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Creating a More Democratic Health System: A Critical Review of Constraints and a New Approach to Health Restructuring

by

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The views expressed herein are solely those of the author and do not necessarily reflect those of the Commission on the Future of Health Care in Canada.

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Highlights

There is much pressure to renew our health system and increase public control over decision making. Despite this, various reform initiatives have yielded marginal results. Consequently, understanding the barriers of reform and what can be done to increase public control over the health system is a salient issue that threatens the legitimacy and future of the Canadian health system.

By assessing the broader political-policy context and how governance structures and processes have inhibited change, public debate, and the rise of alternative models of health, the study argues that:

- ◆ Old governance structures and processes have the kind of capacity and autonomy required to make it very difficult for outsiders to transform the system and institutionalize values of democratization.
- ◆ The struggle to restructure ideas, processes, boundaries, institutions, and forms of knowledge has proven difficult given the power of the old biomedical monopoly, territorial-ideological divisions among reformers, and the problems of communicating and coalition formation across groups and jurisdictions.
- ◆ Major institutional barriers to health restructuring are discussed, including the state, the market, and collegial system.

The discussion paper recommends:

- ◆ Creation of a permanent national commission to challenge old monopolies, and increase public control over the principles and future direction of the health system.
- ◆ This new institution would make it easier to create new forms of knowledge and establish best practices based on an evidence-based approach and not simply the territorial-ideological needs of the old elite who continue to defend processes that are designed to divide Canadians.
- ◆ New forms of dissemination need to be created that ensure economic decisions take into account health outcomes.
- ◆ Need to rethink fee-for-service system and research and advertising activities of drug companies.

Executive Summary

In the 21st century there is much pressure to renew our health governance system in a way that would increase direct public participation over the principles and direction of the health care system. Informed by the assumptions of neo-institutionalism, the purpose of the paper is to highlight the various contradictions and constraints that have always complicated the search for new solutions. The paper argues that these fault lines and inherited monopolies from the past have made it difficult to contest the power and legitimacy of established ideas, processes, and institutions; consider alternative health perspectives; or increase citizen engagement in decision making.

The analysis assesses the broader political-policy context and how inherited governance structures and processes have influenced the pace and direction of health restructuring. Through focussing on policy innovation and factors known to influence regime shifts, the paper examines recent efforts at health care reform and the factors that have made it difficult to increase public involvement in health policymaking. Despite increased pressures from both above and below to reconceptualize health issues and find different ways for encouraging new levels of inclusion and participation, insufficient attention has been placed on employing major theories of policy regime change to inform critical debates on how old biomedical biased ideas, processes and institutions have inhibited new democratic reforms, and what, if anything, can or should be done to address these. The major institutional barriers to health restructuring are discussed, including the state, the market, and collegial system for the purpose of generating new insights that can be used for informing the discussion and recommendations of the Romanow Commission.

The analysis concludes with a number of recommendations for increasing public ownership and control over the health system. With respect to policy innovation and knowledge-creation, it is argued that real change will require new evidence-based strategies and the creation of a more level playing field that should finally make it easier to contest the dominance of an elite-constructed biomedical regime and build public support for new reforms, yet without threatening the traditions of collective responsibility that continue to be important to Canadian values and identity. The method proposed is to establish a permanent national commission to facilitate the kind of information infrastructure and research links required to unite Canadians and challenge old monopolies. Such a mechanism, it is argued, would enable citizens everywhere to support, shape and compare best practices based more on evidence than on the agendas of dominant interests who have always monopolized the health public discourse in the past. It is argued that we need to reform the health system, but in a way that is evidence-based, less divisive, and truly serves the national interest. This will require finding new ways to challenge and contest the monopolies of province-centred, top-down, market biased, biomedical policy regime and then constructing new forms of knowledge and partnerships based on these. The establishment of a national commission would provide such an opportunity. New forms of dissemination are also discussed that would ensure economic decisions take into account health outcomes. Finally, the discussion paper recommends that governments need to rethink the fee-for-service payment system for doctors that helps perpetuate the old system, and the research and advertising activities of drug companies.

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Introduction

The 21st century opens with a fresh challenge for Canada's health care system. In response, academics and decision makers are spending much effort and time conceptualizing and theorizing about two closely related issues: the benefits of public participation in the planning and implementation of health care services; and how can we go from "here to there" with respect to creating a more open, democratic, and effective health system in an era when globalization, corporate concentration, and efficiency concerns are a high priority, and the nation-state itself is being questioned from both above and below. These revolutionary changes that are taking place have posed a number of dilemmas for a country that has, in the past, relied upon health policy for the purposes of reinforcing a common sense of national identity and citizenship.

The dichotomous nature of the health restructuring debate and effort to balance competing objectives has made it difficult to advance new approaches. As one would expect, this has created problems as well as challenges for an already complex decision-making structure well known for its ideological diversity and territorial competitiveness. Several key issues need to be addressed in discussions over the future of health and health services in Canada. First, the advantages and disadvantages of public participation. Second, the different forms of public participation that have emerged. Third, the extent to which these forms of democratic engagement and accountability have made it possible for citizens to shape the values and direction of the health care system. Finally, what can be done to sustain or encourage new levels of inclusion and participation.

The purpose of this discussion paper is to be provocative and to discuss the various constraints and contradictions that have worked against public involvement in health policymaking. The intent is to first provide a better understanding of why this has occurred and why this poses a problem for reformers hoping to achieve both health care reform and increased democratization. Emphasis will be placed on exploring why public participation is important to the system, what has been accomplished, and what can be done to further enhance or encourage a more citizen-based approach to health policy.

Context

During this period of health care restructuring, old assumptions, visions, and organizations upon which our health governance system is based are being questioned and contested by critics. As a result of a broader understanding of the determinants of health, there has been growing pressure to change the Canadian health system. Even though reformers agree that new approaches are required, there are different models competing for power and public support. By nature, paradigm shifts are not smooth processes. Whether regime shifts occur depends on a number of factors – including the strength of the old Canadian policy regime and who controls the discourse.

A common challenge for reformers is the strength and autonomy of the old system of governance being contested. Changing citizen expectations or the behaviour of the policy actors is never easily accomplished so long as the old system remains institutionalized and rewards old patterns of behaviour. This essay is reflective and assumes that there is a need to understand the game we have built first before we can begin to assess the prospects for launching new health strategies. If we are committed to deal with a variety of new health challenges in a more participatory way, we should begin by analysing the policy context, and the barriers to structural change. The traditional reliance that has been placed in the health system of governance upon market mechanisms as well as the medical pressure groups who have operated as “agents of government” also need to be considered in the mix.

There are different views on whether the status quo is adequate, or whether there is a need for a different conceptualization of health, health delivery systems, scopes of practice, and ways to measure outcomes of interest. These debates involve value and political judgements and the system we have constructed has both systematic biases and means for defending itself. There are very different critiques and divergence of views on health issues and the kind of reforms required to address these.

For decades, health promotion advocates have presented a convincing argument that since social determinants of health matter more to the health of the population than biomedical services, it is only logical that new strategies and mechanisms replace outdated ones (Lalonde 1974). These efforts to establish a more “people-centred,” community-based approach to health have been hampered by historical institutional arrangements and the competing elite (Raeburn and Rootman 1998). These researchers are highly critical of the monopoly of the medical profession and a health system that was never designed or intended to allow citizens and communities to directly participate in the creation of new forms of knowledge and dissemination required for addressing the social nature of disease. The population health approaches are concerned with social determinants of health and are aimed at planning health services based on the needs of the population. This approach is more quantitative.

These various paradigms, which assume direct public participation will improve the design and delivery of health services, have attracted much attention. They have played their part in legitimizing and mobilizing reform-seeking groups and politicians dedicated to their cause. However, competition between these approaches (despite various efforts to merge them) has complicated the quest of seeking a more participatory, framework on determinants of health

(Hayes 1999; Frohlich 1999; Beatie 1995; and Federal, Provincial and Territorial Advisory Committee on Population Health 1994).

Furthermore, in other academic and political circles there is interest in reducing the role of the state, and particularly the national state. It is clear there are mixed motives and objectives in this fundamental struggle to control the future.

Presently in Canada there are divergent views on problem identification and the necessary changes required. In Alberta, British Columbia and Ontario, for example, the provincial governments appear to be more concerned with fiscal realities and cost reduction than providing support for a failing public system. As a result, they are defining the crisis differently and have a more decentralized, market-oriented model in mind for restructuring. In Quebec, there would likely be less support than in Atlantic Canada for any approach calling for strengthening of the centre and increasing Ottawa's spending power. These ideological-territorial battles over redistribution through the Canadian welfare state are not new, but provide critical insights for understanding the different responses to the health crisis.

During the days of the Rowell-Sirois Commission and the Second National Policy, Ottawa assembled a group of experts who relied upon Keynesian assumptions about economic and social development to legitimize a push for a regime change that was supported by poor provinces but also "threatened the economic and political powers of Alberta, Ontario, Quebec, and British Columbia" (Tomblin 1995, 34). The commission succeeded because it created a powerful national myth and then mobilized an influential coalition in support of a new common set of Canadian values and institutions. This was an important watershed in our history since it helped Canadians define themselves as different from Americans. This kind of vision has had less support in certain provinces and ideological circles. As a result, once in place, there was little political incentive to change it or open up Pandora's box, even when circumstances changed. Because the new approach became a symbol of national pride and not just a way to define and solve health problems, it later posed a dilemma for reformers.

The political right agrees with the assumptions of health promotion reformers that there would be benefits associated with decentralizing power and making communities more responsible for health issues. Yet, more attention is placed on the need to eliminate expensive state bureaucracies and cut costs. While both the political left and right see the value of these kinds of changes, the critiques presented to the public have been very different. Despite an apparent consensus on the merits of increased public participation, these deeply embedded historical divisions and dissimilar models of civic engagement have likely complicated the task of mobilizing the kind of public support required to effect change.

In this contest over ideas, public opinion can be an important catalyst for change. Yet, given the existing power and autonomy of the current system of governance with its well deserved reputation for elitism, behind the scenes approach to interest group politics, and concentrated executive-corporate power, it would be a mistake to assume that public opinion will necessarily determine the future direction of the health care system (Savoie 1999; Pross 1993). Plebiscitarianism and the concept of direct democracy is a popular idea for those who believe that the culture and health needs of Canadian society have changed, but even if this is true, our

institutional system was never designed as a republic. Institutionally speaking, public opinion was never intended to determine policy and political outcomes in Canada. Consequently, there is a need for a more institutional or neo-institutional approach to the challenges of health restructuring.

Health reform cannot be viewed in isolation. Rather, it should be seen as part of a much larger ideological-territorial debate. Governments are being pressured from both above and below, and there are new voices calling for the weakening of the nation-state and the strengthening of continentalism and the role of subnational governments (Tomblin 1995). In provinces like Alberta, Quebec, Ontario and British Columbia, alternative market-centred models and continental visions are now being conceptualized and debated in the health and other policy fields.

In Alberta, the Klein government hired Don Mazankowski to complete an analysis and a new health vision for the future (Alberta 2002). These reforms, which are the result of ideological-territorial struggle, will, when implemented, increase reliance placed on the private sector in the delivery of health services in that province but will also be used to pressure other provinces to adopt similar practices. The likelihood of this occurring depends on the capacity to develop new models or contest the ideas defended by the right. Real power comes from controlling public knowledge and forms of dissemination. The Alberta, Ontario, or more recent British Columbia visions of health naturally compete with more nation-centred, equity-focussed approaches by the Atlantic provinces, Saskatchewan, and Manitoba. In the end, whether changes occur or not (and the direction these will eventually take) will ultimately depend on the sense that there is a policy crisis, the governance and decision-making processes involved, and the extent to which the general public is well informed. Much of this will also depend on the ideas that are presented and the way these debates are organized for public consumption. The public needs to be informed that there are a variety of options from which to choose, and not be bullied by right-wing critics, who may claim that there is no choice but the status quo and a private system, for example.

In the past, despite modernization theory and all the predictions about the inevitability of centralization, Canada continued to carve out a more decentralized path. In an era of globalization when there are predictions about the unsustainability and decline of the nation-state and associated policies, Canadians need to recognize that we can again make our own choices, but based on our own values, forms of public innovation and evidenced-based knowledge.

Whether Canadian society buys into a new public health vision will depend very much on the opportunities for a good debate. Despite much rhetoric about the need for civic engagement, Milner provides much evidence that civic literacy and political knowledge is not increasing in Canada (Milner 2001).

Understandably, democratic processes, forms of dissemination, and public institutions are important since they do play a critical role in deciding who participates and how issues are framed. Most citizens operate at the margin of politics and express themselves only occasionally either through surveys or voting every few years.

Canada is not unique in feeling pressured to change. Jurisdictions and health systems around the world are being challenged both above and below. Globalization, new forms of communication dissemination, the rise of international organizations, and other factors have all played their role in supporting new conceptions of community and health. This has come in the form of new theories on social cohesion; external pressures for primary health care; grassroots demands for increased control and participation in setting priorities for the health system, as well as new knowledge and evidence that social and economic conditions contribute more to our health status than medical care does (World Health Organization 1977, 1986). These democratizing pressures have both a domestic and international component (Commonwealth Foundation 1999; Wyman, Shulman and Ham 1999).

In the current context, a number of Canadian citizens are not well-informed on contemporary health issues or new approaches. As a result, they continue to identify with the old regime. This naturally has created a number of dilemmas and contradictions for health reformers because some of the possible new remedies being proposed are considered to be unthinkable and un-negotiable.

Since various citizens accept the notion that the national Medicare system is what defines us as Canadians, it is little wonder that reforming the system has proven to be difficult. These kinds of issues have not received enough attention in the debate over health restructuring, and new calls for more direct public participation, which are popular with health reformers but also for the supporters of the Reform-Alliance Party, are being heard. They do, however, help explain the kind of political dilemmas that have been created and why bringing about a regime change has posed so many problems. These dilemmas also help us to better understand why the national government and others who benefit from the old regime would be motivated to perpetuate these old myths and refuse to give up control over the discourse, despite structural problems within the system.

Regime Changes

As illustrated by Peter Hall, the institutional-political context, and rules and practices of the existing polity are important for understanding patterns of public opinion, institutionalized networks of policy innovation and learning, and also for determining whether new visions or theories are administratively and politically viable. Answering these kinds of questions requires knowing more about the structures, democratic practices and dissemination processes that have been relied upon to define and solve problems and how these, in turn, have shaped political and policy outcomes, as well as reform processes (Hall 1989). Hence assessing the extent to which there is likely to be increased public participation in the planning and/or delivery of programs in the near future (as advocated by various reformers) will ultimately depend on the strength of governance structures, and decision-making practices.

As illustrated by Bradford, in Canada, our federal cabinet-parliamentary institutions and party/interest-group systems have not been effective catalysts for innovation. Nor have they been effective instruments for initiating new debates or mobilizing the kind of new coalitions required for institutionalizing new reforms. As a result, there has been a long history of relying on experts in royal commissions to fill this institutional gap (Bradford 1998). Therefore, whether a more people-centred health vision emerges in Canada or not will be greatly influenced by who controls the discourse and the strength of the old policy regime. Even though public opinion is important to any discussion on health reform, we also need to consider established political processes and traditions and the extent to which new models of civic engagement threaten or are compatible with these.

A major problem with the debate over revitalizing the health system is that it is dominated by various myths that have been politically constructed. For example, the idea of a publicly financed, integrated system where all Canadians have equal access to the same essential services at equal costs is largely a myth, but a convenient one. While various services are being privatized or de-listed, many others like home care, dental, or pharmacare have never been fully covered by Medicare or regulated by the *Canada Health Act*. Besides, depending on where you live in the country, the kinds of services available are not the same. Another powerful myth is the idea that biomedical services contribute most to our health status. These contradictions between “myth” and “reality” create public confusion and an opportunity and incentive for reformers to pressure for change. Despite this, these various myths do resonate with most Canadians and are a reflection of the old monopoly powers and institutions that we have relied upon to generate research and deliver programs. Under such circumstances, bringing about structural change has been difficult, despite much evidence that a more democratic, social determinants approach would bring substantial health benefits.

The tendency has been for governments to respond to a difficult situation by “blaming the other guy,” and defending the old monopolies and interests that they either inherited or relied upon to seize power in the first place. As in the past, our political institutions have proven incapable of advancing or championing new policy ideas on their own. This dangerous political game between Ottawa and the provinces has itself become a political problem and, as in the past, the solution has come in the form of a federal royal commission (Tomblin 1995, Chapter 2;

Bradford 1998, Chapter 1). Predictably, the provinces have responded by having their own hired guns working on government-sponsored studies.

As a consequence of these developments, a number of Canadians have become increasingly cynical and frustrated with a system that provides little opportunity to take ownership of an issue that they care about. The only thing they can do is wait for the next government study, observe how the media responds, operate at the margins and, if there is an opportunity, vote for or against the governing party.

Ironically, at a time when we are experiencing policy failure and there is a clear need for new approaches and more debate, the defenders of the old national paradigm appear to have little political incentive to frame these issues differently. Structural change does not always come easily (when circumstances change) because old, inherited, overlapping, societal and state traditions make it very difficult to change direction. According to the logic of neo-institutional thinking, our complex and divided federal system makes it possible for old identities, visions, and boundaries to survive and it limits what can be achieved, even when conditions change. This model offers critical insights for understanding the significance of inherited policy regimes and how these complicate any drive for structural change. According to Cairns, “We must learn to think in terms of politicized societies caught in webs of interdependencies with the state, and we must think of the latter as the embedded state tied down by multiple linkages with society, which restrains its manoeuvrability” (Cairns 1995, 33).

Public Attitudes

Canadians have often been characterized as more elitist, conservative, and less entrepreneurial than Americans (Lipset 1990). Such characterizations tend to play down the different regional sub-cultures and dialects that divide the nation or the recent impact of the Charter and other trends on Canadian culture (Cairns 1992). Even though there were always regional differences, historically speaking, most Canadians have come to identify with and support the concept of a publicly financed, socialized system of medicine.

With the democratization of various health services (beginning in Saskatchewan in the 1940s), the general public supported the notion of a public, universal system, despite the fact the system was never entirely public. The five principles specified in the *Canada Health Act* in the 1980s also struck a chord with voters and reflected the way most Canadians felt about health issues. Trudeau used this legislation to defend his pan-Canadian vision against continentalism, province-building and Quebec nationalism.

In the past, despite the politically significant regional differences displayed by different provinces in the heated political battle that took place over the Second National Policy (1940s-1970s) and pitted Ontario, Quebec, British Columbia, and Alberta against the central government and the have-not provinces, once the intense battle was over and the new policy regime was institutionalized, things did gradually settle down (Tomblin 1995, Chapter 2). Naturally, there was little incentive to reopen the debate.

With the rise of free trade in the late 1980s (and the abandoning of the very idea of national policies during the days of the Macdonald Commission that helped spawn a new continental era) and the rise of more right-wing research institutes, there was a new opportunity for Ontario, Alberta, Quebec, and British Columbia to again defend a more decentralized, North American, neo-liberal vision. The strategy of aggressively pushing the health issue into the country's public discourse really only gained momentum in the late 1990s, a period of national crisis, public debt, neo-liberalism and increasing global-continental trade.

Health care became the dominant political issue during 1997 federal election (O'Reilly 2001, 18). As demonstrated by O'Reilly, "both the federal and provincial/territorial governments were associated with grand vision statements during the second half of the 1990's." (O'Reilly 2001, 21). The Ottawa-sponsored National Forum on Health provided another opportunity to make the case that principles and values associated with Medicare still mattered.

On the other hand, Ottawa had to respond to globalization, and the fiscal imperative. There was a need for a new public discourse. Governments, in pursuing their goals, are often forced to deal with competing objectives and it has proved politically convenient to keep these debates in separate boxes. This helps to explain some of the ambiguity and slipperiness associated with public opinion, the aggressive style of federal-provincial sparring (shifting blame) and inconsistent, at times contradictory government policies that have emerged. The federal government responded to this dilemma by supporting the principles of Medicare, making cutbacks, and then blaming the provinces for mismanaging the system. With the provinces and political opposition divided, it proved to be an effective political strategy for the Liberal

government, even if it did little to improve the overall health system. It also did much damage to federal-provincial relations. This intense, elite-dominated, insular, ideological-territorial competition has made it very difficult to bring Canadians together into the process of debating and reconstructing a national health vision.

The provinces responded by blaming Ottawa for cutbacks. Ironically, the increased salience of the health care issue may have made it more, not less, difficult to involve the public and reform the system. With the rise of a symbolic, high stakes political game, health became an important intergovernmental issue. The governments responded in a predictable way, by seizing control of the issue. As a consequence, the public and other interests likely had fewer opportunities to control the health agenda or discourse.

There is much evidence to suggest that once health became the major intergovernmental issue, it was no longer possible to work through normal political processes. Rather, as evidenced by the recent 2002 premiers' meetings held in Vancouver to discuss the health policy crisis, coupled with the flurry of provincial government generated reports that have suddenly emerged, both levels of government have gone out of their way to try and gain control over what is discussed, the values and social interests that are most relevant to these discussions, and the course of actions being considered for reforming the system.

As in the past, Canadian citizens have taken on the role of spectators. Despite this, public opinion cannot and should not be considered unimportant to the changing politics of Canadian health policy. Quite the contrary, when effectively mobilized, public opinion can be a very powerful political weapon. Public opinion is a powerful political resource that governments and other powerful interests manipulate either to push a new approach or defend the status quo. Since they play for different audiences and have competing interests, governmental and other interests who compete for power have a natural interest in shaping and mobilizing public opinion to serve their different territorial-ideological objectives. This helps explain why public opinion is by nature volatile and a slippery concept.

Public opinion has become highly volatile, full of contradictions, and difficult to predict (Milner 2001; O'Reilly 2001). Since political survival or pushing new ideas onto the public agenda depends on the ability to mobilize and shape public opinion, it is only logical that in this period of high stake politics and crisis that competing governments, medical organizations, or policy think-tanks would be motivated to shape public opinion, but based on competing territorial-ideological needs and objectives (Rachlis et al. 2001; Fraser Institute 2001; Canadian Centre for Policy Alternatives 2000; *Canadian Perspectives* 2000; British Columbia Medical Association 2000; and Conference Board 2001). A major problem with many of these studies is that they are more prescriptive than concerned with advancing the public's understanding of new health issues.

For the most part, even though there has been much more discussion and apparent interest in reforming the system and providing more opportunity for civic engagement, there is a lack of good comparative evaluation of the different reforms that have been tried provincially, and the "best practices" associated with these. With the exception of a few good studies (Tuohy 1999;

Adams 2001; and Bickerton 1999), there has been little analysis to inform those interested in this debate.

As a result of the walls that have been built by government and other key policy actors who have tended to dominate the discourse and agenda in this high profile, symbolic debate, it has been very difficult for Canadians to come together, focus on common issues, or develop the kind of capacity that would be necessary for informed public participation and discussion. Citizens in Alberta tend to focus on the Mazankowski report (Alberta 2002), while in New Brunswick, most of the focus in the new millennium has been on their own government's vision (New Brunswick 2001). The same is true for other provinces. To a great extent, this competitive territorial-ideological debate has been organized to divide, not unite, the country on health issues.

Getting an accurate fix on public opinion is difficult given this context. In the early 1990s, Canadians were supportive and satisfied with their health care system. They felt their system was better than either the American or British systems of health governance (Blendon 1989; Tuohy 1999, 102; and Gallop Canada 1991).

More recently, there appears to have been a drop in public confidence (Angus Reid 2000). Even though there still remains strong support for the principles of a publicly funded, universal system, starting in the mid-1990s Canadians have become more concerned about the sustainability of the system (Tuohy 1999, 103). Canadians' values and attitudes appear to be changing, as has their sense of frustration over their inability to control the direction that the health system is taking. According to some, the growing sense of crisis has produced more openness to privatization and other, similar changes in service delivery (Conference Board of Canada 2001). Other polls demonstrate the opposite trend. A recent nationwide poll found that two-thirds of Canadians oppose the kinds of cost-cutting ideas being considered by governments in Alberta, British Columbia, and Ontario. Furthermore, the poll suggested that Canadians still have faith in and support the status quo. Most citizens think the solution is improve rather than change medicare (*The Globe and Mail* 26 January 2001, 1).

As indicated by Hall (1989), since bringing about a regime change requires first convincing others that the system has failed – and then mobilizing a coalition in support of a new approach – we should not be surprised that critics have acted this way. On the other hand, as was evident in the case of the Meech Lake Accord, the Charlottetown Accord, and various other examples, critics in seeking a regime are naturally motivated to convince others that the status quo is not an option – even when it may be. These things need to be taken into account as well.

Renewing Health Governance: Motivations and Barriers

We are living at a time when there appears to be much interest in searching for new values and democratic practices that better reflect new realities and contemporary thinking in the health field. Whether fundamental change occurs or not will greatly depend on the capacity of the old regime to adjust, and the power and resources available to the defenders of the status quo. The public health movement in Canada a century ago presented a different conception of health and evidence that public health measures mattered and did more to improve health status than medical services. Despite this, getting government financial and regulatory support was not easily achieved, and there was much opposition from those who had competing ideas or interests.

The biomedical model that gained prominence in the late 19th century and then exploded in the 20th for various reasons, presented a different approach to analysing and treating health problems. It was argued that a clean environment was not enough to improve health status, what was required were new forms of diagnosis and medical care. New models of service delivery emerged and were debated in Canada. After the depression and experience of the war, there was much support for a universal system of coverage, especially as far as hospital and physician services were concerned. But there was never unanimous support for this approach. Ideological-territorial divisions coupled with the growth of powerful Canadian myths made it difficult to redefine health issues, challenge the power of the medical profession or other established ideas, processes or embedded institutions.

In the early 1970s, the health promotion and population health movements emerged to contest the ideas, processes, and institutions associated with the more hierarchical, expert-dominated, biomedical model. Reformers in their critiques argued there was little evidence that medical services improved the health of the population and, as a result, there was a growing need to better understand and address inequalities in health and especially social health determinants. As a result, there was increased pressure and new interest to engage the public more directly in defining the health problems and priorities. These clashed with traditional approaches.

Quest to Increase the Role of the Public: Good or Bad Idea?

Since the Lalonde report (1974), various academic and government studies have highlighted the changing nature of health problems and the kind of new techniques and approaches required to address them. Public participation and community involvement in the planning and implementation is an important part of many of the new social determinant frameworks that have emerged. It is argued that there is a need for a redefinition of health in a way that would better recognize the importance of a clean environment, social cohesion, income, lifestyle behaviours, and other important determinants of health instead of focussing all of our energy on medical services.

Those interested in advancing public participation have done so relying upon various methodologies and forms of analysis that seek very different objectives. Health promotion strategies, for example, have things in common with the defenders of New Public Management and defenders of globalized forms of governance (Barrows and Macdonald 2000). These various competing critiques aim to contest the state's top-down, hierarchal approach and replace it with one that devolves authority and improves efficiency, and strengthens the role of civil society. At the same time, strong ideological disagreements between the equity-centred health promotion perspective and the more market-centred new public management model have contributed to public confusion over the real objectives of a more community-based approach, which defenders of the old regime can and have used to defend the status quo.

Reformers have tended to assume that since the status quo is not an option, we have little choice but to adopt new solutions to address new problems. As a result, little attention has been placed on assessing the status of the social determinants approach against the established paradigm or even new competitors. Nor has sufficient attention been focussed on better understanding Canada's political cultural-institutional traditions that still endure today, and whether it makes sense to try and increase public participation within such a backdrop without doing more preparatory work. There is also a need for further analysis of important changes that have occurred with respect to increasing civic engagement in the governance of the health system, and the impact these have had on priorities and power relations in the future. The rest of the discussion paper will deal with democratic processes and practices of the Canadian public health system with the view that we need to better understand the obstacles to reform first before new strategies can be developed. As a result, as argued by Tuohy, "the organization and finance of health care delivery in Canada was much the same in the 1990s as it was in the 1970s" (Tuohy 1999, 90). On the other hand, there have been many attempts to reform the system.

Benefits of Public Participation

Since health involves much more than medical services, it is imperative that there are increased opportunities for public participation and community-determined priorities and mandates. These are required to develop new frameworks and approaches in light of new evidence that population health needs are influenced by various socio-economic determinants. We need to recognize the value of more evidence-based, community-centred, integrated structures and systems that are more interdisciplinary in approach, and more capable of reinforcing the kind of collective willingness required for the public to take ownership of health issues, while avoiding the competitive turf wars fought among the competing elite across disciplines and communities that have characterized these debates in the past. Since democracy comes in different forms, there are dissimilar models for encouraging or increasing public participation in the governance of the health system. In order to understand which forms of public participation might be best for Canada, we need to take into account cultural and institutional traditions and the kinds of reforms being proposed.

As indicated by Tuohy, there are three institutions that have been relied upon in our health decision-making system. None of these were specifically designed to facilitate direct public involvement. These mechanisms include: the market, the state, and a collegial system.

In the case of the latter, for example, members of the medical profession have historically performed an important role as “agents of government.” These organizations that were created to carry out these kinds of functions were never very open or democratic. As Pross has demonstrated, Canada’s institutionalized pressure groups had a good understanding of how a cabinet-parliamentary government operates, and preferred working behind the scenes, outside of the public view (Pross 1975, 10). In the process, they have played an important role in both designing and implementing various public policies and have enjoyed much autonomy. In describing this kind of arrangement, Tuohy stated, “[w]ithin broad budgetary parameters established by provincial governments, physicians have been central to decision-making systems at various levels from central joint profession-government ‘management’ committees at the provincial level, to the level of autonomously constituted hospital medical staffs, to the level of independent individual practices” (Tuohy 1999, 30).

Even though this mix of institutions and policy traditions served us well in the past, they also likely made it difficult to implement new reforms, including the notion of empowering communities and allowing them to take more control over health issues. In practice, from the start, there were various components of our health system that were never intended to be controlled by public institutions. For example, the medical profession is paid, for the most part, on a fee-for-service basis. Other professions such as physiotherapy, dentistry, the pharmaceutical industry, chiropractics, home care professionals, massage therapy and optometry do not receive the same level of public recognition or financial support. There is evidence that a number of these professions would have preferred operating within the public rather than private market system, but they were never given much chance to do so, in part because of opposition from the medical profession (O’Reilly 2001, 28-29). The medical profession has attained a special status within the Canadian society, which is further reinforced by its historical domination over medical research and education. There is little question that the dominant status and legitimacy

of the bio-scientific medical profession has been greatly enhanced by its control over what is taught and the kind of issues and themes that are researched at medical schools.

Over 30 percent of health expenditures are private and not covered by provincial public programs, and the same services are not covered in every province (O'Reilly 2001, 40). As with any institution, the market mechanism has both strengths and weaknesses. However, it was never designed for the purposes of direct community empowerment or civic engagement. Even though the pharmaceutical drug industry in Canada would be concerned about public relations, for example, there has been little incentive for this industry to build the kind of mechanisms that would be required to allow citizens more effective control over company decisions. When we consider the economic power and interest that drug companies have in promoting and defending the old biomedical model – coupled with their close links with government, the medical profession, and medical research – this poses yet another big challenge for those seeking a more determinants, community-centred, population approach to health (Lexchin 2002).

The third mechanism that has been involved in establishing general principles and controlling the direction of health policy is the state. The nature of our political institutions and the way they are structured are important for understanding where we have been and where we are likely going on this issue. It is also important for addressing the issue of Canadians' sense of ownership and control, or lack of, over the health system.

As we have seen, even though there has been much national debate on the future direction of the Canadian health care system, it is for the most part a provincially based system. Federalism is about diversity and what we really have is a series of provincial health care systems that both compete and cooperate. Recently, it has become clear that federal-provincial competition has made it difficult for Canadians to work together on health issues and feel part of a common project.

The federal government, through its spending power, royal commissions, research institutes, intergovernmental bargaining and legislation, has tried to influence and create a national political discourse only with limited national processes and institutions. It has also played its part in promoting and building political coalitions, shaping common values and turning issues to its own advantage. All of this has complicated the reform of the health system because, while the public has come to identify with the idea of a national health system, there have been few institutional opportunities for them to actually engage on a national basis, unless Ottawa decides to mobilize a coalition. As indicated by Banting, Ottawa has a long history of exploiting the welfare state and its spending power primarily for purposes of legitimizing the power of the centre (Banting 1987, 176). In the past, provincial governments have responded by asserting and defending their own jurisdictional powers and territorial interests against outside attacks.

Reform and Restructuring Projects: Are They Making a Difference?

Recently, there have been various attempts to restructure and reform both the intergovernmental and health system. This is evident in the 1984 *Canada Health Act* and various intergovernmental agreements, including the Social Union Agreement (Adams 2001). Much of this was in reaction to growing public cynicism and frustration. However, as far as some critics are concerned, these kinds of reforms did little to address underlying structural problems, encourage significant public participation, or push the system in a direction that would address data requirements and other limitations or reflect the variety of new practices and models that are available for addressing health problems. For instance, a number of critics have expressed concerns about the fact that while the *Canada Health Act* deals with older established areas of health policy (such as hospital and physician services), it provides little support or guidance for a number of other essential services such as pharmacare, health promotion or home care. Adams argues that for the most part the *Canada Health Act* does not “speak to the contemporary concerns of the quality of health, relevance, responsiveness, and acceptability of services to the public, the efficiency, effectiveness or affordability of the services, the public accountability for the services provided and their outcomes, or the manner in which the services are delivered to and accepted by the public” (Adams 2001, 65). Nor was it designed to go very far in encouraging the development of new models and tools required for adequately addressing nonmedical determinants of health.

Despite these limitations, we do need to draw attention to the fact that there seems to be growing recognition and increasing opportunities for contesting old approaches in a way that could, if it continues to be supported, strengthen public participation, improve our ability to address new health problems based on evidence, while generating better outcomes. Our focus will now shift to discuss some of these reform ideas and initiatives, taking into account both sides of the issue, and paying attention to some of the constraints involved, in an attempt to better inform the Commission’s discussions and final recommendations.

There are various challenges in assessing the Canadian experience of public participation in terms of governance of the health system. Part of the problem is there are different criteria and objectives that could be assessed, depending on the values, interests, processes or assumptions informing the analysis. For most economists, and certain interests, keeping costs down would likely be a top priority. For others, health outcomes, social cohesion or dealing with health inequalities is considered to be more important than economic efficiencies. There is not a universal approach for assessing various new experiments in stakeholder-community participation, and how these have worked in coming to terms with a variety of health challenges.

As noted by Howlett, there is much Canadian material on the “role played by private- or public sector patrons in aiding the formation” and “tools related to group creation and manipulation” required for legitimizing old power structures and approaches (Howlett 2000, 419). Effecting internal changes and replacing embedded societal and state institutions (and corresponding interests and values) is easier said than done, even in a period of crisis. The fact that change is never neutral and there are winners and losers makes it difficult to build support for any new model, particularly if the old regime remains strong, underlying structural conditions do not change, and there is little opportunity to contest established monopolies and

old sources of knowledge, innovation or popular myths that have been politically constructed and institutionalized.

The fact that there are various experiments, commissioned studies, and planning processes taking place and organized by competing stakeholders, and ideological-territorial interests is a reflection of our diverse, democratic system that is trying to adjust to a policy crisis, and new sources of competition. This is something we should be proud of but we also need to make sure that the competition is fair and balanced, or within the “public interest.” As discussed above, the public has always been part of the health system, but because of our institutional structure and cultural traditions, the tendency has been to view society as a resource to be manipulated and organized by the competing elite.

Understandably, unless conditions change and there is both incentive and opportunity to properly assess the pros and cons of public participation on the governance of the health system (whether we are dealing with dissimilar models of regionalization, new forms of direct democracy, fee-for-service, new health human-needs-based forecasting models, privatization or other restructuring ideas), it is unlikely that we can go very far in judging these experiments, their impacts on reducing costs, or improving the health needs of the population – unless certain things continue to happen.

Judging Recent Restructuring Experiments in Public Participation

Health care reform and the need to improve health, reduce costs, and deal with a series of policy crises has become a popular national preoccupation in Canada, as it has in other countries. Much of the restructuring has been designed for the purposes of:

- shutting down hospitals, removing duplication and other expensive forms of infrastructure (especially in rural communities);
- eliminating full-time nurses and administration;
- institutionalizing, where possible, and promoting through public rhetoric a more non-institutional, community-based, determinants health model;
- regionalizing health services within provinces (sub-provincial restructuring has occurred everywhere except Ontario);
- and finding new ways to promote policy learning and coordinate services across provinces (cross-provincial regionalism).

As a result of globalization, increasing costs, changes in fiscal federalism, rural depopulation, and rise of new social movements, there is growing pressure to reform or replace the current health system and the kind of policy instruments associated with it. Yet, there are a number of powerful countervailing forces that should not be underestimated, nor should we assume that some of the new reforms and mechanisms that have emerged are necessarily within the public interest, or even intended to push the system in a new direction. In the end, whether or not new forms of public participation and health models replace old approaches will greatly depend on the extent to which current processes, forms of knowledge and structures are considered creditable by policy actors, and whether there is sufficient public trust or legitimacy associated with the old system. If not, there will be little choice but to consider new approaches and policy instruments more capable of mobilizing a new coalition in support of a new regime. Otherwise, other political competitors will take on this role.

Sub-provincial regionalization is a very popular health restructuring strategy that, in theory at least, attempts to reduce costs, avoid duplication, while also providing increased opportunities for citizens and communities to participate more directly in health decision making. Regionalization as an approach to restructuring has much to offer, but a major problem with evaluating this concept is that it has various meanings in different policy settings and can be used to defend very different, even competing objectives, which may be politically controversial. For example, in the field of economic development, regionalization tends to be associated more with addressing efficiency issues than dealing with equity concerns. It has been used to justify cutting services or downloading blame. Cross-border regionalism (for example, recent efforts of the Atlantic Premiers to coordinate and integrate health policies) and sub-provincial regionalism logically work at cross-purposes since the more power is devolved at the community level and the more policy diversity that exists, the more difficult it will be to integrate or coordinate

policies at the executive level across provinces (Tomblin 2002; Council of Atlantic Premiers 2001). Understandably, this could complicate any future nation-centred campaigns seeking to coordinate cross-jurisdictional health policy integration and collaboration across the country. Hence there may be a need to coordinate these different regional experiments or at least take into account their impacts on other planning experiments.

It is too early to say anything substantive at this stage about the nature or impact of this restructuring approach on patterns of public participation in the governance of the health system until more comparative research is available. At the cross-provincial level, since these discussions take place at the executive level and behind closed doors, there has been limited opportunity to promote direct public input.

Sub-provincial regionalization involves both devolution as well as centralization of power. In practice, regionalization may involve the elimination of local community structures and hospitals that people identified with, may have influenced, and depended upon. Whether newly appointed, integrated boards are more democratic and accountable is still open to debate, but the majority of provinces have so far avoided establishing even partially elected boards. Likewise, devolution of power depends on having sufficient resources and capacity to make independent decisions at the community level. Since provincial governments continue to maintain ultimate control over these kinds of experiments (as evidenced in recent massive changes in British Columbia that were imposed from above), it is still open to question whether community-based forms of sub-provincialism have the kind of autonomy and capacity that would be necessary to gain control over the principles and future direction of the health system. Moreover, since these new regional structures never had a direct impact on doctor salaries or the economic market-practices of drug companies (Lomas 2001), the jury is still out on whether regionalization, by itself, can, at least as currently structured, ever hope to generate the type of knowledge, or even mobilize the kind of public enthusiasm and support required for addressing certain problems or for moving the health system in a new direction. In the case of Nova Scotia, for example, the 1996 provincial government campaign to erect community regional governance structures that appeared to strike a chord with the public was completely stymied by the decision of the new regional hospitals to “remain outside of the regional structure.” In the end, this kind of power and defensive strategy “effectively undermin[ed] the province’s restructuring effort and depriv[ed] the regional and community health boards of institutional support” (Redden 1999, 1373). Unless or until these power differentials and institutional deficiencies are addressed, regionalization remains a limited option.

The question of which forms of public participation are most useful for the effective operation of the health system has received some attention in the literature, as has the issue of how different forms of citizen participation influence problem definitions and policy solutions. But, here too, there is a need for further research. The results of one study based on a survey of members of health boards in Saskatchewan suggest that regionalization has improved the system, resulted in better decisions, and enhanced local control (Lewis et al. 2001). However, there was some confusion among board members on what kind of powers the boards actually had, and much criticism of provincial government restrictions and lack of board autonomy. There was also evidence that there were few differences in preferences of appointed versus elected members, or between health providers and board members without a health background. The

research provided no evidence that appointed or elected members perceived health problems differently, which refutes the claims of some critics that these kinds of institutions are bound to be dominated by special interests and hence incapable of defending or promoting the public interest. It should be noted, however, that “there were no objective measures or survey items to verify the regional health authorities have in fact developed locally sensitive mechanisms for improving effectiveness and efficiency” (Lomas 2001, 344). While there was clear support among board members for the need to reform the system based on a wellness as opposed to biomedical model, there was also a majority perception that the kind of vision or plan that would be required to build public support and implement this new paradigm never materialized.

There were other problems identified by this study. A major problem was the lack of public interest in voting for board members. Since only 10 percent of citizens even bothered to vote, this does not bode well for those who would like to build support for a more legitimate, democratic health system. If this lack of public support is a result of mistrust, these legitimization problems may need to be better understood and then addressed. Another problem identified by the study was the problem of deficits, especially in Regina. In fact, in 2000, the decision was made to eliminate the practice of partially elected boards and appoint a commissioner to investigate this problem and experiment. For the time being at least, it does not appear that this experiment in democratization is operating efficiently or is in a position to become more fully institutionalized; in fact, it has been temporarily abandoned. Regionalization experiments in other parts of the country also seem to be in a constant state of restructuring, which indicates their lack of legitimacy, autonomy, or capacity to deal with new health challenges, especially those related to costs. In addition, it seems logical that these authorities have never been in a good position to mobilize the kind of coalition necessary to defend themselves against outside competitors, adjacent ideas, processes, and expectations.

There are different perspectives on which forms of public participation would be best suited for the efficient functioning of our health care system. Much of this depends on the values or priorities that are being promoted or defended. On the political right, the idea of decentralization, civic engagement, and making communities more aware of the costs and responsibilities for delivering services is important to this system of analysis. The same could be said for various advocates of private-public partnerships, even though the jury is still out on whether private medicine is more efficient than public services (Canadian Health Services Research Foundation 2002; Wilson 2001).

Within the United States, such critiques are a clear reflection of cultural, institutional, and policy traditions, and have likely contributed to a tradition of not relying upon the state to deal with problems of disparity, including health disparities. Various critics suggest that too much localization and democratization may create a situation where there is less willingness or opportunity for redistributing resources to those most in need or unable to defend themselves. This has certainly been evident in conflicts between have and have-not provinces, but also between urban and rural communities within Canadian provinces. Traditionally, Canadian cultural, institutional, and policy traditions have been more collectivist in orientation and as a result, more focussed on equity issues and problems of need.

There is always a danger that too much decentralization, democratization or privatization would create a very different political dynamic in the country and make it much more difficult to deal with disparity problems, or build a coalition in support of a needs-based health system that has always reflected Canadian collectivist traditions as opposed to American values of individualism. In Oregon, for example, experiments with more direct participatory forms of governance seemed to have worked to the disadvantage of certain groups, and especially those with low socio-economic status (Redden 1999). Hence there is still some question whether a more participatory model would foster a better health system for everyone. In fact, it could very well add further to health and income disparities, but this does help explain why such an approach is more popular on the right.

A Patient's Charter is another instrument for reforming the health system and linking the public to it. It has received a fair bit of attention in various restructuring debates. In the United Kingdom, for example, the idea first emerged in 1991 under the Thatcher government (Tuohy 1999). It was revised in 1995 and later abandoned. It has been the centre of much controversy and debate ever since. Some of the problems with the idea of a patient's charter have included: the fact that it was a top-down creation; people and stakeholders did not identify with it and were threatened by it; the charter was designed to promote a consumerist culture or approach rather than a needs-based one; it encouraged competition and not the sharing of best practices across health units; the emphasis was more on process, rather than outcomes; the focus was more national than community-based; it "encouraged people to cheat;" reinforced a "blame culture"; and "it muddled the concept of rights and aspirations giving patients rights but no effective redress when these rights were not delivered" (Dyke 1998). Another problem with the idea of a patient's charter is that it creates a discourse focussed on rights and this makes it far more difficult for politicians to make changes that require, by definition, compromising rights. Finally, in the United States, the concept of patient's charter has been justified as a means for guaranteeing a certain level of service. A major problem with this approach is that it would further complicate health processes and the mechanisms required for protecting patients' rights, which would add further costs for an already very expensive system. There would also be a new incentive to do more medical tests, which, in practice, would further drive up medical costs. Since there have been various problems associated with implementing this concept in other jurisdictions, it seems logical that we should adopt a cautious, more incremental approach. In Britain, for example, there was not the kind of policy capacity or support required to implement these new measures, and there were various negative political and policy outcomes as a result (Tuohy 1999, 182-83).

Where Do We Go from Here?

By exploring the symbolic myths and institutional realities of the health system in Canada, this paper sheds light on the various obstacles that inhibit public control of the principles and direction of the health care system. The intent was to be provocative and confront some of these myths, but in a way that will allow us to better understand the processes and mechanisms that produced and sustained them. The hope is that by providing more details on the health policy system, this will stimulate public discussion and enhance understanding of a complex policy field.

The question needs to be raised about the kind of democracy we have, or the kind we would like to have. The purpose of much of this discussion paper is to reflect upon how difficult it has been to increase public ownership and control over market mechanisms, executive-dominated intergovernmental relations, or collegial arrangements. These are the structures and processes that we have relied upon but were never intended to provide many opportunities for increasing direct public participation in the health system. Canada's more collectivist cultural traditions are reflected in the public institutions that we have built, and we need to consider both the advantages as well as disadvantages of these. Despite much rhetoric from the right, however, democracy is not just about numbers. In fact, direct forms of democracy, as evident in the Oregon case study discussed above, do pose problems for those individuals or communities who may not have the resources or skills required to defend their interests satisfactorily in a more pluralistic, competitive system.

Canadian representative forms of democracy have always had built within them ways for ensuring that these kinds of interests were not ignored. It has always been understood that effective policy development requires identifying both winners and losers of policy change and then finding ways for compensating or assisting those who have been hurt, but in a way that benefits everyone. As a result, these kinds of policy lessons should not be ignored in the pursuit of a more democratic health care system. If we do, the political and policy outcomes could be very negative. We need to better understand what we have created, what has worked, and what can be done to refine and improve the system, but based on evidence and new partnerships, and forms of dissemination that will appeal to Canadians, address their concerns and reflect their values.

A realistic transformation of the health system is necessary, but it must be based on first understanding and acknowledging what we have created together as a country, and avoiding mechanisms, processes or approaches that will force provinces, communities, and citizens away from turning inward and adopting ill-conceived competitive territorial-ideological strategies that will likely, in the long run, have a very negative impact on the health of individuals and communities. It also requires identifying and conceptualizing both the barriers and facilitators of reform, and then developing new strategies carefully designed to build public support for new reforms and include communities in both the research and implementation process, but without undermining or threatening traditions of collective responsibility that have been so important to Canadian values.

We have created a situation where the state's task of managing health issues and renewing the consensus of who we are as a people and what values count most has posed as much of a challenge as managing a complex health system. What is now required is a new determination to find new ways for moving the system forward, facilitating new innovative strategies, different kinds of knowledge and partnerships that are better designed for gradually breaking down some of the old boxes and replacing them with new ideas, processes, and institutions. This will require a better understanding of the connections between new and old health strategies for individual and community health and discovering new innovative ways for connecting and encouraging different, integrated forms of knowledge (biomedical, social determinants approaches, local community traditions), and finding ways for integrating these in a way that will help us produce better health strategies, but without creating unnecessary and unproductive political divisions or abandoning what has worked in the past.

Relying upon commissioned studies and new forms of research and dissemination has a long tradition in Canada. We should continue to develop and expand this tradition by continuing to foster the growth of diverse, high-quality, evidence-based research that is more capable of challenging and contesting the dominance of a well entrenched province-centred, top-down, market-biased, biomedical policy regime. In this period of policy crisis, there is much pressure to reconceptualize health issues, bring in a more community-based research-policy agenda and push the system in a new direction. In the end, this form of public involvement, which has a long history in Canada, will likely have more impact and be more useful to the longevity and efficient functioning of the health system than many of the reforms (which Canadians have not been very enthusiastic about) in more right-wing critiques.

Recently, there have been many attempts to change the way we investigate and conceptualize human needs in Canada. There is much more interest and emphasis placed on promoting interdisciplinary approaches and finding new creative ways for directly linking researchers, decision makers, citizens, and communities together in an effort to better understand the impact of old and new strategies on human, community and environmental health, which have always been closely related but analysed in separate boxes (Lavis et al. 2002; Lavis 2002). This is reflected in various research initiatives, which include: the Coasts Under Stress Project; Canadian Health Services Research Foundation; and Canadian Institutes of Health Research, Canadian Population Health Initiative, Canadian Regionalization Research Centre, Policy Research Initiative, among other examples. At the provincial level, there has also been much interest in creating public access points and data sets required to bring communities and citizens more directly into the research and policy process. In Newfoundland and Labrador, for example, the rise of the Strategic Social Plan and the development of community accounts that provide useful information on non-medical health determinants for the public, have been very positive and progressive experiments. Similar experiments exist in other provinces. These kinds of initiatives should continue to be supported, but the federal government needs to also play a role in establishing and maintaining the kind of information infrastructure and research links across provinces that will enable Canadians everywhere to support, shape, and compare best practices, but from a national perspective. The idea of involving citizens on any new structures designed to overview the *Canada Health Act*, for example, would be an improvement. But given the fact that the Health Act is limited in scope, there is an even greater need for other reforms, especially those that would ensure that policymakers in non-health policy sectors are forced to consider

health outcomes. New ways need to be found to ensure this kind of information is available and can be used to pressure governments to take into account the health effects of their actions. This idea will not be popular with established interests, but it will be embraced by the general public.

Given the massive disparities between the province-centred, biomedical model and other approaches to health, it is critical that we further develop support mechanisms required for institutionalizing a more community, social determinants, evidence-based paradigm. It is critical that there be a balanced approach to knowledge creation and dissemination, and if we continue to build new data sets and research-policy traditions that are more open, transparent and inclusive, it will be much easier for the public to feel empowered and in control of health issues. Even if the costs are high, the costs and consequences of allowing others to have a monopoly over these kinds of activities are likely much higher and also pose a threat to national cohesion and traditions of inclusion. From this perspective, it would also make sense to reduce the influence of drug companies on research and training of doctors, and reduce or even eliminate their advertising activities. There should also be appropriate steps taken to ensure that doctors are encouraged to promote new health practices (especially wellness), and this might involve new forms of resource allocation or moving away from a fee-for-service payment system. It is time for Canadians to take back control over their health system, but in a way that will strengthen and improve it.

Whether in the area of primary care, regionalization, community and home care programs, and health promotion, there is much interest in developing new alternatives and strengthening public ownership and control over the system. Unfortunately, these new innovations and movements, which pose a threat to the expertise and dominance of the old biomedical model and associated interests, tend to be isolated and lack the kind of political resources and autonomy required to effectively challenge the medical world view. To meet these new challenges and to provide ample opportunity to engage Canadians in a debate that is less divisive and does not simply reflect the ideological-territorial interests of the established regime, there is a need to: provide a clearer direction, shift the balance, and mobilize frameworks and new forms of knowledge for the progressive democratization of the health system. In terms of increasing Canadians' sense of control over health restructuring, the best approach would be to provide more opportunities for alternative models of health to integrate research on a national basis, promote common values, and build the kind of support required to bring about fundamental change.

The best way to increase public ownership and control over the general principles and direction of the health system is to ensure that old monopolies are challenged, and new ideas and options like regionalization and population health approaches are considered. This will require new effective national mechanisms for comparing best practices, integrating research across jurisdictions, while providing Canadians with more opportunity to engage in an open and honest dialogue. We need to continue to support and look for ways that will challenge the power of old monopolies, improve the design of alternatives, and make it easier for Canadians to debate and consider alternative approaches beyond the rather narrow range of options presented by defenders of the old regime. This could come in the form of support for inter-disciplinary cross-provincial research, and a permanent national commission that would be responsible for providing a clear direction, identifying best practices, and reporting on reform initiatives across

the country. As mentioned, in Canada, commissions have played this role in the past and we could go further in creating a permanent structure. New ways also need to be found to ensure that all governments and stakeholders in the health system provide the kind of information required to integrate research and make it possible to evaluate the outcomes achieved by new community models and approaches. Such a commission could also ensure that policymakers and the public are well informed on how decisions in other policy fields influence health outcomes. If these things were done, Canadians would develop a greater sense of control over their health system and they would have more options from which to choose.

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