Public healthcare systems in mature welfare states: Archetypes of reforms

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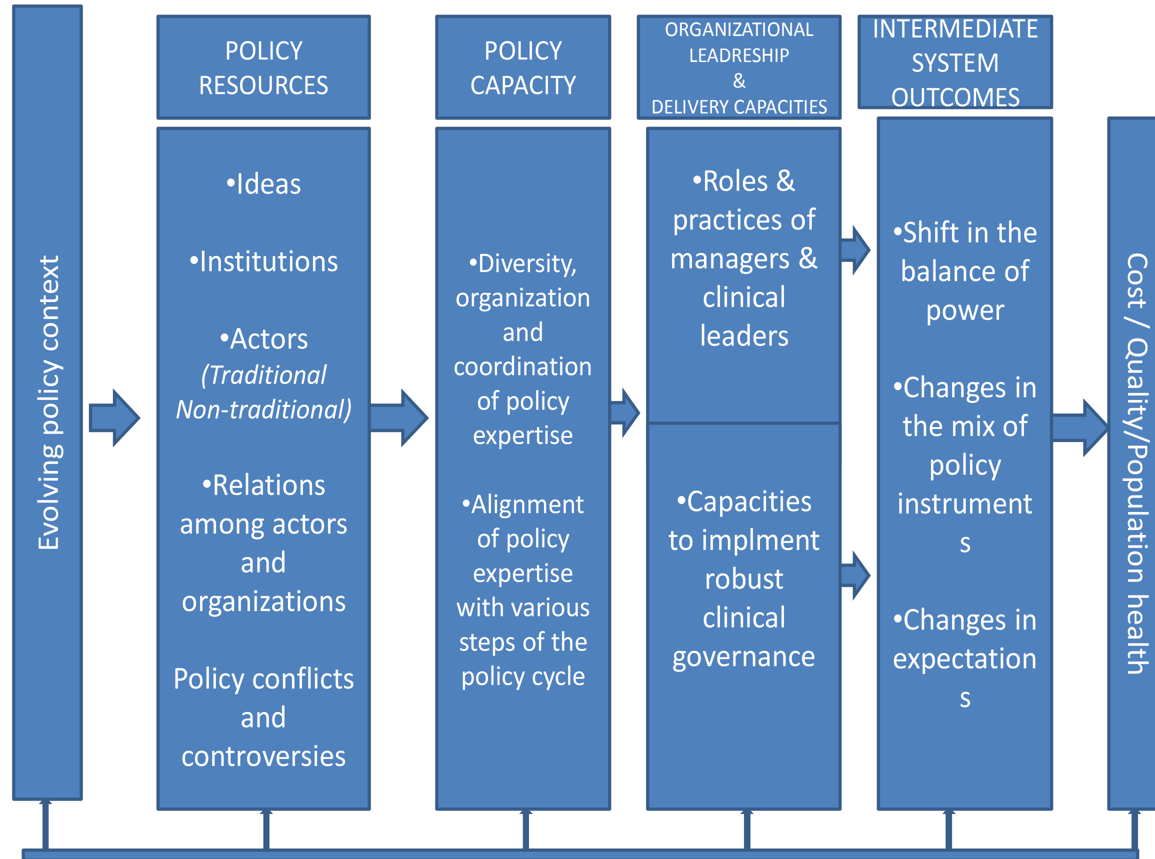
Focus of the presentation

- **policy work performed by reformers and governments to promote and implement reforms**
- **relations between system strategies, capacities for change, and the translation of reformative ideas**
- **attentive to the content of reformative strategies adopted by governments and to the support provided to healthcare organizations and providers to achieve reform objectives.**

Introduction: Health Reforms and transformative capacities

Model of transformative capacity in health systems



(Denis & al., 2015)

"We're ready to begin the next phase of keeping things exactly the way they are."

“ Most notable are the constant fiscal pressures resulting from ever expanding demand and the outsized political influence exerted by the medical profession because of its control over the quality and terms of health services. (Forest & Denis, 2012: 576)

Rather than aiming to secure the basic needs of the public, as is usually the case with pensions or social insurance, health care policy invariably states that patients should expect the "best" care available, as defined by the providers of that care. It is quite a unique situation, especially when compared with other areas of social protection. (Forest & Denis, 2012: 576)

In fact, even if health systems have other characteristics, reform and design must always entail some kind of cost- control measures, accompanied by various mechanisms to secure physicians’ cooperation. ” (Forest & Denis, 2012: 576)

" Embedded within this core organizing dilemma have been continual concerns about quality, responsiveness, and, in some contexts, access, regarding wholly publicly operated service providers. In both primary care and hospital sectors, public command and control structures of organization have lagged (sometimes dramatically) behind patients and citizen expectations. " (Saltman & Duran, 2015:1)

“ *Transformative capacity* ” is defined as a set of resources, levers, and practices mobilized at the three levels of governance of healthcare systems (macro, meso, and micro) to bring about change and improvement. ” (Denis & al., 2015)

“ Transformative capacities ”
are more distributed and collaborative than usually recognized.

A WORD OF CAUTION!

Maynard, A. (2013) ‘Health Care Rationing: Doing It Better in Public and Private Health Care Systems’, *Journal of Health Politics, Policy and Law*, 38 (6), 1103–27.

CHSRF FCRSS
Canadian Health Services Research Foundation
Fondation canadienne de la recherche sur les services de santé

ASSESSING INITIATIVES TO TRANSFORM HEALTHCARE SYSTEMS: LESSONS FOR THE CANADIAN HEALTHCARE SYSTEM

CHSRF SERIES ON HEALTHCARE TRANSFORMATION: PAPER 1

www.chsrf.ca

MAY 2011

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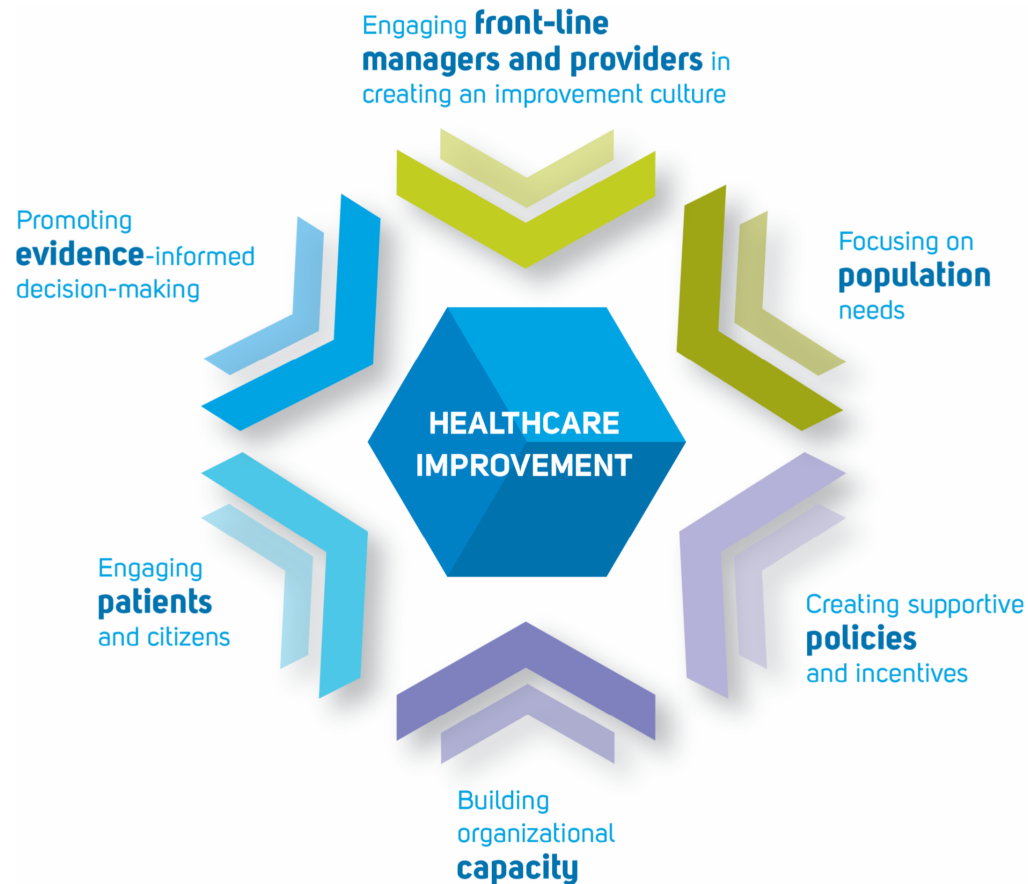

Ten Critical Themes in High Performing Health Systems (Baker & Denis, 2011)

Leadership and Strategy	Organizational Design	Improvement Capabilities
Quality and system improvement as a core strategy	**Robust primary care teams at the centre of the delivery system**	**Organizational capacities and skills to support performance improvement**
Leadership activities that embrace common goals and align activities throughout the organization	**More effective integration of care that promotes seamless care transitions**	**Information as a platform for guiding improvement**
	Promoting professional cultures that support teamwork, continuous improvement and patient engagement	**Effective learning strategies and methods to test and scale up**
	Providing an enabling environment buffering short-term factors that undermine success	**Engaging patients in their care and in the design of care.**

Policy capacity as one ingredient of transformative change in health systems

Governments make “ongoing efforts to increase their decision-making leverage over financial and/or clinical aspects of health system” They look for what – “.. mix of structural and non-structural tools is most likely to produce the types of organizational and behavioral change that national governments are steering to create” (Jakubowski & Saltman, 2013).

POLICY CAPACITY FOR HEALTH SYSTEM REFORM

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Int J Health Policy Manag 2015, 4(5), 265–266

doi 10.15171/ijhpm.2015.85

IJHPM International Journal of Health Policy and Management

Editorial

Health reform requires policy capacity

Pierre-Gerlier Forest[1*], Jean-Louis Denis[2], Lawrence D. Brown[3], David Helms[4]

Abstract

Among the many reasons that may limit the adoption of promising reform ideas, policy capacity is the least recognized. The concept itself is not widely understood. Although policy capacity is concerned with the gathering of information and the formulation of options for public action in the initial phases of policy consultation and development, it also touches on all stages of the policy process, from the strategic identification of a problem to the actual development of the policy, its formal adoption, its implementation, and even further, its evaluation and continuation or modification. Expertise in the form of policy advice is already widely available in and to public administrations, to well-established professional organizations like medical societies and, of course, to large private-sector organizations with commercial or financial interests in the health sector. We need more health actors to join the fray and move from their traditional position of advocacy to a fuller commitment to the development of policy capacity, with all that it entails in terms of leadership and social responsibility.

Keywords: Policy Capacity, Health Reform, Public Action, Leadership, Evidence, Health Politics

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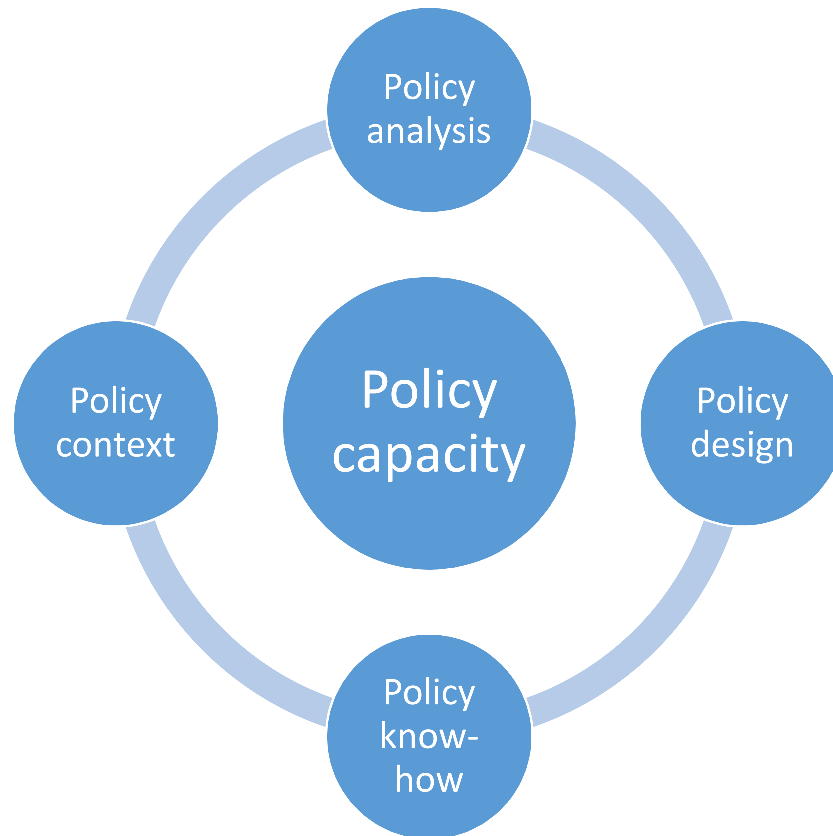
Policy capacity is defined as the capacity of government and other "public" actors to plan, develop, implement, and evaluate purposeful solutions to collective problems. Policy capacity goes beyond policy analysis; it encompasses policy design, policy know-how, and the ability to align policy work with context.

Dimensions of policy capacity Denis, Brown, Forest & al., 2015)



Clinical governance: a machine to translate reformative policies?

"By *clinical care management systems* we mean approaches (including incentives, accountability and capacity development issues) to assuring the design and delivery of effective and appropriate care through guidelines and reminder systems (and related methods and tools) and the development of a clinical/organizational leadership system that provides successful support to practicing clinicians" (Baker, Denis, Grudniewicz, Black, 2012)

Four Habits of High Value Health Care Organizations (Bohmer, 2011)

- *Specification and planning* at operational and strategic levels
- *Design of infrastructure* to match the needs for care
- *Measurement* and oversight
- *Continual study* to understand how to improve care

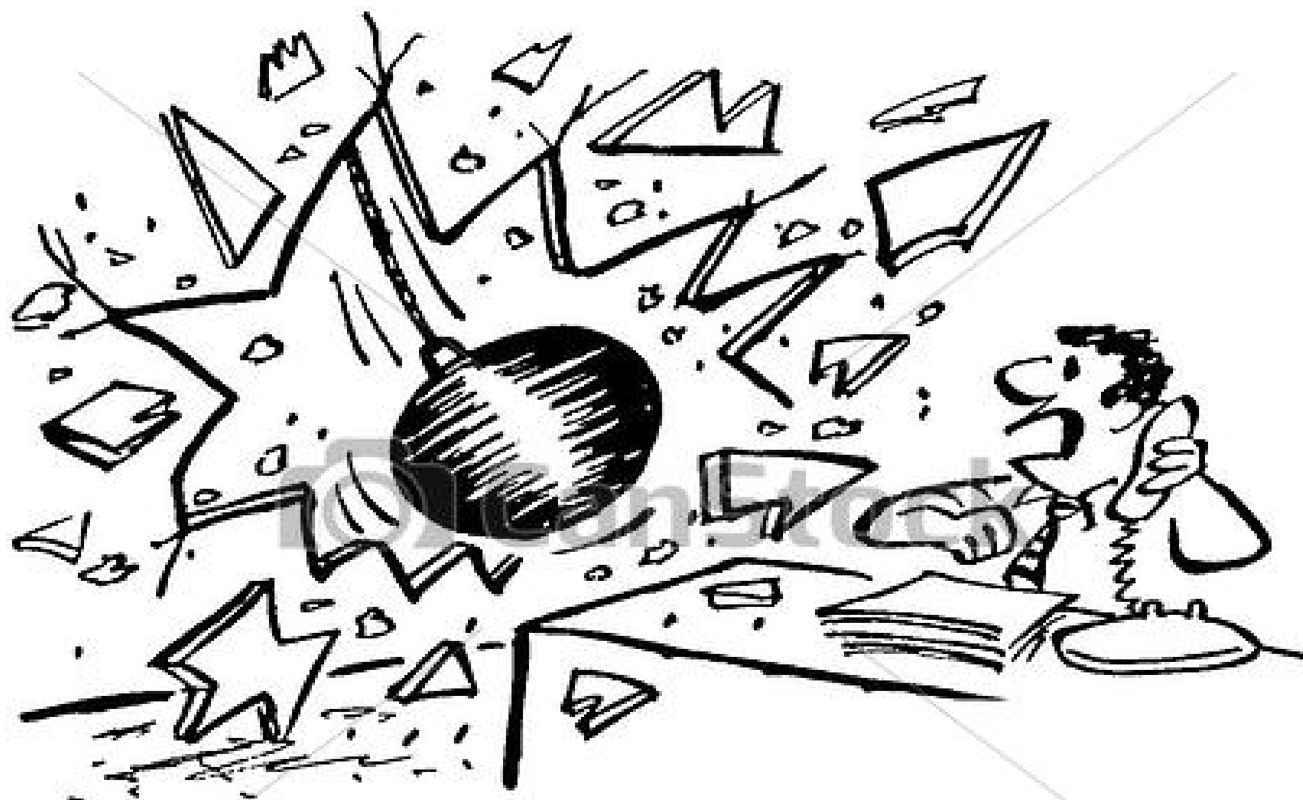
*‘Neither these researchers nor their subjects in the complex world of organizational change and improvement can hope to escape “... **the hazards and uncertainties lying in wait in the punishing contextual terrain** that has to be crossed ...”. That phrase – “the punishing contextual terrain” … so clearly labels the facts-on-the-ground for the ambitious, even courageous clinicians, managers, executives, and others in healthcare who seek to make care far better. They have discovered that **almost nothing about effective action in improvement is installable without constant, recursive adjustments to ever-changing local context**. Researchers who wish to understand how improvement works, and why and when it fails, will **never succeed if they regard context as experimental noise and the control of context as a useful design principle**.’ – Donald Berwick*

Source: Bate SP, Mendel P and Robert G. *Organising for Quality, The improvement journeys of leading hospitals in Europe and the United States*. Oxford: Radcliffe Publishing; 2008.

Emerging themes in the transformation of health systems

- A reform from ***within***
- A commitment to exploit ***latent capacities for improvement*** despite political, instutional and structural limitations
- An attention paid to existing ***basis of mobilisation*** within health systems:
  - ✓Evidence
  - ✓Patient and citizen engagement
  - ✓Management of professional and non-professional human resources
  - ✓Distributed leadership (managerial and clinical)

ARCHETYPES OF REFORMS: FROM STRUCTURAL REFORMS TO COLLABORATIVE APPROACHES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"Can I call you back Harry, I think the restructuring has started."

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QUALITY IMPROVEMENT COLLABORATIVES

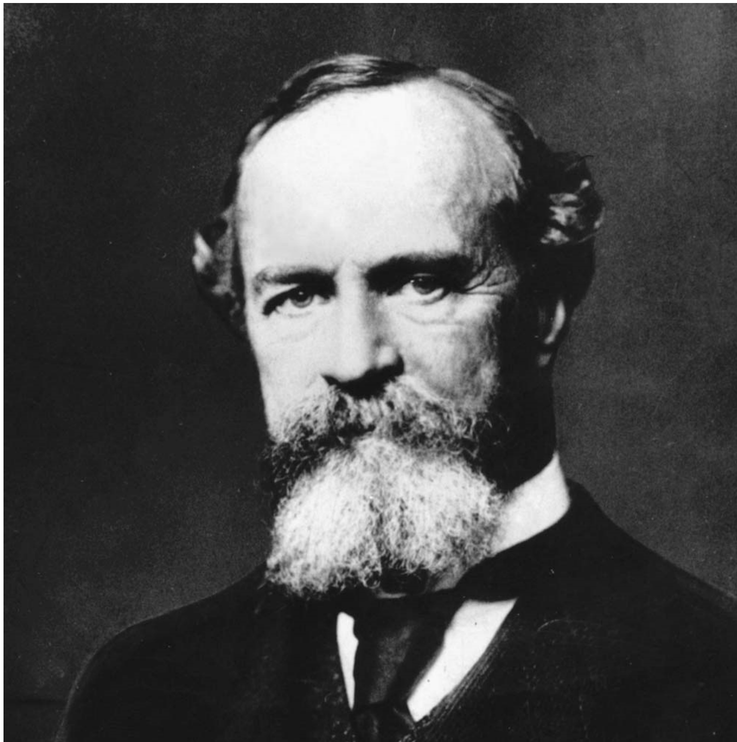
THE
MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Understanding the Components of Quality Improvement Collaboratives: A Systematic Literature Review

ERUM NADEEM,[1] S. SERENE OLIN,[1]
LAURA CAMPBELL HILL,[2]
KIMBERLY EATON HOAGWOOD,[1]
and SARAH McCUE HORWITZ[1]

[1]*New York University;* [2]*Columbia University*

BALANCE BETWEEN TOP-DOWN GUIDANCE AND BOTTOM-UP DYNAMICS



“ Plasticity, then, in the wide sense of the word, means the possession of a structure weak enough to yield to an influence, but strong enough not to yield all at once. ”

(William James, 'The Laws of Habit', *The Popular Science Monthly* (Feb 1887), 434)

Health Care Reform: The Canadian Case

Dimensions of health reforms (adapted from Lazar & al., 2013)

- Governance: devolution of authority, centralisation...
- Financial arrangements: Need-based funding, Activity-based budgeting, alternate modes of paying physicians
- Delivery arrangements: non-profit to for-profit provision, strategic clinical networks,
- Capacity development: managerial and system capacities, development of quality improvement skills and knowledge, alliance between research and delivery
- Programming: delimiting beneficiairies, extension of coverage, expanding services...

Dépenses de santé totales
(secteurs public et privé) au Canada

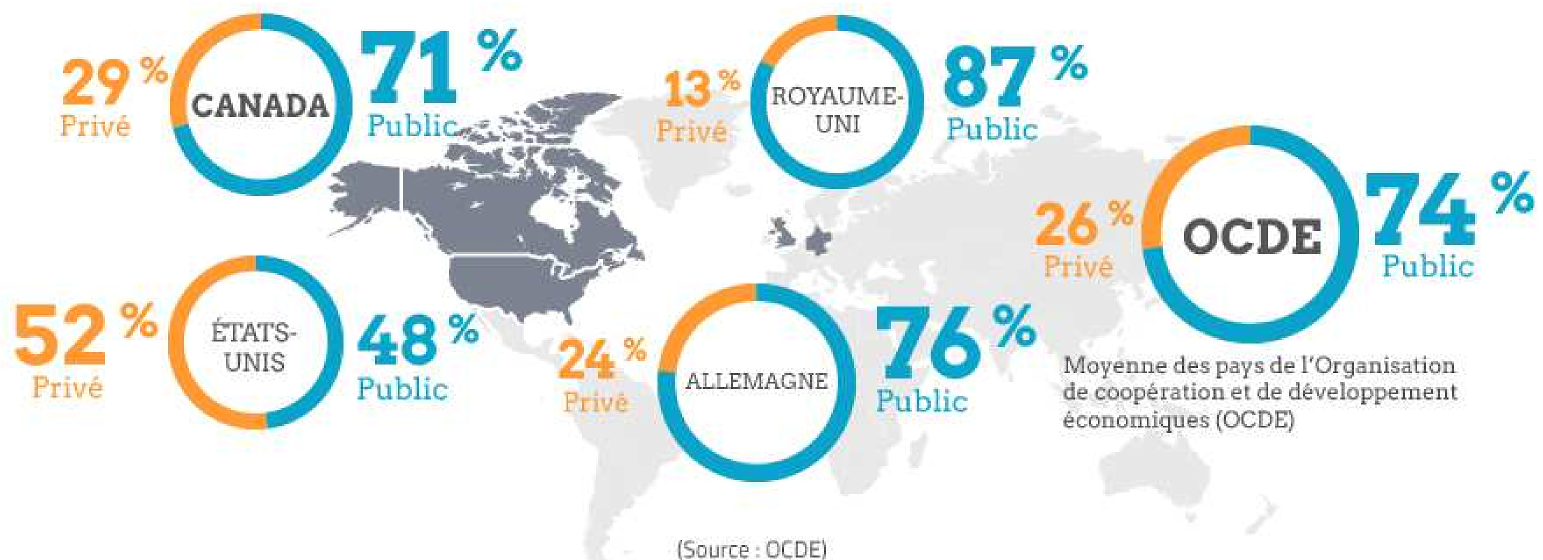
en 2013

par année

(Source : ICIS)

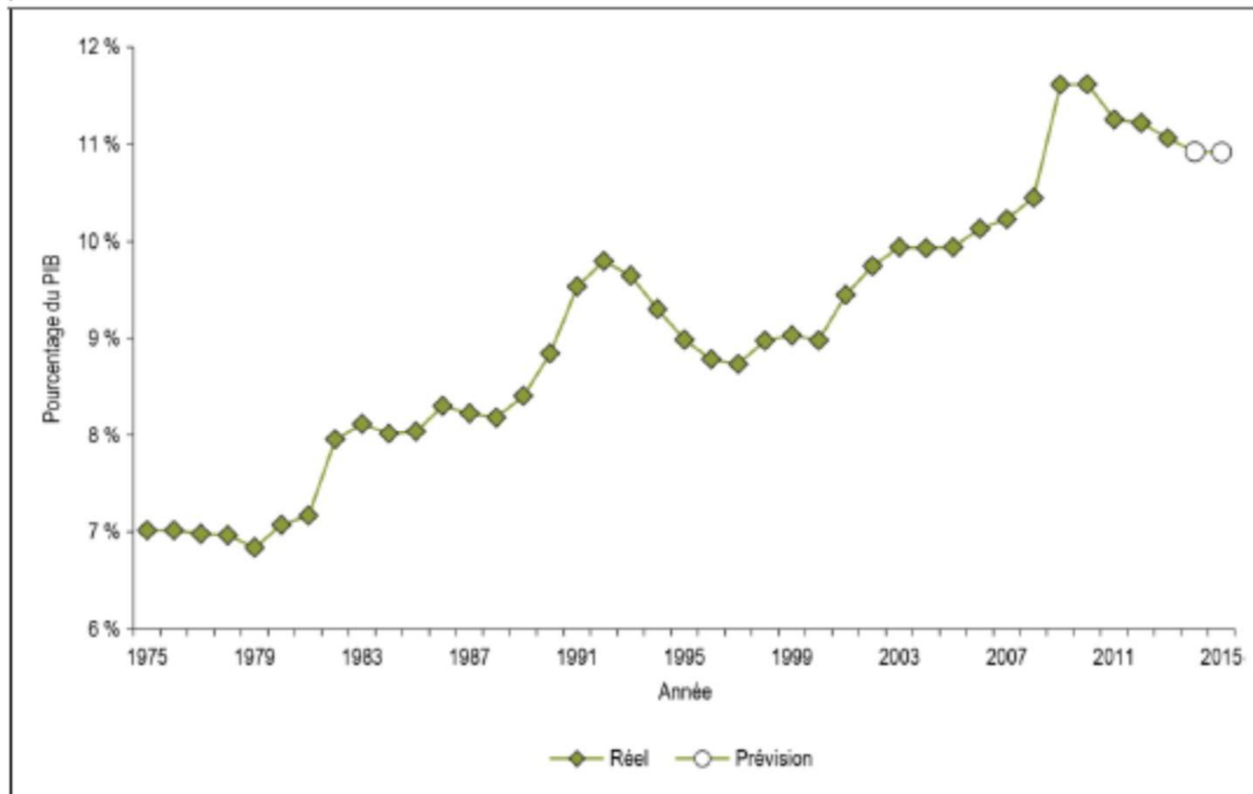
(Source : ICIS)

Comparaison de la part des dépenses des secteurs privé et public



(Source : OCDE)

Figure 1 : Total des dépenses de santé en pourcentage du PIB, au Canada, de 1975 à 2015

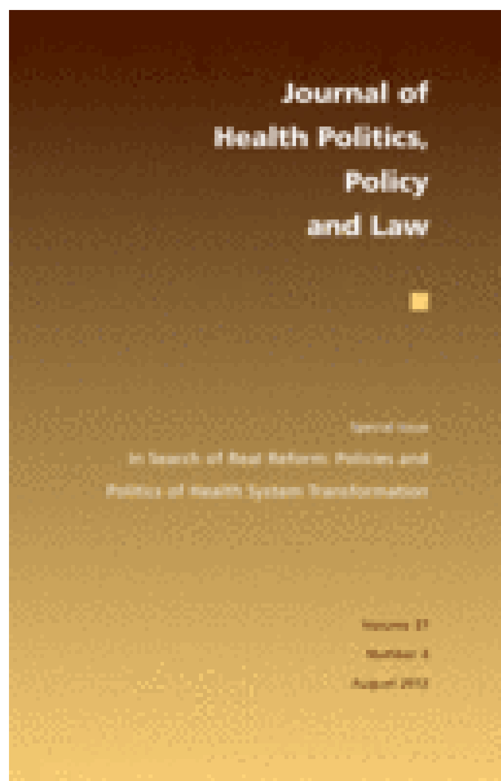


Remarque
Voir le tableau de données A.1.

Source
Base de données sur les dépenses nationales de santé, Institut canadien d'information sur la santé.

(ICIS, 2015:7)

Journal of Health politics, policy and law, august 2012



Paradigm Freeze

WHY IT IS SO HARD TO REFORM HEALTH-CARE POLICY IN CANADA

Edited by
Harvey Lazar
John N. Lavis, Pierre-Gerlier Forest, and John Church

" A System in Name Only — Access, Variation, and Reform in Canada's Provinces "

Steven Lewis, M.A.

***NEJM**, FEBRUARY 2015*

Health policy and reforms in ontario

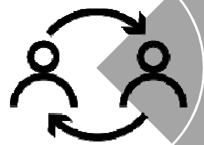
- *In the 1990s, reforms focused largely on* ***reducing hospital capacity and costs****, with some increase in community based services and primary care but limited emphasis on integrating care across the system.*

- *Reforms in Ontario since 2000 have been shaped by the diagnosis that the* ***health system operates as a set of disjointed parts, lacking the necessary integration to properly function and perform.***

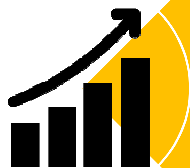
- *The Excellent Care for All Act in 2010, and many other strategies across Canada, have* ***emphasized stronger accountability and an increased focus on quality*** *(Brown, 2012).*
- *However, the political feasibility of further reforms faced* ***reactions from powerful professional groups and associations*** *who influenced both the content of policies and their implementation.*

ONTARIO
Reform narrative

Phase I (1990-2003): Rationalization and creation of a momentum for change



Phase II (2003-2010): Development of stronger accountability regimes within the Ontario health system.



Phase III (2010-today): The Excellent Care for All Act and the challenge of institutionalizing a culture of improvement

Ontario: PHASE I (1990-2003)

Rationalization and creation of a momentum for change

Health Services Restructuring Commission (1996-2000)

Hospitals into 22 urban and regional communities, and closed 31public, 6 private and 6 psychiatric hospitals

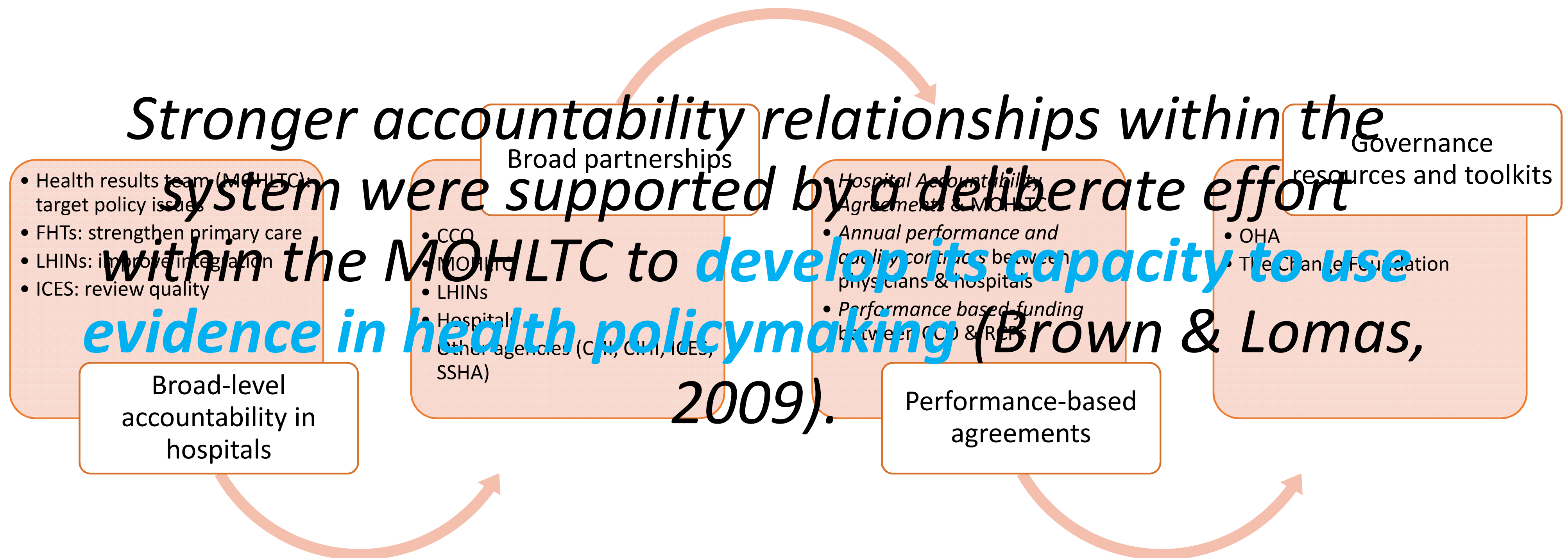
Systems cannot be governed without stronger accountability relationships, and that systems cannot depend solely or mostly on institutional care …

reforms are also a political exercise with uncertain results.

By 2000, a preliminary shift toward accountability and quality measures

Ontario: PHASE II (2003-2010)

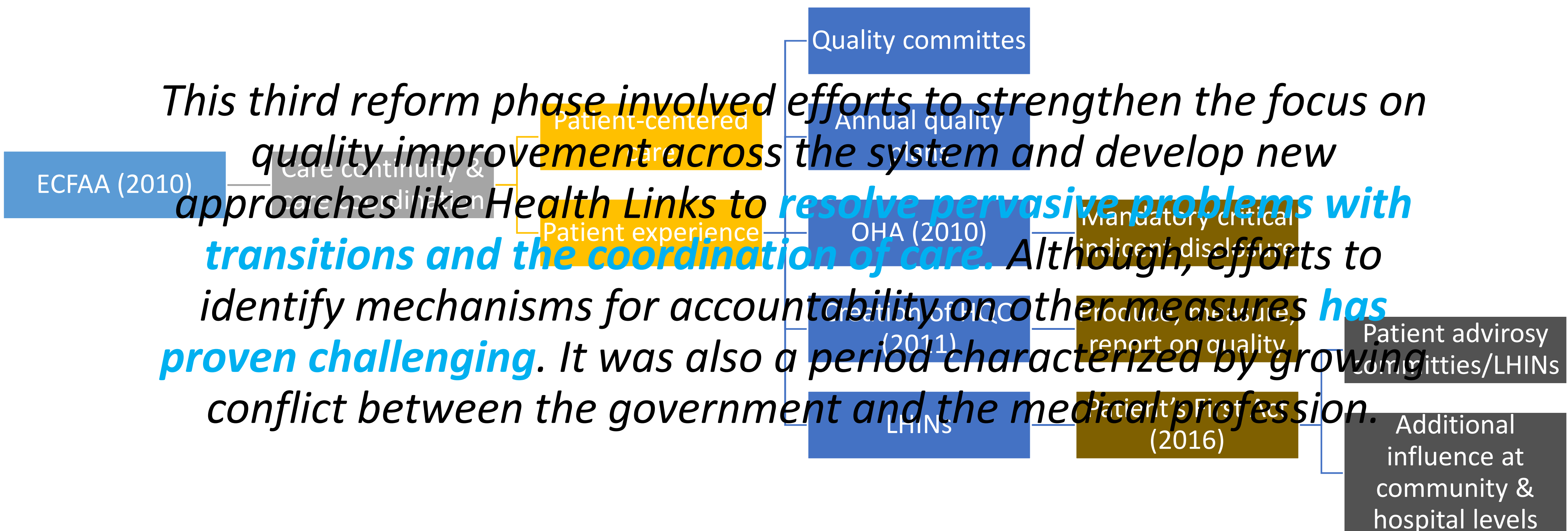
Development of stronger accountability regimes within the Ontario health system



Stronger accountability relationships within the system were supported by a deliberate effort within the MOHLTC to ***develop its capacity to use evidence in health policymaking*** *(Brown & Lomas, 2009).*

Ontario: PHASE III (2010-TODAY)

The Excellent Care for All Act and the challenge of institutionalizing a culture of improvement



This third reform phase involved efforts to strengthen the focus on quality improvement across the system and develop new approaches like Health Links to ***resolve pervasive problems with transitions and the coordination of care.*** *Although, efforts to identify mechanisms for accountability on other measures* ***has proven challenging****. It was also a period characterized by growing conflict between the government and the medical profession.*

ONTARIO

Two dominant logics

Soft regulation

- Increasing accountability of front line providers
- Growing measurement
- Incentives

Low rules

- Improving quality and system integration
- Focus on alternate mechanisms

A *slow-and-steady* approach for system capability and performance

Ontario

conclusion

The meaning of accountability relations in the system remains unclear (Deber et al 2014) and the impact uncertain. Providers may perceive accountability regimes as more threatening than enabling.

Mechanisms for change and improvement have focused primarily on **generating evidence, modifying financial incentives and creating new organizational forms and models of care.**

Government cannot impose effective local strategies, as these necessarily vary depending on local resources, the relationships between providers, and previous integration efforts.

There is also a sense that the various policies introduced over 15 years of reforms **lack overall coherence**. The pace of change remains slow and variable across organizations.

Recent tensions with government over payment contracts have **reduced physician engagement** in reforms.

Health policy and reforms in Quebec

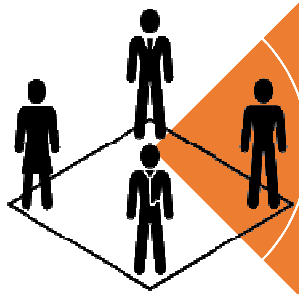
- *In 1988, **coordination and integration of care were identified as major issues** in the management and governance of the system.*

- *Despite some efforts to build regional agencies with local authority, government has sought to **limit the autonomy and independence of healthcare organizations**.*

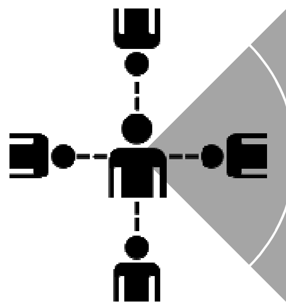
- *More recently, the Castonguay (2008) report deplores **the lack of clarity around accountability and excessive centralization** as major impediments to system improvement.*

quebec

Reform narrative



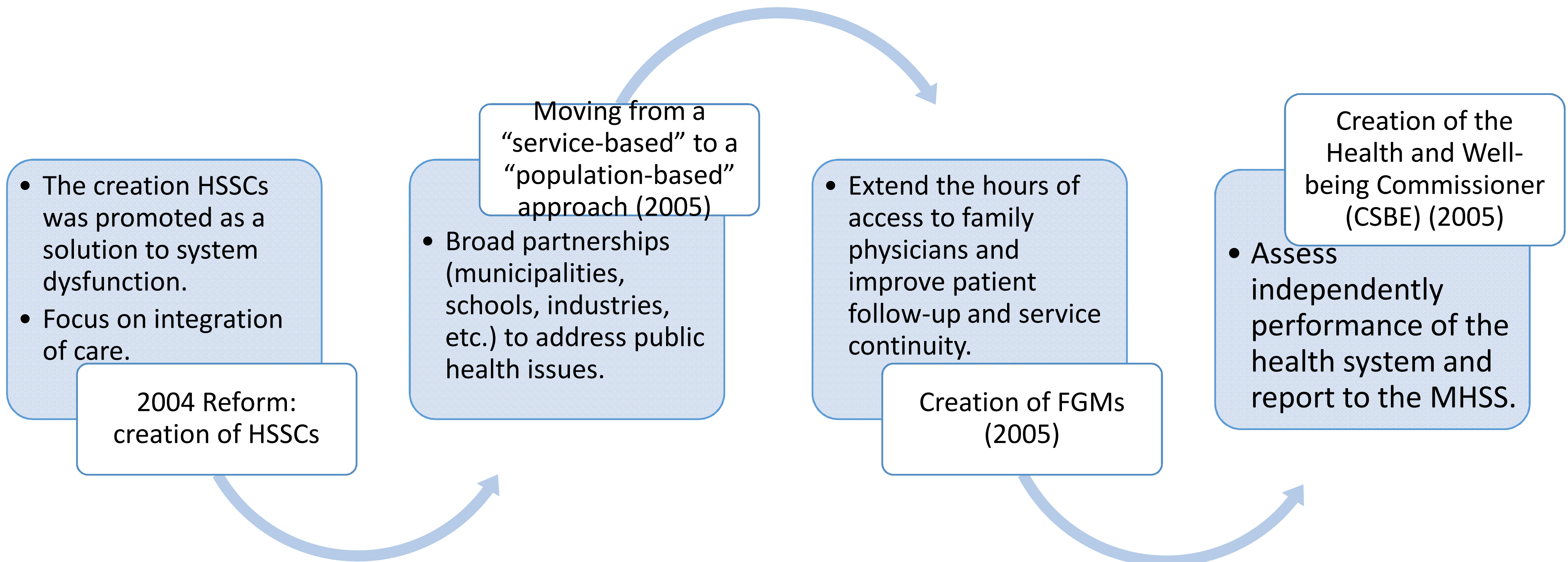
Phase I (2003-2014): Creation of local integrated health systems and networks



Phase II (2015today): Consolidation of a centralized approach to governance and organizational restructuring

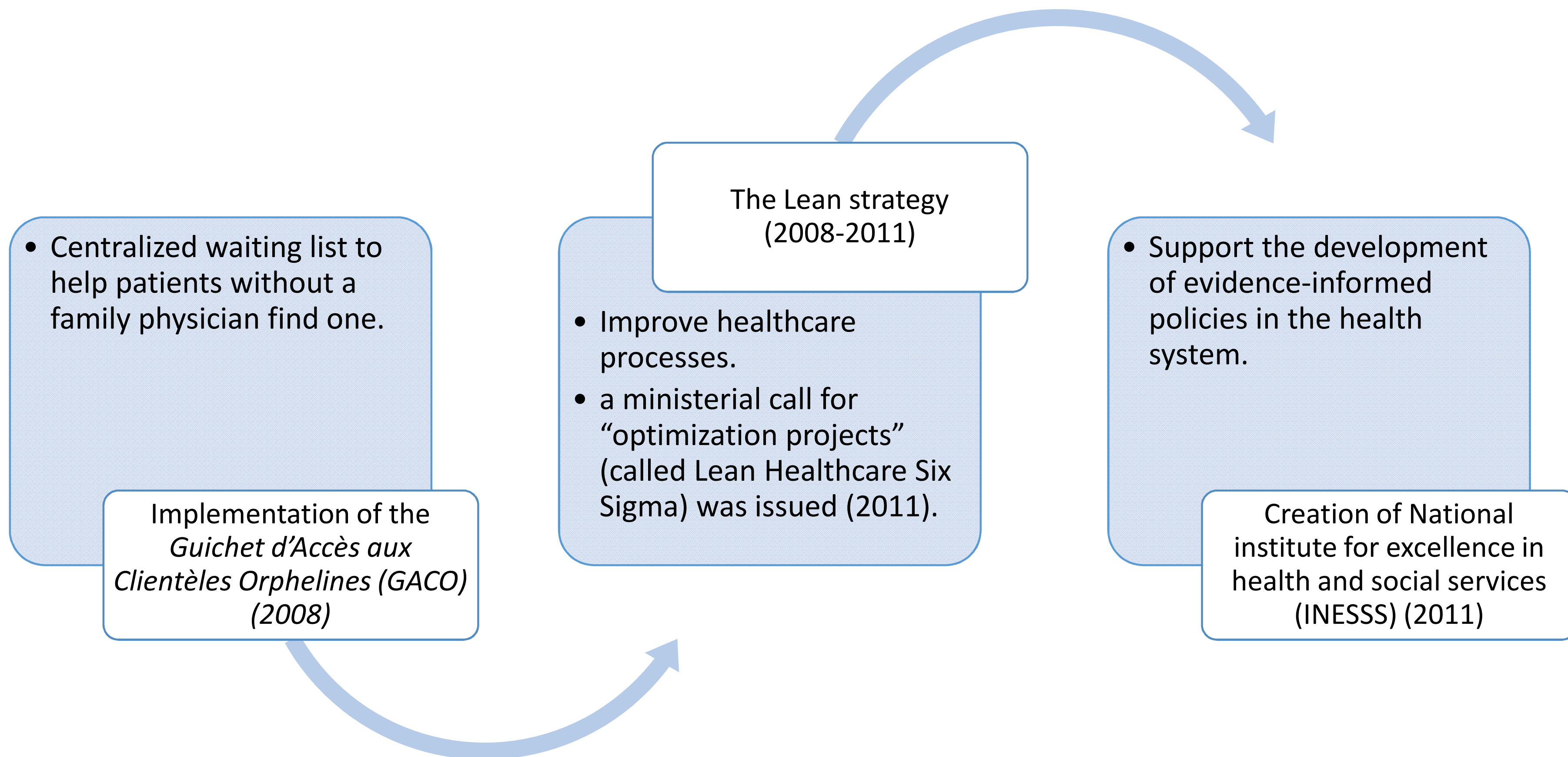
Quebec: Phase I (2003-2014)

Creation of local integrated health systems and networks



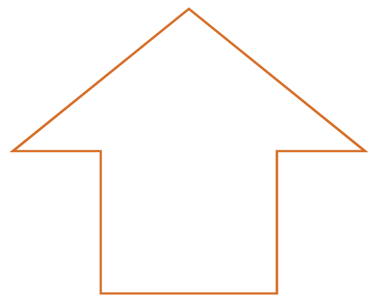
Quebec: Phase I (2003-2014)

Creation of local integrated health systems and networks

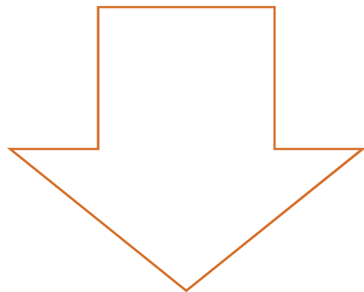


Quebec: Phase I (2003-2014)

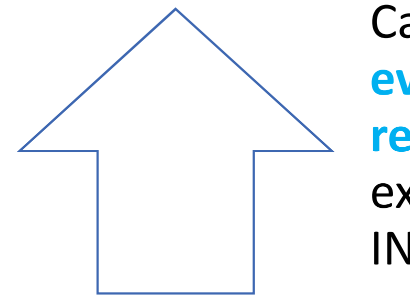
DUAL DYNAMICS



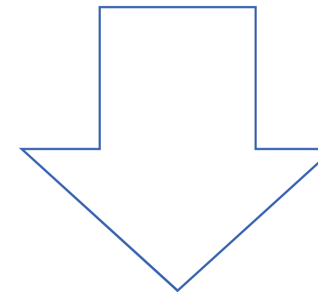
Creation of local integrated health systems is accompanied by increased **centralization**



Diminution of executive **role for the regional health authorities** (RHAs)



Capacity for **evaluation and reporting** were expanded (CSBE, INESSS)

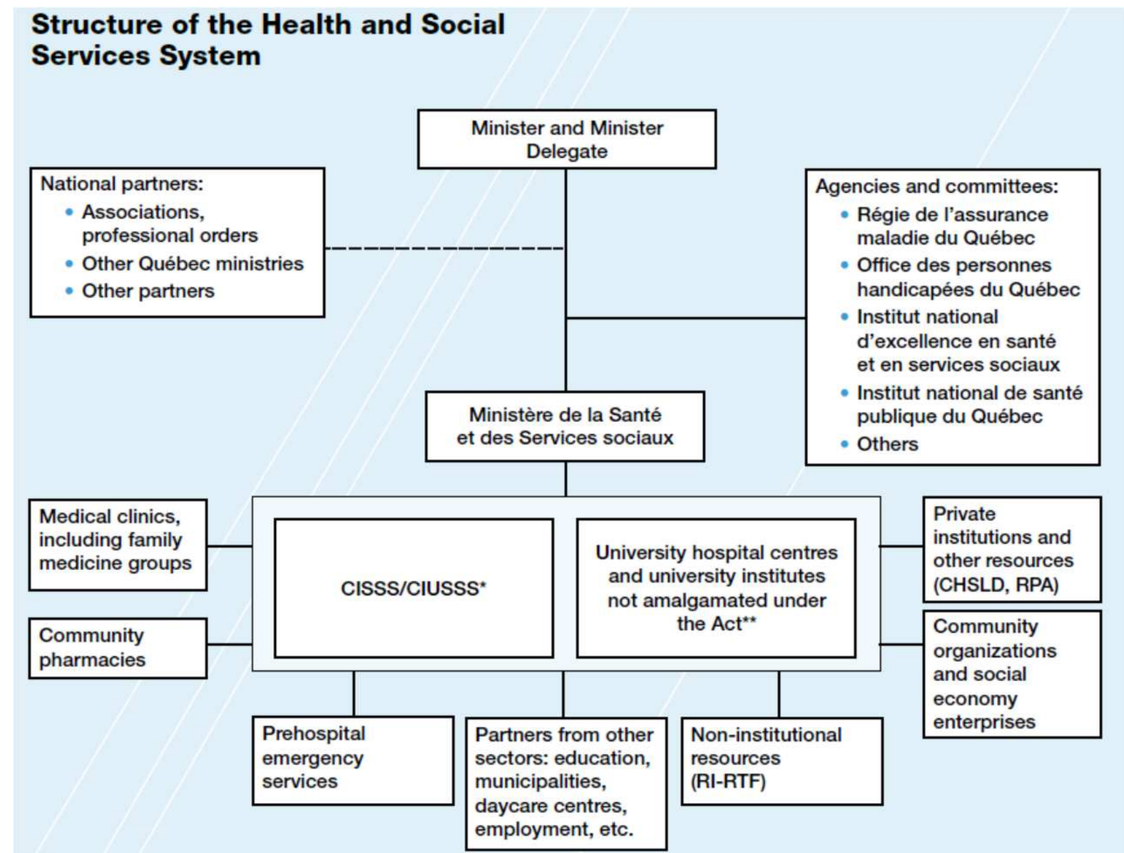


The **relation between these capacities and the governance** of the system was not explicitly delineated

Quebec: Phase II (2015 -today)

Consolidation of a centralized approach to governance and organizational restructuring

- Election in 2014 of a **new Liberal government**.
- From **182 to 34 health organizations** in Quebec.
- 26 large **Integrated Health and Social Service Centres**.
- ***Bill 20**:* defines productivity targets for physicians and stipulates penalties for those who do not comply.
- A new **management framework for FMGs** (2016) providing financial and professional development support.
- Creation of **50 super-clinics** to improve access to care,



Quebec: Phase II (2015 -today)

Consolidation of a centralized approach to governance and organizational restructuring

- *Quebec's healthcare system is living* ***a major shift toward centralized governance****, a significant contraction of the public health sector, and the disappearance of countervailing powers.*
- *There is growing concern that* ***the current reform is overly focused on the acute care*** *sector and access to family doctor, and this at the expense of population health and public health interventions.*
- *Overall, this latest period of reforms is characterized by the determination of the MHSS and the government to* ***exert much more centralised control over the system****.*

Quebec
conclusion

Overall, reforms in Quebec's healthcare system have been characterized since 2000 by **repeated massive restructuring and reshaping of governance** in favor of central government.

This represents a clear break with earlier efforts to strengthen regional health authorities and public participation, by **weaken community organizations and NGOs.**

The level of centralization within the system may **impede improvements that require adapting care processes** to local contexts and priorities.

A by-product of repeated restructuring efforts has been the **diversion of managerial energies away from supporting front line efforts** to improve care.

Engaging physicians in reform priorities remains challenging regarding the current debate around physician payment, and the imposition of productivity targets.

Convergence and divergence across the two cases (ontario and quebec)

Quebec & ontario reforms
divergences

Ontario

- The use of **incentives coupled with improvement targets** (quality-based procedures) is an attempt to reinforce performance management.
- The use of **soft regulations** as observed seems better aligned with the development of a strong and independent cadre of health executives and of clinical leadership
- Ontario has had better results than Quebec in **access to family physicians**

Quebec

- **Clearer accountability relationships** are pursued through increased centralization
- The need to **be punctuated by investments in capacity** development and support for delivery organizations and healthcare providers.
- The growing concern around increases in the **cost of physician remuneration**

Quebec & ontario reforms
convergences

Improve the **organization of family medicine** and access to these services.

Financial investment and development support to improve the organization of medical services.

Improve **coordination** between specialist and primary care services.

Improvements to **access to care** in both provinces seem to be obtained at high costs.

The importance of **looking at the health system more broadly** and of reaching beyond the acute and institutional care sectors seem a promising avenue (HQO, INESSS).

Quebec & ontario reforms
Transformative capacities

The integration of care

- Ontario had fostered a low-rule approach (HealthLinks) coupled with incremental development of governance within the LHINs.
- Quebec has relied on structural integration coupled, in the early phase of the 2004 reform, with a low-rule approach.

The mobilization of evidence to improve practices

- Ontario, with the growing role of HQO and the LHIN appears to be in a more favorable position in this regard than Quebec.

The role of patient

- Ontario Patient's First Act (2016)
- In Quebec, bottom-up initiatives in a variety of clinical settings and universities have led to significant development and experimentation in patient partnerships.

The development of workforce skills to implement best practices and work in networks

- In Quebec, capacity development of the workforce appeared more present during the 2004 reform period.
- In Ontario, the focus on developing local capabilities to improve care have been supported by a government funded educational program IDEAS.

Modifications in the range of services

Quebec & ontario reforms
conclusion

- **Two critical policy and political factors:**

1. The engagement and leadership of the medical profession in the reformative journey
2. The ability of these systems to reallocate funding around alternative sectors of care (community-based care and non-institutional care)

Four lessons learned:

1. Through the experience of reforms, health systems have developed **a variety of strategies and levers** to bring about change and improvements.
2. They face challenges in **using these levers consistently and in a cumulative manner** within a coherent framework to support change and improvements.
3. Recurrent interest to reshape governance is **symptomatic of the difficulty to secure capacities to activate transformative levers at a sufficient scale**
4. Learning across different reforms period is not easy to achieve and is **highly dependent on change or continuity in the politics and politicians in power.**
5. The challenge is in **creating sufficient momentum and support** in a system to challenge the status quo and reproductive forces.

LESSONS LEARNED - CANADA

- Reforms from outside predominates over reforms from within
- Commissions and political/policy elites involved in the design of reforms
- Much less attention is paid to implementation issues and to broader health challenges (equity, population health, environmental health issues…)
- Concerns for the impact of reforms on clinical work and outcomes do not appear to be predominant with the exception of recent policy initiatives in Ontario and initial phase of reform in Quebec
- Persisting challenges in the integration of the medical profession in the design and implementation of health system reforms

CANADA VS OTHERS OCDE COUNTRIES (Denis & al., 2016)

- **Canada:** Structural reform and law, governance, funding and incentive mechanisms (macro)
- **Netherlands:** generation of societal support; structural reform, shift in funding (macro)
- **England:** Repeated structural reform, legislation; clinical governance; introduction of general management/clinical leadership (macro to meso)
- **Scotland:** Eschewing structure reform. Focus on conceptual work (policy clarity and consistency), collaboration and capacity building (macro, meso, micro)

Systems supporting the work of reform?

(Cloutier et al. 2015)

Design of reform

- **Conceptual work:** efforts to establish new belief systems, norms and interpretive schemes consistent with reform
- **Structural work:** efforts to establish structures, roles, rules, organising principles, resource allocation to support reform

Delivery of reform

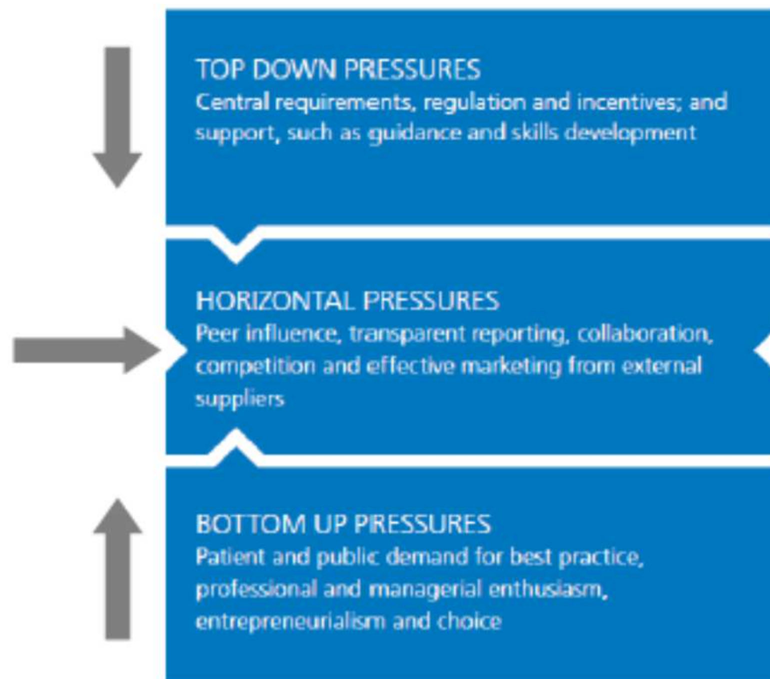
- **Operational work:** efforts to implement concrete actions affecting every behaviour of those linked with reform
- **Relational work:** efforts aimed at building linkages, trust and collaboration between people involved in reform implementation. Include discussion of non-traditional stakeholders here (e.g. advocacy groups; patients; think tanks etc)

conclusion

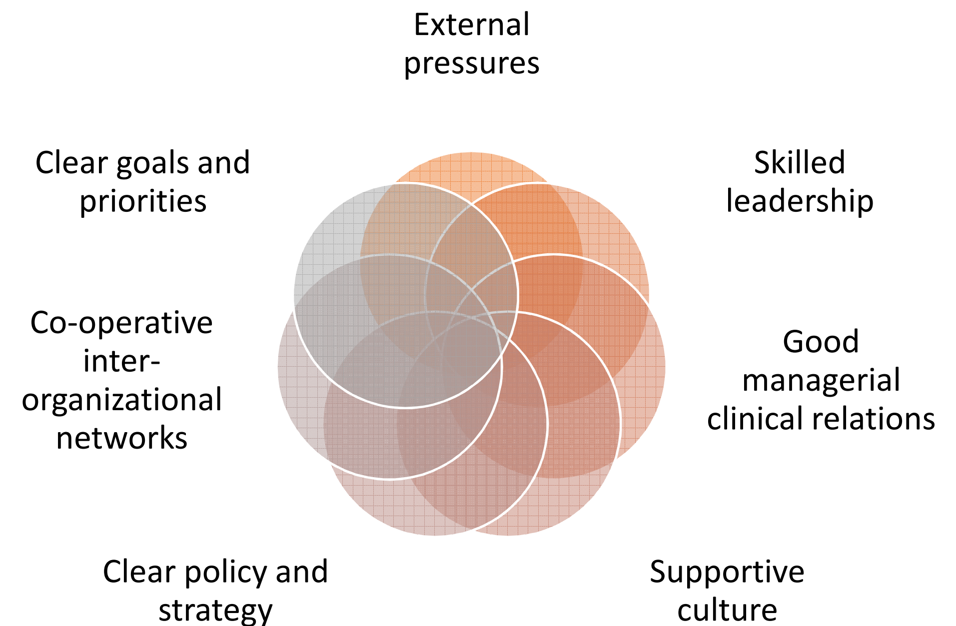
“as the analysis of successful IHCDSs in the United States shows, these cannot simply be created by government diktat: they require careful organizational design, good information systems, and longevity to develop a distinctive organizational culture to develop “systemness.” (Bevan & Janus, 2011:160)

Receptive context for change and innovation

Types of pressure to accelerate change and innovation (HIS, 2013)



Characteristic of a receptive context (Buchanan & Fitzgerald, 2013)



Source: Department of Health NI&EDIaSI. Innovation, Health and Wealth: Accelerating adoption and diffusion in the NHS. 2011. Available from: http://www.midtech.org.uk/wp content/uploads/2010/05/InnovationHealthandWealth.pdf; Buchanan, Fitzgerald & Ketley, 2013, p. 128

COUNTERVAILING POWERS AND ALIGNMENT OF INCENTIVES TO CREATE ENABLING CONTEXT FOR CHANGES

A pragmatic approach to health reforms – balancing system optimization with transformative action within the political economy of health

Principles behind a pragmatic approach to health reforms

- A ***political agenda*** aligns with tangible transformative and improvement goals
- Attention in reforms to both ***operational challenges*** and ***political contingencies***
- A careful use of strucural change to limit the risk of ***entropy*** (« crowding out »)
- More attention on how ***local context*** and ***system's logics*** influence the behaviors of providers and organizations
- Importance to rely on and to regulate ***professionnal entrepreneurs***

A WORD OF CAUTION! THE SIGNIFICANT ROLE OR POLITICS AND THE POLITICAL-ECONOMY THAT SHAPE HEALTH SYSTEMS

« The *politics of this redesign* phase differ from both the "high politics" of welfare-state establishment and the stealth politics and short-term budgetary unilateralism of welfare-state retrenchment. *In the redesign phase, opportunities for re-allocation and re-investment are seized upon by certain actors within the health care system who see the potential to benefit from them. These may be "policy entrepreneurs" who want to bring a new idea to fruition. Or they may be "organizational entrepreneurs" within the health system itself, who seize upon newly available resources to innovate within the shifting context.* Alliances between these different types of entrepreneurs, moreover, create yet further impetus for change." (Tuohy, 2012)