POLICY
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DECISION-MAKING IN HEALTH: WE NEED A MORE COMPLEX CALCULUS

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Running Medicare, Canada's largest and most cherished social program, requires both a clear vision of what health care should be and careful calculation of the usually very complicated effects that any changes in the system might have. Though decision-making should be based mainly on the careful weighing of costs and benefits, it cannot ignore the small-p politics of who in the system will support, oppose or be indifferent to proposed changes. In our public system, big-P politics also has its place. But at the moment virtually the only element governments apply in the calculus of health care decision-making is how they look in the next day's headlines. In that sort of environment we will never get the fundamental changes the system needs.

La gestion du système canadien d'assurance-maladie, le premier de nos programmes sociaux et celui qui nous est le plus cher, nécessite à la fois une vision claire de ce que doivent être les soins de santé et la capacité d'estimer les répercussions souvent complexes des changements qu'on pourrait lui apporter. Les décisions en la matière devraient donc reposer sur une évaluation précise des coûts et avantages des changements proposés, mais elles ne peuvent faire abstraction des questions concernant l'appui, l'opposition ou l'indifférence suscités par ces propositions. Pour autant, il va sans dire que les questions plus fondamentales ont aussi leur place dans ce débat. Mais pour l'instant, les seuls aspects pris en considération par nos gouvernements quand ils évaluent les options possibles relativement aux soins de santé ont trait à l'image qu'ils présenteront dans les journaux du lendemain. Dès lors, comment imaginer qu'on apportera un jour à notre système d'assurance-maladie les changements fondamentaux dont il a tant besoin ?

Public policy decisions are rarely simple. Decisions in health and health care affect Medicare, Canada's most cherished and most expensive social program, and good decision-making requires the development and application of a particularly careful and complex calculus. Lamentably, in all too many jurisdictions the phrase "governmental decision-making in health" is a contradiction in terms. That this is so relates directly to the simplicity of the calculus currently used by governments to make decisions in this very complex field.

Over the past 20 years or more, successive federal and provincial governments have wrestled hard with many decisions relating to the preservation and enhancement of Medicare. Despite the high priority accorded to seeking solutions to health care's now abundant problems precious few of those wrestling matches have been won. As a consequence, opinion polls now regularly show widespread public concern about Medicare's continued viability. Providers complain about underfunding. Patients complain about long waiting lists. And newspapers employ the rhetoric of crisis when reporting on health care.

If there is a crisis, real or impending, it is in the downward spiral of public confidence. Increasingly, people doubt that those they elect to govern or, more precisely, to lead the health "system" either know what to do or are prepared to make the changes necessary to fix Medicare's all too obvious problems. The rhetoric, the public's concern and all those lost wrestling matches are all primarily the result of applying to health a much too simplified decision-making calculus. They are also the result of governments confusing management with governance and generally neglecting the latter while doing the former badly.

The calculus of decision-making used by those charged with governing the development and operation of our vaunted health services "system"—a term I put in quotation

marks because what goes on in our health-care sector is too disorganized to be considered a system—should take into account many more factors than it currently does.

What is needed most of all is a clearly articulated, widely communicated and generally understood vision, a centrally important function of governance. What do we want to accomplish by having a health services system? Is the purpose to optimize the health status of the population? Is it to provide sick and injured individuals with health-care services? These purposes, both important, are not the same. If the vision of Canadian health care is that it do both—which is my own view—let's say so up front.

In fact, no government in Canada has clearly articulated its vision of the health services system and what we should and should not expect of it—this despite the fact that every province now spends at least 40 per cent of its budget on health care, while overall health spending, including public and out-of-pocket expenses, accounts for over nine per cent of our gross domestic product.

Once a vision is agreed upon, decision-making must focus on answering the question "Will this particular policy or decision help us realize our vision for the health services system?" If the answer is "Yes," how much closer will it bring us to that vision and over what period of time? If the policy or decision under consideration relates primarily to the enhancement of health in well people, which of the many determinants of health does it affect, how does it affect them and how powerful is this effect?

And then there are what might called "beneficiary criteria." How should the benefits derived from the decision or policy under consideration be measured? Should it be in terms of peoples' access to health services, the quality of those services, the cost-effectiveness of their provision and/or other criteria? Decision-making should be strongly influenced by the answers to such obvious questions as who and how many will benefit? By how much? And over what time frame?

Sadly, neither government nor anybody else has the information necessary to answer these questions. The present state of development and application of information management systems in health and health care throughout Canada's provinces and territories is simply inadequate. The governors and managers of our health system don't have the data necessary to know what is going on, let alone to predict confidently what might happen as a result of making changes. We are trying to run 13 interlinked provincial and territorial enterprises, a $95 billion business nationwide, with an information system that the operator of an ordinary corner store would consider seriously deficient. Any other business run this way would soon be out of business!

Strategic considerations constitute another set of factors that need to be taken into account but usually aren't. Few decisions stand on their own; they have secondary effects on related policies and previous decisions. The decision-making calculus should take these into account by factoring in answers to questions like: What are the collateral effects of this decision or policy? Will the affected initiatives be influenced positively or negatively? And what will the overall impact be?

Another obvious, indeed now predominant question is what the implementation of a policy or decision will cost, both in terms of operating and capital costs. The cost question may well be very hard to answer, given the paucity of health information, but by itself, it is relatively simple. Of course, information about costs is useful only if the benefits can also be measured. Cost-benefit analysis is what is important in the calculus of decision-making in health.

Take, for example, the decision made at the meeting of first ministers just prior to the last federal election to reinject $23.4 billion into provincial transfers over the next five years. What benefits will result from these new moneys? The announcement that they were coming did effectively remove health as a campaign issue, buying the incumbent government (temporary) peace on this front. But will this restoration of most—though not all—of the money previously taken from the provinces to eliminate the federal deficit really solve or even alleviate any of the problems facing medicare? The main reason to doubt that it will is that we don't have any idea how much money "the system" really needs in order to operate effectively. We just don't have the data, although comparisons with spending and health status in other jurisdictions do raise serious questions about the idea that the problem is underfunding, as the usual mantra has it.

It may turn out that the financial deal struck by the first ministers was just about the worst possible outcome for the long-term health of our "system." The application of another "greenback poultice" allowed everybody, once again, to delay action on major reforms that are needed to bring medicare into the 21st century.

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But the decision-making calculus has to consider costs measured in more than money. Take labour costs, for example. Are there enough of the right kinds of people with the right kinds of training and experience available to do whatever is being proposed? If not, how long would it take and what resources would be required to produce those personnel? Another cost is administrative. What would it cost to manage the proposed change?

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Other factors to include are lessons from elsewhere. The oft-repeated boast that Canada has "the best health-care system in the world" leads many Canadians to conclude that we have nothing to learn from anybody else. That is not true. Health care is a high priority in all developed countries; and we can learn much that is useful from elsewhere. In fact, we can learn a lot from the United States, where the world's most expensive non-system of health services leaves about twice as many people as there are in all of Canada without much, if any access to health care. In the land of great contrasts south of our border there is everything from the truly awful to the truly wonderful, including in health care. We could do a lot worse than learn from the best American practices—for example, some truly impressive not-for-profit health maintenance organizations/integrated health systems provide their members with excellent care at realistic cost. The accountability measures introduced in Britain and New Zealand are another example we should study carefully. Interesting and useful things from which we could profit are going on in health and health care in many countries.

The decision-making calculus we need should therefore include answers to such questions as: Has this idea been tried elsewhere? What were the results? How comparable is "elsewhere" to here? How could the idea be modified to get the best results in the Canadian environment? And so on. It should also include a crucial question about implementation: How easy or difficult will it be to apply a particular policy or decision? The best ideas aren't any use at all if they can't be applied effectively.

One of the key problems in making implementable health-care decisions relates to the "players" who have to be brought onside. There are many such players to consider but doctors are key. Thus a crucial question in any change is whether doctors are going to support it, oppose it or be indifferent to it. Most people still trust their own physicians and consider them a source of good advice on all matters relating to Medicare. "Organized medicine" is not so highly regarded but it benefits from the high degree of confidence held in individual physicians. Answering the question, "What will the doctors do?" is not easy. Doctors are highly individualistic. Their organizations are well funded but fragile coalitions of competing interests—family doctors vs. specialists, urban doctors vs. rural doctors, surgeons and other proceduralists vs. non-proceduralists, and so on. But there are two issues on which physicians will usually stand more or less united: matters that affect either their incomes or their freedom to exercise individual professional judgement.

There are many other important players, of course—nurses, occupational and physical therapists, pharmacists, dentists and so on. In total, there are over 20 separate health professions, each with its own jealously guarded qualifications and skill sets. It's a good question whether contemporary society is well-served by this plethora of turf-protecting "guilds," but for the time being they exist and must be considered.

Inter-specialty rivalries can be expensive for the system. For example, Ontario's Health Services Restructuring Commission conducted an analysis of OHIP billings which showed that in 1997 fully 33 per cent of billings by specialists, a total cost of about $1.4 billion, represented work that could and should have been done by family doctors. Are we really so short of specialists as is often claimed? Or are we using our very highly trained specialists and the very expensive equipment and facilities of our hospitals to do work that could and should be done closer to home by providers of primary care?

Similarly, are we really so short of family doctors? In Ontario, the five most frequently used physician billing codes account for about 69 per cent of the total amount billed by family doctors, a total of $1.2 billion. Many of the services those bills represent—intermediate assessments/well baby care, general assessments, minor assessments, individual psychotherapy and counselling—could well be provided by nurse practitioners, nurses and others among the very well-trained health professionals we have in every province but are losing to other countries where they find more satisfying and permanent work.

Throughout Canada we are not using our well- (and expensively) trained, highly qualified

health professionals—specialists, family doctors, nurses, pharmacists, rehabilitation therapists, the lot—to anything like the full extent of their capabilities. What we are doing is like employing an electrician to change a light bulb. Our failure to use capable, lowest cost personnel is an expensive and inefficient use of scarce resources, including both money and the expertise of very talented people.

There obviously are other important implementation issues to consider but everything of any consequence done in the health services system depends on people doing it, so the decision-making calculus must also include the following questions: Who are the players and how can they be brought onside? Who will be opposed and why? Can that opposition be converted or neutralized and, if so, how, and at what cost? Health is a very people-intensive business. Unless and until the providers of care believe that change is in their own best interests and, to be fair, also in the best interests of their patients or clients, it just won't happen.

In the calculus of decision-making in health, politics is of the same order of importance as these "people factors." No policy is going to be made or decision taken without consideration of the real-world issue of how it plays out with those who elect the politicians who are expected to govern the health services system and other things) on our behalf. Although it is logically a sub-category of implementation, politics, both large "p" and small, has come to dominate the whole calculus to a degree that is both enormous and dangerous and justifies its being put in a separate category of its own. Politics is now the central element in the simplified calculus used by governments in making decisions related to health and health care.

Politics is important because Canadians are committed to a public health and health-care system. The system is public in the sense that it is based on the principle that all members of society should share the risks and consequences of disease and injury that until medicare were borne alone by those affected, their families, and anyone who would extend them charity. It is public in the sense that a very significant proportion of the costs of providing health services to the population, running now about 70 per cent (down from 85 per cent not many years ago) is met from the public purse. It is also public in the sense that most people look to government, and to provincial governments particularly, to guarantee their entitlements to service—which are usually expressed as one or another of the five famous principles of the *Canada Health Act*: universality, accessibility, portability, comprehensiveness and public administration. Most of all, the system is public because people hold their elected representatives responsible for the efficient and effective operation of the health-care system. And therein lies the major political problem: Virtually everything associated with health and health care is now intensely politicized. Ministers of health are expected to stand up in their legislatures and answer personally for every fault and error, imagined or real, in a non-system that involves a multitude of institutions, organizations, and entities and many thousands of people, few of whom would willingly acknowledge being part of a system, much less accountable to the minister for what they do.

All Canadian provinces save Ontario have tried to reduce the severity of this problem by creating regional health authorities to decentralize the management or operation of many components of the system. But even in those provinces where regionalization has been extensive, policy-making and decision-making in health remain intensely and ridiculously politicized.

I began to think about the calculus of decision-making in health in 1996 when I was asked to chair Ontario's Health Services Restructuring Commission. The Commission's whole purpose was to take politics out of health decisions, particularly decisions related to hospitals. It was set up under extraordinary legislation that gave it what amounted to the power of the government to restructure Ontario's public hospitals. These numbered slightly over 220 at the time and contained over 11,000 empty beds—the equivalent of 35 medium-sized hospitals. These beds were empty primarily by virtue of cumulative budgetary restraints imposed by several previous governments. The Commission's power, which eventually was tested to the level of the most senior courts in Canada, was binding on affected hospitals and the government alike as long as two conditions were met: that its procedures met the test of natural justice and its decisions were made in the public interest.

While the Commission was set up to be independent of government, in fact, implementation of its decisions was almost completely dependent on government's own decisions. Its second responsibility was to advise the Ontario govern-

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ment, through the minister of health, about restructuring, reinvesting in, and otherwise taking actions in respect to health services other than hospitals. Changes made in the hospital sector clearly will affect home care and long-term care in important ways. It would have been very easy for the government to frustrate the Commission's directions on hospitals by refusing to act on its advice respecting these other, alternative services. In its early days the Commission was frustrated by the government's inaction but, in the end, the recommended reinvestments in community-based services were made so that hospital restructuring could proceed. In the end, the government complied with its advice, though it took some time to do so.

Why was the Commission established? What stimulated this new government to empower a group of 11 volunteers to take on such politically loaded decisions as closing hospitals? The explanation is that four previous governments of three different political stripes had each wrestled hard but unsuccessfully with health reform. In 1995, the new government inherited an out-of-control deficit which it had promised to do something about. The province then was spending over 30 per cent of its annual budget on health care, with hospitals taking the largest part of that. The government was suspicious that the bureaucracy in the Ministry of Health was not really committed to spending less. Most importantly, it had been out of power long enough to stick to a "don't spare the horses" approach when it came to change. The result was the Restructuring Commission.

By the time the Commission completed its legislated mandate in March 2000, it had directed the rationalization of Ontario's urban hospitals. It had ordered 14 amalgamations involving 44 once separate and distinct hospital sites. It had created 14 hospital partnerships where none existed previously, and it had directed that 33 hospital sites be closed. Following its recommendations, albeit with some delay, the government had begun massive reinvestment of both capital and operating funds in home care and long-term care.

In making its decisions, the Commission applied most of the criteria described in the complex calculus I described earlier, but with one major exception: political considerations were completely ignored. All of the changes to urban hospitals, many of which were far-reaching, created a political furor, with the result that many backbenchers became nervous about decisions pending on the small hospitals in their ridings in rural and Northern Ontario. So just before the last provincial election the Cabinet withdrew the Commission's decision-making powers, converting it into an advisory body. When the government went to the polls a few months later, however, the results showed that none of the Commission's decisions had hurt it with the electorate, rural or urban.

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In any case, ignoring political considerations here as elsewhere, the Commission's advice on rural and northern hospitals, given subsequent to the election, was that none should be closed or merged with others. Politics aside, closing rural and northern hospitals would have diminished people's access to essential health-care services. The Commission recommended that rural and northern hospitals should instead be directed to work together in networks, supporting one another to improve the quality of service they offer and also to achieve administrative savings that could be redirected to patient care.

Important as hospital restructuring was, the really significant work done by the Commission took place in the last year of its mandate, when it undertook to provide the government with advice on how to deal with some long-neglected systemic issues that are much more fundamental to the preservation of medicare than hospital restructuring. In that final year, it issued reports and recommendations on health information management, primary care reform, system accountability and performance evaluation, system integration (beginning at the grassroots) and academic health science networks.

Unfortunately, little has happened since. The Commission's reports, like those of so many past advisory bodies, now lie gathering dust on out-of-sight bookshelves, having been displaced from the work table by matters considered more vital by political advisors to premiers and ministers—things such as today's (or tomorrow's) clippings from big-city newspapers.

To be fair, the Ontario government has continued with a project initiated early in the Commission's life—"Smart Systems for Health"—a project intended to lead to a solution of the information management problem. Smart Systems was loosely linked to another initiative, the Smart Card project, now abandoned, which was intended to enhance the access of all citizens to a spectrum of government services, including health services. The pace of progress is ponderous, however, and real, usable products are not yet in sight. The government has also

established a semi arm's-length body to take charge of primary care reform in Ontario. But this key step of primary care reform is also proceeding with agonizing slowness. As for system accountability, performance evaluation, system integration, and academic health science networks, or rural health networks, for that matter, nothing much is going on. Citizens have a right to ask "Why not?"

The answer can be found in the simplified calculus now used by all governments in Canada in policy- or decision-making related to health and health care. It contains, at root, only one element: how will this policy or decision play out politically? How will it affect the government's chance of re-election? In fact, the calculus may be even more simple-minded: what will the headline in tomorrow's newspaper be? Decision-making aimed at these objectives quite simply is not useful in governing/leading Canada's most cherished and costly social program.

A second difficulty, apart from trying to judge how policies will strike headline writers, is that we Canadians are not known for our warm embrace of change. According to William Thorsell of *The Globe and Mail*, "The phrase 'change for the better' is an oxymoron in the Canadian psyche." The double whammy inflicted by the highly simplified decision-making calculus we are currently using in health care is that the default condition is to maintain the status quo—to do nothing instead of something. The inevitable result is that more and more money is injected into the system while the fundamental problems—no health information, undisciplined waiting lists, nursing shortages, the patchwork quilt of home care services, there is quite a list—get worse.

Why have our governments abandoned governance/leadership of Canada's cherished provincial/territorial health-care systems? The answer lies in the nature and style of contemporary electoral politics. In the latter half of the 20th century, federal and provincial politics moved from parliamentary democracy to what Jeffrey Simpson describes as an "elected dictatorship," one for each of the federal, provincial and territorial governments. In the age of television, public opinion polls, and an increasingly "turned off" electorate that has been made skeptical at best and cynical at worst by advertising, political parties have the whip hand in elections. The parties' dominant role is reinforced by adherence to the first-past-the-post electoral system, which confers virtually absolute power even on governments elected by a minority of voters. These factors, combined with the accompanying transformation of parliamentary debate into theatre—and not very good theatre at that—and of backbenchers into bit players, have concentrated the electoral focus on party leaders, who naturally have responded by surrounding themselves with professional political advisors. In modern Canadian government, unelected staff in the prime minister's office has far more influence over public policy and decision-making than have cabinet ministers, ministers of finance and Treasury/Management Board possibly excepted. In a few short decades, Canadians have accepted presidential government but without any of the checks and balances that exist in the congressional system south of the border.

Bismarck defined politics as the art of the possible. Sadly, it seems these days that what is possible is circumscribed from the outset by focus groups and public opinion polls, both of which are strongly affected by necessarily simplified, superficial information, primarily as reported in the media. In fact, defining politics in that way, as the art of the possible, sells politics and politicians short. To my way of thinking, a better definition is that politics is (or should be) the art of *making possible* that which is desirable and necessary in a strong, compassionate and coherent society.

Some may read me as indicting contemporary politicians and condemning their craft. I intend nothing of the sort. I have worked with and admired a large number of politicians over the years, including several extremely able and dedicated ministers of health. To a person they have been sincere, hard-working and as frustrated by resistance to change as those of us from whom they have sought advice and counsel from time to time.

Provincially and federally we must help our political leaders find ways of applying a decision-making calculus that is considerably more comprehensive, no matter how it plays out in the headlines of big-city dailies and on television. Otherwise Medicare as we know it will more than face a crisis. It will fail.

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