A Cross-Provincial Study of Health Care Reform in Canada

Academic Literature Review – Synthesis Paper

INTRODUCTION

State-financed health insurance programs are a significant component of the modern welfare state in Canada. Health systems comprised 9.7% of the Canadian gross domestic product in 2001, the largest category of social spending after pensions (Canadian Institute for Health Information 2003). Moreover, health programs are among the most visible and popular programs of the welfare state. At the same time, and for some of these very reasons, health programs are a profoundly political and hotly debated public policy issue.

From their origins as a policy idea in Germany during the late nineteenth century to their current distinctive arrangements around the world, publicly sponsored national health programs have been in a state of constant flux and contestation, like much of the welfare state itself. However, unlike other elements of the Canadian welfare state, medicare programs represent an unparalleled degree of intervention into traditionally private, market-based systems of resource allocation. Although all social programs have the goal of redistributing societal resources, cash benefits (such as pensions) simply offer income supplements to citizens to allow them to continue participating in the market to obtain necessary goods and services, leaving the production and supply of those goods largely unaffected. Health programs, in contrast, affect virtually every aspect of the supply and demand for health related goods and services. They fundamentally and directly alter the market, and thus affect the livelihoods and well being of numerous and diverse groups, from providers to consumers to insurers, representing virtually every citizen in the polity. They have precipitated the development of highly differentiated state structures for their implementation, as well as the formation and mobilization of powerful non-state actors. Finally, state-sponsored health programs represent an underlying set of values and beliefs about the sphere of politics: the appropriate division between collective and individual responsibilities, or WKH GRPDLQV RI µSROLWLFDO FRQWHQWLRQ¶ DQG WKH GL
WKH GRPDLQV RI µSROLWLFDO FRQWUROµ 6WDUU 6WDU

It LV XQVXUSULVLQJ WKHUHIRUH WKDW &DQDGD¶V KHDOV reform or restructuring of health care programs has been at or near the top of virtually every federal and provincial government agenda in Canada since the mid-1980s. Following decades of rapid growth in health expenditures, the containment of public health expenditures was the primary target of these attempts at reform and restructuring. The economic downturns of the 1970s and 1980s, accompanied by high levels of unemployment, population aging, and the development and diffusion of expensive new medical technologies, all contributed to the perceptions amongst government leaders, as well as societal groups, of an imminent cost crisis. By 1996, bolstered by this sense of urgency, Canadian governments had succeeded in reducing real per capita spending on health care ±among only four nations in the OECD that were able to do so. Since that time, overall public expenditures on health care have been rising once again.

In addition to and perhaps because of the perceptions of a crisis in the costs of health care, health care programs and the welfare state more generally have been subject to criticisms of stifling labour markets and distorting work incentives, as well as compromising the competitiveness of the national economy in an increasingly globalized world. The critics include conservative political and opinion leaders who have held political power at the provincial and federal levels during this period. These individuals and their supporters have questioned the

appropriateness and effectiveness of government in the health arena, and have extolled the virtues

7KH LPSDFW RI LQVWLWXWLRQV RQ JRYHUQPHQW¶V FD
decisive role of federalism for the development of a national health insurance system in Canada. Provincial governments served as laboratories for innovative experimentation with different forms of insurance programs and were able to mobilize political pressure to force the hand of an otherwise reluctant federal government (Maioni 1998; Taylor 1987). Institutions also create RSSRUWXQLWLHV RU FRQVWUDLQWV IRU VRFLDO JURXSV W
organization of pr RYLGHU LQWHUHVWV LQ WKH KHDOWK ILHOG PLU
subsequently facilitates differential accommodation within provinces as well as coordination between provincial associations (Tuohy 1989:158). Finally, institutions mediate between new policy ideas and policy outcomes, making some ideas more likely than others to be integrated or adopted into the political arena. As Tuohy (1992) notes with respect to Canadian federalism, for example:

> The existence of federal and provincial governments creates institutional niches for different views about the appropriate melding of state and market, individual DQG FRPPXQLW\ DQG UHJLRQ DQG FRXQWU\« 7KH IDF
> and provincial jurisdiction is never *settled* means that these competing views are always in play and are addressed anew with new policy issues. (p. 52, original emphasis)

Ideational Approaches

,Q DGGLWLRQ WR LQVWLWXWLRQV SROLF\PDNLQJ RFFX
political ideas. These

Interest-Based Approaches

Interest-

In the health sector, the growing visibility of these public interests is evidenced by the activities of such groups as the Council of Canadians, the Canadian Health Coalition and its SURYLQFLDO FRXQWHUSDUWV LQFOXGLQJ $OEHUWD¶V)U Coalition. In addition, there are numerous identity-based groups making claims and challenging health policy at all levels of the Canadian polity: groups representing ethnic, cultural, linguistic and sexual minorities, socially and economically disadvantaged populations, and demographic populations, among many others (Barlow 2002; Redden 2002). Trends toward greater citizen engagement in Canadian health care have been scrutinized with reference to rationing medical services (Redden 1999), system governance (Abelson et al. 1995), system management and decision-

Social policies, especially health care programs, have been used in Canada to create a pan-Canadian identity and constituency based on shared experiences that transcend the territorially circumscribed economic, cultural and linguistic cleavages of Canadian society. ³>7@KH FRUH RI WKH FLWL]HQVKLS UHJLPH ZDV D VWURQJ pUROHFWLQJ WKH VRFLDO ULJKWV RI LQGLYLGXDOV DQG W regime included social programs, health care in particular, and was premised on the idea that ³&DQDGLDQ FLWL]HQV VKRXOG KDYH HTXDO ULJKWV regardless of the province in ZKLFK WKH\ OLYH ´ /D]DU DQG 0F,QWRVK %DQWLQJ Canadian citizens of the post-war social union contributed to higher levels of equity and efficiency in the design of the welfare state than could KDYH EHHQ UHDVRQDEO\ H[SHFWHG IURP D PRUH GHFHQWU WKH IHGHUDO JRYHUQPHQW¶V UROH $ QXPEHU RI SURYLQFHV FODLPHG JRYHUQP Canadians are highly attached to the Canadian universal health care system, believe it is part of WKH &DQDGLDQ LGHQWLW\ DQG UHVLVW FKDQJHV WKDW Z EHOLHYH WKDW 0HGLFDUH HPERGLHV &DQDGLDQ YDOXHV «´

Notwithstanding public opinion, however, provincial governments have increasingly challenged the legitimacy of both the notion of a pan-Canadian identity and the federal JRYHUQPHQW¶V UROH $ QXPEHU RI SURYLQFHV have argued for FODVVLFDO IHGHUDOLVP[1] which is based on the recognition of distinct political communities within the larger federation. In Canada, the identity of these communities are multiple and contested. The people of Qu bec have long envisioned themselves as a nation distinct from the rest of Canada on the basis of their language and culture. Other regions of Canada have argued their own distinctiveness within the federation on economic and geographic grounds. These regional identities correspond broadly to territorial-provincial boundaries, and as such, are constructed and nurtured by provincial governments in large part through public policy (Banting 1995; Cairns 1988). For many, the legitimacy of federalism lies in its capacity to recognize and respect the sovereignty of these different identities and communities (Gagnon and Erk 2002). To the extent that provincial governments are subject to the actions or decrees of the federal level, their own legitimacy is challenged and their sovereignty is threatened. Thus, from this perspective, the use of the federal spending power through targeted and conditional transfers, DV LV WKH FDVH ZLWK WKH &+67 IRU KHDOWK SURJUDPV violation of the federal principle on which Canadian federalism was based (No l 2000).

Policy Preemption. Tp(thre)550.944 322.01 T[(.)-209( )-209non of the6(s)] TJ7.94 50l>is 1 163.1 25 Iontarg2

This pattern of policy preemption ±that is the initiative

critical role in forging an ideological compromise among provincial governments on the main GLUHFWLRQV RI VRFLDO SROLF\ ´ %DQWLQJ 7KLV C system itself, rather than an ideological predisposition of federal governments. Political parties at the federal level have tended toward a brokerage role and have been less inclined to adopt strongly ideological positions (see discussion of federalism and political parties). As the ideological commitment of different provinces to the goals of medicare is arguably less certain than it has been in decades, the moderating function of the federal government seems particularly important today (Boase 2001; Deber 1996; Fierlbeck 2001).

On the issue of efficie Q F \ %DQWLQJ DUJXHV WKDW ³D VWU WKH LQWHUQDO HFRQRPLF XQLRQ´ E\ ³UHGXFLQJ IRUPDO form of residency requirements on one hand, and by reducing inefficient incentives to mobility in WKH IRUP RI VKDUSO\ GLIIHUHQWLDWHG VRFLDO SURJUDPV RQ WK[2] Furthermore, a national mechanism OLPLWV WKH H[LW RSWLRQV RI FDSLWDO DQG PLWLJDWHV D of social provision. In sum, the efficiency argument rests on the observation that pan-Canadian programs have contributed to the strength and development of the national economy in the post-war era.

Blame Avoidance. Voters tend to be more sensitive to concentrated losses imposed by government than they are to diffuse benefits. As a result, elected officials are more preoccupied with avoiding blame for unpopular decisions than claiming credit for popular ones, since the negative consequences of their decisions are more likely to haunt them at election time (Weaver 1986). In a federal system, passing the buck or using other governments as scapegoats are two strategies that policymakers will engage in when facing difficult decisions with unavoidable negative consequences. The temptation shift the blame to the other level of government is particularly strong during times of austerity, when budgetary cutbacks must be made (Pierson 1995). Blurred lines of accountability, such as in areas of joint or overlapping jurisdictions, facilitates generating or shifting blame between governments but creates difficulties for the electorate in attributing responsibility for unpopular policy decisions.

-RKQ 5LFKDUGV DUJXHV WKDW ³DOO YDULDQWV jurisdiction and reduce political accountability of any one government for the quality of social SURJUDPPLQJ ´ +H VXJJHVWV WKDW VWUXFWXUDO DFFRXQWDELOLW WLJKW¶ FRPSDUWPHQWV RI FODVVLFDO IHGHUDOLVP DUH ting

G\VIXQFWLRQDO ´ DQG ³&DQDGLDQV KDYH FRPH WR H[SHFW JHQHUDOO\ DQG WKH KHDOWK FDUH V\VWHP VSHFLILFDOO\«
seem to have reached the limits of their tolerance for jurisdictional disputes, they continue to believe that health care should be the responsibility of all governments. In particular, federal involvement in medicare is supported by a very large majority of Canadians (81%) who believe WKDW ³WKH IHGHUDO JRYHUQPHQW VKRXOG EH DFWLYHO\ margin of 59 to 39%, Canadians believe that the federal government has a key role in sustaining

In Canada, the federal parliamentary tradition means that power is concentrated at each level of government but also dispersed between levels (Tuohy 1992:28). Federalism creates a point of strategic uncertainty in the decision process and thus mitigates against the strength of the state in a number of policy sectors because of the often lengthy, complex and unpredictable intergovernmental negotiation required to implement policies. Nevertheless, electoral and parliamentary vetoes are influential in shaping the policy preferences of individual governments and can affect the intergovernmental dynamic. For example, the potential for an *electoral* veto served to overcome what appeared to be an intergovernmental impasse in the implementation of the national hospital insurance program. Although a number of provincial governments had exerted a great deal of pressure on the federal government to implement a national program, it was the perception of the CCF as a real and significant threat to the electoral fortunes of the governing Liberal party that seemed to be the crucial impetus for federal action. Similarly, at the provincial level, the CCF in Ontario was drawing voters away from the governing Conservative SDUW\ ZKLFK VXEVHTXHQWO\ ³FDYHG LQ´ WR WKH &&) GHF (Maioni 1998). The significance of *parliamentary* veto points is particularly evident in the debates surrounding the *Medical Care Act* of 1966. The federal Liberal party had formed a minority government in 1965 with the support of the newly formed NDP, which was led by the former premier of Saskatchewan, Tommy Douglas. The threat of NDP defection from the informal parliamentary coalition, with the subsequent defeat of the government, was likely an important factor in forcing the federal government to overcome the deep divisions within the Liberal party on the feasibility of a national medicare program as well as trenchant opposition from a number of provincial governments to such a program (Maioni 1998).

In general, however, the infrequency of minority governments and the strength of party discipline at both levels of government in Canada concentrate accountability within the governing party, making electoral vetoes more significant than parliamentary vetoes. When accountability is concentrated and easy to tr-119(nau(o sl5f312(c)4 63 Tm[(9)-1[(s)-124(s))-19(thak(a)4(s)

reduce overall expenditures with a minimum of community complaint, and deflect whatever complaints arise away from the provincial government. Fifty-seven per cent of the surveyed board members [of regional health authorities in Canada] believed this was provincial JRYHUQPHQWV¶ PDLQ PRWLYDWLRQ IRU GHYROYLQJ DXWKR regional authorities were saddled with aggressive expenditure reduction plans at the very beginning of their mandates only serves to reinforce this perception (Lomas 1999). The extent to which regional authorities will, in the medium term at least, be a successful blame-avoidance strategy will depend on the willingness of the authorities to tolerate the expenditure reduction targets being imposed on them. Once they reach the threshold of their willingness to bear the brunt of the blame for difficult decisions, they may abandon their provincial allies and instead ³MRLQ ZLWK DQG RUFKHVWUDWH WKH ORFDO GLVFRQWHQW

Ontario is the only province that has not experimented with decentralizing decision-making authority. It engaged in a different type of buck-passing exercise by creating the Health Services Restructuring Commission (HSRC). The HSRC was unusual in that, unlike other ad hoc commissions of government, which are usually given an advisory manda

justify federal regulation of drugs, new technologies, and narcotics (Flood 2002). The federal JRYHUQPHQW¶V UHOLDQFH RQ *Unified Health Act* as its principal instruments for shaping health policy, therefore, can been understood as the direct result of judicial interpretation of the federal jurisdiction. Notwithstanding the broadly understood division of powers, given its complexity and high political, social and economic salience in PRGHUQ VRFLHW\ ³KHDOWK LV QRW D PDWWHU ZKLFK LV V instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending on the circumstances of each case on the nature or scope of the health problem in TXHVWLRQ ´ (VWH\ DV FLWHG LQ)ORRG

Charter-based judicial review is a more controversial role of the courts because it has a much more direct impact on policy decisions. Charter-based adjudicat LRQ ³FOHDUO\ SXWV W in the position of overruling the democratically elected representatives of the people on value-ODGHQ TXHVWLRQV RI SXEOLF SROLF\ ´ 6KDUSH DQG 6ZLQ taken a purposive approach to interpreting the Constitution and the Charter and have extended judicial review to include the substantive content of legislation ±adopting both value-protecting and process-protecting functions into judicial review (Manfredi 1993). This has raised concerns that the judiciary is no longer subject to any constitutional or democratic limits, that judicial review transfers policy making authority into the hands of non-elected and unaccountable officials, and that it perpetrates a tyranny of minorities by allowing interest and advocacy groups to use litigation as a means to influence policy, by-passing the more democratic legislative institutions (Ajzenstat 1994; Hutchinson and Petter 1988; Manfredi 1993; Morton and Knopff 1992). Counter-arguments to these views hold that the Charter does contain clauses (including section 33, the notwithstanding clause, and Section 1, the reasonable limits provision)

about the distribution and delivery of programs and services on a health needs basis, and the large state and non-state bureaucracies that manage and administer the system on a day-to-day basis. :KHQ D VHW RI LGHDV EHFRPHV GHHSO\ LQVWLWXWLRQDOL entire mission is defined by these ideas. Instead, the ideas function as a broad mandate authorizing and guiding actions by maQ\ GLIIHUHQW RUJDQL]DWLRQV´ 0RR Clark, in a comparison of Canadian and American geriatric health policy, suggests that this LQVWLWXWLRQDOL]DWLRQ RI FROOHFWLYLVW LGHDOV LQ W only for tKH &DQDGLDQ JRYHUQPHQW¶V FRPPLWPHQW WR SURYL DOVR IRU WKH NLQG RI SROLWLFDO SURFHVV DGGUHVVLQ &DQDGD¶V FROOHFWLYLVW LGHDOV@ KHDOWK FDUH GLD element are FKDQQHOHG LQWR WKH SROLWLFDO SURFHVV«´ DQG DUH F social issues. (Clark 1991: 275).

The negative side of institutionalized stability is stasis ±once institutionalized, ideas can have effects that reach well beyond their currency and power to persuade. For example, in &DQDGD ³VRFLDO ULJKWV KROG FRQVWDQW WKH PHFKDQLF logic of the system, not caused by social rights but defined by them, are dependent on stable patterns of public finance and service provision. This reluctance to question social rights seems WR WUDQVODWH DV UHOXFWDQFH WR TXHVWLRQ WKH LQVW Redden goes on to argue that the idea of health care as a social right has made it difficult to respond to changing needs and challenges associated with different patterns of health and illness in modern society. Moreover, notions of citizenship and community can no longer be premised on the existence of µXQLYHUVDO¶ KXPDQ H[SHULHQFHV RU QHHGV O to understand the meaning of a right to health care and the direction of citizenship development as it pertains to health care, in order to deal with those citizens who are members of groups that have much different experiences with access to medically necessary services (stigmatized populations, including AIDS patients and the mentally ill), that is, groups that are differentially entitled and particularly dependent on services that fall outside the parameters of the general SXEOLF SODQ´ 5HGGHQ

7KH HFRQRPLF VKRFNV RI WKH V DQG WKH GHYHO discourse created fertile grounds for challenging medicare principles and the notion of health care as a right of social citizenship. This challenging discourse has three important tenets that GLVWLQJXLVK LW IURP WKH VRFLDO ULJKWV GLVFRXUVH) catches individuals who have failed to find their niche in the market economy, rather than SURWHFWLRQ DJDLQVW WKH PDUNHW¶V IDLOXUH WR SUR VXEVLVWHQFH´ 0DLRQL 6HFRQG WKH XQLYHUVDOLW -tested approach to allocating societal resources. Finally, there is an emphasis on individual rather than FROOHFWLYH UHVSRQVLELOLW\ ,Q WKLV SDUDGLJP ³WKH ZLWK WKH IDLOXUH RI SHUVRQDO LQFHQWLYHV UDWKHU WKD basis of means WHVWLQJ LQYROYHV UDQNLQJ DFFHVV WR VRFLDO SURWH opening the door to the redirection of funding priorities in which clientele groups are played off RQH DJDLQVW DQRWKHU«´ 0DLRQL 7KLV DOWHU native discourse is found in a number of discussions of and proposals for health system reforms, including: user charges (Barer et al. 1994); private, for-profit health care facilities (Evans et al. 2000); medical consumerism (Feldberg and Vipond 1999); medical savings plans (Hurley 2001); deinsurance and privatization (Ruggie 1996); and internal markets (Jerome-Forget and Forget 1995), to name just a few.

%RWK WKH µVRFLDO ULJKWV¶ DQG µQHZ ULJKW¶ LGHDV around which societal groups have mobilized. For example, Evans (1997: 427) argues that

³FXUUHQW LQWHUHVW LQ PDUNHW DSSURDFKHV UHSUHVHQWV EHHQ SURPRWHG ZLWK YDU\LQJ LQWHQVLW\ WKURXJKRXW \LHOG GLVWULEXWLRQDO DGYDQWDJHV IRU SDUWLFXODU L GHYHORSHG D FRPSHOOLQJ QDUUDWLYH DERXW KRZ D YHUV

mechanisms

used by powerfully entrenched interests to defeat the Clinton Health Security plan in the US. Groups have also formed coalitions around the social rights discourse in order to mobilize opposition to privatization policy proposals, such as the popular movement against Bill 11 in Alberta (Bhatia and Coleman 2003; Boase 2001), or the Canadian Health Coalition lobby to pressure the federal government to take action on extra-billing in the early 1980s (Taylor 1987). In order to have purchase, ideas must be framed in compelling ways, and will often appeal to fear, anxiety or insecurity, such as evoking perceptions of crisis in the sustainability of health care costs (Boychuk 2002),[4] in the consequences of population aging (Clark 1991, 1993), or in the dangers of globalization and free trade (Barlow 2002; Williams et al. 2001).

Ideas may also be focal points based on their (non-material) appeal to appropriateness or best practice within a professional/scientific epistemic community (Haas 1992) or a broader advocacy coalition (Sabatier 1993). The distinctive worldviews or ideas (as distinct from interests, as discussed above) of crucial actors in positions of influence ±including researchers, experts, and even politicians ±make possible coalitions based on shared principled beliefs (Hall 1997: 184). The inclusion of experts suggests that causal perceptions, more so than perceptions of potential material gains or losses, are the critical shared elements in these coalitions. For example, Laycock and Clarke (2002) suggest that the Canadian Alliance and the post-1984 3URJUHVVLYH &RQVHUYDWLYH SDUWLHV VKDUH D ³PDUNHW private markets in mediating social relations, with a limited, residual role for the state. They are joined in their beliefs by various conservative think tanks and business groups, as well as academics and policy analysts from a broad range of organizations. Similarly, the NDP fits into a ³µVRFLDO GHPRFUDWLF FLWL]HQVKLS¶ PRGHO LQ ZKLFK SR constraining the opera WLRQ RI WKH SULYDWH PDUNHW DQG LWV YDOX and also has allies in the academic and professional communities of experts. Together, each of these allied groups form an advocacy coalition ±³SHRSOH IURP D YDULHW\ RI SR (elected agency officials, interest group leaders, researchers, etc.) who share a particular belief system ± that is a set of basic values, causal assumptions, and problem perceptions ±and who show a non-

> medical profession in health matters, which in turn explains the pattern of investment and organization in health services. (Lewis 1999: 154)

The institutionalized biomedical model has also resulted in a deep resistance to a broader understanding of health and its determinants from a public policy perspective. Alternative understandings of health, such as social determinants and population health perspectives[5], are beginning to challenge the biomedical model but with limited success. Part of the reason for this is government institutions ±their various departmental portfolios and divisions, supported by their bureaucracies ±ZKLFK ³EORFN WKH SDWK WRZDUGV PXOWLSOH V QHZ SXEOLF KHDOWK ´ /HZLV ,QVWHDG KHDOW initiatives are XVHG E\ JRYHUQPHQWV LQ DQ LQVWUXPHQWDO ZD\ PHDQV WR WKHVH HQGV ´ /DYLV)RU LQVWDQFH adopted the rhetoric of a determinants of health approach to consolidate budgets and management structures in departments relating to various determinants of health. However, the restructuring

DGGUHVVHG ´ %U\DQW ity of care and history of service to q &RQVLGHUDWLRQV RI TX
SDUWLFXODU FRPPXQLW\ ZRPHQ LQ WKH FDVH RI WKH
H[DPSOH ZHUH JLYHQ GLIIHUHQW ZHLJKW LQ WKH &RPPLVV
by societal actors. Similarly, in the case of the bilingual Montfort Hospital in Ottawa, the
&RPPLVVLRQ¶V UHFRPPHQGDWLRQV IRU FORVXUH ZHUH FU
issue of language, and its particular social and political significance in Canada (Cohn 2001; Tuohy 1999). Aronson and Neysmith (2001) describe how the use of medical criteria for allocating home care resources has contributed to social isolation and exclusion of elderly women

INTERESTS AND POLICY CHANGE

The relationships between the state and societal actors is at the heart of interest-based approaches to public policy. Although formal institutions are an important context within which these relations are mediated, these institutions not only shape state-society relations, they are themselves shaped by state-society relations. The accommodation observed between the state and societal groups in health care is not in a *direct*

policy network governing health ± third-party payers were effectively shut out, and other

converge in the 1990s as governments soug K W W R E R W K ³ D V V H U W W K H L U U R O H
to elaborate the terms of their accommodations with the profession. In this process, both the
L Q I R U P D O P H F K D Q L V P V R I W K H µ P X W X D O D F F R P P R G D W L R Q ¶
narrowly focused P H F K D Q L V P V R I W K H D G Y H U V D U L D O F R O O H F W L Y H
(Tuohy 1999: 210). Tuohy contends that the new relationships facilitated greater collaboration between government and the profession, and resulted in the development of formalize G µ F R P D Q D J H P H Q W ¶ ± bipartite or tripartite joint management committees ± in most provinces. These structures enabled a number of important cost control measures to be implemented, such as global budgets for physician services, reductions in the supply of physicians, delisting and privatization of some services, and alternative payment mechanisms. Moreover, governments were able to absolve themselves from managing conflicts within the profession, as disputes about fee scales between different specialist groups mounted, by expanding and formalizing the involvement of medical associations. The degree to which co-management relations have become institutionalized is demonstrated by the intense conflict that ensued between a newly elected Ontario government and the Ontario Medical Association when the government dismantled the joint management structures and took over many of their functions, including powers over the fee schedules and the supply of physicians. In the end, the government was forced to reinstate both the bargaining power of the OMA and a number of joint management committees (Tuohy 1999).

The experiences of the 1990s demonstrate, according to Tuohy (1999: 230), that governments are not unwilling to exercise their legislative power in the face of professional R S S R V L W L R Q Z K H Q Q H F H V V D U \ E X W S U H I H U W R ³ H V W D E O L
Z L W K W K H S U R I H V V L R Q > Z L O O @ S U R F H H G ´ , Q R W K H U Z R
clientele relations to the adversarial relationships associated with pluralist politics, a continuation of longstanding corporatist patterns in Canada. Moreover, governments relied on blunt policy instruments (such as budgetary caps) to make adjustments within their health systems during the 1990s, further reinforcing the arms-length relationship between the state and the members of the S U R I H V V L R Q 2 Y H U W L P H W K H W K U H D W R I J R Y H U Q P H Q W ¶ V
L Q I O X H Q F H R I W K H P H G L I P W L V H5p € p € p À W 00 S U ð € W K

toward a decline of deference to and trust in governments and politicians to act in the public interest (Pal 2001; Nevitte and Kanji 2002). These changes are also reflected in the erosion of confidence Canadians have in their health system, as well as in governments to effectively manage the system. That said, however, Canadians still feel there is a strong and necessary role for all levels of government in the system (Mendelsohn 2002). Furthermore, tensions within society are more complex and paradoxical, making decision making even more difficult. Mendelsohn (2002: 21) sums up very well some of these tensions:

that break in important ways from trad L W L R Q D O V W D W H U H J X O D W L R Q R I G L V H
1992: 37). In addition to issues of treatment (for example, coordination of hospital services, more home care, availability of and access to experimental drug treatments and alternative therapie V D F W L Y L V W V ³ D O V R S X V K H G I R U I X U W K H U U H F R J Q L W

agencies making policy for the sector. Such organizational attributes will often vary significantly from sector to sector a Q G I U R P F O D V V W R F O D V V ´ & R O H P D Q D Q G 6 N care arena, the political power of medical associations appears to be increasingly limited, although they remain among the most influential interest groups in the sector. These limitations are imposed by governments with strong state capacities who are not unwilling to exercise their authority. However, the profession still retains a great deal of public credibility and commands a significant degree of technical authority over medical care by virtue of the biomedical paradigm. Nor does the influence of scientific knowledge in modern society appear to be waning; indeed, it seems to be gathering momentum as epistemic communities composed of researchers from the physical and social sciences work to broaden and deepen evidence and information to inform clinical and policy decisions. Furthermore, governments with concentrated authority must exercise it with particular caution during times of austerity, when difficult decisions with unavoidably negative consequences must be made. As a result, according to Tuohy (1999), a mutually accommodating relationship seems to have emerged after a period of high conflict and confrontation. This this accommodation reflects a stabilization of the fiscal context, where not all decisions are necessarily zero-sum and redistributive, and improvements in information technology which have helped to alter the balance of power between practitioners and government actors.

Relationships between the state and its citizens appear to be less clear and much more complex than those between the state and interest groups. Citizen engagement initiatives through devolved governance and deliberative democracy, for example, have yielded limited results in terms of policy impact or even with respect to broader democratic goals. Perhaps these mechanisms for engagement are as yet only weakly evolved in a polity that has traditionally been structured around a deference to authority and limited citizen involvement, and must be developed and institutionalized over a longer period of time than the decade or so that they have been in place. It may also be that the post-modern values and characteristics of Canadian society vis vis the state are still in flux, and thus cannot anchor these relationships in particularly firm ground. As Abelson and Eyles (2002: 22) conclude:

> If public involvement in the health system (however defined) is considered a value in its own right, and this view appears to be largely supported, the basis upon which we judge its success or failure, and the quality of the evidence used to make this judgement needs more careful consideration. Participation may never produce greater efficiencies nor is public participation likely a necessary condition for the efficient functioning of the health system. It has the potential, K R Z H Y H U « W R V W U H Q J W K H Q F L W L] H Q F R P P L W P H Q W W R the expression of democratic values.

INTEGRATIVE MODELS FOR HEALTH POLICY ANALYSIS

Political Economy

Political economy approaches seek to understand policy change in the context of particular relationships between the state and society within capitalist systems. Post-World War

beginning in the late 19th century (Polanyi 1944). These problems created fundamental LQHTXDOLWLHV EHWZHHQ FODVVHV UHJLRQV VH[HV FXOWWHQVLRQV « WKDW SURYLGH [the health care] dynamic aspects of the [health care] system and much of the basis for FKDQJH ´ $UPVWURQJ DQG $UPVWURQJ :KLOH SRO structural aspects of state-

In the past two decades, many analysts argue, a fundamental shift in Canadian political economy has been occurring ±one that is promoted under a neo-liberal rubric calling for a shrinking role for the state accompanied by a growing emphasis on private markets and other forms of privatization (Burke, Mooers and Shields 2000). In health care, the results of this shift are evidenced in the political preoccupation with cost-containment and greater privatization of risks, costs and health care provision (Armstrong and Armstrong 1996; Drache and Sullivan 1999). It is particularly pronounced at the margins of the hospital-medical boundaries of medicare, in areas such as rehabilitation, homecare and pharmaceutical coverage (Gildner 2001; :LOOLDPV HW DO SURILWL]7KHLRQ¶ RI KHDOWK FDUH LQ WKHV agendas premised on a neo-liberal ideology about a limited role for the state, as well as by the interests of capital represented by business groups and associations, who are keen to expand a highly lucrative private market in health care goods and services. Critical political economists and Marxists argue that the state is captured by the interests of capital and is thus an instrument for benefiting the capitalist classes at the expense of the working class. Even the limited gains made by labour in the implementation of universal health insurance are now being eroded in the name of globalization and competition.

Historical Institutionalism/Policy Legacies/Path Dependencies

The historical institutionalist approach begins with the premise that institutions create path dependencies or logics that reduce the range of possible policy alternatives at any given point in time. These analyses bring together all three variables ±institutions, interests and ideas ± in various ways to explain the direction and pace of policy change over time.

Mary Ruggie (1996), in her comparative study of three different liberal welfare states (Canada, the United Kingdom and the United States), suggests that changing patterns in &DQDGLDQ KHDOWK SROLF\ DUH HQWLUHO\ FRQVLVWHQW Z

libera weriticare state4(s)] TJETBT/F2 12 Tf1 0 0 1060282.4144.66 Tm[(0B1)] TJETBT/F1 12 Tf1 0 0 1 54282.4144.66 Tm[(

profession and the state kept the system relatively stable though under increas LQJ SUHVVXUH (Tuohy 1999: 249). Tuohy elaborates on certain conditions under which policy change is likely to occur, but concludes that those conditions are a function of chance and factors external to the health system ±VLPLODU WR .LQJGRQ¶V XQSUHGLFWDble policy windows. Major policy initiatives require a consolidated base of authority within the state for policy action accompanied by extraordinary political will; these factors come together very rarely and usually only by a coincidence of external factors (Tuohy 1999: 11). The direction or type of policy change, however, is determined by the institutional mix and balance of key actors within the health sector, and this is largely path dependent.

,Q GHVFULELQJ WKH IRUPDWLRQ RI &DQDGD¶V PHGLFDU, Jacob Hacker (1998: 59) argues

SXEOLF ³$V ERWK D VHW RI LGHDV DERXW WKH QHFHVV
interactive process of policy change construction and communication, discourse can create an
LQWHUDFWLYH FRQVHQVXV IRU FKDQJH ´ 6FKPLGW

Policy frames are the combination of normative and cognitive idea elements that together form a particular policy pa UDGLJP ³$ IUDPH LV D VHW RI FRJQLWLYH D actor within a policy sphere. Frames help actors identify problems and specify and prioritize their interests and goals, they point actors toward causal and normative judgments about effective and appropriate policies in ways that tend to propel policy down a particular path and to reinforce it once on that path, and they can endow actors deemed to have moral authority or expert status ZLWK DGGHG SRZHU LQ D SROLF\ GHEDWH 6FKPLGW New policy frames may become important when the dominant ideas or frames fail to meet expectations or when their consequences are overwhelmingly negative and undesirable (Legro 1999). The development of the welfare state and government-sponsored health programs in the post-war era were the result of the failure of existing private market alternatives to adequately meet the needs of Canadians (Taylor 1987). However, the failure of old ideas does not necessarily dictate which among many alternative policy frames will succeed. New ideas themselves must be persuasive in order to succeed dominant paradigms. This success depends on the compatibility of the new ideas with extant core values and norms and the consistency between the normative and cognitive elements of the policy frame (Bhatia and Coleman 2003). For example, the attempts of the Alberta government to introduce greater elements of private financing into the health care system failed LQ SDUW EHFDXVH RI WKH LQFRQVLVWHQF\ EHWZHHQ WKH SROLF\ IUDPH

necessity and appropriateness of the policies, can impose sanctions through periodic elections and SURWHVWÍ In multi-actor systems where policy construction occurs across a wider range of policy actors (i.e., in a larger policy network), such as in countries with strong corporatist networks, persuasion occurs between the key policy actors who represent their constituencies, minimizing the need for broader public debate or communication (Schmidt 2002; Singer 1990).

Multiple Streams

Finally, the multiple streams (MS) model brings together many of the variables discussed above to explain agenda setting ±how do issues become defined as problems and get onto a JRYHUQPHQW¶V SULRULW\ DJHQGD" ,Q WKLV PRGHO WKH DQG FKDQJH LV WKDW ³SROLF\ PDNLQJ LV RIWHQ WKH IDWH 2001: 49) Windows of opportunity for policy change are opened when three streams ±problems, policies, and politics ±come together to identify a problem and a set of policy solutions to go with it; normally, each of these streams operate relatively independently of one another. The RSHQLQJ RI D ZLQGRZ DOORZV DQ LVVXH WR ULVH LQ SUL 1995). Joe Blankenau (2001) uses the MS model to explain the passage of the Medical Care Act in Canada.

7KH µSUREOHP¶ VWUHDP FRQVLVWV RI *indicators* or measures that suggest a change has occurred, a *focusing event* or crisis that causes or intensifies a problem, or *policy feedback* from existing policies which suggests goals are not being met. In this stream, problems are identified and defined to be SXW IRUZDUG RQWR D JRYHUQPHQW¶V DJHQGD . suggests in the health care issue area, the important indicators of a problem are measures of cost, quality and access. When medicare was established, key indicators that were used to identify a problem were measures of access to health insurance for a large portion of the population, and

profession, but was strongly endorsed by consumer groups and labour; in the end, the latter groups were able to counter the opposition of the medical profession. Finally, changes in the governing party at the federal and provincial levels brought in political leaders who were committed to medicare and who worked hard to create the policy window that ultimately resulted in the passage of the legislation (Blankenau 2001).

Blankenau concludes from his analysis using the MS model that it is a useful tool for understanding the dynamics of policy change, but that the underlying variables (namely, institutions, ideas and interests) ultimately drive the policy process. The MS model, particularly when used in comparative analysis, helps to illuminate which of these factors that were most important or influential in shifting the policy dynamic in favour of policy change. In the case of & D Q D G D ¶ V 0 H G L F D O & D U H $ F t, Blankenau points to institutional variables that created pressure in two of the three streams. Federalism influenced the policy stream by enabling the demonstration of effect of medical insurance in Saskatchewan and giving the federal government a role in the development and implementation of the policy, while the parliamentary system created pressure in the politic1 0h(stro)-3(nc)3Lithm[(in)-71(therpr)3(of)3urTh69on of thC(r)-3(r)-( )-/NDP(e)4(nt)-s20(ste( )-6

changes are the product of circumstances that are almost entirely exogenous to the health sector. However, the direction or shape of the reforms is endogenous to the system.

Bibliography

1. Abelson, Julia, Pierre-Gerlier Forest, John Eyles, Patricia Smith, Elisabeth Martin, and Francois-Pierre Gauvin (2003). Deliberations about deliberative methods: issues in the design and evaluation of public participation processes. *Social Science and Medicine*, 57: 239-251
2. Abelson, Julia and John Eyles (2002). *Public participation and citizen governance in the Canadian health system*. Commission on the Future of Health Care in Canada.
3. Abelson, Julia, Jonathan Lomas, John Eyles, Steven Birch, Gerry Veenstra (1995). Does the community want devolved authority? *Canadian Medical Association Journal* 153: 3-12.
4. Adams, Duane (2001). Canadian federalism and the development of national health goals and standards. In Duane Adams, Ed., *Federalism, Democracy and Health Policy in Canada*. Kingston: McGill- 4 X H H Q ¶ V 8 Q L Y H U V L W \ 3 U H V V
5. Ajzenstat, Janet (1994). Constitution-making and the myth of the people. In C. Cook, ed., *Constitutional Predicament: Canada After the Referendum of 1992*. Montreal: McGill- 4 X H H Q ¶ V 8 Q L Y H U V L W \ 3 U H V V
6. Alford, Robert R. (1975). *Health Care Politics: Ideological and Interest Group Barriers to Reform*. Chicago: University of Chicago Press.
7. Angus, Douglas E. (1991). Review of Significant Health Care Commissions and Task Forces in Canada Since 1983-84. Ottawa: CHA/CMA/CNA.
8. Armstrong, Pat and Hugh Armstrong (1996). *The Undermining of Canadian Health Care.* Toronto: Oxford University Press.
9. Armstrong, Pat, Hugh Armstrong and David Coburn, eds. (2001). *Unhealthy Times: Political Economy Perspectives on Health and Health Care in Canada*. Oxford University Press.
10. Aronson, Jane and Sheila M. Neysmith (2001). Manufacturing Social Exclusion in the Home Care Market. *Canadian Public Policy / Analyse-de-Politiques*; 27(2): 151-165.
11. Atkinson, Michael M. (1993). Introduction. In Michael M. Atkinson, Ed., *Governing Canada: Institutions and Public Policy*. Toronto: Harcourt Brace Jovanovich Canada Inc.
12. Banting, Keith G. (1987). *The Welfare State and Canadian Federalism*. Montreal and Kingston: McGill- 4 X H H Q ¶ V 8 Q L Y H U V L W \ 3 U H V V
13. Banting, Keith G. (2001). The past speaks to the future: Lessons from the post-war social union. In Harvey Lazar, Ed., *Canada: The State of the Federation. Non-Constitutional Renewal* . L Q J V W R Q , Q V W L W X W H R I , Q W H U J R Y H U Q P H Q W D O 5
14. Banting, Keith G. (1995). The welfare state as statecraft: Territorial politics in Canadian social policy. In S. Leibfried and P. Pierson, eds., *European Social Policy: Between Fragmentation and Integration*. Washington: Brookings Institute
15. Barer, Morris L., Vandna Bhatia, Greg L. Stoddart, and Robert G. Evans (1994). *The Remarkable Tenacity of User Charges.* 7 K H 3 U H P L H U ¶ V & R X Q F L O R Q + H D O Being and Social Justice, Ontario.
16. Barlow, Maude (2002). *Profit is Not the Cure: A Citizen's Guide to Saving Medicare*. Toronto: McClelland and Stewart.
17. Begin, Monique (1988). *Medicare: Canada's Right to Health*. Ottawa: Optimum Publishing
18. Bhatia, Vandna and William D. Coleman (2003). Ideas and discourse: Reform and resistance in the Canadian and German health systems. *Canadian Journal of Political Science*, forthcoming.

38. Checkel, Jeffrey T. (1999). Social construction and integration. *Journal of European Public Policy* 6(4): 545-60.
39. Church, John and Tom Noseworthy (1999). Fiscal austerity through decentralization. In Daniel Drache and Terry Sullivan, eds., *Health Reform: Public Success, Private Failure*. London: Routledge.
40. 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*; 12(4): 485-508.
41. 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*; 5(3): 265-281.
42. Coburn, David (1993). State authority, medical dominance and trends in the regulation of health professions: the Ontario case. *Social Science and Medicine*, 37: 841-50.
43. Coburn, David (1988). Canadian medicine: dominance or proletarianization? *Milbank Quarterly*; 66, supplement 2, 92-116.
44. 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.
45. Cohn, Daniel (2001). No place to hide: the BT4 448.03 Ttfceyo09(be)4(t61(Ag(fa)-2(c)4us-99(t269(R)-

74. Gildiner, Alina (2001). *What's Past is Prologue: A Historical Institutionalist Analysis of*

94. Hurley et al. (1997)
95. Hutchinson, A.C. and A. Petter (1988). Private rights/public wrongs: the liberal lie of the Charter. *University of Toronto Law Journal*. 38:278-297.
96. 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.
97. 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). 5ETl(o)10( )] TJEhid(f)-.

130. Maslove, A.M. (1996). The Canada Health and Social Transfer: Forcing the issues. In G. Swimmer (Ed.), *How Ottawa Spends 1996-97: Life Under the Knife.* (pp 283-301). Ottawa: Carleton University Press.
131. Maslove, A.M. (1998). National Goals and the Federal Role in Health Care. In National Forum on Health (Ed.), *Striking a Balance: Health Care Systems in Canada and Elsewhere.* Ottawa: Editions MultiMondes.
132. Maslove, A.M. and B. Rubashewsky (1986). Cooperation and confrontation: The challenges of fiscal federalism. In M.J. Prince, Ed., *How Ottawa Spends 1986-87: Tracking the Tories*. Ottawa: Carleton University Press.
133. Maxwell, Judith, Steven Rosell and Pierre-Gerlier Forest (2002). Giving citizens a voice in health care policy in Canada. *British Medical Journal*, 326 (May 10): 1031-33.
134. McFarland L., and C. Prado (2002). *The Best Laid Plans: Health Care's Problems and Prospects*. Montreal: McGill- 4 X H H Q ¶ V 8 Q L Y H U V L W \ 3 U H V V
135. Mendelsohn, M. (2002). *Canadians' Thoughts on their Health Care System: Preserving the Canadian Model Through Innovation.* Report for the Commission on the Future of Health Care In Canada.
136. Mhatre, Sharmila L. and Raisa B. Deber (1992). From equal access to health care to equitable access to health: A review of Canadian provincial health commissions and reports. *International Journal of Health Services* 22(4): 645-668.
137. Moore, Mark H. (1988). What sort of ideas become public ideas? In Robert B. Reich, Ed., *The Power of Public Ideas*. Cambridge: Harvard University Press.
138. Moran, Michael (1999). *Governing the Health Care State: A Compar1(6(e)4v4(e)4()-189(C)dti)-2(c)4(h)A*

148. 2 ¶ 1 H L O O 0 L F K D H O 6 W H S S L Q J I R U Z D U G V W H S S L
government and the new Canada Health and Social Transfer. *International Journal of Canadian Studies*, 15:169-184.
149. O'Neill, Michael A. (1998). Entrenched interests and exogenous change: Doctors, the state and policy change in Canada and the United Kingdom. *Journal of Commonwealth and Comparative Politics* 36(1): 1-19.
150. O'Neill,-Michael-A. (1996). Health as an Irreversible Part of the Welfare State: Canadian Government Policy under the Tories. *International-Journal-of-Health-Services*; 1996, 26, 3, 547-559.
151. 2 ¶ 5 H L O O \ 3 D W U L F L D 7 K H I H G H U D O S U R Y L Q F L D O
Duane Adams, Ed., *Federalism, Democracy and*

188. Schmidt, Vivien A. (2002). Does discourse matter in the politics of welfare adjustment? *Comparative Political Studies*, 35(2): 168-193.
189. Sharpe, Robert J. and Katherine E. Swinton (1998). *The Charter of Rights and Freedoms*. Toronto: Irwin Law.
190. Shillington, C.H. (1972). *The Road to Medicare in Canada*. Toronto: Del Graphics.
191. Simeon, Richard (2002). *Political Science and Federalism*. Kingston: Institute of , Q W H U J R Y H U Q P H Q W D O 5 H O D W L R Q V 4 X H H Q ¶ V 8 Q L Y H U V L W
192. Simeon, Richard and David Cameron (2001). Intergovernmental relations and democracy: An oxymoron if there ever was one? In Herman Bakvis and Grace Skogstad, Eds., *Canadian Federalism: Performance, Effectiveness and Legitimacy*. Toronto: Oxford University Press.
193. Skocpol, Theda (1996). *Boomu 0 0 1 91PETBT/F6 12 Tf1 0 0 1 212.69 72.32i212 T7.44 0 0 1 145 53 (6)200*

207. Taylor, Malcolm G. (1986). *Insuring National Health Care*. Chapel Hill: University of North Carolina Press.
208. Taylor, Malcolm G. (1987). *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. Institute of Public Administration of Canada: McGill-Queen's University Press.
209. Taylor, Malcolm G. (1989). Health insurance: The rollercoaster in federal-provincial relations. In D.P. Shugarman & R. Whitaker (Eds.), *Federalism and Political Community: Essays in Honour of Donald Smiley.* Peterborough: Broadview Press.
210. Taylor, Malcolm G. (1990). *Insuring national health care: the Canadian experience*. University of North Carolina Press.
211. Thelen, Kathleen and Sven Steinmo (1992). Historical institutionalism in comparative politics. In S. Steinmo, K. Thelen and F. Longstreth, Eds., *Structuring Politics: Historical Institutionalism in Comparative Analysis*. Cambridge: Cambridge University Press.
212. Tuohy, Carolyn J. (1976a). Private government, property and professionalism. *Canadian Journal of Political Science*, IX(4): 668-81.
213. Tuohy, Carolyn J. (1976b). Pluralism and corporatism in Ontario medical politics. In K.J. Rea, J.T. McLeod, Eds., *Business and Government in Canada: Selected Readings*, Second Edition. Toronto: Methuen.
214. Tuohy, Carolyn J. (1987). Conflict and accommodation in the Canadian health care system. In R.G. Evans & G.L. Stoddart (Eds.), *Medicare at Maturity*. (pp 393-434). Calgary: University of Calgary Press.
215. Tuohy, Carolyn J. (1988). Medicine and the state in Canada: the extra-billing issue in perspective. *Canadian Journal of Political Science* 21(2); 267-296.
216. Tuohy, Carolyn 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.
217. Tuohy, Carolyn J. (1992). *Policy and Politics in Canada: Institutionalized Ambivalence.* Philadelphia: Temple University Press.
218. 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.
219. Tuohy, Carolyn H. (1999). Dynamics of a changing health sphere: The United States, Britain and Canada. *Health Affairs*, 18(3): 114-134.
220. Tuohy, Carolyn H. (2002). The costs of constraint and prospects for health care reform in Canada. *Health Affairs* 21(3):32-46
221. 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.
222. Vail, Stephen (2001). *Canadians' Values and Attitudes on Canada's Health Care System. A Synthesis of Survey Results.* Conference Board of Canada.
223. Walters, Vivienne (1982). State, capital and labour: the introduction of federal-provincial insurance for physician care in Canada. *Canadian Review of Sociology and Anthropology*, 19(2): 157-172.
224. Weaver, R. Kent (1986). The politics of blame avoidance. *Journal of Public Policy*, 6(4): 371-398.