RESEARCH PAPER

How Timid or Bold Are Ministries of Health and Provincial Health Authorities in Canada in Planning for Healthcare Quality?

Dans quelle mesure les ministères canadiens de la Santé et les autorités sanitaires provinciales sont-ils timides ou audacieux dans la planification de la qualité des soins de santé?

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Abstract

Introduction: World Health Organization (WHO) guidelines recommend countries set quality plans for their health systems with clear priorities, indicators and targets. This paper examines whether Canada's federal, provincial and territorial governments are applying these principles.

Methods: We evaluated plans from 2010 to 2019 for 14 ministries of health and four health authorities in provinces with a single authority against a rubric that considered the existence of indicators, baselines, targets, time frames and progress reports.

Results: Ratings ranged from A+ to F with a median B/B-. Most jurisdictions had indicators, but only five of 18 jurisdictions had clear baselines, numeric targets and time frames. Irregularities were observed, such as vague indicators; setting goals to "improve" without targets; announcing targets only after plans had ended; setting minimal targets; removing targets after missing them previously; or inappropriate characterization of progress.

Discussion: Most Canadian governments are reluctant to set quality targets. We speculate there may be fear of criticism if targets are missed. However, several jurisdictions had clear, ambitious plans that may serve as examples for others.

Résumé

Introduction : Les lignes directrices de l'Organisation mondiale de la Santé (OMS) recommandent aux pays d'établir, pour leurs systèmes de santé, une planification de la qualité des soins qui comprend des priorités, des indicateurs et des objectifs clairs. Le présent document évalue dans quelle mesure les gouvernements fédéral, provinciaux et territoriaux du Canada appliquent ces principes.

Méthode : Nous avons évalué les plans, entre 2010 et 2019, de 14 ministères de la Santé, et quatre autorités sanitaires dans les provinces ayant une seule autorité, en fonction d'une grille qui tenait compte des indicateurs, des données de référence, des objectifs, des échéanciers et des rapports d'étape.

Résultats : Les cotes allaient de A+ à F avec un B/B- médian. Il y avait des indicateurs dans la plupart des administrations, mais seulement cinq des 18 administrations étudiées s'étaient dotées de bases de référence, d'objectifs numériques et d'échéanciers clairs. Des irrégularités ont été observées, comme des indicateurs vagues, l'établissement d'objectifs d'« amélioration » sans cibles, l'annonce de cibles seulement après la fin des plans, l'établissement de cibles minimales, l'élimination de cibles après les avoir ratées ou la caractérisation inappropriée des progrès.

Discussion : La plupart des gouvernements canadiens hésitent à fixer des objectifs pour la qualité. Nous supposons qu'il pourrait y avoir une crainte des critiques si les objectifs ne sont pas atteints. Cependant, plusieurs administrations se sont dotées de plans clairs et ambitieux qui pourraient servir d'exemples pour les autres.

Background

Governments in Canada have exhibited major interest in healthcare quality over the past two decades. During this period, seven ministries of health have established provincial health quality or patient safety councils to promote quality improvement. Multiple jurisdictions have legislated mandatory reporting of critical incidents (Milligan et al. 2021), and Ontario requires that healthcare organizations establish quality committees of boards and link executive compensation to quality results (*Excellent Care For All Act*, 2010). Governments have also invested in the measurement of quality; federal/provincial/territorial health ministers agreed to adopt common quality indicators in the 2003 Health Accords for strengthening the health system (Health Canada 2003), and subsequently, the Canadian Institute for Health Information (CIHI) expanded data collection to include wait times, patient experience, hospital safety and quality in long-term care and home care (CIHI n.d.a., 2019).

Another key role of governments is quality planning. The *Handbook for National Quality Policy and Strategy* of the World Health Organization (WHO) (2018) recommends setting goals that are "clear and meet a particular need, and should also be time bound, with a means to assess progress and achievement" (p. 22). Decades of psychology research show that organizations and individuals achieve better results when they set specific goals (Locke and Latham 2002). A clear goal directs attention to important tasks and wards off distractions. An ambitious goal has energizing effects, which stimulate effort and persistence. These findings are consistent with the SMART (Specific, Measurable, Achievable, Relevant and Time-Bound) goal framework in the management literature (Doran 1981), which states that goals should be specific, measurable and have a time limit for completion. According to the Country Planning Cycle Database of the WHO (WHO n.d.), which archives national plans of ministries of health, many countries have followed these principles by setting ambitious multi-year goals to reduce undesirable outcomes by 40% to 50% (Chan et al. 2019).

This paper explores whether governments in Canada have adopted key principles of good planning: the establishment of clear and measurable targets, timelines and progress reports. Within Canada, there has been interest in facility-level target setting. Ontario's *Excellent Care for All Act*, 2010, mandates that healthcare organizations establish annual quality improvement plans with targets, and academic health centres in Canada have published guidelines for quality plans emphasizing measurable goals, targets and annual evaluation (Collaborative for Excellence in Healthcare Quality 2012). What is not known is whether these principles have been applied to an entire federal/provincial/territorial jurisdiction. One possible reason why governments might avoid committing to clear goals is that they may risk criticism from the opposition and media if targets are missed.

Methods

This paper followed a qualitative research design using the historical method. We constructed an evaluation framework based on the above-mentioned principles of planning, searched for past examples of quality plans and rated them according to the framework.

Scope

This paper examined the planning principles of setting measurable targets with a clear time frame and regular monitoring. Other components of planning are also important, such as resource allocation, governance and accountabilities, but they are beyond the scope of this analysis.

Inclusion/exclusion criteria

The authors examined planning documents for each federal, provincial and territorial ministry of health in Canada and analyzed plans for health authorities managing healthcare for an entire province (i.e., Alberta, Saskatchewan, Nova Scotia, Prince Edward Island [PEI]) as these plans encompassed the entire health system. They also examined plans for the entire jurisdiction but within a specific sector (e.g., for long-term care, seniors, public health, cancer, mental health, etc.) issued either by the ministry or its designated planning bodies (e.g., provincial cancer or public health agencies).

Excluded from this study were regional health authorities for sub-regions within provinces/territories, health information agencies and research institutes. Provincial quality councils were also excluded; their role is to support quality improvement (*Excellent Care for All Act*, 2010; *Health Quality Council Act*, 2002; *Health Quality Council of Alberta Act* [2011]) and not target setting. The time period for inclusion of plans was from 2010 to 2019, inclusively. If an organization had plans for different time periods, only the most recent plan was evaluated. "Strategy" and "plan" were used interchangeably to allow for differences in definition between jurisdictions.

This article did not require ethics review as it examined only publicly available documents and no data on individual subjects were used.

Search strategy

The authors searched government websites using search engines, such as Google, employing the following search terms: [strategy; strategic plan; operational plan; development plan; plan; quality plan; annual report] in combination with [ministry of health, department of health, name of health authority] and [each province/territory, Canada].

Scoring algorithm

The authors developed a rubric for scoring system-level health plans based on recommended best practices underscored by WHO guidelines and other seminal research or frameworks (Appendix 1: Table A1, available online at longwoods.com/content/27154). Plans were scored from zero to seven, where one point was awarded for each of the seven criteria. Partial or minimal implementation of an item in the rubric was scored as a half or quarter point. Situations resulting in partial points included meeting the criteria for only a few of the priorities listed or major methodological flaws (e.g., setting targets, but announcing them only after the plan expires). Also, if the system-level plan of a jurisdiction failed to meet a

particular criterion, partial points were awarded if at least some sector-specific plans met the criteria. Minimal scoring was awarded where only one narrowly defined example of the item was found. A letter grade was assigned based on the numeric score as follows: A (6.5), B (5), C (3.5), D (2) and F (1 or less), with a "plus" or "minus" for a half-point above or below these levels (e.g., A+ for a score of 7, A- for 6).

Planning information may appear in multiple documents; for example, priorities could be in a strategic plan, indicators and targets in an accompanying operational plan and progress in an annual report (Appendix 1: Table A2, available online at longwoods.com/content/27154). Scoring was based on the ensemble of such documents.

All three authors participated in the assessment of plans against the rubric. Each plan had at least two independent initial assessments, and discrepancies in scores were resolved in subsequent group discussions.

Validation

The authors prepared a detailed description of the justification for each criterion of the rubric for each jurisdiction (available upon request). This information and a draft of this manuscript were sent to each deputy minister of health and each provincial health authority's chief executive officer (CEO), with a request to identify missing plans or misinterpretations. Eight jurisdictions responded. Some additional documents were identified, but scores did not change.

One jurisdiction, however, challenged the validity of the criteria for stretch targets, arguing that achievability was critical and unrealistic goals would lead to demoralization. In response, we conducted a sensitivity analysis of the scoring with this item removed.

Results

There was wide variation in scores for clarity and in ambitiousness of planning, ranging from A to F with median B/B- (Table 1). Most jurisdictions had indicators, but only five of 18 fully met the criteria for clear baselines, numeric targets and time frames. Detailed footnotes in Table 1 describe the justification of partial or minimal scores.

Quebec's Ministry of Health and Social Services (MHSS), Nova Scotia Health Authority (NSHA) and Health PEI (the provincial health authority) received the highest scores (A or A+). Quebec's 2015–2020 strategic plan (Gouvernement du Québec 2015) was notable for having three main priorities, multiple objectives within each priority and at least one quality indicator for each objective. Annual reports described progress toward goals in each year, and targets remained consistent throughout the planning period (Gouvernement du Québec 2016, 2017, 2019a, 2019b).

Nunavut, Manitoba and Ontario had the lowest scores (F, F and D respectively), with almost no indicators or targets. In Manitoba, there was no system-wide plan; its cancer plan (CancerCare Manitoba 2016) mentioned some indicators, but no targets. *Patients First*, the system-wide plan of the Ontario Ministry of Health and Long-Term Care

TABLE 1. Scoring results by jurisdiction

Jurisdiction	Indicators	True quality indicators	Baseline	Targets	Stretch targets	Time frame	Progress report	Grade
Ministère de la Santé et des Services sociaux du Québec	●	●	◑^	●	●	●	●	6.5/A
Nova Scotia Health Authority	●	●	●	●	●	●	◑^^	6.5/A
Nova Scotia Department of Health and Wellness	◑&	◑&	◔^	◔^	◔^	◔^	◑++	2.5/D+
Health PEI	●	●	●	●	●	●	●	7/A+
PEI Department of Health and Wellness	◑&&	◑&&	○	○	○	○	○	1/F
Health Canada	●	◑%	●	●	◑±	●	●	6/A-
Alberta Health Services	●	●	●	●	○	●	●	6/A-
Alberta Ministry of Health	●	●	●	◑‡	○	●	●	5.5/B+
British Columbia Ministry of Health	●	◑%	●	●	○	●	●	5.5/B+
Saskatchewan Ministry of Health	●	●	◑@	◑‡	○	●	●	5/B
Saskatchewan Health Authority	●	●	◑@	●	○	◑#	◑+	4.5/B-
New Brunswick Department of Health	●	●	●	◑‡	○	◑#	●	5.0/B
Yukon Ministry of Health and Social Services	●	●	●	○	○	○	○	3/C-
NWT Department of Health and Social Services	●	●	●	○	○	○	○	3/C-
Newfoundland and Labrador Department of Health and Community Services	●	●	◔##	○	○	○	◑++	2.3/D+
Ontario Ministry of Health	◑*	◑*	◔$	◔$	◔$	◔$	○	2/D
Manitoba Ministry of Health, Seniors and Active Living	◑**	◑**	○	○	○	○	○	1/F
Nunavut$$	○	○	○	○	○	○	○	0/F

Legend: ● = yes; ◑ = partial; ◔ = minimal, ○ = none

^ Baseline data are reported for some, but not all indicators.

& Business plan had no indicators; accountability report had structural indicators but only one quality indicator for wait times.

^ One stretch goal for smoking with baseline and target in tobacco control plan; all other plans had no baseline, target, time frame.

^^ Progress reports exist but cover some, not all indicators, and frequency of reporting is ad hoc.

&& Strategic plan had no indicators. Sector-specific plans for opioids, seniors, suicide prevention had no indicators; partial points awarded as plans for cancer, wellness and mental health have vague references to indicators.

% Partial score awarded; some true quality indicators exist, but the plan mainly contains structural measures.

± Partial score awarded as there is only one stretch goal.

‡ Partial score given as some indicators have targets but majority do not.

@ Partial score; target is reported as a percentage decrease, but actual baseline and target values not disclosed.

Partial score; target was announced only after deadline had passed.

+ SHA reported on progress annually in past years, but in 2019–2020 this info was removed; hence, partial score.

Strategic plan has indicators but no targets or baseline. One of six sector-specific plans (joint replacement) had baseline but no targets.

++ In annual report or accountability report, progress on structural indicators is reported but no data on quality.

* Score for Ontario's main plan "Patients First" is zero. Ten sector-specific plans were identified, of which eight had no indicators or targets. Two sector-specific plans (smoking and mental health) had indicators; partial points awarded.

$ The smoking plan had baseline, targets, stretch targets and time frames; all ten other plans lacked these elements.

** No system-level plan identified for Manitoba. Sector-specific plans exist for cancer, Alzheimer's, mental health, falls and injury prevention. Cancer plan had indicators and partial points are awarded. No targets were identified.

$$ No indicators or targets in business plan, nor in sector-specific plans for suicide prevention or continuing care.

NWT = Northwest Territories; PEI = Prince Edward Island.

(Ontario MOHLTC 2015), had no indicators or targets. Nine sector-specific plans were identified for cancer, access to care, public health (two plans), smoking reduction, renal care, mental health, critical care and planning at the regional level (i.e., local health integration network) (Cancer Care Ontario 2019a, 2019b; Public Health Ontario 2013; Ontario MOHLTC 2013; Ontario Ministry of Health and Ministry of Long-Term Care 2018; Ontario Renal Network 2019; Ontario's Mental Health & Addictions Leadership Advisory Council 2017; Critical Care Services Ontario 2018; Health Shared Services Ontario 2018). Among these, mental health had indicators but no targets while smoking reduction had indicators, stretch targets and time frames. All other plans had no indicators. In particular, Ontario's public health plan was boldly titled *Make No Little Plans* (Ontario MOHLTC 2013) but contained no indicators or targets.

Scores were higher for plans from the four province-wide health authorities compared to ministries of health (average, 6.0 vs. 3.5). In the two provinces with health authorities that achieved high scores (Nova Scotia and PEI), the ministry of health received very low scores.

Only Saskatchewan had a perfect match in priorities between its ministry and the health authority (Saskatchewan Ministry of Health (n.d.a.: 4, 7, 9, 10; SHA n.d.). For the other three provinces, the description of priorities was different between the two. For example, the business plans of the Nova Scotia Department of Health and Wellness (2018, 2019) listed six priorities: collaborative primary healthcare; continuing care; mental health and addictions; orthopedic surgeries; digitalization; and redevelopment of facilities in two sites. The priorities in the *2016–19 Strategic Plan* of NSHA (n.d.a.) were quality, workforce and citizen engagement.

Several provinces fulfilled the criteria for stretch targets. Examples include the following:

- Increase the proportion of residents with a family doctor from 66% (pre-2015) to 85% (Gouvernement du Quebec 2015: 10).
- Increase the proportion of cancer patients receiving surgery within 28 days from 60% (pre-2015) to 90% (Gouvernement du Quebec 2015: 11).
- Decrease the 90th percentile wait time for hospital beds for admitted emergency department patients from baseline 49.9 hours (2017–18) to 16 hours (2018–19) (Health PEI 2018: 16).
- Reduce the difference between the actual and expected length of stay from 2.4 to 1.67 days from 2017–18 to 2018–19 (Health PEI 2018: 16).
- Decrease hospital standardized mortality ratio from 112 (FY14/15) to 93 (NSHA 2017: 5).
- Improve patient experience from 81.9% (over multiple previous years) to 90% (NSHA 2017: 4).
- Decrease smoking prevalence to 5% by 2035, from 17.4% in 2015–16 (Health Canada 2019: 23).

There was variation between jurisdictions in time span of the plan, ranging from one, three and five years. In several cases, the annual reports of the ministry included results of indicators in the plan and hence were judged to be a progress report. Some jurisdictions (Alberta Health Services [AHS], Quebec) had standalone progress reports, which closely mirrored the structure of the plan, making it easier for the reader to evaluate progress.

Sensitivity analysis

There were only minor changes in relative rankings after removing stretch targets from the rubric. The lowest six jurisdictions scoring D or lower remained in the lowest six. The top five with A- or higher remained in the top five; however, British Columbia and Alberta ministries of health rose in relative ranking to join this top group. There were no changes in relative ranking for the middle group (B to C-). A complete table of these results is available on request.

Examples of irregularities in planning

VAGUE INDICATORS

The Ontario government's 2015 "Patients First" plan outlined four priorities: access, connect, inform and protect (Ontario MOHLTC 2015). Each priority had only vague descriptions of improvements, such as "see a specialist sooner," "more innovative approaches based on evidence" and "expand patient engagement" (Ontario MOHLTC 2015: 6–7). A one-page collage described past achievements for assorted indicators (e.g., increase in pharmacies offering flu shots from zero to 2,400) but there was no clear assignment of these indicators to a specific priority, nor was it clear whether these indicators were to be used for future monitoring (Ontario MOHLTC 2015: 8).

INTENDED DIRECTION WITHOUT NUMERIC TARGETS

The *Performance Measure Framework 2014–2019* (Yukon Department of Health and Social Services 2014: 3–5) specifies indicators for its strategic plan (e.g., *Chlamydia* incidence, smoking prevalence and vaccination rates). The framework contains baseline data, but the target is simply to "decrease" or "increase" these measures.

RETROSPECTIVE TARGETS

The New Brunswick Department of Health published information on whether the targets were met, but the target for a particular year was publicly disclosed in an annual report *after* the completion of the planning year (Government of New Brunswick 2015, 2016, 2017, 2018).

In contrast, *The 2017–2020 Health Plan and Business Plan* (AHS 2017: 15–18) contained targets for each of three future fiscal years, and its year two and year three progress reports describe whether these targets were met (AHS 2018: 15–18, 2019: 16–19). Quebec's

2015–2020 strategic plan (Gouvernement du Québec 2015) specified a completion date of 2020 for all targets, and each subsequent ministry annual report from 2015–16 to 2018–19 (Gouvernement du Québec 2016, 2017, 2019a, 2019b) consistently reported progress toward these targets.

CHANGE OR ELIMINATION OF TARGETS

In New Brunswick, some targets shifted from year to year for reasons that were not transparent. For hospitalizations for ambulatory-care sensitive conditions per 100,000 population where lower is better, the target as reported in the *Health Annual Report 2014–2015* was 535 in 2014/15 and the actual performance was 548 (Government of New Brunswick 2015: 7). The next year, a more ambitious target was reported (454) and the performance improved (477), although it was still short of the target (Government of New Brunswick 2016: 8). Without explanation in the subsequent year 2016–17, performance was much worse (542) and the reported target had been revised to 516 (Government of New Brunswick 2017: 9). After missing this target again in 2017–18 (Government of New Brunswick 2018: 7), the target was eliminated in 2018–19 and reported as "N/A" (Government of New Brunswick 2019: 7).

Similarly, the *Plan for 2018–19* of the Saskatchewan Ministry of Health (n.d.a.) proposed a "35% reduction in emergency department waits" (p. 5). The *Annual Report for 2018–19* noted that the target was missed and waits had actually increased (Saskatchewan Ministry of Health 2019: 8). In the *Plan for 2019–20*, the target became non-specific: "reduction in emergency department wait time…" in selected cities (Saskatchewan Ministry of Health n.d.b.: 4).

MINIMAL TARGETS

Some targets represented only minimal improvements, such as AHS's target to reduce unplanned hospitalization readmissions from 13.5% to 13.2% over three years (AHS 2017: 16).

NARROW REPRESENTATION OF OVERALL QUALITY

Targets were sometimes defined for a very narrow subset of activities within a sector or patient group. For example, the *2019/20–2021/22 Service Plan* of the British Columbia Ministry of Health (2019: 9) aims for "continued improvement of hospital services," but the sole indicator was the *Clostridium difficile* infection rate. There were no indicators for broader hospital issues, such as the rate of adoption of best practices or other adverse events.

MISREPORTING OF PROGRESS

In Ontario, the *Patients First: Action Plan for Health Care – Year-Two Results* report stated that "During the last two years, we've made great strides to improve the health care experience … For example: 94% of people in Ontario now have a family doctor or other primary healthcare provider" (Ontario Ministry of Health and Ministry of Long-Term

Care 2017: 1). However, in the original plan released two years previously, the same figure of 94% was quoted as the baseline (Ontario MOHLTC 2015: 8).

REDEFINING INDICATORS AND OBSCURING EVALUATION

NSHA set targets for primary care access – defined as the percentage of patients with a family doctor across multiple years (NSHA 2016: 3, 2017: 4). But later, it changed the definition to the number of persons who found a new doctor in its *Healthier Together 2016–19: Measuring Our Progress* report (NSHA n.d.b.: 9), making it impossible to ascertain if the original target was met.

UTILIZATION MEASURES INSTEAD OF INDICATORS

Many plans reported utilization measures instead of true quality indicators. There is no information on the percentage of persons who did not receive the services indicated for their condition. Examples include the following:

> "Frail seniors will be provided with 10,000 more rehabilitation therapy visits".
> *Patients First* (Ontario MOHLTC 2015: 11).

> "Number of patients being provided oral systemic therapy."
> *2016–2021 Manitoba Cancer Plan* (CancerCare Manitoba 2016: 30).

> "Number of priority surgeries in targeted areas completed."
> *2019/20–2021/22 Service Plan* (British Columbia Ministry of Health 2019: 5).

RELIANCE ON DESCRIBING STRUCTURE

Structural indicators describe milestones, such as the introduction of a program, new facilities or staffing increases. They can be useful for describing key investments needed for progress but should be complemented by process or outcome indicators describing adoption of best practices or achievement of a desired result. Nunavut's *Business Plan 2018–2021* only described structural changes, such as "expand the use of Telehealth" and "incorporation of traditional knowledge in programs" (Government of Nunavut 2018: 137, 138). The *2016–2021 Manitoba Cancer Plan* monitored the number of "molecular tests made available" and "surgical leaders in the province" but had no process or outcome indicators (CancerCare Manitoba 2016: 31, 32). The *Strategic Plan 2019–2022* of PEI's Department of Health and Wellness called for the "redevelopment of a provincial health plan" but had no quality indicators (PEI Department of Health and Wellness 2019: 7).

DATA AVAILABILITY

Some provinces acknowledged lack of data as a barrier to planning and aimed to address this gap. The *2016–2021 Manitoba Cancer Plan* identified "Enhanced Reporting on Performance, Quality and Safety" as one of its six strategic objectives (CancerCare Manitoba 2016: 7).

It proposed expanded health information system infrastructure, data collection on patient experience and public reporting of standardized indicators. Similarly, the *Strategic Plan 2017–20* of the Newfoundland and Labrador Department of Health and Community Services (2017: 14) specified using eHealth technology and evidence to improve healthcare as a priority to inform future health planning and policy development.

Elsewhere, however, plans lacked targets despite evidence of rich data sources. For example, the *Ontario Critical Care Plan 2018–2021* lists past accomplishments, such as an increase in the percentage of life-or-limb-threatening cases transported within four hours in one region or improved Intensive Care Unit-to-ward transfer times at one hospital (Critical Care Services Ontario 2018: 25). However, these indicators were not used for setting firm targets (Critical Care Services Ontario 2018: 22).

Discussion

This paper demonstrates wide variation between jurisdictions in Canada in planning for healthcare quality. Some jurisdictions had clear priorities, bold targets and a consistent method for reporting to the public on progress toward goals. In other jurisdictions, some or all of these elements were missing, resulting in plans that lacked clarity and ambition. We observed multiple examples of the lack of indicators, baselines and targets, as well as shifting or withdrawal of targets, minimal targets and targets announced only after the plan was complete.

Jurisdictions lacking a clear plan can still achieve improvement but must do so without the benefits of setting targets. Bold targets can mobilize the hearts and minds of workers within complex adaptive systems to move in the same direction. Don Berwick, former CEO of the Institute for Healthcare Improvement, used the phrase "some is not a number, soon is not a time" to launch the 100,000 Lives Campaign in 2004, aimed at recruiting American hospitals to implement six patient safety interventions to prevent this number of deaths within 18 months (Berwick et al. 2006: 325). Although the exact count of lives saved is disputed (Wachter and Pronovost 2006), even critics acknowledge the campaign's remarkable impact in galvanizing organizations toward a common goal.

Weak target setting is inconsistent with commonly used leadership frameworks. Kotter's "8 steps" for leading transformational change include "establishing a sense of urgency", which corresponds to having a clear baseline that highlights problems requiring attention, and "creating a vision," which corresponds to having bold targets (Kotter 1995: 61). Similarly, the Hoshin Kanri planning framework within Lean methodology (Zairi and Erskine 2015) emphasizes setting multi-year targets with yearly milestones and identifying actions at each organizational level to support the achievement of targets.

Our findings raise the question of why the clarity of planning varied widely. First, it is important to identify key actors involved in creating plans. Within governments, these include the ministers, senior civil servants and planning departments; within health authorities, these include the CEO, board, senior management and planners. One theory is that ministers are elected officials facing intense public scrutiny and may be more risk averse in

planning. Risk aversion by the bureaucracy advising the minister may also be a contributing factor. Survey data demonstrate that public managers perceive a more risk-averse organizational culture compared with non-profit managers (Chen and Bozeman 2012) and that persons with low-risk tolerance are more likely to choose careers in government than in non-profit organizations or the private sector (Dong 2017). Higher job security may draw risk-averse individuals to the civil service (Lewis and Frank 2002) and rules-based processes may discourage risk-taking behaviour (Bozeman and Kingsley 1998). These factors could help explain why ministries had substantially lower scores than health authorities.

The government–media relationship may also contribute to risk aversion. Studies show that bad news predominates over good news (Stafford 2014; Vanderwicken 1995), likely due to greater consumer demand for negative stories (Trussler and Soroka 2014), which in turn is driven by the tendency of humans to pay more attention to negative events. This cognitive bias is believed to originate from a survival mechanism to quickly identify threats. Furthermore, when a negative event occurs, humans are more likely to attribute the outcome or "assign blame" to a particular actor compared with when a positive event occurs (Morewedge 2009). Hence, goal setting comes with high risk and low reward; failure generates more media attention, criticism from the opposition and blame on governments, but success is less likely to be noticed and attributed to government efforts.

Risk aversion theory, however, does not fully explain the observed variations and the reason why some jurisdictions, such as Quebec's MHSS, achieved high scores. Other explanations for variation include regional differences in political culture, government–media relations or communication strategies. One factor that may counter the negative impact of risk aversion is the well-documented intrinsic motivation of civil servants to serve the public good (Perry and Wise 1990). Future qualitative research should examine why some governments manage the risk of bold planning better than others.

The WHO's quality planning guidelines stipulate that governments should consult broadly with stakeholders in developing plans. It is not clear whether this has occurred in Canada; in all planning documents reviewed, there is no description of stakeholder consultations. Involving leaders of healthcare institutions, professional associations and patient groups increases support for the plan's goals and participation in its implementation. Furthermore, shared ownership of the plan could allow political risk to be shared, especially if the plan includes commitments by stakeholders to make measurable improvements that contribute to the plan. Future research should examine the degree of stakeholder input into planning and examine whether such input will lead to clearer, bolder plans.

The cause of the observed wide variation in scores is not known and warrants further investigation. One hypothesis is that Canada is a federation with limited ability to set national standards for quality planning. Another is that the larger and more complex the system, the more reluctant governments may be to set bold plans because complexity hinders the ability to influence actors and institutions. Although there is insufficient statistical power

to test this hypothesis, it appears less likely as there are examples of large and small health systems within the highest and lowest rankings.

Another hypothesis is that some governments have chosen to delegate planning and target setting to health regions and consider this task to be operational. In two provinces with health authorities that achieved high scores, the ministry scored very low. Future research should explore this hypothesis. Even if policy makers believed that planning should be devolved to health regions, it would not explain the absence of targets in areas of the exclusive purview of the ministry.

Another potential cause of variation is that changes in government might lead to a ministry to stop progress reports until a new plan is released. There is insufficient data to examine this hypothesis because in most jurisdictions the political party did not change during the most recent plan. Future studies could examine changes in planning and reporting after elections with change in government.

One enabler of good planning is data, which requires significant investment. Lack of data was acknowledged in plans in Manitoba and Newfoundland, and both promised to establish measurement systems. Most jurisdictions participate in the National Ambulatory Care Reporting System and submit emergency department data allowing measurement of wait times but as of 2021/22, Newfoundland, New Brunswick and the Northwest Territories were not yet submitting data (CIHI n.d.b.). Similarly, PEI, Quebec, the Northwest Territories and Nunavut have not yet committed to measuring data using the Resident Assessment Instrument-Minimum Data Set in long-term care homes (CIHI n.d.a.). Investments to address these data gaps will require strong political will.

Few jurisdictions set stretch targets. One possible explanation is that planners are reluctant to commit to unrealistic targets, which could lead to the demotivation of staff. Another is a lack of knowledge on what constitutes an achievable stretch target. CIHI's *Your Health System* portal allows users to compare a hospital's results against averages for peer groups but does not report the best results attained by any institution (CIHI n.d.c.). Health Quality Ontario (n.d.) publicly reports which facilities have the lowest wait times. Such information could be used for target setting, but this information is subject to interpretation as superior results could be due to factors beyond the control of a health provider, such as differences in case-mix even after adjustment, available resources or geography. Ideally, research should be undertaken to determine if superior results obtained in some sites were due to skilful implementation of best practices or these other factors. If the former, then the result could serve as a benchmark.

Study Limitations

This study did not investigate the reasons why governments are reluctant to set targets. Future qualitative research using interviews with past and current public officials could provide insight.

Although the authors conducted an extensive search, it is possible that some plans were missed. This limitation was mitigated by asking the ministries of health and health authorities to identify missing sources or misinterpretations.

This paper only examined target setting. Other elements of good planning include the use of evidence to define priorities; the assignment of adequate resources; clear accountabilities for action; and stakeholder engagement. These items warrant further evaluation. Future research could also examine whether plans succeeded in their implementation.

Another limitation is that this paper is a cross-sectional analysis examining variations in planning based on the most recent plan. However, it is possible that scores may fluctuate over time, due to changes in risk-tolerance of government, technical knowledge of planners or other factors. Interestingly, while Nunavut had a score of zero, a previous public health plan developed in 2008 – before the study period – with multiple indicators and targets, would have scored highly (Government of Nunavut Department of Health and Social Services 2008). Future research could examine what factors lead to shifts in planning scores over time.

Conclusion

Governments and provincial health regions in Canada varied widely in the boldness and clarity of their plans for improving quality. Many jurisdictions appeared wary of setting targets for improvement, likely because of risk aversion to negative publicity if the target was missed. A few jurisdictions nonetheless developed bold plans. Future research should examine enabling factors for clear planning so that lessons can be shared with others.

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