Contested Ground
Why are some policies healthy and others not?

Conference Summary
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Contested Ground: Why are some policies healthy and others not? Conference
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# Contents

2 About CHSPR  

2 CHSPR’s Health Policy Conferences  

3 About the 2016 Conference  

4 About Bob Evans  

5 Welcome Remarks  
   Victoria Schuckel, Executive Director, Research and Innovation, BC Ministry of Health  
   Deborah Money, Executive Vice Dean, Faculty of Medicine, University of BC  

6 Opening Plenary  
   Robert G. Evans, Emeritus Professor, University of BC  

9 Contemporary Canadian Health Policy Challenges  
   Danielle Martin, Vice President, Women’s College Hospital, Toronto  
   Colleen Flood, Professor, University of Ottawa  
   Jeremiah Hurley, Professor, McMaster University  
   François Béland, Professor, Université de Montréal  

14 Can We Learn from Other Countries? Can Other Countries Learn from Us?  
   Ted Marmor, Emeritus Professor, Yale University  
   Charles Normand, Professor, University of Dublin  
   Ivy Lynn Bourgeault, Professor, University of Ottawa  

18 Improving the Health of Populations  
   Michael Wolfson, Professor, University of Ottawa  
   John Frank, Professor, University of Edinburgh  
   Jeannie Shoveller, Professor, University of BC  

22 Health Care Policy Innovation  
   Ian Morrison, President Emeritus, Institute for the Future  
   Steven Lewis, President, Access Consulting Ltd. and Adjunct Professor, Simon Fraser University  
   Michael Rachlis, health policy consultant and Adjunct Professor, University of Toronto  

26 “Healthy” Policies—Critical Success Factors  
   John Lavis, Professor, McMaster University  
   Heather Davidson, Assistant Deputy Minister, BC Ministry of Health  
   Robert G. Evans, Emeritus Professor, University of BC  

29 Supporters and Conference Organization
About CHSPR

The Centre for Health Services and Policy Research (CHSPR) is an independent research centre based in the School of Population and Public Health at the University of British Columbia (BC). Our mission is to stimulate scientific enquiry into health system performance, equity and sustainability.

Our faculty are among Canada’s leading experts in primary health care, health care funding and financing, variations in health services utilization, health human resources, and pharmaceutical policy. We promote inter-disciplinarity in our research, training, and knowledge translation activities because contemporary problems in health care systems transcend traditional academic boundaries.

We are active participants in various policy-making forums and are regularly called upon to provide policy advice in BC, other provinces, and abroad.

We receive core funding from the University of BC. Our research is primarily funded through competitive, peer-reviewed grants obtained from Canadian and international funding agencies.

For more information about CHSPR, please visit www.chspr.ubc.ca.

CHSPR’s Health Policy Conferences

CHSPR’s annual health policy conference creates an opportunity for those interested in health policy issues and challenges to hear about emerging research and engage in interactive dialogue with experts in thematic areas. The conference draws leaders and researchers from universities, governments, industry, health authorities, and health and patient organizations from BC, the rest of Canada, and beyond. For summaries of past conferences, please visit www.chspr.ubc.ca/conference/past-conferences.
About the 2016 Conference
Contested Ground: Why are Some Policies Healthy and Others Not?

On April 5-6, 2016, two hundred health care managers, policy makers, researchers, students, patients, and interested members of the public from across Canada (and a number of other countries) came together to celebrate the career, vision, contributions, and impacts of the work of Robert G. (Bob) Evans, emeritus faculty at CHSPR. Bob Evans has spent his career exposing ‘inconvenient truths’ about the impacts of interests, positions, and policies in the health realm, and this conference featured speakers addressing some of his most visible lifetime preoccupations. Themes included international perspectives on contemporary Canadian health policy challenges, health care financing, legal challenges, and the role of broader health determinants.

The overarching objective of, and motivation for, the conference program was to address the difficult challenge of improving health care systems in developed countries. There is no shortage of good policy ideas or, in many cases, of evidence in support of those ideas. But because any policy change creates winners and losers, health care policy is always intensely “Contested Ground”. Potential losers are frequently in a position to block or subvert progress because those who stand to lose are concentrated and strategically placed, while the beneficiaries are diffuse and disorganized. Taking off from that starting point, this conference explored why some policies are ‘healthy’ and others not. Some survive the contest, while others, although potentially also contributing to a more effective and efficient health care system, and/or improving a population’s health, don’t. Still others, with well-understood unhealthy effects, thrive like weeds.

This document presents highlights and lessons learned from the presentations and discussions at the 2016 conference. To view the conference program, speaker biographies, slide presentations, and audio recordings, please visit www.chspr.ubc.ca/conference.

Bob Evans has spent his career exposing ‘inconvenient truths’ about the impacts of interests, positions, and policies in the health realm, and this conference featured speakers addressing some of his most visible lifetime preoccupations.
About Bob Evans

A founding member of CHSPR, Bob Evans has, for decades, been widely recognized as amongst Canada’s most visible, articulate, and accomplished health policy analysts and commentators. He is also viewed as amongst the ‘fathers’ of the fields of health economics and population health. His ground-breaking comparative studies of health care systems and funding strategies have shaped policy in Canada and provided insight to governments and health agencies worldwide. A decorated academic, Professor Evans is the recipient of Canada’s highest honour for lifetime achievement, having been appointed as an Officer of the Order of Canada. He also served as a member of the BC Royal Commission on Health Care and Costs in 1990, and of the National Forum on Health, chaired by the prime minister of Canada, from 1994 to 1997. His canonical works, *Strained Mercy: The Economics of Canadian Health Care* and the edited volume *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations* (on which he served both as lead editor and as contributing author) are considered classics in their fields.

Bob is a Fellow of the Royal Society of Canada and an Institute Fellow of the Canadian Institute for Advanced Research, where he was director of the Population Health Program from 1987 to 1997. In 2001, he became the first Canadian (and the second non-American) to win the Baxter International Foundation Prize for Health Services Research.
Welcome Remarks

Dr. Morris Barer, a faculty member at CHSPR and the conference chair, welcomed everyone to the 28th annual CHSPR Health Policy Conference, celebrating the career of Dr. Robert G. Evans. In his remarks, Dr. Barer recalled his colleague Greg Stoddart’s description of Bob Evans as “the Wayne Gretzky of health economics”, “not only because he performs his craft at a different, higher level than anyone else, but also because he elevates the game of all those around him.”

Dr. Barer noted that the members of the conference program committee were also well along on an edited collection of Bob’s seminal writings. The collection, titled An Undisciplined Economist: Robert G. Evans on Health Economics, Health Care Policy, and Population Health was to have been available, indeed launched, at this conference, but delays in the publishing process pushed back the launch date. The book is a collection of sixteen of Evans’ most important contributions, including two new articles, and is expected to be available from McGill-Queen’s University Press in late summer 2016.

Before introducing Bob as the opening plenary speaker, Dr. Barer introduced Victoria Schuckel from the BC Ministry of Health and Deborah Money from the UBC Faculty of Medicine, each of whom offered opening comments and reflections.

Speakers

Victoria Schuckel, Executive Director, Research and Innovation, BC Ministry of Health
Deborah Money, Executive Vice Dean, Faculty of Medicine, University of BC

Victoria Schuckel welcomed the conference delegates on behalf of the BC Ministry of Health and the Province of BC, and acknowledged our presence on Musqueam, Salish and Tsleil-Waututh lands. She noted that the CHSPR conferences are always places for sparking reflection and dialogue, and spoke of her vision of disruptive change in the health care system to move toward truly patient-centred care. She offered Airbnb® and Uber® as examples of disruptive change, but emphasized that in the meantime incremental change needs to be based on good, rich data; high quality research; motivated service providers and regional administrators; an engaged public; and enabling provincial policy. She noted CHSPR’s and Bob Evans’ long-standing, important, even if not always popular, contributions over many decades, and wished the audience a great experience of learning, reflection, and networking throughout the conference.

Deborah Money welcomed delegates on behalf of the University of BC in its Centennial year, noting that the longevity of the CHSPR Conference speaks to its quality and the impact of the work undertaken by its faculty, such as that conducted and inspired by Bob Evans.
Opening Plenary

Speaker
Robert G. Evans, Emeritus Professor, University of BC

“Life”, said Søren Kierkegaard, “can only be understood backwards but must be lived forward.”

Taking this cue, Dr. Evans used his presentation as an opportunity to look back on and to try to understand a 45+ year career that had, like most, been lived forward without the benefit of foresight. Most economists, he claimed, tend to “steer from the rear view mirror”, while at the same time claiming to be able to offer insights about the future. Unfortunately, as J.K. Galbraith remarked, economists predict the future, not because they know what is going to happen but because people ask them. They (we) then recommend various policy responses—typically divergent—which are rooted in theories about what people ought to do, rather than on careful observation of what they actually do. Four hundred years after Sir Francis Bacon’s acknowledgement of our debt to Machiavelli for writing of what men actually do, Evans believes that economists still need to be able to separate propositions or theories about how people ought to behave, from the actual analysis of what they really do. This was a central theme of his talk.

Dr. Evans divided his career into two phases, the first centering around an effort to understand and interpret health care systems from an economic perspective, and the second focusing on the broader determinants of health (of which the health care system is only one). In both phases he has had to struggle against the “habitual modes of thought”—including his own—that Keynes identified as the principal obstacles to intellectual progress. Evans and his colleagues have coined the term intellectual “zombies”—ideas that have no evidentiary foundation yet nevertheless keep returning to life because they serve influential economic and ideological interests.

In this struggle, Evans credited his wife’s experiences as a front-line nurse with inspiring his initial interest in the health care system. In particular, he noted a significant discrepancy between the theories of economic behaviour taught to aspiring young professional economists, and what she reported as to what actually went on in hospitals. The medical literature tended to be consistent with her account. Yet hospitals were a major and rapidly growing sector of the economy. So why is traditional economic theory so misleading when it comes to the health sector? In his 1974 paper, “The Market for Lemons”, George Akerlof provided an important clue. His analysis of the market for used cars illustrated what can happen in markets with asymmetric information, in which one party to the transaction possesses critical information not available to the other. In his example, the seller of the car has the informational advantage (and it is in the seller’s interest to keep it that
way). In such situations, the assumptions underlying standard models of economic behaviour do not hold, and strange things can happen.

Turning to health care, informational asymmetry between patients (NOT consumers!) and providers is the most pervasive and fundamental feature of transactions in this sector. And this asymmetry explains why health care systems are organized the way they are and why they function the way they do. Akerlof’s “lemons” model is directly applicable to the ‘market’ for ‘private’ health insurance, for example, explaining why, where such insurance is widespread, it actually covers a relatively small part of actual health care expenditures because it systematically excludes the “lemons”—the high-risk/high-cost patients. Even for the low-risk members of the population, private insurance survives only with large public subsidies through the tax-expenditure mechanism and an associated significant degree of de facto compulsory enrolment.

The extension of the concept of asymmetric information to interpret the structure and functioning of health care systems themselves, as opposed to simply their financing structures, requires a good deal more caution about “habitual modes of thought” in economics. The bottom line, however, is that most of traditional economic theory is of very little help, or worse, positively misleading or mischievous, to the understanding of health care ‘markets’ or as a guide for public policy. The economist’s baggage does offer a large selection of ‘spare parts’ from which useful frameworks of understanding can be assembled, so long as their builders are careful to respect what people do, and not what they ought to do. Off-the-shelf models from the textbooks are hazardous to your intellectual health.

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The risks are real. Kenneth Arrow’s famous 1963 paper, “Uncertainty and the Welfare Economics of Medical Care”, sent an entire generation of bright young economists down the wrong road into unproductive and even noxious swamps from which some have never found their way back.

In an environment characterized by asymmetric information, agency becomes important, and so it is not surprising that we find it used extensively in medicine and throughout health care systems—for example, self-regulation is nothing more than the medical profession undertaking certain
regulatory functions as agent for an insufficiently informed public (read government). Similarly, individual physicians or other regulated professionals (are expected to) serve as informed agents acting on behalf of their patients. Realistically, most patients most of the time will have insufficient information or understanding to make informed decisions amongst diagnostic and treatment options. But some of the most vexing problems facing health care systems everywhere are rooted in the fact that individual agents can take advantage of their agency roles. Evans suggested that it is rarely a good thing when one party has near total discretionary power over decisions affecting others, without effective oversight.

In the other world in which Evans has worked extensively—the social determinants of health—one often finds health promotion giving too little attention to the influence of the social environments in which people live, work and play. Too much attention is given to healthy or unhealthy ‘choices’—the decisions and actions of the individual. As a result, victim blaming for maladaptive health behaviours and conditions, such as smoking and obesity, is endemic. In reality, one’s decisions are typically strongly influenced by social or cultural environments that are largely outside the realm of personal control. How these environments ‘get under the skin’ to have biological as well as behavioural implications is still a very active field of research.

In response to a question about whether there was any hope that economists and economic principles could become more useful in the context of health care, Evans responded with a resounding “no”. For economists collectively, and as a discipline, he sees no hope. So many academic economists, particularly in the U.S., continue to follow the same old “habitual modes of thought”, and progress has been made in spite of them, not because of them. The best hope is either to work around them, or to seek out those economists who have for various reasons broken those habits. In some cases they will have suffered through serious personal or family illness in their lives and so have had very direct experience with how decision-making actually takes place in health care. This provides a quick cure for fantasies about the role of sovereign, fully-informed consumers. Others have had the good fortune or good sense to choose to work with collaborators who actually work in, and understand, how the ‘system’ behaves.

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Contemporary Canadian Health Policy Challenges

Four of the most taxing, yet important, contemporary Canadian health policy challenges are drug costs and financing, legal and regulatory considerations, the never-ending quest for the holy grail of financing and funding, and the increasingly important issues related to caring for seniors and others requiring long-term care. For the most part, the Canadian health care system is still failing to make significant progress on any of these fronts, despite extensive opportunities.

Speakers

Danielle Martin, Vice President, Women’s College Hospital, Toronto
Colleen Flood, Professor, University of Ottawa
Jeremiah Hurley, Professor, McMaster University
François Béland, Professor, Université de Montréal

Danielle Martin, Vice President of Medical Affairs and Health System Solutions, family physician at Women’s College Hospital in Toronto, and an assistant professor at the University of Toronto, made the case that we keep missing our windows of opportunity for creating a national Pharmacare program, despite widespread evidence that the current drug financing model is failing the needs of Canadians, and that a national program could be constructed that would meet those needs and would, overall, cost Canadians less than the patchwork of plans currently in play.

Evidence shows that one in five Canadians are not able to afford to fill their prescriptions, leading to avoidable complications of disease. Doctors and patients are being left to scramble, as best they can, to ensure that necessary medications are actually secured and taken as suggested. Dr. Martin characterized the current national dialogue as one in which we are fixated on blaming others and passing the responsibility rather than working together to design and implement solutions to a very serious health equity problem.
In order to move forward and successfully implement a national Pharmacare program, Dr. Martin suggested that we need a strong unified plan that includes both defensive and offensive aspects. We need to be protecting the Pharmacare brand, advocating for long-term solutions rather than more interim, patchwork, ‘solutions,’ exposing stakeholder interests, and ensuring that the discourse is informed by the research evidence. We need to be enlisting corporate champions, clinician leaders and the Canadian public to engage actively in this discourse, and to ensure that the research evidence is available and easily accessible to all.

In summary, Dr. Martin noted that we need to be “…unmasking the impacts of the [pharmaceutical] inequity, the high costs of the [pharmaceutical] inequity, and the human costs of the [pharmaceutical] inequity on Canadians”. Once these ideas become entrenched in the minds of all Canadians we will be primed to heave Pharmacare through the proverbial policy ‘window of opportunity.’

Colleen Flood, a professor at the University of Ottawa, University Research Chair in Health Law and Policy, and the inaugural director of the Ottawa Centre for Health Law, Ethics, and Policy, spoke about how the Canada Health Act and its current legal and regulatory guidelines need to be modernized to better meet the needs of all Canadians.
Canadians are so proud of our single-payer universal health care system that we fear tampering with the *Canada Health Act*, despite the fact that the health care system overall is no longer meeting the health needs of Canadians. The *Act* is not sufficiently comprehensive to meet the vast array of health care needs of patients; in particular it does not reflect, or take into account, the fact that increasingly important components of the system are not covered. As a result, we are providing insufficient and/or inadequate access to those needing home care, community care, mental health care, infant care, or ambulatory prescription drugs. The *Act* also does not ensure adequate accountability; the processes in place lack adaptability and transparency, leading to secret ‘back-room deals’ and lack of evidence behind coverage decisions.

Dr. Flood proposed that we open up the *Canada Health Act*, adapt it and change it to meet the health care needs of Canadians today. The new *Act* should, she suggests, be legally fair and just; adaptable; evidence-based; be structured so that it can evolve over time; and come with processes through which it can be challenged. If we have evidence-based, fair and transparent processes we will be able to determine the baskets of health care services that will be covered and the appropriate mix of coverage for those services.

Dr. Flood stressed that the power of law should be a transformative tool for change in our health care system. Through changing the current legal and regulatory guidelines we can improve the health care delivery system for Canadians. But change will require some courage, and most importantly, leadership; none of us will be well-served by leaders who are afraid of change.

Jeremiah Hurley, the Dean of the Faculty of Social Sciences, a professor in the Department of Economics, a member of the Centre for Health Economics and Policy Analysis, and a member of the Department of Clinical Epidemiology and Biostatistics at McMaster University, presented on the changing health care environment and how this is challenging how health care should be financed and funded.

Health care is a highly complex and dynamic ‘organism.’ This poses significant challenges for those tasked with making financing and funding decisions. Dr. Hurley highlighted a number of important characteristics of the environment within which those decisions needs to be taken:

1. Currently, due to slow economic growth, the Canadian government is struggling to fund all public services, including health care;

2. There is a growing physician supply which creates increased pressure on provincial physician remuneration ‘envelopes’;
3. There is constantly increasing patient demand for better and quicker access to all health care services; and

4. There is uncertainty about the outcomes of current and potential new challenges to the legal undergirdings of the current system, particularly the *Canada Health Act*.

This dynamic has resulted in increasing numbers of private clinics and increasing pressures from physicians interested in providing more privatized health care (meaning direct patient payment), despite this being in contravention of the *Canada Health Act*.

In the face of these current environmental challenges, any new funding and financial incentive policies need, simultaneously, to improve quality, control costs and support system change. These policies need to take into consideration the fact that how health care is financed and funded has direct effects on patient behavior—the types and amounts of care patients seek. Dr. Hurley also noted that designing financial incentives that will achieve desired objectives is particularly tricky in health care precisely because of the complexity of delivery arrangements. He noted that financial incentives also turn out to have unintended consequences that can be difficult to reverse. For example, it is important to take into account the decision scope and the organization of practices (e.g. teams).

Dr. Hurley believes that with respect to funding, we need to look more broadly than has been the practice to date, including using a mix of financial and non-financial incentives, and examining blended funding systems. Finally, Dr. Hurley stressed the importance of improving health care system literacy amongst members of the public in order to create a strong and informed public dialogue about how best to finance and fund our system.
François Béland, Professor in Health Administration at Université de Montréal and an Associate Professor in the Division of Geriatric Medicine at McGill University, discussed how the out-of-date way we deliver and plan for long-term care for seniors is inadequate to meet the needs of the aging Canadian population.

The way we currently conceptualize and deliver long-term care is not much different than it was two decades ago, despite the fact that the ratio of elderly to younger individuals is increasing. Expenditures on all services for seniors, including home care, nursing homes, physician services, and prescriptions costs, are all increasing and are projected to continue to rise. On average, the last couple of years of life are the most expensive years of life from a health care cost perspective, which is why policy makers need to focus on how to provide services in the most cost effective way during this last stage of life.

In Canada, the mix of financing for long-term care is becoming more private-heavy, leaving increasing numbers of patients without adequate long-term care services. Dr. Béland noted that this is not the best method for meeting the needs of this population. In addition to the challenges of affordability, the health care system needs to be far more integrated in order to meet the complex needs of an aging population. We need to consider that the disabilities and health problems that elderly patients face are parts of very complex processes often involving multiple chronic diseases that require a holistic approach to the patient. Long-term care has an important part to play in supporting these patients, but absent appropriate integration with other (e.g. social, housing, financial) services and supports, the aging trajectory for many Canadians will be more difficult than it needs to be, or than most of us would hope it would be when it becomes our turn.

Canadian health policy makers could make better use of current demographic and health care cost data, to build an up-to-date and innovative plan for providing long-term care to seniors. If we re-conceptualize long term care as a part of a process, this will allow the system as a whole to adapt and integrate services, including health, social and residential services, to better meet the needs of seniors in Canada.
Can We Learn from Other Countries? Can Other Countries Learn from Us?

This session offered perspectives on the prospects for, and limits to, cross-national health care system learning and importation. Speakers used case studies to illustrate the promise, and the challenges, of cross-national learning, focusing on system-level reforms as well as reforms targeted at specific segments of societies.

Speakers
Ted Marmor, Emeritus Professor, Yale University
Charles Normand, Professor, University of Dublin
Ivy Lynn Bourgeault, Professor, University of Ottawa

Theodore Marmor is Professor Emeritus of Public Policy and Management and Professor Emeritus of Political Science at the Yale School of Management. His scholarship primarily concerns welfare state politics and policy in North America and Western Europe, with a particular focus on major spending programs. He opened by presenting himself as a south of the border advocate of many of Bob Evans’ ideas.

Dr. Marmor’s talk was in three parts. First, he presented his rules of the game for cross-national research; second, he defended the proposition that much cross national learning is not learning at all, but is misleading, false, and dangerous; and third, he elaborated on one example of cross national research in an area of public policy dispute: patient cost sharing.

1. Rules of the game for cross-national research. Where nations share a similar constitutional and institutional structure, natural experiments can occur; however, these are always uncontrolled and to extract learning requires inferential and/or theoretical leaps. An inferential leap is required when dealing with the fact that there will always be differences that may matter between otherwise seemingly comparable jurisdictions. Theoretical leaps may be required if one is attempting to draw learnings about one industry from experiences in another—as Bob Evans has often pointed out, consumers act differently than do patients, for example. Given these challenges, Dr. Marmor concluded that if any learning is to result from cross-jurisdictional comparisons, something powerful must be going on.

2. Much cross-national learning is (intentionally) misleading. Commentary in this areas is filled with myths, foolishness, and interest groups advancing claims to those whom they think will not know the difference. Like any other evidence, ‘truth’ here is in
the eye of the beholder, and the same stylized facts can be, and are, harnessed to buttress or refute claims and counter-claims. How else, for example, could it be possible for there to be passionate advocates for a national health insurance program in the U.S. who claim that Canada provides all the necessary evidence to support such a plan for the U.S., while at the same time there are equally passionate opponents who claim that the failures of the Canadian system mean that the U.S. should adopt ‘anything but.’

3. **Patient cost sharing.** There has been a debate in the U.S. for decades about cost sharing for patients insured under Medicare. Over this period, patients have increasingly been conceptualized as customers—in order to make sure the patients have ‘skin in the game.’ This is a theological idea—there is no evidence that people treat medical care like any other consumer good. The fact that this sort of debate gained any traction in the U.S. came from sheer inattention, both to home-grown (U.S.) evidence, and to cross national evidence—Canada and various European countries have provided perfect natural experiments, but the U.S. does not seem to be able to learn from them because powerful interests want to ensure that the status quo (or something very close to it) continues.

Dr. Marmor concluded by deeming cross-national comparison a promising form of intellectual inquiry that can be illuminating even where policies cannot be transplanted, and warned that occasionally there will be findings so important that no one should ignore them.
Charles Normand is the Edward Kennedy Professor of Health Policy and Management at Trinity College, Dublin. He has worked for 25 years on the economics of health and health care, with a particular interest in understanding the ways in which aging affects use of health and social care, and on financing of services for older people. He spoke about financing and delivery of care at the end of life.

Dr. Normand spoke to results of recent research asking people from three countries what they want from end of life care and how they want to pay for it. The main findings he presented are:

1. Sometimes the process (how services are delivered) is as important as the content.
2. People want services to be available, whether they need them or not.
3. People want to minimize the burden on family.
4. People want to pay ahead of time, through tax or insurance, not at the point of care.
5. People want to participate in decision making but want experts to help make choices.

He noted that while individual care needs at the end of life are unpredictable, varied and often complex, they are overwhelmingly predictable in the aggregate. He argued that rationing (by price, insurance status, or time) should thus be unnecessary. He also noted that there is unanimity in the loathing of the psychological and financial impacts on patients and family of having to sort out payment (and, where available, reclamation) during and after serious illness. He concluded by addressing the implications of his work for funding and delivery of care, arguing that funding for end of life care needs to be simple and rely on prepayment, needs to come from a single source so that people get the services they need, not the services that are available, and that care needs to be brokered by experts.

...funding for end of life care needs to be simple and rely on prepayment, ... come from a single source so that people get the services they need, not the services that are available, and .... be brokered by experts.
Ivy Lynn Bourgeault is a Professor in the Telfer School of Management and Institute of Population Health at the University of Ottawa, and the Canadian Institutes of Health Research Chair in Gender, Work and Health Human Resources. Dr. Bourgeault also leads the pan-Canadian Health Human Resources Network. She spoke about the health workforce, noting that workers are the backbone of the health care system and the recipients of most health care spending, that most major policy issues implicate the health workforce either directly (e.g. care costs) or indirectly (e.g. education costs), and that the successful implementation of most health reforms will be dependent on buy-in by the health workforce; health care workers thus need to be a key focus of our discussion and planning.

Dr. Bourgeault argued for the importance of having a sustained infrastructure to meet knowledge and evidence needs for effective workforce planning. Many countries have (or have had) national agencies on the health care workforce, including New Zealand, England, and Australia; and the U.S. has coordinated regional health workforce centres. Dr. Bourgeault described some of the key functions and accomplishments associated with those national health workforce organizations. In contrast, Canada has a range of professionally and/or jurisdictionally isolated organizations in this area; the necessary collaboration and knowledge sharing and translation between these various organizations rarely happens, leaving Canada at a disadvantage relative to comparator countries when it comes to capacity to plan effectively and efficiently for health workforce futures. Because provinces/territories are all struggling with the same issues, but face widely varying health human resources 'circumstances', there is an important role for the federal government in this space.

Dr. Bourgeault concluded by describing some of the roles that the Canadian Health Human Resources Network has been attempting to play in the absence of any formal Canadian structure, but she noted that much more is needed if Canada is to be able to plan effectively within an environment where technologies and capabilities are constantly changing, and often changing very quickly.
Improving the Health of Populations

“There is something that powerfully influences health and that is correlated with hierarchy per se. It operates, not on some underprivileged minority of “them” over on the margin of society, to be spurned or cherished depending upon one’s ideological affiliation, but on all of us. And its effects are large.” —Robert Evans, 1994 (Introduction to Why are Some People Healthy and Others Not?, p. 6)

The session focused broadly on variations in the health of populations, exploring how these are identified and measured, why policy interventions designed to address them often fail, and sharing some examples of programs and policies that have been successful in addressing them.

Speakers

Michael Wolfson, Professor, University of Ottawa
John Frank, Professor, University of Edinburgh
Jeannie Shoveller, Professor, University of BC

Dr. Michael Wolfson is a former Assistant Chief Statistician at Health Canada, and now Canada Research Chair in Population Health Modeling in the Faculty of Medicine at the University of Ottawa. As a founding Fellow of the Canadian Institute for Advanced Research’s Program in Population Health, his body of work has focused on modeling approaches to measure health inequalities across populations.

In his talk, Dr. Wolfson discussed different approaches to measuring health inequalities. He acknowledged that a central failure of mainstream economics has been its inability to effectively deal with population heterogeneity, and to sort ‘just’ from ‘unjust’ sources of inequality. Further, conventional approaches to measuring inequalities are typically cross sectional and treat health status while living as a separate issue from mortality.

HealthPaths, in contrast, relies on microsimulation modelling which uses individual life course trajectories and focuses on functional status rather than the presence or absence of diseases or biomarkers. The model outcome is health-adjusted life expectancy (HALE), which is a product of several composite risk factors: socioeconomic status, physical function, mental condition, and sensory function. The empirical results are used to simulate counterfactuals: “what if unjust sources of health inequality were removed?” The HealthPaths simulation model has demonstrated that physical function has the largest impact on life expectancy but not on HALE. Mental condition, which does not affect life expectancy, has the most substantial impact on HALE.
Dr. Wolfson digressed briefly to note that current evidence on the effects of BMI (body mass index) suggest that millions of people are being misclassified as “cardiometabolically unhealthy”. For example, being simply “overweight” has been found to be associated with lower all-cause mortality.

The measurement of full lifecycle HALE and the impact of health inequalities requires more than “piecemeal epidemiology”. Rather, a coherent network of estimated dynamic relationships embodied in a microsimulation approach is needed.

Dr. John Frank is Director of the Scottish Collaboration for Public Health Research and Policy and holds a chair in public health at the University of Edinburgh. His research and professional interests concern the determinants of population and individual health status, and especially the causes, remediation and prevention of socio-economic gradients in health.

Dr. Frank discussed why most policies that are put in place to address inequalities in health are ultimately doomed to failure. He started off by presenting four possible hypotheses as to why:

1. Area-based initiatives are doomed to fail because spatially concentrated areas of multiple deprivation are simply too difficult to turn around.

2. Most policies that might be effective are slow-acting; some will take an entire generation to show significant impact.

3. Most policies are ‘too little, too late;’ they do not address the deeper structural origins of socioeconomic status that affect health over the life course.

4. Government policies across ministries are too inconsistent or are completely misaligned with each other, such that ‘the right hand giveth, while the left hand taketh away.’
Dr. Frank then presented comprehensive research evidence suggesting that none of these four hypotheses adequately explains why incentives to reduce health inequalities very often fail. This of course leaves us with the question, if not these four reasons, then why are many such policies doomed to failure?

Dr. Jeannie Shoveller is a Professor at the University of BC School of Population and Public Health and the Director of Epidemiology and Population Health and the Drug Treatment Program at the BC Centre for Excellence in HIV/AIDS. She leads and supports interdisciplinary research on social inequalities and health outcomes, including HIV.

Dr. Shoveller reinforced Dr. Evans’ idea that social hierarchies and gradients affect the whole of society, not just an “underprivileged minority” at the margin, and spoke about how this idea has shaped her approach to her work in HIV over the last 25 years. Effectively addressing health issues that arise from this gradient involves working both within and outside the health care system, and goes beyond just “tinkering around the edges”. She provided several examples of programs of research where an explicit focus on targeting underlying social and health inequalities with policy interventions has successfully improved health and other outcomes.

One such example is Insite, North America’s first medically-supervised injection facility, which provides a place for people using drugs to inject safely and be connected to health and social services. It has survived legal challenges (all the way to the Supreme Court of Canada) and significant scientific and political scrutiny. Key health impacts thus far include reduced syringe sharing, overdose avoidance, improved uptake of detox programs, and reduction of drug use and disorder in the surrounding neighbourhood. Insite is an example of the legal, health and social sectors collaborating to develop an evidence-informed policy intervention that addresses social and health inequalities.
The risk of HIV transmission among sex workers, and among young gay and bisexual men, are additional examples of health issues that would be amenable to structural interventions arising from collaboration across government sectors. To successfully address these complex problems, we need to move beyond victim blaming and informational interventions (e.g. handing out pamphlets) to more directly target health inequalities and change risky behaviours.

Ensuring health for all depends on a combination of healthy policies, legal supports, low threshold employment, and other structural interventions originating from within and beyond the health care sector. Policies that “[tinker] around the edges” of these complex issues end up being ineffective because they fail to address the social and structural contexts that underlie existing inequalities.

Successfully tackling any health issue that is affected by social and health inequality means changing social norms that affect, and are influenced by, us all.

Policies that “[tinker] around the edges” of these complex issues end up being ineffective because they fail to address the social and structural contexts that underlie existing inequalities.
Health Care Policy Innovation

There are health care policy approaches that seem to work in both theory and practice, but are not adopted widely. Nations are continually working towards creating more successful policies and fewer failures, in order to improve health care systems. The session was intended to address the question of whether innovation or transformation can be expected to lead Canada and/or the U.S. to the health care ‘Promised Land.’ The session was run as a panel discussion, with short opening comments by each of the speakers, followed by a longer interactive discussion.

Speakers

Ian Morrison, President Emeritus, Institute for the Future

Steven Lewis, President, Access Consulting Ltd. and Adjunct Professor, Simon Fraser University

Michael Rachlis, health policy consultant and Adjunct Professor, University of Toronto

Ian Morrison, an author, consultant, and futurist specializing in long-term forecasting and planning with particular emphasis on health care and the changing business environment, began by noting that all nations continually strive to improve their health care systems through innovation and transformation. The main goal is always to maximize value, which he defined as:

\[
\text{Value} = \frac{(\text{Access} + \text{Quality} + \text{Security})}{\text{Cost}}
\]

All nations go about balancing this equation differently to meet the health care needs of their citizens. Dr. Morrison and speakers Michael Rachlis and Steven Lewis, both health policy consultants, agreed that Canada and the U.S. both have examples of successful experiences in this regard:


2. Canada: Hamilton Mental Health Program, Toronto Arthroplasty Model, cultural shift away from over-abundance of medical interventions to more holistic care.
However, Drs. Morrison and Rachlis noted that, despite these examples of innovation, the U.S. still has the worst health outcomes out of 11 OECD countries and Canada has the worst access to health care for its patients.

Steven Lewis acknowledged that we have made strides in innovation and that we are not in short supply of innovative health care policies; however, we do face a shortage of successful implementation of innovative health care policies. He suggested that there are four main factors that prevent effective implementation of innovation:

1. **Certain people do not want change.** Currently we get bad health care value for money; however, physicians and health care workers are benefiting from this. Innovation and transformation frequently mean improved efficiency which, given the relative importance of health human resources in health care costs, translates to fewer health care jobs, and/or lower fees, wages and salaries in the sector.

2. **The system works relatively well for the upper and middle class.** The system works reasonably well most of the time for most middle/upper class citizens who have decent employer extended health coverage, so they do not see a problem with the current system.

3. **There is consensus on what to change, but it is too hard to change it.** There are a lot of moving parts in the health care system, including different provincial and jurisdictional processes, which to some people seem to create an insurmountable coordination challenge.

4. **Many people want change but different people want different types of change.** Each interest group advocates for different policies and each requires a different re-allocation of services and money. This lack of agreement, with different groups pulling in different directions, makes consensus on what to change (and how) extremely challenging.
Lack of effective implementation of policies coupled with policy researchers focusing too much on identifying problems and not enough on finding effective solutions, has created an ineffective environment for innovation. The panel discussed five main ideas for increasing the chances of successful implementation of innovations:

1. **Patient engagement.** There was widespread agreement that most Canadians feel that the health care system works well for them personally, most of the time. This is the main reason progress is slow. Yet at the same time, system-level statistics suggest that there are serious problems with the systems in both countries, in terms of cost, quality, and access. Even in the U.S., only 10% of patients get the best mix of cost and quality from the top clinics (e.g. Kaiser, Mayo, Group Health, etc.). Not only do we need to provide facts and research as to why the system is not working, but we need to find ways to penetrate public understanding, in order to create the sorts of pressures to which politicians are likely to respond. All patients (and future potential patients, which means all of us) should be invested in the process of understanding what is going on, and then advocating for a better system.

2. **Physician engagement.** In order to truly have innovative policies adopted, physicians and medical associations need to be invested in the change. There needs to be a transparent and honest dialogue between medical leadership and the public about improving system outcomes in both Canada and the U.S. Physicians are in a strong position to take leadership roles in advocating for evidence-informed changes that will lead to better outcomes. Examples include inter-health-professional care teams, health information technology innovation, and evidence-based prescribing. Without this dialogue and support from physicians, it will be hard for any effective change to occur.

3. **Clinical governance.** A major impediment to innovation uptake is the lack of effective clinical governance in the public interest. Canadian policy makers and researchers need to look at the formal decision making processes including governance arrangements, what laws and regulations affect health care systems, to determine whether changes can be made to these in the interests of more effective, efficient and responsive health care systems.

4. **Political environment.** We have all of the tools and resources, “the gas vapour” to enact change; we just need politicians willing to advocate effectively for evidence-informed innovations. The process of drafting, and then moving, legislation through provincial (and federal) governance systems is difficult, often bruising, and always complex. It requires passion, perseverance, and dedication. Some of the most far-reaching changes to the Canadian system have originated, and been driven by, change-champions at the federal level. Some of the key challenges facing the Canadian
system today will not be effectively addressed without similar federal leadership. Other challenges can only be addressed at the provincial/territorial level, but even here, partnerships across provinces, and federal assistance, can be important elements for change.

5. **Research.** There is currently too much micro- and not enough meso- and macro (system-level) research. The micro research is too specific and not generalizable enough for policy makers to use. Many of the key challenges facing our health care systems are at the macro-level, and so require research approaches that are appropriate to often complex, multi-faceted, challenges. Researchers also need to be more engaged in work that pulls together various strands of research and communicates it in effective ways to those tasked with developing and implementing policy change. Researchers also need to be willing and able to work with policy-makers to ensure that changes are evaluated in real time and tweaked as necessary.

Drs. Rachlis, Morrison, and Lewis concluded that there are many promising innovations and innovative ideas ‘out there’, both north and south of the common border, but that we are likely to continue to fall short more often than not on the road to the health care ‘Promised Land.’
"Healthy" Policies—Critical Success Factors

In this final session, chaired by Jonathan Lomas, panelists John Lavis and Heather Davidson reviewed the keys to policy success (and failure) in Canadian jurisdictions, emphasizing the various roles of governments, leadership, and interest groups. Bob Evans then provided a response, to this session, and to other ideas presented throughout the entire conference.

Speakers
John Lavis, Professor, McMaster University
Heather Davidson, Assistant Deputy Minister, BC Ministry of Health
Robert G. Evans, Emeritus Professor, University of BC

John Lavis holds a Canada Research Chair in Evidence-Informed Health Systems and is Director of the McMaster Health Forum, Co-Director of the WHO Collaborating Centre on Evidence-Informed Policy, Associate Director of the Centre for Health Economics and Policy Analysis, and a professor in the Department of Clinical Epidemiology and Biostatistics at McMaster University. His research focuses on the roles of governments, interest groups, and researchers in health policy making.

Dr. Lavis addressed the question “Why is it so hard to reform health care policy in Canada?” by discussing the results of a study that used key informant interviews and documentary analyses to understand the factors associated with the nature and extent of health policy reforms in five Canadian provinces over the past 25 years. The study focused on policy issues where reform was considered or undertaken, such as regionalization, alternative payment plans for physicians, for-profit delivery of care, and content of prescription drug plans, and was neutral about whether reforms were desirable or not. Seven cases of substantive reform and 17 cases of no or limited reform were identified.

Factors associated with substantive reform included a new government or government leader, a campaign commitment to reform during an election platform period, an appointed champion once a party was in power, policy announced during the first half of a mandate, and perceived fiscal crisis. Notably, these are all external factors not under the control of the health care system. Factors associated with maintenance of the status quo included resistance from “insider” interests—particularly medical associations, which proved to have an effective veto on changes affecting physicians’ freedom to choose their payment mechanism and a near veto on changes affecting clinical autonomy—and “outsider” interests, such as public interest groups, who have successfully (so far) protected the Medicare legacy, but have been unable to extend it.
Dr. Lavis closed by emphasizing two critical findings:

1. Substantive reforms were driven by changes in government and fiscal crisis.
2. Interest groups, whether public or medical associations, resisted change.

Heather Davidson has worked for the BC government since 1991 in a series of progressively more senior positions, mostly in the Ministry of Health, where she is currently Assistant Deputy Minister of the Partnerships and Innovation Division. She was an early advocate for evidence-based policy and decision making and has maintained strong linkages with the research community throughout her government career. In her words, she has spent her 25 year career championing evidence-based health policy.

Dr. Davidson structured her talk around the idea of a journey through the development of her understanding of the relationship between the health care system and the research enterprise. She discussed the value of her close and long-term relationship with Drs. Barer and Evans around issues of physician supply policy, lauded Dr. Lomas’ “Improving Research Dissemination and Uptake in the Health Sector: Beyond the Sound of One Hand Clapping” (Centre for Health Economics and Policy Analysis, McMaster University, 1997), and identified an understanding of research and policy as processes, not products, as central to creating effective policy, research, and decision making relationships. She ended by noting that the newly-established Academic Health Sciences Network in BC uses a model where using research evidence is seen as a key part of the process of care delivery.

To close the conference, Dr. Evans returned to the podium. He first invited his wife, Susanne Evans, to read a selection, below, from the Edinburgh Review of 1843 by Robert Torrens, a 19th century political economist.

“One of the great obstacles to the progress of the Moral Sciences is the tendency of doctrines, supposed to have been refuted, to reappear. In the Pure and in the Physical Sciences, each generation inherits the conquests made by its predecessors. No mathematician has to re-demonstrate the problems of Euclid; no physiologist has to sustain a controversy as to the circulation of the blood; no astronomer is met by a denial of the principle of gravitation. But in the Moral Sciences the ground seems never to be incontestably won; and this is peculiarly the case with respect to the sciences which are subsidiary to the arts of administration and legislation.” —Robert Torrens, Edinburgh Review, 1843
Dr. Evans invited the audience to draw any parallels they should choose to ideas and experiences discussed during the conference.

Dr. Evans then returned to John Maynard Keynes, announcing that the post-conference homework is to read the last section of Keynes’ *General Theory of Employment, Interest and Money*, wherein Keynes argues that the influence of ideas is far greater than is commonly thought. Keynes also argued that new ideas rarely have immediate influence, particularly in economics, and that views harden early (“there are not many who are influenced by new theories after they are twenty-five or thirty years of age”). Thus, the important thing is to get your ideas across to young people; when they eventually reach positions of power and influence, those new, by then old, ideas will have influence.

Evans also channeled Keynes in warning of the power of ideas, noting that the wrong ideas produced Hitler (and Daesh). The idea that ideas matter must motivate researchers, since we are trying to find out the “stuff” that becomes ideas. Dr. Evans’ overall impression of the homework piece is that he really likes Keynes here, but is not sure he is right. In Bob’s words: “Really—read the homework. Fine writing, really persuasive, I just wish I believed it.”
Supporters and Conference Organization

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