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The Globalization of Healthcare: International Agreements & Ontario Academic Health Science Centres

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Abstract

Health systems are beginning to recognize the tremendous opportunity that globalization and international activities present for Academic Health Science Centres. This study explored the nature of international agreements within Ontario Academic Health Science Centres (OAHSC) and presents the exploratory findings to begin to develop an academically defensible body of literature on the topic. This study employed a constructivist grounded theory qualitative methodology, interviewing 14 participants who hold leadership positions within OAHSCs that actively participate in, or interface with, institutions that participate in international agreements (IAs). A conceptual framework is proposed that highlights the: (1) drivers, (2) barriers, (3) international activities, and (4) benefits for Ontario, that are associated with the IAs within OAHSCs. The findings highlight that IAs that are common to OAHSCs typically are either: humanitarian or business development in nature, in both cases, are focused on building health system capacity in the host country. Generally, IAs focus on three deliverables: (1) needs assessments, (2) advisory services, and (3) education training, however, in some instances, OAHSCs are starting to pursue licensing and third-party management of hospitals abroad as a part of the business development strategy.

Keywords

“globalization, healthcare, academic health science centres, international agreements, international activity, health systems, Ontario, Canada”
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Chapter 1: Introduction

1 Preamble

This chapter will act as an introduction to the topic of globalization and begin to explain how global trends are making the world increasingly connected. The chapter will provide an introduction to international agreements (IAs) within the context of the Ontario health system, specifically IAs with Ontario Academic Health Science Centres (OAHSCs), and then provide a justification as to why this body of research has the potential to meaningfully contribute to, or motivate, a body of academically defensible literature.

1.1 A Globalized World

As of today, the world is more connected, at least in the digital sense, and it will continue to be more connected tomorrow, and yet again the day after next. Today, the world is more connected than it has been throughout history. Gone are the days of carrier pigeons and smoke signals. These have been replaced with the instantaneous communication pathways of e-mails, e-transfers and an ability to “share my location” on virtually all GPS location service enabled devices. The need for personal and rapid dissemination of information is voiced through technology like Siri and simple voice commands like “O.k. Google” that allow us to seamlessly voice prompt information on life’s most important decisions such as where is the nearest gourmet restaurant, how many Titleist golf balls were in play at the 2015 Masters’, and an ability to respond to a text message that reads, “Sweetie, don’t forget to pick up the milk…”; all of this without taking your hands off the steering wheel of your everyday Ford Focus- it really is all about the simple things in life.

In today’s interconnected world, through Facebook and other social media sites, like Twitter and Instagram, we are now able to follow friends, and in some cases complete strangers, virtually, to all corners of the world; you can be lost in wanderlust in the comfort of your favourite sweatpants, having never left your living room. Through our connectedness, it is now possible for once long-lost acquaintances to connect through social networks and become best friends; all the while never having met or engaged in
conversations that unpack basic questions that any best friend should know, like, “what’s your favourite type of food?” In fact, as a result of our need to share, tweet, pin and like each other’s posts, the question of, “what is your favourite type of food”, never would have been a question in the first place, as their Pintrest account highlights their most recent culinary adventures.

Although health systems have been described as dysfunctional and out-dated, there are facets of health systems that are starting to adopt facets of globalization. Slowly, as health systems move to models in which, just like Amazon and Facebook, we are all connected through global networks, the health sector will continue to evolve into an industry that readily adapts to global pressures.

One such pressure is the emergence of accelerated rates of emigration, immigration and overall migration patterns of populations. While it is true that, throughout history, people have been known to explore and travel to different parts of the world, unlike the voyages of Christopher Columbus whose expeditions once took weeks or months, international travel can now be completed within a few hours. What this means is that infectious disease that would have been once fatal over the span of weeks/months can now be introduced to new populations while the carrier host is asymptomatic. This trend has been studied at length and is known within academic circles as epidemiology. By and large, the process in which the spread of infectious disease has been catalyzed has been sited by many academics (e.g., Richard Barker, Malcom Gladwell, etc.), as well as the Director of the World Health Organization (i.e., Margaret Chan), as having increased significantly as a result of the prominence of global travel. For example the, “2 billion air passenger journeys per year ensure they [i.e., infectious disease] spread across the globe in hours, not the three years it took the Black Death to make its way from Asia into every corner of Europe” (Barker, 2010, p. 36). With that being said, it is difficult for the average person to truly appreciate the magnitude of 2 billion air passengers a year within the context of their own communities, since 2 billion people is still only slightly larger than the population of China. To give regional context, between Toronto Pearson International Airport (YYZ) (31.8M), Vancouver International Airport (YVR) (19.4M), Los Angeles
International Airport (LAX) (70.6M), Hartsfield- Jackson Atlanta International Airport (ATL) (95M) and London Heathrow International Airport (LHR) (74.4M), there is a combined annual passenger traffic of 291.2 million passengers/year (i.e., roughly the population of the United States and a little more than 8 times the Canadian population; the passenger traffic through YYZ alone is equivalent to the population of Canada). The impact of international travel and the spread of disease has been felt several times on a Canadian level, one example being the case of Severe Acute Respiratory Syndrome (SARS) in 2003:

**Case Study 1- SARS**

The Severe Acute Respiratory Syndrome (SARS) outbreak of 2003 was a devastating pandemic that claimed the lives of 916 people; 44 cases were Canada alone (Helen, 2013). Globally, it is estimated that 8,422 people were infected with the disease, of which 428 were Canadians (ibid).

In November of 2002, a pneumonia-like disease started spreading throughout the Guangdong Province of China (Auais & Smith, 2014). It wasn’t until February 11th, 2003 that the World Health Organization (WHO) released an official statement describing the disease and providing warning (ibid). The disease started its international spread on February 21st, when a physician from the Province of Guangdong, who had been working with patients and displaying the SARS-like symptoms, traveled to Hong Kong with his wife (Dempsey, 2013). During his stay, he infected many people from many different countries; two of the infected people were Canadians, one from Vancouver and one from Toronto (Auais & Smith, 2014).

Vancouver had been preparing for H5N1, and when they heard of the SARS outbreak from Asia, they treated it the same as they had been preparing for H5N1. As soon as the effected individual entered the Emergency Department, they were in quarantine within 5 minutes, effectively controlling the spread of the disease. Toronto, however, was not as fortunate. The Torontonian travelled home and was asymptomatic until February 28th, where she then developed a fever and dry cough, and was prescribed antibiotics and sent home. This treatment was later found to be ineffective since the disease is viral and not bacterial. She later passed away at Scarborough Grace Hospital on March 5th. This woman infected several family members and health care providers, who were all unaware of the events transpiring in China. On March 7th, the woman’s son returned to the same hospital with similar symptoms, and passed away on March 13th. By March 25th, more than 5,000 Torontonians had been exposed. (Auais & Smith, 2014; Helen, 2013).
By April 5th, SARS had reached 18 countries, and taken an 8th life in Toronto (Helen, 2013). On April 12th, the first step towards a cure arrived from a scientist in British Columbia (Auais & Smith, 2014). He successfully mapped out the full DNA sequence of the virus, which was shared globally in an effort to work together internationally to develop a treatment (Helen, 2013). It was not until July 2nd of 2003, that the WHO removed Toronto from the list of SARS-affected locations, and not until July 9th of the same year, that the outbreak was ended worldwide (ibid).

Arguably, a more global world is one where infectious diseases, which would otherwise be isolated to communities and/or regions, can now rapidly be transmitted across international borders. However global forces are not intrinsically negative. Health systems globally have been the benefactor of many by-products of globalization. One such benefit of being a globalized industry is that patients have the advantage of benefiting from a globalized supply chain.

**Case Study 2- Global Distribution**

In many emerging markets and/or economies in transition, “1 in 9 children die before their 5th birthday from preventable and often neglected causes like dehydration from diarrhea” (“Cola Life”, n.d.). What is shocking is that many of these markets do not have access to simple oral rehydration salts and/or zinc supplements, but have access to Coca-Cola. In fact, in Africa, “the Coca-Cola system is the largest private employer…. It has 170 bottling and canning plants and it works with 900,000 retail partners” (Fiarbourn & Gibson, 2007, p. 121). Coca-Cola is, “sold in stores, restaurants, and vending machines in more than 200 countries” (Vadav, Stapleton & Wassenhove, 2013, p.51), which makes Coca-Cola one of the most recognized brands and widely available products in the world. Unlike Coca-Cola, pharmaceutical companies who make the medication to treat and prevent these illnesses, experience difficulty when trying to distribute the pharmaceuticals to remote villages as a result of insufficient or underdeveloped distribution channels (Fiarbourn & Gibson, 2007).

In an effort to remedy insufficient distribution channels many not-for-profit organizations (e.g., Cola Life) and other pharmaceutical companies (e.g., Merck & Co.) have partnered with Coca-Cola to leverage their innovative distribution channels as a mechanism to deliver life-saving medication and treatments to remote areas. What these organizations typically arrange is for, “the empty space between Coke bottles in crates to transport public health commodities” (“Cola Life”, n.d.). What makes Coca-Cola unique in its distribution channels is that they, outsource its warehousing and transportation operations to third-party companies…[that] helps increase the frequency of shipments to the retail
points of sale without increasing cost…[whereas] in contrast, medicines are limited to certain dispensing points that must be able to ensure adequate equipment for storage and have staff capable of providing accurate dispensing advice” (Vadav, Stapleton & Wassenhove, 2013, p.54-55). Where the challenge has proven to be uniquely about the distribution of medication, Coca-Cola’s distribution network is an innovative example of how globalized supply chains have positively impacted health services in emerging markets and/or economies in transition.

Although there are undeniable benefits, as highlighted by the Coca-Cola distribution network example, with respect to product distribution within a global supply chain, there are also examples of a global supply chain when speaking in reference of human resources. The global supply chain of human resources is more controversial than that of product distribution as it is often the emerging markets and/or economies in transition that suffer from negative consequences from reduced human resources in an effect commonly known as “brain drain”. Brain drain occurs when workers from emerging and developing markets, leverage their professional training received in a particular country and leave that country for other opportunities abroad. This leaves their country of origin without the skilled professional they invested in training; often highly trained healthcare professionals from developing and emerging markets flock towards developed markets for learning opportunities, high salaries and an overall improved quality of life (Walton-Roberts, 2015).

There are many different factors within the concept of globalization and globalization in relation to the delivery of health services. In general, the forces of globalization operate in a “push” and “pull” type of relationship (Walton-Roberts, 2015); the concept of globalization will be explored further in Chapter 2.

1.2 International Activities within the Ontario Health System

Since the inception of the Canadian universal health system in 1966, Canadians have taken great pride in our publicly funded health system and further identified healthcare as one of the most fundamentally important features of our society (Snowdon, Schnarr, Hussein & Alessi, 2012). However, a failure to adopt new technologies, as well as innovative processes and procedures, is leading to diminishing efficiencies, exponentially increasing costs and an inability to deliver high quality care and value to Canadians
(McKinsey & Co., 2012). In order to ensure that the Canadian health care system can sustain, and improve upon its ability to deliver effective and efficient health services to Canadians, it needs to transform into one that is highly productive and sustainable. We need to rethink how we engage the consumer in the delivery of care, maximize preventative health services and finance our health system.

Despite a burdened health system, Canada is fortunate to be considered among the top educated countries in the world relative to the percentage of its population that has completed tertiary education (OECD, 2012). In comparison to less fortunate countries, having a highly educated population positions Canada as a world leader with respect to trained expertise and capacity for the generation of new knowledge from post-secondary institutions. In the emerging and developing countries of the world, there is a massive health human resource shortage with an estimated global shortage of more than four million workers (Chen, Evans, Anand, Boufford, Brown, Chowdhury et al., 2004). Often, in these emerging and developing economies, there are few opportunities for graduate, postgraduate and medical education required to gain an appreciation for developing sophisticated health systems (Merritt, Railey. Levin, & Crone, 2008). This leaves a tremendous opportunity to leverage Canadian expertise and experience, in the interest of Canadian economic prosperity, to aid in the creation of developed health systems within these emerging economies (Romanow, 2002).

In light of increasing healthcare costs, as a health system, we need to employ mechanisms that decrease expenditures, as well as strategies that have the potential to generate additional revenue. However, given the public nature of the provincial health system, these mechanisms and strategies should not be solely evaluated with respect to financial return on investment, but also employed to deliver value to the populations who support and fund the provincial health system. Although the nature and drivers of international partnerships that are being solicited by OASHCs are generally undefined, as OAHSCs continue to broaden their market to emerging and developing economies, it is increasingly important to identify how, and if, these partnerships contribute to their respective OAHSC and provincial health system. To begin to create a body of academic
literature surrounding the nature and drivers of IAs for OAHSCs, this thesis will identify what these agreements specifically achieve in the context of their respective OAHSC, as well as the provincial health system, relative to advancing the goals, strategic priorities and overall health system performance for the people of Ontario. If IAs are going to become prolific within the provincial health system, it is important that we understand the return on investment through the lens of the Ontario taxpayer.

In September of 2014, according the Ministry of Health and Long-term Care (MoHLTC), 13 OAHSCs disclosed that they have participated in some level of IAs within the last 5 years (i.e., between 2008-2014). It is important to note that, “all active hospitals reported having policies and practices in place to ensure that with respect to any IPS [International Patient Services] and IAs, public funds are not used, access to insured services is not adversely affected, and revenues are directed to the benefit of Ontarians” (personal communication with Service Ontario, March 2015). It is also important to note that, while the focus of this thesis is not on IPS, IPS patients represented less than 10% of all non-Canadians admitted to Ontario hospitals in 2013-2014 (i.e., less than 1% of overall all patients admitted) and are considered by the MoHLTC to be a low-volume niche activity (personal communication with Service Ontario, March 2015).

1.3 Research Purpose

“Globalization is a complex, multidimensional phenomenon that has already influenced the way hospitals operate and will increasingly impact the healthcare landscape and patients’ experience in Canada and worldwide” (Cortinois, Downey, Clossen, & Jadad, 2003, p. 14). However, the nature and extent to which Ontario Academic Health Science Centre’s (OAHSCs) are engaging in globalization is unknown. In Canada, decisions involving health systems are largely left to the discretion of the provincial governments. As such, this thesis will focus on the Ontario health system. In Ontario, 13 of the 24 members of the Ontario Council for Academic Hospitals have broadened their boundaries beyond provincial/ national frontiers and have engaged in IAs. Several OAHSCs currently engage in IAs with foreign countries. However, the drivers, whether philanthropic or financially motivated, have not been identified in the academic literature.
These commercial activities may include providing consulting services and have been speculated to also include the provision of patient-care in exchange for revenues that may have the potential to be reinvested into the provincial health system and/or their respective OAHSC. However, the nature and implications of these agreements is unknown, and the impact these partnerships have on capacity within health systems has also not been described to date.

International activity within OAHSCs has gained controversial attention in the public media and is a politically charged topic in Ontario. Articles that have been featured in the Toronto Star, Globe and Mail, National Post, as well as daytime radio talk-shows on the Canadian Broadcasting Corporation (CBC) radio, have emphasized the public concerns regarding Ontario’s health system, specifically OAHSCs engaging in IAs. What appears to be concerning the people of Ontario is the lack of understanding and transparency regarding the conditions, stipulations and return on investment for the provincial health system as a result of soliciting IAs. As such, there is a need for an academically defensible evidence base that explores the nature and drivers of these IAs. The focus of this thesis was on identifying the nature and drivers of IAs between OAHSCs and foreign nations in emerging or developing economies. This thesis examined the nature of IAs with OAHSCs and will seek to identify what these agreements achieve (e.g., global leadership development, capacity, innovative, economic development, etc.) for their respective OAHSCs, as well as the provincial health system relative to advancing the goals, strategic priorities and overall health system performance for the people of Ontario. This thesis addressed the following:

1. What is the nature of international agreements that are being employed by OAHSCs?
2. What are the drivers and motivations that influence these agreements?
3. What organizational advantages to OAHSCs result from international agreements?
4. What impacts, both positive and negative, do these international agreements have on the Ontario health system?
1.4 Study Limitations

As part of ensuring sincerity and transparency within the research process (i.e., indicators of quality qualitative research; see chapter 3 for additional information), it is important that the limitations of the study be prominently disclosed to the reader (Tracy, 2010). The disclosure of the limitations is not an effort to reduce the findings of the study, but rather to provide the reader with enough information so that he/she can come to their own conclusions about the findings. The following are potential limitations of the study:

- Organizational diversity of participants

The organizational homogeneity of some of the study participants is a potential limitation of the study. While the researcher made efforts to secure participants from a variety of OAHSCs who participate in IAs, ultimately 14 people (on behalf of 7 different OAHSCs) consented to participating in the study. Of those 14 people, 5 individuals represented one OAHSC and 3 others were representatives of another (see section 3.3 for additional information), leaving the remaining 6 participants to represent 5 OAHSCs.

- Securing appropriate participants

Securing appropriate participants with knowledge of IAs proved to be challenging as contact information for individuals who were procuring IAs within OAHSCs often was not prominently available on organizational websites. Additionally, after initial contact (i.e., through email recruitment), some organizations declined to participate on behalf of the entire organization, despite recruiting participants as individuals as opposed to soliciting organizational participation. Further, some individuals who were identified as key contacts to recruit as participants in the study were not reachable by email (i.e., the recruitment email was undeliverable to the email address that was publically available) suggesting that the individual had either changed their email address or moved to a different institution.

- Theoretical sampling
While the 14 telephone interviews were in-depth, they may not have represented the views and opinions of all OAHSCs that participate in IAs. There may have been organizational biases, as highlighted above and in section 3.3. Further, due to a change in the Primary Investigator, as well as availability of study participants, true theoretical sampling was not completed. As explained in section 3.3, due to the long period of data collection and the simultaneous analysis of data, memo-writing, and the flexible nature of the interviews, the researcher was still able to conduct some level of theoretical sampling to explore ideas and concepts that were described by other study participants.

- Confidentiality and non-disclosure agreements related to international agreements

Due to the confidentiality and non-disclosure agreements (NDAs) that were commonly associated with IAs among OAHSCs, it was not possible to conduct an a priori analysis of the agreements themselves; these agreements are confidential and subject to NDAs to protect the competitive advantage of the OAHSCs.

- Change in Primary Investigator

As explained in sections 3.3 and 3.6, a change in the Primary Investigator of the study, which occurred after the data had been collected, was another potential limitation of the study.
Chapter 2 : Literature Review

2 Preamble

In virtually every industry, from commodities to fast-food chains, to manufacturing, globalization has played an increasingly prominent role in the evolution, innovation and prosperity of an array of different industries. However, globalization and healthcare and health systems are often viewed as mutually exclusive. Healthcare is traditionally received on an individual basis from municipal, provincial, and sometimes-national providers, and outcomes are not measured based on market performance but are rather intrinsically tied to the patient. Despite the nuances between the health industry and other sectors, healthcare represents 11 percent of Canada’s Gross Domestic Product (GDP) and employs over 2 million workers; ultimately as the business of healthcare grows, healthcare in Canada will (and is) begin to perform similar to other industries and shift towards globalization through mechanisms such as international partnerships. Further the, “advances in information and telecommunications technologies, increased international mobility of service providers and patients, and growing private sector participation” have yielded the increase in the globalization of health services (Smith, Chanda, & Tangcharoensathien, 2009, p. 593; Smith, 2006).

This chapter provides a review of academic literature that examines the phenomenon of globalization and then specifically explores globalization in the Canadian health system.

2.1 Understanding Globalization:

The term globalization is a word that is frequently used to describe the relationship between global cultures, economies, markets and other social phenomenon that occur within respective societies (Mittelman & Hanaway, 2012; Robertson & Featherstone, 1990; Levitt, 1983; Robertson, Brown, Pierre, & Sanchez-Puerta, 2009). Frequently globalization is referenced in the context of being a powerful force that is shaping our current and future history in a multitude of facets (Mittelman & Hanaway, 2012). Despite its prolific use in a multitude of different academic, business, media and social circles, the term globalization has acquired a number of different meanings, with varying degrees
of precision (Robertson & Featherstone, 1990). Within the context of healthcare, and specifically international partnerships, the interpretations of, and drivers of globalization, are not well described. As healthcare, both provincially and globally, transforms to adopt policies, processes and business models that are aligned with the 21st century, globalization will likely have a significant impact on the way we administer, execute, evaluate and finance health systems in the future.

Dr. Theodore Levitt, a professor at Harvard Business School, first coined the term globalization, in his Harvard Business Review article, *The Globalization of Markets* (1983). Levitt articulates that modern technology has facilitated a society where, “almost everyone, everywhere, wants all the things they have heard about, seen, or experienced via the new technologies” (Levitt, 1983, p.2). Levitt goes on to explain that peoples’ broadened sense of wants and desires has created a, “new commercial reality- the emergence of global markets for standardized consumer products on a previously unimaginable scale [and that] corporations geared to this new reality benefit from enormous economies of scale in production, distribution, marketing and management” (Levitt, 1983, p.2). With the emergence of global markets for standardized consumer products, Levitt proclaims the demise of multinational corporations and articulates an insightful difference between multinational and global corporations. In the article, multinational corporations are defined as corporations that, “operate in a number of countries, and adjust its products and practices in each- at high relative costs” (Levitt, 1983, p.3). Whereas, the interpretation of global corporations are those corporations which, “operate with resolute constancy- at low relative cost- as if the entire world (or major regions of it) were a single entity; it sells the same things in the same way everywhere” (Levitt, 1983, p.3). Simplistically, Levitt describes globalization as a process of global homogenization of cultures, markets and other social tendencies that would otherwise be heterogeneous.

Although Levitt first coined the term “globalization” in reference to the emergence of modern technology in the early 1980’s and credited that emergence as both a stimulant and catalyst of globalization, globalization is not a recent phenomenon. In fact,
Mittelman and Hanaway (2012) suggest that the exploratory voyages of Christopher Columbus, Ferdinand Magellan, and other 15th and 16th century explorers in the Renaissance era were the first to conceptualize globalization. With that being said, Mittelman and Hanaway (2012) do acknowledge that globalization in the modern era is doubtlessly, “fueled by advancement in telecommunication technologies and incentivized by immense economic rewards” (Mittelman & Hanaway, 2012, p. 5). They articulate as a result of these technological advances that, from the perspective of economics, “national boundaries are dissolving to give way to single global markets for labor, manufacturing, finance and service (Mittelman & Hanaway, 2012, p. 5). The interpretation of globalization of Mittelman and Hanaway is comparable to that of Levitt as they see globalization reflecting the amalgamation of what were once regional, provincial and/or national markets into a singular, inter-connected global enterprise. In general, according to Görg and Greenaway (2004), the concept of globalization has four dominant drivers. The four drivers of globalization can be seen in Figure 1- Drivers of Globalization (Görg & Greenaway, 2004, p. 173).

**Figure 1- Drivers of Globalization (Görg & Greenaway, 2004, p. 173)**

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imitation</td>
<td>Adoption of new production/ management methods</td>
</tr>
<tr>
<td>Skills Acquisition</td>
<td>Increased productivity of complementary labour</td>
</tr>
<tr>
<td>Competition</td>
<td>Reduction in inefficiency and/or faster adoption of new technology</td>
</tr>
<tr>
<td>Exports</td>
<td>Scale economies</td>
</tr>
</tbody>
</table>

Robertson and colleagues conceptualize globalization in the modern era as the, “increases in trade, migration, and investment across borders that are associated with the fall of regulatory barriers [that] directly affect workers in both developed and developing countries” (Robertson, Brown, Pierre, & Sanchez-Puerta, 2009, p.1). Yet again, the theme of assimilation of what would otherwise be heterogeneous markets appears in their interpretation of globalization. What is interesting about the interpretation of Robertson et al. (2009) is the inclusion of migration (i.e., a humanist perspective) as a proponent of globalization; this is consistent with the perspective of globalization presented Mittelman and Hanaway (2012) who credit 15th and 16th century explorers as the early pioneers of
globalization. Robertson’s interpretation of globalization addresses both labour and migration as proponents of globalization, inferring that people are indeed a part of a global economy (Robertson et al., 2009). However, it is important to identify that there are interpretative differences between migration and labour in relation to globalization. The notion surrounding labour in a globalized economy recognizes the potential for outsourcing employment while maintaining distinguishable regional localizations; this is prevalent in the manufacturing industry (e.g., Apple products that are designed in California, but made in China). In contrast, within the same globalized economy, the concept of migration views human resources to be transient and readily interchangeable as a commodity itself (e.g., brain drain\(^1\)). For example, Canadian trained health human resources (e.g., doctors, nurses, etc.) who either: (1) return to their country of origin to practice medicine, or (2) participate in philanthropic missions to underprivileged regions of the world, are examples of human resources acting interchangeably as a commodity within the context of globalization. Further, as Canada cements itself as a global leader with respect to the percentage of its population that has completed tertiary education, its highly trained, highly skilled workforce will become coveted around the world. This is particularly relevant in the domain of Canada’s highly trained health professionals.

Simplistically, globalization can be viewed as global uniformity, however Robertson and Khondker (1998) deliberately proposed that globalization, “does not in itself constitute global sameness, for while many of the institutions of contemporary nation-states have become similarly patterned there is nonetheless considerable local variation” (Robertson & Khondker, 1998, p.28). Instead, “globalization involves the promotion or ‘intervention’ of difference and variety” (Robertson, 1995); otherwise positioned as a level of heterogeneity. This dialogue positions that it is overly simplistic to define globalization as global homogenization as there are often regions and/or nations that participate in the process of globalization yet maintain idiosyncrasies that are unique to their region.

\(^1\) Brain Drain: “A situation in which many educated or professional people leave a particular place or profession and move to another one that gives them better pay or living condition” (Merriam Webster Dictionary, 2014)
It becomes apparent in the literature that there are three predominant perspectives in the globalization debate: ‘homogenizers’, ‘heterogenizers’ and proponents of a ‘hybridized model’ (Featherstone, Lash & Robertson, 1995). Typically, ‘homogenizers’, “subscribe to some sort of notion of world system...they look primarily at the presence of the universal in the particular, whether as commodification or as time-space distanciation” (Featherstone, Lash & Robertson, 1995, p. 4). In contrast, ‘heterogenizers’ have a tendency to, “dispute that a system exists, will disclaim the distinction of universal and particular, and see the dominance of the West over ‘the rest’ as that of simply one particular over others” (Featherstone, Lash & Robertson, 1995, p.4). Complimenting both the positions of globalization as an act of homogenity and heterogosity is the position of a hybridized model. Within the context of culture, hybridization is defined as, “the ways in which forms become separated from existing practices and recombine with new forms in new practices” (Rowe & Schelling, 1991, p. 231). Essentially, following the hybridized model provides a platform for both homogeneity and heterogeneity within the context of globalization. Within the context of health systems, globalization is often viewed from the perspective of a hybridization. In healthcare, best practices are often founded in scientific evidence and are a combination of evidence and practices that have been trialed and evaluated around the world. For example, Christiaan Barnard performed the world’s first heart transplant in South Africa in 1967. Heart transplants are now performed around the world. While the best practices are adopted to meet the needs of the population and capacity of the attending doctor, they are still founded in the evidence that was first created in South Africa.

Hybridization models of globalization give privilege to the concept of glocalization; the notion of “think globally, act locally” (Featherstone, Lash & Robertson, 1995, p.49). Glocalization refers to, “the combination of intense local and extensive global interaction” (Wellman, 2002, p. 13). McDonalds is an excellent example of successful globalization yet its menu is often tailored to meet the desires of the local community. Ken Booth, an international relations theorist, ventures that there are many instances of communities who follow the “think globally, act locally” mentality; that, “identity
patterns are becoming more complex, as people assert local loyalties but want to share in
global values and lifestyles” (Lipschutz, 1992, p. 396). The hybridization model provides
a mechanism to explain how, despite globalization and the incomplete notion of global
homogeneity (Hamelink, 1983; Schiller, 1989), there remain differences between
cultures, markets and politics. The benefits to the hybridization model in conceptualizing
globalization are that it is not as focused on establishing finite boundaries but rather it
embraces the mix-and-match reality of how the region, national and global systems
interact (Featherstone, Lash & Robertson, 1995). The notion of “thinking globally and
acting locally” is important to consider when developing health systems, as health
systems must deliver value to the populations they serve. Although outside the scope of
globalization with respect to magnitude, healthcare in Canada is an excellent example of
hybridization; the Canada Health Act (CHA) stipulates conditions that the health system
must meet, however the individual jurisdictions (i.e., provincial, regional and municipal)
are empowered to execute strategies that are best tailored for the respective populations.
When considering globalizing the Canadian health system abroad, it will be important
that these strategies leverage a hybridization model; building in successful elements of
the Canadian health system, while at the same time incorporating aspects that address
local needs and values.

Many believe that the terms globalization and internationalization can be used
interchangeably. However while these terms share related processes, to do so would be
an over simplification of the processes that these models entail (Knight, 2004).
Globalization relative to internationalization can be defined as the, “flow of technology,
economy, knowledge, people, values, [and] ideas…across borders…[that] affects each
country in a different way due to a nation’s individual history, traditions, culture and
priorities” (Knight & de Wit, 1997, p.6; Knight, 2004). Contrastingly, internationalization
refers to, “the processes generated by underlying shifts in transaction costs that produce
observable flows of goods, services and capital” (Milner & Keohane, 1996, p. 4).
Simplistically, internationalization, “expands the tradeables sector within an economy,
thus reducing the amount of economic activity sheltered from world market
forces…[this] increases the sensitivity of national economies to world market trends and
shocks...[and may] affect the relative price of domestically produced goods” (Milner & Keohane, 1996, p. 5). Further, internationalization emphasizes the, “increasing importance of international trade, international relations, treaties, alliances etc.” (Daly, 2006, p.187). For example, the North American Free Trade Agreement (NAFTA) is an example of internationalization and not globalization as it is an agreement between two nation states to foster trade relationships. In contrast, the presence of Pepsi Cola in Canada would be an example of globalization. It is important to distinguish between globalization and internationalization when speaking about the globalization of Canadian health services as individual hospitals are independently and strategically soliciting international partnerships; they are not soliciting partnerships on behalf of the provincial and/or federal government as, “trade negotiations traditionally involve people concerned with trade, finance, foreign affairs, in isolation from health professionals” (Smith, Chanda, & Tangcharoensathien, 2009, p. 593). It is important to articulate that Canadian hospitals are undertaking globalization and not internationalization, as, to a certain extent globalization activities are outside the scope of the World Trade Organization (WTO) and trade agreements such as NAFTA and the General Agreement on Trade in Services (GATS). It is suggested in the literature that health services would benefit from operating outside of trade agreements as it would increase, “efficiency, specialization and quality gains, public-sector cost savings, expansion of service provision, export revenues and remittances, transfer of technology and skills, and increased patient choice” (Smith, Chanda, & Tangcharoensathien, 2009, p. 599), while at the same time allowing to, “reverse course on market access of national treatment if the experiment [i.e., trade of health services] produces unsatisfactory results” (ibid).

As a whole, internationalization empowers the nation state. In contrast, globalization has less of an emphasis on the need for independent region/states and/or nations. Globalization seeks to encompass the, “fast and continuous inter-border flow of goods, services, capital (or money), technology, ideas, information, cultures and nations” (Dulupcu & Demirel, 2005, p.4), whereas internationalization promotes the inter-border exchange of goods and services with definite and finite respect of territorial boundaries. Because the emphasis of this thesis was on exploring the nature, impact and drivers of
international partnerships with OAHSC’s and considered the implications on trade agreements to be outside the scope of research, the author explored the research and its associated findings through the lens of globalization within the context of healthcare.

2.2 Globalization and Healthcare in Canada:
Healthcare has lagged in its process towards globalization in comparison to nearly every other industry (Crone, 2008). Healthcare has lagged behind other industries largely due to insufficient advances in information and telecommunications technologies, as well as inefficient mobility for health professionals. However, with the advances of the 21st century, these hindering elements have been transformed to mechanisms that meet the needs of health systems, setting the stage for health systems to engage in globalization efforts (Smith, Chanda, & Tangcharoensathien, 2009). From agricultural, to manufacturing, to telecommunications, nearly every industry has recognized the potentials effects of globalization on imitation, skill acquisition, competition and export. The extent to which OAHSC and the Ontario health system are engaging in globalization is largely undefined in the academic literature; very little outside of grey literature explores the nature and outcomes of international agreements with OAHSC. However, given the prominent role of healthcare in both the provincial and national economy (i.e. 43 percent of Ontario’s provincial budget and 11 percent of the national GDP), and the rapid globalization of other sectors, elements of the health system will ultimately lend themselves to globalization to ensure that the system can continue to deliver value to the taxpayers who fund the system (CIHI, 2013b).

In 2002, the Romanow Commission, *Building on Values: The Future of Health Care in Canada*, suggested that, “it is time for Canada to use both its positive relationship with developing countries and its considerable expertise in health care to help improve the health and health care around the world” (Romanow, 2002, p.243). To meet Canada’s international obligations, the Romanow Commission suggested that Canada should seek to strengthen, “foreign aid programs to assist in training much needed healthcare providers for developing countries and in promoting public health initiatives designed to prevent the spread of illnesses” (Romanow, 2002, p. 243). It is suggested that investing in
health systems abroad may allow not only for increased international collaboration between healthcare providers, but also increased diplomatic cooperation and elements of national security (Canadian International Development Agency [CIDA], 2001; Romanow, 2002; Owen & Roberts, 2005). Although diplomatic cooperation and national security are outside the scope of globalization, if the globalization health systems are a catalyst to improving the workforce, creating capacity through innovation and stimulating international collaboration and enhancing economic growth, then these elements are important to consider and identify as drivers of the globalization of health systems.

Within the 34 countries that are part of the Organization for Economic Co-operation and Development (OECD), an overwhelming majority have developed and sophisticated health systems that are comparable to the Canadian health system. Despite little opportunity for the globalization of Canadian health systems within other OECD countries, “70 percent of the world’s population- 4.5 billion people- live in the emerging economies of Asia, the Middle East and Latin America…where essentially all regulations and standards are created from scratch as [their] system[s] develop[s]” (Crone, 2008, p. 117,119). Within these emerging economies, “life expectancy is increasing, as are the number of consumers with the means and willingness to pay out-of-pocket for one-time, life-transforming interventions like cardiac surgery, joint replacement, cosmetic surgery and bariatric surgery” (Crone, 2008, p.117). While life expectancy, as well as financial prosperity, are increasing in these developing and emerging economies, there are often few opportunities for graduate, postgraduate and medical education that are required to gain an appreciation for developing sophisticated health systems (Crone, 2008). This leaves a tremendous opportunity to leverage Canadian expertise and experience, in the interest of Canadian economic prosperity and demonstration of leadership, to aid in the creation of developed health systems within these emerging economies (Singer, 2009).

In the years since the Romanow Commission, the globalization of Canadian health expertise, through a combination of models that leverage not-for-profit and for-profit frameworks, have been identified as forms of international collaboration within the health sector. Within Ontario, several OAHSCs have engaged in the globalization of healthcare
through soliciting international consulting opportunities in developing and emerging economies where Canadian health systems knowledge and expertise are provided for financial compensation (personal communication with MoHLTC, 2014). Although Canadian international health systems consulting projects in developing and emerging markets is emerging within the Ontario health system, the nature of these agreements is largely unfounded in the academic literature. The extent to which the nature of these agreements are understood is predominantly through grey literature sources (e.g., Globe and Mail, Toronto Star, National Post, CBC etc.) that have focused on the international agreements of SickKids Children’s Hospital (SickKids), University Health Network (UHN), Sunnybrook Hospital, and Mt. Sinai Hospital and the financial impact of these partnerships. The opinions expressed in these articles and media outlets may not be an accurate representation of international activities.

Recently, the international activities of OAHSCs have emerged as topic of public interest, and have most frequently been discussed in public discussion forums and grey literature rather than the academic literature. In an interview with CBC radio (April, 2014), Dr. Bob Bell, former CEO of UHN and current Deputy Minister of Health, addressed these international agreements/ partnerships with foreign nations/ governments and noted that the globalization activities of many OAHSC’s are motivated by several factors including: humanitarian efforts, revenue generation, and economic growth for both the OAHSC and province at large. Dr. Bell suggested that the globalization of the OAHSCs may in fact be a solution to wait lists as he identified that, “for every international patient that is treated, [it is estimated that they] could treat two (2) incremental Ontario patients from the waiting list” (Bell & Tremonti on CBC Radio, 2014). Although these findings are unfounded in the academic literature, conceptually this suggests the globalization of OAHSC potentially provides an opportunity to increase system capacity, generate additional revenue, and facilitate improved access to patients as well as advance innovative research priorities.

From an academic perspective, the Romanow Report (2002) would suggest that these international agreements should be conducted as philanthropic missions. It is also
possible that the delivery of health services/expertise in developing and emerging economies may have the potential to advance and enhance the strategic priorities of their respective OAHSCs. In a report written by the former Chief Executive Officer of the University Health Network in Toronto, Tom Closson, it is noted that the revenues from, “international consultations completed every year at the University Health Network, are reinvested to support a number of innovative ventures, such as a program aimed at improving health services access for ethnic minorities in Toronto” (Cortinois, Downey, Closson, & Jadad, 2003). The report further proposes that international agreements could be a mechanism to, “deal with diminishing public funding and...[could be] an alternative source of revenue” (Cortinois et al., 2003). Other reports also support that, “globalization [could] provide the opportunity to decrease the [health system] reliance on the Canadian tax dollar” (University Health Network, 2001). Ultimately there is a diverse range of views and perceptions regarding the role of international agreements within the Ontario health system; international agreements have the potential to impact global leadership, capacity, workforce, and economic prosperity. However, due to an absence within the academic literature, the natures, drivers and impact of these partnerships are left to speculation. It is the ambiguity in the nature of these agreements and the vagueness within the literature of what these agreements achieve, if anything, that this thesis seeks to generate a body of academically defensible evidence to explore the nature of these agreements.

There is a gap in the literature that explores the nature and impact of international agreements between OAHSCs and foreign nations/governments. In particular, there is a need to identify what they achieve for their respective AHSC and the significance of their impact on the provincial health system, if any. In, SickKids in Qatar- Responding to a Request for Proposal, a business case written by the Ivey Business School it was suggested that, in 2002, SickKids sought out global opportunities as a mechanism to maintain adequate levels of revenue to continue funding world-class research, and to overcome financial deficits (Smith, Cramm & Snowdon, 2014). Correspondingly, in 2005, SickKids established an international subsidiary, SickKids International (SKI), to create a global platform to, “improve children’s health through excellence in clinical care,
education and biomedical research” (Smith, Cramm & Snowdon, 2014, p.3). SKI then established three priority focus areas: Global Child Health Program, the International Patient Office, and Business Development Services. Of the three priority areas, “BDS was designed to provide advisory services to international government, medical institutions and organizations from which a source of new revenue could then be generated…to fund new and ongoing innovative research and strategic projects, as well as clinical care, at SickKids” (Smith, Cramm & Snowdon, 2014, p. 3). Ultimately, “the vision of ‘Healthier Children. A Better World’ has led to the scope of operating internationally”, and SickKids has sought out international partners to fulfill this vision (Smith, Cramm & Snowdon, 2014, p. 8). It is important to note that SickKids is not the only institution participating in international agreements. Ultimately there is a need in the academic literature to articulate the nature of these international agreements and identify the impact, if any, these agreements have on the OAHSCs and Ontario.
Chapter 3 : Methods

3 Preamble
This chapter will describe the methodological approach and design of this program of research.

3.1 Study Design
The researcher employed a grounded theory approach and interpreted the qualitative results from a constructivist paradigm (Charmaz, 2003; Guba & Lincoln, 1994). Congruent with grounded theory methodology, this study assumed the relativism of multiple social realities, acknowledging that the political and social realities in the different geographical locations around Ontario will be different from each other but will share similarities (Charmaz, 2003). As the nature of international agreements within OAHSCs have not been well described to date, employing a grounded theory approach allowed for the discovery of new knowledge and concepts related to these agreements. The allowance for the discovery of new knowledge and concepts is congruent with grounded theory philosophy in the sense that, “the researcher has no preconceived ideas to prove or disprove...Rather, issues of importance to participants emerge from the stories that they tell about an area of interest that they have in common with the researcher” (Mills, Bonner, & Francis, 2006, p. 25-26). Additionally, the type of qualitative research that had been conducted in previous research projects by the researcher had subscribed to a constructivist grounded theory methodology, as well as the research experience of the study’s initial primary investigator. Further, this study provides insight into the motivations that drive these partnerships, as well as the perceived impact that these agreements have on the strategic priorities of their respective OAHSC and larger Ontario health system.

Key characteristics of grounded theory were built into the design of this study to increase the credibility of the findings. Based on the insights of Glaser (1978, 1992), “the following criteria for evaluation a grounded theory [were built into the study design]: fit, work, relevance, and modifiability” (Charmaz, 2003, p. 251; Glaser, 1978; Glaser 1992).
These criteria should be considered when designing a grounded theory study in the following ways: “theoretical categories must be developed from analysis of collected data [i.e., fit]...It must provide a useful conceptual rendering and ordering of the data that explains the studied phenomena [i.e., work]...[it must] offer analytic explanations of actual problems and basic processes in the research setting [i.e., relevance]...[and allow for] research [to] modify their emerging or established analyses as conditions change or further data are gathered [i.e. modifiability]” (Charmaz, 2003, p. 251-252; Glaser, 1978). It is also important to highlight that “grounded theory methods specify analytic strategies, not data collection methods” (Charmaz, 2003, p. 257). As such, to account for these criteria, study characteristics included: i) simultaneous collection and analysis of data; ii) a two-step coding process; analysis of data will start with open coding and will then be followed with line-by-line coding to avoid the researcher from imposing their own beliefs on the data; iii) memo writing aimed at the construction of conceptual analysis; this helped to identify patterns in the data and to explore new ideas and/or understandings; and IV) theoretical sampling; theoretical sampling was used post hoc prior to the completion of the study to develop emerging themes and make them more definitive and informative (Charmaz, 2003). While researcher bias was mitigated through the use of line-by-line coding, constructivist grounded theory acknowledges that the research and his/her personal biases are a part of the knowledge creation process (Charmaz, 2003). Consistent with a ground theory approach, as the study progressed, the research question, interview guide and coding used to analyze the data were refined to be more specific based on the findings from employing a constant comparative methodology.

3.2 Definition of International Agreements

3.2.1 International Agreements vs. Medical Tourism

It is important to differentiate between IAs, as discussed in this thesis, and medical tourism. In April (2015) the Conference Board of Canada released a report entitled: Briefing 2- Should Canada’s Hospitals Open Their Doors to Medical Tourists? In this report medical tourism was defined as, international travel for the primary purposes of receiving medical treatment (Conference Board of Canada, 2015; Alsharif, Labonte, &
Lu, 2010). In the context of this thesis, IAs were interpreted using the definition provided by the MoHLTC that describes IAs as, “hospital agreements with foreign governments or organizations for the provision of health-care related consulting and other services” (personal communication with Service Ontario, March 11, 2015) and in general exclude the treatment of international patients. As such, because the IAs discussed in this thesis, as described by the participants of the study, excludes provisions for clinical care, there is a distinctive difference between the IAs discussed and medical tourism; participants generally supported this differentiation between terms.

Medical tourism has been a contentious topic of debate in the province of Ontario. In response to the public outcry on the topic of medical tourism from organizations such as: The Registered Nurses Association of Ontario (RNAO), Canadian Doctors for Medicare, and The Association of Ontario Midwives and Association of Ontario Health Centres, Minister Dr. Eric Hoskins (Ontario Minister of Health and Long-term Care) released a statement reaffirming the MoHLTCs position that:

“Hospitals were informed that:

- They cannot use public dollars to care for international patients,
- They must put any revenue generated from these activities back into hospital services that benefit Ontarians, and
- They must not displace any Ontarian in favour of international patients.”

(MoHLTC, November 2014, para. 3)

The statement went on to further to request that Ontario hospitals, “not market to, solicit or treat international patients, with the exception of international patient activity related to a hospitals existing international consulting contracts” and/or emergency situations (MoHLTC, November 2014, para. 5). As such, it is because of these challenges on the topic of medical tourism that it becomes important that IAs are clearly differentiated from medical tourism as IAs do not provide direct patient/clinical care.

3.3 Study Sites, Recruitment and Sampling

This study explored the health system from a macro level through interviewing health system leaders from across the province of Ontario. OAHSCs were the general focus of
this research. Health system leaders helped to identify the nature and impact of international agreements within OAHSC’s. The study was limited to OAHSCs based on the list of public hospitals that were surveyed in September 2014 by the MoHLTC. The survey identified that OAHSCs were the only public hospitals in Ontario that were actively participating in international agreements.

This study used purposeful sampling and remained highly flexible. Participants were recruited from institutions that were identified by the MoHLTC as being active in the space of international agreements and further recruitment of participants relied on the recommendations of study participants (Patton, 2002).

Theoretical and purposeful sampling was used to increase the credibility of the results (Charmaz, 2003). That is, as the study progressed, the researcher would, “look for precise information to shed light on emerging theories…and help us to identify conceptual boundaries and pinpoint the fit and relevance of our categories” (Charmaz, 2003, p.265). While theoretical sampling in its pure sense, “demands that we have completed the work of comparing data with data and have developed a provisional set of relevant categories for explaining our data” (Charmaz, 2003, p.266), due to a change in the Primary Investigator of the study, as well as the availability of study participants, returning to, “the field to gain more insight about, when, how, and to what extent they [i.e., the categories for explaining our data] are pertinent and useful” (ibid) was not a viable option; more insight is provided in section 1.4. Despite not returning to the field to gain more insight into the emerging categories and themes, because data collection and simultaneous data analysis occurred over 12-week period, it was possible to explore emerging themes and to define the gaps between categories with participants throughout the initial data collection period.

In total, 31 introductory emails were sent to potential study participants, soliciting their voluntary participation in the study; introductory emails included text in the body of the email, as well as attached the letter of information (see Appendices 1 & 2), and were equivalent to that of a “cold call” (i.e., participants were first introduced to the study
through email without preemptively soliciting potential participants). Potential participants and their associated emails were identified through publically available information (e.g., websites, newspapers, etc.) as well as through the suggestions of active study participants; in the scenario where a study participant recommended the researcher recruit another specific individual, as aligned with the procedures approved by the Research Ethics Board at The University of Western Ontario, initial contact was always made by the researcher. Of the 31 introductory emails: 17 participants responded with a positive response indicating their interest in participating in the study, 5 declined to participate, and 3 emails were not delivered; the outstanding 6 participants were followed up with as described in Procedure 3.4 but did not express either positive or negative interest to participating in the study. Of the 17 potential participants, 14 interviews were successfully scheduled; the remaining 3 participants who had initially identified a positive interest in participating in the study had scheduling conflicts that made them unavailable during the data collection phase of the study. The 14 participants were representatives of 7 different OAHSCs; the number of participants per OAHSC was as followed:

Figure 2- Breakdown of Number of Participants per Institution

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<tr>
<th>Institution</th>
<th>Number of Participants</th>
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<td>A</td>
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3.4 Procedure

Informed consent was gathered first in writing, by virtue of an email articulating the purpose and intent of the research study and requesting the participant’s voluntary participation. In the event that the initial recruitment email and letter of information were insufficient in recruiting participants, follow up emails were made to participants approximately two weeks after initial contact. For those participants who indicated a
positive response participation in the study, interviews were scheduled at a mutually agreeable time. Participants were informed at the beginning of each interview that they were being recorded and were promised anonymity (i.e., both as an individual and organization) with respect to anyone outside of the research team; the one exception, as highlighted in the letter of information (see Appendices 2), where a participant’s identity may have been revealed was in the circumstance where representatives from Western University’s Research Ethics Board required access to study related records to monitor the conduct of the research; verbal consent was then captured at the beginning of each interview.

3.5 Data Collection

This study employed in-depth, individual, semi-structured qualitative interviews. Each participant engaged in a semi-structured telephone interview, lasting 20 to 100 minutes in length (averaging approximately 65 minutes), which were then audio recorded and transcribed by Transcriptions Plus; in total, verbatim transcription of interviews yielded approximately 220 pages of transcription. Leveraging in-depth, semi-structured, interviews with an open-ended interview questioning technique, is consistent with constructivism’s ontology as it recognizes that, “realities are apprehendable in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature, and dependent for their form and content on the individual persons or groups holding the constructions” (Guba & Lincoln, 1994, p. 110). Further, true to the epistemology of a constructivism paradigm, through embracing a semi-structured and open-ended questioning technique, it allowed for findings to be created through transactional conversation between the researcher and study participant (Lincoln & Guba, 2003). Additionally, the study encompasses both dialectical and hermeneutical methods of data collection, which provided a platform to allow individual constructions to be elicited and refined through interaction between and among investigator and respondents (Guba & Lincoln, 1994).

In the interviews, participants were asked to explain the nature of the international partnerships that may be employed by their respective OAHSC. They were also asked to
articulate the motivations that drive their organizations to solicit these agreements, as well as the perceived impact of these agreements from the perspective of the OAHSC and provincial health system. As participants shared their insights into IAs within OAHSCs, the researcher actively participated in the exchange of information through asking additional probing questions into areas and/or categories of interest as they emerged throughout the conversation. Again, this is consistent with grounded theory methodology as often, “data collecting may demand that researchers ask questions and follow hunches, if not in direct conversation with respondents, then in the observers’ notes about what to look for” (Charmaz, 2003, p. 257). Detailed information regarding the interview guide is provided in Appendix 4- Participant Interview Guide and more information regarding “observers’ notes” are explained in the following section 3.6.

3.6 Data Analysis

Data analysis began simultaneously with data collection and was an inductive process to remain consistent with grounded theory methodology (Charmaz, 2006). As data collection progressed, the researcher undertook a variety of actions to ensure reflexivity with the data; the researcher actively: undertook interview notes (i.e., notes secondary to audio recording and verbatim transcription of interviews to capture reactions and impressions that would otherwise be untranslatable in a transcription of the interview (e.g., intonation, pauses, etc.)) while collecting data to narrow in on topics of interest, verbally dictated reactions and immediate thoughts after each interview, and also kept a reflective journal as the analysis of data continued to capture how the ideas and concepts developed overtime; this documenting (i.e., transcription of dictated reactions and thoughts after each interview, as well as hand written reflective journal entries and interview notes) resulted in approximately 50 pages (i.e., combined total) of interview notes, commentary and reflective journal entries, in addition to the 220 pages of interview transcripts. The processes described above, often referred to as ‘memo writing’, “aids us [i.e., the researchers] in linking analytic interpretation with empirical reality...[and] provide the grist for making precise comparisons, fleshing out ideas, analyzing properties of categories, and seeing patterns” (Charmaz, 2003, p. 261-262). Additionally, through writing interview notes, verbal dictation and memo writing, helped
the research develop a dialectical self, which helped the researcher identify, “subjects’
unstated assumptions and implicit meanings… [and] how these assumptions and
meanings relate to the conditions in which a category emerges” (Charmaz, 2003, p. 265),
which can otherwise be described as reflexivity. According to Lincoln & Guba (2003),
“reflexivity forces us to come to terms not only with our choice of research problem and
those with whom we engage in the research process, but with our selves and the multiple
identities that represent the fluid self in the research setting” (Lincoln & Guba, 2003, p.
283; Alcoff & Potter, 1993). Most importantly through engaging in the reflexive process
of memo writing, “we interrogate each of our selves [i.e., the researchers] regarding the
ways in which research efforts are shaped and staged around the binaries, contradictions,
and paradoxes that form our own lives” (Lincoln & Guba, 2003, p. 283).

As part of the reflexive process, the researcher acknowledges that his experience with the
Ivey International Centre for Health Innovation at the Ivey Business School (the Centre)
and its’ research on health system change and transformation influences his approach to
the research process. Additionally, the Centre’s focus on bringing business practices to
the health system, undoubtedly influence the lens of the researcher. Additionally, the
researcher also acknowledges the challenge of changing Primary Investigators after the
data had already been collected and that the new Primary Investigator’s area of expertise
was in quantitative methodology, as opposed to constructivist grounded-theory.

The analysis of the interview transcripts began with sensitizing the researcher with the
transcripts, which offered ways of seeing, organizing, and understanding experiences
(Charmaz, 2003). For each interview transcript analysis was supported using NVivo 10
data analysis software. Coding started with open coding to define actions and/or
important events within the data (Charmaz, 2003). Secondary to open coding, line-by-line
coding was used to sensitize concepts and lead to refining and specifying themes and
ideas, after which focused coding was used to find, “the most significant and/or frequent
earlier codes to sift through large amounts of data” (Charmaz, 2003, p. 259). Focused
coding accounted, “for the most data and categorize[d] them more precisely…[which
allowed the researcher to make an] explicit decision about selecting codes [to provide] a
check on the fit between the emerging theoretical framework and the empirical reality it explains” (Charmaz, 2003, p. 260). In addition to focused coding, axial coding was used, “to make connections between a category and its subcategories (Charmaz, 2003, p. 260). As part of the analysis, memo writing, as described above, was used to help the researcher generate new thinking, identify patterns and encourage new interpretations the data and codes.

3.7 Quality Criteria

“Qualitative literature is brimming with criteria for qualitative goodness…and stands in marked contrast to the relative consensus in the quantitative community that good research aims for validity, reliability, generalizability, and objectivity” (Tracy, 2010, p. 839). Within qualitative work, quality standards criteria, “are often framed as more flexible and contextually situated than rigid quantitative criteria” (Tracy, 2010, p. 838; Ellingson, 2008; Golafshani, 2003). However, according to Tracy (2010), “high quality qualitative methodological research is marked by (a) worthy topic, (b) rich rigor, (c) sincerity, (d) credibility, (e) resonance, (f) significant contribution, (g) ethics, and (h) meaningful coherence” (Tracy, 2010, p. 839). These previously stated indicators of high quality qualitative research will be explored in greater detail below, based on the explanation as described by Tracy (2010), as well as their relationship to this thesis.

**Worthy Topic:** “research that is relevant, timely, significant, interesting, or evocative” (Tracy, 2010, p. 840).

- As highlighted in section 1.3, the nature of IAs within OAHSCs in the province of Ontario have not been well researched to date. As a result of the gap in the academic literature, and a misrepresentation of IAs within the grey literature, it is important that people understand and appreciate the nature of IAs as they currently stand within.

**Rich Rigor:** “Descriptions and explanations that are rich…bountifully supplied, generous and unstinting (Tracy, 2010, p. 841; Winter, 2000).
There are a number of factors within the quality criteria of rich rigor that determine the quality or richness and rigor of a study. When examining the richness of this particular study, it is evident through both the length and depth of participant remarks rich quality interview data. With respect to the rigor of the research and the amount of time in the field, or in the case of this study, the number of participants, “there is no magic amount of time in the field...[but rather] the most important issue to consider is whether the data will provide for and substantiate meaningful and significant claims” (Tracy, 2010, p. 841). Additionally, other criteria for which, “rigor is also judged [is] by the care and practice of data collection and analysis procedures...these may include an evaluation of the number of pages of field notes, the time gap between fieldwork and development of field notes, and whether researchers evidence a learned understanding of participant observation and field note writing practices” (ibid). With respect to rigor of qualitative interviews, “demonstrations of rigor include the number and length of interviews, the appropriateness and breadth of the interview sample given the goals of the study, the types of questions asked, the level of transcription detail, the practices taken to ensure transcript accuracy, and the resultant number of pages of interview transcripts” (ibid). The processes for which: recruitment, sampling and study sites, as well as data collection, and data analysis procedures are described in detail above in sections: 3.3, 3.4, 3.5, & 3.6.

**Sincerity:** “marked by honesty and transparency about the researcher’s biases, goals, and foibles as well as how these played a role in the methods, joys, and mistakes of the research” (Tracy, 2010, p. 841).

- The researcher has engaged in self-reflexivity as highlighted in section 3.6 and was transparent in disclosing study complications with respect to: recruitment of participants, changes to the Primary Investigator, and data collection as highlighted in section 3.3. Additionally the researcher prominently highlighted additional limitations of the study in section 1.4.
**Credibility:** “refers to the trustworthiness, verisimilitude and plausibility of the research findings” (Tracy, 2010, p. 842).

- “One of the most important means for achieving credibility in qualitative research is thick description...in-depth illustration that explicates concrete detail...[and] provide enough detail that readers may come to their own conclusion about the scene” (Tracy, 2010, p. 843). It is the opinion of the author that, in the context of this study, the researcher supports his findings with detailed quotations from study participants, ensuring that the reader has enough information to appreciate the context in which the participant shared their remark(s).

**Resonance:** “refers to the research’s ability to meaningfully reverberate and affect an audience” (Tracy, 2010, p. 844).

- One specific element of resonance explores the transferability and naturalistic generalization of the study’s findings. When considering qualitative research, formal quantitative understanding of generalizability are not applicable to qualitative research, “because statistical generalizations require random representational samples using data that is isolated for any particular context or situation” (Tracy, 2010, p. 845). When exploring the transferability of qualitative studies, “research may create reports that invite transferability by gathering direct testimony, providing rich description, and writing accessibly and invitationaly” (ibid). By providing rich description (as mentioned above) and through writing this thesis in an accessible and invitational manner, this study aims to invite the reader to absorb the information within this thesis and apply relevant findings to their own situational context.

**Significant Contribution:** “gauge the current climate of knowledge, practice, and politics, and ask questions such as ‘does the study extend knowledge?’ ‘Improve practice?’ ‘generate ongoing research?’” etc. (Tracy, 2010, p. 845)

- This research has both theoretical and practical significance, given that it is the first academic study to look at the nature of IAs amongst OAHSCs as well as the
need to understand these agreements. Additionally, the study holds heuristic significance as future research will continue to build and answer the questions that are raised in this thesis (see section 6.3 for future research goals).

**Ethics:** “a variety of practices attend to ethics in qualitative research, including procedural, situational, relational, and exiting ethics” (Tracy, 2010, p. 846-847).

- As part of a thesis involving human participants, procedural ethics approval was granted by the Research Ethics Board at The University of Western Ontario, as highlighted in section 3.8. Additionally, the concept of “exiting ethics” (Tracy, 2010) was considered when presenting the results of this study; it is important to note that in section 4.2 the researcher articulates that, while the findings of this research are a result of the insights provided by the participants, the results may not reflect the IAs of each individual organization that participated in the study, but rather may represent the themes that were generated upon analysis of the data.

**Meaningful Coherence:** “meaningfully coherent eloquently interconnect their research design, data collection, and analysis with their theoretical framework and situational goals” (Tracy, 2010, p. 848).

- As highlighted in section 3.1, constructivist grounded theory was specifically selected based on the alignment of the study purpose and objectives with previous research experience and expertise of the initial primary investigator.

Beyond Tracy (2010), other authors, such as Lincoln & Guba (2003) suggest that another criteria of quality qualitative research, in particular constructivist inquiry, involves “authenticity”. According to Lincoln & Guba (2003), the concept of fairness was considered to play an integral role in authenticity. “Fairness was defined by deliberate attempts to prevent marginalization, to act affirmatively with respect to inclusion, and to…ensure that all voices in the inquiry effort had a chance to be represented in any texts and to have their stories treated fairly and with balance” (Lincoln & Guba, 2003, p, 278). In writing this thesis, the researcher made efforts to ensure that opposing arguments were fairly and unbiasedly.
3.8 Ethical Considerations
Ethics approval was granted from the Ethics Review Board at The University of Western Ontario prior to study initiation.

It was not anticipated that inquiry in this field of research would trigger negative emotional responses from participants. Participants remained anonymous in the research, and all identifying markers were removed from interview transcripts, subsequent publications and other methods to disseminate study findings.

3.9 Reporting
This thesis will be reported and published for public access as a master thesis in the thesis library at the University of Western Ontario; aligned with University policies and procedures, the author reserves the right to embargo the thesis for publication for a set period of time. For participants who indicated during their interview that they wished to receive a copy of the final thesis after its defense, an executive summary and full text of the thesis will be sent to those participants via email. A portion of the thesis, or its entirety, may also be made available through the Ivey International Centre for Health Innovation at the Ivey Business School at Western University and may be used in future thought leadership publications.

Other knowledge translation and dissemination activities may include submission of abstracts and manuscript submissions to a variety of conferences and/or peer-reviewed journals, as well as preparation and publication of case studies through Ivey publishing. Examples of potential target journal submissions include, but are not limited to: Healthcare Policy (CIHR), Canadian Health Policy Journal (CHP), and the Canadian Journal of Public Health etc.
Chapter 4 : Results

4 Preamble

This chapter will discuss the qualitative findings of the study. Firstly, demographic information on the participants is described. Then, the conceptual model based on the findings is presented. Lastly each conceptual category is explored in greater detail and subthemes are explored in detail.

4.1 Demographic Information

The results of this study were derived from transcriptions of 14 in-depth telephone interviews with health system administrators in senior leadership positions from across Ontario; position titles included: Program Manager, Director, Managing Director, Executive Director, Vice President, Executive Vice President, President, Chief Executive Officer and Executive Chairman. The 14 participants (men 10, women 4) were representatives of 7 different OAHSCs (see section 3.3 for additional information), of which 5 OAHSCs had identified to the MoHLTC in November of 2014 that they participate in international agreements. Two participants identified that their organization(s) did not currently participate in international agreements but they were currently exploring the potential of adopting such agreements, or had prior experience administering international agreements in a previous role.

4.2 Conceptual Model

The results of this study answer the research question: “What is the nature of international agreements within OAHSCs?” The operative word in the research question is the term “nature”; “nature” was left intentionally ambiguous to provide the participants with an opportunity to share their insights and perspectives on international agreements within OAHSCs. The term “nature” was operationalized as encompassing not only the direct services and activities that fall within international agreements but also the drivers, barriers and benefits (both direct and indirect) as a result of the international activities of OAHSCs. “International agreements” was interpreted by the researcher, based on the definition provided by Service Ontario, to include, “hospital agreements with foreign
governments or organizations for the provision of health-care related consulting and other services” (personal communication with Service Ontario, March 11, 2015); generally international agreements were interpreted to exclude the treatment of international patients. The results of this study are captured in 4 general conceptual categories: (1) Drivers, (2) Barriers, (3) International Activities, and (4) Benefits for Ontario; these 4 categories are then further divided into sub-categories that unveil the breadth, depth and complexity of international agreements within OAHSCs. These categories evolved as themes emerged from the analysis of the interviews. In the conceptual model (Figure 3-Conceptual Model of International Activities), the 4 conceptual categories appear in a linear fashion, often implying chronological order. However, in the case of this conceptual model the series of conceptual findings portray the results in an order that is readily accessible to the reader but may not be reflective of the procurement process of international agreements within OAHSCs. The model of procurement for international agreements is outside the scope of the initial research question, but may merit future research consideration.

It is important to note that elements within the following conceptual model may not be a definitive representation of the international activities of individual OAHSCs. Rather, the following conceptual model represents generalized findings that explore the nature of international activities within Ontario. The intention of this program of research was to be exploratory in nature and was designed to begin to understand the different elements, facets and benefits of international activities of OAHSCs. As such, while the results of this study may not be entirely reflective of individual international activities, these findings no less offer important insights into the growing field of international activities of OAHSCs.

The following sections of this chapter will address each of the 4 conceptual categories and provide greater insight into each area of interest.
Figure 3- Conceptual Model of International Activities

Drivers
• Altruism & Global Health Promotion
• Extension of Hospital Mission, Vision & Values
• Insufficient Revenue from MoHLTC
• Opportunity to Commercialize Knowledge
• Organization of Pre-Existing Professional Activities

Barriers
• Bureaucracy
• Capacity
• Cultural Differences
• Risk Aversion

International Activities

Benefits for Ontario
• Increased Capacity
• Cultural Awareness of Health Professionals
• Extended Opportunities for Economic Development
• International Reputation
• Support of Hospital Operations & Strategic Priorities
• Increased Opportunities for Staff

International Agreements

Humanitarian

Needs Assessment

Advisory Services

Business Development

Education & Training

Licensing & Management

Fee-for-Service

Humanitarian

International Patient Services
4.3 International Activities

International activities (see Figure 3- Conceptual Model of International Activities) within OAHSCs are predominately divided into two mutually exclusive categories: (1) International Patient Services, and (2) International Agreements.

4.3.1 International Patient Services

International Patient Services (IPS) serve to treat international patients on either a fee-for-service or humanitarian bases. According to the MoHLTC, “international patient services are medically necessary hospital services provided to persons who have come to Ontario from outside Canada for those services” (personal communication with Service Ontario, March 11, 2015). International patients may be treated domestically when they require highly specialized services that are not available in their country of origin. While outside the definition of MoHLTC, for the purposes of this research, IPS also includes the provision of emergency services and hospital services that are provided to non-Canadians in Ontario for unrelated educational, personal or business reasons (e.g., international students, tourists, business travelers, etc.). In general, patients are treated on either a humanitarian, or fee-for-service, based model which is based on a patient’s and/or country’s ability to pay:

“…at the time we already had an international patient program where we were seeing, a very small program, its 1% of what we do, in looking and bringing XX [patients] who can’t get care in their own country, bringing them here to XX [OAHSC] and I think the other part of that was we actually had a fund and it was called the XX [Charitable Fund] that was a group of ladies had, done fundraising around, for XX [patients] who were from developing countries who would not be able to access care, and so this fund was created and they did fundraising on an annual basis to be able to provide this for XX [patients] to come and have, and predominantly most of it was surgery, come and have care here.”

-Participant D

“So if the country can afford it, it definitely can’t be humanitarian… I mean any patient whether its humanitarian, they can pay or not, somebody is paying, its costly. Whether it’s their government paying or the charity organization paying or private donor is paying; somebody is paying. So to me, this is only my opinion, that humanitarian is considered when the service is not available in their own country.”

-Participant I
“So from the international client service, it is focused on meeting the needs of those individuals who are not Canadian residents, so they live overseas and they are accessing services from our facility that aren’t available in their home countries. There are 3 criteria, so the individual applies a) they cannot have, they can’t be a Canadian resident and have access to OHIP; b) they must be returning back to their home country after they receive the service; c) and they have to have a method of payment for that service; so typically it’s either out of pocket, government funded or a third party insurer…”

-Participant B

It is important to highlight that, regardless of whether IPS falls into the domain of humanitarian or fee-for-service, IPS services and/or International Activities (IAs) do not receive funding from the MoHLTC, nor are they supported through any other allocation/investment of public funds (i.e., tax-payer investment):

“…There was no money for an operational budget for the XX [program name for international patients] so if you think about the other members of the system, they’re all publically funded institutions, and public funds are not permitted to be used for international activities and every year we have to sign an attestation to the Ministry of Health [MoHLTC] that we have not used public dollars to fund international activities.”

-Participant K

For the context of this study, it is recognized that IPS are included within the category of “international activities”. However, it ultimately falls outside the initial scope of research for this particular study and merits future research consideration.

4.3.2 International Agreements

International Agreements (IAs), as defined by the MoHLTC, are, “hospital agreements with foreign governments or organizations for the provision of health-care related consulting and other services” (personal communication with Service Ontario, March 11, 2015). While these generally exclude the treatment of international patients, it is worth noting that the MoHLTC did indicate that, “in a few cases, IAs have included commitments to review IPS referrals” (personal communication with Service Ontario, March 11, 2015). For the purposes of this study, participants were adamant that the IAs that were pursued on behalf of their organization(s) strictly excluded provisions for treating patients and that their role was exclusively consultative in nature:

“…so advisory in nature, advisory services, education. We do not do clinical care.”

-Participant D
“…Clinical care is specifically excluded from our contracts. This is not a, the American institutions will often compete very heavily for price on the services that they’re providing so that they can attract patients, because the ultimate objective is to attract patients to the United States from these countries. But we don’t do that because we will only take patients at XX [OAHSC] based on humanitarian need.”

-Participant F

“…That’s the one way that we provide the training and education. The other way is we occasionally send teams of clinicians and other health care professionals to our partner countries to do side by side training in a clinical setting. We do not provide direct clinical care.”

-Participant K

Similar to IPS, in general IAs that are pursued by OAHSCs fall into the categories of: (1) **Humanitarian**, or (2) **Business Development** and are categorized based on a countries/organizations ability to pay for services. 

In the context of IAs that fall within the domain of humanitarian efforts, these are often based on need and a country’s situational context. For example, some participants noted situations where they provided services on a **Humanitarian** basis to those countries that experienced natural disasters and/or were unable to provide highly specialized services to a patient in need:

“…So that also, if you know, our hospital, we’re involved in lots of other things internationally with third world countries, various types of programs, we have a nursing program in XX [African Country] and XX [African Country], that’s cofounded with CIDA [Canadian International Development Agency], we do lots of humanitarian work…”

-Participant F

“…Well I think I can give you an example for humanitarian. There are a number of different ways. One, the government of Canada identified XX [African Country] as a country Canada wants to help. And they gave us money, seed money, to go there and help them develop and to train XX [nursing specialty] so we developed a curriculum for the university in XX [African Country] and we did help them. So when we do humanitarian at minimum we need cost recovery. Okay so the government gave us money, we are not making any, any profit on that. The money gave they gave us would be enough to send the staff to XX [African Country] to spend the time there and educate and deliver further education and train the faculty in the university there to deliver the course later. So that’s one sort of the humanitarian, but a request came from the government of XX [African Country]. There are requests like in South Africa, there is lectures in hospital who they are building it and they want us advisory, if what they are doing is right. They don’t have money. They don’t have, they can’t afford to hire consultants for American or a hospital to come
to them, so we do that. And the third one is individuals from the hospital, they take time off, vacation, or unpaid leave and they are willing to go and do like XX [Charitable Hospital Program], they go to third world country, and help with that. So all of these are humanitarian efforts.”

-Participant I

“So it still, it’s still a work in progress to be honest even 5 years in but certainly the model would be looking for grant, granting organizations, foundations, we did have a successful CIDA [Canadian International Development Agency] program that we ran that I came in at sort of the midway point of that. We’ve applied for successive CIDA grants and have not been successful, to me it’s just we don’t really fit their model of development. Which is okay, not everybody does. But basically we have relied on private grants from rotary clubs and individual donors and church groups…”

-Participant K

In some instances, IAs fall under the lens of Business Development. IAs that fall within business development typically have associated revenues that are generated on behalf of the respective OAHSC; these types of engagements are, at the very least, cost neutral and often generate returns with a margin:

“This is a revenue generating business where we see whether the client has the where-with-all to be able to finance what they want to achieve, and that the environment is ripe and ready for that to be done.”

-Participant F

“…well so I mean as I alluded to a bit earlier, this is a fee based service. So when we do this work through XX [OAHSC] there is ultimately a revenue model associated with it. We’re not in a position to be able to do this for free.”

-Participant L

“You know, with the hospital ultimately there is a project that might involve provision of consulting and services and that sort of thing, if that did materialize then there may be revenue associated with that…”

-Participant E

A critical component of the narrative, as told by the participants, was that, regardless of whether the IAs fell into the categories of humanitarian, or business development, the primary objectives of IAs were not necessarily profit driven but rather focused on developing meaningful partnerships with the client organization:

“I think it’s not about the money…The money may have been the initial driving force behind it and certainly is a valid reason for us continuing to do it, but it’s not the only benefit that we’re reaping as an organization, as a system, as a society from participating in this type of work”

-Participant B
“I think this is true with any, whether it’s working with Ghana or maybe going to Johannesburg or going to Ethiopia, we set up an evaluation framework so that we absolutely together, can measure what the outcome of the relationship is, and I think that’s really important for the partner and the international partner and ourselves, to sort of say here’s the impact of the relationship, so it’s not just financial, its deeper than a financial relationship. Yes, there’s a contract, there’s revenue associated with it, but we talk about the relationship more as a partnership and working through that.”

-Participant D

“…it is really about the, the impact that we are making in a partnership wherever in the world it may be in terms of the improvement of XX’s [patient’s] health. We’re not going into these, again we’re not an American hospital where the mindset is how much money can we make. That’s usually one of the last things we’re thinking about here. We’re focused on what’s the need, what’s impact, where is the gap in terms of the care that’s being provided to those XX [patients] in that part of the world, how can we potentially then help them address it…”

-Participant L

“I think it was the basic principle that was behind it and that we would say you know, how does this fit into this, is the thing that we can teach them, mentor them, and then help them sustain this particular ability or skill or program, that’s, I said this is how we’re going to evaluate this, not how much revenue we generated or you know, how many people we put there or other typical you know sort of quantitative measures…”

-Participant F

It was apparent across both the categories of humanitarian and business development that OAHSCs who pursued IAs did so with the interest of building capacity within the organization of their respective clients:

“…We believe fundamental for our program is to help whether you’re a developing country or developed, that we’re actually able to help you, help them build their own capacity within, and enhance the level of care that they’re providing…We help countries build capacity and we help them build sustainability and help them improve their care in their country, and you know, one might say well that’s kind of motherhood and apple pie, but actually it’s not. It really is important for these countries to be able to do that because its expensive to send kids, adults, off shore and if you read in that conference board of Canada, I think its billions of dollars being sent in sending patients elsewhere. That’s huge for a country…”

-Participant D

“Our work is more around how can we help you enhance your capacity or help you develop your resources so that you can get to a point where we can guarantee somewhat that there would be some sustainability measurements put in place, so that the work efforts from both parties is not wasted.”

-Participant H
“There are lots of consultants around, there are lots of people that set up businesses to own and operate and function, but the problem is that a consultant’s report is not worth very much to these people, it’s not as if these are sophisticated businesses that need just some guidance to point them in the right direction. They need to have infrastructure built, they have to know what’s valuable part of that infrastructure and what isn’t, they need to know how to keep renewing themselves. And a lot of these countries will bring in people to provide care, to operate their hospitals, but at the end of the contract you know, say in 5-10 years’ time, they’re left with nothing. People depart, and they’ve got nothing to show for it. We on the other hand like to train their people and show them what needs to be done, show them how we do it, and then continue to give them advice on an ongoing basis.”

-Participant F

As a part of creating capacity in the host country (i.e., client), OAHSCs work with the client organization to determine what types of services are needed. In different scenarios, depending on the client’s requests and based on the general needs of the community and/or country, different combinations of services are used to maximize capacity within the client organization. Often, the first step in determining what services would maximize capacity is the completion of a comprehensive Needs Assessment to understand the scope, nature and needs of the client organization:

“…The needs assessment does help clarify further in terms of you know, the current status of the organization or where are the gaps, it is what their requesting truly, truly what exists, what can we do to help support closing those gaps, how can we put not only recommendations forward, but how can we dedicate resources to help with their implementation, how can we help them build their resources, how can we help them sustain it, all of those questions are obviously happening during the needs assessment as much as possible.”

-Participant F

“…Well I think you know, what you do is a needs assessment so you work with your client, because that’s what they are, you work with your client in helping them to understand what they need. Because many times you know clients in these countries that have little experience in what we do, are not exactly sure what they want.”

-Participant M

“…We’re not just showing up, setting up a tent and doing whatever the hell we think is right. We are only there at the request of our guests. Of our hosts I mean, and I think that goes a long, long way to mitigate it and really focusing on the fact that the project that is under consideration has really been developed collaboratively with the host, so that we’re not trying to solve a problem that doesn’t exist…”

-Participant K
To build capacity in the host organization, in general according to study participants, OAHSCs leverage two types of services: (1) **Advisory Services**, and (2) **Education & Training**. Advisory Services include a wide array of services that typically leverage OAHSCs' general knowledge of operations, standards of best practices and/or experiences in different elements that are associated with health systems. For example, “**Advisory Services**” may include elements that are indirectly associated with patient care (e.g., creating standards of best practice and regulatory bodies) or intangibly associated with healthcare (e.g., advising on the construction of a new hospital) within the client organization:

> “Sometimes we’re asked to go in and provide advice and guidance in respect to operations and how you set pieces up do. Things like model of care development and service delivery. We’ve been asked to develop a framework for a new service so clinical governance would be that example, and to bring what international best practices are to bear on the development of that framework.”

> -Participant B

> …That project, it includes all functional areas of the hospital, so we pretty much helped them commission a new XX [specialty] hospital from human resources to governance structures to clinical education, to medical education, to perioperative services, everything…”

> -Participant G

> “…The second basket would be advisory services, and advising clients who are constructing or developing new facilities on how to develop those facilities. And that could be starting with supporting their efforts and design because they you know, we’re not an architectural firm, but we can work with an architect to, to look at specifics of design, so where should a nursing station go, how much recreation space is good for certain levels, certain degree of illness, you know, how much walking area is required, do you want a certain percentage of the floor to be occupied by rooms, and what may that percentage be and then how much free space or common space do they want, so a lot of things like that we could contribute so that could be part of the advisory scenario. And then other advice during the construction process or prior to launch of the facility might be how do you structure your organization, you know, how many, what are you, what should your staffing ratios be, how do you, how do you develop organizational policies and procedures. And then so on…”

> -Participant N

The second basket of services that are often provided within IAs include the provision of **Education and Training**. These services utilize the defined expertise that OAHSCs have with respect to education and training and provide similar services to the client. Types of
education and training may include bedside instruction, observerships within the respective OAHSC, and/or placements in more formalized medical training and education programs (i.e., medical school):

“So it covers you know, a variety of different areas, some of which are traditional academic aspects to an international partnership, so let’s just say in China as one example, we have memoranda of understanding with a couple of institutions over there, considering a third one that would govern the exchange of students, and that’s at different levels, it could include medical students, it could include residents or you know, specialist training of doctors. It could include graduate students, so student exchange, faculty exchange whereby you know, faculty may go and do courses and lectures, that sort of thing.”

-Participant E

“...We do observerships, paid observerships for people from other countries, will come and spend a week or two, or three or four, shadowing, observing and getting educated on XX [specialty] rehabilitation, and that could be in any health discipline, so and those are both fee for service.”

-Participant G

“…The education deliverable itself is in classroom education or bedside mentorships and not hands on care, but mentoring staff who deliver care, we have a program called the XX [name of program] so people coming to XX [OAHSC] to observe or do hands on learning, and we also look at continuing education and offer it at XX [OAHSC] to international groups or take it to the learner’s country, organization and offer it on site.”

-Participant H

“…One is training and education, so that is to specifically for companies or entities that are interested in training their staff on how to take care of XX [patients]. And that could be anything from nurse aids or you know, personal support workers (PSWs) all the way up to how do you train CEOs and to kind run the facility like a nursing home or you know, an assisted living facility, an independent living facility, so, so those are the individuals and the levels that we train, and then the material would be anything within the realm of XX [patient] care that we do at XX [OAHSC]. It could be training them at a high level on XX [specialty] principles, what happens to XX [patients] as they age, or it could be very specific. If the client wanted to learn specifically about dementia care and what do you do with people who have advanced dementia, how do you take care of them on a day-to-day basis? So that’s the content piece. The content is pretty broad and the target audience could be pretty broad.”

-Participant N

While many of the IAs are focused on building capacity abroad, some IAs are opportunistic to commercialize intellectual property. Associated processes that are common practice within OAHSCs are licensing and 3rd party management. While these
types of IAs are not common across the organizations that were interviewed, some participants suggested that these types of opportunities (i.e., Licensing & Management) were becoming more sought after by OAHSCs as they offer a greater return on investment (ROI):

“The third basket is I would say management of the facility. So we offer clients the, the opportunity or the option for XX [OAHSC] to appoint someone to help manage the facility, it could be an executive director type or it could be a senior nurse, who would work at the property day to day, and guide that company and that company’s manager how to run the facility and that could be you know, short term like a few months or it could be a few years, depending on what they need.”

-Participant N

“What’s happening now is many of the potential customers, and one in particular that is a customer of ours right now, as interested as they seem to be in us teaching them how to do what we do, they’re also interested in us actually managing their facilities and their programs, perhaps side by side with them, or licensing our programs to them and providing oversight that they’re successfully implementing our licensed programs, and that’s really what the consumer demand has been in China.”

-Participant M

“…And then the final thing I would say that we also could offer the clients are brands, license, in either whole or limited fashion, so they could sell we want to brand it a XX [OAHSC] facility or they could say we would like to use your brand on our marketing material, its going to be called ABC Facility, but we still want to market the fact that we’re affiliated with XX [OAHSC] and that XX [OAHSC] is training our staff and so forth.”

-Participant N

“…go to like anything that involves intellectual property like the development of a new car or a phone, what’s happening is you’re taking the knowledge of technology and IP and you’re able to deploy it in a vast way, you’re human resources and your labour come in so if you’re making a car you spend all your time making the car and spend millions of dollars designing it, making it right, making sure all the parts are perfect, but once you deploy that IP then you just, you’re paying for manufacturing so you’re paying a per unit cost for manufacturing the car, but that’s a lot less than the price you charge for the car so you make your money in the back end…so that’s the way I look at this business, is if we can develop a management model that is perfected, it’s going to cost us up front. So once we deploy it our costs become auditing costs, making sure that that client is following what we’re doing, making sure that they’re not hurting patients and residents and you know, there’s still a fair degree of responsibility, but then we can, if that client has like you know, what we like is when the client has a lot of capital and they’re building a lot of facilities, if that client is building 20 facilities in China and they have our IP and our processes for one, they might
want to use them in all 20 in which case technically we would be making a lot
of money off of all 20, but only the hard work one time, you know. So
building that IP, spending the money up front and then deploying it, so that’s
really you know, I use other industry as an example because it’s not, it’s not
the first time this is being done, it’s just we’re doing it in a different type of
industry, but it’s the same concept whether you’re selling phones or cars or
hotels or XX [patient] living, you have to figure out a way that when you’re
sleeping your product is making money.

-Participant N

Conversely, other OAHSCs are highly protective of their brand and adamantly
underscored that they do not have interest in engaging in IAs that simply license their
brand; they wish to exclusively engage in IAs that increase the capacity of the client:

“I think it would be unlikely that we’re going to see a big bricks and mortar
building in the middle of a dessert or a jungle you know with XX [OAHSC]
you know in neon lights on the top of that building.”

Participant E

“…So they’re not buying our brand. I think that we’re pretty protective of the
brand and I think that brings on different discussions, but when you take
some place like XX [location in the Middle East], there, that’s why I talk
about their goals, their philosophy is similar to ours, so they want to build
their own capacity, and have their own sustainability of their programs and so
that’s why they were such a good match with us….“

-Participant D

4.4 Drivers

The category of “drivers” refers to the rationalization or initial interests that enticed
OAHSCs to pursue IAs. The drivers of IAs in this study were explored from the
perspective of OAHSCs and were not viewed through the lens of international partners.
Rather, the drivers explored why OAHSCs may choose to pursue IAs. In some cases,
multiple drivers may have influenced a decision to pursue IAs and, in other situations, the
decision to pursue IAs may have been isolated to one particular driver.

In the interviews, participants suggested that a driver of pursuing international work
through IAs is related to Altruism and Global Health Promotion. Many participants
felt a sense of moral obligation to contribute to the health and well-being of populations
abroad, acknowledging that other people are not as fortunate as Canadians who have
access to highly specialized and sophisticated health systems:
“...And ultimately all of this, everything I’m telling you is really, it has, really the main goal and objective is enhancing XX [patient] health globally. That is probably our first priority, because when we’re engaged in any opportunity whether it’s for profit or not for profit, are we enhancing XX [patient] health globally.”

-Participant H

“And you know, I again as much as I talked about the legacy, for me the opportunity to continue to do the work that I do here in my community at the hospital here, and I know I have an impact, I see it every single day, I know we do good work at the end of the day, you know, I go home and my kids know that you know, I’ve done something valuable for their community. To be able to continue to do that and then replicate that effort and outcome in a developing country, to me was a real motivating factor to say you know, to have the chance to do something locally and internationally at the same time is a very unique position to be in. and frankly, my upbringing was just such that you know, this you know, I grew up in an environment, I grew up in a very political household actually and we were always just, we were always just sort of taught that you know, we’re pretty lucky to be here and there’s people around the world that can, would benefit from support and I really, I really truly fundamentally believe in the model that the XX [international program] represents, that it is truly about partnership, it is truly about local needs... And that’s on a personal level. And you know what, it’s just a sense of just you know, personal fulfillment and leaving your mark on a broader, in a broader way is quite emotionally fulfilling”

-Participant K

“...We have a responsibility, I would argue, a moral responsibility to make sure that we’re not sitting on all of that knowledge as well, and now we are helping to transfer it back into the proper global health care community to make sure that practitioners in India and Africa and The Middle East, you name the jurisdiction are also being able to benefit from that knowledge and hopefully apply it back to their clinical practice to help their XX [patients] on the ground there, that to me is what global health care is all about... I mean you cannot do what we do here at XX [OAHSC] and not think for one moment that we have a right to sit on it within this hospital and not allow other XX [patients] somewhere else around the world to benefit from that knowledge because they don’t happen to be located in XX [city in Ontario] or Ontario, there’s something just wrong morally, but that whole mindset. If we’ve got the kind of expertise here then we have a right to sit on it within this hospital and not allow other XX [patients] somewhere else around the world to benefit from that knowledge because they don’t happen to be located in XX [city in Ontario] or Ontario, there’s something just wrong morally, but that whole mindset. If we’ve got the kind of expertise here then we have a moral responsibility to be making sure that all XX [patients] can benefit directly or indirectly from that knowledge, and directly might be that the XX [patients] gets treated here in some cases, which has happened which is why I run the international patient office, if they can’t get in their home country, you know quite frankly they’re going to die if they don’t get a chance to come here, we have some degree of a responsibility to make sure we can provide that care, or we can find a way of helping enhance XX [specialty] health care practice in that particular country so they don’t need to send those XX [patients] abroad and those XX
[patients] have exposure to highly qualified individuals that would be able to treat them there, based on what we can establish there.”

-Participant L

Other participants cited that engaging in international work through IAs is an **Extension of the Hospital Mission, Vision and Values** (MVV). The Board of Directors (BOD) of each OAHSC creates their MVV statement independently; the BOD is expected to represent and reflect the values and priorities of the communities they serve. As such, many of the MVV statements of OAHSC include the provision related to providing care, advancing care or reputation on an international level:

“…”So we are a resource not only for the XX [patients] that live in our specific catchment area but also for XX [patients] across the province and in some cases across the country. Our vision is to create a XX [vision statement of an OAHSC], so it really is about you know removing barriers and trying to optimize the quality of care that those XX [patients] receive in all aspects of their life. And our mission is to look at that sort of XX [elements of a mission statement of an OAHSC] and allowing them to really live that vision of a full participatory life.”

-Participant B

“…”So the office was created to really have that mandate and also to work cohesively with all the partners, all internal departments to meet the vision that we have, which is XX [vision statement of an OAHSC]”

-Participant H

“…”It’s part of our culture within XX [OAHSC] to try and make sure we can really help XX [patients], but it may sound a bit cliché and tad trite, but our you know, it makes sense for us because our vision statement is XX [vision statement of an OAHSC], and so we’re constantly trying to live to that vision statement and there’s no dot, dot, dot but only if you’re in Ontario XX [vision statement of an OAHSC], so we try to come at it from that perspective.”

-Participant L

Another driver of pursuing IAs derive from the increasingly diminished and/or **Insufficient Revenue from the Ministry of Health and Long-term Care**. Many participants suggested that, in order to continue to deliver world-class health services to the populations they serve and Ontario at large, they felt increasingly pressured to explore alternative revenue sources to maintain and expand upon the services that are provided:

“…”Well I was the initiator of the whole thing and what happened was that XX [OAHSC] which relies on funding for I guess from the government, philanthropic support, needed to have a commercial engine to fund its operational deficit, as well as to fund its you know, the, the ability to continue to do the research and all the innovation…”

-Participant C
“So there has to be a revenue stream and XX [foundation], there needs to be a margin associated with that, in order to help XX [OAHSC] enhance its reputation and deliver care so, so the, the I mean if you look at a hospital out of its budget the ministry provides 66% of the funding for the hospital right, so you’ve got 34% that a hospital is going to have to make up that difference and as such, 66% you know, shrinks to now, well it was greater than that, but as it shrinks 65, 64, you’re not bringing in revenue based on parking and coffee shops and stores, so the commercial, that’s not the way you’re going to do it and I think a lot of hospitals they realize that now and get that, and so there are opportunities to be able to enhance and generate revenue”  
-Participant D

“...You know, nobody has enough money for, especially, I guess the other thing the hospital recognizes that we’re not going to be number one in the world by the amount we’re funded by the province of Ontario, so we have to find alternative sources of revenue to insure that we remain a world leading, it’s easy enough to be a provincial leading institution here, but to be a world leading institution it’s going to take far more resources than the people of Ontario can provide us.”
-Participant F

“...That’s important because if [the MoHLTC] doesn’t pay quite frankly a hundred percent of operational costs in any hospital, not just XX [OAHSC]. They pay about 60% of our operational costs on an annual basis which means you’ve got to come up with another 40% and a portion of that 40 is not coming from our international work and that get raised through the XX [OAHSC] foundation and through grants that the research institute gets, which helps bridge that gap as well but there’s a small portion still outstanding that needs to be bridged and that has to be bridged through various revenue generating initiatives on the part of the hospital as a whole, one of which is our international advisory activity.”
-Participant L

Many participants cited that, beyond insufficient revenues from the MoHLTC, they recognized there is an Opportunity to Commercialize Knowledge, regardless of the financial standing of their respective OAHSC. The participants described an opportunity to commercialize the extensive knowledge and resources that OAHSCs have invested in developing (e.g., clinical programs, standards of practice, architectural design, etc.):

“And we saw an opportunity for providing the kind of expertise that a lot of hospitals in developing areas would require. The financial resources to do it are really the least of the problem because it’s the ability to structure systems and put into place safety measures and educational programs so that the level of care provided to XX [patients] can be elevated to that provided in developed countries. So we also saw a niche opportunity because a lot of countries or hospitals or institutions hire consultants who would come and
provide a report telling them what needed to be done, but they didn’t tell them how to do it.”

-Participant F

“XX [OAHSC program] was created because we needed a vehicle to be able to extract the great ideas that we wanted to share that were housed at XX [OAHSC], and monetize them and then find clients. So we needed a vehicle to do that and so that’s why we created XX [OAHSC], but I wouldn’t say it was an ah-hah moment. I think it was basically recognizing certainly that there was increasing demand for us to share our ideas, there was, we started to see a willingness to pay and in addition, we saw commercialization as a very effective vehicle to help other people develop their expertise as opposed to solely relying on the conventional path which is peer review publications and education presentations”

-Participant M

“We also realized there’s a lot of value for commercial entities, so those exchanges tend to be academic non-profits, right, that’s just part of the world, that they believe in exchange and that’s very good, it’s all necessary. But there’s another part of the world where there are private companies and even governments who are desperately in need of services to help them build a commercial enterprise, so they’re building a nursing home, they’re building a hospital, they’re building a facility or rehab facility and they don’t know how to do it and they need best practice, they need all that knowledge. So in that realm they said well why don’t we create a parallel realm that focuses on, on the business side to say well, there’s a need, there’s a demand for this around the world, there’s an explosion in the number of seniors around the world, many countries in the developing world don’t know how to go about building this industry, they’re taking a lot of guesses and they’re, there’s a lot of, you might say, uncertainty, so as far as Japan, China, the South East Asia, all these countries that I’ve visited, everyone’s doing, it’s almost like a trial and error basis, so we said at that point, in 2012, there’s a market demand for this, we are already doing it to some extent, we don’t really package it and sell it, but we kind of have the idea and but we need a vehicle to do it, so we can’t do it out of the hospital, we can’t do it out of our nursing home, we can’t say well XX [OAHSC] doctors are going to start selling things. Right, first of all it, they had conflicts of interest because a lot of times they’re not, they’re not, that’s not their mission, and then of course they’re not business people, so they’re not really interested in selling and packaging and all that, so that’s the bottom line. We felt like there was a market demand, we felt like there was an opportunity for Canada to make money because the funds you know, these types of efforts that anything we make, anything XX [OAHSC] makes or receives that money comes back to the parent company, and the parent company can therefore expand its own offerings to Canadian citizens”

-Participant N

Another driver included the **Organization of Pre-Existing Professional Activities**. It was reported that it is common that health professionals (e.g., clinical and administration)
within OAHSCs often volunteered and/or collaborated with international organizations. In an effort to maximize efficiency and further ensure that the services that were being volunteered further advanced capacity in international organizations, it made sense to organize pre-existing professionals’ efforts that fall within the international space:

“…Our board decided that there should be sort of governing body that was looking at international activities as well as international partnerships that the hospital would be apt to engage in. The hospital obviously was no stranger to international collaboration whether it be through several residents, researchers, other health care professionals, but we did not have the standard approach or governing body that looks at the international activities across the organization… So with the international XX [education program] I was able to do that because now the program was legit, if you will, but solid, we had some good members, it is offered as part of the hospital international arm which is under us, and the idea was to centralize and coordinate all the international learning through us, international. It was a lot of hard work and convincing to do that, you can imagine every department, every professional wants to do their own thing, so that program took a lot of time to set up, but it did, and it’s a very successful program and now I have engaged 50% of the hospital’s divisions…”

-Participant H

“…And then he said you know, this is good, but we have to focus on training the people there and that’s when the rotation started up, another physician had gone over to Uganda around the same time, came back had a similar conversation and at some point somebody said, we should probably organize this a little bit, so we’re not just running around and that’s kind of how it evolved.”

-Participant K

“One is that we have always been involved in international work on the academic basis, so we, we’ve for many years have had outreach through our research and our, and our faculty. In fact, we have our doctors are all faculty members at XX [Research Intensive University in Ontario]. So that’s why, and so they have had collaborations on a non-profit basis for many years and you know, in countries as far as Russia, South America and the Middle East, and we run regular, for instance we run regular video conference rounds where we gather doctors from all over the world and they are you know exchanging notes around a specific case for instance, like someone might have a specific disease and they talk about that disease. So you might have a room, a virtual room with a video screen and doctor from Morocco and somebody from Saudi Arabia and somebody from you know, Moscow, somebody from Eastern Europe and then they’re all talking about this together, they’re all interested in the topic, and we do that regularly, those type of exchanges. We also have exchanges where our faculty fly back and forth or they might go to a conference and talk about cases, and they might visit different hospitals and so forth, so that has never been new, that’s
always, and that’s pretty common with many, many teaching hospitals. What we decided in 2012 was why don’t we do that, but why don’t we do it in [an organized manner], we continued to do that, but that’s not going to change.”

-Participant N

4.5 Barriers

The category of “barriers” identifies items, situations or processes that were identified by participants as concerns or impediments to pursuing IAs.

The theme of Bureaucracy emerged. Participants cited that pursuing IAs was frequently impeded or delayed by inordinate levels of bureaucracy and/or by organizational structure that imposed delays and an inability to react quickly to potential IAs.

“So certainly when an opportunity comes, if there isn’t anything that is overtly a deal breaker from my perspective, I would usually have a conversation with those individuals and flush out what the ask is, and then it would go to my VP, who’s the VP of human resources organizational learning and development, and business affairs, that’s her bucket. She and I would have a conversation over it, usually there’s some back and forth and additional information gathering, etc., it would then go to our senior management team for consideration, and again there’s usually a number of rounds where the idea is considered, additional information etc., and then they would make a recommendation to our board of trustees.”

-Participant B

“XX [OAHSC] now realizes and I basically said to them you don’t run and create a business based on being hamstrung by an organization that is not commercially oriented or restricting it because a foundation doesn’t have funds. So I’m at a point with them and saying basically we move forward or I’m out of here because this has been going on, we’ve wasted opportunity for 5 years, there’s huge value creation opportunity in many, many different ways…”

-Participant C

“You know it’s just how you have to approach a lot of these things, the mindset when you look at the current structure is I call it an alpha-paralysis, but basically it’s this need to get as many people involved in the decision making process as possible to try and cover every single base that you could potentially conceive of, and that’s not a bad thing, don’t get me wrong, risk mitigation – critically important to any business, but the mindset within a lot of government agencies including a hospital like this is to basically get everybody involved there, the government is not exactly a business oriented entity, whereby they sort of recognize the need to make informed, but expeditious decisions. That can slow things down quite a bit and I think quite frankly a lot of people take advantage of that to add unnecessary layers of
responses if you will, that are likely to be needed, but not necessarily to the full extent that they are.”

-Participant L

**Capacity** within the respective OAHSC that was pursuing IAs was a common consideration that OAHSCs evaluated prior to pursuing IAs. Participants were adamant that IAs would not be considered and/or pursued if it was determined that pursuing such IAs would negatively interfere with the access and/or quality of care that Canadian patients could expect to receive:

“I mean a lot of these are traditional activities, having students come and so forth, but even within the med school there’s capacity limitations on taking additional students and so forth, so there’s capacity constraints all around…”

-Participant E

“…Second of all the area responsible has to have the capacity, if they don’t have the capacity then we have to hire people to back fill while, because once again, one of the most important principles is that this, that we do not, we do not do anything that adversely affects our hospital’s capacity to serve Ontario residents.”

-Participant F

“Up front, in the beginning when they didn’t know, they thought that this is going to take more time and energy and that there wouldn’t be enough staff to care for this, for XX [patients] here. In Ontario, Canada, and it’s a very legitimate and valid concern. But what they didn’t understand is that we would put the proper resources in and there about be backup and back filling and capacity build up to be able to do that, and that we would never, ever, participate in anything international initiative whether on the XX [global health program] or on the XX [OAHSC] international side if it meant that it was going to impact care in XX [city in Ontario], we would never do that, that was one of our principles. So I would say that was probably the main thing that people were really concerned about, was capacity internally, and how XX [patients] were going to be cared for here.”

-Participant H

An alternative position on **capacity** as a barrier to pursuing IA was the capacity of the client organization. It was articulated that, in order to ensure success for both parties engaging in the IA, the client organization would have to have the resources and ability to implement and sustain the changes as recommended by the OAHSC.

“Number two, capacity is definitely up there of that organization and the ability to, not just capacity in terms of availability of resources, but ability to implement and then on top of that, ability to sustain. So if we are on the ground and we’re you know as a project management office or we have been doing work and not necessarily have a team on the ground, and now we are done, that becomes a challenge because they rely on us and if they, if they don’t have the right measures put in place or we’ve worked hard to put the
right measures in place and they don’t give it as much attention once we’re gone, things might regress. So it becomes a challenge to work with the client to make sure that those things are put in place…”

-Participant H

In some situations, the Cultural Differences between the respective OAHSC and the partnering client organization as a part of the IA were cited as common barriers. Some participants cited that there were sometimes language barriers that may have limited the scope of engagement that an OAHSC could pursue. Others noted sometimes differences in the way business is conducted, as a result of cultural norms, as being a barrier to pursuing IAs.

“Well the interesting thing is often you know, sometimes their language, not very often because if you can’t communicate then you can’t help, you can’t create a safe environment so we don’t get involved. But if the level of English is not at the level, if it’s at the level of being able to receive what’s being said, but not necessarily comprehend it then you get into a bit of difficulty. We’ve had miscommunication and so that’s one of the difficulties, sometimes they’re cultural, in some cultures it’s even more so than North America the concept of blame and retribution, and you get into trick situations, the other is the fact that they’re so invested in, the culture is so invested in saving face that when it comes to evaluating critical events you’ve got to be really, really careful about identifying individuals and if there is a specific problem with an individual you have to be very careful how you handle it tacitly, and a lot of these cultures are very different from our North American ones and we have learned a lot.”

-Participant F

“So I guess you know, anything, you go in, you need to kind of forget about any preconceptions of doing business as you would do business her in Canada. It is in many parts of the world especially in developing countries, it’s a bit of a wild west and so you know, agreements sometimes don’t mean that much, there’s very little enforcement of agreements, the rule of law is different in different countries, so you know now, I think you got, I guess one of the things, one of the take aways is you’ve got to pick your partners pretty carefully when you’re looking internationally”

-Participant J

“…But that has been a real challenge in China because they have a hard time really knowing what they want and it takes a very long time, culturally there and I’m going off on a tangent, but China is very challenging for a whole variety of reasons, largely relating to cultural differences, in just how you come to agreement on what it is they want and what it is we can provide. And much of that is all dependent on how well we’ve built the relationship with them.”

-Participant M
“…And then the second thing I would say is the readiness. Because there are a lot of countries where there’s, there’s the demand but they’re not ready and what I mean by that is this is a very different industry. It's not like building cars or hotels, where people just accept it right, you know in most countries you accept that hotels are a thing of need and you do it. But senior living is a new concept for many people, and they don’t particularly feel comfortable putting mom or grand mom into a facility just yet, because like I said, their culture was different until recently…so there has to be a readiness from the market and the individuals to say yes.”

-Participant N

Canadians are commonly known to be risk-averse in comparison to some of their American counterparts (Deloitte, 2011). With respect to OAHSCs, and according to the participants’ BODs and other hospital administrators, that perception of risk-aversion continued into the arena of IAs as Risk-Aversion sometimes stifled many of the IAs:

“So, so I do think that international innovation and creation of building linkages and relationships, I think it has fundamentally, its fundamentally stifled right now because we’re just, we afraid of the perceptions. And as leaders you take chances and you learn, I mean even to go internationally and learn and understand what’s going on, without even actually coming away with an absolute tangible outcome, it doesn’t happen the way it used to…but it’s the public’s perception right and every month, so we’ve gotten to this extreme place in health care, for example I have to do attestations every three months on not just my expenses but all of my direct report’s expenses. They get reviewed by the board, every little line item, they get posted on our website. Again no issue with full disclosure, but the problem is the average, the media has a skewed the perception of the average resident to say you know, a flight to London, England – what a waste of money, right. They just and the perception of advancing health care and ultimately benefitting them is just not seen, right.”

-Participant A

“What’s been unexpected was just how challenging it is to get some of these projects off the ground right, so you know I kind of alluded to the fact that we’re a very conservative organization you know, I’ve got projects I’ve been working on for two years that will likely be another two years before they see the light of day. Which in a private enterprise would be unheard of you know, unless they were massive and highly risky. Nothing that we’re doing is massive or highly risky, but it’s risky in this context. Right just because people it’s a new area for people that they aren’t comfortable with, so I think for me that’s been a surprise, is just you know, how slow we are to take advantage of some of these opportunities.”

-Participant B

“But basically, when you have a board of lay people who represent a hospital and they’re all terrified about making a decision and its not their main job, you know, there’s some very smart people on the board of XX [OAHSC] and
very well to do people who’ve succeeded in business, but bring them together and there’s a lot of nervousness, are we doing the right thing, you know, are we going to get in trouble with government, etc. etc. it’s the strength of leadership and vision and what’s lacking is somebody having a, I’ll put it simply – the balls – to move forward with it…but you know, it’s the fiduciary, the governance, elements that are restraining people from moving forward.”

-Participant C

4.6 Benefits for Ontario

Across the interviews, it became apparent that IAs offered numerous benefits to the patients of Ontario and the Ontario economy at large. The benefits that are reported in the following section reflect the advantages of IAs that were identified as benefits by the participants in the study.

Many participants cite that Increased Capacity in their respective OAHSC and/or the Ontario health system was and/or could be increased as a result of participating in IAs. Participants often cited that, as a result of additional revenues, they were able to hire additional staff (e.g., physicians, nurses, etc.) that would be able to provide additional care beyond that which is expected by patients of Ontario.

“There is a fee, and with that the basis for the fee would be enough that it would be say revenue neutral to the organization but with a margin. So with that margin it would be or that becomes important that we don’t use tax payer dollars to do any of this work so it generates income so that we can go and do the work, and it allows us to help build capacity here at XX [OAHSC]. So that might be to hire more physicians, that may be to hire more nurses, that may be to help us establish a program, so that until there can be secured funding that comes from the ministry of health to pay for that or its really about identifying dollars that can be given to the hospital so that it can be used for strategic priorities.”

-Participant D

“…they will come here for a year and they’re funded by the China scholarship council funding agency in China, and they come and they spend a year here in our labs, so they’re contributing to our research capacity, and the progress of our research projects…”

-Participant E

“So there are strategic projects, there are, I mean we see it all the time, I see it at the money we use it not only to pay for jobs, it creates jobs, so it builds capacity within the system, within our system.”

-Participant I
“The fact that we are able to generate some revenue that allows us to increase the capacity within XX [OAHSC] means we can treat more XX [patients] from Ontario within XX [OAHSC]…”

-Participant L

Other benefits cited included accentuating the Cultural Awareness of many of the health professionals who participated in IAs as a result of being exposed to patients and cultures. It was highlighted that, in many cases, as a result of the multicultural diversity of many Canadian communities, it is important to have health professionals who are culturally aware and sensitive so they can deliver high-quality, value driven, patient-based care:

“So now that they’ve been you know, a lot of them many times to the Middle East they have a better understanding of the cultural challenges, the differences and an understanding of what is the norm, so when they’re now treating those children and their families here, they have an understanding of why some of the things that they’re asking for might not make sense for that family and be feasible…you know we had one family for example who you know, wanted to have appointments at 9:00 at night, and our staff are saying well why on earth would we do that, you know, you need to have your children in bed at a regular time, you now, 5:00, 6:30, 7:30 in order for them to be well rested for the next day, why would we offer you an appointment at 9:00 at night. And then they go to XX [city in the Middle East] and realize, well their days because of the weather are quite extended you know, they don’t start until noon hour because its so hot, so its not unusual to have 11:00, 12:00 at night and have youngsters, 3, and 4 and 5 years old still in the park playing, so just an understanding of that sort of goes oh okay, I understand why you’re asking for that. We still don’t necessarily know that we’d be able to provide it but I understand why you’re asking.”

-Participant B

“One is you know providing opportunities for our students to have an international experience, and whatever that might be, it might be for research, it could be clinical training and so forth, so to provide an opportunity, diversity, you know becoming involved in other cultures and understanding other health care systems”

-Participant E

“So they’re learning how to work with people who work in a very different cultural context, politically, but also socially. You know, its an 80% Muslim country so women have to operate in a different manner than men. They’re just learning a lot of things about how one cares for XX [patients] with disabilities in a very different context.”

-Participant G

“It can play in a number of different ways actually, so I mean one of the things, the big things is the cultural dynamic. Many people that do go abroad to do the work in XX [city in the Middle East] get a chance to interact with the patient at the front line level in that cultural environment. And start learning the nuances of how to deliver care to a different group of people than
they might normally be used to back here which means when they come back here they’re much better at basically stepping back if you will just a little bit and looking at the total, if you will, of the care they may be providing to a patient by paying more attention to the family dynamic and if there’s a cultural dynamic they start paying a bit more attention to that as well, it speaks to the whole family centered care model that we have here at XX [OAHSC], but we find that they just tend to be better attuned to the environment here and they tend to then deliver better care.”

-Participant L

Another benefit for Ontario that arises from OAHSCs engaging in IAs is the emergence of new market opportunities for Ontario-based vendors and suppliers, which subsequently spurs Economic Development. In some cases, participants noted that the engagement of OAHSCs in IAs provided a platform for Ontario/Canadian vendors and services to access markets that would otherwise not be accessible to them:

“Another thing that it does for Ontario and you asked me what does it do for XX [OAHSC], but I think what it does for Ontario is that it opens up market opportunities for Ontario vendors and suppliers, so you know, when we go in to the Middle East or in China we can bring with us our suppliers and vendors from Ontario. So we provide a distribution vehicle for our you know, all the different companies that support health care delivery in Ontario.”

-Participant M

“So the government you know, our government, the Canadian government is keen to broaden how Canadian expertise across the world, you know, so we’ve got, we’ve been part of many delegations, Canadian government delegations that have gone to South East Asia, Japan, China, and the objective is always the same right, it is trade but trade and investment, so investment back in Canada by a foreign company, and trade out bound trade from Canada to foreign countries that bring revenue dollars back to Canada, and that’s kind of the, yea, that’s kind of the big picture and the overall reasons.”

-Participant N

“One of the examples would be you know, we’ve got expertise in adapting toys for XX [patients]. Right, so making them accessible for XX [patients], and using them as part of our therapy interventions. Well who else needs expertise for that sort of piece? Well toy manufacturers, is there an opportunity for us to take that expertise and support toy manufacturers and the work that they’re doing, stuff along those sort of lines, you know how else is the expertise that we have applicable.”

-Participant B

“its huge [re: implications for international trade]! And I mean even when you think about some of the opportunities that we’ve seen, as you know… it really, the international business is, international relationships is, its really, you realize how important it is, you also realize how small Canada is. And actually but even though we’re small, we do have a lot to offer other countries.”
Participants also noted that engaging in international markets increases the **International Reputation** of both the respective OAHSC, as well as Ontario and, to some extent, Canada as an entire country.

“There’s definitely greater awareness of who we are right. So I would say even in Toronto, not a lot of people know about XX [OAHSC] itself, we’re a much smaller organization compared to the academic health science centres that are there. So this work has certainly given us a higher profile across our XX [city in Ontario] peers, but also internationally. We’re now receiving and fielding requests from international patients because they have reached out to other partners and especially in the Gulf region and have been told that you know, we’re one of the places that they could access, so we’re seeing an overflow there.”

- Participant B

“So, you know there is something to be said for the, as much as we may question the money that goes into education, certainly at the university based level and the graduate level in particular, the quality of the education in this province is turning out high quality health care practitioners in my particular case, and that’s having a huge impact on the quality of the service that we provide within our hospitals as well as the other hospitals those individuals may go to as well if don’t stay within Ontario to practice. And that has a huge reputational value.”

- Participant L

“For XX [OAHSC] it builds our international recognition, when Harvard medical school China hires a XX [OAHSC] to train them in XX [specialty], it says that we in Beijing think that XX [OAHSC] in XX [city in Ontario] is at the top of the field and that’s why we’ve chosen them. We go to Cleveland Clinics Cardiovascular health, we go to Mass General for you know robotic surgery, but we go to XX [OAHSC] in Toronto for and I think that has collateral benefits in terms of helping us to attract the best staff, its gets our donors more excited about what we’re doing, and quite frankly it tells our government, hey these guys are special. If people outside of Ontario want to invest in what XX [OAHSC] is creating, it must be that XX [OAHSC] is doing something of value. And I’ve found this government to be very supportive of that, very supportive. I go on trade missions with the premiere and she gives me a big smile and a handshake when she knows that I’m pounding the pavement and trying to bring a made in Ontario solution abroad.”

- Participant M

Additionally, participants commonly suggested that IAs help to **Support Hospital Operations, Clinical Programs & Strategic Priorities**. Predominately, operations, clinical programs and strategic priorities of the respective OAHSC are supported through the reinvestment of the associated revenue that was generated by the IA. Examples of
achieving this theme included purchasing the latest technology or expanding upon a clinical program that requires funding that may not be provided by the MoHLTC.

“So within the you know hospital objectives, you know there would be ministry or growth funding that will come in to care for patients, and then we’ll have capital needs as well that comes in, so often times it may take something like an oncology program identified that they would like to start a palliative care program, but somehow you have to find those dollars within the globe or you have to get some department and you need physician funding in order to start those programs. Sometimes that’s more challenging than you might think, and so with, with this program we actually helped or with the funding from this we actually helped one of the departments to set up a XX [specialty] palliative care program.”

-Participant D

“It’s also helped us in terms of developing more programs, being able to hire more staff, it’s given us the ability to partner with other organizations at a different level, so on the sort of at the international level, which we hadn’t done before, so it’s taken our organization to the next level from that perspective”

-Participant H

“It also generates income for us so what that does is allows us to take that money and reinvest in clinical care in our hospital, and the monies are you know, we’re gaining from those experiences…”

-Participant G

“…And then ultimately the, once we’ve paid for those individuals, any surplus revenue that we generate goes back into the hospital to supports its ongoing operations…So we are a division within the hospital, and as a result of that we don’t sit on any of the revenue we generate other than paying our overhead costs, our salaries and our rent if you will within this structure, all other money goes back into the hospital to support its operations.”

-Participant L

Another benefit of IAs, as noted by the participants, is that IAs provide **Increased Opportunities for Staff**. When speaking about offering staff increased opportunities, many participants did so through the lens of professional development; often times, professional development referred to improving clinical skills, exposure to diseases and other illnesses that may not be present within North America, opportunities for research collaboration and teaching of peers, as well as opportunities for recruitment for staff:

“Yea I mean I think for us it’s the opportunity for our staff to have greater development opportunities and for them to bring those development opportunities back to their day to day practice and improve the care that they provide to Canadian citizens”

-Participant B
“I mean I mentioned different disease process and all that stuff, so we’ve had 4 or 5 of our surgical trainees go over there, cardiac surgery, plastic surgery, general surgery, urology, and they spend you know, up to 2 months in the hospital over there working on the services over there, they’re very busy, see a different patient mix, and those sorts of things, so that’s been very beneficial for our students going over there…”

-Participant E

“I would say definitely our staff, from physicians, from nurses, from all the allied health professionals, they have been exposed to international work that they might not have been exposed to had they not been at our hospital. And that has given them sort of another level of professional development, that has really opened up their eyes, not from a knowledge, not just from a knowledge perspective but also from a skills perspective…there’s been a lot of pluses, and also actually its created one other thing I’ve forgot is more interest in terms of new people, new staff who want to come and work at XX [OAHSC], it created sort of this magnet for health care professionals to come work with us because we have this arm.”

-Participant H

“We’ve had a number of the nurses in particular comment about how their exposure to that international experience has actually reinvigorating them about their own clinical practice and their love of nursing and why they got into it in the first place, when they are back here as well…For the physicians the ability to interact with their peers often times means from either a clinical or a research perspective they gain a much better understanding of some of the underlying causes of diseases that they may be either researching and/or treating here…there’s a lot of genetic diseases that we’re seeing that you would not normally see here in Canada, but are very common in the Middle East and parts of Asia because of a certain dynamic that are at play there. Exposure to that knowledge helps the physicians or the surgeons here do a much better job of better managing or better directing the type of research that needs to be done in order to identify what needs to be done in order to treat that XX [patient] appropriately.”

-Participant L

“…I know that our CEO had an opportunity to go over and meet with the staff, and listening to the conversations they have about what the impact has been to them when they come back and to their clinical practice, when you talk about unintended consequences, that’s something that I never really thought about either, but these experiences really helped them enrich the way they care for patients as well, it gives them another perspective, so very positive.”

-Participant D

4.7 Other Findings
The following are findings that emerged from data collection, however they are considered outside the original scope of the research question; with that being said, given
the exploratory nature of this study, these results no less inspire intellectual conversation surrounding the implications for IAs and Canada’s global identity. The following themes can generally be categorized as implications for Canadian foreign policy. The following findings will highlighted here in Chapter 4, but will be discussed at greater detail in 5.3 Other Considerations for International Agreements & Globalization.

One participant reflected how IAs may be helping to advance the Millennium Development Goals (MDG) as part of the United Nation’s (UN) mission to combat issues like poverty eradication, environmental protection, human rights and protection for vulnerable populations. As one participant commented:

“As a result of all of this [re: MDG], in general, there have been significant reductions in infant mortality rates in the last 15 years, globally, some countries have done better than others, admittedly, but in general its’ been a huge improvement. What has happened however, and where people now are starting to see the impact from a tertiary care [perspective] is while more children have had the opportunity to survive where they might have died in infancy if not right at birth as a result of some complication, those children again might have died as a result of a tertiary care need, like a congenital heart defect or you name it, are now surviving but they can’t get the care they need in their home environment because the MDGs were never set up to basically put money into the tertiary care end of the health care spectrum, so at the primary/secondary end of the spectrum, so now there’s an increasing demand for pediatric care where we play, that I would argue in general for adults, at the tertiary care level in those countries to meet the ever increasing demand, demographic demand that they’re seeing as a result that more children are living now than ever would have lived in the past, but with conditions that they’d never had to treat in the past because those children didn’t live long enough to get to a center for treatment. So its both a positive and a negative if you will in terms of great idea and its worked very well, but now the health care community in general globally needs to step up to bridge that gap of the tertiary care end of the market so that those children can get the care they need in their home country and if not there then they have to potentially look at coming to a place like XX [OAHSC] where they’ll be treated”

-Participant L

Another finding of the study was related to the intertwining of IAs and the implications for immigration and refugees. As one participant suggested:

“…In many cases these families are immigrating to Canada and to the US and other parts of the world, but for us they’re coming to Canada and to Toronto for economic reasons, for but now the XX [patients] are needing to be treated here
as well, and they are Ontario citizens, they may have been born elsewhere, but they’re Ontario citizens now, and so they need to have access to that care, so it’s a very interwoven kind of field…”

-Participant L

Other study participants noted how IAs may be influencing international diplomacy or have an impact on Canadian relationships with foreign diplomats.

“…We work with the Canadian government and the Ontario government so the ministry of economic trade and development….We also worked with the Canadian government so the department of foreign affairs so we actually wouldn’t go anywhere that Canada does not have a presence… they don’t have an influence necessarily where we go, but where we go they happen to have either an embassy or a consulate, and so we’ll always connect with them, usually beforehand or during the process. Sometimes we’ve used the Canadian government to help us get a contract actually. So that’s part of what their role has been and how Canada advanced its role or its exports in other countries, so they can be incredibly helpful”

-Participant D

“…We worked and continued to work very closely with the Canadian embassy in Beijing and they also helped us with potential clients. And they haven’t brought too many opportunities to our attention, but they do help us evaluate you know, we’ll tell them who we’re talking to and they’ll help us understand who these people are and whether they think it’s a good idea to continue talking to them, and the trade representatives in China and the other staff you know, we visit them almost every trip. I’ve met with the Canadian ambassador to China, and he’s very helpful and so that’s it. I think the government’s been very supportive, both federal as well as provincial government. “

-Participant M
4.8 Summary of Results

The following table summarizes the results of the study:

**Table 1- Summary of Results**

<table>
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<tr>
<th>Drivers</th>
<th>Barriers</th>
<th>International Activities</th>
<th>Benefits for Ontario</th>
</tr>
</thead>
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<td>Bureaucracy</td>
<td>International Agreements</td>
<td>Increased Capacity</td>
</tr>
<tr>
<td>Extension of Hospital Mission, Vision &amp; Values</td>
<td>Capacity</td>
<td>• Humanitarian &amp; Business Development</td>
<td>Cultural Awareness for Health Professionals</td>
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<tr>
<td>Insufficient Revenue from the Ministry of Health and Long-term Care</td>
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<td></td>
<td></td>
<td></td>
<td>Increased Opportunities for Staff</td>
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Chapter 5 : Discussion

5 Drivers of International Agreements

Important insights into the drivers of IAs emerged from this study; based on the interviews conducted as part of this study, the following are drivers of IAs: altruism & global health promotion; extension of hospital mission, vision & values; organization of pre-existing professional activities; insufficient revenue from the MoHLTC; and an opportunity to commercial knowledge. While each individual driver offers important insight as to why OAHSCs would be motivated to pursue IAs, the five identified drivers, for the purposes of discussion, can be categorized into two general categories, as motivated by: (1) individual and/or organizational values, or (2) commercial opportunity.

Individual & Organizational Values

This study identified an inherent underlying value proposition for pursuing IAs. This study highlighted that: (1) altruism & global health promotion (personal values), (2) organization of pre-existing professional activities (personal values), and (3) extension of hospital mission, vision & values (community and organizational values), were drivers of IAs.

In many cases, participants cited that the pursuit of IAs was fueled by a type of altruism and/or moral obligation to improve the lives of patients around the world. While all participants recognized that providing patient services in a timely fashion to Canadians was paramount to other agendas, participants also noted feelings of privilege and a desire to ensure that patients everywhere have an opportunity to benefit from advanced healthcare and health systems (i.e. one should not be without lifesaving knowledge and resources as a product of where someone is born). Additionally, given that an element of IAs appears to be driven by the organization of pre-existing professional activities, it suggests that, in many cases, health professionals were already pursuing international work to help support health services abroad. In this light, health professionals would not be volunteering their time and resources unless they valued the work on some personal level as they are often not compensated for their individual efforts.
In Ontario, there are 24 members of the Council of Academic Hospitals of Ontario (CAHO), each with its own mission, vision and value (MVV) statements. Interestingly, 10 OAHSCs (i.e. members of CAHO) have mission and/or vision statements that infer or directly mention actively pursuing globalization as an institutional. As a result of maintaining a publicly administered health system, organizations are governed Board of Directors (BODs), which include representatives of the community the organization services (Snowdon, Schnarr, Hussein & Alessi, 2012). “For each organization, the governing board establishes the MVV as the foundation upon which strategic initiatives and priorities are implemented relative to health care service delivery” (Snowdon et al., 2012, p. 21). Since BODs establish the MVV statements, which are revisited on a regular basis during strategic planning activities, it is expected that these statements reflect a hospital’s unique and enduring purpose (Snowdon, et al., 2012). As a result, in lieu of polling citizens/residents of every community in Ontario, one can suggest that the MVV of Ontario hospitals can be seen as a proxy for the values of the citizens/residents of Ontario, Canada. Considering that BODs represent the values of the communities they serve, and the MVV statements are expected to represent the organizational values, the findings of this study suggest that Ontario citizens, and OAHSCs with globally orientated MVV statements, identify IAs as a valued priority.

**Commercial Opportunity**

The other high-level theme that emerged from the category of drivers was that of the need, and opportunity, for commercial development. In many cases, while the pursuit of IAs was not driven by motivations of profit, IAs did provide opportunities to compensate for decreased funding from the MoHLTC through the commercialization of the knowledge, skills, human resources and other aspects of intellectual capacity that had been developed by the OAHSC. Participants highlighted that OAHSCs have a unique advantage with respect to a commercial opportunity as the knowledge and skills within our OAHSCs are incredibly valuable and highly sought after in the global market place.

5.1 **Barriers of International Agreements**

**Organizational and Social Constructs**
The barriers to IAs, as highlighted by the participants, included: bureaucracy, capacity (organizational), cultural differences and risk aversion. The vast majority of the barriers to IAs cited by the participants in general reflect organizational and social constructs that impede international agreements. For example, internal bureaucracy, risk aversion and capacity tend to be organizational barriers that inhibit the pursuit of IAs. In contrast, cultural differences refer to individual, organizational and societal norms that may hinder the procurement of international agreements abroad. It was unclear, after interviewing all of the participants, to what extent these barriers impacted an organizations’ ability to pursue IAs, or if OAHSCs missed potential IAs as a result of these barriers, but it was apparent that often accompanying IAs were barriers that needed to be overcome.

5.2 Benefits to Ontario from International Agreements

The benefits that Ontario experiences as a result of IAs, as highlighted by the study participants, include: increased capacity, cultural awareness of health professionals, extended opportunities for economic development, international reputation, support of hospital operations & strategic priorities, and increased opportunities for staff. While each subtheme in the results provide important insight into IAs, from a high, generalized, level these findings can be divided into two categories: (1) people advantage, and (2) organizational & provincial advantage.

People Advantage

The people advantage refers to the various opportunities, as solicited by IAs, that benefit the people on Ontario and/or the staff of the respective organization. For example, increased capacity is an advantage to the citizens and residents of Ontario as it reduces wait times, whereas accentuated cultural awareness of health professionals also improves the patient experience, as health professionals are more culturally aware and attuned to the needs of the patient based on his/her beliefs and values. Further, additional benefits that result from IAs also improve staff opportunities and growth from learning and teaching in new environments and cultures. While several participants commented that they had conducted internal reviews and surveys that solicited staff feedback and opportunities to share their experiences, this topic may merit future academic exploration.

Organizational & Provincial Advantage
Another theme that emerged from the category of “Benefits for Ontario” was the idea that IAs create organizational and/or provincial advantages through creating: international reputation, support of hospital operations and strategic priorities, and extended opportunities for economic development. In this theme, the benefits to Ontario reflect advantages that indirectly benefit patients through advancing other priorities of the province and/or the respective OAHSC.

When it comes to supporting hospital operations and strategic priorities, across the spectrum of hospitals in Ontario, hospitals have had to compensate for falling revenues as the MoHLTC has shifted from global budget formularies to health-based allocation measures (HBAM) and quality-based allocation models (QBAM). That is, in Ontario, hospitals traditionally have been allocated funding from their respective Local Health Integration Networks (LHINs)\(^2\) in the form of a global budget\(^3\). However, there are significant challenges that pertain to global budgets as often, in an effort to remain within the budget, hospitals would restrict services to patients. This reform to the way hospitals and long-term care homes are compensated aims to drive a system that is patient focused through compensating organizations based on, “how many patients they look after, the services they deliver, the evidence-based quality of those services, and the specific needs of the broader population they serve” (Ontario Government, 2014). This new level of funding is intended to be patient centered, however it also restricts the amount of discretionary spending hospitals have to invest into strategic priorities. Therefore, pursuing IAs, and their associated revenue, provides OAHSCs with unrestricted funding (i.e. outside of HBAM and QBAM) that provide the opportunity for OAHSCs to invest in the strategic priorities of the hospital.

Additionally, Academic Health Science Centres receive a large proportion of their operating budget from the MoHLTC, they also have other sources of revenue that help to fund day-to-day hospital operations. In fact, there are many different mechanisms of

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\(^2\) **Local Health Integration Networks** are allocated funding by the Ministry of Health and Long-term care based on a Health Based Allocation Model (HBAM).

\(^3\) **Global Budget**: “A fixed amount of funding is distributed to a health care provider, such as a hospital or long-term care home, and that provider then delivers services under its mandate to patients for a fixed period of time (usually one year),” (University of British Columbia, 2013)
revenue generation in play in OAHSCs. Many OAHSCs have revenue generation models that leverage other commercial services (e.g., Parking, Food Services etc.), as well as research funding that is allocated by external organizations such as the Canadian Institutes of Health Research (CIHR), and the Natural Sciences and the Engineering Research Council of Canada (NSERC). These help fund research and strategic priorities for the OAHSC. As previously mentioned, the results of this study suggest that, in the event that an IA does produce revenue (noting that not all IAs generate revenue), the associated revenue is reinvested into the OAHSC and is used to advance strategic priorities that enhance patient care within their respective OAHSCs.

Themes such as “extended opportunities for economic development”, may merit future research consideration as Ontario looks to diversify its portfolio of economic exports to bolster the economy and GDP growth. It is worth noting that, in the case of ameliorating Canada’s economic advantage through the globalization of healthcare, several reports have highlighted the concern that globalization of healthcare and Canada’s involvement as a member of the World Trade Organization (WTO), may have implications on trade agreements similar to the North American Free Trade Agreement (NAFTA), and the General Agreement on Trades and Services (GATS). One of the cautions, “involves opening up delivery of medical services to for-profit entities, hospitals or specialized clinics…as once there is a significant foreign presence engaged in for-profit delivery of health care services, any attempt to restrict its access to the market in the future may result in relatively high compensation claims” (Romanow, 2002, p. 238). Despite this caution, in the interim, “there is a strong consensus that the existing single-payer monopoly of Canada’s health care system is not subject to a challenge under NAFTA” (Romanow, 2002, p. 237; CCPA, 2002; Epps and Flood, 2002; Johnson 2002). It is interesting to consider the implications on NAFTA if Canadian public-payer hospitals are engaging in revenue generation activities. These considerations are outside the scope of this thesis but may merit future research consideration.
5.3 Other Considerations for International Agreements & Globalization

The remaining elements of this discussion that can be categorized as foreign policy and are inclusive of the following themes of: the millennium development goals, immigration & refugees, national security, as well as foreign diplomacy.

Millennium Development Goals

At the Millennium Summit in 2000, all 189\(^4\) members of the United Nations (UN) unanimously, “adopted the UN Millennium Declaration, committing their nations to new global partnership to reduce extreme poverty and setting out a series of time-bound targets, with a deadline of 2015, that have become known as the Millennium Development Goals (MDG)” (United Nations, 2007). The MDG strive to promote, “basic human rights - the rights of each person on the planet to health, education, shelter, and security” (United Nations, 2007) As a member of the UN and signatory of the MGD, Canada has an obligation to, “ensure that globalization becomes a positive force for all the world’s people…[of which] these efforts must include policies and measures, at the global level, which corresponds to the needs of developing countries and economies in transition” (United Nations: General Assembly, 2000, pp.2). The challenge with the MDG is that, while some nations have been successful at reducing child mortality and improving maternal health across a variety of spectrums, these improvements have yielded new challenges for developing countries and economies in transition. The MDG called for an immediate investment into several different elements of community health, all well intentioned investments to reduce child mortality and improve maternal health. However, while children are living longer and mothers are experiencing greater health benefits, it has resulted in these countries and economies being underprepared and without the proper expertise and resources to address health concerns that otherwise would have been fatal at birth.

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\(^4\) In 2000, the United Nations was comprised of 189 member nations; since 2000, the membership has grown to 193 members with the addition of: Switzerland (2002), Timor—Leste (2002), Montenegro (2006), and South Sudan (2011). Retrieved from: http://www.un.org/en/members/growth.shtml#2000
**Immigration & Refugees**

Building off the limitations of the MDG, the increased demand and limitations of tertiary care in developing countries and economies in transition has also posed an interesting dilemma for Canada in relation to its position on immigration and refugees. In many cases, the countries that are subject to the greatest support from the UN in addressing the MDG are also the countries/ economies with large numbers of families immigrating and/or claiming refugee status in Canada.

This is yet another example of the globalization of healthcare, but it may in fact raise an important ethical question; a question of if we, as a country, are ensuring that children and adults alike are living longer but with greater complexity and comorbidities, to what extent do we have a responsibility to ensure they have access to the level of complex care that they require. This question may merit robust discussion amongst scholars in the ethical arena, but is outside the scope of this research.

**National Security**

In 2001, the Canadian International Development Agency (CIDA) launched CIDA’s Action Plan on Health and Nutrition to Reduce Poverty in Developing Countries that pledged doubling spending over a 5-year period from 2001 to 2006 from $152M to $305M. These funds were earmarked to variety of different areas including: “nutrition, food security, sexual and reproductive health, communicable and non-communicable diseases, water and sanitation, health systems and public policy” (CIDA, 2001). With respect to CIDA’s effort in the area of health systems, CIDA aimed to, “strengthen the capacity of national, regional and local health systems to provide universal access to services for the poor” (CIDA, 2001). While it is without doubt that CIDA’s efforts were intended to build capacity in developing countries and economies in transition, it also serves to address the warning of the World Health Organization’s (WHO) report (1997) that warns that, “the increased mobility of people across the globe means that health problems that at one time would have remained relatively isolated in part of the world can now spread faster and more widely” (Romanow, 2002, p. 240; WHO, 1997). Further
CIDA also notes that, “investing in global health helps to ensure Canadians’ own health and security” (CIDA, 2001).

**International Diplomacy**

In 2002, the Romanow Commission report, *Building on Values: The Future of Health Care in Canada*, suggested that, “it is time for Canada to use both its positive relationship with developing countries and its considerable expertise in health care to help improve the health and health care around the world” (Romanow, 2002, p.243). To meet Canada’s international obligations, the Romanow Commission suggested that Canada should seek to strengthen, “foreign aid programs to assist in training much needed healthcare providers for developing countries and in promoting public health initiatives designed to prevent the spread of illnesses” (Romanow, 2002, p. 243). It was suggested that investing in health systems abroad may allow not only for increased international collaboration between healthcare providers, but also increased diplomatic cooperation and elements of national security (Canadian International Development Agency [CIDA], 2001; Romanow, 2002; Owen & Roberts, 2005). Some of the participants in the study suggested that, on some level, when their respective OAHSC pursued IAs, there was also an engagement with the Canadian embassy in the country of interest.
Chapter 6: Conclusion

6 Preamble

The purpose of this thesis, as highlighted in chapter 1, was to address the following:

1. What is the nature of IAs that are being employed by OAHSCs?
2. What are the drivers and motivations that influence these agreements?
3. What organizational advantages to OAHSCs result from international agreements?
4. What impacts, both positive and negative, do these international agreements have on the Ontario health system?

6.1 Nature of International Agreements

This study sought to explore the nature of IAs within OAHSCs and answer the research question: “what is the nature of international agreements within Ontario Academic Health Science Centres?” The study was motivated by the fact that very little was known about the nature of the activity in which OAHSCs engage in the international space, aside from the few articles written in grey literature sources.

The present findings suggest that, in OHASCs, there are different types of international activities that take place and fall into two distinctive categories: (1) international agreements, and (2) international patient services. This study focused on IAs and excluded international patient services from the scope of the research, as participants were adamant that the types of IAs that their respective OAHSCs engaged in specifically excluded provisions for providing care to international patients; services provided through IAs were consultative in nature.

Overall, the interviews revealed that OAHSCs that pursued IAs did so from two perspectives: (1) humanitarian, and (2) business development. It is important to highlight that, regardless of intention, OAHSCs pursued international IAs that could help other countries increase their respective capacity and standards of care. Generally, both the humanitarian and business development initiatives, as part of IAs, appear to offer similar
services which include: (1) needs assessments, (2) advisory services, and (3) education and training. Unique to the business development arm of IAs is the 4th service of licensing and 3rd party management of services, although, as highlighted in the results, it is important to note that not all organizations that participated in this study agreed that this was a vertical that they saw opportunity/ value in participating in.

This study also explored the perceived drivers, barriers and benefits of engaging in IAs from the lens of OAHSCs. Participants largely identified five main drivers of IAs: (1) global health promotion, (2) extension of the hospital’s mission, vision & values, (3) insufficient revenue from the MoHLTC, (4) opportunity to commercialize knowledge, and (5) organization of pre-existing professional activities. The interviews also revealed barriers to IAs included: bureaucracy, organizational capacity, cultural differences, and risk aversion. Additionally, participants also highlighted the following as perceived benefits to Ontario as result of OAHSCs engaging in IAs: (1) increased health system capacity, (2) accentuated cultural awareness of health professionals, (3) extended opportunities for economic development, (4) international reputation, (5) support of hospital operations & strategic priorities, and (6) increased opportunities for staff.

6.2 Implications for Practitioners

While the results of this study do not lend themselves directly to policy recommendations, the results no less offer important insights for governments (i.e., policy makers) and hospital administrators to consider when making decisions in relationship to OAHSCs and future IAs. Policy makers and administrators should consider the potential benefits of IAs for OAHSCs and the province of Ontario, as highlighted in section 4.6. Additional research should be employed, using quantitative and qualitative methodology, to explore the extent of these benefits across the province of Ontario.

6.3 Recommendations for Future Research

As this is a new area of research, at least from the lens of OAHSCs, there are numerous possibilities for future research consideration. For example, a study into how these IAs interface with international trade agreements, or the implications of IAs for our health
system, are interesting questions to consider. Further exploration into the impact these opportunities have on the professional development of staff, both from a cultural awareness perspective, and in terms of encouraging health professionals to think from a systems perspective while helping to transform health systems abroad, also warrants further study.

Another area for potential research is the impact IAs have on medical suppliers’ abilities to penetrate markets that they would not otherwise be able to access, and the impact these opportunities have on the economic growth for the province of Ontario.
References


Registered Nurses’ Association of Ontario. (February 5th 2015). Letter to Minister Hoskins: Protect medicare with legislated ban on medical tourism: Retrieved from:  


Appendices

Appendix 1- Email Recruitment

Email Recruitment

**Subject Line:** Invitation to participate in research

You are being invited to participate in a study conducted by Andrew D. Scarffe in partial fulfillment for his Master’s degree in Health Sciences at Western University, supervised by Dr. Anne W. Snowdon, Professor and Chair at the Ivey International Center for Health Innovation. Briefly, the study involves an exploration into the nature of international agreements within Ontario Academic Health Sciences Centres. Ultimately this research hopes to create a body of literature that informs the potential impact these agreements have on their respective academic hospital and larger provincial health system. As a participant in this research you are being asked to take part in a phone interview about the nature of international partnerships and Ontario Academic Health Science Centres. The interview would be scheduled at a mutually agreeable time and is expected to last approximately one hour; please see the attached letter of information for more information.

If you would be willing to participate please contact Andrew Scarffe at the contact information given below. For your convenience, we will contact your office to determine whether you are able or willing to participate in this study.

Thank-you,
Andrew Scarffe
Research Analyst, MSc (2015), Ivey International Center for Health Innovation
Dr. Anne Snowdon
Chair, Ivey International Center for Health Innovation
Version Date: 09/03/2015
Appendix 2- Letter of Information

Letter of Information
Dr. Anne W. Snowdon
Academic Chair, Ivey International Centre for Health Innovation
Ivey Business School at Western University

Principal Investigator: Dr. Anne W. Snowdon, Academic Chair, Ivey International Center for Health Innovation at the Ivey School of Business at Western University

We would like to invite you to participate in a research study entitled: “The Globalization of Healthcare in Ontario: Identifying the Nature and Impact of International Partnerships on the Ontario Health System”. This study is being undertaken as a thesis in partial fulfilment of a Master’s of Health Sciences in Health Promotion and partnership with the Ivey International Center for Health Innovation located in the Ivey School of Business at Western University in London, Ontario.

Within the Ontario health system international agreements and partnerships are emerging as a trend amongst some of the leading Academic Health Science Centres. However, outside of the grey literature (i.e. Globe and Mail, National Post etc.) there is a gap in the academic literature that neutrally identifies the nature of these international agreements, the motivations behind them and what these partnerships stand to achieve for the health system. This study will attempt to understand the nature of international partnerships within Ontario Academic Health Science Centres. Ultimately, by developing an understanding of the nature of international partnerships, this research hopes to develop a body of evidence that is currently absent from academic literature.

What does participation in this study involve?
As a leader in the Ontario hospital system, you are being asked to participate in this study because it is believed you have professional experience in the area of hospital management, and are familiar with the nature of international partnerships within Ontario Academic Health Science Centres. You are being asked to participate in an interview lasting approximately an hour.

We ask that you read this letter of information and consent AND IF YOU AGREE TO PARTICIPATE PLEASE E-MAIL ANDREW SCARFFE USING THE CONTACT INFORMATION BELOW. You may keep a copy of this letter of information and consent.

Prior to beginning the interview this letter of information will be read and you will be asked to provide verbal consent in lieu of signing this consent form. Each interview is expected to last an hour. The interview will be audio recorded with a tape recorder and the dialogue from the interview will be typed into a computer document. Individuals who do not wish to be audio recorded will not be eligible to participate in the study. You may choose not to answer any of the questions in the interview.

Who can be included in this study?
1) Participants must currently, or within the last 3 years, be in the role of a senior leadership position with, or that interfaces with, Ontario Academic Health Science Centres;
2) Participants must be knowledgeable about international partnerships and/or agreements within Ontario Academic Health Science Centres;
3) Participants must be able to speak and understand English; and
4) Participants must consent to an audio-recorded interview.

Are there associated benefits or risks with participating in this study?
THERE ARE NO KNOWN RISKS TO PARTICIPATING IN THIS STUDY
There are no direct benefits to the participants. There may be indirect benefits to participants in that they are helping to provide background knowledge to ameliorate how strategic priorities of Academic Health Science Centres are achieved within the province of Ontario.
Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your role in the health system.

Confidentiality and Informed Consent
An initial statement of consent is required to start the interview. All of the information collected by the researcher will remain confidential, and will be permanently deleted after 5 years. If the results of the study are published, you will not be notified; your name will not be used and no information that discloses your identity will be released or published without your explicit consent to the disclosure. Only individuals directly involved with this study will have access to any information that would reveal your identity. The one exception is where the representatives of Western University Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.
Data storage and security measures are in place: Any identifying information will be kept in a locked office at Western University. Any identifying information will be maintained in a separate and secure location. Any electronic data, files or audio recordings will be password protected, encrypted and/or stored in password protected computers. The identifying information collected will not be retained and information from this study will be destroyed upon completion of the study through a professional shredding company and be permanently deleted from the password protected computers.
If you have any questions associated with this project, please do not hesitate to contact me (see contact information below). If you have any questions about your rights as a research participant or the conduct of the study you may contact the Office of Research Ethics at the University of Western Ontario at XX or by email at XX
Sincerely,
Dr Anne W. Snowdon, Academic Chair
Ivey International Centre for Health Innovation
Andrew Scarffe
Research Analyst, MSc (2015)
Ivey International Center for Health Innovation
Appendix 3- Verbal Consent Script

Verbal Consent Script

Thank-you for replying to our e-mail and agreeing to take part in a phone interview to help us explore the nature of international agreements within Ontario Academic Health Science Centres. Just so you are aware as well I am going to record our phone call and interview today to be able to analyze the data at a later time. Before we begin I am going to read our letter of information and consent. I will also e-mail you a copy of the letter of information and consent if you do not have the copy that was emailed to you. *Letter of information will be read.*

Do you have any questions?
*If yes, questions will be answered.*

Do you agree to participate in this study?
*If yes, interview will proceed. If no, interview will end.*
Appendix 4- Participant Interview Guide

Participant Interview Guide

1. Could you please briefly describe your role and day-to-day responsibilities?
2. From your perspective what does the globalization of healthcare mean to you?
   a. What are the opportunities?
   b. Consequently, what are the barriers?
3. What is the nature of international agreements that are being employed by your respective Ontario Academic Health Science Centres (OASHC)?
   a. How do you decide where to go?
   b. What services do you provide?
4. What do you identify as the drivers and motivations that influence these agreements?
   a. What were your personal goals and/or motivations for pursuing international agreements?
5. What are the principle objectives of your international agreements?
   a. How do you measure if these objectives are being achieved?
6. To what extent have international partnerships impacted the strategic priorities of your Academic Health Science Centre?
   a. What were expected outcomes?
   b. What were unexpected outcomes?
7. What impacts do these international partnerships have on the Ontario health system?
   a. What impacts do you perceive to be positive/ constructive?
   b. What impacts do you perceive to be negative/ detrimental?
8. If we were to look ahead, 10-15 years from today, to what extent would international partnerships be involved in the Ontario health system?
   a. What would these partnerships achieve?
9. If there were one concept that you would want to highlight from this interview, what would that be?
Curriculum Vitae

Name: Andrew Scarffe

Post-secondary Education and Degrees:

University of Western Ontario
London, Ontario, Canada
2009-2013 BHSc

The University of Western Ontario
London, Ontario, Canada
2013-Present MSc

Honours and Awards:

Western Graduate Research Scholarship

Western Libraries Open Access Fund
Western University
2015

Mitacs-Accelerate Graduate Research Internship
Ivey International Centre for Health Innovation
Ivey Business School at Western University
2013-2014

Related Work Experience

Teaching Assistant
The University of Western Ontario
2013-2015

Research Analyst
Ivey International Centre for Health Innovation
Ivey Business School at Western University
2013-2015

Lecturer
Thompson Rivers University
Beijing, China
October 2015

Research Associate
Ivey International Centre for Health Innovation
Ivey Business School at Western University
2013-Present

Publications:


Abstracts:

Teaching Materials: