# Health Care Reform Opportunities and Barriers

## New Evidence From a Recent Period

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# The Research Team: Matrix Management

## *Central Coordination:*

- Queen's School of Policy Studies: Lazar (PI), Aaron Holdway
- Forest (Trudeau Foundation)
- John Lavis (McMaster)

## *Issue Coordination*

Regionalization: Tomblin

Needs-based Funding: McIntosh

APP: Church

For-Profit: Gildner (McMaster)

Wait Times: Sanmartin (STC)

Drugs: Pomey

## *Provincial Coordinators*

- NL: Tomblin (Memorial)
- PQ: Pomey (U de M)
- ON: Lavis (McMaster)
- SK: McIntosh (Regina)
- AB: Church (Alberta)

# Project Funding

- Canadian Institutes for Health Research
- Health Canada
- Together provided 2/3 of $ requirements

# The Big Policy Question

- Why is it so hard to reform health care in Canada?
- A simple question but little systematic research to answer it
- This a **preliminary** report of a multi-site project intended to shed light on this question
- Assumption: it is hard to reform health care

# Status of Project

- Research 98% plus done
- Analyzing data
- This is a preliminary report

# Research Methodology

- Chose specific period of time: 1990-2003
- Purposively selected case studies that were:
  - Substantial reform issues in their own right
  - Representative of the big policy question
  - Subjected to a common set of questions
  - In a representative number of provinces (NL, QC, ON, SK, AB)

# Issues Selected

- Regionalization (governance arrangement)
- Needs-based Funding for Hospitals (financing arrangement)
- Alternative Payment Plans for Physicians (financing arrangement)
- For-Profit Delivery (delivery arrangement)
- Wait Times (delivery arrangement)
- Drug Coverage (insurance coverage)

# Specific Research Questions

1. What kind and how much reform did occur during the assessment period as reflected in new law/policy?
2. How do we explain the Five-Province Result?
3. How do we explain the differences among provinces?

- Other research questions beyond scope of presentation.

# Question 1: What kind and how much policy reform occurred:1990-2002/03

- First methodological question: how to measure nature and extent of policy reform? Reference point?
- Decided that the consensus of the grey literature from the mid-1980s through 2002/03 would serve as the basis for determining the “ideal” kind of reform and “ideal” maximum
- Reviewed grey literature focusing mainly on broad reports (not single issue reports)

# Determining Nature and Extent of Reform

- Determined the grey literature consensus for each of the 6 issues
- The consensus is called “comprehensive reform”
- For the 6 issues, “comprehensive” is defined (based on 2 to 5 elements)
- To the extent that policy reform fell short of comprehensive, report defines three other levels of reform:
  - Significant
  - Moderate
  - Limited

# Determining Nature and Extent of Reform(2)

- By and large the grey literature supported the existing health care model and focused on ways to improve its performance (incentive structure, coordination, access) or broaden its coverage (drugs, home care, etc.)
- But some provincial governments wanted to move in a different direction than grey literature
- These alternative directions are referred to as “counter-consensus” reforms

# Determining Nature and Extent of Reform(3)

- By using grey literature consensus as reference point, the team is **not imposing its normative view** of what should have been
- Nor is it saying that the grey literature consensus position was the “right” one
- But these reports are well researched and a consensus of them is a reasonable standard against which to compare actual results
- We are aware the world has moved on - that some consensus positions of earlier period not today’s consensus

# Extent and Nature of Provincial Policy Reforms Relative to Grey Literature Standards 1990-Early 2000s

| | Regionaliza-tion | Needs-based funding | Alternative payment plans | For-profit delivery | Wait list manage-ment | Prescription drug coverage |
|---|---|---|---|---|---|---|
| **Newfoundland & Labrador** | Moderate | None | None | Limited | None | None |
| **Quebec** | Counter-consensus Limited | Limited | Limited | None | Limited | Comprehensive |
| **Ontario** | None | None | Moderate | Counter-consensus Moderate | Moderate | Moderate |
| **Saskatchewan** | Significant | Significant | Limited | Significant | Significant | Counter-consensus Limited |
| **Alberta** | Significant | Significant | Limited | Counter-consensus Limited | Limited | Limited |

# Key Results

- Most policy reforms were directionally consistent with grey literature consensus - only 4 of 30 in opposite direction
- 18 of 30 “limited”, “counter-consensus limited” or “none” - in brief relatively little reform
- NL an outlier: did much less reform than others
- SK: 4 of 6 issues involved “significant” reform
- AB and QC: lots of process and reports but two-thirds of cases involved “limited’ reform or none
- Drug reform in QC and regionalization/needs-based funding in AB exceptions to pattern in those two provinces
- ON: Pragmatic, harder to summarize, the “tortoise” (?)

# Question 2: How to Explain The Five-Province Result

- Remember 5-province result taken as proxy for extent of Canada-wide health policy reform
- Same method followed by all researchers
- Search of public documents plus interviews
- Interviews included usual ethical guidelines
- Roughly 8-10 interviews per case (?)
- Questions combined open-ended and probes
- Common coding framework

# Theoretical Framework

- Three stages of decision process
  1. How issue got on government agenda (radar screen)
  2. What caused government to conclude it had to make a decision
  3. Policy Choice

- Stages 1 and 2 were analyzed in terms of problems, politics, and policies

- Stage 3: Ideas, interests, institutions, external factors (3Is and E)

- Results reported in way that combines the 3 stages but much of focus is on 3 Is and E

# Examples of Independent Variables

- **Ideas**: values (what should be); knowledge (what is)
- **Interests**: provider groups (like OHA, OMA, unions); Ministry of Health officials; societal groups etc
- **Institutions**: legal framework (provincial and federal); policy legacies (core bargains); policy networks etc
- **External Factors**: election timing; change of government; economic crisis; technological change
- Also: **problems** that won't go away; **media**
- Over 30 independent variables were found to be *very important or important in* explaining outcomes in 30 cases (coincidence that number 30 arises twice)

# Grouping Variables into Categories

- Most of the 30-odd variables were grouped into categories (excluded those appeared in only a few cases)
- Ended up with 4 primary categories of explanatory variables and 4 secondary
- Primary categories were ones in which *very important* explanatory variables occurred most frequently (bracketed numbers in next table)
- Categories interact with one another (?)

# Number of Times Primary and Secondary Categories of Independent Variables Having an Important/Very Important Influence Reform Decisions in 30 Cases in 1990-2002/2003 Period: Five-Province Roll-Up

| Categories of Independent Variables | Pro-Reform | Middle Territory | Anti-Reform | Counter-consensus Reform | Total |
|---|---|---|---|---|---|
| ***Primary Variables*** | | | | | |
| **Ideas- Political Values and Ideas** | 30 (14) | 1 | 2 | 4 (3) | 37 (17) |
| **Interests-Insider Group Politics** | 33 (2) | 19 (8) | 19 (4) | 3 | 74 (14) |
| **External- Elections and Political Leadership/Change** | 22 (9) | 4 | 9 (2) | 8 (5) | 43 (16) |
| **External- Fiscal Conditions** | 10 (4) | 1 | 11 (6) | 2 (1) | 24 (11) |
| ***Secondary Variables*** | | | | | |
| **Institutions** | 22 (1) | 9 | 4 (1) | 1 | 36 (2) |
| **Ideas- Knowledge** | 27 (2) | 7 (2) | 2 | | 36 (4) |
| **Interests- Civil Society** | 12 (2) | 1 | 3 | 1 | 17 (2) |
| **Institutions- Federal government/federal-provincial relations** | 16 | - | - | - | 16 |
| **Total** | 172 (34) | 42 (10) | 48 (13) | 19 (9) | 281 (66) |

# Extracting the Messages

- This table has a lot of information - many pages of write-up to explain its derivation
- Too much to cover in allotted time
- Except to note that pro-reform influences constituted > 3/5$^{th}$ of total which is consistent with previous table showing that 2/3$^{rd}$ of cases were consistent with grey literature direction
- Again, it is frequency of the second number in each cell that mainly explains distinction between primary and secondary

# Extracting the Messages (2)

Of 4 principal categories, two

- Endogenous
  - Political Values and Ideas
  - Insider Group Politics
- Exogenous
  - Elections, Political Leadership/ Change
  - Fiscal Conditions

# Extracting the Messages (3)

## Endogenous: Political Value and Ideas

- Medicare legacy **an all pervasive** impact
- More reactive than proactive
- Protective of the status quo
- Legacy challenged by Neo-Liberalism* but only tepidly

* Neo-liberalsim involves less regulation, more competition and more choice for consumers.

# Extracting the Messages (4)

**Endogenous: Insider Group Politics**

- Unique power of medical profession where autonomy/compensation potentially affected
- Hospital associations less influence than docs but more than other provider groups
- Ministry officials often played constructive ‘behind the scenes’ role in facilitating pragmatic change within framework of medicare legacy
- Individual physicians/hospitals also ‘behind scenes’ roles
- On balance insiders *more reactive than proactive* (resist, moderate, negotiate but not originate) (?)

# Extracting the Messages (5)

**Exogenous: Elections, Political Leadership and Political Change**

- The broad design of democratic politics affords *regular* opportunities to challenge status quo: proactive category

- Findings
  - Changes in political leadership, whether due to a general election or the election of a new leader within a governing party, are positively associated with health reform;
  - This association is most significant when the new leadership takes office with a strategic plan for health reform or, alternatively, a strategic plan with consequences for health reform; and
  - There are political champions within the government that are determined to advance the reforms.

- The ideas that are the feedstock for these politically managed reform agendas come from other categories (knowledge, values, insider groups)

# Extracting the Messages (6)

## Endogenous: Fiscal Condition

- Fiscal conditions **dominated politics** for half the period we covered and its shadow lasted until end of period

- Findings
  - Had some positive effects on reform. Some governments decided that certain reforms would simultaneously improve health systems and help with deficit reduction by improving incentives, efficiencies, and services (regionalization, needs-based hospital funding, APP)
  - Had some negative effects. Same issues seen through different prism led to concern would harm fiscal agenda (e.g., Rae vs. Romanow governments)
  - Negative also in sense that worked against wider universal coverage

# High Level Messages

- Exogenous factors main originators of reform.
  - Democratic politics provided mechanism via **regular** elections, leadership turnover, which created change opportunities
  - Crises (mainly fiscal) provided **irregular** (hard to anticipate) opportunities for reform

- Endogenous factors (e.g., problems in current programs) also put items on reform agenda but endogenous served mainly to moderate reform pressures

- Substance of reform based on link between such variables as knowledge and values and the political world with insider groups or less often other societal groups as intermediating variables

- Again, unique power of medical profession to influence outcomes that touched on its 'core bargain' with state

# Question 3: How Do We Explain the Differences among Provinces?

- **Saskatchewan -** most reform
  - Exogenous influences
    - Government came to office with health reform a priority
    - It had a vision and plan
    - Political champions to push plan
    - Fiscal crisis led to plan adjustments (positive and negative)
    - Very weak political opposition
  - Endogenous influences
    - Medicare legacy
    - Strong partnership with Public Service
    - Access to expertise internally and outsiders brought in
    - Absence of objection from insider groups at first

# Differences Among Provinces (2)

- **Newfoundland and Labrador** - least reform
  - Exogenous Influences
    - Closing of cod fishery, economic development, and fiscal crisis dominant
    - No overarching plan for health
    - To extent that there were political champions, they were anti-reform
  - Endogenous Influences
    - Medical profession resisted reform in cases that touched its autonomy
    - Although hospital association pressed for needs-based funding government preferred to keep power at centre
    - Lack of internal technical expertise and outsiders not much used

# Differences Among Provinces (3)

- **Alberta -** second most reform
  - Exogenous Influences
    - Dominance of fiscal issue (oil price drop)
    - Led to change in party leadership/election results confirmed fiscal priority
    - Due to magnitude of health spending, health reform emerged to make fiscal plan viable
    - Political champion
    - Counter-consensus ideas (Neo-liberalism)
  - Endogenous Influences
    - Role of backbench committees as influential intermediating variable
    - PS support for potential efficiencies despite hostility from political level
    - Influence of AMA in protecting autonomy of profession
    - Power of medicare legacy and federal government support (vs. NPM)

# Differences Among Provinces (4)

- **Quebec** - much gridlock and one big bang
  - Exogenous Influences
    - Quebec politics highly competitive: election results in 1993 (PQ) and 2002 (QLP)
    - With both health and fiscal issues sensitive in Quebec politics
    - No overarching plan for reform but intense right/left politics kept pot boiling
    - Comprehensive reform in drugs affected by politics of sovereignty
  - Endogenous Influences
    - Corporatist style of governance with many voices both from within health system and civil society
    - Practice of commissioning reports and more reports to buy time for controversial decisions
    - Medical and hospital associations work to moderate/resist reform ideas that affected their autonomy

# Differences Among Provinces (5)

- **Ontario -** Tortoise (?)
  - Exogenous
    - Fiscal crisis during Rae period and shadow lasted beyond
    - Absence of overarching vision for health (Rae, Harris/Eves)
    - Absence of champions on some cases, presence in others
    - Competitive politics (4 changes in political stripe)
  - Endogenous
    - Public pay/private delivery system deeply entrenched (medicare legacy) within well defined boundaries
    - Joint management committee that involves physicians in policy making
    - Powerful OMA able to shape cases affecting physician autonomy
    - Varying OHA influence in some cases (regionalization, funding, for-profit)
    - Many changes at DM level in health ministry
    - (Then) limited interaction between research community and ministry
    - Pragmatic style of working problems one at a time

# Analysis Continuing

- Still reviewing and comparing
- Feedback welcome
- Thank you

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