003 Accord
		Daily cost of community-based activities, per offender	Ontario
		Percentage of child care centres that provide a developmentally appropriate environment for children	Alberta
	Quality	Influenza immunization, aged 65+ [accessibility]	CIHI
		Screening mammography, women aged 50 to 69 [accessibility]	
		Pap smear, women aged 18–69 [accessibility]	
		Immunization for children [accessibility]	
Production	Quality	Vaginal birth after caesarean (VBAC) [appropriateness]	CIHI
		Caesarean sections [appropriateness]	

Dimension	Subdimension	Indicator	Source
		Reported medical errors/events (e.g., disease surveillance, adverse drug reactions) – to be determined by proposed Institute on Patient Safety) [safety]	2003 Accord
		Overall health-care services [satisfaction]	
		Hospital care [satisfaction]	
		Physician care [satisfaction]	
		Community-based health-care [satisfaction]	
		Tele-health/online information [satisfaction]	
	Volume of care and services		
	Production coordination		
	Satisfaction with services received		
Adaptation	Resource acquisition	Age distribution of practising providers by areas of specialty [health human resources]	2003 Accord
		Number of providers (by specialty) entering and leaving the system each year [health human resources]	
		Ten-year rolling forecast of providers expected to enter system (trained in Canada, incoming from other countries) [health human resources]	
		Number and types of equipment installed [material resources]	
		Number of diagnostic professionals to operate equipment [material resources]	
		Volume flow/wait times for MRI, CT [material resources]	
		Progress on building information systems [information systems]	
		Degree of standardization of information collected and shared for evidence-based decision making [information systems]	2003 Accord
		Degree of technology utilization based on evidence [information systems]	
		Percentage of adults who made an unremunerated contribution to charitable or non-profit organizations, causes, or community development activities, or help through personal initiative to individuals	Alberta
	Adaptation to public needs	Proportion of spending on the five major health problems in relation to needs	Saskatchewan
	Mobilization of community		
	Innovation and transformation		
	Attracting clientele		
Adaptation	System governance		

Dimension	Subdimension	Indicator	Source
	Action on socio-economic determinants		
	Adjustment to other requirements and trends		
Maintenance of values	Consensus on values		
	Organizational climate		

APPENDIX 4. QUÉBEC – INDICATORS CLASSIFIED ACCORDING TO FRAMEWORK DIMENSIONS AND SUBDIMENSIONS

Dimension	Subdimension	Indicator	Source
Goal achievement	Citizens' overall satisfaction		
	Effectiveness	Health-adjusted life expectancy	StatCan (NPHS 1996–1997 and CCHS Cycle 1.1)
		Infant mortality: Number of deaths and mortality rates of infants less than one year old, per 1000 live births	StatCan and provincial data
		Mortality rate for lung cancer	
		Mortality rate for prostate cancer	
		Mortality rate for breast cancer	
		Mortality rate for colorectal cancer	
		Mortality rate for acute myocardial infarction	
		Mortality rate for stroke	
		Potential years of life lost due to suicide	
		Potential years of life lost due to unintentional injury	
		Readmission rate for acute myocardial infarction	CIHI
		Readmission rate for pneumonia	
		30-day in-hospital acute myocardial infarction mortality rate	
		30-day in-hospital stroke mortality rate	
		365-day net survival rate for acute myocardial infarction	StatCan – CIHI
		180-day net survival rate for stroke	
		Five-year survival rate for lung cancer	StatCan and provincial data
		Five-year survival rate for prostate cancer	
		Five-year survival rate for breast cancer	
		Five-year survival rate for colorectal cancer	
		Recidivism rate of young offenders under supervised probation order	Centres jeunesse (youth services)
		Average waiting period between the time the youth is bound by a probation order and committed to the custody of a youth worker[continuity]	
		Average number of youth workers involved per adolescent aged 12–17 bound by follow-up measures, under the YCJA [continuity]	
		Average number of authorizations required per assessment measure [continuity]	
Goal achievement	Efficiency	Number of work hours spent on evaluation-orientation (EO) per completed assessment	Centres jeunesse (youth services)

Dimension	Subdimension	Indicator	Source
		Number of hours worked per adolescent, excluding hours worked by residential staff	
		Occupancy rate of places registered on the operating permits of residential placement facilities or group homes, under all applicable laws	
	Equity		
Production	Productivity		
	Quality	Difficulty obtaining routine or on-going health services	StatCan (Health Services Access Survey)
		Difficulty obtaining health information or advice	
		Difficulty obtaining immediate care	
		Proportion of population that reports having a regular family physician	Statistics Canada
		Self-reported wait times for surgery	
		Self-reported wait times for specialist physician visits	
		Wait times for cardiac bypass surgery (P/T)	Provinces
		Wait times for hip replacement surgery (P/T)	
		Wait times for knee replacement surgery (P/T)	
		Wait times for radiation therapy for prostate cancer (P/T)	Provinces
		Wait times for radiation therapy for breast cancer (P/T)	
		Rate of child injuries (serious or fatal) sustained between the time the child's safety or development is determined to be at risk and the assessment is finalized	Centres jeunesse (youth services)
		Number of children in care awaiting assessment	
	Volume of care and services	Number of home care clients per 100,000 population, all ages (P/T)	Provinces
	Production coordination		
	Satisfaction with services received	Patient satisfaction with family doctor or other physician care received	StatCan (Health Services Access Survey)
		Patient satisfaction with overall health-care services received	Statistics Canada (CCHS)
		Patient satisfaction with hospital care	
		Patient satisfaction with community-based care	
		Patient satisfaction with telephone health line or tele-health services	
Production	Satisfaction with services received	Patient satisfaction with hospital care	Statistics Canada (CCHS)
		Patient perceived quality of overall health-care services	Statistics Canada

Dimension	Subdimension	Indicator	Source
		Patient perceived quality of community-based care	
		Patient perceived quality of telephone health line or tele-health services	
Adaptation	Resource acquisition		
	Adaptation to public needs		
	Mobilization of community		
	Innovation and transformation		
	Attracting clientele		
	System governance		
	Action on socio-economic determinants		
	Adjustment to other requirements and trends		
Maintenance of values	Consensus on values		
	Organizational climate		

APPENDIX 5. QUÉBEC – MODEL POLICY DIRECTIONS AND OBJECTIVES RELATED TO FRAMEWORK DIMENSIONS AND SUBDIMENSIONS

Dimension	Subdimension	Direction	Objective
Goal achievement	Citizens' overall satisfaction		
	Effectiveness	Verify the effectiveness of all public intervention programs by using expected outcome indicators or descriptors to be defined before any program implementation.	
	Efficiency	Offer Quebecers the best possible services for the best possible value, taking into account the setting's characteristics and the service-delivery context.	Decrease by about X%, over the next year, the proportion of patients admitted for care events not requiring hospital admission.
			Obtain, over the next year, a comparative hospitalization index for certain diagnosis-related groups (DRGs) recognized as potentially treatable by surgery requiring hospitalization equal to or less than one (1) day.
			Obtain, over the next year, an average ratio of work hours spent on assessment/referral less than or equal to one standard deviation within the provincial mean.
			Obtain, over the next year, an average ratio of hours worked per adolescent (excluding residential staff) that is lower or equal to one standard deviation within the provincial mean.
			Obtain, over the next year, an average occupancy rate in licensed residential placement facilities or group homes, under all applicable laws, equivalent to a maximum spread of one standard deviation within the provincial mean.
	Equity		
Production	Productivity		

Dimension	Subdimension	Direction	Objective
Production	Quality	Increase access to health and social services offered by Québec's health services and social services network [*accessibility*]	Reduce by 25%, over the next two years, the average time required to admit an outpatient when a bed becomes available.
			Reduce by X%, over the next year, emergency room wait times, from admission to discharge.
			Reduce by X%, over the next year, wait times for radiation therapy for breast or prostate cancer.
			Reduce by X%, over the next 18 months, wait times for cardiac bypass and hip or knee replacement surgery.
			Reduce by X%, over the next two years, the proportion of patients using hospital services offered in their areas of residence.
			Increase to X%, over the next year, the proportion of the population having a family physician.
			Increase by 15%, over the next two years, the proportion of the population registered with a family medicine group.
			Reduce by X%, over the next two years, wait times for medical services.
			Immunize for influenza, over the next three years, 95% of the population aged 65+.
			Reduce by 15%, over the next year, the number of children awaiting assessment (after being reported to youth protection services).
			Increase to X%, over the next two years, the proportion of the population having access to a qualified primary care provider.
			Reduce to X%, over the next three years, the proportion of the population reporting that they had difficulty seeing a specialist.
			Increase to X%, over the next two years, the proportion of patients waiting less than one year for elective surgery.
			Increase by X%, over the next two years, the rate of mammograms for women aged 50 to 69.
			Increase by X%, the proportion of women aged 18 to 69 who have had a Pap smear test over the past three years

Dimension	Subdimension	Direction	Objective
Production	Quality	Make appropriate use of health and well-being resources, only by using what is considered necessary to meet citizens' needs in order to improve or maintain their physical or mental health. [*appropriateness*]	Within the next two years, obtain a comparative index on hospital stays equal to or lower than the 2002 provincial average.
			Within the next two years, achieve a post-caesarean vaginal delivery rate equal to or lower than the 2002 provincial average.
			Within the next two years, achieve a caesarean delivery rate equal to or lower than the 2002 provincial average.
		Provide all citizens with services relying on state-of-the art knowledge and technology [*technical quality*]	
		Take account of users' views and wishes when they indicate the means which they plan to use to cooperate in improving their state of health [*respect*]	
		Create a safe environment that minimizes the risk factors affecting people's physical or psychological well-being [*safety*]	Reduce by 5%, over the next two years, the rate of medication errors.
			Reduce by X% the rate of reported incidents and events (patients attacked by another; runaways; disappearances).
			Reduce by X% the rate of reported medical errors or events (wrong medication or wrong dosage).
			Reduce by 5% the mortality rate in low-mortality diagnosis-related groups (DRGs).
			Reduce by 5% the rate of hip fractures.
			Reduce by X% the post-operative complication rate.
			Reduce by X% the post-operative mortality rate.
			Reduce by X% the anaesthesia complication rate.

	Subdimension	Direction	Objective
Production	Quality		Reduce by 5%, over the next two years, the rate of child injuries (serious or fatal) sustained between the time the child's safety or development is determined to be at risk and the end of the application of measures
	Volume of care and services		
	Production coordination		
	Satisfaction with services received		
Adaptation	Resource acquisition		
	Adaptation to public needs		
	Adjustment to other requirements and trends		
	Mobilization of community		
	Innovation and transformation		
	Attracting clientele		
	System governance		
	Action on socio-economic determinants		
Maintenance of values	Consensus on the system's values		
	Organizational climate		

APPENDIX 6. MODEL PROPOSAL – PERFORMANCE ASSESSMENT DIRECTIONS, OBJECTIVES AND INDICATORS

Dimension	Subdimension	Direction	Objective	Indicator	Source
Goal achievement	Citizens' overall satisfaction				
	Effectiveness			1. **Readmission rate** for acute myocardial infarction (AMI): Risk-adjusted rate of unplanned readmission following discharge for acute myocardial infarction (ages 15 to 84).	CIHI (Hospital Discharge Abstract Database)
				1. **Readmission rate** for pneumonia: Risk-adjusted rate of unplanned readmission following discharge for pneumonia (ages 15 to 84).	
				2. **30-day acute myocardial infarction (AMI) in-hospital mortality rate:** Risk-adjusted rate of all cause in-hospital death occurring within 30 days of first admission to an acute care hospital with a diagnosis of acute myocardial infarction (ages 20 to 105).	CIHI (Hospital Morbidity Database)
				2. **30-day stroke in-hospital mortality rate:** Risk-adjusted rate of all cause in-hospital death occurring within 30 days of first admission to an acute care hospital with a diagnosis of stroke (ages 20 to 105).	
				3. **365-day net survival rate** for acute myocardial infarction.	StatCan – CIHI
				4. **180-day net survival rate** for stroke.	
				5. **Relative five-year survival rate** (lung cancer): Age-standardized five-year relative survival rate for lung cancer).	StatCan and provincial data
				5. **Relative five-year survival rate** (prostate cancer): Age-standardized five-year relative survival rate for prostate cancer.	
				5. **Relative five-year survival rate** (breast cancer): Age-standardized five-year relative survival rate for breast cancer.	
Goal achievement	Effectiveness			5. **Relative five-year survival rate** (colorectal cancer): Age-standardized five-year relative survival rate for colorectal cancer.	StatCan and provincial data

Dimension	Subdimension	Direction	Objective	Indicator	Source
				6. Deaths due to medically treatable diseases: Age-standardized rate of death due to bacterial infections in people aged 5 to 64.	CIHI (codes 001, 005, 020–041, 320, 382, 383, 390–392, 680–686, 711 and 730 180, 401–05, 481–486, 490 from ICD-9)
				6. Deaths due to medically treatable diseases: Age-standardized rate of death due to cervical cancer in women aged 15 to 64.	
				6. Deaths due to medically treatable diseases: Age-standardized rate of death due to hypertensive disease in people aged 35 to 64.	CIHI (codes 001, 005, 020–041, 320, 382, 383, 390–392, 680–686, 711 and 730 180, 401–05, 481–486, 490 from ICD-9)
				6. Deaths due to medically treatable diseases: Age-standardized rate of death due to pneumonia or unspecified bronchitis in people aged 5 to 49.	
				7. Readmissions for selected conditions: Readmission rate for acute myocardial infarction.	2003 Accord
				7. Readmissions for selected conditions: Readmission rate for pneumonia.	
				7. Readmissions for selected conditions: Readmission rate for gastro-intestinal haemorrhage.	
Goal achievement	Effectiveness			8. Recidivism rate of young offenders under supervised probation order.	Centres jeunesse ** (youth services)

Dimension	Subdimension	Direction	Objective	Indicator	Source
				9. Permanency planning for children in long-term care.	United Kingdom *
	Efficiency	Offer Quebecers the best possible services for the best possible value, taking into account the setting's charac-teristics and the service-delivery context.		10. Number of work hours spent on evaluation-orientation per completed assessment. 11. Number of hours worked per adolescent, excluding residential staff.	Centres jeunesse (youth services)
				12. Occupancy rate of places registered on the operating permits of residential placement facilities or group homes, under all applicable laws.	
				13. Expected compared to actual stay: Average number of actual days in acute care hospitals compared to expected length of stay.	CIHI
	Equity			14. Proportion of health spending in the poorest population quintile in relation to the richest population quintile.	Saskatchewan *
Production	Productivity			15. Daily cost of community-based activities, per offender.	Ontario *
				16. Percentage of child care centres that provide a developmentally appropriate environment for children.	Alberta *
				17. Unit costs of foster care.	United Kingdom *
	Quality	Increase access to health and social services offered by Québec's health and social services network.		18. Number of children in care awaiting assessment.	Centres jeunesse (youth services)
Production	Quality	Increase access to health and social services offered by Québec's health and social services network.		19. Difficulty obtaining routine or on-going health services: Percentage of people who have had difficulty obtaining ongoing or follow-up care.	StatCan (2001 Health Services Access Survey and CCHS, Cycle 1.1, 2000–2001)

Dimension	Subdimension	Direction	Objective	Indicator	Source
				20. Difficulty obtaining health information or advice: Percentage of people who have had difficulty obtaining health information or advice.	
				21. Difficulty obtaining immediate care: Percentage of people who needed immediate care for minor health problems.	
			Increase to X%, over the next year, the proportion of the population that has a family physician.	22. Proportion of population that has a family physician.	
			Increase to X%, over the next two years, the proportion of patients waiting less than one year for elective surgery.	23. Self-reported wait times for surgery.	Statistics Canada.
Production	Quality		Reduce to X%, over the next three years, the proportion of the population reporting that they had difficulty seeing a specialist	24. Self-reported wait times for specialist physician visits.	Statistics Canada.
				25. Access to home care: Number of home care clients per 100,000 population, all ages (P/T).	Provincial administrative databases

Dimension	Subdimension	Direction	Objective	Indicator	Source
		Create a safe environment that minimizes the risk factors affecting people's physical or psychological well-being.	Reduce by X% the rate of reported medical errors/events (wrong medication or wrong dosage).	26. Errors and events: Number of reported medical errors and events (e.g., disease surveillance, adverse drug reactions) [safety].	2003 Accord
				27. Errors and events: Reduce by 5%, over the next two years, the rate of child injuries (serious or fatal) sustained between the time the child's safety or development is determined to be at risk and the end of the application of measures.	Centres jeunesse (youth centres)
	Volume of care and services				
	Production coordination				
	Satisfaction with services received			28. Patient satisfaction: Percentage of adult population reporting that they were very or somewhat satisfied with overall health services.	StatCan (CCHS, Cycle 1.1, 2000)
Production	Satisfaction with services received			28. Patient satisfaction: Percentage of adult population reporting that they were very or somewhat satisfied with services received in hospital.	StatCan (CCHS, Cycle 1.1, 2000)
				28. Patient satisfaction: Percentage of adult population reporting that they were very or somewhat satisfied with the community-based services they received.	
				28. Patient satisfaction: Percentage of adult population declaring that they are very or somewhat satisfied with family doctor or other physician care received.	
Adaptation	Resource acquisition			29. Age distribution of practising providers by areas of specialty [health human resources].	2003 Accord
				30. Number of providers (by specialty) entering and leaving the system each year [health human resources].	

Dimension	Subdimension	Direction	Objective	Indicator	Source
				31. Progress on building information systems [information systems].	
				32. Percentage of adults who made an unremunerated contribution to charitable or non-profit organizations, causes, or community development activities, or help through personal initiative to individuals.	Alberta *
	Adaptation to public needs			33. Proportion of spending for the five major health problems in relation to needs.	Saskatchewan *
	Adjustment to other requirements and trends				
	Mobilization of community				
	Innovation and transformation				
	Attracting clientele				
	System governance				
	Action on socio-economic determinants				
Maintenance of values	Consensus on the system's values				
	Organizational climate				

Total: 33 indicators

Uncertainty (shaded areas): 9 indicators

* Indicators for which data will have to be collected because they come from outside Québec. (Check if these are not already being used by local or regional Québec organizations.)

** Identical indicator also available in Ontario (see CSBE, 2004a).