Session I: Health Care Reform

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What Arthur Sweetman asked me to do was to draw out some broad, thematic areas of discussion raised by the papers in this session. You have just listened to four very interesting, very solid papers, which cover a huge range of territory. So this has been a challenging assignment.

In the first instance, we have Pierre-Gerlier Forest's very conceptual paper on how we approach policy questions. We have Mark Stabile's paper on an assessment of a very controversial policy choice – around the de-listing of services. We have Greg Marchildon's preliminary assessment of how we understand one of the biggest reforms of the 1990s, and one that we understand the least about – namely, the regionalization of provincial health care systems. And then we have Herb Emery's paper, modeling of the impact of what is likely to be one of the most controversial policy choices in some provinces – increasing the role of private delivery through access to privately purchased health insurance. In the end, it's going to be P-G's paper, I think, that gives me a window into the other papers and answers one of the questions that was puzzling me as I read the three case studies.

The question that kept hitting me was, "Have we and are we continuing to make and implement health care reform in the absence of good evidence?" All of these papers, in different ways, give me some pause about the impact of particular decisions that have been made and are likely to be made. And a range of factors – either we had poor evidence, faulty evidence or some other factors that were not accounted for in the evidence – have interceded to somehow change the expected impacts of some of the reforms.

Now let me very quickly look at each of the papers in turn. On the case of the de-listing study by Mark Stabile, what in fact we have now is, I think, evidence that probably was not marshalled at the time that these decisions were being undertaken. Given the rather strange impacts that de-listing has had, both on utilization and the like, there are some very, I think, interesting questions about how governments in the future will approach these exercises.

And there is a similar case of action without evidence in Marchildon's account of regionalization in Saskatchewan. He tells us that there were two objectives, mainly, to regionalization. One was to hopefully save some money for the system. And the other was to move some resources away from acute care into what was then called wellness or a population-health approach to service. I would note, however, that when Saskatchewan debated its second wave of regionalization reforms (when it moved from 32 health districts to 12 regional health authorities) there was a very clear acknowledgement inside the *Fyke Commission on Medicare* that "we should not justify a new model of regionalization on the basis that it would save money". The rationale for this was that we knew by that time that the original move to regionalize in the early 1990s did not in fact save money.

The one thing I would also say, just very quickly, about Greg's future research on this topic is that one of the key elements in this is understanding, and one of the things that we don't really understand in the system right now is the fact that a health region is not a health region is not a health region. They vary significantly in their structures, in their governance, in their accountabilities, in their own internal dynamics and their relationships, both with each other and with their respective provincial governments. And that has to be taken into account in comparing results and operations across provinces.

In the final paper by Herb Emery and Kevin Gerrits note that if Alberta is looking to free up money for health care then they might have more success with a provincial sales tax than with a move to private health care insurance. As a one-time Albertan I understand how heretical that view is in that province and I would liken it to trying to discuss daylight savings time in my adopted province of Saskatchewan. But beyond this particular heresy, there are some startling things in Herb's analysis. And I think that whatever one makes of the model and some of the assumptions in the model, and some of those assumptions are major, it's clear to me that the fiscal case has yet to be made for introducing private insurance for services already covered under the public insurance plan. So I come back to that question about whether we have been engaged and are continuing to contemplate large scale health and health system reform without evidence?

The first reading of these papers would seem to indicate that, to some extent, yes, that's in fact what we have been doing. We've been reforming the system with either very limited evidence or very poor evidence. But this is where P-G, I think, comes in and saves the day. Rather than doing it without evidence, he tells us, we have been doing it within particularly limiting frames of reference. That is, we have been marshalling evidence that exists within, or fits within, our particular frames to either advocate for or to dismiss particular reforms. To quote very briefly from P-G's paper: "Policy frames act as filters or more accurately, as dams, hampering the natural flow of evidence. Even with the considerable range of tools and approaches available, policy-makers will typically limit themselves to the tools that are immediately compatible with their own frames of reference and which suggest a specific theory of problem causation, human behaviour, sources of power and authority, and social change."

All three of the case studies that we've heard, I think, provide evidence of exactly the kind of dams that P-G has pointed to. And had we looked at things like de-listing through a different frame of reference, would we have gone through those exercises? Especially, and as Mark Stabile may well know from his own experience there, the time and expense and just the huge frustration within the public service around those de-listing exercises, this was a huge investment of human resources into a process that was time-consuming and painful and problematic.

Greg Marchildon points out that regionalization was itself not a necessary condition for acute care restructuring because Ontario managed to do that without regionalizing. And so far, the evidence appears pretty mixed on how well the government of Saskatchewan has moved the system towards population health and determinants of health. Emery raises a number of fascinating scenarios about the consequences, intended and otherwise, that come to mind in moving toward private health insurance that call for the application of different frames, I would argue, for the increasingly sterile debate around the role of the public and private sectors within the system.

So finally, I would say, if this conference is about new evidence and new directions, then I think we need to take both the exhortation and the cautions – because there are some very important cautions provided in P-G's paper – very seriously. I think we should, in the first instance, open our minds to the idea that we're coming at these issues from within particular frames of reference that are themselves limited to the kinds of evidence that we will accept. And more importantly, we need to open ourselves up to the idea that the various components of our own frames are themselves contestable and subject both to change and to challenge. So I guess the challenge for us, then, is to at least begin a process of trying to break down some of those dams that we've erected around our own lines of analysis.