Creating Strategic Change In Canadian Healthcare

CONFERENCE WHITE PAPER WORKING DRAFTS

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On May 15th and 16th, 2014, parties interested in Canadian health policy reform will gather in Toronto for *Creating Strategic Change in Canadian Healthcare,* the second of a series of three conferences organized by Queen's University. This second conference should be informed by some clear directions coming out of the first gathering, *Toward a Canadian Healthcare Strategy,* in June 2013. The momentum should be continued toward the goal of contributing to the conditions that will encourage positive reforms across Canada.

Principles, priorities, and reform obstacles identified at the June 2013 conference

The participants of the first conference identified the following guiding principles for a Canadian healthcare strategy:

1. Clear standards for health outcomes and system performance
2. A feasible model of affordability
3. A focus on effectiveness and efficiency of care, including revised funding models
4. Patient-centred care, involving patients as partners in the development of goals/objectives, and providing patient access to medical records
5. A common vision/narrative that engages all providers and respects local preferences

From those guiding principles, the following priorities – here reordered with outcomes first, followed by inputs – were identified for reform:

1. A national pharmacare program
2. Better integrated care across the sectors – hospital, community, primary care, specialty, homecare, social welfare (particular attention was paid to integration of services under the "community/home care" umbrella)
3. Primary care reform with strengthened community care (i.e., home, home equivalent, clustered models)
4. Healthcare governance reform. Potential strategies include: implementing cross-party political leadership to set goals that reflect the priorities of the population; moving responsibility away from the political realm towards a stakeholder-based model; establishing a national arm's-length council with the authority to develop and manage accountability and outcomes
5. Nationally integrated electronic health records
6. Increased investments in health information technology, communications improvement, smart systems provision, clinical coordination, and system analysis

Conference participants felt insufficient progress had been made on the reform agenda to date and identified the following major obstacles:

1. Lack of political will and political inertia. Health decisions are politically driven and dependent on the four-year cycles of re-election. Lack of strong leadership and decisiveness. (In other words, fear of getting it wrong and paying a political price)
2. The federal/provincial divide. Governance and decision-making are not unified
3. The public is missing in the conversation
4. We lack a national, empowered and independent health policy body

At considerable risk of over-simplifying, I propose that the highest-level summary of the deliberations from the June 2013 conference is that the path of health policy reform is clear, but politics impedes progress. One can lament the political

obstacles, but they are not going to go away. Although the circumstances differ, the problems being encountered by the U.S. Administration over "Obamacare" are going to make any government more likely to shy away from major health reform. So it is best to strategize on how policy and politics can be bridged to move the reform agenda more decisively forward. Removing the first, second, and fourth major obstacles identified above is to a considerable degree beyond the reach of those outside of government and politics. But the third, engaging the public in the conversation, is well within the reach of conference participants and thus should constitute a major component of the strategy to speed up reform in healthcare. Furthermore, those outside of government and politics can play a role in creating the conditions to bolster the political will to act. This is a primary focus of this paper.

Strong federal leadership not in the cards at this time

Many of the participants of the first conference expressed a desire to see strong, federal leadership in health policy reform. Undoubtedly this would address some of the identified principles (e.g., the feasibility of setting national standards and having some common elements in the "vision/narrative" around which there could be local differentiation) and some obstacles (e.g., the federal/provincial divide and impediments to the creation of a national empowered and independent health policy body). Circumstances change over time at the federal level and such federal leadership on health may someday be feasible, but the current government has made it very clear it is not interested in playing such a leadership role on this file. So participants of the second Queen's health policy conference would be advised to spend some time thinking about how the yardsticks can be moved toward the reform goals without a strong federal presence in the process.

A national perspective on health matters could be exercised by the provinces acting in collaboration, possibly without a strong federal presence. A potential model is through the Council of the Federation, which has been pursuing a health strategy initiative for several years. However, over for the foreseeable future, this is no more likely to strongly support the policy objectives identified at the June 2013 Queen's conference than is federal leadership. To date, little has been accomplished on health reform by the Council of the Federation, and under their organizational structure this shouldn't be expected to change. The political leadership of the initiative seems to change every few years, and the effort is not supported by a permanent Secretariat with the resources and stature necessary to convert statements into action.

Realistically, over the next several years, health policy reform will for the most part have to proceed with individual provinces. This may not be ideal, but it need not be a showstopper. It could, in fact, work quite well. After all, the current medicare system began in Saskatchewan and was subsequently adopted across the country. Many more specific policy changes have begun in one province and then spread. The Council of the Federation's recent move to pay lower prices for generic drugs, which followed Ontario's lead, is an example. The Canadian system of federation affords the opportunity for experimentation in policy, along with the capacity for other provinces to import what seems to work well. If the "system" in any province demonstrates a way of achieving improvements in the effectiveness and efficiency of healthcare at minimum political cost, the probability of those changes being emulated throughout the country is reasonably high, although the record of the provinces' provision of comparable pharmaceutical insurance is not reassuring.

Nonetheless, the likely absence of either federal or cross-province leadership does pose challenges to the reform scenario envisioned by the participants of the 2013 conference. On the process or input side, the common "vision/narrative" will be harder to generate. We are not likely to see a national empowered and independent health policy body, and nationally integrated electronic health records will face additional challenges. On the outcome side, any national pharmacare program will most likely have to follow the procedure of starting at the provincial level and then spreading. Clearly this will take more time.

Impediments to the "political will" to act boldly on health policy reform

Rather than devoting much time to lamenting the lack of federal or cross-provincial leadership on health reform, it is best to diagnose the current situation and devise the most appropriate strategies for moving forward. A starting point is to ponder why more effective reform has not already been achieved. A background paper by Steven Lewis (2013) to the first conference demonstrated that governments have at least been discussing, and in many cases, acting upon key elements of the reforms stakeholders advocate. So why haven't they gone further? The conference participants identified the federal/provincial divide and the lack of a national empowered and independent health policy body as reasons. It is argued here that these circumstances will not likely change over the next few years and that we are best to get over it and move on. That leaves the other identified obstacles: the lack of political will and political inertia and the absence of public involvement in the conversation. The remainder of this paper will be devoted to ideas for addressing these obstacles.

Joey Smallwood, first and longtime Premier of Newfoundland, is commonly purported to have said that he had never had a conversation about healthcare that didn't cost him votes. It is a poignant statement that powerfully connects two of the reform obstacles identified in June 2013. Politicians lack the will to take on health reform because they are afraid the public won't back them. Health is likely the most politically sensitive policy issue, ranking number one in almost every poll of Canadians' interests and concerns. And the fact that Canadians are for the most part quite satisfied and even proud of their healthcare system is frankly a nightmare for a reform-minded politician. A speech beginning with "I am here to tell you how I will fix your healthcare system" is likely to be met at

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best with confusion, and at worst with outright hostility. Search parties would be launched immediately to seek the hidden agenda (with suspicion likely cast on the matter being a public cost-cutting exercise).

Canadians do not think our health system is expensive because all they hear is that it costs much less than its American counterpart (instead, for example, of focusing on it being the second most expensive system among all developed countries). They think the quality is high because the benchmark is the almost fifty million Americans without health insurance. Yet international surveys do not rank Canadian healthcare highly. For example, in a comparison of Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States, the Commonwealth Fund ranked Canada sixth overall. On quality of care, Canada was ranked seventh, or dead, last. Canada also ranked last on the timeliness of care (Davis et al., 2010). As Canadians do not think our system is expensive and as they believe outcomes are reasonable, by definition they feel the system is efficient. Again, it is relative to that in the United States, but Canada fares badly in international comparisons of efficiency – a 2010 OECD report, for example, found that Canada spends thirty percent more on public healthcare than would be required under an efficient OECD benchmark (Organisation for Economic Co-operation and Development).

Canadians also believe we have a comprehensive publicly-funded system because more than half of US costs are in the private domain. Yet the thirty percent share of private health costs in Canada is much higher than among the rest of the developed countries, and our public coverage of pharmaceuticals and non-primary care is so low as to be almost without precedence other than in the United States. Few Canadians have likely heard of and would have difficulty relating to the finding that eight percent of Canadians responding to a 2013 Commonwealth Fund survey reported that they had not filled or had skipped dosages of prescription drugs due to cost (Health Council of Canada, 2014). As a bit of an aside, the lack of awareness of such important aspects of healthcare as Canadians not filling their prescriptions speaks to the inherent inefficiency with which information is used. The pharmaceutical information systems in place in some provinces are specifically for pharmacists and prescribing physicians to monitor the filling and re-filling of prescriptions and to report such information, providing a great opportunity for them to alert to both prescriptions not being filled and people needlessly and perhaps harmfully taking too many prescription medications (which might be issued by different physicians and filled at different pharmacies).

The Canadian public is clearly not as seized with the imperative of healthcare reform as analysts and stakeholders working in the sector. This situation must be understood and addressed before it can reasonably be hoped that politicians will lead a reform effort. At times, challenges in healthcare have seized the public's attention. In the mid-1990s, the public supported governments squeezing health budgets and in the process implementing some reforms because they endorsed the imperative of addressing ballooning fiscal deficits. This support generally waned after a few years, however, especially as there were at least perceived, if not actual, costs such as increased wait times. Over the last few years, the public has again accepted the need to squeeze health, and almost all other public spending, as deficits have once again soared. Yet in neither case was there a public buy-in for comprehensive health policy reforms. Indeed, for the most part, governments did not seek to obtain a mandate to implement such reforms, nor did they put forward plans for reform.

Conditions that foster the "political will" to act boldly

The starting point for comprehensive healthcare reform is a messy misalignment of policy needs and public understanding and support. Health is not the first policy area to confront this situation. Before returning to health specifically, it may be instructive to ponder why and how other fundamental, controversial, and politically-sensitive reforms, such as free trade, the introduction of the GST, and the 1990s reform of the Canada Pension Plan, were implemented.

The major reforms described above were extremely controversial in their day. Free trade was a major issue of contention in a federal election. There were many detractors, as there were to the GST, where the Opposition used extraordinary tactics in the Senate in an effort to block it. The public knew little about the pending problems with the CPP when governments (the federal and provincial governments are joint custodians, although the federal government took the lead on much of the reform process) began the reform process, and there was considerable pushback to higher pension contribution rates and opposition from some provinces, particularly Alberta. So great political will was required in all cases. As an observer (and to a considerable degree, a participant) in these reform initiatives, I believe they proceeded because certain critical conditions were established that gave political leaders the comfort they required to proceed. In all cases the conditions were:

1. Identification of a clear, significant problem with negative externalities beyond the community directly affected
2. A critical mass of analysis/research suggesting a course for policy reform
3. A clear sense of the objectives of reform
4. Models upon which to base policy reform, often drawing upon international experience
5. Alignment of at least some key stakeholders with the intended direction of reform and vocal supporters
6. Options to phase in reforms

The conditions did not all get created simultaneously. They were more or less put in place in the chronological order above. And they were not independent. To a considerable degree, each condition supported the creation of the following. The identification of the problem created a wave of research and support from certain groups. An understanding of the problem and initial

research led to the search for international models. External support was felt to validate the reform proposals and process. The option of phasing in reforms either by degree or by component lessened some of the perceived political apprehension. Each condition, but most critically, all of them acting together, fostered the political will to act boldly.

The biggest problem is an unclear definition of the problem

The greatest pitfall for health policy reform is likely failure on the first point – identification of a clear, significant problem. Analysts and stakeholders will say they have identified the problem(s) and that will be true; but the identification will not have been communicated in a manner that reaches and instills understanding and concern in the general public. Hence, politicians have been reluctant to act.

In recent years, the problem that has likely been most communicated to the public is rising health costs. However, this tends to be a cyclical issue, flaring up when governments hit large deficits and quelling when the path to budget balance is restored within a few years. Those who have attempted to extrapolate longer-run health costs (see, for example, Drummond, 2011; Drummond & Burleton, 2010; Dodge & Dion, 2011) have identified the likelihood of a significant problem. Under the status quo, most analyses predict health costs to rise 6–6.5 % per annum, whereas government revenues will likely only rise around 4% per annum (and in provinces with older populations and weak productivity growth it will be less than this). Budgets can only remain in balance if other spending areas (principally education, as it is the second largest program spending area for provinces) are chronically restrained and/or tax rates are raised substantially and persistently. Furthermore, ongoing restraint in spending in areas such as education will ultimately harm the health of the population because it will undermine the social determinants of health. The financial problem of rapidly rising healthcare costs is real. But again, the analysis has not reached the attention of the general public and the problem seems too far away to attract immediate attention.

On occasion, efforts have been made to grab the public's attention through charges that aging will bankrupt the healthcare system in Canada and so should be the catalyst for reform. But the data don't support the charge, so the efforts fail. Health spending is available by age. It is then a simple matter to extrapolate these data using projections of the Canadian population. This was done, for example, in a TD Economics report (Drummond & Burleton, 2010). The finding of the 2010 report was that aging would add one percentage point of growth per annum to health costs across Canada on average through 2013. This growth is a significant impact considering the overall extrapolation of costs is 6–6.5% per annum. Aging alone will not be a factor to break the system fiscally, however, as costs rise gradually by age and the aging process doesn't happen overnight. Of course, the cost of aging could be higher. The above calculation is based upon the current distribution of spending by age. If new and expensive approaches are discovered to deal with the negative effects of aging, the future cost impact will be larger than suggested by current data. Still, once the data are introduced, it is hard to sustain a drive to reform by playing only the aging card.

One could ask whether Canadian governments "let a good crisis go to waste" by not using the large deficits of the past few years to spearhead major healthcare reform initiatives. Most provinces succeeded in reining in healthcare cost growth, but few used the fiscal context to drive high profile health reforms. And as several provinces are already clearly on a path toward budget balance, the opportunity has to a large extent passed. But this is not necessarily a bad thing, as fiscal crisis proves to be a weak platform upon which to build health reform. It grabs the attention of the public and, as in the mid-1990s, can elicit at least temporary support for restraint, if not reform. However, it places the objectives of reform too decidedly in the fiscal camp as opposed to promoting the quality of care and the efficiency of its delivery.

The public might well get exercised around the inefficiency of health spending if they knew about it – they could have the same or better outcomes using a lot fewer tax dollars – but such messages are only contained in arcane reports by the OECD and others, and thus rarely reach public attention. More likely to excite public attention would be a consensus that our health outcomes are inferior relative to the money spent. But that finding is also mainly contained in reports that rarely reach the public's attention, such as those put out by the Commonwealth Fund. We are indeed fortunate in Canada that some high quality journalists write on health policy matters on a regular basis; unfortunately the readership base is quite small.

In the free trade, GST, and CPP reforms, the presiding federal government played a leading role in communicating "the problem" to the public. But in each case they had important support from other players. The business community was heavily engaged in a communications exercise on explaining the threats to competitiveness created by high tariffs and the former manufacturers' sales tax. The Chief Actuary of the CPP provided a credible, independent voice on the unsustainability of the former CPP regime. The government didn't have to work very hard to instill public concern that the CPP might not be there for retirees at some foreseeable point in the future.

Communicating the "problems" with Canadian healthcare is where we can see the potential value of the sorts of institutions recommended by the participants of the June 2013 Queen's conference – variously described as "a national arm's-length council" or "a national empowered and independent health policy body." To some degree, existing organizations such as the Canadian Institute of Health Information provide valuable information that should inform public understanding and opinion. But CIHI reports do not attract much public attention. And CIHI, and others – understandably, given the sources and mechanisms of their funding – pull a lot of punches, such as fastidiously avoiding inter-provincial comparisons of quality of care. Similarly, the six provincial health

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research institutes do work that could inform the public, but they have not been successful in communicating directly with the public. They have also not followed comprehensive and consistent plans to address health policy issues.

A message for the 2014 Queen's conference is to recognize that as obvious as the problems in the health system may be to participants, this has not been effectively communicated to the public and will not be done so by existing public bodies. An enormous responsibility and challenge falls to analysts and stakeholders to get the message out. The challenge is particularly acute because the relevant groups, whether they represent players in the healthcare system or academics such as the organizers of the Queen's conference, are used to communicating to their peers and have little experience or expertise in engaging the public.

There is typically a sequence to the public's reaction to policy revelations that might not be welcome. Initially the public recoils and does not want to embrace the problem or proposed solutions. But if the issue is communicated often enough, and there does not seem to be credible opposition, then the public becomes more accepting, perhaps even somewhat bored by the affair. That is the time for policy makers to move forward. These conditions are far from being in place for health reform.

Inside the beltway considerable analysis of health policy reform is available

A second condition found behind successful policy reforms is a critical mass of analysis/research suggesting a course for policy reform. The health field is relatively well served on this front. There is fairly tight and growing agreement among analysts and even stakeholders on the direction of appropriate reform. Some of this was reflected in the priorities for reform identified by the participants of the 2013 conference. A broader set of general policy reforms was set out in the 2012 Commission on the Reform of Ontario's Public Services, *Public Services for Ontarians: A Path to Sustainability and Excellence* (chaired by Don Drummond), and over the succeeding two years the road map seems to have met general agreement.

A schematic of the Commission's recommendations (as shown in Chapter 5 of the Commission report; Drummond, 2012) on the direction of reform is reproduced below. Similar recommendations can be found elsewhere. Of course, the schematic represents somewhat of an exaggerated sense of the divide between the current and reformed systems as in many areas some progress has already been made.

General Approach

CURRENT SYSTEM	REFORMED SYSTEM
• Intervention after a problem occurs • Acute care • Hospital-centric • Silos • Resource-intensive minority of patients in regular system • Accept socio-economic weaknesses • Extraordinary interventions at end of life	• Health promotion • Chronic care • Patient-centric • Coordination across a continuum of care • Dedicated channels for the resource-intensive minority • Address socio-economic weaknesses • Pre-agreements on end-of-life care
HOSPITALS	
• Draw patients to hospitals • Historical cost plus inflation financing • Managed through central government • Homogeneous, all trying to offer all services	• Keep patients out of hospitals • Blend of base funding and pay-by-activity • Regional management • Differentiation and specialization along with specialized clinics
LONG-TERM CARE, COMMUNITY CARE AND HOME CARE	
• Not integrated, underfunded and weight on long-term care	• Integrated with weight on home care
PHYSICIANS AND OTHER PROFESSIONALS	
• Not integrated with hospitals and other sectors • Work alone or in groups • Mostly fee-for-service funding • Few standards for medical approaches/conduct of practice • Unclear objectives and weak accountability • Inefficient allocation of responsibilities	• Integrated with primary care being the hub for most patients • Work in clinics • Blend of salary/capitation and fee-for-outcomes • Evidence-based guidelines (through quality councils) • Objectives from regional health authorities and accountability buttressed by electronic records • Allocation in accordance with respective skills and costs; and where feasible, shifting services to lower-cost care providers
PHARMACEUTICALS	
• Little cost discipline from governments • Cost of plans to private employers driven in good part by employees	• Cost discipline through purchasing power, guidelines for conduct of practice • Greater control exercised by employers

Service Delivery	
CURRENT SYSTEM	REFORMED SYSTEM
• Mostly public sector	• Blend of public and private sector (within public payer model)
INFORMATION TECHNOLOGY	
• Little used by physicians and especially across the system • Information conveyed in doctors' offices	• Extensive use that is key to coordination across system and accountability • Information more easily available and conveyed through multiple sources (phone, Internet, etc.)
MEDICAL SCHOOLS	
• No attention to system (cost) issues • Little attention to labour supply issues	• Course(s) on system issues • Role in directing physicians to areas of demand (by area of medicine and geographically)
COVERAGE OF PUBLIC PAYER MODEL	
• Hybrid with almost 100 percent primary, less than half of drugs and limited mental health	• Broader coverage widely recommended but not at all clear this will be acted upon

The policy reform process would be facilitated by individuals and institutions that could compile the various pieces of analysis and research on aspects of policy reform into a compelling, broader vision of how an effective and efficient system might work. Participants of the 2013 conference clearly wished to see a new, national body created to do this, among other things, but we should not lose sight of the existence of several bodies that could play a role. One example will be set out here. The first objective set out by the Council of the Federation health initiative upon inauguration in 2012 was the development of "clinical practice guidelines" (as with NICE in the United Kingdom) that would drive "evidence-informed care." For some reason, this no longer appears explicitly in the objectives as re-formulated at the 2013 gathering of the Council: pharmaceutical drugs, appropriateness of care, and seniors' care (Council of the Federation, 2013). But it remains a worthy endeavour of such a body. It is also surprising that the Council has not more specifically asked the six provincial health research institutes to more formally engage in identifying these clinical practical guidelines. This could address the weakness of the structure of the initiative in not having a permanent Secretariat.

Incidentally, development of protocols on clinical practice guidelines is another example of where progress could still be made despite the absence of the kind of government leadership participants of the 2013 conference called for. Much of the work on stroke, cardiac, and cancer care guidelines was initially done "in the field" and this experience could be extrapolated to other areas. Through collaborations between providers and their institutions, compelling practices could be put forward that governments would likely be interested in funding and implementing.

Clear objectives need to be established for health policy reform

The lack of clarity over the problem of the healthcare system naturally poses a difficulty in presenting a clear sense of the objectives of reform. But analysts and many stakeholders are quite clear on the objectives (as were the participants of the 2013 conference), and it is quite likely that at least internally most governments have a fairly clear idea about what they would like to do. They just have some difficulty communicating that to a public that does not share their diagnosis of the problem, and herein lies the third condition for healthcare reform.

The objectives of healthcare reform will have to be very carefully communicated to the public. Analysts and stakeholders can and should help governments with this. Indeed, this should be a primary focus of participants in the 2014 and 2015 conferences of Queen's. A "vision" piece does not need to be born uniquely within government corridors. It could be developed and articulated by bodies representing the non-government stakeholders in the health and healthcare systems. Such an outcome from the Queen's conferences could fill a vacuum and if done well could ultimately be adopted by a government or two.

Some attention must be paid to, if not lowering the cost of healthcare, then at least dampening future cost increases to some extent. It is unlikely that healthcare costs could, or even should (if health is the most important thing to people, it is natural that healthcare form a growing portion of public budgets) grow less rapidly than the overall economy (and nominal GDP growth tends to generate similar growth in overall government revenues). But it would be very difficult to sustain a gap as large as 6 to 6.5% growth per annum in healthcare costs compared to only about 4% revenue (and nominal economic) growth. Yet it would be a political disaster to lead a health reform initiative with a cost-cutting mantra. It might work temporarily when deficits are at their peak, but that moment has already passed for all Canadian governments. And the mentality of driving the reform agenda through the fiscal lens hardly had a very good track record in the 1990s, as the reforms didn't go deep enough nor were they sustained in many cases. The focus should be on improving the quality of care at an affordable price. The "quotient" of such a formula, of course, is improving efficiency.

The first guiding principle identified for reform by the participants of the 2013 conference was "clear standards for health outcomes and system performance." This is another area in which governments will have difficulty coming up with specifications on their own. Analysts and stakeholders will need to go much further in promoting and adopting ideas that could potentially be funded and adopted by governments.

Successful policy reform models provide comfort

Identification of successful policy models helps to guide the specification of policy objectives and can inform the policy reform process. It is important to

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note not only the outcomes of the reforms, but also the processes followed and the political ramifications. Were the reforms accepted politically? If there was resistance, why and how did the governments respond?

The fourth common condition for policy reform, of having models that have been tried and tested elsewhere, is available for the Canadian provinces, although not in an ideal form. There does not seem to be any jurisdiction in the world that has "perfected" the healthcare model. In its 2010 report on getting more value for money from healthcare systems, the OECD noted that "there is no health care system that performs systematically better in delivering cost-effective health care" (p. 8). In constructing its "benchmark system" against which to compare the efficiency of healthcare in each country, the OECD used bits and pieces from various countries rather than comparing to the entire system in any country. Not surprisingly, the OECD suggested that each country should adopt best policy practices from other countries as opposed to mimicking any one complete system (2010, p. 8). There are examples of parts of systems that work very well (primary care in much of continental Europe, home care in Denmark, etc.). And there is enough variation across Canadian provinces that any government can pick and choose the models that seem to work well. The first Queen's conference dedicated much attention to drawing out best international practices. This will again be a focus of the May 2014 gathering. Attention could broaden to defining interesting practices within Canada, as it may prove easier to import a practice from another province than another country.

Governments love to hear supporting voices

The fifth condition of having some key health stakeholders aligned with vocal support is coming along in Canada, but needs further work. Many organizations, including the physicians and nurses, have published thoughtful pieces on their reform ideas, but to a large extent their ideas circulate amongst their peers rather than being digested by the public. That is the major, and largely unprecedented, communications challenge for these groups. And for the most part the stakeholder groups work alone. If the public's fears of change are to be quelled, it will be helpful to have various stakeholders appearing to work together and being jointly comfortable that their suggested changes will be in the public's interest. In this regard, the coalition between the physician and nurses associations could be promising, and all the more so if the effort extends beyond the national associations to involve the provincial bodies as well. A further problem in communicating the messages of some of the stakeholders is the divide between their national and provincial bodies. The Canadian Medical Association is a good example. The national body has historically engaged with the federal government over national policy matters. The provincial bodies have largely occupied themselves with engagement with their provincial government over compensation. As argued here, however, the policy action, at least over the next several years, will be at the provincial rather than the federal level. Can the national CMA body become more relevant on provincial policy or can the provincial bodies engage more on policy?

"Big bang" reform or "stealth"

Governments take comfort in having options for the design of policy, and in particular for the nature of implementation. In almost every case of past major policy reform, there has been great internal debate over the nature of implementation. The debate has particularly focused on whether reforms should be implemented quickly and broadly or phased in by degree or sector. For example, it was decided to proceed rather quickly on all fronts in the federal government's 1995 Program Review because it was felt that hitting all sectors rather simultaneously would mitigate charges of unfairness. In contrast, the British Columbia government, having decided in 2008 on the bold move of introducing a carbon tax, started it off at a low level with legislated future increases in the rate.

In most policy areas, there is an option to roll out reform as a series of changes as opposed to a big bang approach. Each successive (and hopefully successful) change can lead to another until a comprehensive reform is in place. This notion has considerable appeal in the health space. Indeed it could be argued we are already doing this, as some action on elements of a major health reform are already being pursued by governments across the land.

Two somewhat different notions can be applied to the practice of incremental reform. First, even if the reforms are implemented in a piecemeal fashion it is useful for a government to set out an overall vision. That way people can relate each change to the whole. Even if there are some wobbles and perhaps some negative feedback to an individual reform, stakeholders and the public can see that it is part of a bigger picture that embraces commonly-held objectives. And the reform process could stay on track if the road map is laid out. As discussed above, a "vision" piece does not need to be born uniquely within government corridors, and could, indeed, be developed by participants at the Queen's healthcare reform conference series. This could fill a vacuum and if done well could ultimately be adopted by a government or two.

Second, just as in a health procedure, the reform process can be triaged. Much of what analysts and stakeholders think needs to be done can be accomplished with limited public engagement. These are internal administrative matters affecting mostly stakeholders, but not the public in a direct, or at least negative, way. Once governments set out a vision for the reformed system, they can and should proceed forthwith on the items that can be handled with limited public engagement. Health records and the way physicians and hospitals are financed are examples. Other needed reforms involve the public, but in ways that will almost certainly be positive, while yielding cost savings. An example is more effective and efficient care for the small percentage of the population that accounts for a very large percentage of overall costs. In Ontario, one percent of the population accounts for one-third of overall public health costs

(Drummond, 2012, Chapter 5). The figure is likely similar in other provinces. Naturally, healthcare spending will always be extraordinarily skewed to the very sick or those who have suffered a horrific accident. But a more efficient, integrated approach to their care would bring down the cost substantially and almost certainly improve the quality of their care. Much of the cost for the one percent is driven by an avoidable cycle of being admitted and released from hospital without appropriate support upon release.

Only a few of the recommended reforms will require full scale engagement with the public. The call from the participants of the 2013 Queen's conference for a national pharmacare program is an example of a reform that would require heavy public engagement. Many task forces and commissions have long called for this. Some provinces have introduced partial insurance schemes for pharmaceuticals, but we are no closer to a comprehensive national program than we were 50 years ago. There would also be some tough arguments to deal with. For example, taxpayer dollars would be required to support a public system. For some people, this might simply mean a shift from paying for a private system (through their employer for example) to contributing to the public one, but people might not see it this way. The fiasco with the implementation of Obamacare shows some of the potential pitfalls. Governments will thus need support from analysts and stakeholders to make the case for such a reform. But challenges over a national pharmacare program should not be an excuse to forestall other reforms that will be less politically contentious. The reform agenda does not have to proceed on all fronts simultaneously. For example, it might be determined that home care is a higher priority at this time than pharmacare, and further, that it might be less controversial to implement.

"Political will" is more a product of the conditions than an independent force

The political drive to act boldly and the willingness to accept risk are really contingent on the preceding six factors. They will not be there if politicians anticipate a significant backlash against proposed changes. And that risk remains when the public doesn't understand the problem and the objectives have not been clearly and persuasively put forward. So there seems little point in simply lamenting the lack of political will and risk taking. Rather, the supporting conditions must be worked on.

Debates of the Canada Health Act and privatization are distractions

Before summarizing, I will dismiss two factors that commonly and needlessly distract the healthcare reform process. The first is the notion that sensible things cannot be done due to the restrictive nature of the five principles of the Canada Health Act (public administration, comprehensiveness, universality, portability, and accessibility). The objectives of reform set out by the participants of the 2013 conference seem unlikely to negatively impact the principles of the CHA. More generally, it should be recognized that there is much more flexibility than some claim, as several of the principles are hardly in place now and the federal government certainly doesn't seem bent on taking punitive action.

The second distraction is the suggestion that sensible reform must move health more into the private domain, out of the public. It is critical to distinguish between private delivery of services covered under the single, public-payer model and a two-tier system with more services being paid for privately. The former has been evolving for a long time and will undoubtedly continue. The public no longer seems particularly concerned with who provides the service as long as they can pay with their public card. Effectiveness and efficiency should guide which service provider is chosen. A great deal more could be done on utilizing private resources within the public payer model. For example, more publicly funded services and procedures could be tendered to privately-operated organizations. Putting more costs into the private sphere would be much more controversial. The likely public resistance to higher private costs would substantially raise the bar for the amount of nerve required by governments – probably to the point where it would cripple the desire to proceed on other aspects of reform. At any rate, a debate about public versus private costs seems premature. The main issue at the moment is that costs are too high relative to the outcomes generated by Canada's healthcare system. Making the system more effective and efficient should be the first priority and then attention can be turned to who pays.

Policy and Politics can be bridged on health policy reform

In summary, there remain challenges to bridging the policy and political sides of needed healthcare reform. It is a waste of time to simply lament the lack of political will. Rather, the focus should be on understanding and addressing the conditions that drive political reticence. The attendees of the 2014 Queen's health policy conference can play a major role in this. This note will close by returning to the seven conditions found in common behind major policy reforms in other areas, and will suggest how the participants in the 2014 conference and the Queen's health policy initiative itself can help create the winning conditions for health reform.

1. Making a clearer case for the problems faced by the current system. In turn, this will require unprecedented communications moves by the people and groups involved. A careful balance must be struck to refrain from being relentlessly negative or becoming myopic on single issues, such as costs, but instead show the public (and in turn the politicians) the reform process can transition from identification of problems to

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solutions (solutions being the critical ingredient).

2. The background papers and discussion can sharpen the definition of valuable reforms.
3. The analysts and stakeholders can help governments properly frame the objectives of reform that will not only be acceptable but also appealing to the public. The process must move beyond generalities and make specific proposals. For example, where the 2013 conference left off at identifying the need to establish standards of care, the reform process must now propose some standards.
4. The 2013 conference put a lot of emphasis on drawing in promising healthcare practices from around the world and this will be continued in 2014 and beyond. Greater attention could be paid to some interesting variations in practices across Canada.
5. Stakeholders should continue to work on their own ideas for reform and find better ways to communicate these to the public. But a key to creating the winning conditions for reform will be generating the sense that there is general consensus on how to make improvements. The wide sectoral representation at the Queen's conferences is helpful in this regard. A major challenge will be to communicate the messages in a way that reaches the public.
6. Analysts and stakeholders can help governments triage the needed reforms so political necks are not always on the line. In particular, priorities for reform can be identified. For example, improving home care and its supporting elements may be a higher priority at this time than a national pharmacare program.

If the conditions are created, governments will act. But they will only be ready to act when they peer out of the bunker and assess the air to be relatively calm. Conference attendees can help calm the air with insightful ideas on policy substance and communication.

The health policy reform process is unlikely to unfold as some participants in the 2013 conference urged. There is not likely to be strong federal, or even national, leadership – at least not for the next several years. There won't likely be new national institutions to, if not lead, then at least inform the process. More likely reform will proceed with the players currently on deck. But it can proceed – if the existing players up their game and create the winning conditions so governments don't fear the Joey Smallwood phenomenon of losing votes every time something is said about health. Change will most likely proceed with a provincial government or two embracing good ideas that will have minimal or positive public reaction and then others flattering them by copying their success. Under this process, it will take a while to get to the end game envisioned at the 2013 Queen's conference. But when the problems have been around for as long as they have, steady progress on reform should be welcome.

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JUNE 2013

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TOWARD A CANADIAN HEALTHCARE STRATEGY

Over two days in June 2013, Canadian leaders from healthcare, business, policy and research interacted with twenty-five speakers from across Canada and six other nations to test the potential elements of a Canadian healthcare strategy. By reflecting on lessons learned from a broad set of international perspectives, as well as the unique nature of the Canadian context, the first conference laid the groundwork for shared action on major healthcare challenges.

MAY 2014

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CREATING STRATEGIC CHANGE IN CANADIAN HEALTHCARE

Building on the high-level consensus identified at the June 2013 conference, this second event will address three vital questions:

1. What form could a Canadian healthcare strategy take?
2. What would be the substance of that strategy, particularly in areas of health human resources, integrated care, electronic health records, and pharmacare?
3. What is a viable process for change?

MAY 2015

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MANAGING STRATEGIC CHANGE IN CANADIAN HEALTHCARE

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