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Reliable in their failure: An analysis of healthcare reform policies in public systems

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ABSTRACT

In this paper, we analyze recommendations of past governmental commissions and their implementation in Quebec as a case to discuss the obstacles that litter the road to healthcare system reform. Our analysis shows that the obstacles to tackling the healthcare system's main problems may have less to do with programmatic (what to do) than with political and governance (how to do it) questions. We then draw on neo-institutional theory to discuss the causes and effects of this situation.

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> 'We are surrounded by organizations whose failure to achieve their proclaimed goals is neither temporary nor aberrant, but chronic and structurally determined' ([1] p. 9)

1. Introduction

Reforming healthcare delivery and financing to adapt them to evolving population needs, technological transformation and financial constraints has proven to be a major challenge worldwide [2–5]. In this paper, we use Quebec's situation as a case to discuss the processes and forces that structure health system reform within a neo-institutional framework. Our aim is to provide new insights into the difficulties that lie in the path of reform policies in public systems.

As do all other Canadian provinces, Quebec has a Beveridgian-type public healthcare system, with the government acting as single payer for most healthcare services. For twenty years or more, the healthcare delivery and insurance systems have been the focus of much media attention, public concern and political preoccupation [6,7]. Pervasive problems have resisted all reforms aimed at solving them. Among the problems that have become emblematic of this situation are waiting lists for certain elective surgeries, chronically overcrowded ERs, poor accessibility to primary care, and others [8,9]. The persistence of these problems has prompted never-ending public debate about their causes and potential remedies.

Our hypothesis here is that both causes and solutions are well documented and quite obvious at a programmatic level. To use a medical analogy, the pervasiveness of the problems has little or nothing to do with the diagnosis or the prescription, but a lot to do with treatment compliance. To test this hypothesis, we analyzed the level of implementation of major recommendations emitted by health-related commissions in Quebec.

The analysis is done using a three-step process. First, to analyze the nature and strength of the commissions' recommendations, we draw from well-known and credible sources a consensual list of desirable healthcare system characteristics. We then analyze the recommendations of the three main commissions appointed to advise the provincial government over the past forty years according

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to these characteristics, and we discuss the degree of implementation for each one. In a third step, we test two sub-hypothesis. The first is that most, if not all, of the desirable characteristics identified have been put forward by one or more of the commissions, but only a few have been implemented. The second is that the degree of implementation is directly related to the political acceptability of these characteristics, not to their programmatic importance for system efficiency and performance. Finally we discuss the findings using a theoretical framework that is mostly an expansion of the organizational neo-institutional theory [1,10–14] to a broader systemic level.

2. Desirable characteristics of healthcare systems

2.1. Definition of desirability

The commissions' reports analyzed here are long documents with numerous proposals targeting changes at various levels. As stated in the Introduction, our first step is to establish a list of desirable characteristics of healthcare systems to be used as a framework to analyze and compare recommendations.

Instrumentally, we define system characteristics as desirable if they represent means toward achieving either better quality care or more efficient production. Production efficiency here refers to the relation between cost and effectiveness. Quality of care is related to appropriateness and accessibility. Care is appropriate when the right professional in the right setting provides the right procedure to the right patient at the right time. Accessibility is defined according to Donabedian [15,16] as the degree to which delivery institutions correspond to society's needs and resources are made geographically available. We postulate that accessible care of high quality will on average produce a high level of patient satisfaction. Finally, implementing organizational, managerial and clinical practices that produce efficient and high quality care and patient satisfaction will require significant learning capacities at the system level. Desirable characteristics identified here thus encompass the four dimensions of performance proposed by Shortell et al. [17].

We are aware that our definitions are not the most exhaustive and that there is overlap in the characterization of some concepts. However, the aim of these definitions is limited to providing the basis upon which we can build a list of broad systemic characteristics commonly perceived in the scientific literature as desirable.

2.2. Establishing characteristics

The first and foremost desirable characteristic of a healthcare system is an equitable funding mechanism that allows universal coverage and access regardless of the patient's financial or medical situation [18]. While this characteristic is central, we do not discuss it here nor include it in the analysis, since it remained stable throughout the time period and administrative setting under analysis.

At the delivery level, another characteristic of a good healthcare system is its capacity to treat patients largely through primary care [19]. The Institute of Medicine defines primary care as 'the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community.' ([20] p. 31). Greater emphasis on primary care is seen as lowering total costs [21], as well as improving quality and appropriateness [22].

There is a general consensus [18–20] that some kind of integrated delivery system (IDS) is the most credible organizational model to achieve primary care-centered, high quality, efficient care. Gillies et al. ([23] p. 1182) define IDSs as '. . . large, multispecialty practices, characterized by patient-care teams, defined patient populations, aligned financial and payment incentives, partnership between medicine and management, information technology, and accountability . . .' However, as the evidence shows, IDSs will be able to add value as compared with previous organizational arrangements only if there are managerial processes and incentives leading to clinical integration [24] and to the demise of the dual authority structure characteristic of the autonomous community hospital [25]. Empirical research has demonstrated that structural integration does not automatically create clinical integration; nor does it ensure, in itself, that clinical practice and organizational practice will be aligned [25,26]. The available evidence on the most efficient organizational arrangements required to implement an IDS is mixed. Comparing the virtual networking of small medical practices working under a larger capitation plan to the formal ownership of medical clinics in association with a community hospital shows that both forms have strengths and weaknesses and that both can be efficient IDSs under certain conditions [25]. However, one minimal condition for aligning medical practices with organizational goals is that the IDS must control physicians' remuneration. There can be no serious alignment of clinical and organizational goals if an organization or a system provides clinical and organizational support for physicians' practices while physicians continue to receive pure fee-for-service from a third party. This is, however, the case for the great majority of medical practices in Quebec. Thus, another condition for an IDS to achieve integrated care is that it must control physicians' remuneration [27]. While this condition may not be sufficient [23,28], it appears necessary. Moreover, we contend that physicians should not be paid through a pure fee-for-service but rather through a mixed system [29,30].

Another characteristic that appears necessary to the attainment of IDSs' potential is that they work under a prepayment funding scheme [29]. The most promising form would be some type of capitation formula [20,21,27,28]. There is strong evidence that the world's most efficient systems use such a scheme [31,32] and that this has a direct effect on quality of care and innovation [27,29,33]. In contrast, non-adjusted, closed, purely historical prepayment schemes produce significant counter-incentives to quality (especially prevention) and efficiency (e.g., rationing service quantity rather than acting on unit price).

A related desirable characteristic, still at the delivery level, is that the service basket offered must keep pace with

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the population's specific needs and be proactively adjusted to prevailing demographic, social and economic conditions. This requires good data on needs [34] as well as a population focus in the IDS's role and goals. To achieve both efficiency and quality, it is also fundamental that medical practice be guided by evidence-based guidelines to limit unnecessary interventions, which have been shown to account for a very significant percentage of current medical practices [33–36]. In this process the IDS's role is to provide clinical guidance and leadership in continuous training and evidence-based medicine (EBM) practice [35]. Having a population focus also means the IDS will measure its performance based not only on indicators of quantity/quality/cost of care produced but also on its impact on the global health of the population under its responsibility [36]. This should constitute a first level of accountability at the macro (population) level. At the micro (individual) level, there should be participatory mechanisms that give patients a say in their treatment plans [38–41] and information systems on outcomes that allow them to make informed choices.

Finally, many of the above-mentioned features rely on the existence of a strong computerized and integrated information system [18,23,42]. At a minimum, such a system would include a unique and comprehensive individual patient record accessible throughout the system and used by the professionals [37,38]. These data should also be aggregated at the organization level to allow monitoring of production, intervention rates and outcomes [39]. Aggregated production data should then be assessed in relation with population data as described earlier and the results made available in a clearly understandable format.

To summarize, the characteristics identified here are a system-wide focus on primary care, implemented through IDSs funded by capitation, and responsible for a given population. Those IDSs control physicians' remuneration and pay them in other ways besides pure fee-for-service. Practices are based on a strong integrated information system at individual (clinical), organizational and population levels. IDSs are held accountable both at the individual and population levels.

This list is clearly neither exhaustive nor detailed enough to do justice to the existing literature on each and the relations between them. However, the goal here is simply to propose some obvious and consensual desirable characteristics that can serve as a framework to structure the analysis of the commissions' recommendations and to permit extreme summarization (the shortest commission report is well above 400 pages). In the next section, we compare these characteristics with the recommendations of governmental commissions appointed to advise the Quebec government regarding the future of the healthcare system.

3. Commissions' recommendations and degree of implementation

Since its founding, the principles, functioning and goals of Quebec's public healthcare system have been scrutinized by three public commissions. First, in 1966 the government appointed a public commission — named Castonguay-Nepveu after its two successive presidents — to make recommendations on health and welfare policy. Quebec's current publicly financed healthcare system was created on July 10, 1970, based on this commission's recommendations. Fifteen years later, in 1985, in the context of continuous growth in expenditures and declining public resources, the government appointed Jean Rochon to chair the second public commission on health and social services. Its recommendations, submitted in 1988, were the basis of a large-scale structural reorganization of the system. Finally, again fifteen years later, another public commission was appointed in 2000, chaired by Michel Clair, and tabled its recommendations at the end of that year. The current reforms of Quebec's healthcare system are still clearly influenced by this last commission [40].

All of these public commissions conducted thorough analyses of the prevailing conditions and then made concrete recommendations [41,42]. We analyzed the content of the three commissions' reports [43–45] to examine the convergence between the list of desirable characteristics we established and the commissions' recommendations (Table 1).

First, it should be noted that all three commissions were admirably consistent and convergent in their diagnoses as well as in their recommendations. Second, it can be seen that these commissions suggested reforms that tally with what are now considered desirable characteristics of health systems. However, the high convergence in the commissions' recommendations also hints at a large gap between recommendations and implementation. If the Castonguay-Nepveu recommendations had been fully implemented, obviously the subsequent commissions would not have had to repeat the same diagnosis and suggest, basically, the same solutions. It would be too long and tedious to discuss in detail the degree of implementation of each feature, but we will present some examples.

The Castonguay-Nepveu idea of an integrated network of population-based IDSs was ferociously opposed by physicians' unions and less than welcomed by hospitals. The only elements implemented were the concept of a regional governance level, with greatly limited powers, and the proposed community-level service structure that ultimately became the CLSCs (Local Community Services Centers). However, the physicians' opposition to CLSCs and the lack of government support rapidly made them irrelevant in terms of healthcare production. Physicians' remuneration, work organization and accountability were left untouched, as were hospital structures and financing. Information systems implemented were little more than tools for managing insurance payment plans. No significant mechanisms or initiatives toward a population-based or primary-care-based system were implemented.

Some fifteen years later, the Rochon Commission recommended that the regional structures advocated by Castonguay-Nepveu be given a significant governance role by allocating a per capita based regional budget to institutions in their regions and that the system give priority to prevention and primary care. To do this, it was proposed that CLSCs be turned into significant primary care institutions. Since the medical human resources of CLSCs were at best scarce, or even nonexistent, the commission sug-

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Table 1
Analytical summary of commissions' recommendations.

Desirable characteristics of healthcare systems	Commissions' recommendations		
	Castonguay-Nepveu Commission (1970)	Rochon Commission (1988)	Clair Commission (2000)
Population focus	The reorganizing of Quebec's healthcare system should be based on the principle of being an open system oriented toward providing care adapted to population need and sufficiently proactive to adapt to changing needs and conditions (vol. 4, Tome 2, Ch. V, p. 63).	The system should adopt a population focus to act on the determinants of health problems (p. 88).	Primary care organization should be decentralized and integrated according to the principle of population health (p. 201).
	Health teams should be responsible for providing complete care to specific populations according to the concept of comprehensive medicine (vol. 4, Tome 2, Ch. V, p. 63).	Professional and institutional services should be reoriented around the needs of patients (Ch. 2, pp. 542, 689).	Priority prevention interventions should target specific groups (For example, children in poverty, pregnant women, etc.) and be integrated at a system-wide level (Ch. 2, pp. 40–43).
Focus on primary care implemented through IDSs funded by capitation and responsible for a given population	Build an integrated three-layered system with Regional Health Office (ORS), local health centers (CLS) and community health centers (CCS). (vol. 4, Tome II, Ch. VI, p. 114 and Ch. V, p. 64).	Regional boards should be in charge of funding the institutions in their region. The regional boards should be funded through a capped envelope based on a per capita formula and adjusted according to outcomes (p. 698).	All primary care organizations (CLSCs, long-term care and local hospitals) in a given territory should be merged under the authority of a single board. Ch. 5, R-33, p. 227).
	CLSs should replace general hospitals and become integrated health centers responsible for providing primary and secondary care (vol. 4, Tome II, Ch. VI, p. 104) for given populations (vol. 4, Tome II, Ch. V, p. 64).	Clarify the CLSC's (local community health centers) mission to make them pivotal primary care centers (Ch. 2, p. 522) and reinforce their capacity to provide accessible primary care (Ch. 2, pp. 512, 542).	A primary care network should be the cornerstone of the system and should be built on existing CLSCs and solo practices (Ch 2, R-2, pp. 43–44).
		Solo practices and CLSCs' resources should be pooled (Ch. 7, p. 672) to support coordination of professional work to enhance continuity of services and provide a comprehensive approach focused on results (Ch. 2, pp. 542, 690).	New primary care groups (Groupe de médecine de famille, or GMF) should be created with 6 to 10 physicians plus nurses and be responsible for providing care to a registered patient population (Ch. 2, R-4, p. 52). A new integrated delivery network should be created for specific populations (elderly, chronic care, etc.) (Ch. 2, R-6, p. 65).
Physicians integrated into IDSs	All physicians should be encouraged to work in teams of at least two or three with some nurses (vol. 4, Tome II, Ch. V, p. 63). Those who want to work alone would have be affiliated with a CLS so their patients can get the complementary services and continuity that they would not get from a solo practice (vol. 4, Tome II, Ch. VI, p. 105). Fee-for-service should be progressively discarded and replaced by salary or other forms of payment (vol. 4, Tome IV, Ch. XV, p. 234). Monetary incentives should be added to the payment system to direct physicians and other professionals toward a 'comprehensive health' view and group practice (vol. 4, Tome IV, Ch. XV, p. 234).	Replace the fee-for-service remuneration by a salary-plus-extra system for physicians working in hospitals (Ch. 7, p. 679). For physicians outside hospitals, monetary incentives should target special priority problems (pp. 679, 672)	Primary care physicians (Ch. 2, R-4, p. 53) and specialists (Ch. 2, R-8, p. 93) should be paid according to mixed models including incentives toward special activities.

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Table 1 (*Continued*)

Desirable characteristics of healthcare systems	Commissions' recommendations		
	Castonguay-Nepveu Commission (1970)	Rochon Commission (1988)	Clair Commission (2000)
Strong information systems	For management and monitoring purposes, the Ministry of Health should implement a data collection and treatment unit with strong expertise in statistics and analysis (vol. 4, Tome III, Ch. VIII, pp. 94, 184).	Develop usable and user-friendly information systems to measure performance and productivity. The possibility of applying the most recent innovations in computer networks to healthcare information systems should be assessed by a work group. The computerization of clinical data must be based on strong protection systems and the active participation of professionals. Professionals should be able to analyze their practice profile and compare it with those of their colleagues (Ch. 4, pp. 593–598; 608–609; 695–696).	Effective secured clinical and managerial information system should be implemented and used to achieve the goal of a population focus as well as the capacity to monitor results rather than only outputs. Those information systems should include a unified, unique electronic medical record accessible throughout the system and allow the transmission of diagnostic test results (Ch. 2, R10, pp. 105, 171, 183).
	Information on population health and system outputs, as well as human and material resources should be collected on a continuous basis and transmitted to all decisional levels of the system (vol. 4, Tome III, Ch. IX, pp. 151, 187).		
	An integrated information system should be implemented that takes into account the role of informatics in the delivery system and the participation of professionals in the implementation of the system. An individual medical card should allow the identification of patients and families. A precise disease coding system should permit computerization (vol. 4, Tome IV, Ch. XIII, p. 165).		
Accountability mechanisms at both population and individual levels	Each community-level CCS should have a representative population panel able to assess its activities (vol. 4, Tome II, Ch. VI, p. 117).	Regional and institutional board members should be elected (pp. 479–482).	Performance contracts should be in place between the Ministry of Health and the Regional Board as well as between the Regional Boards. Those contracts should state measurable objectives (Ch. 5, R-36, pp. 232, 224).
		System evaluation should go beyond patient satisfaction surveys. The population should have a decisive influence on the assessment of the appropriateness and usefulness of interventions (Ch. 3, p. 480).	Regional Boards and institutions should take appropriate measures to consult the population (p. 222).

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gested the pooling of all resources in primary care as well as a reform of physicians' remuneration system. Finally, pleas were made for large-scale investment in information technologies and a complete change in system accountability. In practice, regional governance structures were indeed greatly strengthened and given responsibility for allocating budgets to institutions in their region. However, these budgets were strictly historical and thus left little place for significant reorganization [46]. Many legislative modifications were made, but none proved able to modify significantly the functioning of the system.

Twelve years later, the Clair Commission suggested merging all institutions on a sub-regional basis to create integrated delivery systems. However, since most primary care practitioners work in autonomous practice, it also suggested creating networks to pool all primary care resources into a coordinated network that would be the cornerstone of the new system. Then it suggested, for a third time, to change the physician payment system; to re-orient the system toward primary care, prevention and a population focus; to build a strong information system; and to strengthen accountability frameworks. Subsequently, most local hospitals, long-term care centers and CLSCs were merged on a sub-regional basis into what are now CSSSs (health and social services centers) and mandated to adopt a population focus. However, CSSS budgets are still historically based, the physicians working within those structures are in majority still autonomous self-employed entrepreneurs paid a pure fee-for-service by a third-party payer, and there is no form whatsoever of registration of patients. Some family medicine groups (GMF) were created with a portion of capitation-based funding but they account for only a small proportion of services. Most primary care doctors still work outside any form of network and physicians' remuneration is left untouched.

Clearly, as this brief presentation illustrates, it would be unfair to say nothing was done following the commissions' reports. On the contrary, they had a very significant impact on the current structure of Quebec's healthcare system. However, implementation of their recommendations was quite limited, and this, in a very clear, non-random pattern. The unimplemented elements were always those that entailed significant transformations for powerful interest groups (i.e., doctors, hospital associations, teaching hospitals and faculties of medicine) [47,48]. On the other hand, the implemented elements were mostly modifications to the system's administration. These structural reforms were often quite important. For example, each commission had a tremendous impact on the name, role, prerogatives and functioning of the regional level governance body. Another example is the current round of forced mergers to create CSSSs that constitute a major puzzle for managers at all levels. However, the idea that bold restructuring of the administrative structures will prompt (in the absence of any other incentive) a modification of clinical practices, quality of care or population health is not supported by any evidence of which we are aware.

The past forty years have thus shown that the problems of the healthcare system's organization, as well as their solutions, are quite unambiguous. Solutions supported by available scientific evidence were put forward — with admirable consistency — by the three commissions appointed to advise the government on those issues. However, these solutions were never implemented completely and consistently enough to achieve the desired results.

According to Champagne's [49–51] framework, to succeed, reforms need to respect three conditions: (1) a decision must be made; (2) it must be implemented; and (3) it must be based on a good intervention theory—that is, proposed changes should have a strong demonstrated causal relation with expected results. Our analysis reveals failure at each level. First, the pick-and-choose approach to the commissions' recommendations represents, in itself, a decision failure. Second, many components of the legislative proposal are left at the wishful-thinking stage or implemented only very partially [46,52] and thus are implementation failures. Finally, as argued here, the pick-and-choose process drastically undermines the intervention theory by removing components central to the validity of the commissions' entire proposals. In the next section we extend the neo-institutional theory of organizational behaviour to discuss the roots of these failures.

4. Unimplementable solutions

Although the public debate still revolves around recurring problems and arguments over the proper solutions [53,54], our main hypothesis is that the real problem facing Quebec's healthcare system governance is its capacity to adopt and implement appropriate means toward obvious goals. However, analyses of past reforms show that, when pressured to act, governments will totally ignore some issues, however central they may be to the attainment of valued goals; put the reform's emphasis on politically easy targets even if those targets bear little relevance to the problems (i.e., restructuring the regional board each time); delegate tough decisions to other governance bodies (hospitals for clinical issues, Regional Health Authorities for funding cutbacks, CSSSs for horizontal networks, etc.); strike monetary deals with groups (especially doctors) to buy their (very) partial commitment to otherwise politically unattainable reforms and, more generally, dissociate discourse from action.

These solutions have obvious similarities with the organizational neo-institutional literature and, as mentioned in the introduction, we believe this line of reasoning can be usefully applied at a larger systemic level to distance the analysis from overly functionalist postulates often taken for granted. First, Quebec's healthcare delivery system, as a whole, fits the definition of what Meyer and Zuker [13] call a permanently failing organization.

> "Permanent failure sets in when there is little expectation that efficient and effective conduct will be restored ... yet there is little serious disruption of existing organizational patterns. . .. Permanently failing organizations, we argue, yield benefits that motivate investment in and maintenance of them, but these benefits often accrue to those who are in one way or another dependent on organizations rather than those who legally own or control them." ([13] p. 45)

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In this view, it is not the functionalist achievement of organizational — or in this case systemic — performance that explains the system's structural arrangement and functioning, but rather its conformity with key stakeholders' expectations. At a first level, this tallies with Evans' [55] reminder that one person's expenditures are always someone else's income. Physicians' unions or faculties of medicine certainly are powerful actors with lots of clout, but this alone would, in our view, be insufficient to explain the status quo. There is usually not even any need for them to oppose proposals that contradict their preferences, since these are, from the beginning, "naturally" taken into account when drafting legislative proposals [48,56]. As we argue here, conformity with stakeholders' expectations goes beyond abiding by the conscious rent-seeking political behaviour of such groups. At this second level, the incapacity to implement the commissions' recommendations fulfills the neo-institutionalist prediction [12] that, in highly institutionalized contexts such as healthcare, the structural contingency theory postulate that organizational structure will adapt to environmental pressures [57,58] is not valid. On the contrary, structures and practices will be isomorphic with socially structured norms [10–13]. Here, it should be emphasized that certain groups (physicians, especially in specialized medicine, and technology producers, especially pharmaceutical companies) are at the core of the production, diffusion and reinforcement of these social norms [10,12,14,59]. Thus, on the one hand, we have interest groups with obvious vested interests who are pushing politically to defend them. On the other hand — and this is what our extension of the neo-institutional theory brings to the analysis — this is not the only, and perhaps not even the main, driver of the system's capacity to resist reforms. The push to defend professional autonomy, the centrality of the hospital and, within the hospital, specialized and highly specialized care, and the wide diffusion of new technologies with less than obvious clinical benefits for the patient rely heavily on social norms that very much favour physician autonomy, technology and hospital care. These norms are deeply rooted within dominant social values and, as such, structure political action as well as the political acceptability of policy options above and beyond self-interest.

Meyer's and Rowan's [12] framework is interesting at this second level because it suggests hypotheses about solutions organizations use to resolve inconsistencies between functionalist performance expectations and symbolic conformity to low-performing forms and practices. In the context of healthcare reforms, this would describe inconsistencies between, on the one hand, the need to implement efficient models to enhance individual and population health and, on the other, the pressures to maintain the system's conformity with dominant social norms and values. In the short term, the authors suggest four partial solutions, one of which is noteworthy because it so clearly resembles the political discourse on healthcare: promise reform. In this solution, participants acknowledge the current situation is bleak but pledge that reforms are on the way and the future will be bright. This solution is partial because it does not tackle the source of the discrepancies and with time it will become clear that the promised reforms never materialize. The public's current cynicism regarding Quebec's capacity to reform the healthcare system is an example of this [60].

For the longer term, two solutions are proposed for organizations functioning under institutionalized rules and confronted with performance expectations. These are: (1) decoupling structures and rules from practices and activities, and (2) adopting ceremonial evaluation processes. According to this remedy, structural forms and production processes can be defined that conform with institutionalized rules, but are not implemented—or, when implemented, can be decoupled from actual practices through the adoption of ambiguous goals, the absence of linkage between managerial supervision and production activities, and excessive professionalization. The strong decoupling of discourses and actions revealed in the implementation of the commissions' recommendations seems to fit this pattern, as does the delegation of responsibility for achieving results to other bodies like Regional Boards or hospitals [55]. The other solution is to adopt evaluation mechanisms that are as disconnected from the system's ultimate objectives as possible. For example, current performance contracts between CSSSs and Regional Boards are focused on balancing budgets and on monitoring the evolution of service volumes, etc., but steer clear of anything that could link needs with production.

In our opinion, this perspective offers a new understanding of the factors that prevent the implementation of successful reforms in healthcare. We should also mention that none of the reforms studied here had the objective of decreasing total expenditures on health: groups' incomes were not directly threatened. Moreover, the level of professionals' dissatisfaction with the current organization of care delivery is very high; the status quo has few partisans within the medical profession. In such a context, simple rational rent-seeking behaviour alone fails to account for the stalemate. However, our hypothesis is that the reforms proposed were based on interventions that contradicted the social norms with which the current healthcare system is isomorphic.

Our analysis describes a system in an acute double bind between, on the one hand, the official and public discourses that implicitly or explicitly define its performance according to a goal achievement framework and, on the other, its real logic of functioning that relies on the system's conformity with norms and values that push the system in the opposite direction. Since Quebec's healthcare delivery system is almost entirely publicly financed and administered, it is at the political level that this double bind is expressed. Governments are held accountable for the system's poor performance according to a functionalist goal achievement framework and thus are hard pressed to do something about it. However, the system's internal logic is consistent with, and explainable by, the preferences of key interest groups, who would not accept any proposal contradicting their preferences, and, at a second level, with deeply rooted social norms and values convergent with their preferences. As our results suggest, those responsible for the system's governance respond to this double bind mostly by decoupling a strong reformative discourse on the one hand and actual proposal maintaining the system's actual

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functioning in conformity with dominant values and stakeholders' preferences on the other hand. To some extent, this strategy appears successful, since it allows their short-term political survival, something that neither defending the status quo nor implementing radical change would likely accomplish.

5. Conclusion

Each commission was appointed because the organization or functioning of the healthcare system had become a political problem for which no easy solution was available. However, while the commissions proposed solutions that were consistent with available scientific evidence, they did not consider the political acceptability of those recommendations. Modifying physicians' employment relations with hospitals or their payment scheme, re-allocating budgets between institutions, shifting resources from secondary or tertiary care to primary care—all may very well be central to tackling the system's main programmatic problems, but they will also immediately trigger radical opposition from key stakeholders. What our extension of neo-institutional theory adds to this well-known tale is that stakeholders' opposition should not be conceived of only as rational rent seeking. Stakeholders are in fact defending what they perceive to be the proper way of delivering healthcare and, in so doing, are contributing to the production, diffusion and reinforcement of social norms and values consistent with their views. The centrality of interest groups such as physicians' unions, faculties of medicine or teaching hospitals lies in the fact that they are pivotal both in the production and reproduction of these norms and values as well as in their political capacity to veto proposals that contradict their preferences. Their dual centrality in the healthcare reform processes makes them impossible to circumvent. While Quebec's situation is analyzed here as one specific case, we believe the same forces and processes described here operate with various intensities in other contexts [55]. We suggest that the core question in reforming public healthcare systems may have nothing to do with the programmatic level and much to do with the governance level. Drawing on different theoretical bases, Tuohy [61] identified two necessary but insufficient conditions for major policy changes: a consolidated base of authority, such as a majority government with strong support, and a high priority accorded on their agenda to healthcare reform. Since these conditions were generally met after the submission of each commission's report, our analysis shows that, indeed, they are insufficient.

The key issue then is to understand the conditions under which reform policies can successfully effect desirable changes in the public healthcare system. Some conditions for success are obvious (a drastic restructuring of interest groups' power and centrality, an unlimited supply of resources to buy out changes, a sudden burst of governmental legitimacy able to overcome opposition), but unfortunately, those conditions are highly unlikely in the foreseeable future. On the other hand, healthcare systems are rapidly evolving, mostly because of forces outside the realm of public policies such as technological innovations, demographic changes and globalization of trade. Perhaps unforeseen changes may unsettle some systems such that conditions propitious for significant public policies will appear.

However, in the short term, the most promising avenue would probably lie in the emergence of a socially accepted consensus around the simple idea that the real question is not "what to do" but rather "how to do it". In the vocabulary of neo-institutional theory, this means influencing shared norms and values about the nature of health and healthcare in ways that render them compatible with what have been shown to be efficient healthcare delivery models. Although rewording the issue in this way does not make it any easier to address, it might help in understanding the processes at stake.

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