Health Policy xxx (2018) xxx–xxx

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Healthcare reforms, inertia polarization and group influence

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ARTICLE INFO

Article history:
Received 14 August 2017
Received in revised form 28 June 2018
Accepted 9 July 2018

Keywords:
Health policy
Politics
Medical unions
Social network analysis
Quebec (Canada)

ABSTRACT

Healthcare systems performance is the focus of intense policy and media attention in most countries. Quebec (Canada) is no exception, where successive governments have struggled for decades with apparently intractable problems in care accessibility overall, poor performance, and rising costs. This article explores the underlying causes of the disconnection between the high salience of healthcare system dysfunctions in both media and policy debates and the lack of policy change likely to remedy those dysfunctions.

Academically, public policies' evolution is usually conceptualized as the product of complex, long-term interactions among diverse groups with specific power sources and preferences. In this context, we wanted to examine empirically whether divergences in stakeholders' views concerning various healthcare reform options could explain why certain policy changes are not implemented despite consensus on their programmatic coherence.

The research design was an exploratory sequential design. Data were analyzed narratively as well as graphically using a method derived from social network analysis and graph theory.

Results showed striking intergroup convergence around a programmatically sound policy package centred on the general objective of strengthening primary care delivery capacities. Those results, interpreted in light of political science elitist perspectives on the policy process, suggest that the incapacity to reform the system might be explained by one or two groups' having a de facto veto in policy-making.

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1. Introduction

Given the amount of resources invested, the symbolic importance attributed to the concept of health, and the healthcare system's role in determining health, care delivery systems are core components of modern societies. This makes them the focal point of intense policy and media attention. Suboptimal care accessibility or quality, as well as inefficiencies in resource allocation, are generally perceived in the media and political spheres as legitimate policy intervention targets. Common wisdom dictates that governments and public institutions are expected to d̈o somethingẗo correct existing deficiencies. Yet the problem–solution trajectory is far from linear, and in most systems deep-seated performance shortcomings persist despite a seemingly never-ending cycle of reforms [1,2].

Academically, the evolution of public policies is usually explained from a perspective that is more political than instrumental. That is, policies are the product of complex, long-term

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https://doi.org/10.1016/j.healthpol.2018.07.007
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interactions through institutional mechanisms among diverse groups with specific power sources and preferences [3–7]. In such a view, public policies are not oriented primarily towards implementing programmatically sound solutions to tackle documented deficiencies, but rather towards finding a politically acceptable equilibrium for the core stakeholders involved in the policy process [8–13].

Previous research by this team [93–96] suggests that most obstacles to translating evidence on care delivery into structures and practices are political. By this we mean that they can be explained by policy options' level of divergence from dominant social norms and powerful stakeholders' preferences. In this context, we designed an empirical study to examine whether disagreements in stakeholders' views on various healthcare reform options could explain why certain policy changes were not implemented despite broad scientific consensus on their programmatic coherence.

However, the results of this study, as reported in the present article, point in a different direction. Despite a robust sequential mixed-method approach designed to identify and measure intergroup divergences in stakeholder groups' preferences, we mostly found convergence. This article presents the methods and findings of our study and builds on political science theories to provide an alternative hypothesis to the problem–solution divide in healthcare policy in Quebec.

2. Context: Quebec healthcare system reforms

Data for this study come from Quebec, one of Canada's 10 provinces. In the Canadian federal system, healthcare provision comes under provincial jurisdiction. Like all Canadian provinces, Quebec has a public, tax-funded, universal healthcare system that covers all « medically necessary » care. While the financing component of the system performs well, the delivery component has struggled for decades with severe problems in care accessibility, waiting lists, overcrowded emergency rooms, overall poor performance, and rising costs [14–17].

All publicly appointed commissions since the beginning of Quebec's public healthcare system [18–20] have recommended policy options that are consistent with the characteristics of high-performing healthcare systems as identified in most of the available scientific literature [17,21–25]. Very broadly, the recommendations stress the need to improve timely access through the development of an accountable, primary care-centred system relying on interprofessional teams and strong information systems [26]. The same recommendations appear in various other national and provincial commissions' documents [27–30]. However, despite this apparent convergence between scientific evidence and provincial- and national-level public commissions, the analysis of reforms actually implemented in Quebec over the past 20 years suggests that many critical elements (for example, issues related to interdisciplinary care or physician compensation models) were systematically ignored [17].

3. Conceptual framework

Since the middle of the 20th century, most theories on policy-making have acknowledged that stakeholders' opinions and preferences play a core role in policy-making and implementation processes [31,32].

Some of the most obvious theoretical strands that focus on stakeholders' or interest groups' role in policy-making processes are found in the literature on interest groups and lobbying [5,33–42]. Yet, even political science models that were not developed from the postulate that groups are the main determinant of policy-making still attribute a major role to groups' preferences in policy-making processes. For example, the Advocacy Coalition Framework [3,4,43,44] and the literature on policy communities and networks [11,45–51] and on agenda-setting [52–57] all share the common assumption that stakeholder groups' opinions and preferences structure policy-making.

The perceived causal mechanisms involved in the process differ, however, depending on the tradition. Stakeholders can structure policy-making through their capacity to influence public opinion [39,56–58], which in turn can have an impact on legislators through potential electoral consequences [11,12,35,36] or through more subtle ideological structuring processes [8,59,60]. Stakeholders can also influence legislators more directly through the control of valuable commodities [33–35], such as money (through party funding) or, more often, information [38,40,41,61].

Likewise, most contemporary models of policy-making rest on the concepts of policy arenas [52,53,62,63] or subsystems [44,53,64–67]. Those are defined as long-term interactions by a set of relatively stable participants around a given policy issue, aimed at influencing the adoption and implementation of public policies [51,53,65]. By defining multiple agendas (usually political, media, and public), the early agenda-setting models [68,69] played a central role in spreading the idea that policy-making is a broader process than initially thought, in terms of who is involved (not only legislators and interest groups but the media, researchers, etc.) and where it happens (not only in formal governmental institutions but also in private discussions, public opinion, etc.) [52–54].

Questions related to the level of influence that stakeholders and interest groups actually have in policy-making however, largely debated in the literature [70]. Pluralist models suggest that a variety of groups participate in policy-making and implementation processes, which enhances each group's potential for influencing policy agendas while ensuring that specific groups do not always monopolize agendas [5,36,71,72]. However, a significant portion of the literature on interest groups also argues that specific interest groups, such as those representing business interests, have a larger say in policy processes and have even, in the most elitist view, appropriated governmental prerogatives [73–76]. The literature on "iron triangles" has suggested, for example, that tightly knit groups having stable relationships with authorities usually exert the most influence on policy decisions [10,12,47,77]. Along the same lines, certain characteristics of the health policy field, such as the technical complexity of most issues or the political clout of medical organizations creates conditions propitious for elitist processes [6,8,78].

Building on the political science literature summarized above, we hypothesized that Quebec's incapacity to adopt and implement coherent policy solutions to care delivery problems and poor healthcare system performance, despite the high salience of these issues in both the media and political agendas, has political roots. Specifically, we posited that competing interests or views between different types of stakeholders—either between professional occupational groups such as physicians, nurses, administrators, and pharmacists, or between key stakeholders and the healthcare professionals they represent—could explain why effective reforms remain elusive.

4. Methods and data

This project was based on an exploratory sequential design [79] divided into two phases, one involving in-depth interviews with key representatives of healthcare system stakeholder groups and the other, a survey of groups of professionals—physicians, nurses, and pharmacists—and administrators. The sequential approach had two objectives: first, to integrate stakeholder representatives'

Please cite this article in press as: Contandriopoulos D, et al. Healthcare reforms, inertia polarization and group influence. Health Policy (2018), https://doi.org/10.1016/j.healthpol.2018.07.007

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