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Healthcare reforms, inertia polarization and group influence

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ABSTRACT

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

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

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

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

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1. Introduction

Given the amount of resources invested, the symbolic importance attributed to the concept of health, and the healthcare system's role in determining health, care delivery systems are core

components of modern societies. This makes them the focal point of intense policy and media attention. Suboptimal care accessibility or quality, as well as inefficiencies in resource allocation, are generally perceived in the media and political spheres as legitimate policy intervention targets. Common wisdom dictates that governments and public institutions are expected to do something to correct existing deficiencies. Yet the problem–solution trajectory is far from linear, and in most systems deep-seated performance shortcomings persist despite a seemingly never-ending cycle of reforms [1,2].

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

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

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

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

2. Context: Quebec healthcare system reforms

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

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

3. Conceptual framework

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

Some of the most obvious theoretical strands that focus on stakeholders' or interest groups' role in policy-making processes are found in the literature on interest groups and lobbying [5,33–42]. Yet, even political science models that were not developed from the postulate that groups are the main determinant of

policy-making still attribute a major role to groups' preferences in policy-making processes. For example, the Advocacy Coalition Framework [3,4,43,44] and the literature on policy communities and networks [11,45–51] and on agenda-setting [52–57] all share the common assumption that stakeholder groups' opinions and preferences structure policy-making.

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

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

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

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

4. Methods and data

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

views into the survey instrument and, second, to assess the convergence between those representatives' views and the views held by members of the professional group they represented. As we discuss later, data from both components were then analyzed using the same approach aimed at identifying consensus and polarization. The project received ethical approval from the ethics committee of the Research Centre of the Centre Hospitalier Universitaire de Sherbrooke (CHUS).

4.1. Qualitative interviews with representatives of stakeholder groups

The first phase of the study explored the views of key stakeholders in Quebec's healthcare policy arena. We applied an inclusive definition of organized interests "that includes both membership-based organizations [...] and 'memberless' institutions such as hospitals, private companies, and regional boards" [60]. Informants who could articulate the views of each group were then identified on the basis that they occupied, or had occupied, key positions within the groups or organizations (for example, presidents of professional orders, unions, and associations, deans of health profession faculties, CEOs of university hospitals or of regional health and social services agencies, etc.). Thirty-two organizations were identified and invited to participate; of those, 31 accepted (Quebec's union of specialist physicians declined). We conducted 31 interviews, although the number of interviewees was higher, as many organizations opted for group interviews. Interviews were conducted between February 2013 and May 2013. The semi-structured interviews, which lasted from 45 min to two hours, were loosely structured around four themes: 1) the strengths of the current healthcare delivery system; 2) the main challenges and problems facing the system (not presented here, as their analysis ended up being redundant with identified solutions); 3) the best solutions to improve the healthcare system's performance; and 4) the actors and interest groups that appeared to be the most powerful and influential in shaping healthcare policies. All interviews were recorded and transcribed.

Interviews were categorized according to the interviewees' professional groups (11 physicians, nine nurses, nine administrators, and two pharmacists). The categorization was based more on function than training. For example, a hospital CEO who trained as an MD but was working exclusively in hospital management was categorized as an administrator. All transcripts were then reviewed by two different researchers, who independently summarized the interviewees' main comments and ideas. These summaries were then compared, discussed, and combined into a single text. At this step, summaries were analyzed narratively to provide an in-depth understanding of each interview [80,81]. The summaries were then used inductively to build a list of codes or schemata [82] representing the essence of each distinct complex statement or proposition put forward by each informant. Codes were divided into the four themes covered by the interview questions: strengths, problems, solutions, and influential groups. Two researchers worked independently on developing schemata inductively while at the same time coding each transcript. Coding differences were reviewed by the team members in consideration of the original interview transcripts until all discrepancies in interpretation were resolved. At the end of the process the coding structure was composed of nine strengths, 41 problems, 46 solutions, and 10 influential groups. Once the codes were finalized, all summaries were reviewed to ensure coding was consistent throughout the corpus.

4.2. Quantitative survey of professional groups

The second phase of the study examined healthcare professionals' and administrators' views on potential solutions to reform and

improve the healthcare system. Between August and October 2015, a survey was sent by email and/or mail to 2491 people who were either physicians, nurses, pharmacists, or administrators. A random sample of 750 physicians, 748 nurses, and 750 pharmacists was generated from listings of professional registration bodies (Quebec College of Physicians, the Nurses' Corporation, and the Pharmacists' Corporation). For administrators, we targeted persons in top management positions in healthcare institutions and used a census approach targeting the whole population ($n = 243$).

The survey included 29 Likert-scale closed questions and one open-ended question asking respondents to suggest three solutions that the Ministry of Health might consider to improve the healthcare system. Detailed results from this survey are published elsewhere [97]. The analysis provided here focuses on answers to the open-ended question. A total of 919 respondents provided usable survey answers (37% overall response rate, 40% for physicians, 26% for nurses, 45% for pharmacists, and 33% for administrators). The sample was generally representative of each population group (sex, training, location), except for nurses, where university-trained nurses were significantly over-represented. Response rate for the open-ended question was 31% overall, with 774 usable answers (253 physicians, 160 nurses, 291 pharmacists, and 70 administrators.)

While the survey question asked for three potential solutions, the number of solutions provided ranged from one to 10 per respondent, with a mean of 3.2. As in the first phase of the study, answers were independently coded by two researchers. The schemata-based coding structure created for the solutions theme of the first study phase was used as a starting point. The same process adopted in the first phase, of two researchers developing inductive schemata in parallel, was also used here. From the original 46 solutions schemata, three were slightly edited for better fit with the answers provided, one was not used at all, three were merged, and eight new codes were created to capture new answers given by respondents, for a total of 51 schemata-based codes.

4.3. A visual analysis method for qualitative data

In the context of this project, we developed a new method for the visual analysis of qualitative data [98]. This method, derived from the field of social network analysis, is aimed at identifying convergences and divergences in relations between informants and their views.

As presented in the previous section, the endpoint of the coding process of each phase was a binary matrix linking informants to schemata-based codes corresponding to their answers. From a social network analysis perspective, such matrices each constitute a two-mode network [83,84], where nodes represent either informants or their (schemata-summarized) opinions, and where ties represent the links between each informant and their opinions. What connects informants is thus not direct links between themselves, but rather their common answers (codes) in interviews.

The matrices were imported into Cytoscape 3.2.0 software and represented as a set of force-directed sociograms using the Fruchterman-Reingold algorithm [85]. Force-directed algorithms are based on the principle that nodes are mutually repulsive and ties constitute attractive forces. This means that the more a schemata-based node is in a balanced position between clusters of informant-based nodes, the more consensual it is among those informants. The most interesting feature of this visualization approach is that nodes sharing many links will be positioned together, far from the nodes with which they share few links. This clustering effect allows visual assessment of convergence between informants, between schemata, and between informants and schemata. To validate this data analysis approach, we transformed our interview-based two-mode matrix into two one-mode

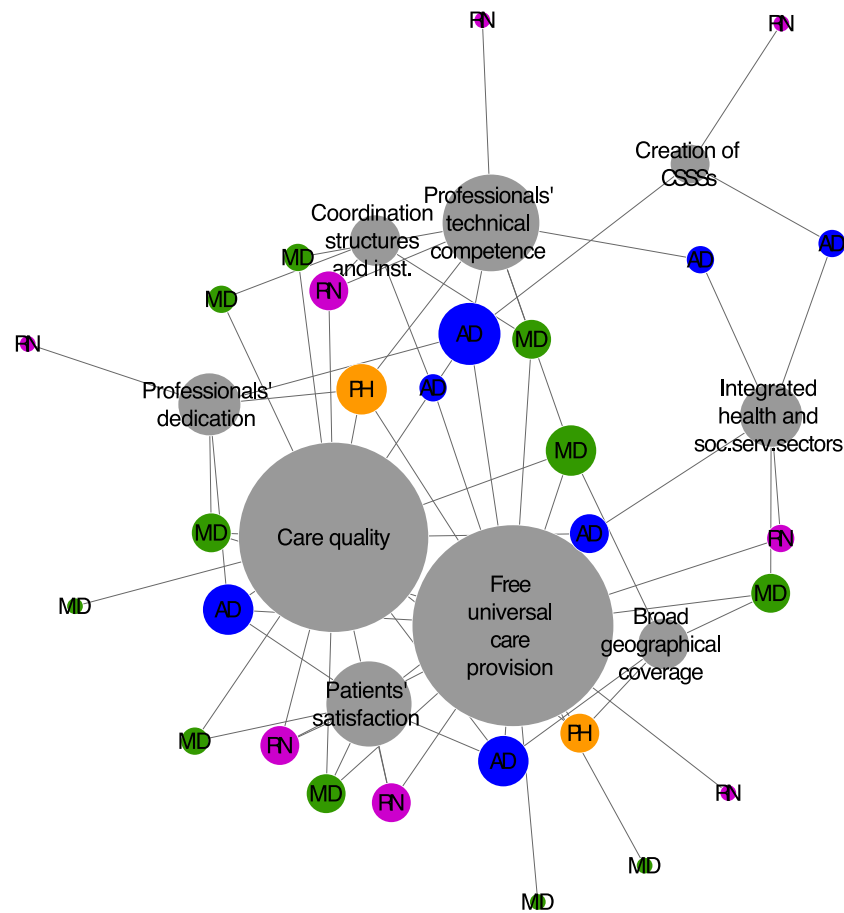


Fig. 1. Strengths of Quebec's healthcare system.

matrices and computed Jaccard similarity coefficients that were plotted using metric multidimensional scaling (MDS). A detailed discussion of this validation approach is published elsewhere [98].

To facilitate visual analysis, we also mapped node colour based on the two types of nodes displayed on the sociograms: schemata/code nodes (light grey) and informant nodes (administrators: blue; pharmacists: yellow; nurses: pink; and physicians: green). Lastly, the nodes' sizes were mapped according to the number of ties connected to one node. In graph theory, the number of ties connected to a node is called the node degree. Larger schemata/code nodes on the graphs thus represent high salience ideas shared by larger numbers of informants. On all sociograms, the node with the highest degree was plotted with a diameter 20 times the size of the node with the lowest degree.

Before presenting the sociograms, we want so to stress that the data visualization approach used here is specifically aimed at identifying inter-groups clustering in opinions and preferences. It isn't designed to facilitate the overview of all participants opinions (readers interested in such an analysis of the data presented here should read [98]). Because of the graph optimization algorithm used, some nodes and text may overlap and make it hard to identify small or peripheric nodes. However, this does not affect the readability of the clustering by colour or the analysis of central nodes.

5. Results

As stated in the Introduction, this project was designed to examine whether polarization in stakeholders' views concerning healthcare reform options could explain why some important pol-

icy changes are not implemented despite broad scientific consensus on their programmatic coherence. However, we found very little group-based polarization. Instead we found impressive levels of consensus. In this section, we briefly present results from the qualitative component summarizing key stakeholder representatives' views on the strengths of Quebec's healthcare system (Fig. 1) and identifying the most powerful actors in policy-making processes (Fig. 2). We then go into more detail on the analysis of the two components' results regarding policy solutions to improve Quebec's healthcare system performance (Figs. 3 and 4).

5.1. Main strengths of Quebec's healthcare system

Of the 31 key stakeholder groups who participated in the qualitative interviews, 28 listed at least one system strength. Two strength-based schemata were particularly salient in the answers: free and universal provision of care (degree of 17) and quality of care provided (degree of 16).

The figure shows a high level of consensus regarding the system's core strengths. The other interesting observation is that there is no obvious clustering of informants according to professional group affiliation (visualized as node colour). This suggests there are no obvious group-based divergences in opinions regarding the system's core strengths.

5.2. Most powerful actors and interest groups in health-related policy-making

Of the 31 key stakeholder groups who participated in the qualitative interviews, 26 identified at least one influential actor or

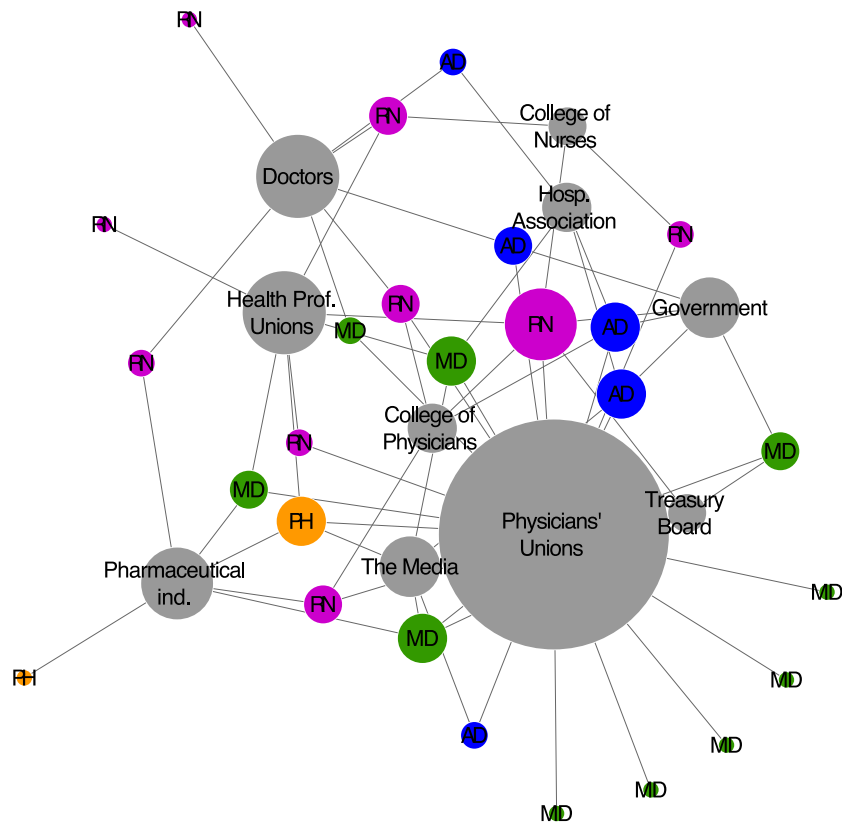


Fig. 2. Most influential groups in Quebec's healthcare system.

interest group. One group-based schema really stands out here: medical unions¹—of which there are one for GPs and one for specialists—were listed as the most influential group in 20 of the 26 interviews. Overall, the core result is that there is a very strong consensus that physicians' unions are the most influential groups in Quebec's healthcare policy-making processes.

Fig. 2 shows some clustering of informants according to their professional group: physicians are mostly located at the bottom right of the sociogram, while nurses are at the top left. This clustering is mostly explained by the fact that almost all physicians (10 out of 11) identified physicians' unions by name whereas nurses identified both physicians' unions and physicians as a generic group.

It is also worth mentioning that narrative analysis of the data suggests most respondents believe it would be impossible to implement significant policy change without the support of the medical unions.

5.3. Solutions to improve the healthcare system's performance

As stated earlier, we have data from both components of our study regarding respondents' opinions on the best solutions to improve the performance of Quebec's healthcare system.

¹ Throughout Canada, physicians are covered by the Rand formula and therefore required to pay union dues, regardless of their union status. In most provinces, the dues are paid to a single body that combines the function of a union representing all physicians in their negotiations with the province and the function of a professional association. Quebec's physicians' representation structures are different from this model. In Quebec, specialist physicians and family doctors are each represented by one distinct Fédération which represent them for contract negotiations. The professional association – AMQ – is distinct from the Federations and relies on voluntary membership from all physicians' groups. We use the generic term 'union' to describe Quebec's two medical federations.

Respondents in all 31 qualitative interviews mentioned policy options they perceived as plausible ways to improve the system's performance. Informants in the qualitative phase each mentioned between six and 24 solution-based schemata (average 13). The five most salient solutions were Strengthen primary care capacities (degree of 28); Rethink the way physicians are paid (degree of 22); Redefine professional roles in primary care (degree of 21); More reliance on performance monitoring (degree of 19); and Increase physicians' accountability (degree of 17).

Even more interesting, however, is the observation that, if the 10 solution-based schemata centred around the highly salient node Strengthen primary care capacities (red circle on Fig. 3) are ranked by their salience, it reads as a quite coherent policy package: rethink the way physicians are paid; redefine professional roles in primary care; increase the reliance on performance monitoring mechanisms; implement a system-wide electronic health record; involve more physicians and nurses in the system's governance; extend the hours for primary care delivery structures; increase nurse practitioner and registered nurse staffing in primary care teams; improve hospital management capacities (this one does not really fit in the list); rely more on pivot nurses and care navigators embedded in primary care teams; make better use of information technologies; and make the system more patient-centric. Overall, while each respondent proposed different solutions, when put together, the solutions that cluster at the centre of Fig. 3 correspond to the essential characteristics of an efficient healthcare system.

Another important element is the low level of group-based polarization. At first sight, there is some group-based clustering in Fig. 3: nurses tend to cluster mostly on the left of the graph, administrators mostly on the right, the two pharmacists are together, and most physicians are in the top left. However, a closer analysis shows that such clusters are linked to preferences for peripheral solution-based nodes. For example, nurse respondents mentioned

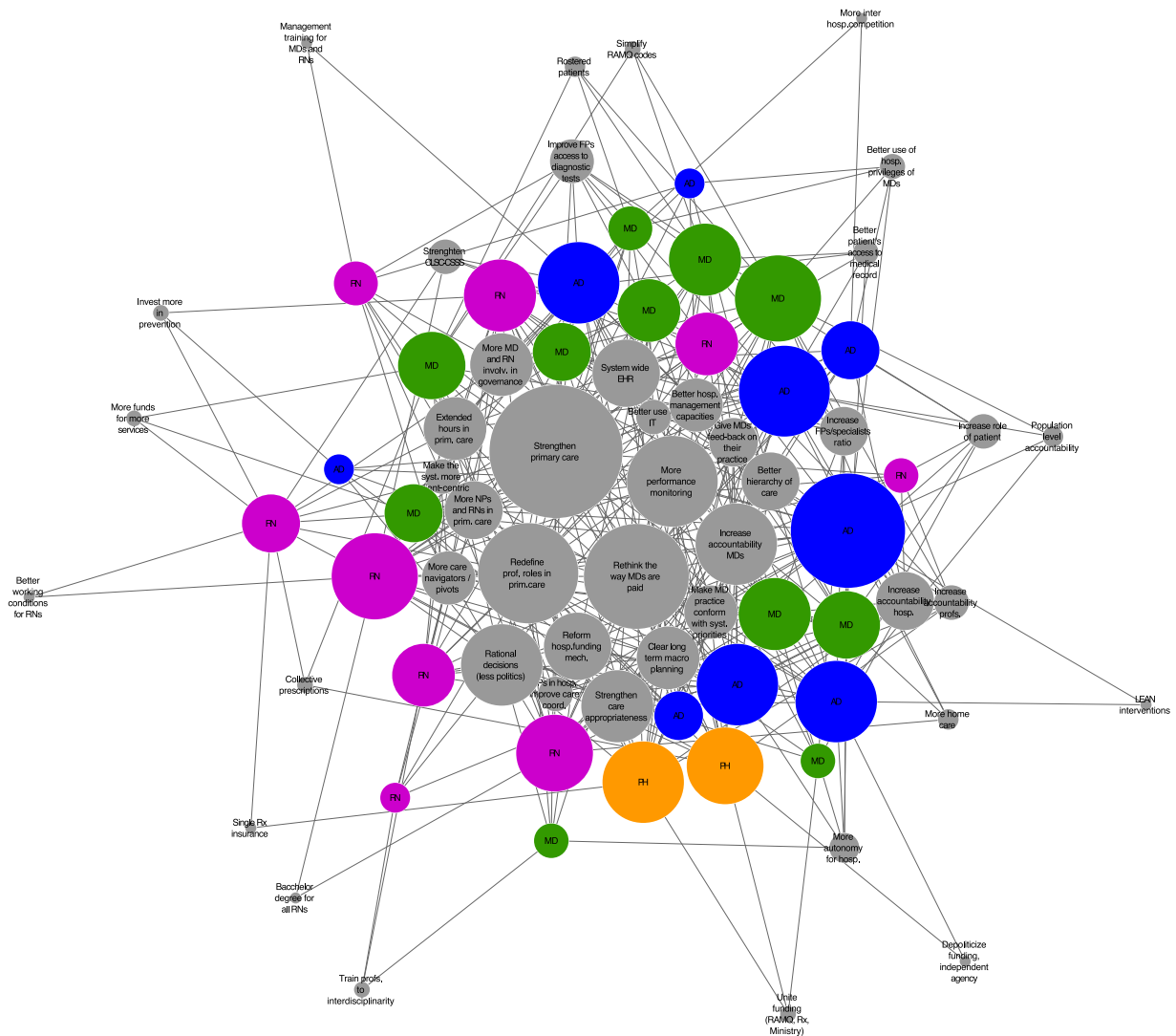


Fig. 3. Component 1 solutions to improve Quebec's healthcare system.

mandatory university level training for nurses (degree of 2) or better working conditions for nurses (degree of 2). However, there does not seem to be any significant group-based polarization of policy preferences for the core, highly salient elements at the centre of the graph.

This lack of polarization was a surprise for us and warranted further consideration. As stated in the Methods section, 31 of the 32 groups invited to participate in the qualitative interviews accepted, with the refusal coming from the specialist physicians' union—the more powerful of Quebec's two physicians' unions. Given the consensus we observed in our data regarding the centrality of physicians' unions in policy-making processes (see Fig. 2) and the lack of observed polarization, we carefully re-analyzed the position of the GP physicians' union in our data set. In the structural analysis, it did not diverge much from the other groups. However, the narrative discourse analysis showed that, when compared to the other interviews, the support expressed by the GPs for policy reform options put forward by other groups was more limited in both scope and form. Moreover, as the consensus among other interviewees pointed towards policy avenues to strengthen primary care, it was not surprising that it generally converged with GP (mostly primary care) physicians' union preferences.

In addition to the solutions suggested in the 31 stakeholder interviews, 774 of the professionals (physicians, pharmacists, and

nurses) and administrators surveyed provided usable answers to the open-ended survey question about solutions they would suggest to the Ministry of Health to improve Quebec's healthcare system. On average respondents provided 3.2 solutions (maximum 10, minimum 1, mode and median 3). On average, each of the 51 solution-based schemata was identified by 47.9 respondents. The five most salient solutions were: Redefine professional roles in primary care (degree of 317); Extend primary care accessibility (degree of 199, this schema is a broadening of Extend the hours for primary care delivery structures from phase 1); Rethink the way professionals are paid (degree of 149, a broadening of Rethink the way physicians are paid); Strengthen care appropriateness (degree of 123), and Implement a system wide electronic health record (degree of 122). Four of the solution-based schemata with the highest salience from the phase 1 qualitative interviews were also in the top-10 highest salience in the survey data.

Once again, the 10 solution-based schemata with the highest degrees and that surround the highly salient node "Redefine professional roles in primary care" (degree of 317) together present a remarkably coherent primary-care centred policy proposal: extend accessibility and hours for primary care delivery structures (degree of 199); rethink the way professional are paid (degree of 149); strengthen care appropriateness (degree of 123); implement a system wide electronic health record (degree of 122); improve care

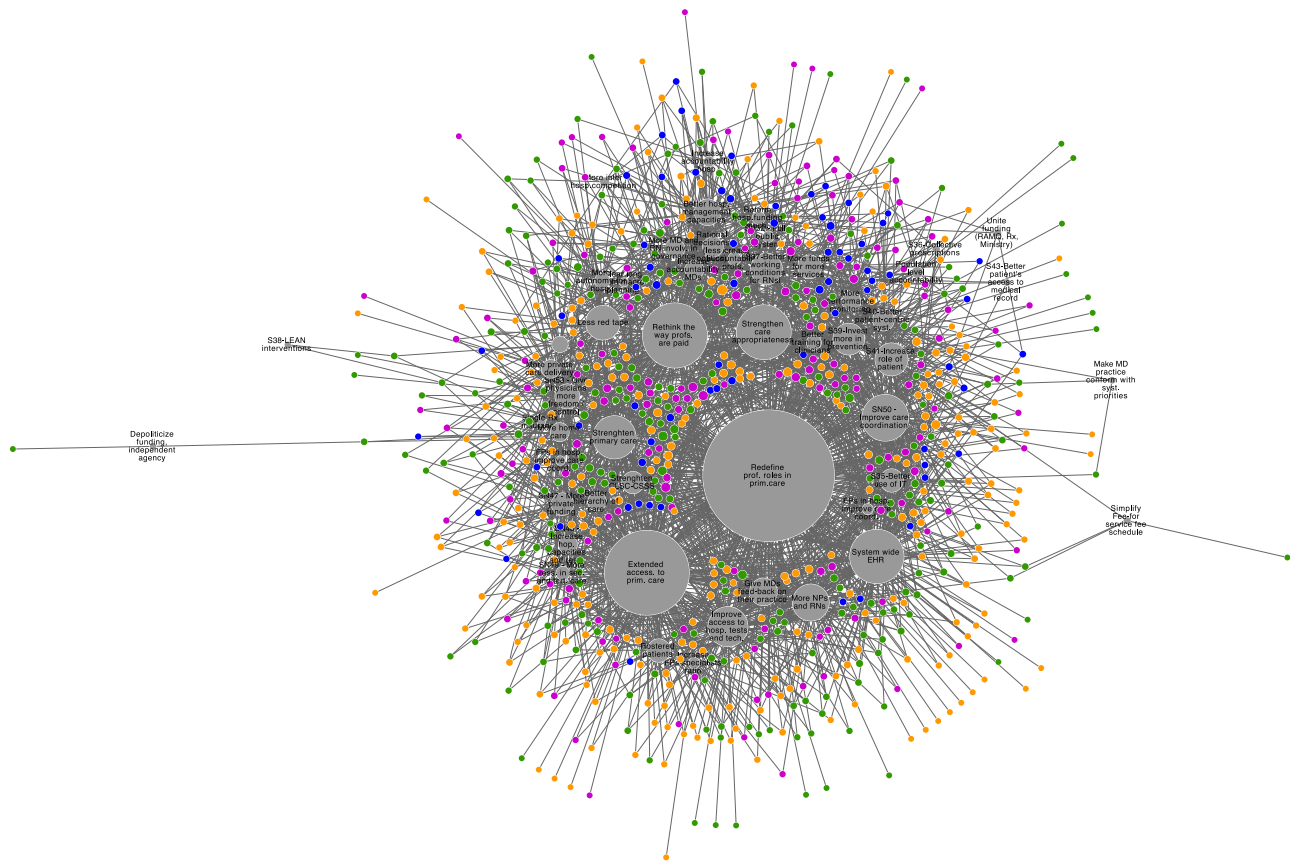


Fig. 4. Phase 2 solutions to improve Quebec's healthcare system.

coordination (degree of 103); generally strengthen primary care (degree of 94); improve access to hospital-based tests and technical platforms for ambulatory patients (degree of 86); increase nurse practitioner and registered nurse staffing in primary care teams; (degree of 78) and increase patients' involvement in care and management (degree of 68). It should be recalled that these data come from a survey-based open question and, given this origin, are impressively coherent.

Another interesting result is the absence of any group-based clustering in Fig. 4. This means that, while individual opinions and preferences may vary, the fact of being a physician, nurse, senior administrator, or pharmacist does not seem to significantly structure those preferences. As stated earlier, our original intent in this project was to measure and study group polarization of policy preferences. When the first iterations of Fig. 4 produced these unexpected results, we tried alternative settings for graph optimization, but no reasonable setting provided any improvement in the identification of group-based polarization.

6. Discussion

The results presented lead to two important observations. First, the performance improvement solutions put forward by informants in both phases of this study constitute an impressively coherent policy proposal centred on strengthening primary care capacities. We describe it as coherent because the diverse propositions making up this proposal are interdependent in their contribution to achieving the broad policy goal of systemic performance improvement.

Given the visualization techniques used here, the fact there is a clear core of solution-based schemata that simultaneously have

high salience and occupy a central position on the graph suggests there is strong consensus on the solutions to be implemented.

Beyond simply describing the content of groups' policy preferences, we also aimed to examine the hypothesis that disagreements in stakeholders' views on various healthcare reform options explain why certain policy changes are not implemented despite broad scientific consensus on their programmatic coherence. As mentioned above, however, our data are not convergent with this hypothesis. This opens the field to alternative explanations. If there are both strong support for coherent reform avenues and significant inter-group consensus around policy options, why is it apparently impossible to reform the Quebec system in a way that solves persistent problems?

We want to discuss two interconnected possible explanations here. First, institutional dysfunctions or large-scale incompetence could be crippling government's capacity for action to such an extent that no deliberate action is possible. Second, the actual policy influence of certain interest groups could be such that one or more groups with no appetite for significant reform have a *de facto* veto capacity over and above any consensus or coalition in the field.

The first source of explanation can take many forms. For example, some political science literature can be used to suggest government action could be limited by institutional failures wherein policy-makers either fail to properly assess stakeholders' preferences or are unable to enact them into policy [86,87]. Alternatively, organizational science literature can be used to stress the practical challenges related to effecting deliberate change in large complex systems [88,89].

The second source of explanation is anchored in elite theory perspectives [8,74,90]. In contrast to pluralists, who see policy-making as a relatively open process, elitists conceive of policy-making as monopolized by interest groups expressing the preferences of the

richest and most educated. Our interviews with stakeholder group representatives—all of them very savvy regarding actual policy-making in Quebec—revealed that, in their view, physicians' unions unambiguously dominate the policy field (see Fig. 2). This result is highly compatible with elite theory perspectives. The centrality and power of physicians' unions is no surprise, as it tallies with previous research [17]. However, our results suggest these groups' power may have been underestimated.

Is Quebec's situation documented here an exception? The political clout of Quebec's physicians' unions is likely somewhat idiosyncratic to the province. Applying the Rand formula to physicians (see first footnote) automatically creates an exceedingly well-funded political actor able to tap into heaps of symbolic capital linked to the nature of medicine and illness. If, furthermore, that actor's mission is solely focused on defending physicians' financial and professional interests [91], it skews the political field in a given direction. Revolving doors—where the same persons switch back-and-forth from union duties to high-level decision-making positions in government—also play a role in explaining the political power of physicians' unions in Quebec². We believe the combination of all those factors explains the peculiar power balance we observed (see Fig. 2). However, we believe that physicians' unions and medical organisations in other jurisdictions can rely on at least some similar power sources [8].

But the paper's conclusion isn't so much about the power wielded by physicians' union than about the potential overemphasis given to inter-group divergences in explaining stalemates in healthcare policy making. As analysts with a long standing interest in Quebec's health policies, we were surprised by the results obtained here. This suggests that, even when paying attention, one can underestimate consensus or overestimate the level of polarization. The availability cascade bias is likely at play here. This cognitive bias describes the artificial overestimation of an idea's credibility through the feedback process of its repetition in public discourses. It relates with the apocryphal quote attributed to Joseph Goebbels discussing propaganda: « Repeat a lie often enough and it becomes the truth ». In particular the functioning of media reporting, where issues tend to be framed dialectically [92], is likely to overplay polarization. But whatever the causes are, overestimating the possibility that health policy reform stalemates are explained by divergences in actors' preferences is potentially damaging at two levels.

First, it might obscure the real veto points and tensions and thus limit the attention paid to those. Second, it might downplay the political acceptability of some reform avenues. Our results suggest there might be underexplored achievable policy targets for health policy reform where a significant consensus exists for evidence-based interventions but where one or a few groups were able to obfuscate the issue and block progress. This would be the policy equivalent of pluralistic ignorance in social psychology. A situation where the collective realization that a consensus is indeed possible would tip the scale towards making change possible.

7. Conclusion

Drawing upon the political science literature, this study explored the hypothesis that Quebec's apparent incapacity to adopt and implement coherent policy solutions to tackle pervasive healthcare delivery problems was, to some extent, explained by competing stakeholder preferences. The data we analyzed do not support this hypothesis. In fact, our results reveal striking inter-

group convergence around what appears to be a programmatically sound policy package centred on the general objective of strengthening primary care delivery capacities.

When taken together, these results are compatible with the strongly elitist hypothesis that the apparent incapacity to implement coherent policy reforms despite broad scientific consensus on their programmatic coherence comes from one or two groups' having a *de facto* veto in policy-making. This conclusion is important at both the practical and research levels.

Practically speaking, there is little doubt left that the specialist physicians' union is king of the policy jungle in Quebec. However, if what we found is true, and if indeed there is a strong policy consensus among most or all other stakeholders, our results can play a role in improving the political representation of those preferences and helping to erode this group's veto capacity.

At the conceptual and research levels, describing a strong concentration of political power hardly settles much. The sources of this power, how it is expressed, and how it interconnects with institutional rules are only some of the questions now opened.

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² As one example, the person who was president of the specialist physicians' union during the interview data collection phase of this study was the health minister during the survey data collection and still was at the time of writing this article.

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