THE STORY OF THE
MANITOBA CENTRE FOR HEALTH POLICY

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CHAPTER 1: INTRODUCTION

Dr. Patricia Martens, the current director of the Manitoba Centre for Health Policy, invited me to tell MCHP’s story through the eyes of the people involved in creating and sustaining it. She said personalities drive the Centre and make it what it is today—20 years after its formal establishment by two of those personalities, Drs. Noralou and Les Roos, the founding directors. Today, MCHP is internationally renowned for its use of administrative data in health research and its expertise in knowledge translation.

The Manitoba Centre for Health Policy is a research unit in the Department of Community Health Sciences in the University of Manitoba’s Faculty of Medicine. Research scientists and their collaborators at the Centre study health services, population and public health, and the social determinants of health using data based on the entire population of Manitoba. With approximately half of their funding coming from the Manitoba government, much of the research is oriented towards answering questions of interest to policy makers. The Centre has had this dual mission from its first contract with the Department of Health. It now has formal associations with five government departments and 11 regional health authorities to address research questions aimed at improving the health of Manitoba’s citizens.

Over the 20 years that MCHP has existed, its success in research endeavours has attracted national and international attention. In 2007, MCHP received visitors from Statistics Canada, Alberta, Ontario, Malaysia, and Australia to learn more about the Centre’s operational model (Martens, 2008; Manitoba Centre for Health Policy and Evaluation, 2008; Manitoba Centre for Health Policy and Evaluation, 2007b). Additionally, the year prior Dr. Martens received speaking invitations from nine of 10 provinces, and Drs. Noralou and Les Roos spent their sabbatical in Australia working with groups in Sidney, Adelaide, Melbourne, and New Zealand (Manitoba Centre for Health Policy and Evaluation, 2007a). Articles written by the Centre investigators explaining their use of administrative databases have been cited as often as 400 times (Lewis, Martens, & Barre, 2009).

This interest in MCHP’s work and its upcoming 20th anniversary inspired this project to document the perspectives of key people from different organizations involved with MCHP at the beginning and over its life-span. These perspectives also illuminate other questions that the research was intended to explore. I asked questions to allow an examination of the socio-political factors—facilitators and challenges—in the development, establishment and continuation of the Centre. An analysis of the participants’ responses will be reported in a forthcoming supplement of Healthcare Policy.
A Quick Look at Methods

The qualitative methods used in this project included a combination of document analysis and semi-structured qualitative interviews. Additionally, current staff was invited to participate through a short anonymous survey using SurveyMonkey (Finley, 2010). Pictures, information about research highlights over the past 20 years, and comments on the accuracy and inclusiveness of the time-line were solicited from staff as well.

Dr. Noralou Roos has remarked that many people deserve credit for establishing MCHP and the number of people named as influential in the interviews makes it obvious why this is so. As Dr. Brian Postl, who at the time was Department Head of Community Health Sciences commented, who knew all of these bits of support would add up to something quite remarkable.

I interviewed 28 participants selected purposefully for their instrumental role in founding and/or sustaining MCHP. Individuals were selected in consultation with MCHP’s executive management team, the founding directors, and Evelyn Shapiro, who mentored the founding directors starting from the early years. The initial list included three times the number of people that it was feasible to interview, with more added as the project unfolded. Participants were selected to represent perspectives from within MCHP as well as from organizations external to MCHP. Concentration is on the years leading up to the establishment of the Centre because the individuals most frequently named were those involved in the start-up. However, I also interviewed people associated with the Centre throughout its history, including several whose association began mid-way and within the past five years.

The response rate to interview invitations was excellent – all consented. Interviews were conducted with the founding and current directors of MCHP, university department heads, deans, and President, minister and deputy ministers of health from the Government of Manitoba, the chair and members of MCHP’s Advisory Board, current and former staff from MCHP and Manitoba Health, and others thought to be influential supporters of the Centre. I interviewed support staff and data analysts as well as researchers. Some of these roles overlapped.

Qualitative in-depth interviews were used because a major goal was to elicit participants’ stories about their role in the Centre’s development. The interview questions were intentionally broad so that participants could raise issues they saw as relevant. I asked participants about their role and their organization’s role in starting up MCHP and in its continuing development, the challenges they encountered and how they were met, propitious and missed opportunities, key issues such as privacy and funding, key events, successes and failures, other influences, and as is usual in qualitative research, questions to follow-up and deepen understanding of responses.

All of the interviews were audio-recorded and transcribed. Interviewees were offered a copy of both records. I wrote short summaries of long interviews, occasionally supplemented with material derived from the Centre’s newsletters, annual reports, or the published literature. I have included extensive quotes from participants’ interviews in an effort to stay as true to their perspective as possible. To improve readability, I have deleted repetitions, false starts, ums and uhs, and words such
as “you know” and “I think.” Longer sections of omitted material are indicated by the use of ellipsis (...). Summaries were sent to interviewees with an invitation to correct or delete comments and to indicate any confidentiality concerns. Most provided some additional information and generally improved the content and writing.

Of the 28 interviewees, eight requested anonymity. The majority of these requests came from current MCHP staff, so I have included their perspectives through a composite of comments on the key questions. This composite includes the responses given by the eight staff who commented through SurveyMonkey.

Throughout the project, I reviewed the following relevant documents:
- Publicly available documents (annual reports, newsletters, materials posted on MCHP’s website, relevant published reports, and articles)
- In–house records (advisory board meeting minutes, external reviews, organizational charts, administrative meeting minutes, photographs, and materials posted on MCHP’s internal shared drive)
- Notes, PowerPoint presentations, and other materials provided by interviewees.

This review assisted with the recording of issues and major events to inform the interviews and was especially helpful in establishing dates for the time–line. The use of these multiple sources allowed cross–validation of some findings and conclusions.

The University of Mantioba Health Research Ethics Board provided ethical approval for this project.

**Project Overview**

Each section in Chapter 3 is meant to be self–contained so that readers can choose to read just a few or many. Although each person tells the story of their involvement with the Centre from their own perspective, there is a reassuring consistency in the narratives. The repetition of certain themes provides a natural focus for what people consider to be most important in the Centre’s evolution.

Each interview also offered a unique and important view of the Centre’s challenges and successes, some of which are not widely known. Others provide insight into organizational perspectives that MCHP staff may not be aware of. And the converse is also true, that MCHP staff share perspectives of interest to external organizations involved with the Centre.

The story sections are presented in a rough sort of chronological order beginning with excerpts from interviews with the founding directors, Drs. Noralou and Les Roos (Chapter 2) and ending with a summary of my interview with the current director, Dr. Patricia Martens (Section 3.14). Drs. Noralou and Les Roos provide an overview of significant events. This brief overview is supplemented with a time–line and a photo gallery (Chapters 8 and 9). More depth on the founding directors’ careers is provided in Chapter 10.
The Centre's history dates back to 1973, when Dr. Noralou Roos met Dr. Paul Henteleff at the
Manitoba Health Services Commission and discovered the existence of the province’s administrative
health data. This resulted in collaboration on the first research studies. Dr. Henteleff’s story is related
in Section 3.1. His tale pre–figures several long–standing themes, such as testy relationships with the
province’s physicians and concerns regarding patient confidentiality that resulted in setting up the
databases in a way that safeguarded privacy but allowed for research. Dr. Henteleff’s story also makes
it clear that Drs. Noralou and Les Roos’ research with the administrative data pre–dated the Centre’s
existence by 15 years.

The next section focuses on Dr. Fraser Mustard’s role in promoting the establishment of the Centre.
Dr. Mustard was President of the Canadian Institute for Advanced Research and a well recognized
national player in the health arena. Many people commented on his zeal for research on the
determinants of a population’s health and how important this was in inspiring the then–Minister of
Health, Donald Orchard and Gary Filmon’s Conservative government to support the Centre. The
seeds were planted in the fall of 1989 and the vision for the Centre sprouted out of these contacts.

At the time of the negotiations for the Centre, Dr. Arnold Naimark was President of the University
of Manitoba; Dr. John Wade was Dean of the Faculty of Medicine; and Dr. Brian Postl was Head
of the Department of Community Health Sciences. They each provide insight into the university
context and the broader societal context for the era in which the Centre evolved (Sections 3.3–3.5).
They each played multiple roles: Drs. Naimark and Wade in creating an appropriate departmental
home for the Centre, Dr. Wade continuing support as a deputy minister in the Department of
Health, and Dr. Postl as a member and subsequent chair of MCHP’s Advisory Board.

The impetus for the establishment of the Centre came from Donald Orchard and Frank Maynard.
On August 3, 1990, the Minister of Health Donald Orchard announced the creation of a $3.5
million health research centre to be funded for three years. The official opening took place in the
Atrium of the St. Boniface General Hospital Research Centre on April 4, 1991, although the
contract between the Province and the University established the official “anniversary date” as Jan.
1, 1991. In Section 3.6, Orchard recalls the rationale for government dealings with the Centre, the
mutual benefit of an arms’ length relationship and the immense pride that he and his government
took in the Centre’s accomplishments. Frank Maynard was Deputy Minister of Health at this time
and provides additional detail on government involvement with the Centre (Section 3.7). Tom
Carson was Deputy Minister of Health a little later and his views are directed more on the necessary
efforts for sustainability (Section 3.8).

Drs. Norman Frohlich, Cam Mustard and Charlyn Black were long–time researchers at the Centre.
Dr. Charlyn Black was also co–director of the Centre with Dr. Noralou Roos for four years and then
acting director for Dr. Roos’s sabbatical year. A common theme running through their interviews is
the importance of addressing research questions of use to the policy process while maintaining a high
standard of scholarship. See Sections 3.9–3.11 for their comments.
Louis Barré and Deborah Malazdrewicz also have a long–time association with the Centre, playing an important liaison role between the Centre and Manitoba Health. Together their perspectives, presented in Sections 3.12 and 3.13, provide an overview of how the province benefitted from the Centre’s research, but also the large non–monetary contribution required of their department to keep the Centre functioning smoothly.

The Centre’s Advisory Board is also credited with an important role in smoothing the way for its success. The list of directors on the first and most recent Advisory Board (Chapter 4) demonstrates the composition of the Board and how it has changed over time as MCHP’s needs changed. Its initial role in establishing a reputation for excellence is demonstrated by the inclusion of internationally established researchers. Over time, local membership increased. Current board membership reflects the inter–governmental participation in the Centre’s funding.

Participants in the interviews frequently commented that the Centre owes its success to its hard working and loyal staff. The list of staff who has worked at the Centre for over 10 years demonstrates this loyalty (Chapter 5). Forty per cent of the original staff of 14 still worked at the Centre when this list was compiled in the fall of 2009. Approximately half of the current 60 full and part–time employees have been with the Centre for 10 years or longer. People told me this was a great place to work, very respectful, and flexible.

Input from staff is represented in Chapter 6. Quotes selected from interviews with current staff and all of the survey responses are reported to provide their perspectives on MCHP’s major challenges, factors in its success, and key events. Research highlights, presented in chapter 7, were solicited from staff to build on a similar compilation from the first 10 years taken from a CentrePiece newsletter compiled by Dr. Carolyn DeCoster (2002).

The people that I interviewed mentioned the lucky confluence of many necessary and enabling factors that allowed the Centre to become established and to flourish. These are explored in Chapter 11, to be expanded upon for a forthcoming article in Healthcare Policy.
Reference List


CHAPTER 2: TALKING WITH THE FOUNDING DIRECTORS, DRS. LESLIE ROOS AND NORALOU ROOS

This chapter is composed of excerpts taken from a joint interview with Drs. Noralou and Les Roos (December 15, 2009) and individual interviews (July 31, 2008).

Gail: As the founding directors, I think people will be interested in knowing what you see as key events in the life of the Centre and what you see as challenges and factors important to the success of the Centre.

Les: Well early on, I remember Noralou, it became clear to me with your talks with Paul Henteleff, the possibilities of accessing the data for the first study, the tonsillectomy study, if that worked, there must be an incredible amount of other good stuff that you could do. That's more or less the way I thought of it 35 years ago.

Noralou: When we started working with the database it was very incremental. We started doing work on tonsillectomy because that's what Paul was interested in studying, and I basically had said, “Anything you want to work on and can get the data for, we would work on.”

Les: I think that's important because obviously Noralou had that awareness that there must be all kinds of things that you could do, or that the researchers could do, if one could get started with it.

Noralou: That's interesting. When we first started, we were only working with kids who had tonsillectomy and their physician and hospital claims for the surgery. Then we decided we needed a comparison group, so we got data on kids who didn't have tonsillectomy. So we had all the kid data, but we didn't have anything else. Then we did an evaluation of the extended care unit at St. Boniface, and we started looking at the elderly data. This was just an incredibly rich, unusual data resource, and so we would identify projects which would take us into it.

Les: Our backgrounds at MIT in the mid-sixties, introduced us to computers at a time when computers weren't being used for research in Manitoba, to say the least. And this was new. It became clear that the data which the Manitoba Health Services Commission had could be used for a whole lot of things, other than paying bills. My remembrance of it is that we talked to John Bunker, and I don't know if it was before or after the first New England Journal paper where we had small area variation, and John said, “You have to talk to Jack Wennberg.” That was in the late 70s.

Noralou: Jack Wennberg was on our advisory board for years. He recognized we were the only people in the country, in fact in North America, who could do this kind of research. About every five years we would bring up somebody like Jack—it was Jack Wennberg one year; it was John Bunker another year—who would come and talk to the Manitoba Health Services Commission about how terrific the kind of research we were doing was, and they would say, “Okay. I guess you can have another five years of data.”
Les: There was sort of the outside validation from well known people in the field.

Noralou: They [MHSC] were clearly going out on a limb, giving us access to these data. Nobody had ever done this before, and it was important for them to know that it was seen outside Manitoba as something which was very important to do, and that it was producing research payoffs.

Les: Well the other good thing, is we continued to get funded by the NHRDP [National Health Research and Development Program] for both salary support and for research projects. And it was very important to have a high success rate to keep the funding coming in because we didn’t have the Centre at that point.

Noralou: You always had to apply for more grants then you expected to get because otherwise you’d have to lay people off. Since we were usually successful, the size of the operation, the staff, etcetera, kept expanding.

Les: All the early studies, up ’til 1990 when the Centre started, were funded by competitive national grants. But in some ways it was easier then because you didn’t have ICES [Institute for Evaluative Sciences], you know you didn’t have all these smart imitators.

Gail: So this went on for 15 years?

Les: Yeah.

Gail: You were in the Faculty of Administrative Studies at the beginning?

Noralou: We both came to Manitoba to work in the business school. I met David Fish who had created a Department of Social and Preventative Medicine with support from Naimark, who was then the dean of the Medical Faculty. And David encouraged me to apply for a Career Award. I moved to the medical school as my primary appointment when I received this award which supported my salary to do research although I kept an office in the Business School. Naimark was still Dean. When the centre was established, John Wade was dean of the Faculty of Medicine and Brian Postl was the department head. They had been pushing for the government to provide some funding for a centre, and that was sort of one stream. It was clear it was to be related to our department but it wasn’t clear what the emphasis was to be. Totally independently of this, there was the Canadian Institute for Advanced Research, CIAR, which Fraser Mustard at the time ran.

Les: They had a Population Health section, led by Bob Evans, and they were trying to get going a group, and Noralou and I were asked to join. They provided some research money, and it gave us a lot of visibility both at the university and with the government.

Noralou: Fraser and Bob recognized that this was a very rich data source for understanding population health. They were making a major effort to meet with ministers of health across the country and tell them how they should really be looking at broader determinants of population health. At one point, Fraser Mustard and Bob Evans and Ted Marmor from Yale, who was also part of this program, independent of Les and I, had come out to Manitoba to meet with the Minster of
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Health and the Deputy Minister. This was in 1989. The Minister at that time was Don Orchard and Frank Maynard was the Deputy. At the last minute, we were told to join them. We weren’t part of setting up the meeting. And Fraser and Bob were talking about how we could do all of these wonderful things in Manitoba that the Ministry should be investing in, enabling us to do this.

Les: So it was kind of a done deal when we walked in: if we kept our mouths shut, we’d get the Centre.

Noralou: There was no discussion of funding. As we were walking out of the meeting, I was talking to the deputy and I said, “Well, you know, if we do this, it will actually take some funding.” And Les and I had been running our operation on about 300,000 a year of research grants. The typical grant was about 100,000 dollars. So walking out of the room I was saying, “It’s going to be expensive to do the kind of things we are talking about.” And the Deputy said, “I wouldn’t worry about the money.” I raised our interest in publishing with him. He assured us there was no problem in publishing. I was actually asked to another meeting which the Deputy Frank Maynard organized with just Manitoba people. He was there; Brian was there. I don’t remember who else was there. At this meeting Maynard had outlined what he wanted: We could do the administrative data but what he really wanted to do was everything anybody had ever asked him for. So we were going to do ethics, we were going to do X, Y and Z.

Les: Yeah, I remember that.

Noralou: These were all things that were sort of going on in the department, and as we were walking out, Brian said, “So what do you think? Can you take this on?” And I said, “You know, if we take it on, the focus will be on administrative data. I don’t have any comparative advantage in any of those other areas. I’m not going to take on an omnibus centre.” So, he brokered the discussion with Maynard that if we were going to do it, it was going to be a research unit focussed on administrative data. The only other thing, when he got the agreement on that, he called me into the office, and he said, “Well Maynard’s agreed to that. So who’s going to run it? Are you going to be director or is Les?” And I said, “I don’t care.” And he said, “You are.”

Les: She’s the political animal and I’m not. That’s fine.

Noralou: So that’s how those decisions got made.

Les: Actually the decision to do something where there’s a comparative advantage is a success factor, if you want. It’s much harder to have a successful research operation when you don’t have a comparative advantage.

Noralou: One of the advantages of having the two Rooses involved in it was Les did a whole lot of fund raising, and basically we just pooled the resources.

Les: Grant money. And it’s not just the money; it’s that people are pretty relaxed about it. Because we got tenure early, it’s always been a priority to be a team player. Is the team going to do well in terms of funding?
Noralou: Just seeing what Pat [Martens, current director] has to do. She’s really handling the whole thing, whereas, Les raised a ton of grant money, and then it just went into whatever we needed to fund, plus he did the repository. It made a huge difference. I didn’t have to worry about the programmers, how things were going to be set up, because Les knew a lot about it.

Gail: So you had a shared responsibility. You really were co–founders. Okay, now we’re up to just before the Centre.

Les: And so it all came together. Naimark was then president, and he decided that we really belonged in the Faculty of Medicine. And with all these forces coming together it seemed to be one of his easier decisions. So that involved moving tenure lines to the medical school.

Noralou: We first started doing a series of what now would be called atlases. We were just doing statistics on the hospital system, the physician system, thinking that’s sort of what we would do—that we would produce a series of reports measuring how the system was working. Mainly, we were able to negotiate having a series of projects pretty much as they do now.

Les: We had 15 years of experience with the data. We’d already had so much experience with analysing the data. There were basically low start–up costs from the government’s point of view. There was an expansion and more powerful computers and so forth but we knew what software worked, and we had programmers who were good, which isn’t true in a lot of other start–up situations, where they really try to start things from scratch. This constellation of innovations is really important—everything sort of has to come together, for it to work.

Gail: So what is everything?

Les: There’s the technical side. There’s the data side, and there’s the small ‘p’ political organizational side. And you really need the interest and the enthusiasm of government for a whole bunch of things. Another thing that was critical, and again based on a fair bit of experience, is to have the entire population registry. So that was a very early request of ours to the government—to have the whole registry, and we’ve put a lot of resources over the years into keeping it healthy. That is a major comparative advantage of our Centre—getting that early and being able to use it for everything. It gives you a denominator for all kinds of epidemiology, small area analysis comparisons, and then you can also trace individuals over time using the registry. We probably go back farther than anybody and are linkable to more datasets than anybody, or we’re at least among the top, certainly on the healthcare side. I have an article that looks at some other centres, and I think that ours goes back further than most. It’s an information infrastructure. We’ve created an information–rich environment by which you can play above your weight.

Noralou: It just sort of builds because you’ve got a critical mass and a critical level of interest and acceptance.

Les: The other thing about Manitoba, it was small enough that everything was in one building, and they didn’t have separate fiefdoms for medical claims and for hospital extracts. Some places have done things very separately. And in Manitoba, people were at least in the same building and did talk to each other. And the situation is different, like you didn’t have the Calgary–Edmonton split like you have in Alberta.
Noralou: Exactly and Saskatchewan the same way—Regina–Saskatoon.

Les: And there were a lot of local factors. Noralou has a very good style with Manitoba policy makers, which makes it easier.

Noralou: Tom McCormack played a critical role in the early years as the Centre was being established. He was the liaison between the Centre and Manitoba Health, and advised most helpfully on all the unknowns naïve academics needed to understand.

Les: We were also very fortunate in Brian [Postl] having very good skills at cultivating the people, and having ministers and deputy ministers who were basically supportive all through. The other thing was—early success. It’s very important that the province and the university have been able to say, “We have something here that’s really good and pretty unique and pioneering, and we should support it.”

Noralou: And the deans. Naimark used to say he couldn’t decide whether we’re the doctor–hating department or the conscience of the medical school. In fact he was very supportive, and so was Anthonisen. We were doing controversial reports, identifying that relative to the number of physicians we had in Manitoba, Winnipeg was really over–supplied, and specialist services were mal–distributed, et cetera. He would organize presentations, invite the whole faculty, and he would be there to introduce us. It gave us an opportunity to have the faculty know what’s going to be in the Free Press headlines tomorrow and to have them ask their questions. So that was really very helpful. He didn’t necessarily agree with our results but he respected how we were producing them and how we were presenting them.

Les: In more recent history, Pat’s unique ability to get along with the regional health authorities, more than get along, to get their enthusiastic support is really important. And the work with the education data opens up all kinds of analyses of educational success. The other thing that’s very relevant—the Housing people and the Justice people see, “Oh wow, if they can do that in Education, what might you be able to do with what we have in Ministry X?” From the larger picture, it points out to Manitoba and to other people that they have an incredible treasure trove if you can set it up to preserve privacy and confidentiality. It just opens up something where you can really continue to innovate and continue to advance the state of the art. At the same time, you get support from more than just one ministry. Those are really important long–term events.

Noralou: I spent a whole lot of time worrying about privacy issues because that’s the one major area where you have got to be squeaky clean. You’ve got to be so careful. As soon as they set up a provincial privacy office here, we said, “We’ve got to meet with them.” It was something which was essential, but it was also something you really had to prepare for, and so within six months, we had a long meeting with them and established regular contact. We ended up being asked to test their privacy impact assessment before they implemented it more broadly. They asked us if we would pilot it, which was great because I think it showed their respect for our interest in trying to do things in the most enlightened publicly responsible way. We also worked through CIHR [Canadian Institutes of Health Research] and part of it was inspired by this. There was another centre, ICES in Toronto, which does similar kinds of work with administrative data, and we had CIHR support for a whole series of meetings. Paulette Collins organized that, probably eight years ago, maybe not quite that
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long. This was a really important attempt to figure out what other people were doing; if other people had best practices we could adopt or if we had worked through issues which they could adopt. It was a way of trying to set up some standards across these centres.

**Gail:** Knowing that this would be useful.

**Noralou:** Another obvious event was when the government changed from Conservatives to NDP. One of the things which we'd always done was to try and keep the opposition informed as to what we were doing, so they would be invited to presentations et cetera. We were told the new government went down a list of funded projects and decided some of them they were going to keep, and some of them they weren't. And there were some questions as to whether they were going to keep the Centre. We were in the middle of a contract but contracts can be bought out or broken. But they decided to keep funding it.

**Les:** We heard various rumours.

**Noralou:** Yeah, a lot of rumours.

**Gail:** So, your decision earlier on to keep the opposition well informed was important to your survival at this point.

**Noralou:** It was very important.

**Les:** And continues to be important.

**Noralou:** And to continue to be a neutral conveyor of evidence and not get involved in anything that is going to be seen as political.

**Gail:** I can see even as we're talking, that Noralou is focusing on the political.

**Les:** Oh absolutely.

**Gail:** And Les, you are focussing on research data.

**Les:** There's a clear division of labours.

**Noralou:** Different skills.

**Gail:** So it's interesting, and it works very well together.

**Noralou:** Yes, but again, I have huge respect for what Pat's doing because it's a big responsibility and it's not easy, trying to do this on your own. A combination of fund raising, staffing, there's just so much that you need to do to keep it going, so challenging.
Gail: Do other challenges come to mind?

Les: Working out the next ten years but that’s a challenge for everybody, right?

Noralou: It was always challenging getting the next contract signed, even when everybody agreed. You know we were, I don’t know, six weeks past when officially we should have sent out layoff notices at the university because we didn’t have our next contract signed. And everybody agreed it was going to be signed. It just wasn’t signed. That was I think the first or second contract. I had Arthur Mauro and Julian Benson, who was subsequently on the Treasury Board, meeting with the minister on my behalf. And I was there to argue for increased funding for the Centre.

Les: This is an issue of course which everybody in the public sector confronts and clearly the university is going through it now. It’s not only the regular expenses, but it’s also inflation and how do you deal with that?

Noralou: It’s why having the additional funding outside of the Centre is so important.

Les: It’s both practically important and it tells the government that you’re really trying. And that’s when the comparative advantage helps you. You could get the grants, and it helps you to wave the grants in front of the government and say, “Look at all the good stuff we’re doing.”

Noralou: Well in fact the first three years we were funded, it was not a government contract. We were funded by the lottery the first three years. On the first contract, we were told that we were expected to become self–supporting, that they would start us with a million dollars a year, for three years. After that, it was expected we would bring in so many grants that we wouldn’t require government funding. As we started the second year, I said to the Minister, “This may be true. We supported ourselves before the Centre started, and I’m sure we’re capable of supporting ourselves after the Centre if the government decides not to put any more funding in. But that means we don’t do projects for you. We do projects that we can get funded from other sources.” They sort of accepted that and decided that they would keep funding us.

Les: There was something else I thought was important. There is a real limit on the amount of funding you’re going to get in Manitoba from a given ministry. And we really pushed it with NHRDP [National Health Research and Development Program]. There was a period early in NHRDP that we were represented well above our population base in Canada but that was just a short period of time. The politics of research are such that we’re not going to get half as much money as Ontario gets, no matter how good we are. That’s just a reality. The other interesting thing on the research side, it’s really important to be seen as a magnet for the rest of Canada. I noticed on the CFI summary [recent successful national grant] that they mentioned the University of Toronto right up—front in terms of people we were collaborating with. And it was like the Centre will facilitate research at the University of Manitoba and the University of Toronto and so and so. It’s good in terms of the research—a different skill set, and it’s also really important in terms of the national profile. When we have a CIHR grant coming up and you’ve got people on it nationally it really helps.
Noralou: There's another thing which was important as the Centre evolved, and that is how our reports are released. Our first contract stated very explicitly that we had the right to publish the results of our research. And we certainly did. But the government was responsible for deciding when and how to release the reports we did for them. And because government is always fighting fires, several reports took a long time before they were released.

Gail: They all got released?

Noralou: They were all released, yes, but often it took six to twelve months before they were released. So when we developed the next contract, we wrote in that the government had 60 days after we submitted a report to them, during which time they were free to release the report as they saw fit. But after 60 days, the Centre was free to release the report. And that has worked well. That's been in every contract since then, which was a huge help because we could organize the release on our schedule. When the government was releasing a report, sometimes there was major media coverage. Reports were typically released down at the legislature. Sometimes, it was more media coverage than one wanted. If we released it, we released it directly. We didn't have the Minister there, and the Deputy wasn't there, although we would brief them before. But that was also a change.

Gail: It was a change which provided more credibility to the report as research, rather than as a government report.

Noralou: Exactly, and we always stressed to government that the major thing they were buying was external, arms–length research; otherwise they might as well have it all done internally. If we weren't credible, we were not very useful to them. So that was one of the key messages they understood. And you know, there was no report where we had a whole lot of pressure to re–write things, re–do things. Another thing which we established very early on, when we started doing our media friendly, public friendly four–pagers; is that we were responsible for developing those. While we always sent the reports to the government to say, “Is there any inaccuracy in this report?” we don't send the four–pagers to them because this is our popularized interpretation of our findings.

Gail: Is there anything else that you would want to say if you were giving advice to people who were starting up a Centre?

Les: Well we always thought that it's important to have something successful early on so you can show people what can be done. I think that's really important.

Noralou: And go for the easy stuff. I always said, “Whatever's available, get it and start there. Don't wait.”
CHAPTER 3: TELLING THE STORY

3.1 Dr. Paul Henteleff

Assistant Executive Director, Health Services, Manitoba Health Services Commission, 1972–74

“One of the roots of the success of the Centre was that Manitoba had extremely good records.”

The Manitoba Centre for Health Policy’s story starts with the data, Dr. Noralou Roos’ interest in it and Dr. Paul Henteleff’s willingness and ability to facilitate access to it.

As the Assistant Executive Director for Health Services of the Manitoba Health Services Commission from 1972 until 1974, Dr. Henteleff played a central role in helping Drs. Noralou and Les Roos get started turning MHSC’s routinely collected administrative information into data for health services research.

In fact, Dr. Henteleff said he applied for the administrative position at the MHSC because it was a chance to get into public policy related to healthcare. He had just completed a year of training in epidemiology and biostatistics at the London School of Hygiene and Tropical Medicine and was interested in population health. Dr. Henteleff’s division supervised the documentation regarding health services, which put him in a key position when Dr. Noralou Roos came knocking on MHSC’s door.

Dr. Henteleff said he met with Noralou Roos shortly after she arrived at the University of Manitoba. She related her background in health services research and asked if there was data available that would lend itself to the kind of studies she was interested in doing. He recalls his reaction: “I was very positively impressed by her and her background and was very interested in the notion that the health services data could be used for knowing better what was going on in the provision of services.”

MHSC, although subsumed into the provincial health department in 1993, at the time was an arms–length manager of the insured health programs in Manitoba (Toll, 2003). The three divisions of MHSC included finance, construction for hospitals and personal care homes, and Dr. Henteleff’s department, which collected information for the purpose of paying hospital and medical billings. Insurance to cover hospital claims dated back to 1958, while coverage for medical claims started in 1969 (Toll, 2003).

Knowing that he was new to the position, Dr. Henteleff consulted with Reg Edwards, who managed the finance division. Dr. Henteleff referred to him as an experienced, knowledgeable, and “model civil servant,” noting he subsequently became the deputy minister of health. Dr. Henteleff was reassured by his advice: “When I told him that Noralou was there looking for access to the data, he said, ‘Well, thank goodness. There has to be so much information in there. At last somebody is going to put it to use.’” With this encouragement and excited by the potential for significant learning, Dr. Henteleff proceeded to facilitate access to the data.
The Story of the Manitoba Centre for Health Policy

1970s Process

The information that the Rooses used for their initial research projects was collected in order to pay the medical bills, consequently there was a strong incentive for physicians and hospitals to submit it, and MHSC had a fiduciary obligation to ensure its accuracy. The written information on the medical claims side, which provided the data for the first study, included the name of the person who was being seen, the name of the doctor, the diagnosis (which was “a one word diagnosis not elaborate”), and the specific service for which a claim was being made.

Dr. Henteleff spoke highly of the staff in both divisions, remembering them as very conscientious and capable: “I remember the man who was in charge of the medical claims side was a real sleuth. He was just so competent.” Sleuthing involved reviewing the claims, searching for errors or billings that “over-stated the basis for the claim,” and checking with trusted physicians in the community to ensure appropriateness. “The point isn’t what the misrepresentations were about. The point is that there was somebody extremely conscientious about seeing to it that it was done right.”

In the 1970s, the claims were submitted on cards. “The material was processed mechanically by machine, not computer. … We went through them to see just what the raw data looked like, which was instructive. Noralou got a very strong motivation to always look at the raw data. How rich it was.”

“That got it started. That was the first publication. Now, they weren’t really established as the Centre in the very official way. That came a few years later. It was simply a research group because I believe her husband Les was involved with them early on too, with handling data.”

Confidentiality Issues

“There may well have been a letter of understanding but it would have been done, not by me, but by the Director of the Health Services Commission. My recollection is in a rosy frame of trust and respect.” Confidentiality issues were soon raised.

There was a committee that had to do with confidentiality, and there were some outside advisors who were involved. … They were looking at whether private information was safe in the hands of the Health Services Commission. … One of the participants was extremely uneasy about the amount of data that was now being made available to an outside independent body. I defended Noralou saying: “Her whole career hangs on not deceiving in this. Her whole career hangs on it. So I think that’s enough reason that you can trust her.” Anyway, it went by. It was passed. It was accepted.

Subsequent to this, a system was devised to extract and sort data in a form that could be linked to a specific individual yet remain anonymous. This was possible because there was a family registration number and an individual number subsidiary to that so you could follow the services provided to individuals. Dr. Henteleff remembers that taped files were processed once a year “to draw off and reassemble the data at very low cost in the form that Noralou could use for other research.”
Vital Statistics
Initially, Manitobans paid an annual medical fee and registered with MHSC every year to validate their Manitoba health insurance card. So information about births and deaths and moves into and out of the province were available to the system because the family registered them in order to receive healthcare. This allowed MHSC to know who was registered for insured services, but it was dropped early—on because of the expense, creating a weakness in data regarding the base population. Even though he was no longer working at the MHSC when the problem arose, Dr. Henteleff assisted in resolving this limitation in the data by essentially arranging for the first data linkages.

Knowing that provincial vital statistics have all the records about births and deaths, he approached them to transfer this information to the base records of the MHSC. However, the staff at Vital Statistics objected to releasing births and deaths data to a researcher. “They said there was no way they could release it. And I said, “But just a minute, you’re a government department, and they’re a government department. Is there any barrier between you and them if it comes to transferring death from vital statistics to Manitoba Health Services Commission so that the other branch of government can close their files?’ ‘Nope no barrier at all.’ So that’s how it got started.”

Reflecting on the tasks required in starting a centre for health policy based on analysis of database, Dr. Henteleff commented: “What I’ve told you about has to do with all local conditions, people, the environment, understanding the local government and politics. … You’re going to have to look after them all. There are no short cuts.”

Unlocking the Data
Dr. Henteleff and his staff at the Manitoba Health Services Commission made the Manitoba Centre for Health Policy possible by making the data available to Noralou Roos for research, by collaborating with her in the early research projects, and by working out solutions to confidentiality issues in ways that allowed tracking the health services provided to individuals and eventually linking anonymously with other databases.

The Rooses worked with anonymized extracted MHSC data for about 15 years and over time added different sources (Vital Statistics, Cancer Registry, education and social services, for example). But it began with Dr. Henteleff and his staff’s interest in and willingness and ability to facilitate access to the data for the first research projects on tonsillectomy practices in Manitoba.

This important contribution is summed up in his symbolic wish: “I have a big brass lock, and I’ve never done anything with it but I’ve always had the idea I’d like to give this to Noralou, and say, ‘This is the lock that was opened so you could get at the data.’”
The First Research Article and Its Aftermath

The following account of how the first research article came about is based on excerpts from an interview with Dr. Paul Henteleff. Fore-shadowed are some key issues that continue to challenge MCHP, such as validity of the data; access to data in a way that protects confidentiality and privacy, but allows tracking of services to individuals; dealing with the media's presentation of research findings; and relationships with practicing physicians.

“This is an old memory, but I know what our first project was. As I remember it, Noralou and I talked about what kind of studies could be done with this for purposes of evaluating medical care. And I said: ‘Well there’s one piece of medical service that has a very distinct quantitative element to it. The standard is: three episodes of tonsillitis is a reason for doing tonsillectomy because people who’ve had that many episodes are better afterwards than they were before compared with people who have a tonsillectomy with fewer episodes.’ That was her first publication based on these records.

“We had to work out how precise do you have to be with what’s written there. Well what if it says sore throat rather than tonsillitis? Do you accept that as tonsillitis, or not? We just made a full word list of diagnostic terms that weren’t precisely tonsillitis but might very well be written casually by a doctor to describe why he or she was seeing the patient at that time. Then we had to decide what if the patient was seen by more than one doctor, and there were various considerations like this that came in. The other thing we were interested in is, ‘Were they being seen by a family doctor, or were they being seen by a pediatrician?’

“So we had, we had all the original cards. That would be impossible nowadays. With this confidentiality, there’s no way those cards, with names and everything on it, would be shown to a researcher by a government office. It was just done in trust.

“We realized when we got into that tonsillectomy business that in effect it was a critique of medical practice, and we had a meeting with people from the College of Physicians and Surgeons to explain what we were doing, and they didn’t see any problem with that.

“And we said, ‘Would you like us to come and show you the results before publication?’ And they said, ‘No, that’s not necessary.’ And it was published and nothing happened until a year or two later. This is the way I understand the story. I wasn’t directly involved. I understand that a journalist was talking with somebody at the University of Manitoba about various kinds of research going on, and the tonsillectomy study was mentioned. It was written up in the newspaper because it found that hardly any of the tonsillectomies appeared to be justified by the accepted criteria for carrying out the surgery. And I vividly remember that my picture was in the newspaper, and I got called to appear at the College by a very angry surgeon who had a very senior role in the College of Physicians and Surgeons. Not Noralou. I was called.

“They argued but you know when it came to saying, ‘These are the findings. Do you find anything in those reports that you find doubtful or suspicious or unbelievable? No.’

“What was unbelievable was how poor the standard of practice was. That’s what was unbelievable. We were on very strong grounds. I never got any repercussions outside that small meeting.”
Later, Dr. Henteleff’s wife commented that they received so many angry calls from physicians they considered getting an unlisted phone number. Despite this, Dr. Henteleff’s peers later elected him to a position at the College of Physicians and Surgeons, substantiating his evaluation that there were no long–term impacts on his career.

The First Research Articles Using Manitoba’s Administrative Data


3.2 Dr. Fraser Mustard

President, Canadian Institute for Advanced Research from 1982—1996
Advisory Board Member, Manitoba Centre for Health Policy, 1991 to–date

“It is interesting you know, it’s turned out we were able to do what we thought it could do.”

It seems fair to say that Dr. Mustard catalysed the formation of the Centre. When you ask people how the Manitoba Centre for Health Policy got started, everybody mentions Dr. Fraser Mustard’s influence as a significant factor. In the late 1980s, Dr. Mustard was already a larger-than-life figure. Formerly vice-president of the Faculty of Health Sciences at McMaster University (1972–1982), his widely recognized accomplishments resulted in more than 15 honorary degrees, induction into the Medical Hall of Fame, and being made a Companion of the Order of Canada, among others (Canadian Institute for Advanced Research, 2009b; Canadian Institute for Advanced Research, 2009a; J. Fraser Mustard bio, 2009). He influenced health policy in Canada through service on many federal and provincial committees, councils, and royal commissions. He had the ear of health ministers across Canada, not to mention many of the senior people in the Manitoba government and at the University of Manitoba.

Both Drs. Noralou and Les Roos indicated that Dr. Mustard played an important role in their careers long before the Centre was established. Les Roos said that joining the Population Health Program of the Canadian Institute for Advanced Research (CIAR) gave them “a lot of visibility, both with the university and with the government.” Dr. Mustard created the CIAR in 1982 to bring together senior scholars and leading researchers from Canada and around the world to collaborate on complex research programs. In 1988, he and Dr. Bob Evans, the Director of the Population Health Program of CIAR, recruited Drs. Noralou and Les Roos as associates. He described the fit between their research programs:

The government of Manitoba had good health records. It’s a publicly financed healthcare system, and as a province they set up a good record system which the Rooses used to look at the healthcare system and health. We had established a program in population health to look more broadly at the social determinants of health, not just healthcare, to better examine how the social environment sets health risks. The Rooses had the potential with the files in the Manitoba government to start to look at society and health. This included healthcare but also the broader social factors that influence health.

Explaining the rationale for recruiting Drs. Noralou and Les Roos, he credits the Population Health Program with its interest in the social determinants of health for playing a key role in stimulating the Centre’s existence: “The Rooses knew the value of the database. The Population Health Program needed access to an integrated database to do its work. So that’s why we approached the Rooses and the university and the government.”
Dr. Mustard said that Donald Orchard, the Health Minister, and Frank Maynard, the Deputy Minister of Health, were already on–side with the ideas of the Population Health Program. He recalled that they approached him with the suggestion for setting up a government–supported research centre at the University of Manitoba. However, both men indicated that their commitment stemmed, at least in part, from prior exposure to Dr. Mustard’s teachings on population health. Donald Orchard said Dr. Mustard’s insightful comments stood out in his reading of Michael Rachlis book “Second Opinion,” motivating him to seek a meeting. From Frank Maynard’s report, it was Dr. Mustard’s presentation to the ministers of health and senior public servants in Charlottetown in the late 1980s that got him excited about the potential for examining health from a broader perspective. After this presentation on the determinants of health, he arranged for Orchard and himself to meet with Drs. Mustard and Evans. This occurred on September 29, 1989, and according to a CIAR report, “The minister and deputy minister of health in Manitoba, in particular, have taken a close interest in the activities of the Population Health Program, and have drawn on its conceptual and research base for the development of the philosophy behind their health programs, and in their public documents” (CIAR, 1992).

Setting up a research centre required obtaining agreement from many departments. Dr. Mustard said: “That involved getting the Rooses to be on–side with this idea, getting the Medical School to be on–side with the idea.” The dean at the time was Dr. John Wade. “I think the President was Arnold Naimark, who was on–side with the idea. So they, Orchard and Maynard, had us make a presentation to the Cabinet ... to get Filmon [the Premier] and the Cabinet to agree with it. They agreed to setting up the centre.”

Dr. Mustard was instrumental in pitching the Centre to others in the Manitoba government and successfully advanced the vision of the Centre. He mentioned two other individuals who also promoted addressing the population health approach within government: He said Frank Maynard “Understood it, put it forward very well, and then another member of the bureaucracy, who was also a Deputy Minister, Tom Carson, he took all the information about the socio–determinants of health and used the material to talk with other senior public servants.”

Dr. Mustard added: “It wouldn’t have occurred without the support of the government of Manitoba and without the support of the university, and of course, the thrust of the Canadian Institute for Advanced Research Population Health Program, which we felt that the Rooses should be part of the program.”

Dr. Mustard has served continuously on the Advisory Board of the Centre from its first meeting in 1991 until the current writing. He explained the role of the Advisory Board as one of “Maintaining equilibrium between the government’s needs and studies of healthcare and the social determinants of health. A key issue was how the results of the studies are made public. We acted as a kind of a buffer body between the government, the university and the communities, including the professionals.”

As indicated, Dr. Mustard has influenced research into the socioeconomic determinants of human development and health. He credits this as the incentive for his involvement: “You get into the deeper issues of what does determine health. So that’s why we started it, because we knew that the
database would be there that could be used to unravel how the social environment gets under the skin to make you vulnerable to health problems as well as the ability to learn and your behaviour.” His involvement with the Centre positioned him to promote further investigation into the role that communities play in early childhood development and how this subsequently affects the health of the population. He indicated appreciation for Dr. Noralou Roos’ understanding and support for this research program:

Noralou is very bright and diplomatically skilled in doing this. She understood that we were really talking about human development and health. She caught on to the fact that early human development has effects on health in adult life. … If you look at the inequities in education, they match the inequities in health. … So she has had some of the people in the Centre look at … early human development and how it sets health effects, how it affects education in the school system. They’ve shifted the program to look at factors influencing human development, health, and education.

MCHP’s data is key to this research: “I’d say Manitoba has one of the best opportunities to be able to show the development of its population and how you can reduce problems in learning behaviour and health. This requires integrating knowledge about conception right through to old age.” And he concluded: “It is the only unit that’s been established in Canada that can do this work. It integrates all the functions which are affected by the way the brain develops.”
3.3 Dr. Arnold Naimark

Dean of Medicine, 1971–1981  
President of the University of Manitoba, 1981–1996

“When it comes to identifying groups in the faculty that have done outstanding work, I would place the Centre high on the list. I was keen on it from the beginning, and it has delivered admirably.”

Dr. Naimark was President of the University of Manitoba at the time the Manitoba Centre for Health Policy and Evaluation was launched. Prior to his tenure as president, he was the Dean of the Faculty of Medicine and was instrumental in developing the faculty structure that subsequently provided a home for the Centre.

Reflecting on his approach upon becoming dean, Dr. Naimark stressed the importance of the prevailing context. “As a new Dean, one thinks about where the medical school should be heading in relation to advances in knowledge and changes in society and what the medical school has as a foundation to build on.” In describing the contextual factors bearing on the evolution of the Centre, he noted: “The Centre represents the confluence of two streams of development. One originated in the social transformation of medicine into a public enterprise as a result of the introduction of universal health insurance; and the other in the changes in the priorities within certain schools in the University of Manitoba.”

He explained the first stream: “It became clear that the ramifications of Medicare would include a variety of social and economic phenomena that were appropriate subjects of academic study. My predecessor as dean, Bill Fyles, had recruited David Fish into the Faculty of Medicine as essentially a “medical sociologist at large” with an appointment in the Dean’s Office.”

Dr. Naimark said the Department of Social and Preventive Medicine, composed of a few part-time professors with traditional public health program concerns, had for decades played “a miniscule” role in the Faculty of Medicine.

So there I was with a department that was a vestige of an earlier era and an interesting fellow who was a medical sociologist without a home. By transferring David to the department we not only found a home for him but also provided a base from which he, as a talented agent provocateur, was able to create a home for other social scientists interested in the healthcare system.

With the foundation that Dr. Fish established in the Department of Social and Preventive Medicine and collateral developments in the Northern Medical Unit led by Dr. Jack Hildes and the Department of Family Medicine under Dr. Gary Beazley, the community–based activities of the aforementioned units formed the Division of Community Medicine, one of four program divisions in the Faculty. Dr. John Wade succeeded Dr. Naimark as dean and played a major role in facilitating the merging of the Department of Social and Preventive Medicine and the Northern Medical Unit to form the Department of Community Health Sciences.
Dr. Naimark noted the second stream of development was the flow of events involving Drs. Noralou and Les Roos. They joined the Faculty of Administrative Studies in 1973, subsequently obtaining joint appointments to the Faculty of Medicine. At the time the name of the Faculty of Administrative Studies reflected a broad view of the types of organization that were of interest to the Faculty. By the time Dr. Naimark began his tenure as president in 1981, new leadership in the Faculty of Administrative Studies wanted to focus the Faculty’s area of interests more narrowly on business enterprises. This led to a desire on the dean’s part to “rationalize” the roles of Drs. Noralou and Les Roos because their interest in public enterprises no longer fit with the corporate philosophy of the faculty, renamed as the Faculty of Management, and recently the Asper School of Business. In 1988, Dr. Naimark, as President of the university and in consultation with Dean Wade, orchestrated the transfer of the Roos’ salary lines to the Department of Community Health Sciences and the termination of their appointments in Management. And so the Rooses ended up in the Department of Community Health Sciences in the Faculty of Medicine.

By then, of course, Noralou and Les had done substantial amounts of work and had developed close relationships with the provincial government. They worked hard to persuade the provincial government that they could be relied on to ensure their use of administrative data would be conducted with rigorous protection of confidentiality and privacy.

Dr. Naimark indicated that while he was president and since, his role was and is mainly one of “cheering from the sidelines” and attending to formalities such as approving contracts on behalf of the university with the government. The attitude towards such contracts was a little different back then: “It was interesting that from the time I served as dean and through much of my presidency, there was a rather snooty attitude at the university about research relationships with either private corporations or governments, and a kind of defensiveness about it.”

Dr. Naimark indicated that he did not share these concerns: “I thought it was something that the government should have been doing for a long time. We need input from researchers and advisors who can provide us with evidence that we need to manage the healthcare system rationally.”

The efforts to establish a formal institution, the Manitoba Centre for Health Policy and Evaluation (MCHPE), came during John Wade’s tenure as Dean. Dr. Naimark commented on both their roles at this time:

He played a very important part in the initial implementation of the idea and in nurturing it when he became Deputy Minister of Health. Over time I had a couple of indirect connections with the Centre in that I was on the Research Council of the Canadian Institute for Advanced Research when the CIAR, now CIFAR, developed a Program on Population Health with Noralou Roos and Les Roos as part of that research group. Fraser Mustard, who was the Founding President of CIAR, and I had been colleagues for many years and shared a strong interest in the development of the MCHPE.
Dr. Naimark commented that without the support the Centre has received from government, the University of Manitoba may very well have lost Drs. Noralou and Les Roos, who are among the most productive and successful researchers at the University of Manitoba. He pointed out that that support has provided a level of funding stability that allowed for thematic research development. Underlying that support was the willingness of Manitoba to, in effect, allow its health system to be a laboratory in which social statistics and administrative data could be mined in order to provide real world evidence for informed policy making.

After stepping down as president in 1996, Dr. Naimark founded and became the first director of the Centre for the Advancement of Medicine, and in this role is often asked to help out in faculty developments. Referring to himself as “an expired university president,” he indicated that one task that he performed in support of the Centre was to act as an informal reviewer for its Canadian Foundation for Innovation application for funds to develop its current facilities in the Brodie Centre. He said, “I had the advantage of being able to provide suggestions from my vantage point as a recent university president and my familiarity with the origins of the CFI.”

Reflecting on factors that people attempting to set up a similar centre elsewhere might need to consider, he said: “Success in convincing the powers that be in the university or in a faculty to support the development of a centre will be influenced by the extent to which they see the centre as being a vital organic part of the whole enterprise and not as a subsidiary enterprise that might as well be in the Barbados.”

Long term success depends on sustaining healthy relationships within the faculty and university. So, his general advice for people wanting to replicate a similar centre in other places is for the proponents of a new centre to be mindful of the need for centre staff to serve their full role as academics, by participating in the overall governance and development of the faculty, “because in the long run, the commitment of the faculty to the indirect support of the centre will depend on whether the centre is seen as a fully engaged participant in the life of the faculty and university.”

He added that careful stewardship of relationships is also essential in dealings with government. “Governments change; priorities change. So if you want to give a research enterprise a footing that can ride out changes in the political ideology of the government, you have to make sure that you have strong and positive relationships with all parties in the environment.”

Dr. Naimark pointed out that a successful contractual relationship with government spanning 20 years and longer is “highly unusual.”
3.4 Dr. John Wade

Dean, Faculty of Medicine, 1982–1988
Deputy Minister, Manitoba Health, 1995–97

“This was an area that we could be world class in. And everybody talks about being world class but we could really do it.”

“I was the dean who formed the Department of Community Health Sciences, which was really the origin of the Centre for Health Policy.” This was perhaps an unusual direction for the former Head of Anesthesiology to take, and Dr. Wade said he took “a bit of flack” for this decision: “A lot of basic scientists, of which I was one, thought this was pretty soft stuff.”

Explaining what led him to depart from the traditional view of health and head off in a social policy direction, Dr. Wade emphasized his work in front-line medicine as a rural GP and later with Dr. Jack Hildes, as an anesthesiologist in Churchill and a Family Medicine physician in Norway House. “And so I became exposed early on to the Northern Medical Unit, to the problems of the Aboriginal peoples. And as Jack said, we were just doing band-aid work. Nobody was really looking at how we were going to prevent all this illness.”

The social context was influential in his thinking as well, as he explained:

I trained at UC San Francisco and lived through the tumultuous years of ’65 to ’68. That was the time in American history that all kinds of social issues were occurring: the Vietnam war, free speech at Berkeley, the Black Panthers, the race riots, and then the flower children, the drugs and Haight Ashbury. And so, you really get a different perspective on social issues than you get from living in a small town or a city like Winnipeg. It was a time of great change and a lot of social activism and social issues. And I’m an anesthesiologist, but I was doing a lot of critical care at that time, so you saw it all. After awhile you realize that fixing people up is one thing, but the origins of their diseases, their problems were quite different. And we were just picking up needs on the back end. Nobody was looking at the front end.

These influences primed Dr. Wade to a broad philosophical base to medical practice. When he started as dean, he met with faculty and the community to develop a strategic plan. “We looked at where this medical school might go. It’s a strong basic science medical school, but we needed a plan. How could we be the best in things, rather than just trying to be another Harvard or UC San Francisco? One of the areas that came up was the whole area of community medicine.” As a practising physician, Dr. Wade was aware that data on the Manitoba population’s use of healthcare existed. In fact, he knew of the origins of the database in the 1940s (see page 28) and saw its potential to benefit public policy: “As a dean, I saw the opportunities for research and excellence in education. It was all there.”

So, with the backing of Jack Hildes, Arnold Naimark, John Horne, Brian Postl, and particularly, David Fish, “we formed the Department of Community Health Sciences.” Recognizing leadership potential in the young Dr. Brian Postl, Dr. Wade appointed him to be the first head of the newly
formed department.

**As Deputy Minister of Health**

Dr. Wade's own appointment as dean ended prior to the Centre's establishment, but he played a role again in his position as Deputy Minister of Health. But first, he followed up his interest in policy with Phil Lee at the Institute for Health Policy at the University of California in San Francisco and his interest in economics as a visiting scholar at the Stanford School of Business. California was doing interesting things with database research, and Dr. Wade thought there were applications for the work being done in Manitoba: “It was clear to me after working with Phil, that it was something that Manitoba ought to do. … This was an area that we could be world class in. And everybody talks about being world class but we could really do it.”

Upon his return to Canada, he did some consulting work, chairing a review, The Future of the Healthcare System for Donald Orchard, Minister of Health in Manitoba. “We had this database, and we had good people. … The Rooses were using the database and they understood [it], but there was no structure.”

Dr. Wade credits many people, some of whom later became leaders in the system, with the concept of an infrastructure to support the database work, naming Brian Postl, Don Orchard, Phil Lee, Fraser Mustard, Cam Mustard, John Evans, Charlyn Black, Mike Moffat, John Horne.

The Rooses were really keen on an institute. It was really Orchard who provided the money to create the Centre for Health Policy, and it was Brian Postl who made sure it was within the university, not within the government. … I felt strongly about it being within the university because I think the last thing we needed was for this to be under the government arm. And they had to have some independence and some intellectual freedom.

There was a funding agreement. The government would ask six questions of the Centre on an annual basis, which they would answer in terms of public policy. … And then they would be free to publish and get grants and have graduate students, the whole bit. So that was the vision.

**Crunch Time**

Dr. Wade was the deputy minister of health during a time when many government–funded programs, including MCHPE, were vulnerable to funding cuts. “Now I happened to be deputy during the crunch time, you know ’95. There was a lot of cost cutting. The feds pulled back. We didn't have resources. … We were cutting everybody. It was a bad time. … The government could have blown the Centre up. It was vulnerable. It was vulnerable.”

He credited two factors for the Centre’s survival: first, the Centre’s placement within the university, and second, the support of key people within government who advocated for the Centre. “If it had been part of government, it would have got cut. I think the fact that we had it in the university protected it. And they had a lot of support. Orchard, while he wasn’t the Minister of Health, was still quite influential.” He also cited strong support from then Minister of Health James McCrae and
Associate Deputy Minister Frank deCock. And Dr. Wade felt strongly about the importance of the Centre. “I was a deputy, and that was the last thing we were going to cut. And we did not cut. It was maintained through the biggest cost cutting we’ve ever gone through. It was protected.”

With reference to cost cutting, Dr. Wade pointed out the emergence of a long–standing issue with physicians: “The gurus, the economists, said ‘Well, if you want to control costs you do two things. You limit the number of doctors in the system, and you limit the number of beds, which means limiting the number of nurses. And so that’s what happened. And we’re only now beginning to recover. It wasn’t a wise decision, but that’s where the cuts were.” He added that one of the Centre’s early assignments was to look at this issue, which may have resulted in some long–lasting anti–Centre sentiment from physicians. “I think a lot of it was provoked by the human resource issues. … There was a lot of opposition to their data by the physicians, and the physicians have been anti–Centre. I never quite understand that, except I guess a lot of us don’t like people saying maybe we’re not doing the right thing.”

Dr. Wade also spoke about physicians’ orientation to medicine: “I think a lot of the docs just didn’t understand. They weren’t brought up in population–based medicine. … We were really good at fixing people who were sick. We taught; we did the hard science kind of research, physiology, pharmacology et cetera. Going into the era of population–based medicine and a different view of the world, that is taking time to evolve.”

Pointing out that although restricted resources are a real problem, they are also an opportunity for great change. During his term, changes included the move to regionalization and implementing centres of excellence for example, for different kinds of surgery. And of course, with these momentous changes to the system, the data analysis that the Centre was capable of providing was helpful, although Dr. Wade qualifies this: “Having the data and influencing policy is really difficult even if you’ve got evidence–based data because politics always trumps evidence. … I think it does influence policy, not as much as a lot of us would like to see, but it does have an influence.” He concluded: “It’s been a great venture and the Rooses have done a great job, and they’ve produced some outstanding people.”

**The Origins of the Database**

“Before there was Medicare, there was prepaid medical care in Manitoba.” And according to Dr. Wade, the majority of Manitoba’s population was covered: “I think 80 to 85 percent of the population was covered by Manitoba Medical Services.” The Manitoba Medical Services was a doctor–sponsored and run medical insurance plan that provided coverage to subscribers for both hospital and physician care. The plan was incorporated under an act of the Manitoba legislature in 1938 (Taylor & Owen, 1954); the organization had its first board meeting in 1944 (Mayba & Cooke, 1996); and it ran until Medicare was introduced in 1968 (Mayba & Cooke, 1996).

Dr. Wade said membership in the plan was boosted by involving labour and business: “When I look back at the original board, because I’ve been involved here a long time, one of the things they did was they brought in people from the labour side. They were very prominent members of the board of the early Manitoba Medical Services. Labour would negotiate in their contract with their employers the funding for health services.”
The Manitoba Medical Services was important to the eventual evolution of the MCHPE because, as Dr. Wade explained, “They were early on, into computerization. It was a business; it was a non-profit corporation. So they computerized the billings, and they established the unique patient identifier.” Dr. Wade explained the rationale for the computerization:

The reason they did it was because they were paying doctors their fees. So they ran a profile on each doctor, and if you were doing things that they thought weren’t appropriate, they wanted to know. You’d get a phone call, and they could pro-rate. … Usually they would pay 90 percent of the actual billings. Well, if you were outside the curve, or not behaving, they’d pay you less. So they ran it, and they were tough.

The physicians controlled the Manitoba Medical Services. “The docs of the day sat on the board. I think the docs always controlled it, and the docs did the policing.” Dr. Wade continued: “There was some early leadership here. Doctor J.C. McMaster ran it. The docs of the day, they were powerful people, such as P. H. T. Thorlakson and M. R. MacCharles. They were forward-thinking. And they didn’t want a government to take over.” Dr. Wade recalled: “There was a big debate about that. They wanted to keep the physician-run billing side. And then for those patients who couldn’t pay, they would be subsidized.” But as we know, Medicare came in, and government assumed more control.

Incidentally, the Manitoba Medical Services left a legacy that further benefitted population health research: “When Medicare came in, the docs of the day said, ‘Look, we got some equity in here, but instead of just giving us a couple of hundred bucks, why don’t you take that and put it into a fund and use it to develop research and education. And that’s the basis of what’s now the Manitoba Medical Services Foundation.” The Foundation provides operating grants and personnel awards to clinician scientists and population health scientists, in addition to basic scientists and has contributed to research efforts at the Centre. In 2000, the Foundation established a Clinical Professorship in Population Medicine. Dr. Alan Katz, currently Associate Director of Research at MCHP, received grant and salary support for 2006—2009 for a population-based research program in primary care prevention (Manitoba Medical Services Foundation, 2009).

“At any rate that’s the story, and that’s why we have the database. It was not government. It was just because the docs of the day wanted to police their payments because if people were over-billing, it was coming out of other doctors’ pockets, so they were tough.” Other provinces also had similar programs, but Manitoba had a unique combination of factors that allowed it to be used for research. “When I practiced in Alberta they had a similar program but they weren’t into computers as Manitoba was. But the best database of all was at Saskatchewan. They were better than us but they didn’t have anybody to mine it. They’re just now getting there.”

And Dr. Wade concluded: “That was the origin of the database. And they had unique patient identifiers that go back into the 50s and 60s. You’ve got the longitudinal, as well as the cross-sectional data.”
3.5 Dr. Brian Postl

Department Head, Community Health Sciences, Faculty of Medicine, University of Manitoba, 1988–1994
Chair, Advisory Board, MCHP since 1994/95; Member since 1991
CEO, Winnipeg Regional Health Authority, 1999 to–date

“The government of the day was quite progressive in their view of this. They allowed it to be structured in a way that they didn’t have full control but they could set a bit of the agenda, the questions they needed answered.”

Dr. Brian Postl was Head of the Department of Community Health Sciences when the Centre was established and in this role was involved with the Advisory Board from the beginning, first as a member, subsequently and to–date as the Chair. This long relationship with research using administrative data began when he was a resident in Community Medicine. Pointing out that the academic component for his residency was within Social and Preventive Medicine, he said,

My exposure to the Rooses and some of the work they were doing was probably the first introduction to what later became the Centre. At that point, it was just peer–reviewed research that they were undertaking. Now, if you fast forward a few years, the Division of Community Northern Medicine and Social Preventive Medicine were merged together, and I became the first head of the combined department.

The first discussions of the concept for the Centre took place within a specific context, which Dr. Postl sketched: “That was going on roughly through the early stages of what would broadly be called healthcare reform of the late 80s, early 90s. There was growing interest from government in trying to find data that could be used in an evidentiary way to help remodel the system … to help them make decisions about restructuring.”

The Deputy Minister of Health, Frank Maynard, had already approached Dr. Noralou Roos about the possibility of providing some help to government in addressing these issues. When she asked Dr. Postl for his opinion, he answered that there was more potential than just responding to a few questions:

“From what I know of your work and the capacity of the database, it seems to me that the relationship needs to be a more formal and a broader one that says, ‘How can the academic strength of the Centre in combination with the practical strength of the database, that was created because people had the foresight to recognize it might be useful one day, come together in a way that could serve government decision making and policy finding?’” … I think Noralou wasn’t sure that this was possible, but she liked the idea. … So I think that little thing became the root.
Others recalled the interchange a little more graphically, perhaps taking on a bit of a legendary tone, adding to Dr. Postl’s reputation for entrepreneurial spirit, people skills and political abilities: “And Brian said, ‘Are you kidding? Ask for over a million.’ Brian just had political smarts and was always available to provide really thoughtful, politically astute guidance.”

Dr. Postl remembers his arguments to government representatives, saying something like:

> Well, never mind the one–offs. These things are never going away. You know the health system is never static, never has been static, never will be static. There will always be pressure to change and improve. And wouldn’t it be sensible to try to build a relationship where you could ask questions of an arms–lengths group but you could then determine in your own context whether there was some policy relevance to the answers?

Dr. Postl said that Maynard was open to this broader proposal, perhaps because he already knew the power of the database for providing support for specific projects and he recognized that there would be many more questions as the re–structuring of healthcare unfolded. They also agreed with the necessity of an arms–length relationship and the preservation of academic independence.

Dr. Postl recognized the potential dangers to academics of government contracts: “Now you know the sceptical part of me would say that’s what governments did through the early 90s. They found cover to do what they bloody well wanted to do, which was to reduce the envelope. I think a lot of folks got a little trapped in that.” He said that it was easy for groups working for government to be seen as tainted because “they were more directly in the employ, or seemed to be more directly in the employ of government.” He contrasted this with MCHP’s arrangements:

> The beauty of what happened with the Centre was that we managed to keep it arms length enough that it was never tainted with this—that they were feeding government what government wanted. They were giving government a set of information and data, and then if government chose to use it in certain ways, that was their business. That was fortunate. … The contract we evolved was very clear that this remained an academic exercise. The interventions of government were at choosing projects and participating in the fact–finding around projects, but that they had no capacity to influence the content of the product. Nor could they delay the publication of it for more than the agreed period, and we had it at 180 days if I remember. So they could fob it off for six months. They could try to ignore it for six months. They could prepare for it for six months, but at six months it was coming out, and it was a public document.

Dr. Postl indicated that despite governments’ strong need to control communications, this has not been an issue with respect to the Centre’s publication of their research results. He said, “I’m not aware of a single episode now in 20 years, where I’ve sensed the government was trying to arbitrarily or unfairly influence a paper that was coming out.” The government has on occasion required
clarification or wanted some factual changes, but they have respected the Centre's academic freedom to publish what they saw as being there. He added, “That part has been remarkable to me because that's not the nature of governments.”

**Advisory Board**

The Advisory Board was initially co–chaired by Dr. Noralou Roos on behalf of MCHP and Frank Maynard on behalf of Manitoba Health. Dr. Postl assumed the chair’s responsibilities after the 1994 review of the Centre recommended that the chair should be external to both organizations. He has chaired the Advisory Board for about 15 years now. He recommended changeover to the 2005 review of the Centre. This was a time of transition for the Centre, and he said, “They got way too nervous. … Once I have the sense that everybody’s comfortable, and there are no imminent threats on the horizon, we’ll find someone that can take some time and move in.”

From the beginning, the Board was important in ensuring an appropriate balance of power between the government and the Centre.

It was a fascinating board. Both sides had to give something up. One of the ways we could ensure that government didn’t exercise too much control was having an advisory board that was jointly appointed. So each side got to name four or five members, and it really created that balance where the university couldn't pretend that they were totally disjointed from the whole thing and could ignore policy needs. And the government couldn't pretend that they could control it. The board became the interface for kind of growling at each other about “what’s next?” It has managed that interface in an interesting way, because the board has no power or authority under the university or under government, but its presence has allowed some of those tensions that would normally develop, to be managed before they amount to much.

This puts the Advisory Board in a position to protect the interests of both government and the university:

The government may have worried early on about just giving money to a university. They do lots of that. The money disappears. The university claims academic freedom … The government was always worried that they would lose the capacity to generate useful material. They would just give money to the Centre, and then the Centre does what it wants. In a very short period of time it would lose relevance to government. So I think there was always a bit of that tone, that the board can ensure that the government did have access to the Centre in an effective way. … They have learned that the interface through the board and with the director has to protect that academic role and capacity, and that it doesn’t serve anybody for them [Centre] to be seen as owned by government.

The Advisory Board’s ability to advance the government’s interests can be deduced from the
commitment of its members. Dr. Postl called the number of deputy ministers sitting on the board remarkable adding, “You’d have trouble getting that number of deputy ministers at a government meeting for deputy ministers. So they’re pretty engaged.” Dr. Postl highlighted a few memorable issues that the Advisory Board has assisted with or discussed over its 20–year history:

There’ve been always fascinating discussions about the role of the Centre. The board has done some significant work in helping continue with funding from government. Those interventions have always been useful. A lot of discussion about the multi-disciplinary capacity of these data sets that ended up supporting the addition of many other data sets now through linkage, now measured in the dozens. So that really brought in Family Services and Housing and Education in very significant ways, all of whom now sit on the board. The whole debate about where it should be placed in the university has come up repeatedly. There’s always been a view that maybe it should be a university centre, not a Faculty of Medicine, Department of Community Health [centre].

Some board members suspect the Centre would achieve greater status from a campus–wide placement, and perhaps less potential for conflict over control of Centre resources. However, Dr. Postl commented: “the Centre has used the board chair and the board to offset in both directions. In some ways that’s why I think the board has been effective by its presence. Not necessarily by anything that happens in a meeting.”

Placement within the University and Relationship with Physicians

To–date, the Centre remains placed within the Faculty of Medicine, which highlights and focuses its role on health:

Its presence within a medical faculty gives it some important traction around health issues. I think they would lose a lot of traction if they were seen to move away from the health impacts of a lot of that stuff. I think government would have much less interest. There’d be interest but Departments of Education and Family Services have relatively little power in government compared to the Department of Health. So if Health is saying, “We need this information to plan services,” it’s a little easier to get money for it than if Family Services or Education are saying it.

Being located in the medical faculty also makes relationships with physicians and the Manitoba Medical Association more relevant. With respect to managing these sometimes tricky relationships, Dr. Postl commented:

Noralou and Les are pretty shrewd. Having me as the board chair didn’t hurt because to take it [the Centre] on, they had to take me on. I was seen as certainly a credible enough physician that it would be a legitimate fight. They wouldn’t be rolling over the Centre, and I’ve had a really good relationship with
organized medicine and the MMA, and slowly it just wasn’t worth the fight to them. So they didn’t fight as much, and slowly more docs got engaged.

A Remarkable Success Story
As CEO of the largest health authority in Manitoba, Dr. Postl meets people from across Canada. He said that when he mentions Manitoba, they mention the Centre. “The Centre is well thought of everywhere in the country. … Of a handful of things, it has made Manitoba an icon around data management and health systems.” Thinking back to the early days, Dr. Postl said:

The odds of this moving to where it is now were very small and took lots of work and lots of determination and lots of little periods of support from people. At the time you wouldn’t have known their support was going to have the impact it did, but you accumulate all of that, and you have what we have. … It really has been a remarkable success story.
3.6 Donald Orchard
Minister of Health, 1988–1993

“I was trying to put science behind some of the decisions we were making.”

Funding for the Manitoba Centre for Health Policy and Evaluation (MCHPE) was started under the watch of Donald Orchard, who was the Minister of Health from 1988 until 1993 in Premier Gary Filmon’s Conservative government. Orchard is widely credited not just with making the Centre happen, but for initiating contact with Drs. Noralou and Les Roos and coming up with the government–university partnership model.

In recounting the background behind his initiative, he recalls multiple influences on his thinking. The primary factors were, of course, his need for information in order to make good policy decisions in a challenging fiscal and political climate and learning of the relevance of the Roos’s work to fill this need. He also mentioned Dr. Fraser Mustard’s advice and influence with Manitoba’s political decision makers. As a member of the Manitoba Cabinet, Orchard also had significant influence with the premier and his colleagues. His willingness to take political risks to advance healthcare was another important factor.

Orchard said when he was the opposition critic for health, he tried to avoid criticizing the government for not spending enough and focused on inappropriate or wasteful spending. Despite his comment that “the easiest thing to do is to get a headline about a cutback,” he continued this focus on value for money when he became Minister of Health. “I knew if we were going to sustain the system, we had to try and make changes. But I also knew that any changes that you were going to take [were] just absolutely fraught with political problems.”

As the health portfolio consumed about one-third of the provincial budget, Orchard concluded an economic approach was needed to improve the healthcare system with an emphasis on patients’ needs. “Therefore, it needs the attention of management; and to get management, we need information. We need facts. We need research, and we need science.”

In exploring his options, Orchard met with Kevin Kavanagh, the CEO of Great West Life, who referred him to the research that Noralou and Les Roos were doing (see page 29). Through Michael Rachlis’ book, Second Opinion, Orchard became acquainted with Dr. Fraser Mustard’s views and the research being done by the Population Health arm of the Canadian Institute for Advanced Research. Orchard invited Dr. Mustard to meet with his colleagues, which was valuable in setting a shared understanding about the potential of the Rooses’ research.

The Approval Process on the Government Side
The initial three-year contract for the MCHPE was $3.2 million (Maynard & Naimark, 1991). Orchard recalls that he brought a discussion paper to Cabinet laying out the concept for the Centre, the funding arrangement with the principal investigators and initial research questions to be addressed, which were called “deliverables.”
As a senior Minister in Cabinet, Orchard’s opinion was respected by the Premier and his colleagues, and he was able to win support for the project despite strong competing demands for the funds even within his own portfolio: “I don’t know the dollar figure, but let’s say it was 500 thousand. That’s probably 135 hip replacements. And those are always the dynamics under which you’re making financial choices.” He remembers his experience:

Now the difficulty I had was the sell. I had a lot of influence in Cabinet … but to come up with a nefarious sort of think tank that was going to help me guide and develop policy and healthcare. … It was an interesting concept to sell. But my colleagues A) had faith in my judgement, and B) they could see the challenge that you face constantly in question period. No matter what you did, it was always labelled a cutback. And media would not do their research, and the headline would be you know XYZ, and you’d spend days putting out fires caused by false reporting based on unfounded questions or unfounded facts in the questions at question period and press releases that went out from the opposition. So they knew that if we were going to succeed, we needed help, and if I had confidence enough to bring this proposal forward, well they supported me. And it went through Cabinet the first time I brought it in.

And so the Centre was funded. “But anyway it all came together, and the Centre started doing some very good delivery. We gave them some topics that we needed to research. … And they came up with reports. And the reports were very useful.”

**Arms–Length Funding**

Government–university partnerships were a relatively new concept in the late 1980s. Orchard’s agricultural background had familiarized him with Texas A&M University’s agri–business–university partnerships, a model which he believed had made Texas A&M a leader in North America research, and one that could be adapted for use in Manitoba:

Well from University of Texas, I thought of doing something with the university in collaboration that had on–the–ground results. It wasn’t like inventing a new widget to harvest cotton or whatever, like they would do in Texas A&M, and then commercialize it and the university would get royalties. But this was the university using an intense concentration of intellectual power to help develop and guide how government spends very valuable resources on a very important program, namely healthcare. So there was more than just a singular agenda in my mind at the time. There’s a whole bunch of reasons I thought this was a good idea. But the primary one was still Kevin Kavanagh saying: “I think you’ve got your people at the University of Manitoba.”

Pointing out risks on both government and academic fronts, Orchard indicated that these were “really challenging negotiations.” Drawing up a business agreement for university–based research raised concerns not just about academic freedom, but also perceptions of loss of academic freedom.
Looking at the risk from the university’s perspective, Orchard explained: “… And you can’t sully yourself by taking money from government and having government tell you what to do. I mean that’s … a whole break from academic freedom. And it was a very delicate matter because we couldn’t invest unless we could get some of the things we needed.”

The need to publish findings without government influence was addressed in the initial meetings and incorporated into the first contract. This required trust on Orchard’s part, especially as he perceived the Rooses to be at the opposite end of the political spectrum from himself. Orchard said that although he expected the privacy of conversations to be respected, he never required the people that he called on for assistance “to be of the faith,” and consequently never requested changes in the Centre’s findings.

Governments are often protective of their information sources, preferring to maintain control over the release of research results that might raise uncomfortable issues. So funding the Centre and having it outside the control of government was potentially risky. Discussing this issue, Orchard first explained the challenges:

I was aware that we could come up with some stuff that would point out that we were doing things wrongly, but that’s what I wanted. … I mean if we weren’t spending money correctly, I knew it had to be changed. But I knew from past experience that making that change is going to run into all sorts of resistance A) politically in the house, and B) from the deliverers of that service that may be impacted directly, like their hip pockets, their revenue streams. So I knew that challenge or making changes that clearly had to be made was fraught with danger.

He then explained why he was not concerned about releasing information to the public:

But it was also good for government to be perceived to be doing the right thing, too. And government is not always perceived in that fashion, but if government has the credibility of science behind some of its decisions, all of a sudden it’s out of the normal realm of decision making. It isn’t me making this decision because I’ve got this ulterior motive or this hidden agenda, or whatever the usual accusations are. I’m doing it because it’s a pragmatic thing to do if you’re going to make the healthcare system better … in other words, deliver better services to more people. So I didn’t fear … negative reports coming out of there. And I must say, I don’t think any Minister should fear that because if you’re doing things wrong, you’ve got to change. You should change.

Orchard said that the general public was inherently wise and that if they were given the information indicating the need for change: “There’s 90 percent would say, ‘Don’t fool around. Change it.’ And so, ‘Let them see the rabbit,’ was sort of a guiding philosophy. And the Centre was part of letting them see the rabbit.”
Value for the Government

Orchard said setting up MCHPE was a decision he never regretted, and in fact, one that he fought hard to protect from funding cuts after it was established. “It was a hard fight every year at Treasury Board. I battled for the Centre each year to make sure the budget wasn’t reduced because we were always looking for areas to eliminate spending.”

Summing up the rationale for continued support, he added: “The Centre didn’t get touched because … [it] was a leading edge of medicine in Manitoba really. I think you could tout the Centre almost any place in the world and it’s recognized now. It’s recognized because it’s good at what it does, and what it has to work with is good.”

The reputation of the Centre was good for Manitoba, and therefore, of value to the government almost from the start. Orchard recalls his pride in being able to present the Centre’s accomplishments at a Ministers conference: “I did a short little presentation on the Centre because I was pretty optimistic and pretty proud of the fact that Manitoba was absolutely unique in Canada and in North America in terms of the database that was individualized and blind, so no one was identified. And then we had these researchers who had spent their careers really mining that database for information and wealth and so, [I was] pretty proud of the Centre.” He commented that within about a year and a half, several provinces had set up their own Centres for Health Policy and Evaluation, but noted: “This was absolutely a Manitoba leadership first.”

The Centre’s research was considered very helpful to government. Orchard referred to it as “impeccable” and “irrefutable.” Its quality meant “it couldn’t be argued [with]. Who’s going to come out and argue that it’s good to tear the tonsils out of the kids in EastMan and not WestMan or downtown Winnipeg?”

Aside from using research results to assist in determining policy, Orchard admitted that he sometimes deliberately used Noralou Roos to “politically neutralize his critics.” He said that when he was making an announcement based on their findings, he would do a two–stager. First, he’d make a Ministerial statement after a question period explaining the policy and the rationale behind it, and then he’d invite the public to meet with the researcher:

“And in the gallery today is Dr Noralou Roos, the president of the Centre for Health Policy and Evaluation, whose work has led us to be able to … develop this policy. And she will be available in room 200 for questions from media, opposition members and general public after question period.” And Noralou would go and explain her report. Well when you do something like that, oh man I would have hated to be in opposition and have to try and oppose that because you’re going to oppose an academic with impeccable credentials, not this Minister of Health that doesn’t know what the hell he’s doing. Even the doctors, some of the medical profession who would normally love to come out and carve a chunk of your hide every time you tried to change something that may impact on their revenue streams. It was backed by science. The MMA [Manitoba Medical Association] had to shut up.
This process enhanced the development and implementation of policy. “We absolutely, on a number of issues, took the rat-pack politics out of healthcare. And it was to everybody’s benefit to do that because we ended up making good policy decisions. We ended up implementing pragmatic programs based on results, based on outcomes.” Commenting that this provided good value for tax payer dollars, he added: “We got value for our investment in the Centre because we ended up with a guideline, a blueprint if you will, for where we should go on certain issues. And everybody won.”

Obviously, Donald Orchard was an important champion of the Centre. “It [setting up the Centre] was the right thing to do, at the right time, and obviously thought to be the right thing to do by other provinces who emulated it, subsequent governments who carried on the funding of it. So, it was the right thing to do and continues to be, as far as I know, the right thing to do.”

How the Minister of Health Met the Rooses

(excerpted from Donald Orchard’s interview)

“We approach it trying to get more services to people, so … how [are] we going to make this thing work? And it occurred to me as I sat in the Legislature and looked across at Great West Life, ‘Here’s a company that had significant healthcare policy in the U.S. How do you determine what you buy? What you cover? And how do you determine the efficacy behind the services that are provided to you?’ I said to myself, ‘Surely Great West Life can guide us. … They must have programs that they use to ensure that the dollars are spent wisely, that the patient is receiving quality care of the right service in a timely fashion, you know doing it right the first time, all the maxims of good management.’ So I set up an appointment, and I took my Deputy Minister with me, and we went over and we met with Kevin Kavanagh who was the CEO of Great West Life.

“… And I sat down in his office and I said, ‘Here’s my problem.’ And I said, ‘Surely in the industry that you’re in, you must have areas of guidance that we can use as an application on how we formulate policy to make sure that we are doing the right things for the right people, and we’re doing it efficiently, good value for money, and we’re doing it with efficacy.’

“Well I don’t know whether that was business propriety secrets that I was asking for, but Kevin said, ‘Well, if I understand what you’re looking for, the nuts and bolts of it was,’ he said, ‘there’s two researchers over at the University of Manitoba, Noralou and Les Roos.’ And he said, ‘I think you should talk to them, because I think they probably can help you with making decisions based more on pragmatic delivery and science than emotion.’

“My objective was to try and make decisions that you would have a difficult time from a purely political perspective saying, ‘Oh well you’re just ruining the system. You’re cutting back to nothing.’ All the usual rhetoric. I was trying to put science behind some of the decisions we were making.

“So we came away from that meeting, and I’m kind of shaking my head, because either I’m not being told the great secrets of the trade for business reasons, or else, maybe they don’t do any better than we do in trying to determine what to pay for.
“So then, I asked Frank Maynard to get a hold of the Rooses, talk to them, find out what the deal is. And we ended up meeting, and hence the concept of funding their research which they had been doing for a number of years sort of in a vacuum. It was excellent research but I don’t know whether anybody was paying any attention. They were doing some pretty excellent stuff, and when you talked to them, to the two of them, and Noralou was the primary voice as I recall, [they] made some pretty interesting statements about the database and how they were able to pull from the database certain trends and determine how well things were being delivered, how well things were being done in the system. And that’s pretty much what we wanted.

“… My meeting with Kevin Kavanagh would have been the summer of ’89 at Great West Life. And from that contact, it starts with my Deputy getting a hold of these Rooses, and finding out what he could about them. No doubt Frank met with them several times before I met with them because he knew what I wanted, and if it wasn’t going to be there, then the issue would die. But then it was there, and we met and I was pretty intrigued.

“… And the Rooses, they were quite remarkable people. It was pretty interesting. I knew from the initial meeting that we were on to something here.”
3.7 Frank Maynard
Deputy Minister of Health, 1988–1994
Co–Chair, Advisory Board, MCHP, 1991–94

“An independent research entity, such as the Manitoba Centre, can serve as the foundation for health policy continuity and reduce the tendency to introduce politically driven solutions to complex healthcare issues.”

“My involvement really began in a most propitious event,” recalled Frank Maynard who was Deputy Minister of Health from 1988 until 1994 and very involved with initiating the Manitoba Centre for Health Policy. He spent much of the first three months of his appointment as deputy travelling to Ottawa, and on one of these trips, he happened to sit beside the then–President and CEO of Great West Life, Kevin Kavanaugh. “We were talking about healthcare and some of the pressures and complexities facing governments.”

Maynard explained his predicament: “I was under great pressure from the politicians who were saying, ‘We’ve got to make some changes. We can’t afford healthcare costs. It’s not sustainable, so we’ve got to do something about it. And we have to do something about it in ways that won’t create chaos.’” So he asked the CEO for advice: “I’ve been looking around and trying to find out where I can get some academic connections in terms of research that may be available at the Health Ministry because we’re facing some very difficult financial issues.” And so he said, ‘Why look outside of the province when you have two of the best people in the country, Noralou and Les Roos, at the University of Manitoba? I suggest you get in contact with them.”

Around the same time, Dr. Fraser Mustard was the key note speaker at the federal provincial Deputy Ministers’ meeting that he was attending. Maynard recalled this as a turning point in subsequent events:

He made a presentation at the time about the determinants of health. I was so impressed with this presentation that I came back and I spoke to my Minister and I said, “I’ve heard Fraser Mustard, and we have to bring him into Manitoba to meet you. And if you are as convinced as I am, Fraser should meet the Premier because we need to get some real serious analytical professional research–based data to help us in the changes we’ve been talking about.” Fraser came and met the Minister; the Minister was impressed. He met the Premier… And this is where we got the support in terms of moving in the direction because he was helpful in giving them [cabinet ministers] the big picture in understanding the determinants of health and, given the database that we have, that we were in an unique position to do things that other provinces would not be able to do.

Maynard then contacted people at the university including Dr. Brian Postl, who headed up the Department of Community Health Sciences in the Faculty of Medicine. “I had a meeting with Brian Postl one morning in the cafeteria and gave him a one–pager which outlined how we would like to see this work, and what were the possibilities, and that really was how we got the Centre of Policy started.”
Maynard said that his first meeting with Drs. Noralou and Les Roos was “interesting because they hadn’t really anticipated any kind of approach like this from government. And so I got a sense, even though it was unspoken, that they were, ‘This sounds great,’ initially. ‘But is it really happening?’” Maynard knew that the Rooses had access to a significant database on health, “But no one was asking them about it or using any of the data. And it’s natural then for them to say, ‘Well, who is this guy? Why does he need it?’ I think I got past that in about 20 minutes.” Maynard said that they might have had some concerns about working with government and issues around academic freedom, concerns which were allayed through the protection granted by the peer review process.

Once these understandings were in place, Maynard said he made a presentation to Treasury Board, stressing, “How beneficial it is to have an external body, non–political body, provide some reports and recommendations that were peer reviewed.” These were the years of healthcare reform. He said, “Politically they readily understood. One, we have to make some tough decisions.” He gave a number of examples to indicate the scope and utility of the Centre’s deliverables such as:

The fact that we were able to monitor the results of bed closures and financial constraints on hospitals provided a level of credibility to the process. We were able to assess the quality of care in personal care homes by using administrative data to monitor outcomes, to monitor a range of health system changes, to assess the cost efficiency of Manitoba hospitals, the utilization of mental health services, to further develop the Population Health System.

Maynard indicated the importance of the role of the Centre’s Population Health Information System which provided up–to–date health and illness profiles, including socio–economic risk factors and patterns of healthcare utilization. “There was academic integrity behind all of the work they did for us. We could say, ‘Well, they didn’t just write this paper last night and hand it to me and say, ‘Let’s do this.’ You know there is integrity in the process.” He was also adamant that the Centre be positioned outside of government, saying the last thing you need is to have it in government. “We appreciated the fact that they were external to government. They had no political axe to grind and therefore as academics they could call it as they saw it.”

It took only one presentation to get Treasury Board approval. Maynard said they chose to fund the Centre through the lotteries rather than the regular departmental funding process because lottery funds had more flexibility. The advisory board was initially structured to assure government that the selected projects would be timely and relevant to decision makers. This turned out to be a non–issue because projects were negotiated outside of board meetings:

I served as co–chair of the advisory board. So that gave the government some sense that we would have an opportunity to participate, to object, or to be able to put forward a different point of view. But that never really occurred because the way things worked out, most of the issues we dealt with, for example what we called the deliverables, were things that both parties, the Ministry and the Centre, agreed that we would do. These were areas where we had to resolve problems. However, we
weren’t overly concerned. … We had a really great relationship, and we trusted each other, and things worked well. We agreed on every product that we were looking at. It was discussed thoroughly beforehand, and it reflected in what they could tell us, in terms of the data that we needed to know, that we otherwise wouldn’t know.

Maynard said the Centre “Directly fed into policy right from the beginning, in terms of when we were structuring or laying out strategies in terms of how we would reform the system.” He added that the Centre played a key role in Manitoba Health’s 1992 report, Quality Health for Manitobans: The Action Plan, which “became the blueprint for us.” This document set the direction for healthcare reform in Manitoba. “It was clear that the Ministers and the Premier were complimented on this, what they called the blue book. And they knew that the blue book came about as a direct result of the work from the Centre and consultations from experts across Canada. So there were lots of linkages positively supporting what the Centre had done and was still doing at the time.” Maynard remarked that in the nineties, there were “fiscal constraints and cutbacks everywhere.” The Centre’s provision of useful research-based recommendations to the government, “made it more difficult to say, “There is politics behind such and such a decision.’”

Speaking of the blue book, Maynard said, “This was something very important for the government.” Although there was initially some political opposition from some in the Premier’s office to publishing the book “because they thought it could expose them to criticism,” in the end, publication turned out to be a good decision. He said even “the opposition parties were supportive. Of course they weren’t as supportive when we started actually making decisions.” The media, too, was supportive of the effort to share information. “The editorials in the Free Press and the media everywhere gave us full marks for the attempt to seriously look at identifying the key issues and providing the data driven solutions so anyone could read and say, ‘Now I can understand why they’re making such a proposal.’ And this represented quite a difference in terms of how we would do business.”

Strong leadership set this change in motion. Maynard indicated he has a great sense of satisfaction for his role in the Centre’s story. He said, “An independent research entity, such as the Manitoba Centre, can serve as the foundation for health policy continuity and reduce the tendency to introduce politically driven solutions to complex health care issues.” This rationale for setting up the Centre remains relevant to this day.
3.8 Tom Carson

Deputy Minister, Health, 1998–2000
Member, Advisory Board, MCHP, 1997–2003
Consultant, Canada West Foundation, 2008 to–date

“The more people who pick it up in their bones, the more people will find ways to make little program and policy shifts.”

In his 31 years of service with government, Tom Carson estimated that he worked with at least 20 different government ministers. His experience led him to a strong recommendation: “It’s absolutely important that the Centre never be seen as being more supportive of one party than another. That’s death.”

He said the Centre needed to play the political game in a sophisticated fashion, suggesting that the Centre should find opportunities to make a presentation to the caucus of each political party every year. “They [the Centre researchers] also need to be willing to share information with the caucuses in a less formal manner than that, so that nobody in those caucuses begins to believe that the only people who benefit from this research are the government of the day.” He added that it was wise to work closely with “somebody who’s big into policy” in each of the parties, and more generally, “Just be willing to respond to anybody who wants to know more and is willing to take the stuff further.”

“Keeping it alive” inside and outside of government was a key message, and one that stood out in Carson’s own approach to equitable population health. Carson said it all began for him when Frank Maynard, Deputy Minister of Health, brought Dr. Fraser Mustard to Manitoba to speak to the deputy ministers in the late 1980s. “Initially he was talking about workplace health, about what the Whitehall Studies tell us about the things that impact and create shorter life spans for people in the working environment.”

At the time, Carson was the Deputy Minister of Culture, a department which included arts, recreation, sports, historians and librarians. Describing this disparate grouping, he noted that “All of them were in their separate little silos,” and that the competition for resources kept all of them fighting to stay there. He found inspiration in Dr. Mustard’s talk, “I was trying to find a way to bring the department together and find something that knit us, something that we all had in common. It took a year, but it came clear to me that the determinants of population health, was what we were really all about.”

Carson added, “It was not an easy sell.” However, he attempted to put this approach into practice: “We tried to rewrite our vision and mission based on what role we have in the determinants … using it to try to figure out why should a government put money into this kind of programming at all. We ended up concluding that community cohesion and community capacity building were a good part of what we were all about.”
He said “If you were really going to look at the determinants, you had to understand all kinds of things that infringe on people’s sense of place and their sense of efficacy. And so every time there was a department committee or inter-departmental committee pulled together to do this kind of stuff, I insisted that our department be part of it.” Consequently, he was drawn into Frank Maynard’s Healthy Policy Committee of Deputy Ministers and the Healthy Child Committee of Cabinet, and eventually he was invited to sit on the Advisory Board for the Manitoba Centre for Health Policy and Evaluation.

Carson indicated “there was a useful side benefit” to his appointment to the Board:

In that the provincial archives were within the Department of Culture where the responsibility for what began as Freedom of Information morphed into protection of personal privacy. … From the beginning I thought Canadians or Manitobans would be completely astonished at what awful information we had and would not be contrary to the idea that we should be sharing information that pertains to health across departments, provided that we had great mechanisms for assuring privacy. … I absolutely always believed in the guarantee of anonymity despite the sharing of data sets.

After eight years as Deputy Minister of Culture, he requested a transfer and was appointed Deputy Minister of Training and Continuing Education. He said, “It opened my eyes to how much the determinants had to do with everything that went on in that department, including literacy programs and literally every program that was there, so that this whole message just carried on making sense.”

After two years in Training and Continuing Education, he accepted a new appointment as Deputy Minister of Health, which placed him in a position to influence the government’s choice of projects for the Centre:

We had a chance to negotiate or suggest deliverables, and the Department of Health, I thought at the time, was not particularly open to population health deliverables. This was just after all the downsizing in the hospitals, so I think people were still looking for new ways to save money and new ways to justify what had happened. So I had gone to Health just at the point where government said, “You know revenues are coming back now, and we’re going to start to reinvest in health.” … [This] gave me the opportunity within the department to say, “Look, I think we’re spending too much of this precious money on analyzing administrative issues in the health system, when we had so much capacity to use the administrative datasets to do population health research.”

Although he appreciated the need to continue addressing health administration, Carson encouraged more research into health inequities: “Now the Centre had done plenty of that kind of research beforehand, but because that’s where my passion was it always felt like there wasn’t enough.”
In addition to applying the determinants of health approach within the departments where he
worked, Carson met with other deputies to persuade them to follow suit. And because he was
passionate about the topic, he accepted speaking invitations to spread the word, perhaps an unusual
role for a deputy minister. As he said, “Very few deputies are actually willing to be quoted in the
media. It’s not supportive of long–term careers, so not many deputies are very interested in doing
that.” However, he said his own talks were “Still pretty controlled. I’d go out and do a speaking
engagement. I might be relatively fl ippant about government, but still within a reasonably tight
framework where your Power Point slides keep you focussed on what you’re going to do; and you’re
not actually pointing big fingers at anybody.” This likely had the side effect of limiting the media’s
interest in what he was doing.

He complimented the Centre on their interaction with the media; but indicated that on its own, it
was not sufficient. “The four–pagers are a great idea, and the willingness to sit down with the media
and help them understand it are all very useful ideas, and it’s great to get the one– or two–day buzz
that comes from that, but that, too, is not enough. That’s a one or two–day wonder and it’s gone,
but the value out of the research is never gone.”

He recommended a number of additional ways to keep the buzz going, some of which may dovetail
nicely with his current position as a consultant with the Canada West Foundation, a position that
allows him to continue to promote action to improve the determinants of health. He described
Canada West as “a research institute that looks at what Western Canada needs to do to be vibrant
and strong going into the future.”

Addressing the Centre’s research, he said “It’s almost as though you need protagonists or antagonists
on the outside who are going to keep picking up that research and do little commentaries around it
so that it stays alive and stays in people’s minds. … You also need to make sure that research gets in
the hands of people who will tinker with it just a little bit and ask some of those questions.”

Although he said it might make researchers nervous to share responsibility for publishing and/or
promoting their results, he suggested the Centre might consider a communications plan to push this
to happen. For example,

I’m wondering whether the Centre should have a group of 8 or 10 advisors
who come from a whole pile of different perspectives, policy perspectives,
somebody from Social Planning Council, somebody who’s got an economic focus,
somebody who’s got a community recreation focus, somebody who’s got a strong
Aboriginal focus. Give them an opportunity just as a paper is being written,
or after it’s already written but before it’s released, give them the opportunity
to think about other interpretations they get out of it, other messages they get
out of that research, that part [from] the way the researchers thought of it.
His point was that it’s good to keep the research alive even if the interpretation seems unusual to the researchers. Keeping it in the news keeps people aware of what’s happening, and it pushes people to think harder and do more. “The more people that know this, the more people who pick it up in their bones, the more people [will] find ways to make little program and policy shifts.” As an example, he said the Centre’s research comparing mortality data for First Nations communities did not get sufficient media attention or follow-up research. A province-wide comparison showed a six-to-eight-year mortality gap between the average First Nations person and the average non-First Nations person and also between different regions. He emphasized the powerful evidence when you drill deeper:

It’s not enough to just apply that data across an entire province, when you can actually look at research that shows that “Well wait a minute. We’ve got First Nations communities where the health outcomes are almost the same, and First Nations communities where they’re not. You’ve got First Nations communities where the gap between men and women is flipped; a couple of them where women actually had the shorter life span.” Boy, I’d love to know what’s going on in that community.

He also stressed the importance of “keeping it going within government.” One way to do this was to have a broad base of support, so having “four or five deputies” with “a real interest” was beneficial. It is important to ensure that the deputy ministers and others working within government departments are well informed because their support will be needed.

Every time there’s a change in government, deputy ministers and others need to be able to decide, “Okay, what are we going to fight for?” Because almost every government, sadly, comes into power with the belief that whatever went on before had to be wrong; and everything is going to look like it’s theirs within a year or two. Every government comes into power with a view about something like the Centre. … Sometimes they saw them as a great tool to hammer the previous government, but “God forbid that I’ll ever let that tool be used to hammer mine.” So, you have to have advocates all the way around who are interested in arguing for you; and in government, people only do that because they understand particular results and can talk about them in a way that allows them to look not too stupid when they’re trying to support something with a new minister who they haven’t got figured out yet.

This also requires consideration when contemplating setting up a centre, keeping in mind that governments would be very aware that such a centre might generate research results that are contrary to government wishes:

Your support needs to be coming from more than one direction, so if somebody wants to make this work in a place where government’s going to be one of the funders, then we need to find a way to make government receptive to the investment because governments are real nervous about investing in
something where they can’t control what it’s going to look like. And you
do that by applying the outcomes, by making something happen out of the
information, and by just continuously repeating it and drawing it out.

Being able to release and discuss research results requires independence from government. Carson
spoke of having seen government prevent the release of benign research results for years for fear of
“What could be interpreted by somebody as bad news, or could make the government look bad, or
could allow somebody in opposition to make it look bad.” Although he said that he could not recall
ever slowing the release of research, he knew it happened because there was a “Natural reticence to
let anything out that might make the government look bad.”

This can also apply to the beginning of the research process, as Carson suggested, “I think the
protection of people’s privacy is, for the most part, a crutch that governments use in order to keep
control over information.” Carson argues against this impulse in a statement of strong support for
evidence–based decision making within government:

We’ve already shown here that you can cross all of those datasets and still
maintain privacy, still produce data that doesn’t allow you to figure out
who’s got the heart disease on my street. So, the only way you can get
around that is by making people want the result, to make them believe they
need the results, and that’s still an unfulfilled part of my life mission.
3.9 Dr. Norman Frohlich
Research Associate, Manitoba Centre for Health Policy, 1991–2008

“The Centre should not be a policy advisory body; it should be a policy support body.”

Dr. Norman Frohlich worked in the Management Committee of Cabinet which became Treasury Board of the Manitoba government before he joined the Faculty of Administrative Studies in 1979. This positioned him to advise Drs. Noralou and Les Roos, whom he first met as colleagues:

It was around that time that Les and Noralou were thinking about approaching government, and since I had just spent three and half years in the Manitoba government at Treasury Board, I knew a fair amount about how government operated. We consulted about how they would approach government, what the sensitivities were, who the decision makers were, the appropriate levels at which to talk to people, all that insider stuff that people in a large organization know, and people on the outside have difficulty finding out about.

Dr. Frohlich had several roles with the Centre. In addition to being an advisor, he served on the Centre's initial management committee, and he was one of the first Principal Investigators to work on deliverables, the government–assigned research projects. He did this for almost the entire existence of MCHP until a few years before his retirement from the University of Manitoba in 2008.

Policy Recommendations and Government

Dr. Frohlich considered his major contribution to be policy advice, based on both his government experience and his knowledge as a political scientist. That advice, which he said the Centre adopted early on, was to avoid offering explicit recommendations to government. “I argued very strongly that as an academic and independent Centre, it was important that we provide the government with the analysis and information that they needed to make decisions in areas that they were concerned about. But it was equally important that we not make specific policy recommendations.”

He stressed: “The Centre should not be a policy advisory body; it should be a policy support body. That’s a very important distinction for longevity.” He said that if the Centre makes specific policy recommendations and the government acts on them then these policies get associated with the government of the day, and this could have some dangerous ramifications. “You don’t want to be captured by one government and to be seen as a creature of one party. That would be a disaster, especially when you’re not. If you were, fine. Then you live or die by the election. But the Centre never had a political agenda.” He added that to survive it is important to be non–partisan and to be seen as a source of impartial analysis.

So what I argued for is—lay out the facts on the particular issue as clearly and as cleanly as possible so that if there is a decision that has to be made, the government should be able to see what they should do. But do not have a section [in your report]
which says, “Policy Recommendations: this is what we recommend you do.” … You can spear what the problems are and even be clear about what kinds of steps one might want to take, but don’t take that extra step that says, “You should do this.”

He added that the Centre’s strategy of briefing members of the opposition also helped “To make it clear to them that they are not the servants of the government of the day. They are support to the Department of Health.”

**Deliverables**

Dr. Frohlich said that “buy-in at the front end” also distinguishes the Centre activity from many other institutions. “The government had a need for information and analysis. … The people who are purchasing the product, the deliverables, want that information for particular purposes.” This led to a process of negotiating deliverables each year “That addressed issues the government was interested in or concerned about, and that the Centre felt could be done. … The kinds of deliverables that need to be negotiated have to be realistic both in their scope and in their difficulty so that they can be delivered in a timely fashion.”

Initially the Centre proposed research questions that they thought would be of value to the government. Over the years, more initiatives came from the Department of Health, although the Centre’s experience with past deliverables sometimes prompted suggestions for analyses that would be useful to the government and to healthcare providers.

Dr. Frohlich commented that the sharing of research findings was always quite extensive and high level: “The Centre briefs the relevant people in the Department of Health on the deliverable and often depending on its importance, the Deputy Minister will be there, the Assistant Deputy Minister, sometimes the Minister. It isn’t just a report that they get and someone has to digest in the bowels of the Department of Health and pass up the line. There’s actually exposure of it in a comprehensible and digestible form.”

The structure of healthcare delivery in Manitoba changed with the implementation of regional health authorities, and the number of relationships with the Centre expanded dramatically from the initial years. Dr. Frohlich said “That’s been crucial to the effectiveness of the advice or analysis that the Centre gives because one of the biggest problems in implementing research is buy-in by the service providers.” He said “When government is paying the bill for the analysis the Centre does and when government, as the Department of Health, is generating the questions and agreeing that this is what they want to know, when they get to know it, they do something with it.”

**Not a Deliverable: Other Ways of Earning Your Keep**

Dr. Frohlich recalled an incident shortly after the Centre was founded that he said gave them enormous credibility. He said, “There was a very large randomized controlled trial on the effects of screening for breast cancer. And the government of the day was thinking of expanding screening of breast cancer to younger women, I think down to 40.”
The government was considering a large expenditure on this program: “I’m pretty sure the figure they were talking about was spending five million dollars, which then was a lot more than it is now.” The government informally asked Dr. Noralou Roos what she knew about this.

It wasn’t a formal deliverable. Noralou knew people who were involved in these trials, and the report of the trials had been delayed. It appeared that the control group, who were not being screened, had lower mortality than the treatment group. And the researchers were looking to see what could account for this anomalous result. Ultimately, she reported to the government that the best evidence so far was that it was not only ineffective on a broad statistical basis to extend the screening to the whole population at that age group, but it might actually be harmful. And the government decided on that basis, “Well, if there’s no real good evidence that it makes a positive difference, why would we spend the money?”

The government rationally decided against expanding the mammography screening program. “So, at some level the Centre saved the government five million dollars per year and possibly stopped some harm in the population. They earned their grant money with that one act.”

The International Advisory Board

International credibility was enhanced through the Advisory Board. Dr. Frohlich commented that the Centre’s international membership served them well and suggested it was important to keep up. “These very high level academics from around the world” gave the Centre credibility. It was also helpful in making the Centre’s research results useful to others, as he said the time they spent in Winnipeg brought them up-to-date so that they knew what was happening, something that might not have occurred just from publishing. “It’s difficult to communicate the breadth and depth of the activity at the Centre. Even when you’re publishing papers, people don’t appreciate how rich and how potentially fruitful the Centre’s database is.”

He said the Rooses recognized this potential early on, and their innovative research attracted worldwide attention. “I think they were absolute pioneers in the use of administrative data to do research.”

The Search for World-Class Experts

(excerpted from Dr. Norman Frohlich’s interview)

“The government was a relatively new Conservative government. Healthcare costs were rising, and they were very concerned about expenditure levels.

“They wanted to hire a world-class consultant to come in and advise them on how to handle this huge issue across the whole range of healthcare provision. They knew that Kevin Kavanagh had connections to healthcare insurance as CEO of Great West Life. There was a division in the States that did quite a fair amount of health insurance. Someone approached Kevin and said ‘Can you find out or give us recommendations on who the best people in the world are on this?’

“Kevin apparently called the director of their operation in the States in this area and said ‘You know,
the people in the government here want to hire world-class experts in health policy. I know that you are interested in the literature and keep up, do you have any recommendations?’ To which this person apparently said to Kevin, ‘This is a joke, right?’ Kevin said, ‘No. No, they’re really serious. They want someone.’

“And this person in the States said, ‘Well, the best people you can get are Noralou and Les Roos who happen to be in Manitoba.’

“I believe it’s a bona fide story. It speaks to the fact that Manitobans need to appreciate better the resources they have.”
3.10 Dr. Cam Mustard
Researcher, Manitoba Centre for Health Policy and Evaluation, 1991–1999

“Population–based administrative data, like the resources the Manitoba Centre has, are potentially of great value to a lot of different research disciplines and researchers.”

Dr. Cam Mustard arrived in Manitoba about the time that the Ministry of Health committed funding to establish the Manitoba Centre for Health Policy and Evaluation: “The name went on the door within the first year.” He was one of the first researchers at MCHPE and an assistant professor in the Department of Community Health Sciences from 1991 until 1999 when he left for Toronto where he is now a professor in the Dalla Lana School of Public Health, Faculty of Medicine at the University of Toronto and the President of the Institute for Work and Health.

Dr. Mustard said that MCHPE was successful from the start because it “absorbed the research infrastructure that Les and Noralou Roos had been very vigilant in tending to and building for at least 15 years prior to that … so the data research environment was very sophisticated,” and he added “as were the quality and calibre of the support staff.”

Research Scientists at Work

In return for the funding that the Manitoba government provided, the Centre staff did research projects called “deliverables.” The deliverables were sometimes defined by the Ministry of Health, but more often the Centre’s director proposed health services research topics to them. “I would say that probably half of my research portfolio was devoted to fulfilling the responsibilities of the funding agreement with Manitoba Health. The other half … would have been devoted to investigating questions that I found of interest.”

This led to MCHPE investigators having “two programs of research,” which Dr. Mustard said was important. “They played off each other and strengthened each other.” He gave the example of research on the reliability and validity of different methods. In one project, they tested people’s recollection of their use of healthcare by comparing their survey responses to the Manitoba Centre data on what services were actually received. “Often that kind of work which is more foundational and focussed on sharpening our knives as tools, just making sure that we understood our methods, would not have been of particular interest to Manitoba Health but it was of great interest academically.” He added that this methodological work also increased the confidence in their work for the province: “We could say, for example, ‘when we observe this difference or when we see this pattern we’re confident that it’s accurate and that you can take it to the bank.’ So there was some good back and forth that way.”

It also worked the other way, that the work done for Manitoba Health stimulated new research interests that often were the basis for funding submissions to peer reviewed granting agencies:
The province, at one point in my time there, indicated that they would be interested in a description of who uses mental health treatment services. None of us had spent time looking at that. In the course of doing that work for the province, I personally developed a lot of academic interest in further understanding why it is that some people get mental health treatment services and other people don’t in a universal publicly funded healthcare system.

He noted people at MCHP and elsewhere had had similar experiences and concluded: “The important observation is—it’s not unusual. Your academic game is improved because you’re doing work that the policy side of the system has asked for, and the policy work that you do is improved by the academic work that you do.”

Influence of the Canadian Institute of Advanced Research

The Population Health Program of the Canadian Institute of Advanced Research (CIAR) influenced the kinds of questions that the Centre investigated and also enhanced the reputation of the Centre’s scholarship as Dr. Mustard explained:

In that first 10–year period, there was a considerable amount of intellectual attention focussed on the question: “What’s the right amount of public wealth that should be devoted to the funding of the healthcare system?” That question continues to be an important question; but in the nineties, there was an emerging recognition that the reasons why some people are healthy and others are not is probably not explained by who uses healthcare and who doesn’t. … Just to use an obvious example, the reason why Aboriginal people in Manitoba have a shorter life expectancy than non–Aboriginal people is not about the health services they receive exclusively. It’s about lots of other things related to the social and economic determinants of health—differences in nutrition and quality of housing, and so on.

These were the sorts of issues of concern to the Population Health Program of CIAR. “So as those ideas were bouncing around in the 1990s, ministries of health to differing degrees across the country absorbed them. And Manitoba was one of the ministries that absorbed those ideas quite easily I think.”

One of the things that helped the Centre become established as a place of original insight into both the challenges of operating a publicly funded healthcare system and the challenges of using public resources to try to improve the health of the population was the connection between the Manitoba Centre and the CIAR Population Health Program. … The program added some prestige to the Centre; but it also brought a set of ideas to Manitoba that might not have come to Manitoba as quickly as they did, as a result of Les and Noralou and perhaps my participation in that program.
What Sustained the Centre?

Dr. Mustard recalled that the first decade of MCHPE’s existence was a time of fiscal restraint.

The healthcare system was asking for more resources, as they always do. And the fiscal environment in the country meant that request for additional funding was not going to be met. … The Manitoba Centre was doing research which indicated that there were some inefficiencies in the way in which healthcare was delivered, which didn't make the providers of healthcare happy but was of some interest to the funders of healthcare. So there was a period of time across this country, basically from 1990 to 2000, when the pressure on the system to be more efficient was the dominant challenge and a research organization like the Manitoba Centre or ICES [Institute for Clinical Evaluative Sciences] was seen to be helpful in managing that challenge by most people.

Speculating on what kept the Centre going within the university, Dr. Mustard pointed out that it was economically viable. “Although I’m sure the leadership of the Centre would always wish for more resources. … When I was there, the Manitoba Centre received about two million dollars a year from the province, and ICES during that period received five million dollars from the Province of Ontario, so on a per capita basis the Manitoba Centre was more generously funded.” He said, “I think it’s a tribute to Noralou’s leadership during the time that I was there that the relationship with the Ministry of Health was always good. … Had that relationship deteriorated then the funding would probably have been jeopardized, and then the Centre would have been jeopardized.”

Another factor that ensured its security within the university was the quality of the scholarship. “And the Manitoba Centre, and it’s really Les and Noralou who set that standard, the Manitoba Centre in its day when I was there was one of the top 10 academic health service research groups in North America in terms of both the amount of research that was published and the quality of the research.”

Additionally, Dr. Mustard said “It’s important to acknowledge that both the chairs of the department and the deans of the Medical School were very supportive,” adding that the Centre’s success was due “in no small measure to the insight of the department chairs over the years.” Naming the first four department chairs, Drs. Brian Postl, Mike Moffatt, Kue Young, and John O’Neil, he said “all four of them fundamentally appreciated the value of the Centre as an academic unit. They appreciated the scholarship.” He added that they supported strong relationships between their department and public health practice, not something that could be taken for granted. He contrasted this support with the stereotype sometimes encountered in universities where close relationships with government might be viewed negatively as potentially steering the research and inhibiting academic freedom.

But they all understood that to the extent that those concerns were true—it was even more important that the scholarship in an academic public health unit had to be in touch with the professional world of practice. They were great leaders because they were able to embrace the structural reality of the
Manitoba Centre which was that at quite frequent intervals, we would be paying visits to the Ministry of Health. So that’s really about how the placing of the Centre inside Community Health Sciences led to its success.

Although the deans of the medical school were supportive of the Centre’s work, there was more potential for tension between the academic work of the Centre and the Faculty of Medicine. “That tension arose because the research that the Centre did would often lead to questions about what the clinical community was doing.” He suggested that the Centre’s research into questions such as why are so many cataract surgeries being done; or why are the waiting lists for specific procedures so long are difficult questions for clinicians. “If you ask those questions inside a faculty of medicine, where the academic leadership of medicine is based, you create some antibodies.” Despite this, “It is fair to say that the deans through my time were very supportive of the tough questioning that might arise from health services research. Certainly Nick Anthonisen was a very supportive dean who actually did some research on the data bases that the Manitoba Centre had, and the dean before him, John Wade.”

And to be fair, he added that the Registrar of the College of Physicians and Surgeons, who was also concerned with the quality of physician practice, “was a strong champion of the principle that there should be an independent health services research organization. He wasn’t always happy with the results, but at no time, as far as I’m aware, did hostility raised by a particular piece of work done by the Centre lead to efforts to close it down.”

Dr. Mustard also credited Manitoba Health for their part in maintaining a positive partnership. The deputy ministers that he worked with were very receptive to the existence of an independent research organization, and the technical staff was helpful in assisting Centre staff to understand the data.

Challenges

Dr. Mustard mentioned several challenges related to staffing. First, he said, “It’s tricky to mentor the generation of scholars who will step into the junior and intermediate roles.” He explained that this is difficult everywhere, but especially so in a smaller centre where you’re training fewer people. Recruitment of new researchers is a related issue: “It’s also very difficult to recruit people to Manitoba so on a competitive basis relative to other cities in North America it’s just a tougher place to either grow your own, or recruit people in.”

The location of the Centre, however, was an advantage when it came to retaining the technical staff. He said this was the inverse of the challenge of trying to recruit people in:

It’s a challenge in any research organization that makes intensive use of secondary administrative data to maintain the technical staff. … One of the things about the Winnipeg scene, at least when I was there, is that people who were there were very happy, and they weren’t going anywhere else. There wasn’t another game across the street that they could go to. So
the Manitoba Centre I think was blessed by having a very stable and very
good group of staff who were responsible for the data environment.

Working with clinical scientists was another area that Dr. Mustard said was a challenge:
“My own view is that the work of the Manitoba Centre would have been better than it was, and it
was very good when I was there, but the work of the Centre would have been improved by having
more collaboration with clinician scientists, people who were trained in medicine, trained in nursing
and had research preparation as well.” This observation has in fact been acted on, as the Centre
has increased its interactions with clinical scientists through the establishment of research associates
(since 1994/95), and more recently, adjunct research scientists and collaborators (since 2008/09)
(Manitoba Centre for Health Policy and Evaluation, 1995; Manitoba Centre for Health Policy,
2009).

Leadership is always important, but the context of an applied health services research organization
located within a university requires an unusual combination of skills:

The leadership has to have academic credentials and at the same time they
have to be able to talk successfully with non–research interests. … If a
person is too much of a policy person and not a strong academic they'll
lose ground in the university environment. On the other hand, if they’re
only an academic and they don't understand the circumstances the policy
makers have to work in, they will not be effective in that relationship.

Dr. Mustard also spoke to a changing environment around privacy issues, perhaps more of a
challenge in the past and now potentially an opportunity. He commented that in the 1990s, the
expectations around data security were very strenuous. “The consequence was that the Manitoba
Centre couldn't be liberal in providing access to the data. There were a lot of requirements and
restrictions—organizational security, physical security, technical security—that meant that even if
you were on the other side of the wall at the Centre in the same building you couldn't get to the
data.”

He said, “I'm seeing across the country a melting of what has been at times quite an icy privacy
regime.” This should allow custodians for these research infrastructures based on administrative
records to adequately protect privacy while liberalizing access to the data. This will stimulate greater
applications of the data to a broader variety of research questions: “Population–based administrative
data, like the resources the Manitoba Centre has, are potentially of great value to a lot of different
research disciplines and researchers.”
3.11 **Dr. Charlyn Black**


“By the ’90s, using administrative data was commonplace, but looking at an entire population’s use and thinking about it as a provincial healthcare system was different. We were really treading on new ground.”

Dr. Charlyn Black completed her doctorate in 1990 just in time to become a founding member of the Manitoba Centre for Health Policy and Evaluation. She started at MCHPE on a post doctorate, continued as a research scientist and completed a four–year term as co–director of the Centre before leaving in 2002 to become Director of the Centre for Health Services and Policy Research (CHSPR) at the University of British Columbia.

Speaking of the early days at the Centre, Dr. Black said, “It was really exciting. I loved working with the data. … It certainly built on some of my thesis work around key concepts and aspects of the process of care that I felt were important. The idea of building a health services research framework that could bridge across multiple silos, if you will, of healthcare was very exciting.” She was referring to bridging the information in the medical plan billings, the hospital and mortality data. “We were trying to find a way to put this all together into a bigger picture. And I think that idea of looking at the epidemiology of healthcare and the bigger picture was such an exciting agenda.”

Dr. Black recalled how she and Dr. Noralou Roos started by sketching the framework and implementing it with an initial set of six reports. “We wanted to do some very basic reports that would validate a lot of the individual data holdings from a population perspective. A lot of that first year’s work was finding a way to lay those out.” They succeeded in developing a model that they used with new data sets, but also produced findings that were useful to the decision makers. These results are pulled together in the first MCHPE Medical Care supplement (Roos, Shapiro, 1995). The examples at the end of this chapter provide a flavour of Dr. Black’s work.

The real excitement, however, was the effort “to confirm and expand our understanding, push the extent to which we could bring population–based analysis to life with the data. We wanted to better inform our understanding of both the data and the patterns of utilization. We were really treading on new ground. … We had things like access and utilization and outcome so the initial data sets then led to this larger publication that was our conceptual model” (Roos et al., 1998).

“By the ’90s, using administrative data was commonplace, but looking at an entire population’s use, and thinking about it as a provincial healthcare system was different. We were really treading on new ground.” She added that by using the same analytic set of concepts to examine data across the healthcare system, “We started seeing patterns of care. Most of the time planners look at, ‘Okay what services are we delivering?’ The population perspective shifted this dramatically to say, ‘How are patients receiving care? Where are they receiving care? And what kinds of services are they receiving?’ That was the genius of this population based approach.”
Health Service Research Context

Dr. Black said, “This was a time of budding interest in health services research.” Her list of the activity at that time provides some context: “You had Jonathan Lomas working out of McMaster on clinical practice guidelines. He ultimately became the founder of the Canadian Health Services Research Foundation. CHSPR was established in 1990. ICES (Institute for Clinical Evaluative Sciences) was also formed around this time. CIHI (Canadian Institute for Health Information) had not yet been formed. The Saskatchewan data had been worked with, but it had been very sporadic.”

CHSPR was populated by health economists while social scientists worked at MCHPE, leading to differences in orientation. “ICES, CHSPR and the Manitoba Centre all sound similar on the surface, but they each are differentiated, both in their research agendas, the way they handle data, and the kinds of questions that they think are important to pursue. I would say of these, the Manitoba Centre has been most oriented to system level policy and responsive to policy–relevant questions.”

What Fosters Success?

Manitoba’s small population is often cited as a detriment to advancing the province’s interests, but it was an advantage in an era of limited computing power. Dr. Black pointed out that Manitoba’s smaller population made it possible to do the necessary computing. Perhaps related to being small, the ministry lacked the resources to analyze their data on their own, and “the paucity of internal analytic talent in the Ministry in Manitoba was also helpful to the Centre. … When I look back historically, in other provinces there have been people who have said, ‘Oh, I can do that. I can analyze the data inside the ministry, and we do not need to involve the research community.’ And this attitude has reduced the extent to which there’s been a sense that researchers could add value.” Dr. Black said in Manitoba there was little analysis or use of the data beyond paying bills. Consequently, the people within the Ministry were supportive of partnering with independent researchers.

She credited Fred Toll, who was responsible for data in Manitoba, for a supportive relationship. “And Manitoba was pretty unique even in the ministry data, in the way it was structured. It was much more possible to put together person–specific and population–based linked data sets. … Because everything was already linked in Manitoba, it didn’t take a lot of work to link the data.” And with the founding of the Centre, rather than acquiring project–specific datasets, the entire set of data became available to researchers. This meant “that we would move to a different role with the data, that we would house and store the data in a very different way.” Eventually this led to the development of the concept dictionary, a detailed list of operational definitions of variables used in MCHP research with links to other web–based resources. This greatly aided efficiency and consistency in accessing and using the data for MCHP research scientists and their collaborators.

Dr. Black’s own research interests and policy background positioned her to understand the policy world, which was important in relating to people in the ministry. “That was a big part of it, and I think that’s a role I played pretty well—understanding the policy world and what things might be on their plates and how could you design a research project that might provide some useful information. … And we really worked to build relationships within the ministry.”
When the regional health authorities were implemented in Manitoba, this role of meeting policy makers’ needs was expanded: “We started to work with people from rural and northern areas. … So kind of reaching out and trying to say, ‘What would be important for you?’ We made a point to really listen for rural and northern issues.”

Dr. Black mentioned receipt of excellent advice from people who really knew how things worked. “We had people with political understanding who were really part of the Centre faculty; not just board members but faculty members.” And she gave examples: “People like Evelyn Shapiro, who played a role in Manitoba Health, knew the policy challenges and issues. … Norm [Frohlich] had worked at Treasury Board. Brian [Postl] with his political smarts as chair of the board. Noralou was hugely diligent. So there were senior people who were very thoughtful about the politics of what we were doing.”

Dr. Black summed up these themes: “A small province; relatively sophisticated data. … And then there is also the prairie pragmatism—that people are much more inclined to figure out ways to work together and get things done.”

**Independence**

Dr. Black stressed another factor for contributing to the Centre’s success: “It received very good advice from the outset, to set itself up as independent and has always worked at preserving that.” She listed some key issues a government–funded centre would need to address: “How much do you respond to what your funder wants you to do? How do you make results known? What’s your policy on who can find out what the answers are? What the questions are? … Whose interests are you trying to serve?”

According to Dr. Black, providing briefings to the opposition was one important way that MCHPE preserved its independence. “When we released reports we made it very clear that we weren’t just briefing the insiders at the ministry, but that we had an obligation to also provide information to the opposition.” As evidence of success in preserving its independence, Dr. Black related an anecdote:

I remember one quote. I think it was when I released the tonsillectomy report. … She was a CBC reporter, and she said, “You know, the Manitoba Centre has had everyone ticked off at it at one time or another. … And this time they’ve ticked off the doctors.” Which speaks to its independence, right. “At one time or another, every group has been ticked off at them.” I thought that was a huge compliment.

**Advice**

When asked what advice she would give to others interested in starting a health policy unit based on the analysis of administrative data, Dr. Black replied:

I’d say get clever faculty who really understand policy, who can work with data. Get advisors who can help funding partners understand how important it is and how useful it is to have independence. Develop data systems that work extremely well that you can use for different purposes but make sure you understand your data and you’re absolutely impeccable and able to be credible when you measure things.
Example 1: Hospital Report (Black & Burchill, 1994)

Dr. Black recalled the hospital report as one of the more exciting research projects that she worked on. At the time, politicians were interested in building new or expanding existing rural hospitals, saying “Well of course we’ll build it, and they’ll come.”

But Dr. Black said that her results were showing “pretty much that people were driving right by their local hospitals. There was a high rate of use of Winnipeg hospitals by rural populations.” The people responsible for planning hospital location asked her to consider if building new hospitals in rural areas was useful and how many beds would be needed in a newly developed centre.

We questioned whether building new hospitals was necessary and if it was the right thing to do. … I ran the numbers, and it didn’t look promising. I ended up making a presentation to an entire caucus of rural representatives on this report, so that was incredibly exciting. It was really challenging because the politicians wanted to expand rural hospitals. I think Noralou was very worried about me coming out with these results. These were very controversial results.

This raised the issue of how a government-sponsored centre could withstand the potential political pressure of delivering unpopular messages. The Centre responded by ensuring the work was well done. “That one in particular, I knew the data so well. I knew the areas of the province so well that I could respond to people’s objections. I don’t know what went on behind closed doors, but it had quite a large effect. There were some very effective people working in the ministry as partners.” In the end, the government directed the reduction of the building plans.

Example 2: Tonsillectomy Report

“We were trying to work with different partners, expand the range of partners we worked with. So, I did a project with the College of Physicians and Surgeons trying to focus on quality of care issues. We developed a kind of tripartite partnership between the College, the Ministry, I think John Wade may have been Deputy then, and the Centre. We did a project on tonsillectomy. There was a small child who’d died, probably receiving an unnecessary tonsillectomy.”

This was an example of “Here’s a problem. How can you develop a project that would provide some perspective on this? What’s really happening across the province?” We worked with John Mansfield. We went into Dartmouth to Elliott Fisher’s group to learn about how they were doing things. We developed a project that looked at how likely kids were to get tonsillectomies; how did this vary across the province. There was also concern about physicians who didn’t do a lot of these surgeries. So we looked at the volumes of surgeries that different doctors did. We published both the rates of surgeries and the volumes of procedures that physicians were doing. And Marni Brownell followed this work up (Brownell, 2002). There was a reduction in the rate of tonsillectomies and there was a drop-off in the number of low-volume providers. They just stopped doing tonsillectomy surgery. There was quite a drop off after this report came out (Black, Peterson, Mansfield, & Thliveris, 1996).
3.12 Louis Barré

Director, Health Information Services, Manitoba Health and Healthy Living, 1997–2008

Main Entry: Louis Barré Fac-tor
Pronunciation: \\ˈloo–ee bahr–ray.fak–tor\
Function: noun
Etymology: Recent usage by Manitoba Centre for Health Policy staff
1 : one who acts as a strong advocate within government in support of an externally funded Centre of Excellence.

Some folks at the Manitoba Centre for Health Policy refer to the “Louis Barré Factor” to signify the presence of a strong advocate within government. Barré was Director of Health Information Services for Manitoba Health and Healthy Living (MHHL) for 11 years until he left in the summer of 2008 to take on challenges at the Canadian Institute for Health Information (CIHI). As the director responsible for the administrative relationship with MCHP, he handled the government’s side of the process from start to finish, from the initial discussions of the research agenda through to disseminating the reports and dealing with follow-up.

Barré said the critical areas of strategic activity in support of the Centre have been “Developing the data, developing the research capacity and developing the partnerships and stakeholders’ support.” His own efforts were focussed on the data and the stakeholder pieces, which seemed to be intimately entwined. Barré’s outline of government staff’s contributions to the work of the Centre make it clear that advocacy on a day-to-day basis to maintain political will is an essential ingredient in the Centre’s success.

What’s fundamentally important is a policy commitment to the work of the Centre … There’s a significant commitment that the Department of Health makes to maintain that relationship. The simple process of transferring data files every year can take weeks of programming work, in addition to the time required to establish the annual research agenda, conduct briefings for report releases, and to generally maintain the relationship. So based just on the time required, if the Department of Health weren’t so fully committed, this wouldn’t happen.

The work that MHHL staff does to support the Centre includes building internal protocols for the flow of data, the often time-consuming management of relationships with data providers, and small “p” political work on an as-needed basis. Barré said, “One of the challenges is always to not lose sight of the big picture.” This is particularly important when the Centre releases an unpopular report.

Where report findings may be controversial, we’re doing everything from data validation to make sure that the work is correct, to working with program people to make sure that we understand the program issues and the implications of the research for care delivery. And if we’re doing patient

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1 Manitoba Health and Healthy Living has been renamed Manitoba Health as of 2009.
safety indicators and it looks like there’s high rates of adverse outcomes in a particular program, then it means working with the managers in those areas to understand and validate the data and conduct multiple briefings with senior executives including the minister, meeting with communications staff, developing media strategies or stakeholder communications strategies to mitigate concerns with how some of the data or research findings may be perceived.

In addition to this administrative commitment, Barré indicated there was a significant effort on both his and the Centre director’s part to “Cultivate and maintain the relationship between the government and the department.”

I’m talking about the turnover of government officials as well as the government itself, the elected officials. When there’s a change in government or senior officials you’re dealing with the briefing process and getting new people to understand and buy–in to the vision. As officials change over, there is a process to make sure that new people are briefed and informed, and the relationships are rebuilt. That’s what I used to do, and Pat [Martens] does a lot of that. If there’s a new minister, deputy minister or senior executive, there are meetings with those individuals. Pat also maintains relationships with other external stakeholders who are key to maintaining the Centre’s support, such as the office of the provincial ombudsman.

Barré estimated that he spent an average of “At least one day a week doing problem–solving, relationship management, building buy–in, dealing with issues, developing the annual research agenda, facilitating the publication of reports, being proactive in terms of advancing the long–term agenda at an administrative policy level, or building the foundation for the funding or the expansion of the funding. Those are all important pieces.”

Relationship building occurred on multiple levels between government and university from very senior levels, but also between researchers and program directors and between computer programmers at both institutions:

We had data programmers at our end who would work with data programmers at the Centre. In many cases, we had aligned data methodologies, so not only would we standardize and work from the same data set, but we had standardized methodologies that would ensure there was comparability of data and findings. So we were aligned at multiple levels. And the depth of this relationship is an important part of the reason the Centre has the quality of work and support for that work that it has and has been able to sustain it.

For example, if we didn’t define geographies in the same way between the university and the province and the regional health authorities, it would be confusing for health planners. The Centre has been highly responsive in coming to the table and having those conversations and spending hours and weeks and months resolving definitional issues and standards in order to ensure that their research products are of high quality.
and are usable. There is a tremendous commitment that people like Pat and the senior researchers at the Centre have. It requires an exceptional commitment to carry out that work because it is not necessarily reinforced within the academic paradigm.

In the decade-plus that he was director, Barré worked with all three directors (Drs. Noralou Roos, Charlyn Black, and Pat Martens) negotiated two contracts including the only increase to funding in the Centre’s 20-year history and saw major changes such as an increased focus on regional needs and data expansions to over 80 datasets.

Comparing then and now, Barré said: “In many respects, it can take more effort during this development phase than it did at the beginning.” Contracts are more complex now because there is more consciousness and legislation around privacy issues. Originally the scope of engagement was much more defined with just a few data sets and just a few players involved in deciding the research agenda and receiving feedback. Barré said that the depth and breadth of the Centre relationship expanded vastly from about the mid-1990s. The increase in data sets means meetings with officials from multiple departments to negotiate the research questions. And there is also a need to be more inclusive on the data dissemination side as well, “So for every report that is produced, there are multiple levels of briefings.”

The negotiations to renew the Centre’s five-year contract with increased funding illustrate both the complexity and the achievement: “When we wanted to expand the funding we were able to get five deputy ministers and five ministers to sign the Treasury Board commitment to increase the funding. This was remarkable because we had five ministers and five deputies who were saying, ’Yes, this work benefits my department in an important way.’” He added, “We can only do that because the Centre produces a quality product and senior government officials bought into the high level vision.” Barré described many benefits for the provincial government, some of which are highlighted on the next page.

Summing up, Barré touched on the political commitment of the government, which supports the administrative commitment, and the underlying shared vision.

I’ve talked about the small “p” political commitment. I’ve talked about the administrative commitment from a managerial perspective and the commitment of the organization in terms of staff resources and time and data. There’s a lot of political capital invested in the Centre. That’s been so important. Certainly we had a vision within government. And people like Noralou and Pat and Charlyn Black and many of the other people who work within the Centre, also share that vision that they were so key in creating. So we’re able to take that compelling vision and use it to drive people’s commitment and push through some of the challenges.
How MCHP Benefits Manitoba

(Excerpts from Louis Barré’s interview)

1. Agenda for sophisticated research into determinants of health:
“First of all, the Centre has pushed the envelope in terms of the academic literature around health determinants, and going back to the early 90s, was able to produce research around population health determinants. Some of the work that the Centre’s been doing for 15 years still can’t be done elsewhere because of the comprehensiveness of data and the ability to link data in the way that it’s been done there. The other benefit would be the direct support to our population health agenda because of the scope of the contents of the data and the nature of the research. The Centre’s researchers did a lot of work on broad issues such as the determinants of health or the health of children or women or seniors or disparities in health by income. And so there was a lot of informative work that was relevant to the government much more broadly that wasn’t just about health outcomes or health services. It was about the broader relationship from a population health perspective between those different factors.”

2. Focused policy-based research:
“In general terms what we got out of it was knowledge. We had the benefit of very focussed policy-oriented research that used our data or the data from different parts of the province to address policy questions or service delivery issues and questions that were relevant to the province. We were able to have the data that came from us be used in a very sophisticated way to address issues that were of interest to us, and that’s what was different from many other researchers whose work is not driven so directly by the defined needs of the policy community.”

3. Support for rural regional health authorities:
“The Centre is a huge contributor of data for the regional planning process. Many of the regions would likely say, ‘We’d be lost without the Centre’s data.’ They get data from their community; they get it from Manitoba Health; and they get it from the Centre. And if you took the Centre’s data out of their mix, they would feel a huge loss. I suspect they would say, ‘You’ve just cut off a huge chunk of what we use for our planning purposes.’ This is especially important for the northern and rural regions that generally do not have the same level of in-house data and analytic capacity that larger regions such as Winnipeg have.”

4. Training and development:
“Another thing we received out of the process was a lot of training and development, not so much for the department but the health system at large received benefit from a lot of capacity building through initiatives like The Need to Know Project. The opportunities for health system administrators and planners to better understand and therefore utilize data and research has been an important benefit for the province more broadly.”

5. Benefits of additional research:
“There was the benefit that we paid for, that is the studies we commissioned. The government has funded MCHP approximately two million dollars a year and for that it received five research studies and all the knowledge transfer that went with them. But it also received all the benefits of
the additional research work that was being independently undertaken by researchers at or affiliated with the Centre utilizing third party grant funding. For example, much of the inequalities in child health research of Noralou Roos and Marni Brownell was funded by federal granting agencies, but completely to the benefit of the province. So there’s an example of that additional benefit the province reaps but didn’t have to pay for directly.”

6. Local engagement:
“The fact that the research is based on Manitoba’s experience and engages local stakeholders increases its relevance and likelihood for use. The research that the Centre does about Manitoba is real to the Manitoba audience. If you’re in the Department of Education and you’ve got the high school completion outcomes or the educational outcomes and standardized test scores, it’s about your students. It’s about your schools and your school divisions and your communities. It’s not a theoretical concept from some international publication. There’s a big difference when the focus of the research is local, and local people have been part of defining, executing, and acting on the research. That relationship is a really important piece of it because the Centre’s delivery model is an engagement model. It’s highly engaging. It’s not what may be a more typical academic paradigm where the work occurs in relative isolation of a provider system or a policy system. It pertains to their situation specifically. And they’re also part of defining it and they’re involved in it so there is a level of ownership that’s not typical of a research process.”
3.13 Deborah Malazdrewicz

Director, Information Management, Manitoba Health, 2008 to–date

“I think it's been successful because it was built incrementally.”

With a 27–year history working with health information for Manitoba Health, Deborah Malazdrewicz is well positioned to reflect on the reciprocal relationship between Manitoba Health and the Manitoba Centre for Health Policy. Malazdrewicz explained her various roles within the ministry over the years:

I was involved with the Centre back when Noralou and Les Roos were not base–line funded, … when they were first functioning as researchers at the university and starting to establish some relationships about building research projects where government was interested in the outcomes with some policy implications. When the actual Centre was developed and the relationship was more formalized, then I became more involved in the transfer of information to the Centre on an ongoing basis. I facilitated the transfer of many of the administrative data sets that went over to the Manitoba Centre and provided content knowledge and expertise and documentation at times to help build the beginnings of the repository many, many years ago. Then I sustained that relationship over a fairly long period of time. I was also involved in The Need To Know Team when that project started in 2001. … Now I’ve moved into the role of Director of Health Information Management.

Malazdrewicz currently manages the contract and the data sharing agreement with MCHP for Manitoba Health. She also facilitates the deliverables process and the Province’s relationship with the Centre more generally.

This relationship has recently become more complex with a 2002 agreement between five government departments, which facilitates new data transfers from Family Services, Housing, Healthy Child and Education Training and Youth. Malazdrewicz noted the significance of this inter–governmental commitment to work towards a better understanding of the health of Manitobans as “very pivotal in the sustainability of the Centre. … These departments are sharing this information so that the Centre is able to do more robust research and analysis in the area of the social determinants of health. So it was much broader than just measuring health status and health utilization, but really trying to delve into what's driving health.”

Protection of Privacy: A Key to Sustainability

Malazdrewicz stressed that the Centre’s privacy policies, technical infrastructure, and protocols for researcher access to the data “give the public a sense of security that their information is being protected.” She said: “A big part of what has made it [the Centre] sustainable is the way they have
approached the development of the repository, and the fact that they’ve been very thorough and very detailed in development of procedures, policies, and processes to support the security of the information.”

Being located within the infrastructure of the university rather than within the private sector is seen as beneficial. Researchers who access the data go through several review processes. Transparency is demonstrated through widely shared business and security audits. There are policies to restrict industry’s use of the data, again adding “even more levels of comfort and security that that information could not be utilized by drug companies, etc. for their own benefit.” She pointed out that the Centre now has datasets from outside of government, from clinical offices, for example, “so it’s obvious that clinicians feel confident that this information is in a secure environment.”

However, the most basic protection is that the Centre does not get nominal information. Malazdrewicz explained how the extracts for transferring data to the Centre are created in a way that protects anonymity but makes it possible to link across time and datasets. Scrambled algorithms are used to link datasets. Her branch’s IT staff get demographic data (but no program data) which they use to link to the population registry to find the PHIN, a 9-digit Personal Health Identification Number that each Manitoban uses to access healthcare. All information that could identify the individual is stripped away and the PHIN is scrambled. Centre staff use the scrambled PHINs to matched with scrambled identifiers associated with the program data. The Centre never gets information that would allow it to identify individuals; it gets these scrambled algorithms. The Health Information Management branch creates the key to link different datasets but never has the data; thereby, privacy is protected.

Other Success Factors
In mulling over reasons for Manitoba’s success with using administrative data for research, Malazdrewicz observed that larger provinces had separate government departments for different aspects of their healthcare system which complicated the organization of information. It was more difficult, for example, to establish one unique identifier for users across all departments. Manitoba’s health department was small enough that it was organized comprehensively, and this made it more feasible.

At the same time, she said that in the early 1980s, “Manitoba seemed to be very much at the forefront of the development of information systems. There was a lot of investment that went into building electronic systems for secondary use.” Although these systems were basic compared to today’s developments, she said, “The fact that we had them and that we were forward-thinking enough to develop a unique identifier per person … was a cornerstone around a lot of the information. Maybe because we started a long time ago and we’re a small province, we were able to accomplish it. And then once it was accomplished, it’s easier to sustain.”

She added that the PHIN was implemented in 1984 and “that became the beginnings of the opportunity to link across datasets.” There is data that goes further back but it is more difficult to link: “It’s based on family registration, so it’s more of a probabilistic link. So this data, while it has been linked forward, is less reliable.”
The repository is available to the larger research community, Malazdrewicz pointed out with obvious pride: “We now have this huge repository in Manitoba, and it’s the envy of many other provinces and even other countries with all of the different datasets in one place.”

The Deliverable Process

Malazdrewicz said that the ministry and the Centre work closely throughout the deliverable cycle. The Executive Management Committee, which consists of the deputy and the assistant deputy ministers of the divisions of Manitoba Health, starts the cycle by selecting five research topics. A sixth deliverable is devoted to three highly interactive knowledge translation days, where the research process and results are discussed with the people who use the information.

Potential topics come from many sources. The regional health authorities and the Need to Know Team and others involved in delivering programs within Manitoba Health have brought forward many specific questions. The Centre’s director and researchers also bring forward ideas based on working with regional people, their experience with past projects, and exposure to the new datasets. The Executive Management Committee members have their own concerns about the value of specific programs, sometimes based on fiscal matters or issues raised in the media.

“And those ideas are put together on kind of a long laundry list of possible concepts. … The Executive Management will review these, vet them, discuss them over several different meetings, and bring them down to a short list.” The Deputy meets with the Minister of Health and the Minister of Healthy Living, and they decide on the top five for the next year, and the Centre is advised of their choices.

Then the principal investigators (PIs) are chosen for the project and work with Dr. Patricia Martens on the composition of the working group. On the government side, they have a lead director responsible for the deliverable who reports directly to an assistant deputy minister, several members who are subject–matter experts from government departments or clinical areas and a person from Health Information Management to provide expertise around the dataset and to ensure that the working group is making progress.

This process works well, she said. “It brings the opportunity for other people to become involved and to inform the Centre’s understanding of the dataset or the questions around that particular topic.” The PI, with support from their research coordinator and programmers, develops the methodology and the scope, which is brought back to the working group. The goal is to “bring to the table a really broad understanding of what needs to be looked at, how to get the most out of the deliverable.”

She added, “The working group is used as a touch–back point to make sure they’re on a par with where they’re supposed to be going, where the people in the working group feel that these are the right questions or do we need to tweak it a little bit? Do the preliminary findings look right? Or is something not jiving?”

The process also “keeps the interest of government throughout the life of the deliverable.” Malazdrewicz said that program people often benefitted from their involvement in the process. Sometimes they learned that their anecdotal information was not valid and that they needed information based on data to make better decisions.
Once the deliverable is in draft form, Malazdrewicz said she organizes briefings with the Executive Management Committee, the directors of program areas, and branches within the department. The PIs present the preliminary findings, providing another opportunity to clarify results. Closer to the release of the deliverable when the final draft and the four–pager arrive, Malazdrewicz sends a briefing note to the director and the lead assistant deputy minister. The director prepares an advisory note for the minister, and if a lot of media interest is anticipated, in–person briefings with the minister and the minister’s staff will be scheduled prior to the release of the report to enable them to respond to questions that may come up around the project.

“And then it goes live and we deal with it.”

**Political Support: An Appreciation for Evidence–informed Decision Making**

Malazdrewicz said the release of the findings can cause some discomfort for the Ministers: “There are certain deliverables that cause a little bit more angst because … some of the findings suggest that we’re not doing as well on certain aspects of child health or other things, and that’s not a popular situation to be in.” Issues related to patient safety, quality of care indicators, or physician activity can be sensitive.

However, she said this did not put the Centre’s funding from the province at risk. She said that the Centre has become integral to the healthcare system. “It’s something that’s developed over the years through some of the deliverables that have provided some very new and important information that has helped government make decisions.” Malazdrewicz gave a specific example where the Centre’s analysis was helpful:

> There was a point in time in the 90s where we thought, “Oh no, our population is aging. We don’t have sufficient beds in our hospitals to be able to deal with that down the road.” And when we actually did an investigation and looked at the data we found that we probably had more beds than we needed. That allowed the government to make a very unpopular decision and cut beds, but here we are many years later with many less beds. And we’re fine. But it was a decision that government couldn’t have made without the information because it was just kind of an assumption that we needed more. … But the reality of what was really happening was, we have a healthier population, so as we age, we're more active. We do not need the same things that the elderly did many years ago.

Malazdrewicz said, “Our present ministers are very supportive and look forward to the information coming out of the deliverables.” She said that the Centre’s research reports help them understand the issues in the healthcare system and where there might be opportunities to develop alliances across departments around program development. “So they see huge benefits in the deliverables. … It’s a constant opportunity to be looking at new and different things.”
Malazdrewicz indicated the importance of communication to the relationship between the Centre and the deputy and ministers in the government:

That transparency and open dialogue has allowed us to be able to have difficult or challenging conversations if necessary, whether it’s around a particular deliverable or whether it’s around sustainability of funding to the Centre. I think that’s a key part of it. It’s all about the relationships and the open communication. … And that’s hard to get sometimes in government because government likes to protect its information and its agenda or its needs or concerns or its weaknesses. But our present ministers are very open to trying to do better.

Malazdrewicz said the Centre faced a major challenge several years ago when the Treasury Board questioned whether continued investment in the Centre’s research was providing adequate return on investment (ROI). Steven Lewis was contracted to review the issue. “He did a very thorough review of research projects that had been done at the Manitoba Centre, the findings in those research projects and the potential savings to the healthcare system.” Lewis concluded that MCHP had numerous positive impacts, including “reputation, research revenues and productivity, varying influence on policy and system management, and a major cultural and intellectual influence on the Manitoba environment. The quantifiable ROI from research grants alone is close to 200%, but the real impact is likely to be far greater” (Lewis, Martens, & Barre, 2009).

Malazdrewicz suggested that an appreciation for evidence-informed decision making has spread through Manitoba in the last few years. She credited Dr. Patricia Martens, the larger research community and funding bodies such as CIHR (the Canadian Institute of Health Research) and CHSRF (Canadian Health Services Research Foundation) for their promotion of knowledge translation. She specifically mentioned the Rural and Northern Day, which started 12 or 13 years ago, and more recently The Need to Know Team, for foundational work with small regions. She said, “The Rural and Northern Day was huge for the Centre’s reputation. … That day grew from a very small number of 20 or 30 people in the first few ‘Days,’ to over 200 people.” She added that The Need to Know Team “brought Manitoba Health into the picture and actually helped build stronger relationships between the regions and Manitoba Health because we were all at the table together, and we were all working towards the same goal. … What’s evolved is recognition of the need for valid information, and making an investment in an organization like the Centre has provided us with that.”

The Centre “Evolved Over Time”

Malazdrewicz said that the Centre has had many visitors who want to understand Manitoba’s model and relationships. “And they would like to go back to their provinces and build the same thing, but I think it’s been successful because it was built incrementally. That’s my personal opinion, but you can’t possibly hope to do it all at once.”
Consequently, she recommended starting small, for example in the health sector, with shared goals of furthering knowledge about improving the healthcare system and people’s health. She stressed that in starting a new research organization, people would need to “take the utmost care with the information so that the government would be willing to share it [data] in this relationship.” This requires the development of documents and protocols to protect privacy and resolve legal and funding issues. She also stressed the importance of working beyond government, to engage regions. “And once you have some small successes, you can show government the benefit of the outputs of this organization. Then you can look to building some of those linkages across other systems such as Education or Family Services.”

Malazdrewicz concluded: “I enjoy working with the Centre. I think it’s a fabulous organization. … They’re never satisfied with just churning out information; they’re constantly trying to push and understand it better, to add more data sets, to build a more robust, a more informed model of what’s going on. So I think that’s been a big part of the success—that continuing investment in knowing more and asking more of what they have in the data.”
3.14 Dr. Patricia Martens

Research Scientist, Manitoba Centre for Health Policy, since January 1999
Acting Director of External Relations, January 2003 to May 2004
Acting Director, Manitoba Centre for Health Policy, June 2004–June 2005
Director, Manitoba Centre for Health Policy, 2005 to–date

“Personality is a huge driver at the Centre. I don’t know if the Centre would ever have become what it is today without the personalities involved, like the Evelyn Shapiros and the Rooses.”

Dr. Patricia Martens has a knack for creating teachable moments, perhaps because she was a high school math and chemistry teacher in her first career. She invents entertaining ways to convey a message, whether it’s using cat’s cradle to teach about complexity; or composing lyrics to thank staff for their hard work on a successful grant; or her trademark use of provincial and international deer signs to highlight different approaches to healthcare research and urge caution regarding the use of indicators.

This talent is excellent for maintaining the Manitoba Centre for Health Policy’s reputation as it stimulates literally hundreds of invitations for speaking engagements. In one year alone, she was invited to tell MCHP’s story in nine out of ten Canadian provinces.

And although her use of metaphors suggests differently, Dr. Martens described herself as a linear thinker. She said the trick about managing the Centre is that “It’s like running a business within a university.” Comparing leadership styles with the founding directors, she said Drs. Noralou and Les Roos were amazing visionaries. She then described her own style as more pragmatic. “I want things organized and visible and transparent and equitable and all those kind of things, right. I’m more of an administrator.”

MCHP as a Maturing Institution

Transitioning from the founding director to a new director was highlighted by many as a key event. People mentioned that it was a move to a new stage in MCHP’s development and a time of heightened anxiety. One person said, “The retirement of the Rooses from running the Centre was another period.” Pointing to the strong leadership of the founders, he continued, “There’s always a risky period to see whether the next generation can pick it up and keep it going. And I think Pat’s done a good job of that, but that was something you had to test.”

Dr. Martens recalled: “Noralou wanted to try a few different models for running the Centre. She tried a co–directorship for several years, and then she tried a tri–partite model, kind of co–acting co–directors. Each of us took on some of the responsibilities of the director.” Just four years after joining MCHP as a researcher in January of 1999, Dr. Martens accepted responsibility for negotiating the deliverable projects with the province in her role as Acting Director of External Relations. In June of 2004, she was made the Acting Director while MCHP conducted a national search for a new director. And one year later she was the successful candidate. One staff person’s comment
echoed many: “So it didn’t happen overnight, but that had quite a profound effect because their management styles are very, very different.” Such comments were usually followed with a comment indicating both were strong leaders or had “boundless energy.”

Dr. Martens’ initial actions upon becoming Acting Director of the Centre were focused on organizational structure. The previous director had done well with an informal structure, but MCHP was not only three times its original size, it was also carrying out increasingly complex projects with the expansion of the number of datasets to 90–plus and increasing relationships with providers and research collaborators. Dr. Martens brought in a more formalized structure in response to a staff recommendation: “She brought organization to our organization. At our first retreat, that was one of the things that really came to the forefront. … So that was one of the first things that Pat did, was bring in the org chart, so that everybody knew where they fell in the org chart and how their job was important to the rest of the organization.”

She also set up weekly meetings with an executive committee, consisting of the director, the executive assistant and three associate directors covering the repository, research and administration areas. She meets once a month with the sector managers to get an update and overview of Centre activities and concerns. Dr. Martens said, “This is such a big organization if I didn’t have those monthly meetings, I would not have a clue about all the really exciting stuff happening. The people who work here are just so creative and so smart, and they start these wonderful initiatives.” She added, “As well, these meetings help the managers understand how their initiatives may assist, or sometimes overlap, with other initiatives, and how we can work “smarter” to ensure the jobs get done by the right people at the right time.”

One of Dr. Martens’ first tasks as the official Director of the Centre was to develop a new strategic plan, as recommended by the 2005 external reviewers. A year–long self–examination culminated in a fairly unique strategic plan. Dr. Martens, herself, went from somewhat sceptical about the value of the exercise to being surprised at its usefulness.

We spent a lot of time after that review, internally at the Centre and working with some of our stakeholders, to try to document our mission, our vision, our values, and our goals. I’m not married to the process but we did it, agonizingly over a year and a half. And it’s a very useful document. It made me realize that we have three pillars at the Centre. It was probably the first time that we’d articulated it, although everyone knew it intuitively. There’s the Research Pillar, the Repository Pillar, and then there’s the Knowledge Translation Pillar. And it made us formalize the fact that all of our work is going to fit under one of those categories. Everybody in the Centre is working towards those three ends. And we have to make sure that we’re supporting all three pillars.

Dr. Martens included a visual representation of the Centre’s mandate in the strategic plan. “It was funny because a lot of people said, ‘We don’t like that picture, because no strategic planning has a picture.’ I said, ‘I don’t give a rip. I’m a visual person, and this picture is more important to
me than all these words.’ And so I was adamant that we keep the picture, and I’m very glad for it because it sticks in everyone’s mind. It’s always a quick way of illustrating the Centre’s work during presentations about MCHP.”

Reflecting on the strategic plan, Dr. Martens observed, “What we do has not changed since 1991, but has become more complex with the addition of numerous datasets and the changing environment of healthcare.”

**The Need To Know Team**

Part of the changing environment has been establishing long-term working relationships with the regional health authorities. “One of my real loves is The Need to Know Team and the whole regional health authority collaboration with MCHP and Manitoba Health. And that began by a strange series of events. I credit Charlyn Black with really helping me make that happen.”

Dr. Black started the Rural and Northern Healthcare Days in 1994 as a half-day lecture series on the deliverables that were relevant to rural regions. Dr. Martens was asked to oversee the Rural Day: “In 1999, I was the new kid on the block.” And she pointed out the new kid on the block gets the jobs that others are too busy to do. She decided to change the format:

I said, “We’ve got this wonderful new deliverable that Charlyn and I had worked on called the RHA Indicators Atlas. So instead of just lecturing about it, how about if we give maybe a 20-minuter on how to read these graphs, and then have people from the different regional health authorities sit around the table with one of the researchers from the Centre, and just look at the data and say: ‘What is this meaning to you? Does this make sense to you? What should we do about it? What should you do about it?’”

It took a little persuasion to get going initially, but Dr. Martens said, “There was a wonderful response from the regional people and from the researchers.” She added, “In some ways it takes the burden off the Centre. We’re just there as part of the group, talking about the research, and they [the regional people] are just as knowledgeable as we are, but in different areas—they know the context. So that’s where it started.”

The Rural Days continued as interactive sessions and attracted more and more people. Drs. Black and Martens were also involved with the CEOs, reporting Centre activities at their monthly meetings. “Then Charlyn and I said, ‘Well, this is fine and dandy, but wouldn’t it be great if we could involve the regions at the very start of the research project, not at the end like that?’ So I wrote up this grant application for the Canadian Alliances for Health Research program [a strategic grant from the Canadian Institutes of Health Research] in 2000 to see if we could fund a team to work together with us. And it was actually funded in 2001.” Dr. Martens concluded, “That was the start of our really close interaction with regional health authorities—first it was geared to the rural, that is the non-Winnipeg RHAs, and then later, we expanded to include Winnipeg.”
The Need to Know Team consists of decision makers and planners from Manitoba’s 11 regional health authorities, academics and graduate students, data analysts associated with MCHP and high-level planners from Manitoba Health. The team works collaboratively on research, three-way capacity-building and knowledge translation. Their first project, completed in 2003, was an updated provincial Indicators Atlas to assist regional health authorities in developing their five-year strategic plans. In 2004, the team produced a mental illness report that garnered national attention. It was one of the first ‘population-based’ analyses of mental health prevalence and use of the healthcare system. One of the interesting findings was that in a five-year period, one in four Manitobans had at least one diagnosis of depression, personality disorder, anxiety disorders, schizophrenia and/or substance abuse. And in 2005, the efforts of The Need to Know Team, led by Drs. Randy Fransoo and Patricia Martens, resulted in a report on the differences in men and women’s health status and use of healthcare.

In November of 2005, the Canadian Institutes of Health Research awarded Dr. Martens, MCHP and The Need to Know Team a national Knowledge Translation Award for Regional Impact. Their recognition outlines the teams’ achievements:

The CIHR Knowledge Translation Award recognizes merit in an exceptional individual or team currently involved in a collaborative health research or development project that aims to advance and expand the understanding of knowledge translation and also leads to improved health for Canadians, more effective health services and products and a strengthened healthcare system. Since 2001, The Need to Know Team of the Manitoba Centre for Health Policy, headed by Dr. Patricia Martens, has been a textbook example of KT in action. … Researchers, regional health authority representatives and provincial planners collaborate on research from the development of the research questions through to ensuring that the resulting data are used in evidence-based decision making and planning. Working together as a team builds capacity among both academics and planners and facilitates dissemination and application of research results in the ‘real world’ of decision making (Canadian Institutes of Health Research, 2005).

Contract Negotiations

Many people have commented that the strong relationship between MCHP and the regions has been critical to the Centre’s survival. Referring to The Need to Know Team, Dr. Martens said:

And that has been our saving grace. I hate to say that so strongly but when governments think, “Why are we funding the Centre?” The regional health authorities say, “We need these people. They are incredibly valuable to us. They are capacitating our region. They’re giving us good information for our planning that you expect us to do. We don’t know what we would do without the Centre.” So there has been a real support backing for the Centre because we have been so closely allied with the regional health authorities.
This is particularly relevant during grant negotiations. Grants with the provincial government are negotiated every three years for a five-year period. “Right now for example our grant was recently renewed from 2010 to 2015, so we would begin re-negotiations for another five-year term starting in 2013.” Under ideal conditions, this rolling contract provides some stability for MCHP staff. However, when the Centre requested an annual increase of about half a million dollars to bring the contract up to $2.325 million per year, the contract wasn’t formalized until the very last moment, as related below by a staff person:

Noralou had spoken about it [the need for an increase] with the prior agreement. Noralou was around for awhile during that transition period, and she was helping make the case. We were all aware that the Centre hadn’t got an increase for a long time, but Pat really took the bull by the horns and said, “Look, we really have to do this.” And she really pushed it to the 9th hour to try and get that funding in place. We’d started negotiations in the third year of that contract, and it was in the fifth year of that contract, which expires the 31st of March. It wasn’t until February that they actually signed off on the increase. Had it gone another two or three weeks, the university may have forced us to sign layoff sheets. But we didn’t get to that point, not signing the contract. It was a bit tense there for awhile. So it was a real success story for Pat because the Centre had been funded at the same level for a long, long time.

Dr. Martens, too, recalled these as exceptionally difficult negotiations. She attributed the success to assistance from many others:

I’m sure if push had got to shove, in an instant they would have renewed us for 1.85 million. But I couldn’t sustain it at 1.85 million. I was sweating buckets. I mean you’ve got 60 people full- and part-time; just inflation and your salaries alone. I couldn’t bring in that much extra funding. … That was 13 years, and our staff had tripled. The demands for deliverables were much greater, etc., etc. I think it was partly the lobby of the regional health authorities as well as some key people in Manitoba Health who knew that this was valuable work for their own processes. It finally got the Treasury Board to sign off on an increase.

This responsibility to ensure adequate funding for the Centre is deeply felt. “As Director of the Centre I have a heavy weight on my shoulders to bring money in to keep everybody employed.” The university provides several tenure-track positions, the space and a small amount of operating funds; however, the Centre has to be self-sufficient with respect to the majority of its budget of close to four million dollars a year. “We have to bring in all the money to keep ourselves going. And so you have to run it a bit more like a business, but at the same time, you’ve got all these academics, right. And they don’t really fit into a business model.”

One of her goals is to protect newer researchers from too much administrative work so that they can get the grants and publications that they need for a successful academic career. “We look at them as the same as they would be if they were on a tenure-track position, so we’re trying to mentor them.”
Nurturing Researchers

Dr. Martens commented that working at the Centre gives researchers a great head start. “Speaking from personal experience, the Centre is a really good place for new researchers because first of all they get handed these projects, and they don't have to go find the funding to do them. It's like getting handed a three hundred thousand dollar CIHR grant.” Assigned projects come with the resources needed to conduct the research, including a research coordinator and trained programmers, opportunities for team work and networking and lots of assistance from experienced researchers. Researchers are encouraged to write up the deliverable project results for submission to peer-reviewed journals.

Although a potential drawback is that researchers get projects in areas they would not choose themselves, Dr. Martens said it often turns out to be interesting for them and broadens their perspective on population health. Sometimes they come across something in a deliverable which they build on for a CIHR grant. So Dr. Martens concluded: “It isn’t surprising that our new researchers are so well geared to get new investigator awards and MHRC awards, etc. Their careers will often be twice as fast as the ordinary route of a brand new researcher desperately trying to look for a fifty thousand dollar grant. Especially with mentorship like I was privileged to receive from incredibly successful research scientists, like Noralou and Les Roos.”

Drawing on her own experience and that of her colleagues, she said, “That’s been a successful model for the Centre. A lot of the people who work at the Centre, like myself” and she named four colleagues, “we’ve all got CIHR New Investigator awards, I think, partly because of that massive support early on.” She suggested that early success leads to further success, as for example her receipt of the national CIHR/PHAC Applied Public Health Chair in 2007.

It’s a busy life, as those close to Dr. Martens will tell you. Anyone aspiring to be director of a large organization such as MCHP should be prepared to work long hours. Someone who knows Dr. Martens well suggested that she has the equivalent of three jobs—there’s the administration, the small p politics, all the work sustaining relationships, the numerous speaking engagements, and then teaching and research. Dr. Martens has a time-honoured solution: “The only way I keep going is you’ve got to have a real good sense of humour, and a lot of people around here laugh a lot and that helps.”
Reference List


CHAPTER 4: THE BOARD OF DIRECTORS: INITIAL AND MOST RECENT

First Advisory Board: 1991

Co-Chairs
Frank A. Maynard, Deputy Minister of Health, Province of Manitoba
Noralou P. Roos, Ph.D., Director, Manitoba Centre for Health Policy and Evaluation and Professor, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba

Members
Nick Anthonisen, M.D., Ph.D., Dean, Faculty of Medicine, University of Manitoba
Morris Barer, Ph.D., M.B.A., Professor, Department of Health Care and Epidemiology and Director, Centre for Health Services and Policy Research, University of British Columbia
Michael Bessey, Acting Deputy Minister, Industry, Trade and Tourism, Province of Manitoba
Charlie Curtis, Deputy Minister of Finance, Province of Manitoba
John L. Hamerton, D.Sc. Head, Department of Human Genetics, Faculty of Medicine, University of Manitoba
Anna M. Hunt-Binkley, B.N., LL.B., private law practice in Brandon, Manitoba
Philip R. Lee, M.D., Director, Institute for Health Policy Studies, University of California, San Francisco
Arthur V. Mauro, C.M., Q.C., President and Chief Executive Officer, Investors Group Inc. and Chairman of the Board, St. Boniface General Hospital
J. Fraser Mustard, M.D., Ph.D., O.C., President, Canadian Institute for Advanced Research, Toronto
Arnold Naimark, M.D., President, University of Manitoba
Brian Postl, M.D., Professor and Head, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba and Head, Community Health Sciences, Health Sciences Centre
Tannis M. Richardson, B.Sc., Chair, Fundraising Committee of the Juvenile Diabetes Foundation and Director, Mrs. James A. Richardson Foundation, Paul H. T. Thorlakson Foundation Inc. and L.E.A.F. National Leadership Committee.
Leslie L. Roos, Ph.D., Director, Manitoba Research Data Base, Manitoba Centre for Health Policy and Evaluation and Professor Department of Community Health Sciences, Faculty of Medicine, University of Manitoba
John E. Wennberg, M.D., M.P.H., Director, Center for the Evaluative Clinical Sciences and Professor, Epidemiology, Community and Family Medicine, Dartmouth Medical School, New Hampshire.

Most Recent Advisory Board: 2009
The following people served as members of MCHP’s Advisory Board for all or part of the fiscal year ending March 31, 2009.

Chair
Brian Postl, M.D., Chief Executive Officer, Winnipeg Regional Health Authority

Ex Officio Members
Lawrence Elliot, Acting Department Head, Community Health Sciences, Faculty of Medicine, University of Manitoba
Sharon Macdonald, Department Head, Community Health Sciences, Faculty of Medicine, University of Manitoba
Patricia Martens, Director, Manitoba Centre for Health Policy
Tannis Mindell, Treasury Board, Province of Manitoba
Leslie Roos, Founding Director, Manitoba Centre for Health Policy
Noralou Roos, Founding Director, Manitoba Centre for Health Policy
Dean Sandham, Dean, Faculty of Medicine, University of Manitoba
Arlene Wilgosh, Deputy Minister of Health

Appointees of Manitoba Health and Healthy Living
Martin Billinkoff, Deputy Minister, Family Services and Housing
Harvey Bostrom, Deputy Minister, Aboriginal and Northern Affairs
John Clarkson, Deputy Minister, Manitoba Energy, Science and Technology
Gerald Farthing, Deputy Minister, Education, Citizenship and Youth
Heather Reichert, Deputy Minister, Advanced Education and Literacy
Monique Vielfaure Mackenzie, Chief Executive Officer, South Eastman RHA

Appointees of the University of Manitoba
David Collins, PhD, Dean & Professor, Faculty of Pharmacy, University of Manitoba
Joanne Keselman, PhD., Vice President, Academic, University of Manitoba.
Fraser Mustard, MD, PhD., O.C., President, The Founder’s Network, Toronto
Luis Oppenheimer, MD, Provincial Director of Patient Access, WRHA.
Leonard Syme, PhD, Professor of Epidemiology and Community Health (Emeritus) University of California, Berkeley
Mark Taylor, MD, Vice President Medical Affairs, Lakeridge Health Corporation

CHAPTER 5: WHO’S BEEN AROUND SINCE THE BEGINNING (OR BEFORE)? FOR 10 YEARS? FOR 15 YEARS?

1973 Noralou P. Roos
1974 Leslie L. Roos
1975 John Patrick Nicol
1976 Evelyn Shapiro
1985 Bogdan Bogdanovic
1987 Ruth Bond
1989 Leonard MacWilliam
1991 Marni Brownell
1991 Shelley Derksen
1991 Eileen Bell
1992 Shannon Lussier
1992 Randy Walld
1993 Charles Burchill
1993 Marina Yogendran
1994 Natalia Dik
1995 Carole Ouelette
1995 Randy Fransoo
1995 Anita Kozyrskyj
1996 Jo-Anne Baribeau
1997 Greg Finlayson
1997 Ruth-Ann Soodeen
1997 Ken Turner
1998 Colleen Metge
1999 Pat Martens
1999 Linda Romphf
1999 Linda Kostiuk
1999 Rod McRae

Chapter 6: Comments from Current MCHPers

Small numbers preclude going into detail regarding survey and interview respondents. Other than the past and present directors, I interviewed five current staff members. Seven people responded to the invitation to contribute answers via the SurveyMonkey questions. Although there are not many respondents, there were programmers (or data analysts), researchers and support staff participating in both methods of data collection. Respondents were roughly split between shorter term employees (employed at the Centre for less than 5 years but more than 1 year) and longer term employees. Specific questions were asked during the interview about key events, challenges, factors important to success as well as advice for those attempting to start a centre. These topics also came up in other parts of the interview, were coded as such, and are without reference to the question. As indicated earlier, the interview responses have been selected to represent peoples’ major concerns as I understood them. They are edited for readability. The survey responses are presented verbatim other than removing people’s names and identifying features from negative context.

6.1 What were the major challenges that MCHP has faced?

Maintenance of stable funding is a universal challenge for research organizations and was frequently mentioned as key to retaining competent staff. Relationships with the government and the university and personnel and data issues were other frequently mentioned challenges. Many of the challenges mentioned were also mentioned as successes. For example, the “hostile audit” of 1997, which was mentioned by several people, was always told in a way to suggest a life-threatening event that turned out to improve the Centre’s relationship with the province. Contract negotiations and transitioning directorship were other such challenges, well met.

Similarly, the Centre’s success has created new challenges. Its very existence as a specialized research unit within the university makes for sometimes difficult relationships with other departments that are less well resourced to do research. The successful CFI grant created the merge and move challenges related to combining two different work cultures as well as personnel– and data–related challenges linked with growth. Large organizations will always have personnel issues and research organizations will always have data issues. Staffers related some workaday challenges here, and for the most part, discussed how they were dealt with.

Funding

The biggest problems come from mostly the funding. The negotiations: What deliverables they’re working on? What money do you need? That’s all between the directors and Health. If there’s a long delay in polishing that off, then people start to get nervous. But we’ve built a three–year delay into that—we start negotiating three years early.
Relationships with the Province

There was in 1997, I would say a grievance, a complaint, an issue, a concern raised from somebody at Manitoba Health, which had Manitoba Health send a couple of auditors to visit us for six months. Now, it also was an extremely positive thing to happen. It turned out to be a good thing. To be looked at under a microscope is uncomfortable but it came off as a malicious accusation and a big potential bump that had very positive repercussions. The feedback from that audit was one of those things that really helped build a level of trust.

When we’re releasing a deliverable that’s saying things that are not necessarily favourable, there gets to be a bit of tension. Within the contract it’s stated that within 60 days of providing information to Manitoba Health, we’ll publicly release the report, if it hasn’t been released before that point in time. And sometimes, depending on the information, they’re not always very happy about that. While I’ve been here, there’s been some of those sorts of interactions, where things get a bit touchy, but at the end of the day, we’re at arms length from government, and that’s really very important for the Centre to maintain. We’re not controlled by the government, and they may not like what we have to say but we’re still going to say it. It doesn’t always go down well with them. Other centres that have come here to find out how we manage to be around for so long, they find that quite remarkable, that that’s in our contract, that we have that autonomy because other places don’t.

I would say that the relationship with government, and it’s both in bureaucracy and the political, particularly the political masters is a key—process of nurturing that needs to be ongoing and fed on a continual basis. You cannot leave it dormant and say, “We’ve got a good relationship with them, and ignore it. It has to be an ongoing process, and it then creates a time tension because on the one hand, you’re working very closely, nurturing a relationship with a funder; on the other hand you have to maintain your academic freedom and not be seen to be doing the bidding of government in terms of policy decision making.

Clinician mistrust. I think it is some suspicion that we may be in government’s pocket. From time to time, I think people might wonder about that. … In many respects we need to treat government in the same way we treat industry in terms of being suspicious of their goals and ensuring that we are maintaining our independence of thought, at the very least, in the work that we do. … Our relationship with government, in terms of let’s say deliverables, is in negotiating the initial research questions. The questions are very broad, always. The role of government often is on a working group, which is really an advisory group. It does not dictate to the researchers what they are going to do or how they are going to do it. It helps us identify questions of interest to government. But the part about government is this—they’re there for public good, whereas industry is there for profit. That’s a key difference. So, if the government is interested in the question for the benefit of the public, then that in my view, is a valid question, as long as I’m allowed to answer that question in an appropriate way.
Relationships with University

Well I think our relationship with the university is also very important. As an academic unit we function within the university’s environment, and that has both advantages and disadvantages. Working within the university, particularly in some areas, allows [us] to apply for grants within the university structure, etc. On the other hand, the university academic structure doesn’t always work well for units within departments. … The Centre’s mandate is research—whereas the university as an institution has a broader mandate. And within the Department of Community Health Sciences there’s clearly a mandate. So that comes to the whole issue of funding, where some of our positions are funded directly by the Centre. These are researchers and they are very often involved in activities that are not strictly research; they do teaching, they do mentoring of other people. Well that administration potential within the department, that’s not necessarily what the Centre is funded for. On the other hand, other people in the Centre are funded by the university, and if you’re a university employee or academic position then you have responsibilities for research, teaching, administration. So there’s a tension there potentially. Clearly we cannot exist purely on our external funding. On the other hand, the university doesn’t give us a lot of funding or a lot of support. So we’ve got this challenge in addressing that relationship.

Challenges for the Centre—well, I guess we’ve had a difficult time sometimes within the department because there’s some departmental jealousy, more probably within the faculty.

Personnel Challenges

Our growth. We are growing so much, and it’s a big challenge to find office space for people, because we have lots of students who work for us as well. I just don’t know how much longer we’re going to be able to fit within this centre.

Communication. I think communication has always been a challenge and will continue to be a challenge. We hear frequently at the various different meetings, staff meetings, retreats, that we just don’t communicate well enough within our own department.

Les oversaw St. Boniface, and Noralou oversaw the university and bringing the two sites together was very challenging, very challenging.

We see the strengths that people have and the areas that they like to work in, so we give people lots of wonderful opportunities to take courses, to go on workshops, so that they can work to their potential. … That’s one of the big challenges is to make sure that the people are being remunerated for the job that they’re doing and that doesn’t always happen. They don’t always get the recognition for the job that they’re doing. They get it within the Centre. We recognize our people. Pat is very good at doing that as well, but the recognition doesn’t happen within the university.

To mention it, part of the success is finding and maintaining good people—and the maintaining of it, I guess is the challenging part because often times umm—uh people will gain some experience and then look for greener pastures, right. But apparently no greener pastures exist around these parts because people are quite happy to stay there for lifetimes. I think the average person has been here for 15 or more years.
Well personal challenges are self-imposed. The fact that I live outside of Manitoba is a real challenge for me. They’re so good about connecting us by phone, and they’ve got this incredible phone system, but meetings by phone are really difficult.

Data Challenges

One of the challenges of our work is that it’s predominately Manitoba data, so the answers aren’t necessarily the same in other provinces. So while we’ve succeeded in making our research relevant nationally and internationally, there are many specific research questions that are local in nature that are important. And I think it’s important that provincial governments have the opportunity to answer those questions for their system.

Well I think that perception of being physician non-friendly is probably the key one that comes to my mind. The other part of that is: there was a perception that it’s very expensive to do research for the Centre. I don’t think people know what happens behind the doors but people see the cost of using the data as being expensive. It’s the people who aren’t [used to] doing the research, the clinicians who think, “Now there’s data, let’s just use it. It’s partially lack of understanding of the research process as much as anything else.

Quality assurance. The data acquisition officer is responsible for taking data in one format that comes from Manitoba Health and Healthy Living and putting it into the database that allows us to do analysis. That is a key step that has to be done right and any errors in that process can result in significant problems with the data. … So quality assurance to me is a key challenge with this process, that the assumption that you’ve got data, you can analyze it, is very naïve. There a significant amount of work goes into cleaning and manipulating the data for analysis.

I think bringing in new data, we’ve learned a lot. We started with all these Manitoba Health databases that were structured probably relatively simple at the end, whereas we’re bringing data from completely different sources [now]. They’re all kinds of challenges in understanding the data and the value of the data etc. and cleaning the data. So that’s a challenge, that whole process. The structure of our data in terms of being linkable data is a huge strength when it comes to bringing in new data sets.

Right now we are in a very considerable growth phase that I don’t know is maintainable. I don’t think it’s maintainable. Back in 1970—again, that’s before the Centre, I realize—there were three [data sets] and by the time the Centre came around there might’ve been 10 and now there’s 80, depending on how you count. … Just keeping that up-to-date is a very considerable piece of work. And I think we’re doing it, but I have this fear that we may over-run our carrying capacity.

Well the big risk is if you’re doing a population health study, you’re looking at the same people over and over again and they’re getting into the denominator. … So we stripped the names out and vital stats, and then wrote this probabilistic program. It tends to come out in more recent years at close to 99% .
When somebody comes to work with the Centre, if you know right up–front that you need to have 5 sets of approvals and it’s going to take four months minimum to get there, you can be annoyed at that but at least you know up–front. … The number of approvals builds up, mostly because none of the data is ours. We house the data, help access it, but you need to have approvals from the stewards of the data.

**Survey Responses**

Yikes. Don’t know many of these, but here’s what comes to mind:

Less than universal, consistent support from Govt. I remember in the 1999 election, the NDP candidate for the Maples actually had printed in a handout that he thought the govt should stop wasting almost 2 million a year on this health research centre, and use that instead to provide more health services! The party was elected; not sure if this member was or not, but likely not every NDP MLA supports/ed MCHP.

We also had a rough patch with one particular Health Minister—he really stirred some things up, I understand.

There was also someone who was MCHP’s main liaison person at Mb Health for a while, and he really tried to get MCHP in trouble. Tried to sell us out to Pharma industry, then tried to shut us down. On his last day in office, ordered a brutally detailed audit of MCHP, which resulted in two auditors at MCHP full–time for like 6 months. Turned out okay, but a real hassle at the time, which carried a real threat.

In getting things going at the start, there was no doubt huge challenge in getting real respect for research based on admin data. Nobody believed it was useful—especially physicians, who didn’t seem to see the irony in telling us that physician billing data was so poorly entered that it was useless.

I see anything that has an impact on staff as being major.

Amalgamation into one location from one location under Noralou’s leadership; the other under Les’s leadership. This historically meant two very different work–styles evolving on the two campuses, one accustomed to the very directed, strong leadership of the former and the other to the more freewheeling creativity–inspiring leadership of the latter, and it was a real challenge to merge the two groups of staff.

Change in directorship also affected staff—moving from Noralou’s directorship to Pat’s was a challenge. Partly as a result of this change, partly as a consequence of the growth resulting from the merging of the two campuses, (perhaps other factors as well—e.g., changes in the larger context of the U of M) MCHP has become increasingly bureaucratic and micromanaged. The paradox is that while the apparently desired effect is one of a “flat” organization, MCHP has actually become even more hierarchical.
Retaining qualified staff with a decent work ethic.
Renegotiating contract with Manitoba Health to provide stability to keep MCHP funded.
Continually encouraging/motivating researchers to submit proposals for more funding to ensure financial viability in the future.
Ensuring good morale of staff.

It was a huge challenge to get the CFI proposal done, and later there was a lot of hesitation from employees about moving to one place, especially the St. B group, here you have to give the credit to Noralou for getting through that. The deliverable got delayed and that has to be addressed. Although there were other challenges later, but by this time the centre was at the forefront and it was much easier to deal with.

Moving past being a “The Roos” project
6.2 What factors do you see as important in the Centre's success?

The majority of participants mentioned the necessity of nurturing a strong and trusting relationship with the government, and the importance of meeting their needs in order to ensure stable long-term funding. Entering the research environment prior to today's more stringent privacy requirements allowed the Centre to demonstrate their ability to protect confidentiality and inspire trust. Other frequent themes were strong leadership and the retention of good people so that there was a strong team of people with a deep understanding of their work at the Centre. On occasion, the necessity of doing high-quality research was explicitly stated. More often it was implied in comments such as those recognizing the excellent database and the good decisions around its usage as foundational to the Centre's success or general comments about being useful to government. Processes that allowed government input while protecting the research process and academic freedom were raised throughout the interviews.

The selected quotes from current staff suggest some of the effort behind these summarized themes. Responses to survey questions on advice for those attempting to start up a centre and additional comments are added here. The side-bar is one participant's reflection on similar themes.

**Government Relationship**

My experience here tells me that if you don't have the support and the buy-in of Government and the university and some other influential people who have the ability to influence Government on your behalf, you just don't have a hope.

The nurturing of the relationship between the Centre and Manitoba Health, having both the bureaucracy and political level, has in some respects insulated us from both politics and economics. We've been through both Tory and NDP governments and worked closely with both of them because we have nurtured a relationship through the bureaucracy. We do high-quality work that answers questions that they may have, regardless of their political leanings. And politically, in economic times while you look for places to cut, if you see the Centre as being of value, you don't cut the Centre's budget. So, the fact that we continue to be seen and valued by the political masters for the work we do means that we have to-date been relatively insulated from bad economic times.

What I've told people is: it takes a lot of patience. I'm not speaking from my own experience here, but I know Noralou and Charlyn Black and Les and Evelyn Shapiro spent all sorts of time establishing the relationships with Government and establishing the trust. And Pat has continued that. That's a big part of her work, just communicating with the government departments.

[The biweekly meetings] with Pat and Deb are just to trouble shoot, update on what's going on, to keep a really open line of communication so that nothing becomes a problem, and there aren't any surprises. … You have an opportunity to throw things out on the table. Well, the Centre's lasted a long time, so it must've alleviated some issues before they became issues. I would say open communication is always a big plus for success, but it's a time commitment on both sides, right?
The executive level, they communicate lots. But if you look at the next step down—the analyst level, they’re not the bureaucrats, they’re not the policy maker level, but the people who turn the crank—they talk to each other as well. And while that has some potential pitfalls with skipping the bureaucracy, it does mean that there’s a much better understanding of how the Centre works not at just the high level but all the way down the chain.

When we get visitors from other places that want to put these centres in place, they tend to forget that the Centre has had more than 30 years worth of relationship building, not the Centre, I realize it was 20 years, but there was trust and that relationship building that is a huge. … Most groups want to get up and going full blown right away. I guess you can do it, but to go from zero to sixty in no time is fraught with pitfalls.

It’s all about trust. I think it’s all a track record, and the fact that privacy and confidentiality and all the new legislation came in over the last—is it ten years now? Maybe a little more. Personal Health Information Act, and all this new legislation which didn’t exist before, when those rules came in, there had been a good track record of using the data in a completely trustworthy way.

We’re answering questions that are of interest to them. We’re providing them with information that they may not be able to get themselves, and that is useful for their own planning and policy development.

And the talk around the table is, “Government do this. Government do that.” And then MCHP, they’re always brought into the discussion by Government as being part of the process or going to do some work or deliverable. Certainly, they’re going to have the Centre do this. So they’re seen as a partner, really seen as a very strategic and important partner. That’s the critical thing. They’ve obtained that status of strategic and important partner with Government. So now government depends on them. That’s the critical step you need to achieve in order to have some sort of a lasting relationship—Government depends on you.

Whenever there was some sort of a hiccup in the relationship or problem, this person was like a champion an unbelievable champion on the government side. He would always come to the Centre’s rescue. I think it was very significant. [There were] a lot of key moments where things could’ve gotten pretty seriously derailed. He was there to smooth things over, work out problems or move the agenda forward. … He’s an unbelievably huge supporter of the Centre.

**Funding**

We’re very supportive of reclassifying our staff and retraining them and keeping them current. It gets to a point where you don’t ever want to let them go, so you need to get more money from somewhere. So the increase was really beneficial in helping us retain the high quality staff we have, as well as allowing us to continue down this road with opening up the access and expanding the repository.
If the funding doesn’t come at the get–go, good luck trying to get it down the road. If you are surviving year after year, they’ll say, “Well, you’re doing really well there, just keep going.” And so you never get support. Your ability to survive can be an Achilles heel. … [Once they contribute financially], people are now vested, they have a vested interest in the outcome and will start to make further investments to see those initial investments pay off. So there’s something quirky about the start of these things—it’s so critical.

**On People and Working Conditions**

The only other very important thing for the success of the Centre is attributable to the people who work here, basically. They’re very committed to the Centre, and I think at the end of the day, the vast majority actually enjoy what they do. You can have good leadership, and it will still fall apart if you don’t have good people who actually work hard and do a good job.

**Longevity** is hugely important because they have that background, the understanding of how things are done, the background on the data itself. So people have had lots of chance to work on lots of different data sets and have a really very deep understanding of the administrative data, how it goes together and how we build it and the kinds of methodologies that we use as well as a very good comfort level with being able to discuss with each other on new data and new methodologies and where things are at.

I think the atmosphere here is more collaborative than you’d find in other places. We help one another, and I got that right from the time I arrived here. It’s always been everybody helps each other. It’s not just collaborative but a very supportive working environment.

The people that I’m working with don’t need a whole lot of supervision. They’re very good at what they do. They’re all great over–achievers, hard workers.

I think it’s a really good environment. People are treated well. It has more of a university feel than a big bureaucracy feel to it, so a little more latitude for people to explore, to promote themselves within the organization. It’s a good quality of family life, or good emphasis on balancing work and outside interests. A real plus at the Centre is that they have a lunch room on–site, and they encourage the use of it. People get to know each other, and the bonding I think helps retain people as well. That is just a great way for people to really go beyond their demanding work environment and get more depth in the relationships.

There were always opportunities to try your hand at something different. There’s support from management, or whoever you want to call it, for people to take the initiative and run with something. It seems like that’s encouraged right across the organization.

It’s not usually a very high stress environment, and that may be because of some of the freedoms that you have. That’s not to say there isn’t a ton of work, but most of the researchers are not what I think of as the A–type personality, you know “Get this done now.” We work on a time–line, so to make this work we’re not getting hung up over a whole variety of little things.
The Story of the Manitoba Centre for Health Policy

Leadership

Strong leadership is the main thing that has allowed us to get where we are now. Noralou was a very strong leader. She was known nationally, internationally; both the Rooses are still known internationally for the type of research that they did. Pat, when she first came on, wasn't as broadly known but certainly over the last three, four years has really got her name out there. People know who Pat Martens is. They know who the Manitoba Centre is. They know the type of work that we do, and I think it's because of the two directors that we've had at the Centre as our strong leadership.

They hire good people. We're able to recruit good researchers, principal investigators, and we're able to retain people. I think that's another really important thing—that we have lots of people who have been here a long time, and it's because we have good leaders who support us, allow us to do what we want to do, allow us to work to our strengths and provide guidance and opportunities for us. The retention of lots of good people has to do also with our flexible work environment. That seems to be one of the recurring things that people say the reason they stay here is because we have a flexible work environment. … People here work very hard but we allow them flexibility to work the hours that work best for them in order to maintain a balance with their home life and their work life. So we're not an 8:30 to 4:30, one hour for lunch. We have lots of people that come in at seven and work 'til three, or come in at nine and work 'til five. As a result people are willing to really go the extra mile because they know that they have the flexibility to balance their work life with their home life.

The leadership has been phenomenal. I can't say enough good about Noralou, as you've noticed. And I think Pat's done an outstanding job, very different from Noralou, very different style and very different approach to things but I think she's done a terrific job bringing people together and also being the face and the voice of the Centre.

Having the same director for—how long was Noralou director—for a long time. Sometimes it's a bad thing I guess, but for the Centre it's a very good thing to have very little turnover at that executive level.

Probably the high energy. There was just so much going on, and Noralou has boundless energy and so does Pat. It's like the energizer bunny. They just don't stop. And it's fairly contagious, I think. It's a bit wearing but I think it's also fairly contagious.

Data Decisions

Les or Noralou or somebody had made a decision that all the analysis would be done using SAS, which in the grand scheme is a really good thing. What it means is all of the data analysts speak the same language; all the data systems are the same; all of the support facilities are the same. Code can be shared between projects without too much grief. … I've seen some other groups that had allowed their researchers and their analysts to use whatever programs they knew and were comfortable with, but after ten years they wound up with research that they couldn't replicate because somebody had written a program that nobody else understood anymore. … So the choice of one package to do the analysis and data support.
On our website we’ve been attempting to be very transparent about the process for accessing and using data, system access, data use, approvals, all of that kind of thing that people have to go through. So that would increase the ability of outside researchers to work with your data sets.

We’re a bit unique here in that we have this really good relationship with Manitoba Health and have developed this process for the de-identifying the data before it comes here. So although we treat the data as if it were identifiable, in reality, it’s not. And that model is unique across Canada.

Well, the terrific database. Whenever I present this I say that these two people had this tremendous foresight to build this in a way that it would be useable, not just for them, but to continue to build a longitudinal database before really anybody was doing this. I just can’t say enough about how forward-thinking they were and how carefully they did it. It’s such a great resource, and everybody knows it’s a great resource. In fact, we are the envy of the whole country when it comes to this kind of work. So that’s number one, and I say all that because it’s not just a database, it’s the people who have nurtured the database and developed the database. So that leads into all sorts of other things that make it easier for research grants.

I think that the whole structure and the way the data is set up and used is a key component to both the success of this place and surely confidentiality and privacy and all those other things.

Each database is separate. You could link the data using the scrambles from the linkage but they are separate databases. So they’re not linked databases. They are separate databases that can be linked to ask specific questions out of different sources. It allows you to bring in new databases and run it, as long as you can structure it in a way that the link is there. I think it makes it much easier.

Research Issues

[The freedom to publish has] always been in the contracts. … And it’s not something we would ever be willing to give up. Part of that has to do with academic freedom. These are academics, although they’re working under contract, they’re still academics, and they need the freedom to publish what they research.

The way we have things set up at being arm’s length from government is really important for our credibility as researchers

It’s all made public, and there are always peer reviews. There is always external review of studies before they’re made public. … So while the question may be one of interest to government, how we answer it is our responsibility, and we make every effort to ensure that we are doing high quality research. And while the funding success has been based on our nurturing of our relationship with government, our success as an academic unit and our reputation beyond government is based on the quality of the work that is being done and the recognition that work has received throughout the world in terms of being pioneering in doing this kind of work. … So on the one hand you’ve got a successful funding model and relationship; on the other hand, you’ve got a successful model of
doing high quality research ... which is part of closing the loop with government. If the work wasn't of high quality and accepted and widely respected throughout the community, I think government would seriously look at saying, “It's all very well for them to give us answers, but are they the right answers?”

One Participant’s Summary

So for other Centres, summarizing what I’ve talked about, it’s very critical to get some stable funding in place along with a clear understanding of what the relationship is based on so that the deliverables are [clear] for both sides at the beginning. And that’s a critically important starting place.

Then after that, it’s important not to disengage but to continue to engage as much as possible. Unfortunately that means probably most of the effort has to come from the Centre’s side, to engage government and to find those champions within government who are willing to work with you, benefit from you and then advocate for you, because you’re going to need references when that re-negotiation phase comes up. You’re going to need those people throughout the whole organization to be able to step up to the plate and speak on your behalf about the value. So it’s critically important to maintain those relationships.

That’s going to be a large investment by the Centre that you have to take into account in the funding. So the funding has to cover all the time you’re going to spend courting the funders, right? It’s bizarre, but that’s part of it. You’re building infrastructure so you cannot be funded at the level of just what it costs to do the deliverable because you need to build capacity to attract and maintain good staff, to meet other demands using this infrastructure. Why is that important? If you can compete nationally for grants and contracts, I think the record indicates pretty fairly that you can leverage every one dollar of provincial money into one to two more dollars of federal and provincial granting money. You can double or triple your budget if you aren’t being sucked to death by that relationship. So it’s got to fund you, and then fund enough capacity, so you can go out and get the other money.

That extra capacity that was originally developed to meet federal grants and contracts and other extra provincial grants is capacity that now benefits government because it’s expertise you’ve developed here that you can call upon for all those other government deliverables. So it’s being able to see that big picture and say, “Okay, we’re not just negotiating for you for X, and what’s the cheapest way we can get it? Rather, we need to make an investment here so that we have a capacity that is available to us down the road to call on. And we recognize that in order to be there and develop the expertise, you need to be able to also go after grants and contracts and that’s just not in dealing with us. So you’re going to have your eggs in multiple baskets and we’re going to help initiate this process, get it started. And we’re funding that infrastructure and not just deliverables.”

And then from the Centre’s side, what it needs to do is invest in people and build all those quality of life things, make long-term commitments in relationships, keep the people around as long as possible. Their expertise is invaluable.
Survey Responses

1. Funding, especially the initial funding. That won’t guarantee success but is an important enabling factor.

2. Leadership—that is the “what do you do with the money part” (a) deliver a good product in a timely manner with the appropriate “presentation.” I think the appropriate “presentation” is a key factor: is how you get the message across. Noralou is particularly skillful at this, as is Pat.

3. Building a great team that wants to stay with you. This means you are not spending a lot of time investing in retraining people and allows you to become more efficient. The people skills of Roos’ were obviously important in that regard.

Funding—Leadership—People Skills. That’s it.

—

This is tough too, but here goes:

Good leadership—meaning somebody who could work with govt and university types, and also get the work done. Should also say, though, that Manitoba has enjoyed pretty good government all through the Filmon and Doer administrations—largely centrist type approaches, nothing radical that might have negated or radically expanded MCHP’s role (both of which would be problematic).

The programming staff—whose stability is debatably more important than that of the researchers, because they are the keepers of the details, wherein the devil resides (though in our case, the devil may now be calling the Concept Dictionary home).

The continued high interest and investment in healthcare—because if this segment were shrinking rather than expanding, things might be very different. In this respect, I think we also have decent job security for the foreseeable future (though you never know).

—

Noralou’s strong leadership, no question, and Les’s extensive knowledge of databases, as well as a certain kind of pragmatic fearlessness exhibited by both. Factors like these were absolutely key to the Centre’s development and ensuing success.

Pat as director continues to ensure the Centre’s success by protecting this strong foundation, making sure all bureaucratic needs are met and watching for opportunities to build the Centre.

—

Continual funding to meet payroll & allow for maintenance & required growth.
Retaining qualified staff.
Encourage research utilizing MCHP data repository.
Keep/build harmonious relationships with other U of M departments and other research organizations to foster continual research.

—

The people: good people who enjoy their work.
What advice would you give others who are attempting to set up a research centre based on administrative data?

The most important thing is the contract with government. Have to keep your academic independence to do the research the way researchers see fit, and to publish results regardless of what the findings were. Also need multi–year funding to be able to offer at least reasonable job security for all staff—you simply don't get great people applying for term positions all that often.

Like everybody else before you, you should come visit MCHP and learn about the place (but please offer us $5000 to cover the staff time spent preparing and doing the visit)

Anonymity is great. I know some places have all the identifying data, etc—but think that adds more work and more distractions than you need. Nice to be able to say that even if some printout went astray, it’s extremely unlikely that anybody’s private info is being 'out–ed'

Do the research on establishing a centre (e.g., network, network, network).

Make sure all your staff feel invested. The researchers alone can't do it. If everyone feels like they are contributing to the whole, they are going to do their very best work and not just their “job”.

Is there anything you would like to add?

It’s an awesome place to be a part of. Pat is an outstanding leader. She’s already transformed the administrative and financial sections to be much better organized than they were before. And she’s making great headway turning it into a real team mentality. There is some risk in the more formalized organizational stuff, though, as we’re now starting to see some real bureaucratic type thinking by some people, so that might need to be kept in check sometime.
6.3 What do you see as the key events in MCHP’s existence?

The most common responses from both the survey and the open-ended interviews focussed on negotiations for contract renewals, the CFI that allowed the merging of the two worksites and brought in new datasets, and the transition in directorship from the founding directors to the current director. These are indicated in the time-line, but responses here provide a sense of staff attitudes towards these events.

Transition in Directorship

The transition between Noralou and Pat would have been a key event—very key. Their styles are very, very different.

When the directorship moved from Noralou and they were searching for a new director, so that was obviously a key event. And I thought it was handled pretty well. Noralou took a sabbatical and put an acting directorship in place, which I thought was a really smart way of exploring the potential for new leadership and how things would work after, not that there was any assumption that there would be any internal replacement but it was an opportunity to demonstrate some of the potential for leadership from inside the unit and how that would work. And then when the formal announcement came there was internal leadership that could step forward and apply for the position. I’m not familiar with that model of nurturing succession being common in the university environment.

Merging Worksites

Well I think coming together on one side was a key decision. That was before my time but it was obviously a key step in terms of bringing everybody together, and it was almost like they were two separate units.

Well, the move of course. When we got our first CFI grant to build this [centre], that was the biggest thing that I recall. Well, it was a difficult time because we had the people who worked at St. Boniface worked under Les, and the people who worked at Bannatyne worked under Noralou. Different work styles, so when the two campuses came together, we had to try to create a work environment for all of the research support staff, understanding that they had different work styles and were used to working differently and for different people as well. Even moving was difficult. People coming from St. Boniface were very apprehensive. They called Bannatyne, “the dark side.” And I think they just thought that because we worked under Noralou, who was the director, things were much stricter. I don’t think it was like that at all, but that was their impression at the time. I think we only lost one support person.

People still worked as Bannatyne and St. Boniface even after we moved together. It took quite a while for people to start working as the whole programmer group, the whole research support group, the whole PIs. People were so used to working in their own teams from St. Boniface or Bannatyne that we continued to work that way until a conscious decision was made that we really needed to start working in teams that have both groups of people together. And then when Pat started working on the org chart, and brought in the different areas, the different teams, then I think it became a lot more cohesive.
Data Events

The other thing that in my mind that’s really key [event] of the last five years or so has been the access to some of the new data sources particularly in education, the work that’s being done that is really exciting and trail blazing. While 19, 20 years ago, the Centre was a real innovator and trail blazer in terms of using and administering data for health policy research, many other Centres now exist doing that same work. The number and nature of the new databases we’ve got, in terms of education and social databases and housing and those kinds of things, once again is a dramatic moving the yardstick forward in terms of this kind of research and what can be done with linking these sorts of data sets.

I think the first CFI that the Centre got was really kind of a milestone because it brought in social datasets. It built the Centre, and it brought in education and family services data. So it had quite an impact; now all of a sudden there is a bit of a different focus and with this new CFI that we have, and we’re looking at bringing in Justice data. … With the housing, with the social data sets, it’s kind of opened up a whole new avenue for the Centre. It’s quite ground–breaking actually. There isn’t anywhere in Canada that has all of that data all in one place and at an individual level, currently. Other places are certainly trying to get there but they’re not there yet.

And the new mode of access [Research Access Sites] is a key development in terms of facilitating access to the data.

Manitoba Health came up with this idea of PHINS—that was something they started in 1984. They were trying to develop a way to change the Pharmacare … From ’84 to ’94 Manitoba Health used the PHIN internally. It was never known to the patient or the doctor or in hospital records. But it’s been in place and using the same scrambling system since January 1, 1984.

And in this era we’re talking entirely about health information until ’79 when we brought in Vital Statistics mortality information—cause of death, which we can use. And again it’s interpreted as being an anonymous report. It’s one–line per individual but they’re not releasing names, addresses.

Other Key Events

We have this five–year contract, and we start talking about renewing it at three years which means there’s two years worth of discussion leading up to the Centre being shut down, if that happens.

I don’t know how many times we’ve switched governments, maybe three times but they have different ways they see things, ideologies. So we’ve lived through at least three where we continue to get support from both sides and we continue to have that access to either the Minister, or Deputy Minister and be able to do briefings.

We got some funding from CIHR, to work with ICES on privacy issues. We put on some national workshops, so there was a lot of involvement. It was a total benefit for the Centre. We were trying to harmonize processes and policies across similar organizations so that researchers wouldn’t find it so problematic to get access to the data.
After the move, I think the next biggest thing was the Need To Know grant. That was huge, the Need To Know, and it still continues to be. It's a nationally recognized part of the Centre now.

Some of the big events have also been our five–year reviews, where we bring in three external reviewers. They review our strategic plan. They interview a lot of people, and then they come back with a report. Those have been instrumental in the way that we continue to do work here because they've always given us some really good ideas on what’s not working and how we can move forward.

**Survey Responses**

1) Founding of MCHP
2) Amalgamation from two campuses into one
3) Change in directorship

Contract with Manitoba Health.
Development of the Data Repository.
CFI funding allowing for two sites to merge into one at the Brodie Centre.
Continued leadership & transition of directorship from NPR [Noralou Roos] to Pat Martens.

In 1995 (I think) the contracts were for more years (3 I think) than every year.

Getting the CFI first round and building this space and amalgamating the St. B site and HSC into one unit. There were a lot of cultural differences in the 2 groups that had to be overcome and it took a few years to feel comfortable. CFI also helped expand the databases we got, which in turn gave you a lot more diversity in the research that we could do.

The contract with Manitoba Health.
The appointment of Pat Martens as director... It moved past a “The Roos” project

No doubt the Canada and Manitoba budget deficits from the late 1980s through mid–1990s. You gotta believe that the main impetus in the Filmon government’s search for answers would not have been present, or as acute, had there been plenty of money around. I don’t at all mean this to be cynical; crises often provide opportunities, and I think this was one of them. … Obviously MCHP has out–lasted the deficit crisis of the mid–1990s, and a good part of its ongoing success is driven by its ability to make & keep itself relevant as time marches on.
Also obvious is the presence, capability, and resourcefulness of the Rooses.
CHAPTER 7: LOOKING BACK: RESEARCH HIGHLIGHTS

7.1 The First Ten Years

Looking Back

Unexpected or intriguing findings from the past ten years

Incidence of low birthweight in Canada in 1989: 55 per 1000 live births; in Manitoba: 44. But there was a big difference for married versus unmarried women in Manitoba, 41 versus 51. (1991)

Range in mean adjusted length-of-stay for gallbladder surgery in Winnipeg hospitals, 90/91: 6 days to 8.5 days. Potential hospital days saved if all hospitals had LOS of shortest-stay hospital: 1,310. (1992)

Proportion of population age 75+ residing in a nursing home, 91/92: 13%; age 90+: 52%. (1993)

Days of hospital care per 1000 population in 91/92 for low variation conditions, i.e., those where there is agreement that hospitalization is necessary: lowest rate region, 71; highest, 96. For high variation conditions: lowest rate region, 396; highest 907. (1993)

Potential savings in 91/92 if all hospitals had same cost-efficiency of most efficient hospital: $100 million. (1994)

Of the one in ten Manitobans being treated for mental health disorder in 91/92, per cent suffering severe illness: 15%; per cent of mental health acute care dollars for severe illness: 68%. (1994)

Pregnancy complication rates for women in lowest income and education quartile: 459 per 1000 women; for women in highest income and education quartile: 258 per 1000. (1995)

Number of surgeons performing tonsillectomy in 93/94: 73; number doing fewer than 10 procedures: 40 (55%). (1996)

Per capita spending in 93/94 on physicians: $305 per Winnipeg resident, $230 per non-Winnipeg resident; on hospital care: $492 per Winnipeg resident, $525 per non-Winnipeg resident, 1997)

Median waiting times in 1996/97 for eight routine elective surgical procedures: lowest, 17 days for breast tumour surgery; highest, 48 days for varicose vein surgery and for tonsillectomy. (1998)

Number of prescriptions dispensed by retail pharmacies in 1996: 6.7 million. Most commonly prescribed group of drugs: nervous system drugs (e.g., painkillers, antidepressants) at 1274 per 1000 population. (1999)

Premature mortality rate (deaths before age 75), ratio of highest to lowest by RHA: 2.1; ratio of highest to lowest by Winnipeg Community Area: 2.2. (1999, 2001)

Of 68 rural hospitals, number with at least 50% of in-area hospitalizations: 18. Number with occupancy of 70% or more: 9; number with occupancy of 50% or less: 20. (2000)

Per cent of long-stay patients (hospital stays of more than 30 days) discharged to a nursing home: 13%, discharged home: 52%. (2000)

Teen pregnancy rate in Manitoba: 6.3%, in Canada: 4.2%. Proportion of Manitoba children fully immunized by age 7: 83%. (2001)

Proportion of seniors age 65+ living in single unit houses hospitalized for flu in 98/99: 7%, living in seniors apartments: 12%, living in nursing home: 13%. (2001)

Patients admitted for a medical condition in Winnipeg hospitals in 98/99, per cent appropriate on day of admission: 95%; per cent of subsequent days appropriate: 58%. (2001)


From: DeCoster C. Research Highlights First 10 Years. CentrePiece: Manitoba Centre for Health Policy Newsletter. 2002;Fall(12).
7.2 Unexpected or Intriguing Findings from the Second Ten Years

The overall health status of First Nations people living in the south of the province was much worse than those living in the north – there was almost twice the premature mortality rate (i.e., death before the age of 75) in Dakota Ojibway Tribal Council compared to Keewatin Tribal Council (9.3 vs. 4.8 per 1000). (Martens, 2002)

Amputations related to diabetes complications were 16 times higher for the First Nations population compared to all other Manitobans (3.1 vs. 0.19 per 1000 for ages 20-79), and 32 times higher in the southern tribal council of DOTC (6.2 per 1000). (Martens, 2002)

Prescription drugs cost Manitoba about $170 million in the year 2000, up a whopping 58% from five years earlier. Since then, costs have continued to rise and in 2008, the province spent over $2.3 million on prescription drugs. (Kozyrskyj, 2009; Metge, 2003)

One in four Manitobans over a five-year period had a diagnosis of at least one of several mental health issues (depression, anxiety, substance abuse, schizophrenia, personality disorders). They used hospital services twice as often as those without these diagnoses; however, only 1 in 10 of their hospitalizations was for mental illness. (Martens, 2004)

The proportion of children from low-income areas who pass the Grade 12 Language Arts test was 75% when only the test takers were included. It dropped to 27% when all of the children who should have been writing the test were included. (Brownell, 2004)

Females use more health services than males, but not once you remove services related to reproductive issues. (Fransoo, 2005)

There is no gender bias in cardiac care after a heart attack, even though there is a significant sex difference when comparing catheterization rates. The situation is completely confounded by patient age: it’s not that men are treated ‘more aggressively’ than women; it’s that younger patients get more treatments, and men tend to be younger when they suffer a heart attack. (Fransoo, 2005)

Residents of personal care homes who had two (or more) doctors prescribing to them were more likely to be taking potentially dangerous drugs. The proportion of residents who were taking nine or more drugs almost doubled after admission (from 4.8% to 9%). (Doupe, 2006)

Of 13 non-emergency procedures looked at, waits got shorter for three waits, stayed the same for four and got longer for six. More importantly perhaps, none of the waits for the four life-saving procedures got longer. (De Coster, 2007)

Almost three times as many babies died in their first year in Manitoba’s poorest urban neighbourhoods compared to the wealthiest urban neighbourhoods. During the years 2001 to 2005, there were 7.6 and 2.8 deaths per 1,000 infants in the lowest and highest income neighbourhoods, respectively. (Brownell, 2008)
Roughly one in five children under 17 years of age in some Winnipeg neighbourhood clusters were taken into care at some point during a three-year period. And 45% of children in some neighbourhoods received services from Child and Family Services over the same time period. (Brownell, 2008)

People who received at least half of their care from the same doctor over two years had better health outcomes. Continuity of care was one of the few factors significantly related to a number of health outcomes, including lower amputation rates in diabetics, higher rates for breast and cervical cancer screening, and higher rates of childhood immunizations. (Martens, 2008)

Breastfeeding initiation rates increased more rapidly in Winnipeg’s least healthy areas, lessening the gap between most and least healthy areas over time. There was no improvement for those living outside Winnipeg, suggesting a positive impact of federal and provincial initiatives (e.g., CPNP; provincial Families First initiatives) available in Winnipeg over this period. (Martens, 2008)

Rural women’s mammography rates increased substantially after the implementation of a rural mammography screening program. The resulting decreased gap between rural and urban women’s rates was not seen for Pap testing where no such program was available. (Martens, 2008)

Almost 1 out of every 5 adults living in Winnipeg visited an emergency department in 2004/05. A large portion of these visits were for fairly minor medical problems. Forty per cent were triaged as being less urgent or non-urgent; however, 17% of visits resulted in hospitalization. About half of visits (55%) lasted less than 4 hours, while a quarter (25%) lasted 6 or more hours. (Doupe, 2008)

Childbirth remains the most frequent reason for hospitalization in Manitoba and topped the list for the type of hospitalization that cost Manitobans the most. We spent a little over $11.3 million on hospitalizations for the 6,819 normal deliveries that took place in 2005-06. (Finlayson, 2009)

Many studies have reported that wealthy people are more active in their leisure time than poorer people. However, when all physical activity is combined (leisure + work + travel), the opposite pattern is revealed (Fransoo, 2009).

The rate of physician visits made by children has decreased over time. People under 40 years of age also had decreased use of generalist services while those over 40 used more generalist Services. Greater demand for service by some age groups may decrease service for others. (Katz 2009)
Reference List


CHAPTER 8: TIMELINE

8.1 Health Insurance in Manitoba

1944 Manitoba Medical Services covered majority of Manitobans for medical and hospital expenses with patient identifiers for physician billings.

1958 Insurance to cover hospital claims.


1973 Universal coverage for medical and hospital care with no user fees or usage limits. July: Nursing home services covered.

8.2 Pre–Centre Events

1972 December: Noralou and Les Roos move to Winnipeg to take up appointments in the Faculty of Administrative Studies, University of Manitoba.

1973 Noralou Roos explores Manitoba Health Services Commission data with Paul Henteleff, Assistant Executive Director for Health Services, MHSC.

Confidentiality issues are raised, leading to a system for extracting and sorting data in a form that allowed data on individual patients to be linked across different files and in the same file across time.


1979 Tonsillectomy results discussed in the legislature and reported in the media.

8.3 Establishment of the Centre

1988 Department of Community Health Sciences formed by John Wade, Dean, Faculty of Medicine. He appointed Brian Postl as the first head. Arnold Naimark, President, University of Manitoba arranged transfer of Noralou and Les Roos to DCHS.

Fraser Mustard and Bob Evans recruited Noralou and Les Roos as associates of the Population Health Program, Canadian Institute for Advanced Research (CIAR).
1989  September 29: Fraser Mustard met with Minister and Deputy Minister of Health, Donald Orchard and Frank Maynard.

October 12: Noralou and Les Roos, Fraser Mustard, Bob Evans, and Ted Marmor met with Donald Orchard and Frank Maynard to discuss concept of policy centre.


November: Other names considered:
The Manitoba Centre for Health Care Policy and Evaluation
Population Health Research Unit
Centre for Health Services Research
Health Care Analysis and Intelligence Institute

1989/90  Staff at Drake moved to St. Boniface Research Centre.

1990  March 5: DCHS Council minutes indicate working group set up to recruit staff and locate office space.

April 1: Manitoba Centre for Health Policy and Evaluation funded April 1, 1990 to March 31, 1994. (Retroactive approval by Treasury Board for $3.5 million from the Health Services Development Fund Initiative.)

August 3: Donald Orchard, Minister of Health, announced creation of a $3.5 million centre for health research to employ 14 people.

August 15: MCHPE Operational? Draft letters dated July 30, 1990:
1) from Noralou Roos to W.A. Simms, VP Administration requesting start–up accounts so that contracts can be offered “to permit our beginning operations by August 15, 1990”
2) from Noralou Roos to Frank Maynard, Deputy Minister, Manitoba Health, also mentioned August 15.

First contract states “anniversary date” for MCHPE will be January 1, 1991 (February 4, 1991).

February 4: First contract signed. An advance of $390,000 implies earlier start–up.

April 4: Official Opening of MCHPE
Invitation reads: “The Honourable Donald W. Orchard, Minister of Health, will officially open the Manitoba Centre for Health Policy and Evaluation on April 4, 1991 at 10:00 a.m. in the Atrium of the St. Boniface General Hospital Research Centre.”

April 5: Ronald Wall’s open house in honour of the opening of MCHPE.
8.4 First Ten Years, MCHPE

1991 Noralou Roos is Director, MCHPE.
Les Roos is Director of the Population Health Research Data Repository.

1991/92 Twelve Manitobans (including Deputy Minister Frank Myanard) visited John Wennberg’s Center for the Evaluative Clinical Sciences at Dartmouth Medical School in Hanover, New Hampshire.


1993 First Rural and Northern Healthcare Day.
First five–year contract ($1.9 million per year).

1993/94 First two fellowships for clinicians conducting research using the data base offered (worth $20,000 each).

April: First external review of MCHPE by Steven Lewis and Maurice McGregor.

1995 "Crunch Time:" Decrease in federal transfers and large cost cutting by provincial government. MCHPE is protected, although funding is decreased.
December: Medical Care Supplement


PHIA legislation passed.

Winnipeg’s “Flood of the Century” threatens St. Boniface Research Centre.

1998 New five–year contract, now renewable every three years.
1999  Continuity with change of government.

Interactive format introduced for Rural and Northern Healthcare Day.

June: Medical Care Supplement


July 1: CFI grant: 1999–2003 ‘Data infrastructure for improving health and human capital’ funded Brodie Centre, Education and Family Services datasets ($2.7 million, 40% from CFI; 40% from the Manitoba Research and Innovation Fund, and the remaining 20% from other sources).


8.5 Second Ten Years, MCHP

2001  New name: Manitoba Centre for Health Policy (MCHP).

The Need To Know Team is funded.

MCHP awarded Health Services Research Advancement Award by CHSRF.

October 1: First day in new premises. St. Boniface and Bannatyne divisions are merged to Brodie Centre.

November 2: Come Celebrate a New Chapter: Grand Opening of state–of–the–art data laboratory at Brodie site.

2002  October 1: One Year Together Celebration.

Winter: Healthcare Management Forum Supplement


November/December: Canadian Journal of Public Health Supplement

2003

First Manitoba Health Day.

First WRHA Day.

Royal Bank of Canada grants $750,000 over five years to research children’s health.

Evelyn Shapiro Award for Health Services Research established.
(First recipient: Randy Fransoo–May 14, 2007)


2004


Summer: Carmen Steinbach, MCHP’s first retirement.

June 2004 to June 2005: Pat Martens is Acting Director and implements new organizational structure.

2005

January/February: Canadian Journal of Public Health Supplement


Spring: Canadian Journal on Aging Supplement


June 2005 to–date: Pat Martens is Director.

June 13: Lupina grant to support web–based research Knowledge Translation through Concept Dictionary ($625,000).

November: The Need To Know Team awarded national Knowledge Translation Award.


June: MCHP hosted CIHR’s IPPH–IHSPR Summer Institute.

2007  Les Roos stepped down as Director of Repository.

April: Contract renewed at $2.35 million a year, first increase ($495,000) in 13 years.

May 31: Current strategic plan adopted.

2008  November: Treasury Board of Manitoba commissioned Steven Lewis to review MCHP impact. Estimating the Return on Investment in the Manitoba Centre for Health Policy.

2009  June: CFI grant ”The Manitoba Centre for Health Policy’s ”LEADERS” Initiative: Leading–Edge Access and Data Enhancement Research Strategy” to set up pilot for repository access sites (RAS) and additional datasets (funded $3.6 million: 40% from CFI; 40% from the Manitoba Research and Innovation Fund and the remaining 20% from other Manitoba sources).

8.6 A Timeline for Data–Related Events

-1974: Manitoba Health Services Commission dropped annual registration (i.e. no premiums, annual renewal, or employer reporting.) MHSC got data on deaths from Vital Statistics.


1980: Data linkage program.

1982: Received first complete set of data (age 25+).

1984: PHIN implemented internally at MHSC and scrambled for MCHPE.

1985: Adopted SAS.

1985/86: Started getting Census data.

1988: Received data on the whole population (all ages) from MHSC.


1990: Started to develop the Concept Dictionary.


1993: MCHPE goes online; POPULIS.

March 31, 1993: MHSC integrated into the Department of Health.

April, 1994: PHIN went public in preparation for drug program.

1995: Concept dictionary on Web; DPIN.

1996: Transition to UNIX completed.

1998: First project website: "Health reform in three provinces." Charlyn Black, use of PMR to order graphs and data; Demise of mainframe.

8.7 A Timeline for Leadership at the Centre

Jan 1991–May 2004 Noralou Roos is Director, MCHPE/MCHP.

Jan 1991–2006 Les Roos is Director of the Repository.


Jan–Dec 1997 Charlyn Black is Acting Director while Noralou Roos is on sabbatical.


Director, Noralou Roos.

Acting Director of External Relationships, Pat Martens.

Acting Director of Research, Verena Menec.

Acting Director of Administration, Carolyn DeCoster.

June 2004–June 2005 Pat Martens is Acting Director. Implements new organizational structure:

Associate Director of Research, Carolyn DeCoster (until 2007).

Chief Administrative Officer, Paulette Collins (to–date).

Director of Repository, Les Roos (until 2006).

June 2005 to date Pat Martens is Director.

2007–2008 Associate Director of Repository, Lisa Lix.

2007 to date Associate Director of Research, Alan Katz.

2008 to date Associate Director of Repository, Mark Smith.
8.8 University and Political Leaders

Deans in the Faculty of Medicine

1972–1981  Arnold Naimark
1988–1999  N. Anthonisen
1999–2004  Brian Hennen
2004 to–date  J. Dean Sandham

Department Heads of Community Health Sciences

1972–1987  David Fish, Social and Preventive Medicine (Acting in 1972)
1987–1994  Brian Postl, first Head, Community Health Sciences
1994–1998  Mike Moffatt
1998–2001  Kue Young
Jan–Mar 2002  Charlyn Black (Acting)
2002–2007  John O’Neil
2007–2008  Lawrence Elliott (Acting)
2008 to–date  Sharon Macdonald (Appointed, Sept. 1, 2009)

Ministers and Deputy Ministers of Health, Government of Manitoba

<table>
<thead>
<tr>
<th>Date</th>
<th>Minister</th>
<th>Deputy Minister</th>
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<tr>
<td>May 1988–Sept 1993</td>
<td>Donald Warder Orchard</td>
<td>Dr. John Wade Jan 1995</td>
</tr>
<tr>
<td>Feb–Oct 1999</td>
<td>Eric Stefanson</td>
<td>Dr. Ron Hikel May 2000</td>
</tr>
<tr>
<td>2006 to–date</td>
<td>Theresa Oswald</td>
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Healthy Living Ministers
Kerri Irvin–Ross
Jim Rondeau
Reference List

Notes from Noralou Roos’ files (e.g., draft proposals, notes on meetings, draft letters).

Manitoba Centre for Health Policy and Evaluation: a proposal of the University of Manitoba; 1989.

Proposal for a health care analysis and intelligence institute (from Dr. Noralou Roos’ files; 1989.


Timeline from MCHP 2002 Strategic Planning Meeting. 2002.


Manitoba Centre for Health Policy. Annual Report. Winnipeg, MB: Manitoba Centre for Health Policy. 1991 to date.

Manitoba Centre for Health Policy. CentrePiece. Winnipeg, MB: Manitoba Centre for Health Policy. 1995 to date.


Marchessault G. Deborah Malazdrewicz. Interview in Winnipeg, MB. April 24, 2009. 2009g.

Marchessault G. Donald Orchard. Interview in Winnipeg, MB. October 5, 2009. 2009h.


CHAPTER 9: MCHP PHOTO GALLERY
Noralou and Les Roos, just before they moved to Manitoba in 1972.

Results of first published research using administrative database discussed in the legislature and reported in the media, 1979. The tonsillectomy papers were published in New England Journal of Medicine and Medical Care:


Above: Les Roos in his Drake Centre office at Fort Garry Campus, University of Manitoba, Dec 1989
Left: View from office, Fort Garry campus
Some key influencers in the Centre’s start-up, late 1980s (L to R:)
Top row: Dr. Fraser Mustard, President, Canadian Institute for
Advanced Research; Dr. Bob Evans, Director, Population Health
Program, CIAR; Donald Orchard, Minister of Health
Bottom row: Frank Maynard, Deputy Minister of Health; Dr. Arnold
Naimark, President of the University of Manitoba; Dr. John Wade,
Dean, Faculty of Medicine; Dr. Brian Postl, Head, Department of
Community Health Sciences.
One of the papers leading to provincial funding of the Manitoba Centre for Health Policy and Evaluation.

The Winnipeg Sun coverage of Donald Orchard's announcement creating the Centre, Aug. 4, 1990.
INVITATION

MANITOBA CENTRE FOR HEALTH POLICY AND EVALUATION

OFFICIAL OPENING

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The Honourable Donald W. Orchard,
Minister of Health,
will officially open the
Manitoba Centre for Health Policy and Evaluation
on April 4, 1991
at 10:00 a.m.
in the Atrium of the
St. Boniface General Hospital Research Centre
351 Tache Avenue.

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Refreshments to follow.

April 4, 1991 Official opening of MCHPE at St. Boniface General Hospital Research Centre.
Top: L to R: Donald Orchard, Minister of Health; Frank Maynard, Deputy Minister of Health, Noralou Roos, Director, Manitoba Centre for Health Policy and Evaluation, Nick Anthonisen, Dean of Medicine, Faculty of Medicine, University of Manitoba.

Bottom: Audience at opening.
New centre to research health costs

Orchard hopeful

Manitoba’s “world-class” health research centre opened yesterday with high hopes it will bring “progressive” changes to the province’s health care system, Health Minister Don Orchard said yesterday.

“We want to refocus the health care system to make sure we are doing things right,” Orchard said at the opening of the Manitoba Centre for Health Policy and Evaluation.

The centre’s research will assist government in developing policies aimed at improving the quality of health care and the efficiency of Manitoba’s system, Orchard said.

One of the first items researchers are studying is an alternative funding mechanism for hospitals and other health care facilities.

While Orchard refused to provide details about potential changes to hospital funding, he denied it will mean less government dollars for health care facilities.

Dr. Noralou Roos, the centre’s director, said she expects researchers will have their report on hospital funding ready by the end of April.

“Public domain”

Although the government will have the first opportunity to see the report, Roos said the centre’s research won’t “buried,” despite whatever action the government decides to take.

“What we are doing will be in the public domain,” she said.

The centre, located in St. Boniface General Hospital, will receive $3.5 million in casino revenues over the next three years.

After that, Orchard said he expects the centre to be “self-sufficient” by securing national and international research contracts.

The centre will address health concerns which fall outside the traditional health care system, such as the effects of inadequate housing.

“It will help us with the development of healthy public policy,” Orchard said.

The centre is a joint venture between the province and the University of Manitoba.
Ruth Bond in front of St. Boniface Research Centre.

Phyllis Jivan, Kerry Meagher and Carmen Steinbach.
The Story of the Manitoba Centre for Health Policy

Baby boom at the Centre: April 16, 1994
Marina Yogendran, Marni Brownell and Teresa Mayer with their babies.


Celebrating Les’ 60th birthday. L to R: Les Roos; Sharon Bruce; Charlyn Black; Carolyn DeCoster; Pat Martens; Ruth-Ann Soodeen; (Rod McCrae behind Pat).
Top: May 02, 1997, Flood of the Century approaching Research Centre.

July 9, 1999 The Brodie Tour.
July 9, 1999 The Brodie Tour.

“Noralou’s office.”
Noralou Roos addressing the audience at the grand opening of MCHP, Nov. 2, 2001. Seated behind her L to R: unknown; Charlyn Black; Arnold Naimark; Catherine Amour; Joanne Keselman; Donald Orchard; Dave Chomiak.

Donald Orchard, Minister of Health who established MCHP.

Co-directors Noralou Roos & Charlyn Black accepting plaque from Arnold Naimark.
2001: MCHP awarded Health Services Research Advancement Award by CHSRF.

Celebrating the merging of Bannatyne and St. Boniface Research Centre sites.

2003: Royal Bank of Canada grants $750,000 over five years to research children’s health.
Monday, June 13, 2005: Lupina Foundation announced grant to MCHP to support web-based research Knowledge Translation through Concept Dictionary ($625,000). L to R: Dr. Patricia Martens, Director, Manitoba Centre for Health Policy; Dr. Les Roos, MCHP; Dr. Peter Warrian, Managing Director, The Lupina Foundation; Dr. Emőke Szathmáry, President and Vice-Chancellor, University of Manitoba.
November, 2005: *The Need To Know* Team awarded national Knowledge Translation Award.

WRHA Day 2005: Our new director, Pat Martens, doing one of things she does best... teach complex ideas.

Mark Smith explaining MCHP’s functions.
June, 2009: CFI grant "The Manitoba Centre for Health Policy’s "LEADERS" Initiative: Leading-Edge Access and Data Enhancement Research Strategy" to set up pilot for repository access sites (RAS) and additional datasets. Staff performs a congratulatory serenade to Pat.

Evelyn Shapiro congratulating Songul Bozat-Emre upon receipt of Evelyn Shapiro Award for Health Services Research for 2009.

Pat Martens congratulating Theresa Daniuk for service at 2009 “Birthday Friday” celebration.

*The Need to Know* Team, 2008.
The Need to Know Team members acknowledge their 10th anniversary with a thank you to Pat Martens.
Since 1999, workshop days became highly interactive with facilitated round table discussions for eclectic teams from each RHA working with MCHP researchers.

Workshop Days (Rural Day, WRHA Day, Manitoba Health Day)
... highlight a report
... workshop approach
... “teams” LOOK FOR THE STORIES

The Story of the Manitoba Centre for Health Policy

L to R: Mike Moffat, WRHA; Pat Martens, MCHP; unidentified participant; Margaret Fast, WRHA; Randy Fransoo, MCHP; and Alan Katz, MCHP.

WRHA Day.
Decorating reception area, 2004; celebrating, 2005, 2008 and coffee break at MCHP Retreat, 2009

2009 - Charles Burchill training SAS
Cleaning Day, 2009. Carole Ouellette (top); Ken Turner (right); Marina Yogendran (bottom).
Randy Fransoo
King of the Deliverables,
for longest deliverable yet,
September 2009.

Pat Nicol demonstrating data
storage “then” and “now.”
Dr. Patricia Martens, Director, Manitoba Centre for Health Policy since 2004. (Acting Director June 2004—May 2005)
CHAPTER 10: BIOGRAPHY OF THE FOUNDING DIRECTORS, 
DRS. LESLIE ROOS AND NORALOU ROOS

Dr. Leslie Roos is a Distinguished Professor whose work has been cited more than 4,000 times, the highest number for any Canadian social scientist. Les led the development of MCHP’s web–based Concept Dictionary to organize and share knowledge.

Dr. Noralou Roos is a recipient of the Order of Canada and a member of the Royal Society of Canada. Noralou held a Tier 1 Canada Research Chair in Population Health, and was a member of the Prime Minister’s National Forum on Health and the Interim Governing Council establishing the Canadian Institutes of Health Research.

Les and Noralou remain actively involved in a variety of research projects at MCHP.

Drs. Leslie and Noralou Roos’ careers are intertwined but also unique.

Both were born in California. Les was born in 1940 in San Francisco and attended boarding school primarily in the east. Noralou was born in 1942 in Pomona, in southern California, which at the time was a small town. In Grade 8, her family moved to Oregon. She was student body president during high school, already demonstrating and perhaps honing, proclivities useful in her subsequent interactions with government.

Les and Noralou both went to Stanford, where they met and married in 1963, the day after Noralou graduated with an undergraduate major in political science (with distinction and departmental honours). They have two children, 20 years apart. Their son, Chris, is in the real estate business in Calgary and has made them grandparents. Their daughter, Leslie, graduates this year from Brown University.

Les’s interest in intellectual pursuits was obvious early. While still an undergraduate, he contributed to his first academic article, something that was not common in the 1960s. He received his B.A. (with distinction) in psychology and biology in 1962. Les and Noralou both did doctorates in political science at the Massachusetts Institute of Technology. Les completed his doctorate in 1966 and his postdoctorate, also at MIT, the following year. Noralou received her PhD in 1968. Because getting positions for two academics in the same city was difficult, Noralou stayed at MIT and Les went to Brandeis. Their next stop was Northwestern University, where they were both assistant professors, Noralou in the business school and Les in political science.

2 Based on material provided by Shannon Lussier, Mya Kraft and the Rooses, as well as interviews with the Rooses. Boxed highlight is from a letter written by Patricia Martens and Randy Fransoo, dated Jan, 2010.
They ended up at the University of Manitoba because Les decided that he wanted to work in a business school—although some suspect his attraction to fishing might have played a key role. These two California natives drove to Winnipeg in the midst of swirling snow and ice in December of 1972. Despite this inauspicious start, they are still in Winnipeg, more than three decades later.

Before coming to Winnipeg, they had fellowships in Washington DC. Noralou met Canadian colleague Don Anderson there. He advised her to contact David Fish who was recruiting social scientists to the medical faculty. Noralou collaborated with David Fish on research on the careers of physicians, and from there began exploring the Manitoba Health Services Commission’s administrative database for its research potential. Thus began the Rooses’ journey studying health and healthcare in Manitoba.

The Rooses started as associate professors in the Faculty of Administrative Studies in January of 1973, becoming full professors shortly after. Noralou and Les held joint appointments in the Faculty of Medicine from 1973 and 1980, respectively. Their primary appointments moved to the Department of Community Health Sciences in the Faculty of Medicine around 1989.

Noralou and Les founded the Manitoba Centre for Health Policy in 1991. Noralou was its director until May 31, 2004. Les was director of the Population Health Research Data Repository until 2006. They are now senior research scientists at the Centre and remain active in grant–funded research and other academic pursuits.

MCHP was highly regarded for the excellence of its research right from the start. In the first external review of the Centre, the reviewers noted: “The Centre is highly productive, has met the expectations of Manitoba Health, has an outstanding and in some ways unique resource in the database, and has at its core excellent scholars with well–established and/or growing reputations. These strengths are so universally acknowledged and virtually self–evident that they require no further confirmation” (Lewis & McGregor, 1994). The second review repeated, endorsed and extended this evaluation to cover the following five years (Hamerton, Stoddart, & Dector, 1999). The most recent review also sets a positive context: “We want to emphasize that our overall impression is of a high–functioning, internationally acclaimed, and well–run Centre that is having an impact on both the academic and the service world in an exemplary fashion. Indeed, we would concur with one of the many laudatory comments from our interviewees that the Centre is ‘a jewel in the crown of the university’” (Lomas, Horne, & Kavanaugh, 2005).

Both Noralou and Les have received many honours over the course of their careers, starting with national fellowships while they were still students in the U.S. Both held highly esteemed Career Scientist Awards from the National Health Research and Development Program, Health Canada for over 20 years and both were associates of the Population Health Program of the Canadian Institute for Advanced Research.

In 2006, Les became a Distinguished Professor, a title held by only 20 University of Manitoba professors. This honour was bestowed upon Les in recognition of his outstanding research and scholarship. He has written three books and has published more than 200 peer–reviewed papers.
In 2004 he was declared a “Highly Cited Investigator” by the Institute of Scientific Information. Researchers world–wide cited his work over 4,000 times, the highest number of citations noted for any Canadian social scientist. Les was the first Canadian Fellow of the Association for Health Services Research. His work contributed substantially to MCHP’s receipt of the 2001 Health Services Research Advancement Award from the Canadian Health Services Research Foundation and the 2005 Regional Knowledge Translation award from CIHR. Les has also received awards for his teaching and outreach from the University of Manitoba.

Noralou Roos was inducted into the Order of Canada in 2004, and in October 2009, she was elected to the Royal Society of Canada, the country’s most prestigious association of scholars and scientists. She held a Tier 1 Canada Research Chair from 2001 to 2007 and was a member of the Prime Minister’s National Forum on Health and the Interim Governing Council that established the Canadian Institutes for Health Research. Citations to her work place her among the top 100 Canadian scientists according to The Institute of Scientific Information. Earlier honours included receipt of “best article of the year” award from the American Association for Health Services Research and Development for a 1988 JAMA paper co–authored with Jack Wennberg, Woman of the Year Award from the YWCA of Manitoba in 1988 and the Toastmaster’s Public Service Award in 2000.

These awards recognize the Rooses’ remarkable contributions to health and healthcare research, a few of which are highlighted below.

**Pioneering New Research Methods**

Noralou and Les effectively created a new medium for research when they pioneered the use of administrative record linkage for health services and population health research. Together with their team and Jack Wennberg (Dartmouth College in the United States), Noralou and Les determined how to use routinely collected administrative data based on health insurance claims for research purposes. Their approach is now used internationally for comparing treatment outcomes and tracking a population’s health status over time and across geography and is spreading to other disciplines. The results of their research have focussed international attention on “evidence–based” clinical decision–making. Noralou and Les have continued to “reinvent research” for over three decades now. Recent innovations include the introduction of longitudinal sibling/twin designs and multi–level modeling to the study of large databases.

**Building a Data Repository**

Remarkably, over 650 papers and reports, appearing in journals such as JAMA, the New England Journal of Medicine and Medical Care, have been published based on the Population Health Research Data Repository. Noralou and Les began developing this database in the early 1970s. It is unique in its comprehensiveness, degree of integration, and orientation around a population registry. Arguably the most comprehensive database on health and health–related factors in the world, it tracks the health and health system use of one million Manitobans for more than 35 years. Important additions to the health database have made it a rich data resource for social policy
research, available nowhere else in North America. In the mid–1980s, Les brokered a path-breaking linkage with Statistics Canada census data. Data from the Ministries of Education and Family Services were added after the Roos team was awarded the 1999 Canadian Foundation for Innovation (CFI) grant to build a state of the art data laboratory at the University of Manitoba. The Rooses have used this capacity to develop a conceptual framework for understanding the determinants of a population’s health.

Constructing the Concept Dictionary

For almost 30 years, Les has worked to create an information–rich environment to facilitate the study of health and healthcare. His leadership in developing the Concept Dictionary—a web–based systematic approach to sharing working knowledge—makes the work done in Manitoba accessible to others. Nearly 50,000 hits from more than 13,000 hosts in a typical month demonstrate broad interest in the Concept Dictionary. The Concept Dictionary is a web–based resource that contains a series of tools for working with administrative data. This work represents an effort to document, find, and transfer concepts and techniques, both within the local research group and to a more broadly defined user community. Concepts and associated computer programs are made as “modular” as possible to facilitate easy transfer from one project to another. The tools, taken together, make up a knowledge repository and research production system that aid local work and have great potential internationally.

The merging of documentation and researcher–to–researcher dissemination keeps costs manageable and provides an innovative method of Knowledge Transfer. This Knowledge Transfer has been facilitated by cooperation with the Epidemiology Supercourse (over 4,000 lectures posted on the Internet). This work substantially contributed to the Centre’s receipt of the CIHR Knowledge Translation award (Regional Impact) in 2005 and was recognized by the Lupina Foundation with a five–year $625,000 award.

Working at the Academic–Policy Interface

Noralou and Les did not just create an internationally–significant and locally relevant body of population–based health care research, part of their success was the ability to communicate their findings effectively to policy makers. Understanding policy makers’ need for research, and communicating the evidence derived from this research, has been a major focus of Noralou’s career. She is widely recognized as a leader in the field for communicating across the academic/policy interface and was invited to develop a supplement on this topic for Medical Care in 1999. This volume, which remains relevant today, is a careful analysis of what was learned about moving research into the policy process. In this volume, Noralou and her colleagues articulated their practices to make the processes more transparent to researchers and policy makers from other jurisdictions, who frequently requested this type of information.
**Mentorship**

The Rooses continue to work with students locally and in other provinces. They have supervised doctoral and postdoctoral fellows with prior educational training at Johns Hopkins, UCLA, the University of Toronto, the University of Alberta, and several local doctoral programs. Their students have gone on to receive CIHR New Investigator awards and to head four major research groups at three Canadian Universities.

MCHP is recognized as the Canadian leader in health database development and security enhancement. Numerous provincial, national, and international organizations have consulted MCHP on data laboratory management and structure. Their work has become a model for extensive government–university collaboration in Western Australia and for the development of health services research centres in British Columbia, Ontario, and elsewhere in Canada. Consequently, they have an active role mentoring others around the globe, leading to world–wide collaborations.

**Current Projects**

As indicated above, Noralou and Les remain active researchers.

Les’ current research focuses on population health and human development using new data (on education and family assistance) and innovative approaches (based on birth cohorts, longitudinal sibling/twin designs, and multilevel modeling).

Noralou led the Canadian Drug Policy Development Coalition and worked with Health Canada and the provinces to establish CIHR’s Drug Safety and Effectiveness Network. She continues to work with community groups, business, and government to bring research on at–risk kids to the policy table and was recently awarded a CIHR grant to work with researchers and journalists across the country towards improving the media’s use of research evidence in their coverage of health policy issues.

**Reference List**


CHAPTER 11: SUMMING UP

Efforts to reconstruct history are necessarily interpretations built on incomplete records of events. If time eats the past (as contended by Yann Martel in his novel “Beatrice and Virgil”), time also feeds the present and the future. Despite the gaps and the layers of interpretation in this record, there was much consistency in my interviewees’ remarks. I believe there are lessons in the story of the Manitoba Centre for Health Policy that will be of interest to those who are trying to establish similar ventures in their own jurisdictions.

A Confluence of Factors

The very uniqueness of the Centre and the context in which it evolved is instructive. The confluence of many necessary and enabling factors that allowed the Centre to become established and to flourish is striking and cannot be replicated in its entirety. The situation included:

- The existence of the Manitoba Health Services Commission administrative claims database set up in a usable manner.
- The willingness of MHSC staff to support external research using this data.
- Manitoba’s relatively small and stable population which made the research feasible given the limited computing power of the day.
- The statistical expertise of Drs. Leslie and Noralou Roos and their pioneering use of the administrative record linkage, becoming known internationally as experts in health services and population health research.
- The social context that stimulated interest in population health.
- Support from strong and politically saavy leaders in academia, government, and respected national organizations such as the Canadian Institute for Advanced Research.
- An environment of fiscal restraint in the late 1980s and early 1990s that prompted the Manitoba government’s search for scientific evidence on which to base difficult decisions in its most costly area—health.

These factors were mentioned as important in prompting the Manitoba government to initiate the discussions with the University of Manitoba and Drs. Noralou and Leslie Roos that eventually resulted in the official establishment of the Manitoba Centre for Health Policy and Evaluation in 1991.

It was fortunate that the early results allowed the government to make sound decisions that also saved them money. This allowed the Centre to start on a successful note.

In retrospect, the actual founding of the Centre seems both remarkable and almost effortless. The staff went from working with Drs. Noralou and Les Roos to working for the Centre, with so little change in day-to-day operations that the start date for MCHPE is not memorable. Occasionally, people refer to work the Centre did in the 1980s, obviously pre-Centre era, further
suggesting a seamless transition. Donald Orchard, as the Minister of Health at the time, spoke of obtaining funding approval on the first round. Investing $3.5 million in a Research Centre that could potentially expose flaws in its operations would be risky for any government. That Premier Gary Filmon’s Conservative government was willing to approve Donald Orchard’s recommendation and assume this risk is another element to add to the above list.

Obviously, there was a great deal of work and effort that under-girded the establishment of the Centre. The 15 years of research preceding the establishment of the Centre is an important part of the story. The Rooses’ and their colleagues’ high standard of research, success in publishing in respected journals and obtaining grants, and their excellent track record in protecting privacy and confidentiality provided a sound foundation on which to establish the new Centre.

And the Centre started with a contract that established important principles such as the freedom to make their reports public after a period of 180 (now 60) days. The placement of the Centre within the university established an arm’s length relationship external to government. The Centre’s Advisory Board was initially structured to assure a balance between academic and policy interests with a strong international membership to promote credibility. Over time the board membership has skewed more locally, especially inclusive of deputy ministers from various government departments, and has provided significant assistance in efforts to add new databases and maintenance of government funding. These are viewed as key components of the Centre’s continued success.

The early years reinforce lessons such as start small and build incrementally. As one person pointed out, there were three databases initially, about 10 when the Centre was established, and, on the eve of their 20th anniversary, there are 90-plus datasets. Initially, the Rooses were among the first to do health services research using administrative data, and Manitoba was unique in being able to follow individual visits to physicians as well as hospitals. Now, the expansion of the datasets makes possible linkages with areas such as education, social services, housing, etc., and provides the ability to address new research questions in population health with a comprehensiveness not possible elsewhere. The datasets, then and now, give the Centre a comparative advantage in publishing and grant competitions.

The Centre’s success over its 20 years of existence is due to the people who work there. Interviewees told me that strong leadership leading a strong team accounted for the Centre’s ability to perform as it does, and they usually stated that stable long-term funding was critical in allowing this to happen. Many other characteristics important to the Centre’s success flow from these umbrella characteristics.

**Adequate and Stable Funding**

The Province of Manitoba funded the Centre generously in the early years, and this enabled it to build needed infrastructure. This continues to be important. Adequate and stable funding is needed to attract and retain highly qualified staff, essential to the Centre’s ability to produce high quality work. A high standard of scholarship maintains credibility, which is needed to maintain the government contracts and to succeed in applications for national grants and other sources of funding. Typically, the Centre has been able to double its research budget, bringing in additional
resources that add capacity of benefit to the province as well as to the Centre. Consequently, funding levels should be higher than what is needed to pay for the contracted projects. They should be sufficient to fund efforts to bring in other sources of funding.

Over the years mechanisms have been worked out to enhance the stability of the financial support deriving from government contracts. The Centre now negotiates five-year contracts every three years. This arrangement has enhanced job security for the staff. On the other hand, the Centre did not receive any increase in funding levels until the most recent contract, clearly a problematic situation.

Although not specifically mentioned, it is also clear that the Centre would not succeed without the significant amount of work done at Manitoba Health to support their efforts. This, too, represents a political and financial commitment from the Manitoba government.

Recruit and Retain Good People
While adequate funding is important to staffing, other less tangible elements are as well. The Centre's reputation is a factor in attracting and retaining researchers; however, being located in a relatively small city and a small department makes recruitment and training harder. This situation is advantageous, however, when it comes to retention of staff, because there is little nearby competition. Competition for researchers has become a bigger issue as similar centres have become established elsewhere. The Centre's limited ability offer tenure-track positions to researchers is also a disadvantage.

Despite this, MCHP has a strong record in retaining staff. More than 40% of the original staff remain. Good staff retention greatly enhances efficiency. In the work that the Centre does, a deep understanding of the data is important; this comes with time and experience. Several staff commented that this was a great place to work, citing interesting and challenging projects with a lot of autonomy, subject to completing projects on-time. Other comments referred to being able to work flexible hours, feeling encouraged to enjoy a good work-life balance, promotion of interaction between staff through use of the lunch room and many impromptu celebratory events. Some noted that efforts were made to support people in learning opportunities, to encourage them to explore new areas of responsibility if interested, and to increase remuneration where appropriate if possible.

The work environment for the research scientists was described as collaborative and supportive. In addition to applying for their own grants, research scientists are assigned deliverables, the research projects contracted by the provincial government. Assigned projects come with the resources needed to conduct the research, including a research coordinator, a programmer, a research support person, and opportunities for team work and networking. Weekly meetings to review individual projects bring the combined experience of a dozen or more research scientists to assist in working through the challenges that are inevitably encountered. Researchers are encouraged to write up the results of these contracted projects for submission to a peer-reviewed journal. For a new researcher, it is a massive amount of support with obvious advantages for their career. Although the Centre's research
scientists sometimes are asked to lead studies on topics they have not previously researched, this can be seen as an opportunity or a challenge. Some have found new areas of interest and a broadened perspective on population health through the exploration of assigned topics.

**Leadership**

Leadership is ultimately about motivating people to work together to accomplish goals. MCHP would not exist without the leadership skills of its founding directors. Interviewees described the current director as having a different leadership style, but equally effective in representing the Centre to the external world and bringing people together to move the organization into an innovative future.

The directors at MCHP have spent huge amounts of time communicating with many groups of people to build and maintain good working relationships.

Foremost amongst these groups is Manitoba Health, the core funder. It is important to develop a strong and committed relationship with the top layer of health department administration. A thorough understanding of the funder's needs is essential. The deliverables have to meet the government's need for policy-relevant research findings. If the government does not find the product useful, then funding is jeopardized. The directors at MCHP and Manitoba Health have a standing biweekly meeting to facilitate this relationship, and processes have been put in place to facilitate collaboration, from the selection of research topics to advising on research processes to dissemination of results so that they are understood and used.

Part of nurturing this relationship with the core funder is the effort to ensure that people know how they benefit from the research so that if needed, there are advocates throughout the organization. These advocates will be around if the government changes and will be able to inform the incoming political leaders of the usefulness of MCHP research.

Political neutrality is critical, so it is important that the Centre communicate with all political parties, being available to and briefing the opposition as well as the party currently in power. The avoidance of policy recommendations also helps to keep the Centre distinct from the government of the day. The Centre’s role is to lay out the research results to support the policy makers’ decision making.

The Centre has made a practice of releasing its reports to the public through press releases and reader-friendly four-page summaries of its research results, with the research scientists available to discuss these results with reporters. It is noteworthy that the government has never attempted to interfere with the Centre’s interpretation of the research results even when reports have been unfavourable.

For over a decade, the Centre has implemented interactive workshops where researchers and regional
planning teams review reports together and discuss context and application. These knowledge translation events have been mutually beneficial as researchers learn more about programs, and program people learn more about research.

A more recent innovation, accomplished by the current director, is an award-winning knowledge translation project that involves researchers, regional health authority representatives, and provincial planners working together to build capacity among both academics and planners. *The Need To Know* Team collaborates from the development of the research questions through to use of results in evidence-based decision making and planning. This long-standing project has fostered a strong relationship between MCHP and the regions, one that is perceived as instrumental in the Centre’s survival through difficult economic times. The regions have indicated to the government that in their view, the Centre’s research is indispensable to their planning processes.

The Centre has demonstrated that it is the use of local data that is most relevant to its work with Manitoba Health and healthcare planners and providers. The potential for using local data to respond to questions of local interest that will engage the community is relevant everywhere. Both the current and past leadership actively support others to make use of administrative claims data for research purposes through setting up Remote Access Sites, web-based resources, and consulting locally, nationally, and internationally. From modest beginnings of two researchers and a program person, the MCHP venture has grown to world-wide collaboration.
APPENDIX 1: RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM
For Individual Interview

Title of Study: The Manitoba Centre for Health Policy: A Case Study

Principal Investigator: Gail Marchessault Ph.D., PHEc, R.D.
Manitoba Centre for Health Policy
Telephone: (204) 789-3666
gail_marchessault@cpe.umanitoba.ca

Co-Investigator: Patricia J. Martens PhD,
Director, Manitoba Centre for Health Policy
CIHR/PHAC Applied Public Health Chair
Associate Professor, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba
(204) 789-3791; pat_martens@cpe.umanitoba.ca

Sponsor: Manitoba Centre for Health Policy, Department of Community Health Sciences, University of Manitoba

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the study staff.

Purpose of Study
The purpose of this study is to examine the socio-political context for factors that facilitated the development, establishment and continuation of the Manitoba Centre for Health Policy. MCHP receives many requests from national and international researchers for this information, and the findings will assist in responding to these requests. The objectives of this study are to document:
1. The social, political, historical and personal factors important in establishing MCHP.
2. The challenges, and how they were met, in the development, establishment and continuation of MCHP.
3. The perspectives of key people from different organizations involved with MCHP in its origins and development.

Approximately 25-30 people will be invited to participate in this study. Individuals will be selected purposefully for their instrumental role in founding and/or sustaining MCHP. Potential participants include the founding and current directors, university department heads, deans, ministers and deputy ministers of health, members of MCHP’s advisory board, key staff from MCHP, Regional Health Authorities, Manitoba Health and other persons influential in the Centre’s history. Additional qualitative data will be collected through focus groups and document analysis.

Study procedures
If you agree to take part in this study, you will be asked to participate in an individual interview at a time and place convenient to you. It is anticipated that this interview will take approximately one hour.
Interview questions will focus on your role and your organization’s role in MCHP, the challenges you encountered and how they were met, propitious and missed opportunities, key issues such as privacy and funding, key events, successes and failures and related matters.

You will be asked for permission to audio-record your interview because the results will be more accurate if your actual words are recorded. You will be sent an electronic copy of the audio-record and transcript of your individual interview. You will have the opportunity to correct or delete comments from the transcript of your own interview, to specify how you wish confidentiality to be handled, and to indicate specific comments that must be kept confidential.

If you provide consent, you may be contacted for a follow-up focus group interview to discuss ongoing analysis. This agreement does not commit you to participate in a subsequent interview.

Participation in these interviews is voluntary. You have the right to decline to participate in any activity, to withdraw from any activity, or to decline to answer any question. You can stop participating at any time without prejudice. All that is required is to let the investigator know.

When the study is completed you will be sent a written summary report, and you may be invited to an information session where results from all interviews are shared. Attendance at such a meeting is voluntary.

**Risks and Discomforts**
MCHP will be identified in reports of findings, and so readers may be able to identify your participation in this study even if your name is not given. It is possible that this could have political repercussions. Although not anticipated, some participants may experience some discomfort or anxiety in identifying concerns about MCHP. There are no physical risks beyond those of daily living.

**Benefits**
There may or may not be direct benefit to you from participating in this study. We hope the information learned in this study will assist other researchers to address identified concerns.

**Costs**
There are no direct costs to you for participating in this research.

**Payment for participation**
You will receive no payment or reimbursement for any expenses related to taking part in this study.

**Confidentiality**
Information gathered in this research study may be published or presented in public forums. Such reports will identify MCHP as the research site. Consequently, confidentiality cannot be guaranteed. Some participants may want their role with MCHP acknowledged. Therefore, you will be asked if you wish to be acknowledged by name, and if so, if there are any parts of your interview transcript that you wish to remain confidential. Attributed quotes will be used only if
authorized. Confidential comments will be used only in summary data describing themes. The collected data will not be used for any other purpose without prior consent of participants.

Where requested, names and other identifying information will not be used or revealed. Identifying information will be removed or altered in presentations or reports, and comments and suggestions will not be attributed to specific individuals except as noted above.

The investigator (G. Marchessault) will conduct all of the interviews and will complete the analysis and report writing. Electronic records will be kept password protected on a hard drive only accessible to the principal investigator and will be destroyed after the study is completed. Audio-records of interviews will be forwarded to a confidential transcriptionist external to MCHP who will destroy them once the investigator confirms receipt. All audio-records, transcripts and notes will be identified with a code number or a pseudonym, not with your name. Signed consent forms, transcripts, any notes with identifying information and an electronic record of the analysis will be kept in a locked secure area in the investigator’s MCHP office. Upon completion of the investigator's term, these materials will be given to the co-investigator (P. Martens) in a sealed envelope with written instructions to destroy unopened on the appropriate date. This ensures secure storage in line with University of Manitoba policies.

No personal health information will be gathered or used in this study. No personal information such as your contact information, consent form or transcript will leave the investigator’s office other than to permit secure storage according to university policy. The researcher will not disclose who was invited to participate in interviews or who declined participation. No confidential information (e.g., transcripts) will be shared with MCHP staff.

Despite efforts to protect confidentiality, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law. The Health Research Ethics Board may review records related to the study for quality assurance purposes.

**Voluntary Participation/Withdrawal from the Study**
Your decision to take part in this study is voluntary. You may refuse to participate, you may withdraw from the study at any time, or you may decline to respond to any questions asked. You may decline permission to be contacted for follow-up. Your decision on whether or not to participate in the interview or focus group will not be shared with MCHP staff, and therefore will not affect your relationship with MCHP.

**Questions**
You are free to ask any questions that you may have about your rights as a research participant. If any questions come up during or after the study, contact the study investigator: Dr. Gail Marchessault at (204) 789-3666. For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.
Statement of Consent
I have read this consent form. I have had the opportunity to discuss this research study with Dr. Gail Marchessault. I have had my questions answered in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member) I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential if I have requested this, but that confidentiality is not guaranteed. I authorize the inspection of any records of this interview by the University of Manitoba Research Ethics Board for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I agree to participate in an interview with the Principal Investigator on the topic of the Manitoba Centre for Health Policy to take place on ______ date at ______ time______.

_____ Yes  ____ No

I agree that this interview may be audio-recorded. The researcher’s recordings will be deleted once the study is completed.

_____ Yes  ____ No

I agree to be contacted to participate in a focus group with the Principal Investigator on the topic of the Manitoba Centre for Health Policy.

_____ Yes  ____ No

I wish to be acknowledged by name in reports deriving from this study.

_____ Yes  ____ No

Participant signature_____________________ Date ___________________

Participant printed name: __________________________________

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given consent.

Printed Name: ____________________________ Date ___________________

Signature: ________________________________ Role in the study: ___________________

Relationship (if any) to study team members: _______________________
(The investigator is a part-time, term employee of MCHP, but is not in a supervisory relationship with any participants.)

The Manitoba Centre for Health Policy: A Case Study

Page 4 of 4  Interview Consent v. 1, January 12, 2009  Participant’s initials: _____
APPENDIX 2: THE MANITOBA CENTRE FOR HEALTH POLICY
A CASE STUDY INTERVIEW GUIDE

This project is about how the Manitoba Centre for Health Policy got established and how people have managed to keep it going now for 20 years. I have two main questions. I’m interested in hearing about your involvement with the Centre and secondly, your thoughts on what factors allowed Manitoba’s Centre to survive (given that other places have not). I’ll be interviewing key players from different organizations involved with the Centre in order to get a holistic view of the Centre’s history. You were selected because (insert reason). I’d like to hear about your role in the Centre’s development. Can you tell me how you first got involved with the Centre.

Probes
For Participants who were involved in establishing MCHP:
1. Thinking back to 20 years ago, or even before MCHP was established, can you provide me with some background about your role in the establishment of MCHP.
   ○ How did you become involved with the Centre?
   ○ What was your role in establishing MCHP?
   ○ What was your organization’s role?
   ○ How did your role interact with that of other organizations? (Department of Community Health Sciences; Faculty of Medicine; University of Manitoba; Manitoba Health; Others)
   ○ What were the key events in establishing the Centre?
2. There were many factors that came together that allowed MCHP to come into existence. In your view, which factors were key to establishing MCHP?
   ○ What other influences were helpful in establishing the Centre?
   ○ Were there any decisions that you consider to be instrumental in establishing the Centre?
3. What challenges did you encounter at the time? How were these challenges met?
   ○ Do you recall any specific crises? If yes, how was the crisis handled?
4. What were the political considerations around establishing the center? Economic considerations?
5. What advice would you give others who are attempting to set up an administrative research centre? What are your suggestions for things to do? Avoid doing?

For participants with continued involvement with MCHP:
6. How did your role with MCHP change over time? Continue interview starting with #2 Probe for those involved in MCHP’s development over time.

For participants who became involved with MCHP after it was established:
1. Thinking back to your first involvement with MCHP, can you provide me with some background about your role with MCHP.
   ◦ How did you become involved with the Centre?
   ◦ What was your role with MCHP?
   ◦ What was your organization’s role?
   ◦ How did your role interact with that of other organizations? (Department of Community Health Sciences; Faculty of Medicine; University of Manitoba; Manitoba Health; Others)

2. The Centre has been in existence now for about 20 years. What factors in your view facilitated its survival?
   ◦ What other influences helped to keep the Centre functioning?
   ◦ Were there any decisions that you consider to be key in facilitating the Centre’s 20-year operation?

3. What challenges did you encounter in your role with MCHP over this period of time? How were these challenges met?
   ◦ Do you recall any specific crises? If yes, how was the crisis handled?

4. Were there any other key events in the life of the Centre?

5. What were the political considerations around the Center’s continuation? Economic considerations?

6. What advice would you give others who are attempting to run an administrative research centre? What are your suggestions for things to do? Avoid doing?
APPENDIX 3: SURVEYMONKEY QUESTIONS
A REPORT ON THE MANITOBA CENTRE FOR HEALTH POLICY

I am writing a report for MCHP based on interviews with 28 people who have been instrumental in the Centre’s history. A major focus for the report is on how it was established, but the factors important in keeping it going for 20 years are also of interest. As many of my interviewees have indicated, the people who work at the Centre are responsible for its success.

I would like to provide others who have worked at the Centre the opportunity to contribute their thoughts on the key events in the life of MCHP, challenges encountered and factors important in its success.

So, I am posting a few of my main questions and invite you to respond to as many or as few as you wish. Depending on how much you wish to say, it could take 5 or 10 minutes to respond to these questions. I plan to include representative selection of anonymous quotes in my report for the Centre, which I understand may be shared at the 20th anniversary event.

If you have any questions, feel free to contact me at Gail_Marchessault@cpe.umanitoba.ca or phone 789-3666 (Wed-Fri).

1. What do you see as the key events in MCHP’s existence?
2. What were the major challenges that MCHP has faced?
3. What factors do you see as important in the Centre’s success?
4. What advice would you give others who are attempting to run an administrative research centre?
5. How long have you been (were you) associated with the Centre?
   - Less than a year
   - 1-5 years
   - 5-10 years
   - More than 10 years
6. Please indicate the type of position you last held:
   - Programmer
   - Project Co-ordinator
   - Researcher
   - Student
   - Support Staff
   - Other (please specify):
7. Is there anything you would like to add?

Thank you for taking time to contribute your thoughts.