Politics, Policy and Practice: Research for Change in Canadian Healthcare

Maureen O'Neil

The challenges facing healthcare policy and practice in Canada today are significant and fundamental. As one paper put it, "The quality and quantity of health care has been endangered by the alarming increase in total health costs of the past several years … and the still more alarming projections for the years ahead." Furthermore, according to the authors, "medical and hospital care are not distributed according to the health needs of the population, nor are they in practice equally distributed as between regions and groups within the province." These are not recent observations but, rather they were, ones made in 1972 by the Manitoba government in its *White Paper on Health Policy*. Now, some 37 years on the shelf, the report is strikingly impressive in the enduring accuracy of its message.

The solutions the report proposes sound equally familiar and urgent. Making health services delivery more equitable and efficient, it says, means putting more health system decisions into the hands of the public – engaging those who have a personal stake in the quality and the results of those health system decisions (Government of Manitoba 1972).

By and large, we are still confronting the same problems of inefficiencies and inequities in healthcare, and still waiting for these urgent solutions. This inertia poses a fundamental challenge to scholars and specialists in public policy and public administration: how do we, as Canadians, induce, decide and execute change in such a large, complex and fragmented system?

Many are quick to fight for technical solutions to fixing Canadian healthcare, but arguably, the most urgent reforms have little to do with the sophisticated technologies found in modern medicine. The deeply rooted problems – involving equity and access, efficiency and effectiveness, responsiveness and responsibility to those who rely on the health services we all pay for – have much more to do with the fiercely complicated and change-resistant political economy of healthcare.

Political Economy and Public Participation: Getting There

Health services research can inform health services practitioners and managers – frequently with excellent results. But we have not done enough to inform the politics and policy making that will inevitably shape health system performance and outcomes. If research hopes to improve health services in sufficient scope and scale, it will have to address two daunting realities: first, the complex political economy of the health system; and second, the necessity of more informed and effective public participation in health system decisions. As Knott and Wildavsky (1980) put it so succinctly nearly 30 years ago, "When constituents do not demand change, and policymakers lack reasons of their own, they [policymakers] have little reason to try new methods or adopt new policies."

Citizens need to know what better care looks like and begin to demand it from providers, policy makers and politicians.

The work of the Canadian Health Services Research Foundation (CHSRF) and other organizations has resulted in improvements to the way we employ collaborative methods to create, share and use research in Canada. It is now broadly accepted that to be relevant and useful, research must be informed by the practical problems of practitioners and managers. At the same time, policy and practice need to be informed by the strong and well-organized evidence that good research can generate.

Yet there is an intricate web of factors that explain why actors in any system are slow to truly embrace change. Those who study the uptake of technologies and other innovations have long told us that lack of awareness alone is almost never the problem. Rather, new information and techniques tend to be applied only when the time is right and when key stakeholders support the change in question.

For policy makers, research is not the basis for a decision unless they see that policy experiments have been tried elsewhere and that evaluations have shown that those innovations work. Even then, we know that policy changes cannot simply be transferred from one jurisdiction to another. To succeed, any changes must account for local context. In short, the research-to-practice model must be adapted in order to acknowledge the social and political content of health system dynamics and to involve the public and politicians.

How Do We Get There from Here?

Successful examples throughout Canadian healthcare provide good reason to be optimistic, but they also reveal much work left to accomplish. For example, a few years ago, the CHSRF, the Lawson Health Research Institute, the Donner Canadian Foundation and a number of mental health groups funded researchers to test a new way to support people with chronic mental illness who had been hospitalized. The researchers identified 390 patients who being discharged from psychiatric hospitals. Many of whom lacked social supports and were considered severely lonely (Forchuk et al. 2002, 2005). Half of the patients were offered the chance to take part in a peer support program, which linked them with former clients of the mental health system and support from the hospital staff until they had connected with a community care provider. The peers provided friendship, understanding and skills for community living. The patients taking part in this program were discharged sooner 116 days per person (representing a savings of $12 million for those in the study alone) and were less likely to be readmitted than were those who did not participate in the peer support program. In fact, the researchers were able to demonstrate that the patients in the program consumed $4,400 less per patient in hospital and emergency room (ER) costs in the first year after discharge (Forchuk et al. 2002, 2005).

The Public Health Agency of Canada tells us that one in five Canadians – six million people – will personally experience mental illness during their lifetime. One-quarter of these will suffer severe mental illness, schizophrenia, bipolar disorder or severe depression (Health Canada 2002). Think of the impact on patients, families and society if the innovation tested by the researchers at Western were common practice in Canada. The fact is, it is not.

Let's take another example – one that involves the CHSRF's flagship program, Executive Training for Research Application (EXTRA). EXTRA invites health services professionals in senior management – nurses, physicians and administrators – into two-year fellowships aimed precisely at improving their skills for finding and applying timely research in their own jobs and organizations. One of the graduates of the EXTRA program, Sam Campbell, a physician and director of an emergency department in Halifax, Nova Scotia, developed an intervention project to deliver better treatment for patients with deep vein thrombosis (Campbell et al. 2008; CHSRF 2008). Most cases can be safely treated in the community, but family doctors are often uneasy in making a diagnosis and refer patients to the ER by default. Rather than work with his peers to develop a new clinical guideline – the strategy that the conventional medical model recommends – Dr. Campbell met the family doctors who were sending patients straight to the ER and worked with them to develop a new pattern of patient management. He also involved nurses, paramedics and even industrial process engineers. In addition, he engaged patients as part of the team and incorporated their responses. This new model of care is now the standard within that institution – although it must be noted, it is not the standard across Canada (Campbell et al. 2008; CHSRF 2008).

As observers of these promising practices, a natural question follows: how do we get there from here? Some would have us believe that if enough decision-makers take up these practices and if we connect decision-makers with each other, these ideas will spread until they become common practice. However, those with a close interest in policy know that system change requires more than awareness. It requires that an informed public is aware that the innovations are available and knows their benefits. Citizens need to know what better care looks like and begin to demand it from providers, policy makers and politicians. System change also requires that policy makers adjust the regulatory, financial and other levers at their control to encourage the implementation of these innovations. And it requires politicians to engage in an open and coherent discussion of these matters and to make tough choices about what is best for Canadians.

The best way to find out and understand what kinds of health services are needed anywhere is to ask the people who need them.

Engaging Citizens, Accelerating Change and Promoting Policy Dialogue

The logic of engaging citizens more actively is obvious and compelling. The best way to find out and understand what kinds of health services are needed anywhere is to ask the people who need them. Dysfunctional healthcare institutions – from ministries of health to local hospitals – are more likely to remain dysfunctional if they can evade accountability to the people they are supposed to serve. And encouraging and informing public activism can animate the interest of policy makers, including political leaders, in the pressing necessities of healthcare improvement.

Asking people what they need, keeping institutions accountable and making policy makers responsive – this is the ordinary logic of democratic governance. But it is a logic that has seemed remarkably absent from the design and operation of the

Table 1. CHSRF's strategic directions 2009–2013

Our Vision
Timely, appropriate and high-quality services that improve the health of all Canadians.

Our Role and Mission
The Canadian Health Services Research Foundation works to improve the health of Canadians by:

1. capturing the best evidence about how healthcare and other services can do more to improve the health of Canadians;
2. filling critical gaps in evidence about how to improve the health of Canadians, by funding research and evaluation; and
3. supporting policy makers and managers to develop the skills necessary to apply the best evidence to improve the health of Canadians.

Our Strategic Themes
1\. Engaging and supporting citizens
3\. Accelerating evidence-informed change
3\. Promoting policy dialogue

CHSRF = Canadian Health Services Research Foundation.
Source: CHSRF (2009).

Canadian healthcare system. Where it has been important is at the high strategic level. The Romanow Commission conducted a series of 12 citizen "dialogues," representing the most extensive, in-depth consultation with Canadians to date about their collective objectives for healthcare. Their response was clear: the Canadian public holds a strong commitment to a healthcare system built on the principles of equity (Commission on the Future of Health Care in Canada 2002).

Asking people what they need, keeping institutions accountable and making policy makers responsive – this is the ordinary logic of democratic governance.

How can we take what we know and engage more public participation in healthcare? One part of the solution is attracting and rewarding lively community representation on hospital boards, health councils and other oversight organizations. We also need to work with these public representatives to ensure they have the skills and confidence to play effective roles in governance. Across the country, there are promising examples of this work – an excellent example is the Community for Excellence in Health Governance (2009), a not-for-profit, member-based organization composed of board members, executives and thought leaders, all of whom share the latest ideas, information, resources, tools and innovative practices via an easy-to-use, web-based platform.

Effective public participation also means including patients and their families on patient safety committees and other advisory bodies in healthcare delivery organizations.

Healthcare providers have an important role to play too – for example, in understanding the experiences of patients and families more fully and incorporating this knowledge into healthcare planning and delivery. And we have to seek more active citizen contributions to macro-level decision-making so that the system adapts to real problems and needs. This can be achieved through exploring new applications for deliberative polling, an approach that involves not just polling a sample of people for their opinions but engaging them in extended conversations and shared learning (Center for Deliberative Democracy n.d.). The product of deliberative polling can be a telling transformation of beliefs and policy preferences.

At the same time, it is equally important that we engage the political level in a meaningful way about issues and options for Canadian healthcare. One way we can do this is by providing the necessary time and space for frank and evidence-informed policy discussions, a practice that the CHSRF will be proud to continue in the coming years. (See Coutts and Thornhill [2009] in this issue for a summary of a recent invited exchange on performance-based payment structures.) Political scientists like to point out that the 1984 Canada Health Act is one of the few pieces of federal legislation that has been passed by parliament unanimously. This is a positive statement of the Canadian value of equity in healthcare. However, we need to make sure that narrow definitions of how we achieve equity do not represent a barrier to innovation in healthcare, particularly that which can be accommodated within the Canadian medicare system.

Over the next five years, the CHSRF will invest strategically to identify, develop, evaluate and apply new ideas to improve the health of Canadians (Table 1). As part of its strategy of "innovation incubation," it will become a national resource for change, with the capability to recognize emerging challenges in healthcare as well as promising practices for addressing them. All our strategic activities will be driven by the understanding that improving health is not just about providing more healthcare:

in truth, tremendous potential is held by citizens and communities to make improvements happen, if they are supported in doing so. HQ

Acknowledgement

This column is based on a February 26, 2009, speech to Queen's University's School of Policy Studies, as part of their Policy Studies Speaker Series.

References

Campbell, S., M. MacDonald, B. Carr, D. Anderson, R. MacKinley and S. Cairns. 2008. "Bridging the Gap between Primary and Secondary Care: Use of a Clinical Pathway for the Investigation and Management of Deep Vein Thrombosis." *Journal of Health Services Research and Policy* 13(Suppl. 1): 15–19.

Canadian Health Services Research Foundation. 2008. "Connected Care: How a Health Science Centre Is Using Evidence to Improve Patient Transitions from Primary to Secondary Care." *Promising Practices in Research Use* 18. Retrieved April 6, 2009. <http://www.chsrf.ca/promising/html/pp18_e.php>.

Canadian Health Services Research Foundation. 2009. *CHSRF Strategic Directions, 2009–2013.* Ottawa, ON: Author. Retrieved May 15, 2009. <www.chsrf.ca>.

Center for Deliberative Democracy. n.d. *Deliberative Polling®: Toward a Better-Informed Democracy.* Stanford, CA: Author. Retrieved April 6, 2009. <http://cdd.stanford.edu/polls/docs/summary/#results>.

Commission on the Future of Health Care in Canada. 2002. *Building on Values: The Future of Health Care in Canada. Final report.* Ottawa, ON: Author. Retrieved April 21, 2009. <http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/hhr/romanow-eng.pdf>.

Community for Excellence in Health Governance. 2009. *My Health Board.* Montreal, QC: Author. Retrieved April 6, 2009. <https://www.myhealthboard.ca/>.

Coutts, J. and J. Thornhill. 2009. "Service-Based Funding and Pay for Performance: Will Incentive Payments Give Canadian Healthcare the Quality Boost It Needs?" *Healthcare Quarterly* 12(3): 42–49.

Forchuk, C., K. Hartford, A. Blomqvist, M.-L. Martin, L. Chan and A. Donner. 2002. *Therapeutic Relationships: From Hospital to Community.* Ottawa, ON: Canadian Health Services Research Foundation. Retrieved April 6, 2009. <http://www.chsrf.ca/final_research/ogc/pdf/forchuk_e.pdf>

Forchuk, C., M.-L. Martin, Y.-C.L. Chan and E. Jenson. 2005. "Therapeutic Relationships: From Psychiatric Hospital to Community." *Journal of Psychiatric and Mental Health Nursing* 12(5): 556–64.

Government of Manitoba. 1972. *White Paper on Health Policy* [Appendix to the report of the Cabinet Committee on Health, Education and Social Policy]. Winnipeg, MN: Manitoba Department of Health and Social Development.

Health Canada. 2002. *A Report on Mental Illnesses in Canada.* Ottawa, ON: Author. Retrieved April 6, 2009. <http://www.phac-aspc.gc.ca/publicat/miic-mmac/index-eng.php>.

Knott, J. and A. Wildavsky. 1980. "If Dissemination Is the Solution, What Is the Problem?" *Knowledge: Creation, Diffusion, Utilization* 1(4): 537–78.

About the Author

Maureen O'Neil is president and chief executive officer of the Canadian Health Services Research Foundation, Ottawa, Ontario.