Reaching beyond jurisdictional boundaries: Collaboration in complex healthcare environments

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Congress Track #: 3 - Improved and sustainable healthcare systems for better outcomes
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Introduction

• Cancer control plans often developed at national or international levels, with national goals and targets, yet implementation often occurs at state/provincial and local/hospital levels

• Some of examples of federated models...
Canada, Switzerland

• Provinces/territories primarily responsible for organizing and delivering most of health services
  • Many have established regional health authorities which fund and deliver hospital, community, long-term care, mental and public health services

• Federal government
  • Regulates safety and efficacy of medical devices and pharmaceuticals
  • Funds health research
  • Services for Indigenous on reserve, members of the Canadian Armed Forces, some veterans, and resettled refugees
  • Administers several public health functions
  • Accords for national and bilateral priorities of provinces/territories
Taiwan

- Single-payer health system
  - Ministry of Health and Welfare responsible for policy
  - National Health Insurance Administration responsible for administering health insurance coverage
- Six regional offices supported by a health information infrastructure
- Municipal and district governments may offer additional benefits for residents within their jurisdiction, such as subsidies for out-of-pocket costs for poor residents.
Objective

• This session will explore how to work effectively across jurisdictional divides, to achieve common healthcare and cancer care goals and targets for all citizens.

• Examples presented today cover federal/provincial collaboration, collaboration between provinces, collaboration within cities, and working with and across countries from an international agency
Collaboration across jurisdictions
A federal-provincial view

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Health care in Canada is a provincial responsibility

- CPAC, the Canadian Partnership Against Cancer, works with the primary implementers – the provinces – to coordinate cancer control in Canada.

- E.g. Jurisdictions collaborating and aligning through screening networks:
  - Breast: established
  - Cervix: established
  - Colorectal: developing
  - Lung: new
Lesson 1: You need to keep the eye on the destination. Regions need to decide the route.

- Often the central group needs to keep the eye on the overall goal – but local context will result in different implementation plans.

- Example: Different recruitment for colorectal screening despite uniform agreement on target age group, screening tests, and key intervals.
Lesson 2: It will take a while to get there. So get agreement on the key signposts before starting on the journey.

• Need to decide on quality indicators of outcome: incidence detection, for example, rather than processes of work

• Idea is to allow for local experimentation but then evaluation of how they worked out using coming definitions.

• Create “natural experiments”. We all want “to be smarter in 10 years”.
Lesson 3: You’re there to accelerate. That’s uncomfortable for others. Learn to help them cope.

In lung screening, needed to frequently distinguish between enabling from instigating.
Lesson 4: Remember to check in on the destination. Again.

• Breast screening getting better at recruitment – but lost track of monitoring low abnormality rates.

• Cervical screening improving in several areas, but takes a few years to adopt new intervals or starting ages – even though these save money.

• Colorectal: confusion between program goals (participation) and population goals (“up-to-dateness”)

• Your role is to be the “honest broker” to remind everyone of the original goals.
• The City Cancer Challenge: City-level collaboration with high-level goals

• T3-55: Reaching beyond jurisdictional boundaries: Collaboration in complex healthcare environments

• Dr. Sue Henshall

• Director, City Cancer Challenge
Why Cities?

- “Cities are taking centre stage in global health and development initiatives.”
- 2016 Global Report on Urban Health, World Health Organization & UN Habitat

Rapid urbanisation

Increased sustainable development challenges in cities

Growing cancer burden with an ageing population in less healthy environments
Our mission is to build a collective movement of cities supported by a network of global and local partners to deliver quality, equitable and sustainable cancer treatment solutions for all.
Factors for Success

**Civil Society**
- The right local stakeholders are engaged
- A strong linkage to the local community is maintained
- The patient perspective is included

**Political Commitment**
- Government is engaged at all levels
- Bipartisan support is garnered

**Multi-sectoral Partnerships**
- All sectors participate
- A commitment to collaboration and partnership is evident
- The expertise, resources and competencies of healthcare industries and private providers are available and accessible to cities

**Local Champions**
- Local champions from across sectors are available to serve as advocates for the initiative and engage key influencers and local partners in the process
City Cancer Challenge Checklist

A tool based on the criteria for the selection for Challenge Cities, which outlines the key drivers of success.
International collaboration
a new framework

Dr Freddie Bray

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Affiliated organisation: International Agency for Research Against Cancer
Partnerships: Leveraging expertise through a common purpose

Country Leadership

Global Coordination

Regional Focus

 Servant leadership focused on building country capacity in cancer surveillance

 A set of guiding principles are used to tailor implementation in each setting

GLOBAL INITIATIVE FOR CANCER REGISTRY DEVELOPMENT

The Global Initiative for Cancer Registry Development (GICR) is a collaboration of key international partners to save lives through reliable cancer data.

This unique initiative, launched in 2011 and led by IARC’s Section of Cancer Surveillance, is the first global strategy to improve the ability to collect, analyse, and communicate cancer data. The GICR facilitates successful cancer control programmes, serving as a catalyst to achieve significant improvements in the quality and coverage of accurate data worldwide.
Progress towards a step change, 2012 – 2018

1. Increase the number of high quality population-based cancer registries (long-term goal)
   - Interim measure: establishment of 6 IARC Regional Hubs and 10 Collaborating Centres

2. Accelerate capacity building through a distributed model
   - Delivery of 62 regional courses, 80 site visits
   - Launch of GICRNet, a framework for local integration to reach a greater number of people: 3 courses, 52 IARC regional trainers
   - Development of an E-learning platform and modules

3. Coordinated model of support, linking need to qualified partners
   - Structured mechanism to request assistance
   - Establishment of GICR Mentorship Programme
Lessons Learned

- Learn from the past
  - GICR model built on experience gained from 50+ years of IARC
  - Incorporate principals that work: tailored support; flexibility; country ownership; scientific integrity; based on international standards

- Be an honest broker
  - Importance of a designated lead that acts on behalf of larger group to benefit the collective

- Focus on strategic areas to achieve overall goals
  - Introduction of GICR Partner Countries to intensify support where commitment and opportunity are strongest

- The ‘so what?’ – data in the context of cancer control

- Collaboration of partners and core funding
  - Good will and funding are necessary but not sufficient; need for both