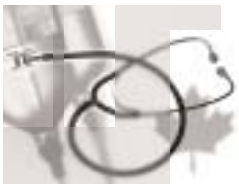
HOW (NOT) TO LOOK AT PROPOSALS TO REFORM CANADIAN HEALTH CARE



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Before seeking to adopt programs or policies from other industrialize countries, Canada has to carefully look at the differences or similarities in culture, history and approach to medical care. But we can adapt our system using other models in sectors like home care. The author cautions against inflated rhetoric raising expectations and urges reformers to be pragmatic because reform is likely to take place only at the margins, and those changes are more likely to be initiated by stakeholders rather than government.

Avant d'envisager l'adoption de politiques et de programmes de soins de santé issus d'autres pays industrialisés, le Canada doit en examiner soigneusement les différences et les similarités en matière de culture, d'historique et d'approche générale. Nous pouvons cependant adapter notre système en nous inspirant de ce que fait l'Europe dans certains secteurs comme les soins à domicile. Mais il faut avant tout éviter les abus rhétoriques et les attentes excessives. Et faire en sorte que les réformateurs se montrent pragmatiques, car les changements toucheront vraisemblablement les aspects secondaires du système et seront l'initiative des parties prenantes plutôt que des gouvernements.

What is the best public-private model for Canadian health care? This question has been central in much of the health reform debates of the 1990s and early 2000s. There has been ample media coverage of critical shortcomings and crises in health care, and recent expert committees claim that the Canadian health-care system is in need of a complete overhaul in order to safeguard the sustainability of the system. Still others conclude that, while adjustments are necessary, the current system is *not* on the brink of collapse.

The answer to the question requires a careful analysis of the underlying assumptions, evidence to support certain claims and an ability to draw inferences from evidence about experiences elsewhere. However, it is not easy to draw lessons from mere descriptions of cross-border experiences. What amounts to the best solution in one jurisdiction may be politically or socially unacceptable in another.

In assessing some of the health reform proposals of the last decade, this article warns against simplistic pleas for wholesale substitution of the current model and frames seven principles as guidance for assessing claims in the reform debate. It also warns against the use of jargon, misleading "persuasive definitions" and easy assumptions about the transferability of ideas or social programs. It concludes that Canada *can* learn from policy experiences abroad as well as from its experience at home.

Most OECD countries subscribe to one set of principles regarding health policies: universal and equal (or fair) access to good-quality services; consumer satisfaction and consumer choice; provider autonomy and, as the bulk of health care is publicly funded, cost control. They also see health promotion and consumer protection as major policy goals. But actual arrangements for funding, contracting and governance vary widely. The modern welfare states have long histories of unique institutional development embedded in their cultures. There is no "final model" of the welfare state, but rather a collection of commonly accepted basic principles. The variety in historical development, institutions and culture reflects in the mix of public and private funding, provision and governance of health care.

Canada's country-specific factors include federal-provincial relations, regional variations and increasingly diverse populations. Dominant cultural orientation includes elements of both rugged individualism (with frugal arrangements of income support for disabled and unemployed workers) and strong support for universal health-care entitlements and acceptance of public governance. Federal and provincial taxation is the main funding source for health care, while provision and management are mostly in hands of private not-for-profit organizations.

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Western European countries have a centuries-long tradition of non-governmental actors participating in the funding and provision of social services. This tradition has shaped the neo-corporatist model in which governments and stakeholder representatives share responsibility for shaping and implementing social policies. A societal middlefield of non-governmental organizations represents large segments of the population. As a "young" country, Canada is not party to this tradition even while non-governmental agencies play an important role in providing social services. Lacking venues for systematic stakeholder involvement in social policies, governments and advisory commissions seek to achieve a delicate balance of gender and minority representation through extensive public consultations and community involvement in the shaping and implementation of social policies, often on an ad hoc basis. In fact, it could be argued that Canada is creating its own home-grown brand of neo-corporatism. Quebec clearly has kept some of the European traditions, though other provinces are less familiar with neo-corporatist policy-making.

In the 1970s and 1980s, the health-care systems of the OECD faced the mounting pressure of increased demand under fiscal strain. Several countries initiated debate about the future of the welfare state, including their health-care systems. This debate showed convergence in health reform rhetoric, but there was little convergence in the basic funding and contracting features of health-care systems.

Reform debates are often framed in general terms of values and principles—the general principles of Canada health Act, for example—but they pay less attention to the question of how to make principles translate into policy measures, or how such measures affect decision-making powers and risks for stakeholders involved. Nor do they pay much attention to the experiences of other jurisdictions.

There is no way to define a "best model," as the efficacy of any given model depends on the institutional context of policy-making. For example, the way governments interact with organized stakeholders varies from country to country. While their funding models diverge, in both France and the United Kingdom the central government plays the dominant role. Both Canada and Germany seek to involve a variety of stakeholders in the shaping and decentralized implementation of health policies, but in different ways. Germany's neo-corporatist model is based on systematic involvement of stakeholder organizations in social policy. Lacking that tradition, Canada is attempting to develop alternative ways to channel and represent the interests of consumers and other stakeholders.

The assessment of the feasibility and acceptability of certain policy proposals requires a systematic review of the experiences of other jurisdiction (and our own experience) and the policy context, including the institutional legacy and position of stakeholders and public support.

Like other industrialized nations, Canada has been under mounting pressure to address health care as part of social expenditures. Efforts to rein in federal spending included a freeze on federal transfers and provincial efforts to delist certain services and restructure the organization of health care. In contrast to other OECD countries, Canada has had little discussion of alternatives to the basic funding model of medicare. In the last decade, several federal and provincial expert groups and commissions have contributed to the growing pile of reports on the future of Canada's health-care system.

As in other OECD countries, reform proposals that shift decision-making powers and affect the positions—and incomes—of stakeholders met with resistance from the public and from health professionals. There is pressure to devolve authority and further decentralize health-care governance. In fact, decentralization and integration are central themes of many reform debates. At the same time, there is pressure to centralize and strengthen government control, for example, in the monitoring of outcomes and the publicizing of health-care services. Interestingly, some reports proposed the expansion of medicare with universal entitlements of home care and pharmaceutical care, two types of health-care services commonly covered by social insurance elsewhere. But in Canada, as in other OECD countries, despite much discussion, the basic contracting model—public funding and private provision of health care—has changed little.

Roughly speaking, the many reports represent two schools of thought on health reform. First, the Health Forum and the report of the Tommy Douglas Institute represent the school of incrementalism, advocating incremental improvements to the existing system. This approach includes increased levels of (public) health spending and improved efficiency of existing services in order to address demographic pressures and technological innovations. A second school of thought claims that the current health-care system is unsustainable and in need of fundamental restructuring, and advocates a shift from

public to private funding and contracting, and a shift from collective arrangements to greater individual choice and individual risk. This school also attaches greater importance to competition and market-like mechanisms (although it does not suggest that the existing medicare scheme be fully replaced). Interestingly, the two schools seem to adhere, for different reasons, to the "health paradigm" of the 1970s and 1980s.

The 1997 report of the Health Forum points to the urgent need for increased health-care funding. It begins by underlining the importance of the basic principles of the Canada Health Act, in particular the public administration and collective funding of health care. It advocates increased emphasis on primary care and home care and an integrated child and family strategy. It points to the need for better accountability and for evidence-based medicine and recommends the creation of a transition fund to implement such policies. The report concludes that there is no need to change the funding model but suggests that improvements be made in consumer information and transparency as well as accountability.

The Canadian Institute for Health Information (CIHI) presented its first annual report in 2000. This report contains a wealth of detail on health-care services in all provinces. All CIHI information is directly accessible in printed and electronic form, and its first two annual reports have become best-sellers. The annual report itself does not contain recommendations for health-care reform. It points to the need for comprehensive information, but in so doing it also changes the world of health care in Canada by providing its information directly to the public.

A recent report from the Institute for Research on Public Policy (IRPP) recommends improvements in the efficiency and quality of health-care services. It proposes the introduction of a patient charter (modeled on the UK model) and increased accountability of health-care governance. It also advocates more privatization and competition within the publicly funded system but stops short of proposing a shift from public to private funding. With the accountability recommendation, this report takes on one of the issues raised by the Health Forum.

The Clair Commission of Quebec consulted extensively with experts, stakeholders and the general public in order to assess the need for reform in the funding and organization of health care in Quebec. It concludes that the system needs a new sense of purpose and advocates revolutions in the funding and delivery of care. It suggests that the only way to address current problems and the "demographic time bomb" of an aging population is to strengthen the role of Quebec's network of community health centres (CLSCs) in the provision of psychosocial and medical services. The commission supports a shift from hospital-based to community-based care through replacement of the solo practice model with groups of general practitioners in order to offer 24-hour access to primary care. The report calls for a renewed emphasis on health promotion and disease prevention.

The Ontario Health Restructuring Commission, headed by Duncan Sinclair, came to similar conclusions. It advocated a two-step approach: first, restructure the province's hospitals by closing the smallest facilities, and regroup specialist functions in larger centres; second, strengthen primary care and integrate services. Interestingly, this commission was mandated to implement its recommended changes.

The Tommy Douglas Institute has taken a more modest and more pragmatic view, recommending a systematic cross-country comparison. Its report shies away from calling for a systematic overhaul of the health-care system. It observes that, in general, Canadians are satisfied with the services they are receiving. However, the report refers to a "crisis in public confidence" and concludes that while the basic structure of medicare is solid, adjustments are needed.

In December 2001, the Advisory Council on Health, chaired by the Hon. Don Mazankowski, presented its report on the future of Alberta's health care. It argued that the system is not sustainable "unless we are prepared to make major changes." The report mentioned problems in health care: rising costs, problems with access and waiting times, shortages of providers, organizational flaws, and too little competition and consumer choice. It advocated new ways of funding health care, giving health authorities more room to negotiate with (competing) health-care providers, and emphasized that patients themselves bear the primary responsibility for their health.

The report of the Saskatchewan Commission on Medicare concludes that "all parties have underestimated the fragility of medicare." It recommends integration of the province's health-care services and reorganization of hospital care by concentrating specialized medical services in three large hospitals and shifting some nursing and rehabilitation activities to community-care centres. The report advocates the creation of an autonomous

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"quality council" for monitoring health care and the promotion of evidence-based medicine. Further, it proposes the creation of "primary health services networks" and of "primary health teams" comprising providers (including family physicians), health district staff, emergency services and pharmacies. Other recommendations include a renewed focus on health promotion and quality of services, strengthening of governance, and increased attention to accountability, education, research and information technology, as well as "structured dialogue" on the future of medicare. However, like some of the reports discussed above, the Fyke report is short on detail.

It is time to pause and think about how to evaluate calls for change in the governance of Canada's health care.

In 2000, a Senate commission headed by Senator Michael Kirby began a two-year review of health care, including the experiences of other countries. The fourth volume of the committee maps out a wide range of issues and options without taking a position. Its final report was published in late October 2002.

In early 2001, a federal commission headed by the former premier of Saskatchewan, Roy Romanow, was formed "to examine the state of health care in Canada including the benefits and negatives of the current system." The Romanow Commission's interim report appeared in early 2002 and contains a wide range of issues and general questions that Romanow wants to discuss with "the Canadian people" in a number of public hearings during the year before finalizing the report. Its findings are to be published in late November 2002.

Finally, a number of recent studies support the idea of extending medicare coverage to home care and drugs. One of the documents from a national conference on home care sponsored by Health Canada proposes a national program with national guiding principles and a nationally defined "basket of goods." Another supports the need for a national approach but rejects the system of federal funding.

The above reform proposals contain some common elements. Most appeal to the underlying principles of medicare framed in the Canada Health Act. At the same time, they pay little or no attention to the question of how such principles might translate into actual policies or governance models. The reports are rife with jargon and "persuasive definitions," terms that express a certain ambition but do not provide an actual description. For example, in discussing options for "integrated health systems"—itself an aspirational definition —the Canadian Health Services Research Foundation defines good governance as "a state of affairs where meaningful participation fosters continued engagement and even joint responsibility on the part of every constituency, in each stage of the policy process, from decision-making to implementation, from monitoring to revision." Other examples are "good governance," "primary care-led reform," "integrated services" and "community-based services." Such definitions express aspirations but do not describe the basic characteristics of the governance model that will lead to the desired outcome.

It is time to pause and think about how to evaluate calls for change in the governance of Canada's health care. Such an evaluation could be guided by seven principles:

1. Beware of inflated rhetoric. Media coverage of "health-care crises" and public outcry about waiting lists can fuel calls for fundamental reform, but widely spread perceptions of problems may not properly represent the extent of real problems.

2. Beware of "aspirational definitions" (or "persuasive definitions"). Such terms can be confusing (actors attach different meanings to them) and misleading (they raise undue expectations).

3. Invoking universally accepted principles such as those contained in the *Canada Health Act* neither helps to frame the steps necessary to improve the health-care system nor explains the actual changes facing stakeholders in terms of decision-making power, financial risks or contractual relations.

4. Assessment should begin with what is likely *not to change* in the near future. For example, hospitals are likely not to disappear within the next one or two decades, and physicians are likely not to lose their dominant position in health policies. International experience shows that funding models are resilient to change. Most changes occur at the margin of the system, leaving intact its basic model of funding and contracting health-care services.

5. There is no blank slate for policy design. Social policies are imbedded in the reality of their institutional heritage. OECD countries show great similarity in the basic principles of their health-care systems but major divergence in organizational, institutional and cultural features. As the efficacy of policies depends on such country-specific context, there is no universally applicable "best model" of health-care funding, contracting and governance.

6. The observation that current systems will not undergo fundamental change does not exclude the need for careful analysis of elements that are generally lacking or problems that require major adjustments.

7. Change is initiated not by governments but through external pressure from stakeholders and organizational changes that force public systems to adjust. Given such pressure, the pathways to such adjustment may deviate substantially from stated policies or intended change.

These seven points entail a good degree of pragmatism. In addressing the pressure for change, they are more helpful than generalized claims that the health-care system will go broke without wholesale reform. The points are especially relevant to some of the core issues in the current Canadian health reform debate. The experiences abroad as well as Canada's own provincial experiences can help to assess a range of feasible solutions for certain issues. For example, the assessment of proposals to expand medicare with home care and pharmaceutical entitlements can start with a study of the arrangements in other industrialized nations as well as the current situation in Canada. Next, such a study should focus on the nature and current provision of the services, the political support for certain options and the positions of the main stakeholders.

Home care is a typical local service related to other community services. Provinces in Canada have already developed home-care services as part of extended health care and social support. Pharmaceutical policy, in contrast, requires a larger scale of operations. The pharmaceutical industry is very international, and European countries are working together closely in developing criteria for market access as they realize there is a need for a larger scale of operation than the national field. Similarly, Australia has a national drugs policy for admitting new drugs to the national formulary. Those experiences suggest that Canada should look at federal arrangements to avoid duplication of effort at the provincial level. In both cases, proposals to reform — or perhaps rather to improve — the Canadian health-care system will lead to success only when they take into account the existing institutional legacies and the positions of the main stakeholders when assessing what scope of options is feasible.

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