McMaster University

Paradigm Freeze: Why Is It So Hard to Reform Healthcare Policy in Canada?

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EVIDENCE >> INSIGHT >> ACTION

Background

- Perceptions of a system ‘frozen’ in place since 1970

- Is that the case?
- If so, why is it so hard to achieve substantive reform?
  - Neutral about whether reform is desirable or not
  - Neutral about which reforms are ‘best’

Methods

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

Methods (2)

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

Methods (3)

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

Methods (4)

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

Methods (5)

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

Extent of Reform, 1990-2003

- Of 30 cases
  - 1 ‘comprehensive’ and 6 ‘significant’
  - 17 ‘none’ or ‘limited’

- So what variables explain the 7 ‘large’ reforms? The 17 ‘status quo’ cases?

Variables Associated with 'Large' Reforms

- Five of seven cases involved
  - Electoral process
    - New government or government leader
    - Campaign commitment to reform during the election period
    - Appointed champion once in power
    - Policy announced in first half of the mandate
  - And perceived fiscal crisis

  - In other words, external factors

Variables Associated with the Status Quo

- 'Insider' interests (particularly medical associations) resisted, slowed and shaped reform
  - Effective veto on any change that affected the freedom of individual physicians to choose their preferred remuneration mechanism (in regionalization and alternative payment plan cases)
  - Near veto on any change that affected their clinical autonomy (in wait-list management case)
  - But less successful when its direct interests were not heavily affected (e.g., form that regionalization took in AB and SK)

Variables Associated with the Status Quo (2)

- 'Outsider' interests (public interest groups / public opinion) protected the Medicare legacy but were unable to extend it
  - Public interest groups / public opinion pressure came into play only on decisions that touched on delivery arrangements and program content, which affected citizens directly
    - AB and SK: put wait times on the government agenda
    - AB and ON: could not prevent privatization from getting on the government's agenda, but did slow and alter the type of reforms
    - ON: put drug reform on the government agenda

Other Variables

- Institutions
  - Joint management committees ramping up but not fully functional
  - Canada Health Act more symbolic than binding
  - Federal/provincial/territorial relations diverted attention to fiscal federalism instead of healthcare reform
  - Policy networks formed around more 'technical' issues
- Ideas
  - Egalitarian values continued to reinforce the status quo rather than to challenge it, and they played a larger role at the agenda-setting stages than at the policy-choice stage
  - Knowledge/beliefs played a larger role at the policy-choice stage

In a Nutshell

- Two critical factors
  - External factors (new government, etc. + fiscal crisis) drove ‘large’ reforms
  - Interests (medical associations and public interest groups) often resisted it

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