Project Research Paper

A Cross-Provincial Study of Health Care Reform in Canada

Academic Literature Review

diverse issues as interpretation and enforcement of the Canada Health Act; the way in which Canada-wide health goals and objectives are handled; cost containment; the role of federalism in national

federal-provincial-territorial health conference system. The introductory and concluding chapters provide a broad overview of the governance challenges facing Canadians in the health area. Starting with a belief that it is imperative to restore public confidence in the health system, editor Duane Adams argues that this requires a modernization of public purpose involving a new set of Canada-wide goals and objectives and that this can only be achieved through more effective and collaborative federal-provincial governance structures.

4. **Angus, Douglas E. (1991). Review of Significant Health Care Commissions and Task Forces in Canada Since 1983-84. Ottawa: CHA/CMA/CNA. [C?]**

5. **Argue,-Gregory-Howard(2000). Policy in the Face of Crisis: Social Democratic Policy in Saskatchewan *Dissertation-Abstracts-International,-A:-The-Humanities-and-Social-Sciences*; 2000, 61, 5, Nov, 2044-A. [A,B,C,D]**

   ABSTRACT: This dissertation examines how the social democratic government in Saskatchewan manages policy change when confronted with a fiscal crisis. It does this through an analysis of economic development and health care policy in the province. In addition, the social democratic reaction to the fiscal crisis in Saskatchewan is compared to similar circumstances in Sweden. This analysis is informed by the literature on the welfare state, social democracy, hegemony, legitimacy and policy construction. It incorporates a nested-theoretical model which considers institutions, policy communities, ideas, interests and paradoxes as important notions to help understand social democratic policy action and change.

6. **Armstrong, Pat, Hugh Armstrong and David Coburn, eds. (2001). *Unhealthy Times: Political Economy Perspectives on Health and Health Care in Canada*. Oxford University Press. [C, D]**

   Chapter 1: From Medicare to Home Care: Globalization, State Retrenchment, and the Profitization
   Chapter 3: Health, Health Care and Neo-Liberalism (David Coburn)

7. **Aronson,-Jane; Neysmith,-Sheila-M. (2001). Manufacturing Social Exclusion in the Home Care Market. *Canadian-Public-Policy / Analyse-de-Politiques*; 2001, 27, 2, June, 151-165. [C]**

   ABSTRACT

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interest group dynamics. Differences in political institutions & class relations are argued to have conditioned the differences in the three nations' health policy trajectories. This conclusion is supported by a qualitative comparative analysis identifying three political institutional, two social democratic, & one policy legacy factor as the critical mechanisms shaping the variance in the health welfare states of these nations.

16. **Blankenau, Joe (2001). The Fate of National Health Insurance in Canada and the United States: A Multiple Streams Explanation.** ***Policy-Studies-Journal*****; 2001, 29, 1, 38-55. [A]**

    ABSTRACT: This article uses the multiple-streams lens to describe why Canada eventually adopted national health insurance in the 1960s, compared with the most recent attempt at adopting national health insurance in the US. The analysis strengthens the lens by paying close attention to the impact of differing institutional frameworks on the streams. It is found that the lens provides a useful description of the complexity of policymaking, pointing out critical elements in the process that are often overlooked. 1 Table, 55 References.

17. **Blomqvist, Åke and David M. Brown (1994).** ***Limits to care: reforming Canada's health system in an age of restraint*****. C.D. Howe Institute.**

18. **Boase, J.P. (1996). Health Care Reform or Health Care Rationing? A Comparative Study of the United States, the United Kingdom and Canada. Presented at CPSA AGM, June 1996.(un pub) [A]**

19. **Boase, J.P. (1996). Institutions, institutionalized networks and policy choices: Health policy in the US and Canada.** ***Governance*****, 9(3):287-310. [A, B]**

    Abstract: This article uses the case of health insurance policy in the US and Canada to try to explain how particular state-societal patterns of intermediation unfold, become institutionalized and effect quite different policy strategies. It begins by outlining the importance of formal political and administrative institutional structure in the exercise of autonomous state action. It then examines the concepts of policy community and policy network as state-specific vehicles of interest intermediation and finally it grounds the theoretical discussion in a comparative description of the evolution of health policy in the US and Canada. It concludes that to a great extent, we are the prisoners of our instutions - both political and societal --

inpatient services with Sunnybrook Health Science Centre. The case study examined the selection and use of knowledge by the Hospital in building its case against closure.

27. **Burke, M. (2000). Efficiency and the erosion of health care in Canada. In Mike Burke, Colin Mooers and John Shields, eds.*, Restructuring and Resistance: Canadian Public Policy in an Age of Global Capitalism*. Halifax: Fernwood [D]**

28. **Burke,-M.; Stevenson,-H.-Michael (1998). Fiscal Crisis and Restructuring in Medicare: The Politics of Health in Canada. In HEALTH AND CANADIAN SOCIETY: SOCIOLOGICAL PERSPECTIVES (3rd edition), Coburn, David, D'Arcy, Carl, & Torrance, George M. [Eds], Ontario: U Toronto Press, 1998, pp 597-618. [D]**

ABSTRACT: Draws on the theory of the welfare state in contemporary political theory to illuminate the current fiscal crisis & restructuring in the Canadian Medicare system. The literature is criticized for its tendency to localize, isolate, & compartmentalize health policy in its own narrow field, which has produced great contradiction & inconsistency in diagnoses of the health care crisis. To avoid this, it is suggested that the current crisis of the Canadian government health insurance system illustrates contradictions & conflicts endemic to welfare states in capitalist societies. It is shown that, in this wider perspective, many of the issues currently debated, eg, role of state intervention in the health sector, differing conceptions of health, changes in the dominance of the medical profession, & the rise of other health professions, demand attention to political implications & practices. Further, it is apparent that the new social & environmental paradigm of health, on the basis of which many recent reforms have been developed, will produce unintended results that may be in direct opposition to their stated goals. 129 References

29. Charles,-Cathy; Lomas,-Jonathan; Giacomini,-Mita; Bhatia,-Vandna; Vincent,-Victoria-A. (1997). Medical Necessity in Canadian Health Policy: Four Meanings and... a Funeral? *Milbank-Quarterly*; 1997, 75, 3, 365-394. [C]

ABSTRACT: To explore the shift in definition of medical necessity, provincial government & national health care association position papers responding to federal legislative & policy reviews of Canada's health insurance program, 1957-1984, were examined, as were more current reports on medical necessity. Four meanings of medical necessity predominated: "what doctors & hospitals do"; "the maximum we can afford"; "what is scientifically justified"; & "what is consistently funded across all provinces." These meanings changed with time as different stakeholder associations & governments redefined medical necessity to achieve different policy objectives for health service coverage. 1 Table, 94 References.

30. **Clark,-Phillip-G (1993). Moral Discourse and Public Policy in Aging: Framing Problems, Seeking Solutions, and "Public Ethics". *Canadian-Journal-on-Aging / Revue-Canadienne-du-Vieillissement*; 1993, 12, 4, winter, 485-508. [C]**

Abstract: Outlines how the approach of public ethics - the examination of the principal values underlying & guiding the public policy process - can further an understanding of the policy response to aging, drawing on examples from Canada & the US. Discussed are: (1) significant social values, particularly individualism vs collectivism; (2) how social problems are defined & solutions to them are sought, including factual & value-related dimensions; (3) the social construction of the "crisis" of aging, including its expression in age-group polarization & the rationing of health care resources; & (4) the nature of public debate & moral discourse as process governing the development of public policy & the importance of values in developing new policies for the future. 135 References.

31. **Clark,-Phillip-G. (1991). Geriatric Health Care Policy in the United States and Canada: A Comparison of Facts and Values in Defining the Problems. *Journal-of-Aging-Studies*; 1991, 5, 3, fall, 265-281. [C]**

ABSTRACT: It is posited that cross-national comparisons of geriatric health care policy must incorporate the different ways countries characterize policies in both factual & value-related dimensions, & that it is the role of gerontology to uncover & assess these dimensions. Given US interest in adoption of the Canadian geriatric health care model, factual dimensions in the US, eg, the demographic-economic crunch, the generational equity debate, & the role of technology, are compared with the findings of Canadian studies on resource allocation & population aging. Observations are made on the relationship between the ethnics & politics of health care. An examination of the value dimensions of individualism in the US & collectivism in Canada shows that the former leads to concern for self-sufficiency & freedom of choice in contrast to the Canadian social & political commitment to a process that will result in a public consensus. It is argued that the absence of this public process in the US reduces the chances of ever reaching a consensus on a geriatric health care policy. 68 References.

32. **Coburn,-David (1988). Canadian Medicine: Dominance or Proletarianization? *Milbank-Quarterly*; 1988, 66, supplement 2, 92-116. [B, D]**

ABSTRACT: Since the early 1960s, changes in the Canadian health care system, especially the introduction of national health insurance & increased government control over the cost & utilization of services, have been resisted by the medical profession. The history of conflicts between the government & the medical profession over control of the health care system suggests that medical dominance has declined; however, the profession is still too powerful to be described as proletarianized. Eliot Freidson's theoretical conception of professional dominance (Professional Dominance, New York: Atherton Press, 1970) provides the best explanation of the position of Canadian physicians, but his argument that power is preserved by having physicians control each other fails to take into account the profession's lack of internal cohesion. 71 References.

33. **Cohn, D. (1996). The Canada Health and Social Transfer: Transferring Resources or Moral Authority between Levels of Government? In P.C. Fafard & D.M. Brown (Eds.), *Canada: The State of the Federation 1996.* (pp 167-187). Kingston: Institute for Intergovernmental Relations. [A]**

34. **Cohn, Daniel (2001). No place to hide: the unfeasibility of using an independent expert commission as a blame-avoidance mechanism in Westminster polities: the case of the Ontario Health Services Restructuring Commission. *Canadian Public Administration* 44(1):26-46. [A,B]**

Abstract: The argument presented in this article is that the appointment of an ad hoc expert commission to carry out governance is unlikely to depoliticize difficult restructuring issues or to deflect blame from governments dealing with such problems in Westminster style polities. Unlike in American-style presidential systems and parliamentary systems with proportional representation experiencing frequent minority governments, such commissions can never be truly independent as there are no serious checks on the government's ability to remake the agency, its mandate, its composition, nor even any barriers to the government's premature termination of an ad hoc expert

appearance that such a commission is an independent agency of governance they must work at cross-purposes to the basic rules for insuring accountability by giving such a body a very vague mandate. This will almost certainly lead to disputes between political actors and the commission over its powers and refocus blame on the government. The ministers of a government employing this strategy

must also be extraordinarily careful so as not to engage in any activities that would undermine the ad-
eady fragile claim to autonomy, otherwise the blame focused on the government will magnify even further. The difficulties involved in employing an ad-hoc expert commission as a means to depoliticize decisions and as a blame avoidance strategy for governments in Westminster-
the Health Services Restructuring Commission (HSRC).

35. **Desveaux,-James-A.; Lindquist,-Evert-A.; Toner,-Glen (1994). Organizing for Policy Innovation in Public Bureaucracy: AIDS, Energy and Environmental Policy in Canada.** ***Canadian-Journal-of-Political-Science/ Revue-canadienne-de-science-politique;*** **1994, 27, 3, Sept, 493-528. [A]**

ABSTRACT: Governments often operate under considerable pressure to respond effectively to the emergence of increasingly complex policy dilemmas. Key difficulties in bringing forth comprehensive policy interventions are identified, & it is suggested that many failures can be attributed to public bureaucracies that are not designed to deal with complex problems, & that all too quickly exceed their policy-making capacities. Also analyzed is why comprehensive policy making does sometimes occur, linking its occurrence to bureaucratic design factors. The analysis draws on & extends Henry Mintzberg's ideas (1979) on administrative advocacy to show how administrative units can be organized to enable bureaucracies to transcend professional compartmentalization & routine; & how structures can be designed for comprehensive policy innovation. Focus is on Canadian federal bureaucracy, presenting three case studies of recent policy experiments related to energy, environment, & acquired immune deficiency syndrome (AIDS). 3 Figures

36. **DiMatteo, L. (2000). The determinants of the public-private mix in Canadian health care expenditures: 1975 -1996.** ***Health Policy*****, 52(2):87-112. [A]**

Abstract: The health care policy issue regarding the balance between public and private health spending is examined. An empirical model of the determinants of the public private mix in Canadian health care expenditures over the period 1975 1996 is estimated for total health care expenditures as well as separate expenditure categories such as hospitals, physicians and drugs. The results find that the key determinants of the split are per capita income, government transfer variables and the share of individual income held by the top quintile of the income distribution. Much of the public private split is determined by long term economic forces. However, the importance of the federal health transfer variables and the variables representing shifts in fiscal transfer regimes suggest the increase in the private share of health spending since 1975 is also partly the result of the policy choice to reduce federal health transfers.

37. **Downie, Jocelyn Grant, Timothy Caulfield and Colleen M. Flood. (2002).** ***Canadian Health Law and Policy*****. Butterworths. [A,C]**

Contents: Featuring chapters written by leading authorities from across Canada, the 2nd Edition incorporates the latest developments in legislation, case law, scientific advances as well as the latest trends in the funding and administration of Medicare. Issues addressed include:

- New chapter addressing the civil liability of physicians under Quebec law, including issues around professional secrecy and the duties to inform, to obtain consent, to treat and to attend
- New federal and provincial privacy legislation and its effect on hospitals and health care providers
- Political and economic forces such as changing funding levels, closures of hospitals, and the net emigration of physicians and nurses

Private financing approaches suggested by the federal Senate Committee and the Alberta Mazankowski Committee
Federal government proposals to limit or prohibit assisted human reproduction technologies, such as cloning

in tort to unborn fetus)
The legal implications of such advances in medical science as the mapping of the human genome, embryo and stem cell research, and cloning.

38. Drache, Daniel and Terry Sullivan (1999). Health reform and market talk: rhetoric and reality. In Daniel Drache and Terry Sullivan, eds., *Health Reform: Public Success, Private Failure*. Routledge. [D]

39. Evans, Robert G., (1993). Health care reform: "The issue from Hell". Canadian Institute for Advanced Research, Program in Population Health.

40. Evans,R.G. (2000). Canada. *Journal-of-Health-Politics,-Policy-and-Law*; 2000, 25, 5, Oct, 889-897. [B]

ABSTRACT: The fundamental principles & basic structural features of Canada's health care system have been constant since 1971. Although the system has evolved to accommodate significant changes in the external environment as well as the changing needs of health care services, it has remained essentially the same. In general, Canadians are satisfied with the system, which is the most popular & successful public program in Canada. Nevertheless, a combination of factors have fueled a widespread sense of crisis & lowered public confidence in the system. The opposition to the system is fueled by economic self-interest because higher-income Canadians object to the tax burden & health care providers want to do away with government restrictions on prices & servicing patterns. 8 References.

41.

through which this permanent conflict of economic interest is expressed in political debate.

43. **Falcone, D. & Van Loon, R.J. (1983). Public Attitudes and Intergovernmental Shifts in Responsibility for Health Programs: Paying the Piper without Calling the Tune? In A. Kornberg & H.D. Clarke (Eds.),** ***Political Support in Canada: The Crisis Years.*** **(pp 225-251). Durham: Duke University Press. [A]**

44. **Flood, Colleen M. (2000).** ***International Health Care Reform: A Legal, Economic and Political Analysis*****. London: Routledge. [C]**

    Chapter 2: Arguments in economics and justice for government interventions in health insurance and

ABSTRACT: This article attempts to shed light on the complexity inherent in health care reform

management. British Columbia, Saskatchewan, Manitoba, Quebec, New Brunswick, and Nova Scotia have published comprehensive plans for health care reforms. The plans reveal a diversity of management approaches, including devolved structures in Nova Scotia, British Columbia and Saskatchewan, strongly centralized, technocratic structures in Manitoba, and variations on these in the other provinces. Though impossible to judge a priori which approaches are most likely to improve management, a number of limitations can be ovserved in the newly created instituions that decrease chances of achieving the stated goals. The changes represent a potential watershed in medicare's history as the provinces embark down divergent paths for planning and managing health care resources. They will provide an intersting natural experiment regardign the effectiveness of the alternative approaches to organizing health care systems as well as challenge some of medicare's principles and the concept of a national system.

60. **Hutchison, B., Julia Abelson, and John N. Lavis (2001). Primary care reform in Canada: So much innovation, so little change.** ***Health Affairs*** **20(3): 116-131. [A]**

    ABSTRACT: The development of Canadian primary care has been shaped by a series of policy legacies that continue to affect the possibilities for change in primary care through their cumulative effects on the health care system and the process of health policy development. The pursuit of radical systemwide change in the face of unfavorable circumstances (created in large part by those legacies) has resulted in missed opportunities for cumulative incremental change. While major changes in primary care policy seem unlikely in the near future, significant Incremental change is possible, but it will require a reorientation of the policy development process.

61. **Immergut, E.M. (1992). The rules of the game: The logic of health policy making in France, Switzerland and Sweden. In S. Steinmo, K. Thelen, & F. Longstreth (Eds.),** ***Structuring Politics: Historical Institutionalism in Comparative Analysis.*** **(pp 57-89). Cambridge: Cambridge University Press. [A]**

62. **Immergut, E.M. (1992).** ***Health Politics: Interests and Institutions in Western Europe.*** **Cambridge: Cambridge University Press. [A, B]**

63. **Lavis,John N (2002):** ***Political Elites and their Influence on Health-Care Reform in Ca*** Tm1 0 0 1 E1 11.4T7()]t

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Abstract: A paper presents a process model of social learning embedded within the larger policy-making process resting at the intersection of the nation's constitutional context, technological change, and political influences exogenous to social learning. The model first distinguishes between the structural and social learning effects of policy legacies. Social learning is then conceptually divided into separate streams of substantive learning and situational learning. The analysis reveals the full extent to which social learning is often a decidedly political struggle over ideas and information in which advocates promote lessons that serve their specific interests within a given institutional context and political setting.

91. Phillips, Susan D. (1996). The Canada Health and Social Transfer: Federalism in Search of a Vision. In Patrick C. Fafard and Douglas M. Brown, eds., *Canada: The State of the Federation*.

92. Pierson, Paul and Miriam Smith (1993). Bourgeois revolutions? The policy consequences of resurgent conservatism. *Comparative Political Studies*, 25(4):487-520. [C, D]

Abstract: Much of the literature on reform politics has focused on social democratic governments. This article reexamines the dynamics of reforms by concentrating on conservative governments in four advanced industrial democracies in the 1980's: Britain, Canada, the US and West Germany. Conservative governments have attempted to dismantle well-institutionalized systems of government intervention in market economies. The authors argue that the sturcture of national political institutions is of central importance in explaining variation across these cases in government goals, strategies and success rates. This article also stresses theneed to consider the distinctive characteristics of different policy arenas. Governments found market-oriented reforms considerably easier to implement in some policy arenas than others.

93. Pineault R, Lamarche PA, Champagne F, Contandriopoulos AP, Denis JL. (1993). The reform of the Quebec health care system: potential for innovation? J Public *Health Policy* 14(2):198-219 [A]

Abstract: The recent reform of the health care system in Quebec can be viewed as the result of a continuous process that originated with the first reform launched in the early 70s. The reform focuses on three elements: decentralization, citizen participation, and outcome-centered management. The context in which the reform is being launched contains both favorable conditions and obstacles to its successful implementation

94. Pink, George and Peggy Leatt The use of 'arms-length' organizations for health system change in Ontario, Canada: some observations by insiders. *Health Policy* 2003 Jan;63(1):1-15 [A]

information about system change to a wide variety of audiences cannot be overstated; (6) system change informed by the use of expert opinion encounters less provider resistance and may result in better decisions; and (7) the reputation of the Chair and the perceived competence and experience of the CEO are critical success factors in the success of an arms-length organization.

95. Prémont, Marie-Claude (2002). ***The Canada Health Act and the future of health care systems in Canad*****a. Commission on the Future of Health Care in Canada.**

96. Prince, Michael J. (2001). Canadian Federalism and Disability Policy Making. ***Canadian Journal of Political Science*****, 34(4): 791 817 [A]**

Abstract: This article examines two types of collaboration in Canada between the federal and provincial governments in the disability policy sector and assesses their implications for the citizenship rights of persons with disabilities. One type of collaboration is across the levels of order in Canada and notable examples are the 1997 multilateral framework agreement on Employability Assistance for People with Disabilities and the 1999 Social Union Framework Agreement. The Provincial/Territorial Council on Social Policy Renewal, a structure established in 1995, illustrates the second type. This study suggests that each intergovernmental arrangement has a particular working model of citizenship associated with it. Contrary to the conventional view in the literature, the article argues that, for disability groups, the first form of federalism is enhancing political rights of citizenship along with the economic and social dimensions of membership in society. Further, the second kind of intergovernmental relations is more than just a fleeting movement of provincialism; it exhibits the potential to play a greater sustained role in shaping Canada's welfare state

97. **Puttee, Alan H., (2002).** ***Federalism, democracy and disability policy in Canada*****. Published for the Institute of Intergovernmental Relations, School of Policy Studies, Queen's University by McGill-Queen's University Press. [A]**

98. **Rathwell, T. (1994). Health care in Canada: a system in turmoil.** ***Health Policy*** **27(1):5-17 [C]**

Abstract: Canada, in common with most countries, is re-examining its health care system. The main reasons for the reappraisal are the rising cost of health care and the growing unease that the cost is fast outstripping the capacity of the tax base to support it. This paper examines the way in which Canada's provinces are attempting to meet this health care challenge. It does this from two perspectives: first, through a consideration of the steps taken to control and/or cut costs and, second, by an exploration of the developing debate about rationing. The paper concludes with some comments about the potential policy implications of such issues.

99. **Rayside,-David-M.; Lindquist,-Evert-A. (1992). AIDS Activism and the State in Canada**
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the capacity to define the issues lost 1985-1990, but AIDS activism has dislodged state policy from a number of its traditional moorings.

100. Redden, C. (2002). *Health Care, Entitlement, and Citizenship*. Toronto: University of Toronto Press. [C]

ABSTRACT: Access to universal health care has become a symbol of Canadian national identity. It is also one of the most contentious and politically charged issues in the field of public policy in Canada. In this study, Redden examines the theoretical dimensions of citizenship and rights in Canada as they intersect with health care politics. She offers possible answers to questions concerning the philosophical and political meanings of the right to health care in advanced industrial socieities, and the effects of globalization and fractured patterns of citizenship on discussions of entitlement, universal human rights, and bioethics. Redden proposes that the recent trends in citizenship development will require a health care system that is capable of recognizing the different

111. Sherwin, Susan (1998). ***The politics of women's health: exploring agency and autonomy*****.** **Temple University Press. [B, D]**

112. Shillington, C.H. (1972). ***The Road to Medicare in Canada*****. Toronto: Del Graphics. [A, B]**

113. **Skocpol,Theda (1996).** ***Boomerang: Clinton's Health Security Effort and the Turn against Government in U.S. Politics*****. New York: W.W. Norton. [A,B,D]**

114. **Smith, Miriam (1995). Retrenching the sacred trust: Medicare and Canadian federalism. In Francois Rocher and Miriam Smith, eds.,** ***New Trends in Canadian Federalism*****. Peterborough: Broadview Press. [A]**

115. **Sokolovsky,-Joan (1998). The Making of National Health Insurance in Britain and Canada: Institutional Analysis and Its Limits.** ***Journal-of-Historical-Sociology*****; 1998, 11, 2, June, 247-280.. [A,C,D]**

ABSTRACT: Scholars examining the development of health insurance reform programs from an institutionalist perspective have drawn attention to the importance of state structures & administrative

occupational experience, but in subjective perceptions of occupational stress, threats to professional status, & differences in values concerning the d

126. Tuohy, C. J. (1988). Medicine and the state in Canada: the extra-billing issue in perspective. ***Canadian Journal of Political Science*** **21(2); 267-296. [A,B]**

127. Tuohy, C.J. (1989). Federalism and Canadian Health Policy. In W.M. Chandler & C.W. Zollner (Eds.), ***Challenges to Federalism: Policy Making in Canada and the Federal Republic of Germany.*** **(pp 141-160). Kingston: Queen's University Institute of Intergovernmental Relations. [A]**

128. Tuohy, C.J. (1992). ***Policy and Politics in Canada: Institutionalized Ambivalence.*** **Philadelphia: Temple University Press. [A]**

129. Tuohy, Carolyn J. (1999). ***Accidental logics: the dynamics of change in the health care arena in the United States, Britain, and Canada*****. Oxford University Press. [A,B]**

Abstract: What drives change in health care systems? Why do certain changes occur in some nations

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Abstract: Health care reform efforts internationally are focused more on efficiency than on effectiveness or equity. We lack a coherent theoretical framework for understanding those reforms or for engaging in comparative research. This paper presents some theoretical ideas that could contribute to such a framework. A model constructed from expert opinion suggests that hegemonic systems, national systems and medical care systems all contribute, with specific elements identified in each. Three sociological ideas are suggested: a model of trends leading to a fiscal crisis and a crisis of alienation; communities, professions and markets as ideal typical organizational alternatives; global post-Fordist and world systems theories; and hegemonic projects. Together these could explain the timing, speed and direction of health care reform efforts throughout the world.

133. von Tigerstrom, Barbara (2002). Human Rights and Health Care Reform: A Canadian Perspective. In Timothy A. Caulfield and Barbara von Tigerstrom, eds., *Health Care Reform and the Law in Canada: Meeting the Challenge*. Edmonton: University of Alberta Press. [C]

support a return to voluntar[illegible]ommercial control of the health system, a shift which could assist in breaking the historical cy[illegible]rofession-government conflict and moving to the politics of accommodation. In the con[illegible] we discuss implications for medical politics in Canada and other countries such as the Unite[illegible]

138. **Wilsford, D. (1995). S[illegible]cing interests: Struggles over health care policy in advanced industrial democracies.** ***J[illegible]f Health Politics, Policy and Law*****, 20(3):571-613. [B]**

ABSTRACT: Given alarm[illegible]al imperatives, states & interests in all advanced industrial democracies have struggle[illegible]ealth care policy. Explored here is the interface between state autonomy in health care po[illegible]he political mobilization of provider interests, especially physicians. Evidence from [illegible]y, Japan, Canada, & GB suggests that, longitudinally, policymakers everywhere h[illegible]d to increase state autonomy in health care, & this has generally triumphed over even effect[illegible]obilized providers. The countries that have most successfully restrained the growth of he[illegible]e expenditures - while still providing ready access to relatively high-quality care - are thos[illegible] states have most actively restrained both demand- & supply-side system interests in policy m[illegible]In each country, states have increasingly articulated their own greater capacities in health [illegible]licy, pushed to do so by the imperatives, especially fiscal, embedded in the policy do[illegible]Tables, 2 Figures, 103 References.

139. Wilsford, David (200[illegible]s, institutions and resources. ***Journal of Health Politics, Policy and Law*** **25(5):975-979. [[illegible]]**

Abstract: Simply put, the [illegible] any health care system in an advanced industrial democracy are threefold and manifest: pro[illegible]od care to pretty much the whole population without breaking the bank to do so. The corners [illegible]riangle are quality, equity, and cost. While these combined goals may be manifest, they are a[illegible]ifestly tricky-perhaps virtually intractable-in all the societies under investigation here in this is[illegible]adly speaking, it is possible to identify 2 general approaches to the seeking of these health care[illegible] goals. The first approach, especially evident in the United States, emphasizes the role of priv[illegible]es, which may or may not be market ones. The second approach, still clearly evident in most[illegible]ountries under study in this issue, and downright pervasive in a country such as France, is [illegible] stresses the collective-goods model of health care.

140. **Wilson,-Donna-M.; K[illegible]net-Ross (1998). An Exploration of Canadian Social Values Relative to Health Care.** ***A[illegible]an-Journal-of-Health-Behavior*****; 1998, 22, 2, Mar-Apr, 120-129. [C]**

ABSTRACT: Explores so[illegible]ues in relation to health care among a sample of Canadian Bioethics Society members & their d[illegible]es (total N = 353), using four Delphi-style mail surveys, 1994/95. Four consensual values em[illegible](1) availability of basic health care to all without serious personal economic peril, (2) more c[illegible]e responsibility & less individualism, (3) acceptance of a social welfare state, & (4) genuin[illegible]rn & caring for other people. Responses emphasized the fundamental nature of thes[illegible]s to the design of the Canadian health care system. As such, reforms

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expenditures; (2) demographic factors, eg, the falling birth rate & aging population; (3) the failure of the provinces to ratify the Canadian Meech Lake accord, which resulted in increased regional & local care disparities; & (4) the 1988 US-Canada free trade agreement. This latter force will make North-South ties preferable to East-West ties, & is likely to lead to taxation policies that favor the rich & privatization. Along with these forces, the premise of universal entitlement & pressures to restructure the present health care system with more emphasis on ambulatory care, community-based care, & prevention will continue. The solution for these problems in Canadian health care is unclear, but at least its current status is better than in the US. 21 References.