A New Perspective on Health Policy for Social Democrats

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The Canadian medicare system has been an important part of Canadian federalism for more than thirty years. For a long time Canadians were among the most satisfied people in the world with how they received health care. By the late 1980s, this began to change. Health care inflation and fears about the sustainability of current health care systems resulted in a process of retrenchment and restructuring. By 1992, growing public concern and dissatisfaction that led Michael Decter to observe that Canadians were no longer smug about medicare.

Things have not improved. We remain worried about the current state and future prospects of medicare. There are a number of widely acknowledged problems. Public confidence has eroded to the extent that many Canadians are not sure that the system will be there should they need it. Overcrowded emergency rooms, intolerable waiting lists, crises in cancer care and even in the water supply fuel this anxiety. Health care professionals are dissatisfied with the current state. They feel overworked, underpaid and seriously undervalued for the services they provide.

Recent increases in funding to the system have momentarily reduced public anxiety but it is widely believed that this is only a short respite. Most significantly there are apparent threats to the guiding principals and values that lie behind the system. Some would argue that all five principles of the Canada Health Act are threatened today, in one way or another.

- The Canada Health Act guarantees Canadian coverage for medically necessary care in hospitals or by doctors. As pressures reduce the scope of what is considered medically necessary, what is medically possible has expanded. This disparity creates tensions around the public's understanding of c*omprehensive* care. Hospital stays are shorter and people are sent home earlier and are required to care for themselves after their stay in hospital. Some services have been "delisted" to save money for the system Recently, for example, physiotherapy outside hospitals, which is not under a doctor's supervision, was delisted in Ontario. This means that less physiotherapy will be available because it is unlikely that hospitals will increase the amount of physiotherapy they offer on an outpatient basis. At the same time people expect more from the health care system. As more and more conditions, from *in vitro* fertilization to erectile dysfunction, have become medically treatable there is some sense that truly comprehensive coverage would include all things that medical interventions can make better.

- Some of the economic burden of illness has shifted from hospitals and the public system to individual citizens. The cost of drugs and home care paid for by individual citizens or their insurers has risen considerably. The greatest out of pocket costs fall on those workers who do not have non-government insurance coverage. Because concern about one's ability to pay is a major barrier to contact with the health care system, those who are most worried about cost to them, experience exclusion from a system which has become less than *universal*, or find the system less *accessible* because of these indirect economic barriers. A pediatric oncologist described the impossibility of a middle class family to afford the extra costs associated with a second incidence of cancer in their child. The first brush with cancer had caused them to mortgage their house.

- Each province has dealt with the pressures on the boundaries of coverage in its own fashion. As Health Minister Alan Rock commented at a National Conference on Home Care (1998),

> … as we look across the country, we see a mixture of long-term, acute and preventive care services. We see some not-for-profit providers, some public-sector involvement and also some commercial and private

> interests at work. We see that some places administer province-wide projects while others turn authority over to regions to make decisions about delivering home care services. Those regions also sometimes offer a choice of services to be provided. … We sometimes see different criteria being applied to decide what services a client needs, different health providers for different services and various approaches in determining how much the client should pay. We also see significant private delivery of services.
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> The increasing divergence of provincial systems means that someone who is treated for a particular condition under medicare in one province might not be covered in another. This reduces the *portability* of medicare.

- Private-sector involvement in health care has been increasing in all areas from laboratory services to insurance cover. Perhaps because of pressure on the public purse the shift from public to private funding has already begun. Private payment for health care has gone from about 25% to 35% in the last decade. As private insurers and furnishers of health services, from physiotherapy to PET scans begin to administer a greater proportion of health :*public administration* comes under pressure.

Public policy in the area of health care has been remarkably impoverished over the last number of years. The great successes of the past like the introduction of medicare, the publication of the Lalonde Report and the passage of the Canada Health Act have not been achieved in recent years. In fact, if health policy were to be measured by levels of public confidence there has been a steady failure for more than a decade.

The outcomes of health policy interventions are not the only reason to think that health policy has been based on a weak understanding of the nature of health systems and organizations. A much better indication of this failure is the glaring fact that policy makers in different countries have taken diametrically opposite approaches to solve similar problems. While most Canadian provinces were regionalizing their health care systems to eliminate independent institutions with the hope of making the system more efficient, the UK was busy creating independent institutions to foster competition with the expectation this too would result in increased efficiency. Similarly changes to funding streams indicated the same lack of understanding of the role of finance in health care systems. While the UK was separating the provider function from purchasing of health care, the US was creating vertically integrated health systems where the insurance funders also began to own and control provider organizations. Many of these responses came from ideological commitments either to market forces or to strong regulatory mechanisms. Often the perceived scale of the problems determined the level of response. Hence, there was widespread and massive restructuring of health care systems in the English speaking world. A conference devoted to the consequences of restructuring concluded that that the major result was a widespread destabilization of health care systems. Some argued that the desire for increased efficiency of the system resulted only in economies that were passed from one sector to another – savings in hospitals shifted the burden of cost or care to other providers and consumers of health care.

It is evident that if a sustainable health care system is to emerge it will require a fundamental shift in how we understand and intervene in health care systems. The good news is that innovative ideas about the nature of organizations and systems, planning and policy development have been emerging, but are only now beginning to be understood. Mintzberg and others have suggested that rational strategic planning models need to be rethought in the light of our better understanding of rapidly changing and significantly less-predictable environments.

At Health and Everything, we have spent the last three years immersed in this somewhat conceptual area. Our support from Federal and Provincial Ministries of health, government agencies and private foundations provided a chance to develop some of these ways of thinking and apply them to health. Our results have been published in several places and we have begun to apply this thinking to particular problems. In this

paper we suggest some approaches that social democrats might resolve the current impasse in health care policy.

A simple distinction between the complicated and the complex can help us understand some of these ideas. Merely complicated problems can be broken down into simpler solvable parts. And once all parts of the problem are solved, the large problem is resolved. Such large difficult problems require careful coordination and resource allocation. Building a bridge and getting a man on the moon are good examples of such problems. The solution can be very complicated, require large amounts of resource and take a very long time. We might say that these problems occur in the context of mechanistic systems. Once they are solved, the solutions become replicable in those systems.

Complex problems are sometimes called "wicked" problems because they have emergent characteristics that cannot be reduced to their constitutive parts. When solved, the solutions do not function as recipes, which can be applied to other, like problems. There a re many good examples of such problems. Often they are problems of prediction. We have learned that there are definite limits to our capacity to predict the weather, the stock market, or indeed, the next drip of the faucet. But they also include problems of how to intervene in complex situations. We know with some precision how to bake a cake, but not how to raise a child. In fact, raising any child may be full of uncertainty, may result in unexpected instability, failure of standardized approaches or surprising successes. The context of these problems has been called complex adaptive systems.

We have argued that that problems relating to health organizations and systems, health policy and health itself are complex rather than complicated problems that occur in the context of complex adaptive systems. The table below lists some of the characteristics of the two kinds of systems.

Table 1 Complicated Mechanistic and Complex Adaptive Systems

Complicated Systems	**Complex Adaptive Systems**
Linearity	Non-linearity
Simple causality	Mutual causality
Equilibrium	Non-equilibrium
Reversibility in time	Irreversibility (time’s arrow)
Determinism	Probabilistic
Optimization	Satisfaction
Certainty	Uncertainty
Closed systems	Interactive systems
Noise and fluctuations suppressed	Opportunity seen in noise and fluctuations
Averages always dominate	Exceptions dominate near critical thresholds

Asymptotic stability	Structural stability at the edge of chaos
Structural constancy	Evolution/structural change
Analysis/reductionism	Holism/synthesis
Reductive characteristics	Emergent characteristics
Convergent thinking	Divergent thinking
Assumed predictability	Predictability severely limited by instability, structural change, and chaos

Interventions in complex adaptive systems require careful consideration and planning but of a different kind than in mechanistic systems. It is more important to understand local conditions and to be aware of the uncertainty that accompanies any intervention. Some preliminary frameworks have organized the thinking about policy interventions in these complex adaptive systems.

Five key elements of such frameworks include

- The need for stability as a counterpart and foundation for change
- The need for a variety of efforts and incremental changes
- The recognition of potential interactions between the constituents of system
- The need to support self-organization as a response to instability
- The need to developing procedures for monitoring and selecting intervention.

These frameworks can be applied to the questions of medicare and healthcare systems, and can act as recommendations for social democrats.

Develop A Stable Central Statement of Objectives

Stability creates the freedom to change. A critical feature is the need for government to subscribe to and maintain the core values of medicare while at the same time containing costs and achieving a high quality of service. Social democrats are seen to support and understand the basic values and principles associated with medicare because they were instrumental in developing the initial ideas and the first implementation of publicly funded universal health care coverage. In the UK the Labour Party remains the widely accepted protector of the NHS for this reason. In fact, Labour was elected in 1997 without a detailed health policy, but with a strong objective of preserving and improving the NHS. In Canada, medicare is part of the social democratic heritage. Canadians trust social democratic motivations with regard to preserving medicare more than that of more conservative parties.

Social democrats must embrace new ways of thinking about health care systems which recognize that the greatest economies in the system will come from creating and maintaining relatively stable structures and a stable funding flow. Any great change in either of these, we have learned from bitter experience, increases pressure on the system and may, indeed, increase costs and the number of contacts. Creating greater

confidence in the system and a belief that it will not be dismantled is a major objective of this stable background.

Recognize that Health and Health Care Interact with Other Social Democratic Objectives

One of the major flaws in health policy is to see health as an end in itself. It interacts with the larger objectives of social justice and well-being. Medicare contributes to these larger objectives not simply by delivering health care to all. It also is an instrument of fair redistribution of resources which is widely approved of by Canadians. (This generosity depends to some extent on the success of the system. It begins to be eroded as the system decays and people fear for their own access.)

Recognizing the interaction between medicare and these other objectives can provide a richer picture of the role of universal coverage. The portability of medicare stands in stark contrast to the American system where workers are tied to their jobs or their location by their current insurance coverage. This lack of portability of health care coverage constrains the independence of individuals and families. There is little doubt that portable health care coverage allows for increased worker mobility and a higher percentage of independent workers in Canada than in the USA.

Because health and health care are so often and carefully measured, the health of the population is not only a good indication of the health care they receive, it is more than likely an excellent indication of the well-being of the population. A social democratic health policy must recognize that it is only one contributor to well-being while measures of health are good indicators of well-being.

Recognize the Good Intentions of Professionals

Most health professionals enter their fields with altruistic motives. The best and the brightest become doctors not because of the millions they might make but because they hope to do some good. It is also an expectation that they will earn enough money to live as their colleagues do in other countries. In fact there are excellent OECD studies which show that doctors in most developed countries work to targets rather than to achieve extreme wealth. They tend to earn between three and five times the national average wage regardless of the structure of the system and payment mechanisms. The differences between different national groups appear to be narrowing over time despite the growing divergence of health care systems. Assuring doctors of their expected income level can attract them to a shared agenda, which must include increasing public confidence and reducing unnecessary expenditure in the system.

Social democrats are in an excellent position to provide assurance of job security for nurses. There is good evidence that the sought for savings that led to reducing nursing job security were never achieved. Higher costs for agency nursing and the defection of nurses to other kinds of work, or to nursing work in other countries are some of the consequences. A recent effort to bring Canadian nurses back to Ontario was gaining ground, until the government claimed that it would again drastically reduce hospital expenditure. Cost savings in health care occur when a stable, loyal workforce can share a stable social democratic agenda. This was a standard part of the health care system until the 1990s when there was a failure to recognize that nurses loyalty to their employers was also a combination of altruism and the expectation of relative job security. Jittery nurses have a hard time providing good care.

Support a Wide Variety of Health-related Programs

Small incremental changes work best in complex systems. A wide variety of small programs within the objective of a shared agenda of strengthening confidence in medicare while containing its costs have a greater chance of success than massive interventions, as we have learned to our regret in the last number of years. Interventions in complex systems are best introduced incrementally so as not to destabilize excessively a system that works. Allowing for differences in local implementation can increase variation. The creation of CLSCs in Quebec has evolved in this way. It is a centrally proposed program with local variations that respond to the particular communities being served. In health and social policy, an

appropriate policy mix of many initiatives is an important way of pursuing large objectives. A good example are the multiple perinatal policies in France or the proposed best policy mix for Children which is the legacy of Suzanne Peters to Canada.

Encourage and Maintain Multiple Points of Access for Health and Social Support

Part of the problem of emergency rooms in Canada comes from the reduction in the points of access to health and social support. As funding cuts reduced the number and scale of agencies and voluntary organizations that provided such support, people in trouble often had to wait until their condition grew more critical and they could come to the significantly more expensive emergency room (or the police station.) When there is no more money for the organization which provides friendly visits to the elderly, the elderly arrive more frequently to the emergency room. Similarly, stopping the suicide help line increases even more urgent calls for help to police of ambulance services.

The creation of this vicious cycle begins with the erosion of alternative points of access to health support which creates more pressure on emergency rooms. Solving the emergency room crisis involves putting more resources into them and those organizations to which they send patients.

A broad social democratic agenda would reverse this vicious cycle by rebuilding the social infrastructure and thereby reducing the pressure on the fewer and more expensive points of access.

Recognize Potential Interactions

In health care the division of labour in the acquisition of knowledge has been enormously successful. In every area of health research, the creation of more than 100 specialties and subspecialties in Medicine and Nursing has led to breakthroughs. A teaching hospital can have more than 400 different job titles. This differentiation of knowledge and task is a major source of the complexity of a health care organization, because it colours the interactions between providers. Policy initiatives often produce unexpected changes in these interactions. An excellent example of this was the introduction of fund-holding to general practitioners in the UK, which dramatically changed the relationships between GPs and hospital doctors. The joke goes that before fund-holding, GPs would send Christmas cards to hospital doctors to gain their help. After fund-holding, cards began to be sent in the other direction.

A major issue in health care systems is the coordination of patient flow across the many boundaries of disciplinary, departmental and institutional boundaries. This has always occurred across institutional boundaries and is most often based on entrenched practice and informal relationships among practitioners. Good policies build on existing relationships across those boundaries and foster new ones. Changing formal boundaries of organizations, even by eliminating them often disrupts existing interactions and can often have the perverse consequence of disrupting the smooth passage of patients though the system.

Encourage Self-organization - an Essential Characteristic of Complex Systems

Elements of complex systems adapt to environmental change, often in unexpected ways. Small local organizations often emerge to support individuals and groups at risk. Self -organization is a common response to conflict, risk and crisis. Policy initiatives must be able to welcome self-organization, by simply not withholding resources. The self- organization of the gay community as a response to the HIV AIDs epidemic is an excellent example of this. The changes in the community itself and the changing attitudes of the public to the gay community are unexpected consequences of these self-organized efforts.

Selection is a Necessary feature of Policymaking in Complex Systems

Because many smaller initiatives will fail as well as succeed, a critical role is that of selecting those initiatives that work for reward and expansion and weeding out clear failures if they result in harm.

(Because these initiatives should be relatively inexpensive they should be given quite a lot of time to succeed as long as they do no harm.) Strengthening the reward and complaints system has already begun in health care. Transparency of service as the institution of clinical governance can help strengthen the system. A lesson from litigation lawyers is that good relations between providers and patients reduces stress on the system. A study in the UK about patient waiting lists showed that simply explaining and clarifying delays to patients is a powerful way of reducing anxiety. These kinds of strategies which make more transparent the resources and services of the system to potential users can serve to help regain public confidence in medicare.

A Short Last Word

This brief attempt to suggest new ways of thinking about health and health care is based on fresh understanding of health and health care as parts of complex adaptive systems. More complete analyses of this kind are described on the web site of Health and Everything which is located at http://www.healthandeverything.org