McMaster University

McMaster HEALTH FORUM

ADDRESSING HEALTH-SYSTEM SUSTAINABILITY IN ONTARIO

29 NOVEMBER 2016

EVIDENCE >> INSIGHT >> ACTION

Dialogue Summary:
Addressing Health-system Sustainability in Ontario

29 November 2016

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

Authors

Kerry Waddell, M.Sc., Co-lead Evidence Synthesis, McMaster Health Forum

Kaelan A. Moat, PhD, Scientific Lead, Health Systems Evidence and Learning, McMaster Health Forum

John N. Lavis, MD, PhD, Director, McMaster Health Forum, and Professor, McMaster University

Funding

The funding for the stakeholder dialogue (and the evidence brief that informed it) was provided by the Ontario Medical Association. The McMaster Health Forum receives both financial and in-kind support from McMaster University. The views expressed in the dialogue summary are the views of the dialogue participants and should not be taken to represent the views of the funder, McMaster University or the authors of the dialogue summary.

Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funder's staff reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

Acknowledgments

The authors wish to thank Ileana Ciurea and the staff of the McMaster Health Forum for assistance with organizing the stakeholder dialogue.

Citation

Waddell K, Moat KA, Lavis, JN. Dialogue Summary: Addressing Health-system Sustainability in Ontario. Hamilton, Canada: McMaster Health Forum, 29 November 2016.

Dialogue

The stakeholder dialogue about addressing health-system sustainability in Ontario was held on 29 November 2016 at the McMaster Health Forum in Hamilton, Ontario, Canada.

Product registration numbers

ISSN 1925-2234 (online)

Table of Contents

SUMMARY OF THE DIALOGUE

Participants were receptive to the framing of the problem in the evidence brief, with a number suggesting that the 'drivers of change' approach to the demand for and supply of healthcare was a helpful way to think about health-system sustainability challenges in Ontario. However, deliberations about the problem led participants to identify a number of specific challenges in the province, including: 1) the health system is not fully meeting the needs of patients; 2) the health system is outdated and in need of modernization; 3) inefficiencies contribute to sustainability challenges, while new 'technologies' (including new drugs) threaten the publicly funded health system's affordability; 4) there are a number of oversights in discussions about health-system sustainability that constrain our ability to understand sustainability in a comprehensive way; 5) the government has few levers to effect change; and 6) there is a dearth of political leadership in the health system.

In deliberating about the elements of a potentially comprehensive approach for addressing health-system sustainability, participants generally agreed that efforts need to focus on both demand-side challenges (element 1) and supply-side challenges (element 2), as well as on a change in types of leaders and shifts in governance (element 3). In discussing element 1, participants highlighted the importance of strengthening links between public health and other sectors (such as primary care) and working towards establishing collective accountability for the health system by helping patients and the public to play a larger role in addressing demand-side sustainability challenges. Turning to element 2, participants focused on the need to modernize the health system while balancing two important considerations: how to support evidence-informed decision-making and how to revise financial arrangements to align with system goals. In discussing element 3, participants identified two types of leaders – leaders who promote a compelling and comprehensive vision for system transformation, and leaders who are willing to take political risks to ensure progress is made over the long term – and two types of governance shifts – changes to governance and accountability structures, and increasing the channels through which empowered citizens can exert pressure on elected politicians and other system leaders – needed to overcome what many participants called "health-system stasis."

In discussing who could do what differently, participants identified four opportunities: 1) tapping into Ontarians' growing dissatisfaction with the health system and articulating a compelling and comprehensive vision for health-system transformation that ensures the sustainability of the system while staying true to our values; 2) engaging patients early and often in decision-making about reforming the health system; 3) using specific priority sectors (e.g., primary care, long-term care, and end-of-life care) as 'test cases' for determining the optimal approaches needed for strengthening the health system, and then scaling up these approaches once a groundswell of support is established; and 4) laying a foundation for health-system reforms that cannot easily be undone.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Participants generally agreed with framing health-system sustainability challenges in terms of demand- and supply-side forces. That said, a few of them identified the need to give particular attention to select aspects of these considerations, or to extend or complement such framing, including:

- by acknowledging that while challenges exist on the demand and supply side, it is at the interface between demand and supply (i.e., the delivery and receipt of care) that many current health-system challenges are most acutely felt by patients and citizens;
- by placing more emphasis on the role of consumer technology and its impact across sectors, including its impact on patients' expectations about healthcare; and
- by giving greater attention to political challenges, which some participants felt had often undermined previous efforts to address sustainability (and which we return to below).

Participants largely focused their deliberation on six dimensions of the problem, namely:

1) the health system is not fully meeting the needs of patients;
2) the health system is outdated and in need of modernization;
3) inefficiencies contribute to sustainability challenges, while new technologies (including new drugs) threaten the publicly funded health system's affordability;
4) there are a number of oversights in discussions about health-system sustainability that constrain our ability to understand sustainability in a comprehensive way;
5) the government has few levers to effect change; and
6) there is a dearth of political leadership in the health system.

The health system is not fully meeting the needs of patients

Deliberations about the problem began with one participant stating that "individuals who are most satisfied with the system are those [who] rarely have to use it." A number of participants agreed with this statement, suggesting that a key dimension of the problem is that the patients who need care the most often can't access the

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened to support a fulsome discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

1) it addressed an issue currently being faced in Ontario;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on three elements of a potentially comprehensive approach (among many) for addressing the policy issue;
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three elements of a potentially comprehensive approach for addressing the problem, and key implementation considerations;
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible ways to address it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) it did not aim for consensus.

We did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior health-system leaders typically need to engage elected officials, boards of directors and others on detailed commitments.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

right care where and when they need it. Some participants gave as an example of such patients those individuals living with multiple and complex chronic conditions, which is a growing segment of the provincial population. Others gave as examples those living with mental health or substance use problems and Indigenous peoples, noting the continued separation of mental health services from central features of the health system like primary care, and the limited acknowledgment of the unique needs of Indigenous peoples and the poor integration of traditional Indigenous practices into the health system. Still others noted that almost any patient with significant healthcare needs would find the current system difficult to navigate, notwithstanding the frequent mentions of making the system more patient-centred.

Discussions about this dimension of the problem gave even greater attention to a number of participants' assertion that patients are increasingly unable to access care when the care they need is best provided outside hospitals, or by professions other than physicians. These participants observed that Ontarians are increasingly paying out-of-pocket or through their private healthcare insurance for home care, prescription drugs and care provided by non-medical professionals. A few participants noted inconsistencies in public coverage, which can be confusing and at times problematic for patients, as well as what seems like an arbitrary process of determining what is 'medically necessary,' with sometimes very different determinations in Ontario compared to other parts of Canada. A number of participants suggested that these issues, taken together, may be contributing to a growing sense among Ontarians that their health system is no longer meeting their needs.

Health system is outdated and in need of modernization

Participants built on the concept of the system not meeting the needs of patients, and attributed this in large part to their observation that the architecture of Ontario's health system has evolved very little since its creation and needs modernization. Participants gave two examples of how the health system is outdated: 1) the scope and nature of the programs, services and drugs that are paid for publicly; and 2) the ways in which policy decisions are made.

First, and building on the points made earlier, participants noted that a very large share of the provincial health budget is allocated to a relatively small set of 'inputs' along the continuum of care (mainly hospitals, physicians and prescription drugs), with the focus of the first two of these allocations largely "frozen in time" over many decades, rather than across a wider array of inputs that might achieve greater value for money. In particular, participants noted that hospital-based and physician-provided care remain eligible for first-dollar public coverage while, say, needed health promotion and disease prevention services, services provided at home and in the community, and prescription drugs, can be unfunded or only partially funded. One participant suggested that, despite the emphasis placed on providing care at the right time in the right place, the health system's key players continue to "worship acute care, with the big Toronto hospitals reigning [over the provincial health system]."

Second, participants suggested that the ways in which policy decisions are made have also failed to evolve, and that this has had several consequences, one of which is the lack of evolution in the nature of the programs, services and drugs that are paid for publicly. Several participants suggested that the complex structure of the Ministry of Health and Long-Term Care and the persisting silos between government ministries and arm's-length government agencies and other bodies contribute to a lack of transparency and inefficiencies in the decision-making process. Many participants agreed that reforms will need to be made to decision-making structures and processes in order to meaningfully address health-system sustainability.

Inefficiencies contribute to sustainability challenges, while new technologies threaten affordability

Inefficiencies were identified by a number of participants as a key contributor to sustainability challenges. For example, one participant attributed to the World Health Organization a statistic that up to 30% of what is done in any given health system provides no value and is essentially waste. Other participants suggested that the lack of integration across sectors and settings and the limited coordination among providers likely

contribute to additional inefficiencies in Ontario's health system, given the potential for duplication in diagnostic tests and therapeutic procedures. Participants noted that the resources lost to waste and duplication could be freed up to support areas that are currently underfunded.

Participants also identified many new technologies as threats to affordability. In some cases, such as new "designer drugs" for cancer, the technology may be needed but is very expensive. In other cases, the challenge lies in the increasing demand among patients for access to expensive new technologies, and the limited efforts among providers to manage patient expectations by explaining what they actually need. In still other cases, the introduction of new technologies has not been well managed, with several participants giving eHealth Ontario as an example of where lots of money was spent, but the anticipated impacts were often not achieved.

Oversights in discussions about health-system sustainability constrain our ability to understand it in a comprehensive way

Participants noted from the very beginning of the deliberation about the problem that sustainability had been a recurring issue on the policy agenda for at least two decades, but it was only later in the discussion that they began to identify oversights in these past discussions that may help to explain why it has never been adequately addressed. The oversights involved not drawing on the research evidence on how to address demand-side drivers, not looking for solutions beyond the health sector, and not learning from other health systems.

Starting with the first oversight, several participants noted that there is a lot of research evidence about the most effective strategies to help patients and citizens make healthier decisions and thereby reduce the burden of chronic disease and the demand for programs, services and drugs to treat these diseases. However, some participants were more cautious about the potential to scale up health-promotion and disease-prevention efforts to the entire population, and particularly among hard-to-reach segments of the population.

Turning to the second oversight, some participants noted that potential changes in sectors other than the health sector (e.g., policies about the built environment that encourage 'active living,' and policies about food and nutrition that encourage healthy eating) are not sufficiently discussed. Others noted that this arises at least in part because of the poor communication among government ministries in Ontario (e.g., between health, education, and children and youth services). One participant noted that recent conversations about health-system sustainability have centred on the changes that can be made within the health sector alone.

The third oversight that was suggested as a constraint on our understanding of the issue and what can be done about it was a tendency to look only at what has been tried in Ontario, and occasionally across the country. As one participant put it, "now that the world has come to Toronto, Toronto no longer thinks it needs to look at the world." Participants highlighted how the lack of meaningful comparisons to and learning from other countries has limited our ability to think differently about sustainability.

Government has few levers to effect change

Despite being the primary payer in the health system, several participants noted that the government has relatively few levers at its disposal to steer the health system in any one direction. Some participants discussed how in the past the government has primarily relied on two levers: changes in how organizations are funded and providers are remunerated, and adjustments to training (e.g., medical school enrolments). With respect to those levers that can influence the health workforce, some participants expressed concern that even these have been relatively ineffective in recent years. Most participants appeared to agree that without the ability to guide the health system in a desired direction, even the most well-intentioned efforts to address health-system sustainability from the top down will ultimately yield little.

Dearth of political leadership in the health system

Underlying much of the deliberation about the problem was a sentiment shared by many participants that political factors significantly constrain action in addressing health-system sustainability, with three key factors identified: 1) a political system that defaults to maintaining the status quo; 2) incentives for politicians that do not align with the need for medium- and long-term strategic thinking; and 3) a widespread belief that the health system reflects fundamental Canadian values that cannot be questioned.

Beginning with the political system's default to the status quo for the health system, several participants described how politicians who had entered office with the best of intentions were consistently met with a public service inside government and many stakeholders outside government – the public, professional groups and health organizations – who were more interested in 'tinkering around the edges' than in pursuing substantial reforms. One participant gave a common example from the public service: despite widespread dissatisfaction with many elements of the health system, suggestions for change often lead to 'turf wars' between branches in the ministry. A second participant gave an example involving the public: despite the many positive aspects of a given reform proposal, citizens often react negatively when suggestions for change involve any changes to the terms (particularly first-dollar coverage) under which they access medically necessary hospital-based and physician-provided care.

Turning to the second political factor, several participants noted that the incentives that politicians face lead them to look for quick wins rather than to pursue medium- and long-term change strategies. Some participants suggested that the four-year election cycle was too short a time frame for anything significant to be pursued in a status quo-oriented system. They argued that politicians' focus on re-election leads them to avoid the risks associated with pursuing fundamental changes to the health system. However, not all participants agreed with this sentiment. As one participant stated: "I don't buy that four years is not enough time to effect change. Wars are won and lost in that time, but if you really want to do something within that time period you can't just wait around till you are halfway through your mandate and then try to be cautiously brave. You have to pursue it from the get go."

The third political factor constraining action was suggested by some participants to be a widespread belief that the health system reflects fundamental Canadian values that cannot be questioned. Several participants mentioned how those running for office are frequently advised not to campaign on proposed changes to the core features of the health system because it would be polarizing, and they would risk losing the support of a large segment of the public. Such changes, particularly transformative changes, were noted to be particularly difficult to package in a way that would be acceptable to a majority of the public. Interestingly, some participants suggested that left-leaning politicians and political parties may have more credibility than their right-leaning counterparts to make the case that Ontarians' values about equitable access to healthcare might be better served by transformative change than by the status quo.

DELIBERATION ABOUT POLICY AND PROGRAMMATIC ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH

Over the course of deliberating about each element individually, a number of participants concluded that to address health-system sustainability, aspects of each of the three elements would need to be pursued. Many participants suggested that tackling only the demand-side (element 1) or supply-side (element 2) drivers would not be sufficient and, while not all participants agreed with the term distributive leadership used to describe element 3, many felt that a change in types of leaders and shifts in governance were needed to address health-system sustainability. Several participants indicated that pursuing one of the elements without addressing all three would in effect, constitute "tinkering around the edges" rather than pursuing the whole-system transformation that most participants agreed was necessary. However, unique considerations were raised within discussions of each element, which are outlined below before returning to participants' more holistic assessment of a potential way forward.

Element 1 – Engage patients and citizens to keep the health system sustainable by addressing demand-side drivers of change

In discussing element 1, participants highlighted two sub-elements that could be pursued in efforts to address the demand-side drivers of change: 1) strengthen links between public health and other sectors such as primary care; and 2) work towards establishing collective accountability for the health system by helping patients and the public to play a larger role in addressing demand-side sustainability challenges in Ontario.

Strengthen links between public health and other sectors such as primary care

Building on the points made earlier about the many silos in the health system in Ontario, many participants emphasized that public health is particularly under-utilized because of its structural separation from the rest of the health system. Participants noted that the alignment of public health-unit boundaries with municipal rather than LHIN boundaries has limited local public-health agencies' interest in and ability to contribute to broader system planning and service delivery. A number of participants suggested that there is an important role that local public-health agencies can and should play, both alone and in partnership with primary-care practices, in driving down the demand for and utilization of healthcare. They suggested that these roles could include designing and rolling out strategies targeting the social determinants of health and unhealthy behaviours, as well as identifying and addressing unmet needs for health promotion and disease prevention.

Work towards establishing collective accountability for the health system

With several participants suggesting that patients' and citizens' sense of accountability to their communities, their health system and to other taxpayers had eroded over the past few decades, discussion turned to three different ways of instilling a sense of collective accountability: 1) increasing health (system) literacy; 2) increasing visibility about the costs of care; and 3) engaging diverse publics in the difficult conversations that need to be had.

Starting with increasing literacy, several participants argued that the attention being given to financial literacy needed to be extended to literacy about health and the health system, including its underlying governance, financial and delivery arrangements, and the many threats to its sustainability. Such an effort, suggested some participants, would provide opportunities for engaging patients and citizens in discussions about what they can do to ensure they are using the health system appropriately. One participant noted that the Ministry of Education could play a role by adding health literacy to educational curricula throughout elementary and high school. Other participants noted that technology can play a role, including later in life, to build health literacy both in general and (through self-monitoring) in ways specific to each individual.

Other participants brought more of a financial lens to the discussion, suggesting that collective accountability could also be supported by providing patients with information on the cost of services (e.g., issuing a receipt or providing an annual bill), or by shifting to a system of medical savings accounts (which citizens can use to purchase needed services). However, one participant warned that many patients already curb their use of programs, services and drugs, even when they're needed, and that such approaches may result in the inequitable under-utilization of needed services.

A few participants noted the value of efforts like the citizen panel that informed the stakeholder dialogue and Health Quality Ontario's Patient, Family and Public Advisors Council in engaging diverse publics in difficult conversations about health-system sustainability. Such efforts can both inform approaches to addressing sustainability and give politicians insights about how to engage their constituents in conversations about addressing sustainability.

Element 2 – Align features of the health system to achieve value for money by addressing supply-side drivers of change

Many participants agreed that an overhaul of the supply side was important, both because of its direct impacts and because of how such an overhaul would likely provide a framework and incentives that could help curb some of the demand for services. In discussing this element, participants focused on the need to modernize the health system while balancing two important considerations: 1) how to support evidence-informed decision-making; and 2) how to revise financial arrangements to align with system goals.

Support evidence-informed decision-making

In deliberating about actions that could be taken on the supply-side, participants voiced their frustration with standards for and existing patterns in the use of research evidence. At the level of managerial and policy decision-making, one participant noted that new reforms are held to a higher evidence standard than existing approaches to doing things. At the level of clinical decision-making, another participant noted the generally limited use of research evidence, particularly in primary care, although they attributed this to the lack of appropriate incentives.

While participants did not come to a conclusion in terms of how best to increase the use of the best available research evidence at either level, they expressed support for government agencies like Health Quality Ontario and research organizations like the Institute for Clinical and Evaluative Sciences taking on a more significant role in supporting efforts to address health-system sustainability. A few participants expressed support for the decentralization of some system-level decision-making to groups that have the skills to find and use research evidence, and a rich history of working with select populations and communities of practice.

Revise financial arrangements to align with system goals

Several participants indicated that current financial arrangements are not aligned in a way that supports health-system sustainability and they suggested two alternatives to the status quo. First, one participant advocated extending the purchaser-provider split from the few areas where it is now used (e.g., home care, cancer care, and work-related injuries and diseases) to the broader health system. Some participants felt this approach could encourage competition among providers that could lead to improvements in service delivery, including greater attention to the patient experience. One participant cited the experience in the U.K. as evidence that some degree of competition among providers could be helpful. Several participants warned, however, that while such a model could be helpful in urban areas, it was less likely to work in rural areas of the province and it could increase inequalities between geographic regions.

Second, several participants advocated changing the way physicians are paid, noting that current arrangements provide perverse incentives that lead to the delivery of high volumes of care, rather than care that is primarily focused on the quality of the interaction between patients and physicians. A few participants suggested that salaries could help to realign the delivery of services with health-system goals. One participant noted, "currently the system incentivizes [doctors] to do all the wrong things and I think any reform process needs to start trusting doctors' professionalism. If we salary doctors they are not going to take a half day and put their feet up … I think what they would do is focus more on what the patient wants and their needs and less on what they are being paid to provide."

Element 3 – Harness distributive leadership approaches that enable the system to innovate and move towards sustainability

In discussing the third element, participants identified the types of leaders and governance shifts needed to overcome what many participants called "health-system stasis." The two types of leaders were: 1) those who promote a compelling and comprehensive vision for system transformation; 2) those who are willing to take political risks to ensure progress is made over the long term. The two types of governance shifts were: 1) changes to governance and accountability structures; and 2) increasing the channels through which empowered citizens can exert pressure on elected politicians and other system leaders.

Leaders who promote a compelling and comprehensive vision for system transformation

A number of participants suggested that to date, there has been little effort by health-system leaders to promote a vision for change that the public could easily understand. Participants stressed the importance of creating a compelling and comprehensive vision, and fostering a collective conversation about this vision among both health-system decision-makers and health-system users. Many participants agreed that modernizing the health system in ways that remained consistent with Ontarians' values could constitute this vision. They suggested that the public would understand that "very few things in our life have been the same for the past 50 years, but our health system has," as one participant said, and that structures and processes need updating, and can be done without jeopardizing values that are seen by many as core to our identity as Canadians.

Leaders who are willing to take political risks to ensure progress is made over the long-term

A few participants noted that, while they understood that some level of consensus among health-system stakeholders was necessary, they feared that policymakers would avoid the decisions needed to set us on a path towards system transformation. One participant stated that if nobody was willing to take risks, "we [will] end up exactly where we are now and people [will] crawl back into their own silos." Several participants made the case that politicians who are willing to take political risks – rather than those who are focused on the longevity of their political careers – will be best positioned to initiate the modernization of the system. However, some participants cautioned that risk-taking politicians should not be so adventurous as to leave out key stakeholders such as physicians, who one participant noted, often "dictate the success of government initiatives."

Changes to governance and accountability structures

Having noted a number of deficiencies in the health systems' governance and accountability structures, several participants called for shifting from a model of politician-led structures to "a non-partisan organization or an independent governance structure that was free from political comings and goings." Their concern was that a governing party, including the premier and minister of health of the day, could not take the 10-to-20-year time horizon needed to move the health system along a trajectory towards sustainability in the same way that a more politically protected organization could. However, one participant warned that no

matter what the governance and accountability structure is, health will "always be an area of public policy, and in the eyes of the public any errors will always return to a political figure as being accountable, even if [decisions were made] by an independent organization."

Other participants noted the self-interest that often governs the silos in the health system, particularly in the acute-care sector, and called for dismantling hospital boards and involving those who currently sit on these boards in the governance of Local Health Integration Networks. These participants suggested that such a change would profoundly shift the power dynamics in the system, and in a way that better supports health-system sustainability.

Increasing the channels through which empowered citizens can exert pressure

In transitioning to a discussion of a second type of governance shift, several participants mentioned the importance of the public in effecting change and, more generally, of a bottom-up leadership approach. Many participants expressed the view that public dissatisfaction with the health system will soon create the tipping point needed to begin the reforms required to address health-system sustainability. Some also noted that the public's support for any planned system change is critical to implementing and sustaining the change. A number of participants therefore supported increasing the channels through which empowered citizens can exert pressure on elected politicians and other system leaders. As one participated noted, "when patients are embedded in the process, we actually have to do a better job … they hold us accountable."

Considering the full array of elements

In considering the full array of elements, there was general agreement that structuring elements 1 and 2 in terms of addressing demand- and supply-side factors was useful in considering what actions should be pursued. Participants generally agreed that efforts would need to be made on both sides to ensure health-system sustainability, while incorporating the many additional considerations raised by participants throughout the deliberation on each of these elements. With respect to element 3, participants' views differed on who should be responsible for initiating change, with some participants believing it had to come from the top down, and others suggesting it would inevitably derive from public dissatisfaction leading to pressure from patients and citizens. Regardless of who should initiate change, participants generally agreed that all health-system stakeholders should be in some way involved, and that the key to successful leadership was to clearly identify who is going to play what role. Despite participants' repeated acknowledgment that the need for change was urgent, most participants generally agreed that the government should continue to pursue incremental change, but in the context of a comprehensive and compelling vision for sweeping transformation. This approach was promoted by a number of participants because of the need to ensure the health system continues to deliver high-quality care to patients throughout the process of change.

In wrapping up this deliberation, participants reiterated the importance of:

- working through how best to restructure the delivery of care and how to balance breadth and depth of coverage;
- recognizing that changes to governance and accountability structures will likely be met by significant resistance, but are ultimately necessary to address health-system sustainability; and
- committing to a genuine involvement of patients and citizens in system-level decision-making.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Discussion about the barriers to moving forward with an approach to addressing sustainability generally focused on three themes: 1) citizens' apparent devotion to first-dollar coverage of medically necessary hospital-based and physician-provided care; 2) citizens' lack of understanding of how the system works and where it is falling short; and 3) stakeholders' and decision-makers' interests.

The first major barrier noted by participants was citizens' apparent devotion to first-dollar coverage of medically necessary hospital-based and physician-provided care. The 'single-tier' publicly funded care provided in hospitals and by physicians is often a point of pride for Ontarians, many of whom have come to see the founding principles of Medicare as symbolizing their core values. Therefore, proposed changes to the health system, particularly when they affect the breadth and depth of these two types of coverage, are seen as attacks on equity and are often met with an intense public backlash. However, several participants suggested that contrasting how the system currently functions with how it could function under a different manifestation of our commitment to equitable access could help promote an appetite for change among the public.

The second implementation barrier builds on the latter point (and on a point made previously) in that several participants noted that citizens don't understand how the system works or where it is falling short. These participants reiterated the importance of raising citizens' health system literacy and sensitizing them to health-system sustainability challenges.

The third barrier to addressing health-system sustainability was suggested to be stakeholders' and decision-makers' interests. Decisions to introduce transformative changes to the health system will inevitably benefit certain sectors, organizations and professionals, while disadvantaging others. Moreover, as some participants noted, some stakeholder groups are fairly consistently benefiting at the expense of others. While by no means a panacea, keeping the conversation focused on the needs of patients can at least help to put these interests in perspective.

Having discussed barriers, several participants highlighted that growing public dissatisfaction with the health system, while a negative on the whole, could create a window of opportunity for change. As one participant noted, "when patients get in front of an issue and start demanding change from political actors, it gives politicians and government an opportunity to respond with change." Participants generally agreed that, while Ontarians had not yet reached this point, they will soon if the status quo is maintained.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

During the deliberation about next steps, participants had difficulty in articulating specific commitments that each constituency could take to move forward, but they did identify a number of places where policymakers and stakeholders could do things differently to help address health-system sustainability. These included:

1) tapping into Ontarians' growing dissatisfaction with the health system and articulating a compelling and comprehensive vision for health-system transformation that ensures the sustainability of the system while staying true to their values;
2) engaging patients early and often in decision-making about reforming the health system;
3) using specific priority sectors (e.g., primary care, long-term care, and end-of-life care) as 'test cases' for determining the optimal approaches needed for strengthening the health system, and then scaling up these approaches once a groundswell of support is established; and
4) laying a foundation for health-system reforms that cannot easily be undone.

McMaster University

McMaster HEALTH FORUM

>> Contact us

McMaster Health Forum
1280 Main St. West, MML-417
Hamilton, ON Canada L8S 4L6
Tel: +1.905.525.9140 x 22121
Email: mhf@mcmaster.ca

>> Follow us

mcmasterhealthforum.org
healthsystemsevidence.org
healthsystemslearning.org

tinyurl.com/mhf-YouTube
tinyurl.com/mhf-Facebook
tinyurl.com/mhf-Twitter

EVIDENCE >> INSIGHT >> ACTION