PARADIGM FREEZE

WHY IT IS SO HARD TO REFORM HEALTH-CARE POLICY IN CANADA

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Sponsors and Presenters

- Sponsors of the work
  - Canadian Institutes for Health Research
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- Presenters today
  - Harvey Lazar, PI and lead editor - framing
  - John Lavis, co-editor - methodology
  - John Church, co-editor - research results
  - Greg Marchildon - commentator
  - Robyn Tamblyn - Chair

Political Context: The Formative Years (1945-1980s)

- Post WWII was period of building health-care systems
  - Public health and supply-side, relatively uncontroversial
  - Demand-side, controversial
    - Competing ideas and interests and "accidents" of history
    - By 1970s, today's Canada-wide medicare model was in place
      - Hospital and medical services covered
      - All else (pharmacare, home care, dental etc.) out
  - Three points of interest here
    - Medicare-covered services widely supported by public
    - Health care became
      - Largest spending envelope in government
      - Canada's biggest industry
    - Unevenness of Canada-wide coverage left room for provinces and territories (PTs) and/or private sector to fill gap (no PT service was first dollar covered)

Political Context:
Dynamics Without Change (1990-2011)

- By 1990, much of 1945 policy vacuum had been filled via
  - Canada-wide medicare: hospital and medical services delivered by PTs under CHA criteria
  - PT programming unrelated to CHA
  - Private arrangements
- High and rising costs sent PTs on perpetual quest for administrative efficiencies and some semblance of cost control
- PTs caught between political popularity of medicare and public finance crises
- No silver bullet found
- Meagre reform

What the Book is About

- Why achieving substantive reform is so hard?
  - Neutral about whether reform is desirable or not, or which reforms are “best”
- What kind/how much reform has Canada experienced in recent years?

What kinds of conditions have facilitated reform and what kinds have retarded it? Are these conditions around now?

Methods

- An empirical study of policymaking processes for a purposively selected sample of six policy issues in each of five different provinces that differed in their affluence, population size, and urban-rural mix (Alberta, Saskatchewan, Ontario, Quebec, and Newfoundland and Labrador), 1990-2003 (with an extension to 2004-2011)

Methods (2)

- Identifying policy issues for study
  - Selected a sector-specific taxonomy of policy domains
  - Identified six policy issues where reform had been attempted or undertaken (based on literature reviews and interviews)
    - Governance arrangements – regionalization
    - Financial arrangements – needs-based funding for regions and alternative payment plans for physicians
    - Delivery arrangements – For-profit delivery of medically necessary services and waiting-list management
    - Program content – Prescription drug plans
  - Identified a ‘policy puzzle’ (i.e., policy decisions and ‘non decisions’ or ‘no go’ decisions that differed across provinces)

Methods (3)

- Selecting analytical frameworks to examine agendas and decisions
  - Kingdon's three streams for agendas
    - Governmental agendas driven by the problem or politics streams
    - Decision agendas driven by problem, policy and politics streams
  - 3I (+E) framework for policy decisions
    - Institutions (e.g., government structures, policy legacies and policy networks)
    - Interests (societal interest groups, elected officials, public servants, researchers and policy entrepreneurs)
    - Ideas (knowledge or beliefs about 'what is,' views about 'what ought to be,' and the two combined)
    - External factors (e.g., release of major reports, political change, economic change, media coverage)

Methods (4)

- Collecting and analyzing data related to agendas and decisions
  - Documentary analysis (bibliographic databases, media databases, Hansard, websites, and old telephone directories)
  - Timeline of key events
  - Interviews with a purposive sample of (238) policymakers and stakeholders, using a semi-structured interview guide
    - 67 in Alberta
    - 37 in Saskatchewan
    - 51 in Ontario
    - 53 in Quebec
    - 30 in Newfoundland and Labrador (where five of six were ‘no go’ decisions)
  - Analysis using the Kingdon and 3I frameworks

Methods (5)

- Coding and analyzing data across provinces and issues (30 cases)
  - Identified additional codes that facilitated cross-provincial and cross-issue analyses
    - Nature of reform – pro-reform (i.e., in direction recommended by grey literature), anti-reform (attachment to status quo) or counter-consensus reform (opposition to status quo)
    - Extent of reform – none, limited, moderate, significant or comprehensive (in reference to grey literature)
  - Applied the codes to each case study
  - Sought feedback from provincial study coordinators
  - Iteratively revised the codes based on this feedback and continued analysis

Extent Of Reform: 1990-2003

- Of 30 cases, 17 “none” or “limited”
- Only 1 “comprehensive” and 6 “significant”
- **MEAGRE** outcomes- consistent with much literature

Variables Associated with Larger Reforms

- 7 cases comprehensive/significant reform of which 5 involved electoral process
  - New **first-time government /government leader**
  - **Campaign commitment** to reform during election
  - Appointed champion once in power
  - Policy announced in **first half mandate**

Plus

- Fiscal crisis, near or perceived crisis

Substantive Reform

- Substantive change along one or all of the major dimensions of health policy: the governance of the system, its financial arrangements, its delivery arrangements, and the types of programming
- Sustained long enough to bring about a transformation in the distribution of power and authority among various groups in the health care system
- Should directly affect its “governing coalition” — the compact of health professionals, experts, and policy makers who decide the orientation of the system

- (Forest and Denis, 2012)

Big Picture

- Insider interests resisted, slowed and shaped reform (e.g. health provider organizations)
- Outsider interests (civil society) protected the Medicare legacy but unable to extend it
- Main pressure for reform came from exogenous factors (i.e. economy, newly elected governments)

Insider Interests

- Organized medicine most influential by far
- Effective veto on any change that impacted freedom of individual physicians to choose form of compensation (fee for service)
  - Seen in two cases: regionalization and alternative payment plans
- Near veto of change that impacted clinical autonomy
  - Seen in one case: wait list management

Insider Interests

- Provincial medical associations had effective veto in areas where their interests/member interests were most affected
- But it was less successful in selling its ideas where its direct interests were not heavily affected (e.g., some physicians in Alberta and Saskatchewan were annoyed that they were not consulted before the regionalization decisions were taken)

Role of Civil Society

- Civil society/public opinion pressure came into play on decisions that touched on issues of delivery arrangements and program content because these touched most directly of on citizens
  - In Alberta and Saskatchewan, public interest groups played a major role in putting wait times on the government agenda
  - In Alberta and Ontario, public interest groups could not prevent privatization from getting on government's agenda, but they did slow and alter the type of reforms
  - An AIDS public advocacy group was instrumental in putting drug reform on the government agenda in Ontario

What About Ideology?

- Egalitarian values that shaped Medicare and the associated policy legacies continued to reinforce the status quo rather than to challenge it (institutionalized through the Canada Health Act)
- Played a larger role at the governmental agenda and decision agenda stages than at the policy choice stage

(Knowledge played a larger role at the policy choice stage)

What About Ideology?

- SK and ON (social democratic) – regionalization, alternative payment plan
- SK and AB (social democrat/conservative) – regionalization, needs-based funding, alternative payment plan
- ON and AB (conservative) – health spending, regionalization
- **Overall, ideology was trumped by other factors**

Institutions

- The provincial ‘state’ grew closer to the hospital sector and provincial medical associations
- Canada Health Act – institution vs. symbolism
- Federal/provincial/territorial relations
  - Little real federal leadership (unlike earlier periods)
  - Federal government diverted attention to other issues
  - Federal cuts led to a provincial focus on fiscal federalism rather than health reform
  - Policy networks formed around more “technical” issues.
  - Joint management committees were ramping up but not fully functional

Summary of Findings

Exogenous factors: new government and fiscal crisis (opening policy windows)

Endogenous factors: insider interests (resisting significant change)

Reflections on Future policy Reforms

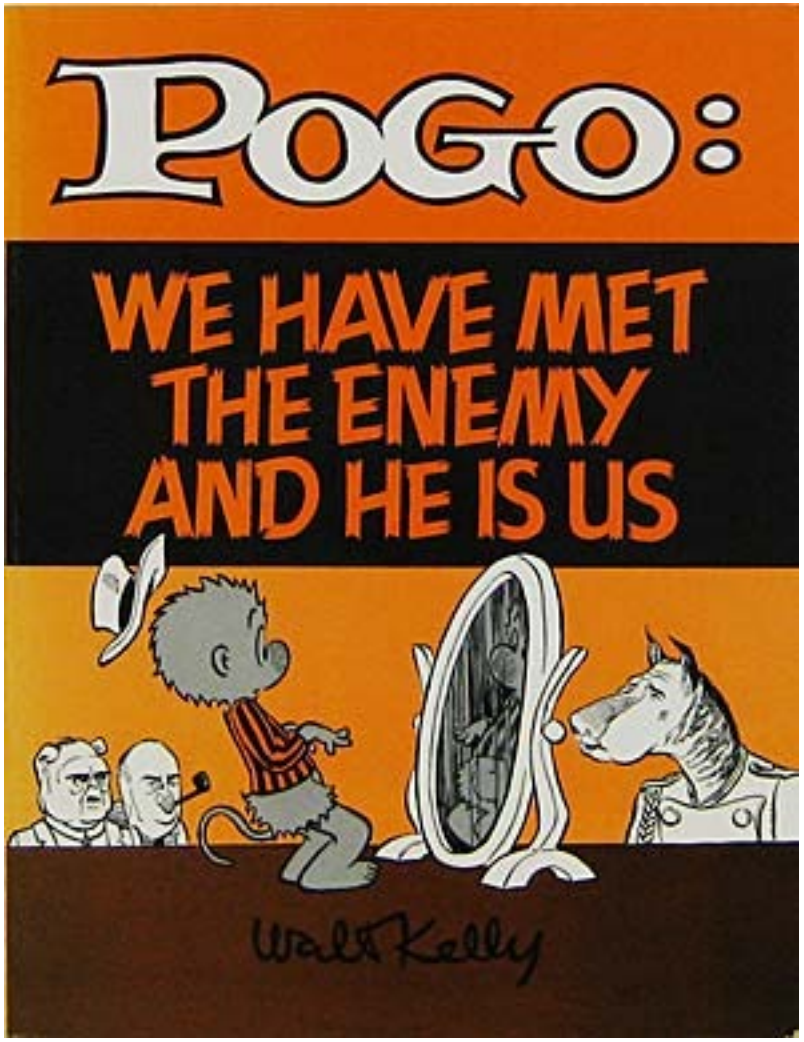
The System We Have

If we were to do it again, would we design it the same way?

What Has Perpetuated the Paradigm Freeze?

- Public opinion
- Civil society groups
- Government-Physician Relations
- Federalism

Who is to Blame?

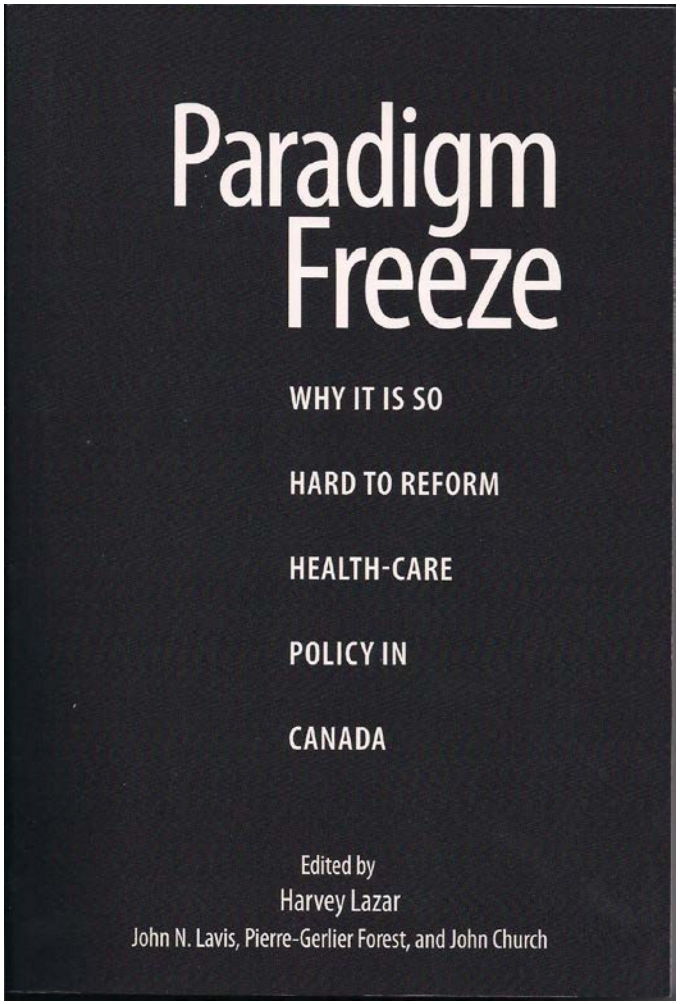


Policy Inaction

Policy Status Quo Is Not Neutral

Meeting the Challenges of the Future?

- What the future holds?
- Government leadership
- Effective institution building
- Transparency in government-physician relations



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