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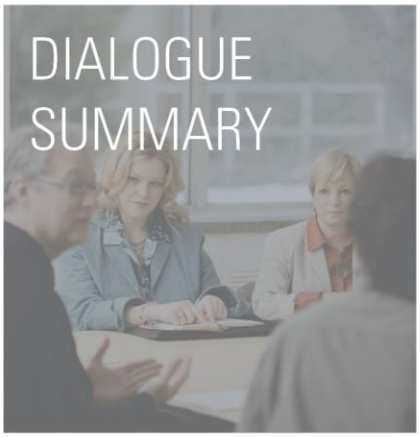


# BUILDING MOMENTUM IN USING THE AVOIDABLE MORTALITY INDICATOR IN CANADA



EVIDENCE >> INSIGHT >> ACTION

# Dialogue Summary:
# Building Momentum in Using the Avoidable Mortality Indicator in Canada

15 February 2013

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Conflict of interest

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# SUMMARY OF THE DIALOGUE

A number of dialogue participants saw significant value in an indicator like avoidable mortality that can bring problems to attention (such as geographical regions or populations within Canada that contribute disproportionately to the avoidable mortality rate) and spur an examination of the sectors, systems, programs and services that contribute to such problems. And no dialogue participants argued that the indicator should not be part of a broad suite of indicators that are reported on and monitored. That said, dialogue participants identified two pairs of interrelated features of the problem that contribute to the challenge of building momentum in using the avoidable mortality indicator in Canada: 1) lack of clarity about how the indicator could best be used (particularly in terms of informing decisions) and by whom it could best be used; and 2) lack of consistent approaches to measuring avoidable mortality internationally, which complicates cross-country comparisons, and the lack of access to avoidable mortality data within the country, which precludes research and analysis groups from using the data to inform decision-making.

Dialogue participants generally supported the first two of the three potential elements of a comprehensive approach to addressing the problem: 1) increasing dialogue about the avoidable mortality indicator and its potential uses, particularly among health system policymakers and managers (ideally through a series of informal interactions about treatable mortality and examples of interventions that have had an impact on the indicator), health professional leaders (particularly if the focus can be on specific conditions and the likely causes of high mortality from these conditions), and the public (with whom the emphasis should optimally be on what the indicators tell them about progress and challenges and not on the methodology); and 2) supporting informed decision-making about prevention and treatment programs, partly by positioning the indicator in the context of a suite of indicators and by developing an international consensus on the approach and terminology, but primarily by supporting the use of research evidence about the prevention and treatment initiatives that would have the greatest impacts on the avoidable mortality indicator (possibly through the use of micro-simulation models that could illustrate whether and how prevention and treatment interventions could affect the avoidable mortality rate).

Many dialogue participants committed to increasing dialogue within their own constituencies about the avoidable mortality indicator and its uses, and to supporting informed decision-making about prevention and treatment programs. Dialogue participants also prioritized: 1) calling for a consensus process at the international level to harmonize the approach and terminology; 2) making available avoidable mortality data to research and analysis groups; 3) incorporating the avoidable mortality indicator in the suite of indicators that governments monitor now; 4) having the Canadian Institute for Health Information (CIHI) continue to develop standards for and prepare reports about the avoidable mortality indicator; 5) having CIHI and/or its partners prepare compelling case studies of interventions and their realized or expected impacts on the avoidable mortality rate, and support interprovincial learning about what is changing (or not) and why.

# SUMMARIES OF THE FOUR DELIBERATIONS

## DELIBERATION ABOUT THE PROBLEM

Dialogue participants identified two pairs of interrelated features of the problem that contribute to the challenge of building momentum in using the avoidable mortality indicator in Canada, particularly as a key link between health system performance and population health outcomes. Both pairs of problem features touch directly or indirectly on what the issue brief called "limited… understanding or agreement about the usefulness of the indicator." One pair of problem features related to the lack of clarity about how the indicator could best be used (particularly in terms of informing decisions) and by whom it could best be used. Dialogue participants differed in whether they saw practical uses for a 'big dot' indicator like avoidable mortality, and in whether they could foresee policymakers embracing the indicator on their own and the public taking significant interest in it. A second pair of problem features related to the lack of a consistent approach to measuring avoidable mortality internationally, which complicates cross-country comparisons, and the lack of access to avoidable mortality data within the country, which precludes research and analysis groups from using the data to inform decision-making.

Beginning with the lack of clarity about how the avoidable mortality indicator could best be used, dialogue participants differed in whether they saw practical uses for a 'big dot' indicator like this one, which gives "a general sense of how we're doing." Some participants saw little value given that the indicator could not instrumentally inform policymaking or performance management given (among other reasons) the many factors that influence it and the time lag between changes to these factors and changes in the indicator. One participant noted: "I'm not sure how it works to inform policy." Other dialogue participants expressed their skepticism that an indicator that could spur the re-allocation of resources away from the health sector would ever be embraced by health system policymakers and managers. Several dialogue participants indicated that they could not foresee the indicator being incorporated into performance-management frameworks that are designed to hold policymakers and managers to account. That said, no dialogue participants argued that the indicator should not be part of a broad suite of indicators that are reported on and monitored.

**Box 1: Background to the stakeholder dialogue**

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

1) it addressed an issue currently being faced in Canada;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on three elements of a comprehensive approach for addressing the policy issue;
4) it was informed by a pre-circulated issue brief that mobilized both global and local research evidence about the problem, three elements of a comprehensive approach for addressing the problem, and key implementation considerations;
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) it did not aim for consensus.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

On the other hand, a number of dialogue participants saw significant value in an indicator that can bring problems to attention (such as geographical regions or populations within Canada that contribute disproportionately to the avoidable mortality rate) and spur an examination of the sectors, systems, programs and services that contribute to such problems. For instance, one participant pointed out that, overall, Canada is doing very well in terms of avoidable mortality rates, but "when you start drilling down, you see that there are 'winners' and 'losers.' Some jurisdictions and populations have been left behind." Another dialogue participant indicated that it would be very helpful to have case studies of how the indicator was used in other jurisdictions to understand a change in the indicator and to act on this understanding.

Turning to the lack of clarity about who should be using the avoidable mortality indicator, dialogue participants differed in whether they could foresee policymakers (and managers) embracing the indicator on their own, and in whether the indicator was likely to attract significant public interest. Some dialogue participants argued that policymakers would be very unlikely to use such an indicator to inform decisions. For example, one dialogue participant noted that health policymakers and managers are typically reluctant to set goals and targets and to release data that could point to what could be perceived as shortcomings of their work. A second participant suggested that when governments do embrace indicators, they use them for 'finger pointing,' and not in a constructive way. A third participant indicated that "it's rare for a macro-level indicator to lead to change." A fourth participant noted that when the indicator was used at the regional level in one province, it was strongly resisted by managers because they felt they had no power to change it. Several other dialogue participants suggested that the indicator was unlikely to be understandable to the general public or lead them to push for action to address any identified problems. One dialogue participant agreed with this assessment, but saw in it a significant opportunity for 'third party' research and analysis groups, such as the Canadian Institute for Health Information (CIHI), the Canadian Partnership Against Cancer, university-based research centres and other non-governmental organizations, who could independently prepare reports that identified problems giving rise to high avoidable mortality rates (and success stories in addressing these problems and in reducing the rates). A few dialogue participants pointed out that such reporting on and monitoring of the indicator could be helpful if it happened both at the international level (to point out how Canada is faring in comparison to peer countries) and at the provincial or regional level (to identify more context-specific problems and improvements arising from past actions). Another dialogue participant also saw in the current situation an opportunity for organizations like the Pan-Canadian Public Health Network, which could promote the use of the indicator to inform policymaking.

Other dialogue participants felt that policymakers and the general public would embrace the indicator on their own now that CIHI had begun to draw attention to it (and now that Quebec's Health and Welfare Commission would soon draw further attention to it, and the government of Quebec's development of a prevention policy could draw yet more attention to it). One dialogue participant noted that the indicator would resonate with the current preoccupations of many policymakers, including those advocating within and beyond ministries of health for a more 'whole-of-government' approach to addressing the health of the population. A second dialogue participant agreed, noting that "when it comes to preventing mortality, we will see that most diseases are multi-sectoral challenges that are under the influence of governments in general, but not necessarily the health system." A third participant suggested that the reports by 'third party' groups could easily "galvanize public opinion around certain topics." A fourth participant pointed out that the release of the CIHI report about the avoidable mortality indicator had captured the most widespread media attention of any of its annual reports (noting that they unfortunately referred to the data as being about 'avoidable deaths'), which suggested a strong potential for public engagement with this indicator.

Moving from one pair of problem features to the second pair, one dialogue participant noted the lack of a consistent approach to measuring avoidable mortality internationally, which the individual noted complicates cross-country comparisons. This dialogue participant noted that while CIHI had commendably achieved consistency in their approach within Canada, there would need to be both a willingness in the country to adapt the approach if the country is to be part of a new international consensus that permits cross-country comparisons, and a commitment to push for such a consensus across Organization for Economic

Cooperation and Development (OECD) countries. The same participant also noted that in going down this path there would need to be: 1) some 'give and take' on terminology given CIHI is using the term 'avoidable mortality' whereas most European countries are using the term 'amenable mortality' (meaning mortality amenable to healthcare interventions); 2) greater attention given, in the selection of conditions considered amenable to intervention, to systematic reviews of the best available research evidence rather than just expert opinion; and 3) acknowledgment that there can be justifiable differences across countries in the conditions considered amenable to intervention (such as skin cancer in Europe and stomach cancer in Japan). A number of dialogue participants supported the call for a consensus process at the OECD level to harmonize the approach and terminology, which is a subject to which the dialogue participants returned to again later in the discussion. One participant pointed out that Canadian jurisdictions are increasingly looking internationally for best practices, and that some degree of comparability internationally was therefore important.

Turning to the lack of access to avoidable mortality data within the country, as noted previously, one dialogue participant noted that this access problem means that 'third party' research and analysis groups cannot use the data to inform decision-making. Many dialogue participants agreed that this was a significant problem and they discussed the many potential reasons for why Statistics Canada does not make available avoidable mortality data through its research data centres for use by qualified researchers and analysts across the country. The hypothesized reasons included bilateral agreements with provinces/territories that prohibit data sharing, budget cuts that have necessitated doing less rather than more, and a lack of expressed demand by research and analysis groups, among others. A few dialogue participants also noted that a related problem is the lack of avoidable mortality data for certain populations in Canada at the national level, such as the First Nations population.

Several dialogue participants contrasted the data-access situation in Canada with the situation in Australia, New Zealand and the United Kingdom, where investments in data infrastructure had facilitated the use of the avoidable mortality indicator. In pointing out this contrast, however, they also noted the need for CIHI nationally (and organizations like Quebec's Health and Welfare Commission provincially) to continue to report on and champion the use of the indicator whether or not 'third party' groups can conduct their own analyses. As one dialogue participant said: "[In Australia, New Zealand and the United Kingdom,] you have central governments that are willing and that have the capacity to institute a kind of report card indicator…. That's what we need in this country. The provinces and territories cannot do it comparatively and methodologically on their own. And if we want international comparisons, we need a body like CIHI to coordinate this. Over time, health system policymakers and managers will catch on and find that it can be a powerful indicator."

## DELIBERATION ABOUT ELEMENTS OF AN APPROACH TO ADDRESS THE PROBLEM

The deliberation about elements of what could be a comprehensive approach to addressing the problem focused primarily on increasing dialogue about the avoidable mortality indicator and its potential uses (element 1), and on supporting informed decision-making about prevention and treatment (element 2). The deliberation focused to a lesser extent on incentivizing actions that prioritize investments in prevention versus treatment, addressing particular conditions or addressing particular inequities (element 3), parts of which one dialogue participant felt should be incorporated within element 2.

### Element 1 – Increase dialogue about the avoidable mortality indicator and its potential uses

The deliberation about the first potential element of a comprehensive approach to building momentum in using the avoidable mortality indicator focused in part on the relevance of promoting the avoidable mortality indicator to specific target audiences, particularly including health system policymakers and managers (and those seeking to inform or influence them), health professionals, and members of the public. Challenges were identified at each of these levels, such as that: 1) health system policymakers and managers usually take up an

indicator as a result of a range of informal interactions about an indicator rather than didactic introductions to one (which suggested the need for a multifaceted approach to engage them as well as those who seek to inform or influence them); 2) health professionals may find avoidable mortality to be too far beyond their control (which suggested the need to target health professional leaders primarily and to help them to identify the conditions that are the main drivers of a high rate); and 3) the public may find the indicator to be too complex (which suggested the need to emphasize the indicator's validity but not to discuss the methodology behind it).

Returning to the issue of public engagement that was raised in the deliberation about the problem, many participants reiterated their view about the value of informing the public about the indicator, while one participant predicted that the public would be enthusiastic about the indicator given their interest in health and wellness (at the individual and community level) on the one hand, and managing their chronic conditions on the other hand. Another dialogue participant advised against underestimating the public's ability to understand the indicator and reminded the group that public engagement can have an influence on policymakers' and managers' sense of accountability and priorities for action. A third dialogue participant recommended finding a companion, positively framed 'big dot' indicator ("something like a health-related quality of life indicator) to complement the negatively framed avoidable mortality indicator. A fourth participant supported this idea, noting that much of what the health system does is to improve quality of life, not reduce mortality.

The deliberations revealed the need to increase dialogue about different aspects of the avoidable mortality indicator and at different levels of the health system. Specifically, among health system leaders at the organizational and regional levels, one dialogue participant noted that there should be increased dialogue about 'treatable mortality,' and about examples of interventions that appear to have had impacts on the indicator. Among health professional leaders, the same participant suggested that there should be increased dialogue about particular conditions and the likely causes of high mortality from these conditions (including medical errors). And finally, among the general public, this participant suggested that there should be increased dialogue about changes in the indicator in lay terms, such as that there was or should be a certain percentage reduction in avoidable mortality within a specified time frame. A few dialogue participants recommended that, before publicly releasing avoidable mortality data, there should be a great deal of system-wide preparatory work to ensure that key system stakeholders are prepared for its release (much as there was for hospital standardized mortality ratio).

**Element 2 – Support informed decision-making about prevention and treatment programs**

The deliberation about the second potential element of a comprehensive approach to building momentum in using the avoidable mortality indicator touched on the importance of positioning the indicator in the context of a suite of indicators, and (again) of developing an international consensus on the approach and terminology, but it focused largely on the third sub-element regarding supporting the use of research evidence about the prevention and treatment initiatives that would have the greatest impacts on the avoidable mortality indicator.

Participants generally agreed about the need to support informed decision-making within the scope of responsibility of the decision-makers being engaged. However, some argued that although treatable mortality clearly falls within the responsibility of those working in the health system (and would undoubtedly attract attention within this sector), only a fraction of preventable mortality can be influenced by those working in the health system. That said, one participant observed that while health system policymakers and managers were not responsible for the health status of the population (being instead primarily responsible for the provision of healthcare services), there has been a shift in the past eight years towards increased investments in population-health initiatives and towards greater emphasis on ideas like 'healthy living' and 'health is everyone's business' (and in support within the health system for such investments and emphasis).

One dialogue participant said that there was a need to make this indicator meaningful in order for it to be used in decision-making: "Alone, this will not help. You need to capture people's imagination." One participant suggested the report that presented the implications of all citizens' risk factors being brought to the lowest level was as an example of an effort to make data something that people can relate to. A second participant suggested giving greater focus to the conditions that are driving trends (or divergences in trends) in the indicator, while a third suggested giving greater attention to small-area variations in the indicator (and the reasons for them). Several participants supported the use of micro-simulation models that could illustrate whether and how prevention and treatment interventions could affect the avoidable mortality rate, and what would happen in circumstances such as policymakers making no investments in prevention.

**Element 3 – Incentivize actions that prioritize investments in prevention versus treatment, addressing particular conditions or addressing particular inequities**

The deliberation about the third potential element of a comprehensive approach to building momentum in using the avoidable mortality indicator focused primarily on incentivizing actions that prioritize investments in prevention versus treatment (as opposed to actions that address particular conditions or address particular inequities). A number of participants grappled aloud with how incentivizing could work. They asked questions like: do you reward or punish based on whether regions or organizations are currently high performers or low performers, respectively, or do you reward and punish based on improvements? A few participants argued that, before incentivizing, there must be an effort to convince politicians that investment in prevention is important. As one participant pointed out: "You need a good story to sell to policymakers before they can incentivize."

Several participants identified the difficulty of prioritizing investments in prevention over treatment, or of shifting resources from treatment to prevention, since there is much more pressure to invest in treatment services. One participant noted that there are also individuals and groups with significant vested interests in the existing health system and that they will not be responsive to, and might actively oppose, any resource shifts. A second dialogue participant agreed and added that there is a need to "invest more resources in prevention – period", since shifting resources from treatment to prevention would not be possible. A few participants built on this point, suggesting caution in framing the issue as either/or. One participant noted that there is a need to think about prevention and treatment as a continuum, rather than as giving or withholding resources from one or the other. The same participant suggested there is a need to raise awareness about the importance of primary prevention interventions and their impacts.

Of the three potential methods of incentivizing actions that were discussed in the issue brief – public reporting, re-orienting existing impact evaluations, and re-orienting existing performance management systems –the first and second methods garnered some support. Speaking of the first method, several participants pointed out the need to engage the public to trigger change among policymakers: "We are underestimating the power of the public. This type of indicator can help the public advocate for certain policies. They can put pressure on the government. We have a duty to influence the citizens; they are part of the equation to influence policymakers." One participant was more cautious about engaging the public: "Bringing in the public is great, but most of the pressures from the public will be for services, not prevention." Turning to the second method, one participant noted that the adoption in 2002 of the Quebec public health act's section 54, which stipulates that government bodies proposing new policies must first go through a health-impact assessment process, has acted as an important incentive. Turning finally to the third method, a number of dialogue participants expressed strong reservations about using the avoidable mortality indicator as part of a performance-management system. One dialogue participant argued that the three-year time lag in reporting about mortality data made the data unusable from a performance-management perspective. Another dialogue participant noted: "This is an indicator capturing long-term effects, but health system managers are making budgetary decisions with short-term effects… so don't tie [the indicator] to performance management."

**Considering the full array of options**

Dialogue participants generally supported the first two of the three potential elements of a comprehensive approach to addressing the problem: 1) increasing dialogue about the avoidable mortality indicator and its potential uses, particularly among health system policymakers and managers (ideally through a series of informal interactions about treatable mortality and examples of interventions that have had an impact on the indicator), health professional leaders (particularly if the focus can be on particular conditions and the likely causes of high mortality from these conditions), and the public (with whom the emphasis should be on what the indicators tell them about progress in and challenges for their province or territory, and not on the methodology); and 2) supporting informed decision-making about prevention and treatment programs, partly by positioning the indicator in the context of a suite of indicators and by developing an international consensus on the approach and terminology, but primarily by supporting the use of research evidence about the prevention and treatment initiatives that would have the greatest impacts on the avoidable mortality indicator (possibly through the use of micro-simulation models that could illustrate whether and how prevention and treatment interventions could affect the avoidable mortality rate).

Dialogue participants also identified several additional elements of a comprehensive approach to building momentum in using the avoidable mortality indicator: 1) calling for a consensus process at the OECD level to harmonize the approach and terminology in order to facilitate cross-country comparisons (possibly with a greater relative focus on preventable mortality or 'health policy intervention-sensitive' mortality because much less attention has historically been given to these domains); 2) calling for Statistics Canada to make available avoidable mortality data through its research data centres or other mechanisms so that 'third-party' research and analysis groups across the country can use the data to inform decision-making; and 3) having CIHI and/or its partners prepare compelling case studies of actions/interventions and their realized or expected impacts on the avoidable mortality rate (possibly drawing from domains like cancer screening and treatment, or like diabetes, that are readily understandable to citizens), present the avoidable mortality indicator alongside a health-related quality-of-life indicator (and as part of a suite of indicators), explain the relationship between avoidable mortality and other concepts like ambulatory care-sensitive conditions, avoidable hospitalizations and premature mortality with which key target audiences may be familiar, and support interprovincial learning about what is changing (or not) and why.

## DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

While dialogue participants reiterated some of the main barriers to implementing the key elements of a comprehensive approach to building momentum in using the avoidable mortality indicator in Canada, they gave much greater attention to potential windows of opportunity for building momentum. Examples of the barriers that were re-emphasized were the lack of availability of avoidable mortality data for research and analysis groups in Canada (with one participant noting, "the most disturbing thing that I heard today is that the data set isn't readily available") and the difficulty of making the indicator appear real and meaningful to policymakers and managers (given the many factors that influence it and the time lags involved).

Dialogue participants identified a number of potential windows of opportunity: 1) public pressure for a greater focus on self-management and healthy living, which creates greater receptivity for hearing about progress in and challenges to getting there; 2) demand among nongovernmental organizations (e.g., First Nations groups) for the data that will allow them to make a case about priorities in their interactions with government; 3) regular meetings of groups like the Pan-Canadian Public Health Network, provincial quality councils, Council of Deputy Ministers, and Conference of the Federation (with the latter being particularly salient if the issue could be framed in relation to guidelines that could have an impact on treatable mortality); 4) provincial and territorial governments' preparation of action plans and reviews of performance-measurement frameworks; and 5) Canadian government representation at the OECD. One dialogue

participant suggested that a key element of engaging policymakers and managers should be helping them to recognize that they are "making many decisions based on intuition and not evidence." A second dialogue participant noted that the health policy community needs to make a strong statement that avoidable mortality is a priority: "If this community doesn't say that it is a priority, governments will never recognize it as a priority."

## DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

When the focus of deliberation turned to next steps for different constituencies, many dialogue participants committed to:

1) increasing dialogue within their own constituencies about the avoidable mortality indicator and its uses, particularly among health system policymakers and managers (possibly with a focus on treatable mortality and examples of interventions that have had an impact on the indicator), health professional leaders (with a focus on particular conditions and the likely causes of high mortality from these conditions), and the public (with a focus on progress in and challenges for their province or territory); and
2) supporting informed decision-making about prevention and treatment programs, primarily by supporting the use of research evidence about the prevention and treatment initiatives that would have the greatest impacts on the avoidable mortality indicator.

Dialogue participants also identified concrete steps that they could take depending on the nature of their organizations and/or roles:

1) most participants drawn from research and analysis groups and some from government prioritized calling for a consensus process at the OECD level to harmonize the approach and terminology in order to facilitate cross-country comparisons, and calling for Statistics Canada to make available avoidable mortality data through its research data centres or other mechanisms so that 'third-party' research and analysis groups across the country can use the pan-Canadian data to inform decision-making (while a few mentioned the need to collaboratively develop a research program focused on the indicator, to support graduate students to conduct research using the indicator, and to encourage micro-simulation modelers to use the indicator);
2) many participants drawn from government prioritized incorporating the avoidable mortality indicator in the suite of 'outcome' indicators that they monitor now (although some emphasized that the indicator would garner much less attention than the more "concrete," "faster-moving" indicators used by organizations such as the Commonwealth Fund), having CIHI continue to develop standards for and prepare reports about the avoidable mortality indicator, having CIHI and/or its partners prepare compelling case studies of actions/interventions and their realized or expected impacts on the avoidable mortality rate, and having CIHI and/or its partners support interprovincial learning about what is changing (or not) and why; and
3) a few participants whose roles linked them to particular forums prioritized finding ways to introduce the indicator and its uses at meetings of groups like the Pan-Canadian Public Health Network, provincial quality councils, Council of Deputy Ministers, and Conference of the Federation.