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Commentary

Policy Capacity for Health Reform: Necessary but Insufficient

Comment on "Health Reform Requires Policy Capacity"

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Abstract

Forest and colleagues have persuasively made the case that policy capacity is a fundamental prerequisite to health reform. They offer a comprehensive life-cycle definition of policy capacity and stress that it involves much more than problem identification and option development. I would like to offer a Canadian perspective. If we define health reform as re-orienting the health system from acute care to prevention and chronic disease management the consensus is that Canada has been unsuccessful in achieving a major transformation of our 14 health systems (one for each province and territory plus the federal government). I argue that 3 additional things are essential to build health policy capacity in a healthcare federation such as Canada: (*a*) A means of "policy governance" that would promote an approach to cooperative federalism in the health arena; (*b*) The ability to overcome the "policy inertia" resulting from how Canadian Medicare was implemented and subsequently interpreted; and (*c*) The ability to entertain a long-range thinking and planning horizon. My assessment indicates that Canada falls short on each of these items, and the prospects for achieving them are not bright. However, hope springs eternal and it will be interesting to see if the July, 2015 report of the Advisory Panel on Healthcare Innovation manages to galvanize national attention and stimulate concerted action.

Keywords: Policy Capacity, Policy Governance, Long-Range Planning

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At the outset of my commentary, I would acknowledge some limitations. First, I am not a political scientist, and certainly no expert in comparative studies. Second, I have no insider knowledge of government machinations surrounding the development and implementation (or not) of health policy in Canada, although I have been a keen onlooker over the past 30-plus years. Hence, at the risk of being parochial my remarks focus on the Canadian context. Forest and colleagues[1] have persuasively made the case that policy capacity is a fundamental prerequisite to health reform. They offer a comprehensive life-cycle definition of policy capacity as "the sum of competencies, resources, and experience that governments and public agencies to identify, formulate, implement, and evaluate solutions to public problems." Importantly, they stress that policy capacity involves much more than problem identification and option development. The authors note the proliferation of sources of policy advice beyond government, including university-based and freestanding think tanks, professional associations and private industry, and they conclude with a challenge to more actors to join the policy fray in a socially responsible manner. I would venture that one actor that needs to become more fully engaged is the citizen. Until the 1980s, in Canada at least, health policy was determined mainly by the political, academic, and professional organization elites. Beginning in the 1980s, advances in survey methodology such as computer-assisted telephone interviewing, and more recently the internet-based survey have resulted in a proliferation of public opinion surveys on health issues, and a recent advance has been the development of deliberative dialogue. The 2001-2002 Commission on the Future of Healthcare in Canada, on which Dr. Forest played a prominent role as Research Director, pioneered the introduction of deliberative dialogue on health issues in this country, and engaged extensively with citizens in its public hearings.[2] More recently consulting firm PricewaterhouseCoopers (PwC) convened a 28-member Citizens' Reference Panel in 2011 that met over 3 weekends and came up with 48 recommendations that compare very favourably to the output of many task forces and commissions.[3] On the issue of social responsibility it will be important to recognize the role that values and interests play in stakeholder engagement in health policy. In a recent paper Tapp presented an analysis using the social medium Twitter to array 44 Canadian think tanks along a "left" to "right" ideological continuum.[4] I would expect to see a call for explicit accountability for policy advocacy among nongovernmental organizations, such as through accreditation standards, in the not too distant future.

What do we mean by health reform? I would define it broadly as re-orienting the healthcare system from episodic treatments of acute injuries and illnesses provided mainly by doctors and nurses in clinics and hospitals to one that is focused much more on the prevention and management of chronic diseases by a wide array of providers across a range of home, community and institutional settings. This approach is well-described in the 2011 declaration of the United Nations

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General Assembly on the prevention and control of non-communicable diseases.[5]

So how does Canada stack up in terms of policy capacity for health reform? Over the past several decades there has been no shortage of the identification of problems and formulation of solutions to health policy problems on the part of many stakeholders. This input has typically been marshalled and weighed by government-struck commissions and task forces, something at which Canada may be unrivalled. A 2011 annotated bibliography of such inquiries in Canada by all levels of government over the preceding century contains some 330 entries.[6]

The most recent contribution, the report of the Advisory Panel of Healthcare Innovation was released without fanfare by the federal government in July 2015 and contains 60 recommendations organized in five areas including patient engagement, systems integration, digital health, value for money and the health industry as an economic driver. The chapter that introduces its primary recommendation that calls for a Health Innovation Fund is entitled *Breaking the Gridlock*.[7]

Many of these reports have been influential, such as the 1964 report of the Royal Commission on Healthcare that resulted in universal coverage of medical services. However, the consensus is that since that time Canada has generally been unsuccessful at reforming our 14 health systems (one for each province and territory plus the federal government) along the lines of the definition proposed above. A recently published exhaustive study of 6 reforms in 5 Canadian provinces concludes that there has been little fundamental change in health policy over the past four decades and holds out dim prospects for the future, stating that "without some sort of insurmountable disruptive force, either a major shift in medical science or a catastrophic economic or political crisis, fundamental health policy reform in Canada is unlikely."[8]

Why should healthcare reform matter in Canada? There are at least two good reasons. First the breadth of universal public coverage is narrow and focuses on hospitals and physicians. Canada is the only country with a universal health insurance system that does not have universal access to prescription drugs.[9] Second there is evidence that Canada is slipping in international standards on some key health indicators. In 1990 Canada ranked forth in the Organization for Economic Cooperation and Development (OECD) in life expectancy at birth, and as of 2011 we have dropped to 10th.[10] Until recently there has been a tendency to ignore this evidence, much like the unwillingness of the emperor to acknowledge that he was undressed in Hans Christian Andersen's 1837 fairy tale of the "Emperor's New Clothes."[11] However, Canada's 10th place ranking out of 11 countries examined by the US Commonwealth Fund in 2014 has captured the attention of health policy analysts. While the United States came in last overall, it ranked fifth on overall quality of care, compared to Canada's ninth place, and fifth on timely access compared to Canada's 11th place.[12] There is concern that as President Obama's Patient Protection and Affordable Care Act continues to expand health insurance coverage for more uninsured Americans that come the next iteration of *Mirror, Mirror on the Wall* the United States will have overtaken Canada.

So aside from the plethora of commission and task force reports, what will it take to bring about substantive healthcare reform in Canada? I will argue that three additional things are necessary to build health policy capacity and will elaborate on them below:

- A means of "policy governance" that would promote an approach to cooperative federalism in the health arena;
- The ability to overcome the "policy inertia" resulting from how Canadian Medicare was implemented and subsequently interpreted; and
- The ability to entertain a long-range thinking and planning horizon.

Policy governance: the term policy governance refers to a model developed by John Carver that is based on a set of 10 principles that guide the relationship between the owners, the board of directors and the Chief Executive. In health policy one could think of the citizens as the owners, the federal and provincial-territorial (PT) health Ministers as the Board of Directors and the Conference of the Deputy Ministers of Health as the Chief Executive.[13,14]

Reflecting on the past 2 decades the most interesting time in terms of the trying to achieve a breakthrough in national health policy that would shape a modern Canadian Medicare was during the late 1990's, following the federal government's announcement in 1995 that it would reduce cash transfers to the provinces and territories by $6 billion over 2 years. This had the effect of bringing the provinces and territories closer together. In 1996 a Ministerial Council on Social Policy Renewal set out 4 recommendations for the PTs in the health policy arena:

- Identify the basic range of services that should be insured in a national health system;
- Develop guiding principles that reflect the realities of the modern health system;
- Focus on the integration and coordination of service delivery systems; and

Establish a process to modernize the Canada Health Act (CHA).[15]

This was followed by the release of *A Renewed Vision for Canada's Health System* by the PT Health Ministers in early 1997 that laid out a comprehensive vision for the healthcare system, including population-based health protection and promotion, personal health services and supports for personal health services.[16] Shortly thereafter all First Ministers (13 Premiers plus the Prime Minister) with the exception of Quebec signed the Social Union Framework, which might have formed a basis of policy governance had it been given a chance.[17] However, shortly after these developments, the federal government began to reinvest in healthcare , culminating in a series of three First Ministers' Accords that injected almost $100 billion in new health transfers. These agreements contained commitments to modernize Medicare, such as enhanced primary care, expanded home-care and providing universal access to prescription drugs (catastrophic coverage), but the consensus is that the agreements have only "bought time not change." It remains to be seen if the report of the Advisory Panel Healthcare Innovation will stimulate any renewal in terms of coordinated federal-provincial-territorial activity on health reform. Looking ahead the prospects for a policy governance framework in Canadian healthcare are not bright. It should be added that the challenges of making

health policy in a federation are not unique to Canada. Hall has reviewed the recent experience in Australia, where a new Commonwealth government is significantly altering the terms of a National Healthcare Agreement that was concluded with the State governments in 2012.[18]

Policy inertia: The Oxford Dictionary defines inertia in the physics context as "a property of matter by which it continues in its existing state of rest or uniform motion in a straight line, unless that state is changed by an external force."[19] I think this is a good characterization of the trajectory of health policy in Canada. The foundation of Canada's Medicare program is based on the simple principle set out originally in the 1950s and 1960s, culminating in the 1984 CHA, that the federal and PT governments would share 50:50 in the cost of hospital and medical services, funded by general tax revenues and subject to the five program criteria of public administration; comprehensiveness; universality; portability and accessibility.[20] The CHA has been extraordinarily effective in preserving the publicly funded character of those services. Table 1 shows public spending as a share of total spending for Canada compared to the average of the 23 member countries of the OECD (including Canada) for which data are available for 2012. Canada stands well above the average in terms of public coverage of physician service, but well below for prescription drugs.

I suspect that the CHA requirement for essentially 100% public coverage of hospital and medical services (ie, prohibition of user fees) has been a barrier to the expansion of Medicare to include programs like prescription drugs and home care. Moreover, the tax-funded basis of Medicare appears to be a barrier to the developmental of alternate funding models that would cover the broader continuum of care. The Province of Quebec provides an excellent example of this in the case of long-term care. Since 2000 three proposals have been advanced that would adopt a social insurance approach based on contributions to fund "loss of autonomy" insurance.[21-23] The most recent of these proposals got as far as a Bill that was introduced in the Quebec legislature in 2013, but the provincial government changed hands in 2014 and the idea has not resurfaced.[24] It should be added that the contribution fund was absent from the 2013 Bill. There has been a recent groundswell of interest in a national pharmacare program and it will be interesting to see what comes of it.[25] On a final point, the original 50:50 cost-sharing principle still survives, although it has been recalibrated by the Premiers to the federal government assuming a 25% share of PT health spending.[26]

Long-range planning: It is well known that over the next several decades the populations of industrialized countries will be aging; indeed, those of countries such as England and Japan are already ahead of Canada. In health policy discourse in Canada there are two schools of thought. The avalanche school predicts that population aging will have an enormous impact on the healthcare system, while the glacier school argues that population aging increases health spending by one per cent or less per year, hence sustainability is not an issue.[27] In 2014 one-sixth of Canada's population (16%) was aged 65 or over and by 2036 this is projected to increase to one-quarter (24%).[28] It appears to me that the glacier school of thought currently holds sway and by 2036 we will know who was right. However, the age-sex profile of health spending has been very stable.[29] If the 2012 age-sex profile is applied to the 2036 population the 65+ population will consume 62% of PT health spending, a marked increase over its current level of 47%, and higher again than the 1991 level of 37%. Health Ministers are beginning to look at ways of mitigating highly concentrated health spending but it seems clear that the demographic shift poses a major challenge for the funding and delivery of healthcare in Canada. Moreover population aging is not a passing phenomenon. By 2063, the outer limit of the official national population projections, 26% of the population will be 65+.

In conclusion, it is time to shift the focus of policy capacity in Canada from problem restatement and option development to issues of implementation and evaluation over a longer term planning horizon than the current four or 5 year cycle of provincial and federal elections.

Table 1. % Public Spending on Selected Health Services: OECD 2012

Category of Service	Hospitals	Doctors' Offices	Prescription Drugs
Canada	91	99	42
OECD (23) average	88	72	70

Abbreviation: OECD, Organization for Economic Cooperation and Development.
Source: OECD.*Stat*.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

OA is the single author of the manuscript.

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