Chapter 1

Why Is It So Hard to Reform Health-Care Policy in Canada?

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Democratic elected governments pay attention to the opinions of their citizens. Sometimes they are able to act on citizen demands in a timely fashion. Sometimes they do so with a time lag. When governments lack an adequate response, they may attempt to redefine the issue in a way that fits with what is achievable and convince the citizenry that it should accept the result and move on.

Paying attention to public opinion is a two-way street. Governments also try to manage the expectations of the public. When economic hard times are ahead, government leaders often try to precondition citizens to the future difficulties. When a military mission encounters unanticipated difficulties on the ground, it is not unusual for governments to redefine the mission to fit with what is achievable.

Due to the ongoing interaction between governments and citizens, it is rare that a single issue remains the leading concern of the public for an extended period. Yet, this has been the situation in Canada. Almost continuously since the late 1990s, Canadians have pointed to health care as their largest “national concern” or the issue that “should receive the greatest attention from Canada’s leaders.” A 2002 poll found that, among 19 issues, “health care was both the highest priority and the one for which the federal government received the lowest ratings” (cited in Soroka 2007, 5 and Figure 5). In 2005, another pollster (Decima) surveyed opinion on 18 issues and again showed health care as the one in which the public was least satisfied by federal government performance (ibid., 9 and Figure 17).

Less than a decade earlier, in the 1980s, worries about health care had barely registered in public opinion data (Mendelsohn 2002, 31). In fact, since the introduction of countrywide hospital insurance in the late 1950s, Canadians have been smitten by that part of their health systems that provided universal, first-dollar, publicly financed hospital and medical services. The public happily received this government program,
eventually called medicare, as a way of enabling Canadians in each province and territory to access hospital and medical services on the basis of the urgency of their health needs, not their income. Subsequently, publicly financed health care evolved into something more—an embodiment of Canadian values.

No health system is problem-free. In the 1980s in Canada there were serious political tensions around the right of physicians to charge patients a fee for their services above the amount specified in the provincial and territorial fee schedules. These schedules had been negotiated between physicians’ bargaining agents (medical unions in Quebec and provincial medical associations in all other provinces) and provincial governments. This dispute was eventually settled, but the political dynamics of the decision process were nasty and, among other things, included a strike by Ontario physicians. Equally if not more salient to this story were cost considerations. Between 1975 and 1990, total health expenditure in Canada grew from 7 to 9 percent of gross domestic product (CIHI 2012, 114). The public sector as a source of funds for health care was equal to 5.2 percent of GDP in 1975, and 6.3 percent in 1990. The governments of provinces and territories accounted for 93 percent of the public sector. By the late 1980s, public finances of the provinces and territories were in dreadful shape and then made worse by recession.

A series of decisions by provincial governments beginning in 1991/92 signalled a period of “retrenchment and disinvestment” in health care (CIHI 2012, 3). Over the next five years, some provinces tightened health-care expenditures more than others but the broad effects were similar across the country. The growth of health-care supply was constrained but demand was not. A supply-demand gap resulted. Although there was little or no scientific data on wait times then, by the mid-1990s Canadians sensed that they were encountering longer wait times than they had hitherto experienced or that were appropriate to their circumstances. This was especially the case for appointments for specialized procedures and diagnostic imaging. Emergency rooms were frequently overcrowded. Evidence of the supply-demand gap showed up in several ways: public opinion data, findings of the plethora of reports commissioned by governments, statements by interest groups, and articles written by the research community.

There was no shortage of policy proposals to fix the problem. In fact, a first wave of provincially commissioned reports landed on government desks around the time that provincial governments undertook their expenditure freezes. Provincial governments had commissioned these reports in the late 1980s in their search for ways to control costs and better integrate services. A second wave of provincially commissioned reports followed in the second half of the 1990s. The federally appointed National Forum on Health undertook a large research effort in the 1990s, and various think tanks contributed as well. At least 18 major reports published
between 1988 and 2002 focused broadly on the issue of health-care policy reform (see annex 1 for a list and discussion of these reports). A larger number were commissioned to deal with a specific issue or narrow range of issues.

Numerous calls for policy reform emanated from these generally well-researched reports. Yet most reform proposals have not been acted on in a substantial way. The architecture of the health system was not much different in 2013 than it had been before all these reports were delivered to governments and made available to the public.

In a 2002 submission to the Commission on the Future of Health Care in Canada (Romanow Commission), the Canadian Medical Association wrote, “Over the past decade there have been countless studies on what is wrong with Canada’s health care system. However, very little action has been taken to solve the problems identified in the reports” (CMA 2002, v). Eight years later the CMA (2010, 31) stated,

In 2001 the Honourable Roy Romanow was tasked by the federal government to study and make recommendations in order to “ensure over the long-term the sustainability of a universally accessible, publicly funded health system.” The Romanow Commission put forward 47 recommendations in 2002 with a view to “buying change.” Similarly, the Kirby … review of the Canadian health care system recommended an additional $5 billion of federal funding per year to restructure and renew Medicare. These reports were followed by additional federal funding in the amounts of $34.8 billion and $41.3 billion in the 2003 and 2004 First Ministers’ Accords respectively. Eight years later it is evident that, for the most part, these Accords bought time, not change.

So many recommendations from so many reports have been set aside that we judged that it was important to understand why this was so. The reports were written by highly competent individuals with strong research teams available to them. Moreover, the authors of the reports were not at the political fringes. Governments rarely select people to head such bodies if they are hostile to the government’s ideological stance.

This book is the product of a research project that began with an interest in why it is so hard to reform health-care policy in Canada and whether Canadian federalism in general or the federal government in particular was contributing more to the problem or to the solution. As we considered this matter, we translated that interest into a more precise set of objectives which are set out in chapter 2.

**Verifying Assumptions**

Asking the question why it has been difficult to reform Canadian health-care policy involves two assumptions: that there was not much policy
reform and that policy reform was desirable. In fact, much of the literature assumed or asserted that reform was sparse without providing systematic evidence that the assumption or assertion was valid. The starting point for this book was to determine whether the assumption of little reform could be verified.

The details of the methodology are discussed in chapter 2. Here it is sufficient to note that we use a case study approach to examine six representative health policy issues: regionalization, needs-based funding, alternative payment plans for primary care physicians, for-profit delivery, waiting lists, and prescription drug insurance coverage. The six issues span four policy domains: governance, finance, delivery, and program content. Each case was studied over the period 1990–2003 in five representative provinces: Alberta, Saskatchewan, Ontario, Quebec, and Newfoundland and Labrador. Thus, this book is based on 30 case studies.

To determine the nature and extent of reform, a benchmark was needed. The consensus position set out in the government-commissioned reports referred to above (sometimes called “grey literature”) for each of the six policy issues was selected as the benchmark. The consensus position itself was assumed to be the highest level of reform that it was politically practicable for any government to achieve. We then analyzed and graded each of the 30 cases on the basis of how close it came to satisfying the benchmark. This method of analysis verified the starting assumption: taking the five provinces as a whole, there was in fact meagre policy reform (chapter 8). In chapter 10, we employed alternative methods of “measuring” policy reform. The alternatives did not alter our assessment of meagre reform.

The governments that commissioned these reports were generally centre or centre-left in their political orientation. Not surprisingly, therefore, the proposals from the literature tended to lean toward government as the optimal mechanism for responding to perceived shortcomings in the health systems. Decisions taken that were directionally consistent with the proposals in these reports are referred to as “consensus reforms” or, for ease of reading, just “reforms.” Decisions that privileged the market or private for-profit sector, whether for the delivery or the financing of health services, are referred to as “counter-consensus reforms.”

Although values influence policy choice in decision-making, the research program that led to this book made no assumptions about what is “good” policy reform. Big and small policy reforms that contemplated an enhanced role for markets in resource allocation (such as competition among imaging labs or surgical clinics) are equated with government-oriented reforms of equal magnitude. Thus, the fact that the Saskatchewan New Democratic government led by Premier Roy Romanow from 1991 to 2001 and the Alberta Progressive Conservative government led by Premier Ralph Klein from 1992 to 2006 had different ideological orientations
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does not matter for the purposes of determining the magnitude of their policy actions. The analysis similarly does not assess the appropriateness of reforms. This book is focused on understanding what makes policy reform, whether consensus or counter-consensus, so difficult to achieve.

In general, and not referring to health care in particular, the years from 1990 to 2003 were characterized by a shift to the political left whereas the years since 2003 have involved a shift toward the political right—toward conservatism and a larger role for markets. For this reason, in chapter 11 we re-examine and update the 30 cases for the 2004–2011 period. We want to determine whether the change in political stripe of governments in four of the five provinces and in Ottawa altered the finding of meagre policy reform.

The second starting assumption was that policy reform was desirable during the years from 1990 to 2003. Policy reform is neither a good nor a bad idea on its own. Context matters. If a health system is working well, lack of reform may constitute a form of desirable stability. If the system is under stress or worse, lack of reform may reflect an undesirable rigidity. During the study period, Canada’s health systems were under stress and at times extreme stress. Government after government appointed commissions, task forces, or advisory committees to provide advice on what could be done to fix the situation (annex 1). Of equal interest for purposes of this study, the data on public opinion support the assertion of a system under stress. Matthew Mendelsohn (2002) undertook an analysis for the Romanow Commission “based on all available Canadian public opinion polls” on health care between 1985 and 2002. He found that “while 61 percent of Canadians thought the system was excellent or very good in 1991 … only 29 percent shared that view in 2000” (1). A citizens’ dialogue undertaken by Judith Maxwell and colleagues yielded similar findings (Maxwell, Rosell, and Forest 2003). In short, the weak reform record paralleled a period of stress when reform was perceived as desirable by many. The meagre outcomes are explained more by health system rigidities than a societal wish to protect a health-care system that was firing smoothly on all cylinders.

POLITICAL ECONOMY

In 2012, Canadians spent an estimated $207 billion on health care, or $5,948 per person, an amount equal to 11.6 percent of forecasted gross domestic product (CIHI 2012, xiii). To put that number into perspective, it is triple the amount Canadians spend on all levels of education (4 percent of GDP, OECD 2011) and an even larger multiple of what is expended on public pensions (3.5 percent of GDP, ibid). Canada has on occasion been referred to as an “energy superpower,” and yet as a share of GDP,
the entire energy industry—including oil, gas, and electricity—is a little over half the size of health care.

Of the more than 17 million Canadians employed in Canada in 2012, close to one in ten were working in the health care and social assistance sectors (Statistics Canada 2012). A large majority of the 1,651,000 people employed in these two sectors worked in health care. In 2009, this included 68,000 physicians, almost 350,000 nurses, and over 240,000 other health-care professionals, including dentists, pharmacists, midwives, and dietitians (CIHI 2011a, 2). That’s around 650,000 professional jobs.

In 2009/10, the health-care industry was a high-paying, high-value-added industry. The “average gross fee-for-service payment per full-time equivalent physician was $293,000” (CIHI 2011c, 32). Registered nurses earned on average $28 to $36 per hour in the 2008–2010 period, depending on location, and licensed practical nurses $22 to $25 per hour (Living in Canada 2012).

The United States spent 17.6 percent of GDP on health in 2010. Canada was one of a grouping of ten OECD countries that came next, spending between 10 and 12 percent of GDP on health in that year. At 11.4 percent, Canada was fourth highest in this grouping and almost 2 percentage points over the OECD average of 9.5 percent (cited in CIHI 2012, 64).

What do Canadians get for their money? In 2010 the Commonwealth Fund International Health Policy Survey compared how people in 11 countries assessed their health systems. The Health Council of Canada used this report to discuss how Canada rated. The Council also compared the 2010 results for Canada with the results from 2004 and 2007 Canadian surveys. The Health Council (2010, 3-5) concluded,

Canadians’ confidence in their health-care system is related to many complex factors including their personal experiences within the system, including stories from friends and acquaintances, and articles in the news. This confidence has been steadily improving since 2004. However it is still below average compared with the other countries surveyed; almost two-thirds of Canadians think the system needs fundamental changes to make it work better.

Of the persons in the countries surveyed, Canadians had the greatest difficulty accessing care in the evenings, on weekends, and on holidays—anywhere other than in hospital emergency rooms (Health Council 2010, 5). Canada ranked lowest of all the countries when it came to the possibility of booking an appointment for the same day or the next day (4). Canadians also fared poorly, compared to others, in how long they had to wait for an appointment with a specialist or to get a diagnosis (5). The difficulties Canadians were experiencing with their health systems at the time Romanow reported had not disappeared eight years later.
Viewing these health system concerns and the relatively high cost of care in Canada through an economic lens provides a further perspective on the price Canadians are paying for system deficiencies. From a public finance perspective, realizing efficiencies equal to 1 percentage point of GDP (and still coming in nearly a point above the OECD average) would free up resources sufficient to increase education spending by more than 25 percent. Alternatively, these efficiency gains could go a long way in alleviating provincial fiscal challenges.

The impact of efficiency gains also has implications for jobs and the economy. With ongoing global economic development and the pace of technological change, health care is almost certain to become a larger part of the world economy and increasingly traded as a high-value-added service. Whether Canada becomes a net exporter of such services or a net importer is another reason to focus on reform.

**EXPLAINING REFORM DECISIONS**

The explanations for the reform decisions in each of the five provinces are set out in chapters 3 to 7. Some provinces accomplished more than others. Chapter 8 provides a single five-province assessment of the factors associated with reforms. Chapter 9 analyzes the data from cross-province and cross-policy issue perspectives. Foreshadowing these analyses, three themes are highlighted below: the extent of reform, barriers to reform, and factors that facilitated reforms.

**Extent of Reform**

No province attempted a “big bang”—a major set of reforms—in one fell swoop. Nonetheless, there were substantial differences among the governments in their broad approaches to reform that led to some variation in achievement. To emphasize the degree of difference, the provinces that undertook the most, Saskatchewan, and the least, Newfoundland and Labrador, are discussed first.

The 1991 general election saw the New Democratic Party (NDP) come to power in Saskatchewan with a large majority. It had made election commitments to “develop a healthcare system based on the ‘wellness’ model” (NDP 1991, 12). Once in office, the new government discovered that provincial finances were in deep trouble. Motivated by fiscal pressures on the one hand, and its commitment to a wellness-based reform on the other, the government quickly rationalized its hospital system (closing many small hospitals and amalgamating others, for example), integrated acute care hospitals and other institutions (like nursing homes) on a
regional basis, and introduced a needs-based system of funding regions and hospitals. Tom McIntosh and Michael Ducie (chapter 4) attribute the speed of government action to a strong partnership between the premier, the minister of health (who had served as health critic for the NDP while it was in opposition), and senior officials in the health ministry. The pace of change inevitably led to resistance. By mid-term, the reform process began to lose steam.

The next planned reform in Saskatchewan was in primary care. Primary care reform was thought to be easier and more effective if physicians were paid through some alternative to the prevailing fee-for-service basis, such as capitation or salary. However, suggestions that the government might impose an alternative method of paying physicians led to stiff resistance from the Saskatchewan Medical Association. The NDP government “took its foot off the political accelerator.” Although the NDP was re-elected three times (1995, 1999, and 2003), the first half of the first mandate was its period of greatest achievement.

Another noteworthy reform was introduced in 2003. After several years of trial and error, in response to the growth of wait times for surgical procedures and diagnostic imaging services, the Saskatchewan Surgical Care Network was established. It employed standardized assessment tools with the aim of consolidating and managing access to surgical procedures and diagnostic services across the province. Saskatchewan made this program mandatory for surgeons.

By contrast, in Newfoundland and Labrador health reform was not a political priority. Stephen Tomblin and Jeff Braun-Jackson (chapter 7) emphasize that the agenda of Premier Clyde Wells, whose Liberal party had been elected to office in 1989, was dominated by the moratorium and then closure of the cod fishery and the consequential adjustment process for fishers. Of the six policy issues studied in this book, Newfoundland and Labrador acted only on regionalization. Its motivation in introducing regionalization was principally cost containment. The Liberals did not increase the political priority attached to health care in the three subsequent general elections that they won. When the Conservative party toppled the Liberals in 2003, its party platform made no firm commitments on health care.

Turning to the other three provinces, Ralph Klein campaigned for the leadership of the Progressive Conservative Party in Alberta with the promise to swiftly balance the provincial budget. John Church and Neale Smith (chapter 3) note that this required that he rein in the provincial health budget. Beginning with a plan to reduce annual health spending by around 18 percent over a four-year period, the Klein government consolidated acute care, home care, continuing care, and public health services under a new regional structure, and introduced a needs-based system of regional and hospital funding. The Alberta government also slashed physician compensation as part of its fiscal plan (Church and Smith 2007,
5-9). In the government’s give and take on physician compensation with the Alberta Medical Association, the latter floated the idea of encouraging alternative payment plans for primary care physicians but on a non-mandatory basis. This began a process, still underway, of encouraging alternative payment plans for primary care physicians. Premier Klein’s successes in these areas were, however, overshadowed by his personal advocacy of for-profit delivery. The Friends of Medicare, made up of local activists, resisted fiercely.

As premier from 1992 to 2006, Klein secured only a modest fraction of what he aimed for, and it has not proven lasting. As with the NDP in Saskatchewan, most of his reforms were crowded into the early years of his first electoral mandate. In these key years, Klein made special use of legislative committees on some issues, purposively bypassing the public service. On other issues, particularly needs-based funding and wait times, he received strong support from the public service.

At the outset of the 1990s, unlike in other provinces, health services in Quebec had been regionalized for close to two decades. In the early 1990s, authority was moved downward from the provincial to regional level and from the regional to local level. In the 2003 general election, the Quebec Liberal Party campaigned in favour of eliminating regional boards. Once elected, the Liberal government moved swiftly to implement its platform but encountered stiff resistance and eventually adopted a compromise which saw the boards become regional agencies with a narrower role than they had previously enjoyed.

On most other issues, Pomey and co-authors (chapter 6) observe that Quebec commissioned numerous reports that led to little or no reform. The one exception, however, was important. In the 1994 general election, the opposition Parti Québécois (PQ) committed to drug reform. The prescription drug policy then in place insured against the costs of drugs for some illnesses and not others and thus insured some people and not others. The PQ acted during the first half of its mandate. Since the PQ was also committed to a balanced budget, it chose not to rely exclusively on public insurance. Instead it created a new universal and mandatory program of drug insurance financed partly through the private sector and partly through the public sector. This was the largest single reform among the 30 cases studied.

The Ontario NDP government (1990–1995) led by Bob Rae had not expected to win office and was not as prepared to take the reins of power as it might have been in other circumstances. It decided not to undertake the kind of regionalization already implemented or in the process of being implemented in other provinces. As for other issues, some of which arose in the Rae years and others during the subsequent premierships of Mike Harris and Ernie Eves (1995–2003), the assessment showed moderate reform. Acting under great pressure from civil society groups, the Rae government’s most significant initiative among the six policy issues we
studied was in improving access to some of the then new and expensive "breakthrough" drugs. The Harris government also chose not to create regional health authorities, but it introduced a program of hospital rationalization (closures and amalgamations) through an arm’s-length Health Services Restructuring Commission. John Lavis and co-authors (chapter 5) describe the Ontario performance during these years as more like the tortoise in Aesop’s fable than the hare.

### Barriers to Reform: Insiders and Outsiders

The factors that explain the reform decisions depended on the policy domain. In the governance and financial arrangements domains, issues were influenced heavily by elite interaction, often with little transparency. The delivery and program content domains involved the public and civil society groups, often with media coverage, as well as elites.

In the discussion that follows, authoritative decision makers, generally a minister or ministers of the governing party, are considered as endogenous variables that we call “insider interests.” It is not only their legal authority but the act of deciding itself that makes them endogenous to the decision process. Their advisors from the public service and elsewhere and those with relatively easy access to deciders or advisors are also viewed as having insider interests and thus endogenous influence. Provider associations generally meet this test. A crucial exception to this definition is that newly elected first-time governments may, depending on their behaviour, be considered outsiders in the early period of their first mandate. This is consistent with the idea of an opposition party running against the “powers that be” or the “establishment” and bringing in its outsider view to “clean house.” It is analogous to candidates in federal elections in the United States running against Washington. Other endogenous variables discussed in the chapters that follow include ideas or institutions when they influence the behaviour of political actors who are insiders.

Variables that are not endogenous are referred to as exogenous and actors that are not insiders as outsiders. Opposition parties are typically outsiders, even if they engage on an issue. The media are outsiders. Even the public is an outsider. As patients, members of the public are not represented by provincial associations of patients that have either the power base or access to the decision process that provincial medical or hospital associations enjoy. As citizens and taxpayers, people do exercise some influence by electing government, but this does not make them insiders. Other exogenous variables include inanimate forces like fiscal crises and certain kinds of technological changes that affect behaviours.

To the extent that insiders saw their interests as potentially vulnerable, they constituted a major barrier to consensus reforms in two of the
four policy domains: governance arrangements and financial arrangements. Provincial medical associations were the quintessential insiders in protecting their interests. Over the 1990–2003 period of study and the update to 2011, their relationships with provincial health ministries became progressively more intertwined. Other provider groups sought, often less successfully than medical associations, to protect their interests in the status quo. Outsiders played a similar blocking role in respect of consensus and counter-consensus reform proposals in the other two domains, delivery arrangements and program content.

In the case of provincial medical associations, much of their influence was taken for granted and in some sense barely noted, not only by the public but even by physicians. This was especially so for some non-decisions. For example, almost every commission and task force that proposed regionalization of health-care delivery insisted that the regional authorities should be responsible for medical budgets. Governments knew that medical associations would strongly oppose the transferring of medical budgets to regional authorities. They therefore chose to ignore these proposals, and the idea disappeared as an issue. In speaking of the power of the Alberta Medical Association (AMA), its executive director has stated, “It’s not so much what we can do on our own, which is minimal actually, but it’s what we can stop, which is a lot” (cited in Archibald and Jeffs 2004).

Delivery arrangements touched Canadians directly. When concerned about developments, the public found a way of communicating with government, albeit not necessarily directly. Civil society groups were, however, quick to draw attention to delivery issues. A majority of Canadians also showed strong support for the values embedded in universal, pan-Canadian, publicly administered and publicly financed hospital and medical services. That politicians took this attachment seriously was reflected in the behaviour of federal and provincial political parties. All parties that aspired to form a government consistently declared their fealty to the Canada Health Act or its values. This federal statute set out the broad criteria and conditions that provincial health insurance law was required to meet in order for provincial health services to qualify for federal financing (discussed further below). Polling data showed that this program, medicare—in essence a provincially administered and financed insurance program, within a framework set by the federal government and with some federal government financial support—was seen by a large majority of Canadians as “embracing Canadian values” (Mendelsohn 2002, 27-28) and as “fundamental to the nature of Canada” (Soroka 2007, 5). Public opinion resisted counter-consensus reform proposals that threatened to weaken the medicare legacy, as seen in the for-profit delivery case. Beyond our six policy reform issues, any proposals that brought into question the first-dollar coverage of hospital and medical services were quickly countered by civil society groups.
Insiders and outsiders did more than fend off reforms they disliked. They also urged reforms that promoted their values or enhanced their interests. But all political actors were better at defending turf than expanding it. The net effects of their efforts tended to cancel out one another. Insiders made it difficult to achieve consensus reforms in the governance and financial arrangements domains, and also exerted considerable influence on delivery and program content issues. Public opinion and civil society groups made it difficult to achieve consensus and counter-consensus reform proposals in the delivery and program content domains. Together, insiders and outsiders posed major barriers to most reforms.

Factors That Facilitated Reforms

Yet some reform did occur. Given the widespread resistance to governance and financial reforms from within the health sector, for those two domains it took factors exogenous to the decision process to force open the windows of opportunity and allow in the reform winds. Fiscal crisis was one such factor on some issues. Fiscal crises obliged governments to contemplate reforms that were politically difficult but that had the potential to make health care more efficient and help contain costs. For the delivery and program content domains, the exogenous pressures for change were more varied, ranging from values that contested the prevailing dominant values (as reflected in the medicare legacy) to technological change.

A further factor associated with reform applied to all four policy domains. It was political change. Of the 30 cases analyzed for this book, the largest reforms typically involved an opposition party attaching priority to health care, campaigning on the issue in a general election, and winning the election. The incoming premier then gave political priority to health care (often through appointing a political champion) and took swift action (in the first half of a first mandate). In order to act swiftly, the incoming government had to know what it wanted to achieve and be well prepared organizationally to fulfill its goals. In some situations, knowing how to use the existing public service was sufficient, in others changes in key public servants were required, and in others still mobilizing political staffers or backbenchers was part of the game plan. The alternative political route was through a leadership campaign within a governing party with the successful candidate making health-care reform commitments and acting on them quickly.

The keys to success were thus mainly exogenous. Political commitment was found to be necessary, but not sufficient, for substantial reform to occur in all four policy domains. Organizational preparedness was also needed to make reform happen. Values were not associated with more or less reform among the 30 cases.
LEGACIES AND LESSONS FROM THE PAST, 1945–1989

The past always influences the present and future. In the final section of this introduction, we note five factors associated with the years from 1945 to 1989 that cast light on or had implications for the period we studied (1990–2003) and the update (2004–2011). First is the broad consensus that health insurance was the priority issue for the health sector during the earlier period. Second, there was the clarity of policy choice associated with the insurance priority. It was possible to articulate the policy options in a manner that enabled people to understand trade-offs. The third relates to the impact of federalism on reform. The next is the Canada Health Act as symbol, and the last the relationship between provincial governments and provincial medical associations.

Health Insurance: The Priority Issue

During the years from 1945 to 1985, health insurance was the priority health policy issue for Canadians. While there were divergent views about how to achieve insurance coverage, there was little disagreement on its importance.

This consensus was a legacy of the 1930s and Second World War. Many Canadians had endured years of penury and desperation during the Great Depression of the 1930s. During the war years, they had paid even more dearly in lives lost, ruined health, and fiscal resources. As the war drew to a close the public mood, in Canada and other democracies, was one that demanded a better world. Individuals and families had done their fair share, and often vastly more, for society. Now it was society’s turn to reward the individuals who had given so much for their country.

The Dominion had prepared for the postwar world. In its White Paper on Employment and Income (Canada 1945) and Green Book on Reconstruction (Dominion-Provincial Conference 1946), the federal Liberal government outlined a new social contract for Canadians. To achieve high and stable levels of employment and income, the government committed to facilitate private enterprise as an engine for job growth, to use public enterprise where the public interest required it for national economic development, and to offset periods of weak labour markets through macrorconomic counter-cyclical policy (fiscal and monetary policy), automatic stabilizers (unemployment insurance), and trade liberalization. A second set of commitments was directed at war veterans to help their integration into society. A third focus was on social insurance. To avoid a return to the social insecurity that had prevailed in the 1930s, the Dominion government further undertook to protect individuals against
the contingencies of unemployment, sickness, and old age (Dominion-Provincial Conference 1946, 59). With respect to sickness, in particular, the vast majority of Canadians had no hospital or medical insurance, private or public. Given the constitutional division of powers that assigned the lion’s share of law-making authority on illness and injury to the provinces, the Dominion’s plans on health were predicated on provincial agreement. Fulfilling the part of that commitment that involved hospital and medical services took a quarter century and then some additional time when the bargain was subsequently challenged. It required deep commitment to achieve what was done.

Compared to the 1945–1989 years, during the period we studied there was less societal consensus about health priorities. It had taken cataclysmic change to facilitate the priority-setting in the post–Second World War years. The absence of clear priorities in the 1990s and beyond was thus not so much a character flaw as a sign of the times. But it affected the record of achievement.

**Competition of Ideas and Interests, and Policy Choice**

During the decades after the war, there was a competition of ideas and interests about how to act on the insurance priority. It can be thought of in terms of two axes of policy choice that sometimes intersect and sometimes do not. On one axis were a range of possibilities from the idea that health insurance should be mainly a matter of personal responsibility and individual choice to the opposite view that it should be mainly universal and mandatory as a matter of law. What were the trade-offs? Was the answer the same for all health services?

A second axis related to the role of government. Was this a matter for each province to decide alone within its own legislative jurisdiction? Or should the decision-making involve the federal government in partnership with the provinces? The implication of federal-provincial partnership was that the federal government would pay a share of the costs.

In practice, the intersection of these two axes created three policy paradigms. One is described as the “Canada-wide public payment/private delivery” paradigm, the “Canada-wide public payment” paradigm or just the “Canada-wide” paradigm. This paradigm, reflected in the Green Book on Reconstruction (Dominion-Provincial Conference 1946, 86-93), had government as the single payer but variation in delivery. In everyday language this is what Canadians now call “medicare.” For medical services, the Canada-wide paradigm contemplated a continued large role for fee-for-service physicians and close to an exclusive role for private not-for-profit corporations in the delivery of hospital services.

A second paradigm favoured “private payment/private delivery.” It reflected the view that individuals should be responsible for their
health-care costs and that the market would provide a choice of competing insurers. For-profit delivery would be common, including in the hospital sector. Provincial governments would play a residual role by subsidizing the insurance of the poor. The federal government had no status in this paradigm.

“Provincial payment/private delivery” was the third paradigm. It involved the individual province as payer with delivery as in the Canada-wide paradigm. Like the Canada-wide paradigm, it too contemplated a continued large role for fee-for-service physicians and close to an exclusive role for private not-for-profit corporations in the delivery of hospital services.

In some provinces the governmental axis (exclusively provincial versus provincial/federal cooperation) was dominant. For example, the government of Quebec has consistently objected to any role for the federal government, whether the government in power leaned to private payment or public payment (Quebec 1998). The government of Alberta has traditionally leaned in that direction also. Conversely, in some other provinces, more weight was assigned to the payment axis. The government of Saskatchewan argued for a Canada-wide public payment arrangement for hospital services in the mid-1940s. But when it was not forthcoming, the government undertook its own hospital insurance plan. A similar set of events accompanied Saskatchewan’s introduction of medical insurance.

The three paradigms reflected well the competing ideas and interests that were current and made it relatively easy to understand policy choices and their consequences.

Impact of Federalism on Reform

In the above discussion of barriers to reform and factors that facilitated reform, there is no mention of the “federal government” or “federal-provincial relations.” Does this mean that Canada’s federal system was a relatively small factor in explaining outcomes?

Federalism may have made a difference in two ways. One was by acting directly on the dependent variables (that is, the actual decision to be made). The second was through indirect routes. With respect to direct effects, the analysis will show that the federal government and federal-provincial relations had a small (barely perceptible) influence on the reform outcomes in the 30 cases taken as a whole.

Yet the history of medicare in Canada prior to 1990 is untellable without an understanding of federalism. At different points along the road different actors prevailed: a single province (Saskatchewan) blazed a trail twice; Ottawa led on several occasions, pulling recalcitrant provinces along; groups of provinces led, dragging Ottawa and other provinces forward on hospital insurance; and all jurisdictions agreed to the creative
use of ambiguity (conditional opting out) to sustain harmony in a federation with much diversity. Put simply, when reform is attempted at the Canada-wide level, whether successfully or not, federalism is a major factor shaping reform decisions. When reform is not countrywide, it follows that federal-provincial relations and the federal government are less visibly engaged. But federalism may be influencing events or non-events in other indirect ways.

For example, the policy agenda of the federal Liberal government of Jean Chrétien, during its first five-to-six years in office (1993 to 1998/99), was quite different from that of most provinces. It emphasized divisive issues in federal-provincial relations, drawing the attention of the media and the public away from important reform issues that were within provincial jurisdiction. A second and closely related example stems from one of those divisive issues. We are referring here to the large cut in federal cash transfers to the provinces announced in 1995 and implemented in part beginning in the 1996/97 fiscal year. With a time lag, provincial premiers decided to give the restoration of these fiscal transfers top billing in their relations with Ottawa. In so doing, they diverted energy that might have been directed to health reform.

The Canada Health Act as Symbol

The Medical Care Act, 1966 required that provincial medical insurance plans provide, as a condition of federal matching grants, for the furnishing of “insured services upon uniform terms and conditions” and that the compensation arrangements for physicians “not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons” (section 4). “Reasonable access” was not defined. By the late 1970s, six provinces allowed extra-billing as part of their accommodation of the medical profession (Tuohy 1999, 93). Physicians in some of the permissive provinces began to step up “extra-billing,” and their freedom to do so was supported by their provincial governments (Taylor 2009, 428-62; Tuohy 1999, 93-95). This triggered a series of responses in Ottawa that led ultimately to the enactment in 1984 of the Canada Health Act (CHA) with all-party support. The CHA authorized the federal government to impose financial penalties on provinces to the extent of extra-billing by physicians or user charges by hospitals and clinics. The aim of the penalty provisions was to discourage provinces from allowing these charges. It is the symbolic aspect of the CHA and the politics of the process that led to it, however, that are of interest here.

By restating and clarifying the broad principles of the old hospital and medical insurance legislation, the CHA gave enhanced profile to the overarching health “rights” of Canadians within the Canadian social contract.9
The process leading up to the Canada Health Act involved much acrimony between the federal government and several provincial governments and between the federal government and medical associations. In separate actions, the Canadian Medical Association and the Ontario Medical Association (OMA) unsuccessfully challenged the constitutionality of the CHA (dealt with together by the court). Physicians in Ontario went on strike. The last recourse for the OMA was public opinion. The language it used was seemingly intended to bring the public to see the CHA as threatening the quality of medical care (Taylor 2009, 455-60).

Public opinion polls helped settle the matter. An Environics Poll in 1977 had asked the following question: “Should medical care be guaranteed by the government?” The answer “yes” was given by 72 percent of respondents. The question was repeated in 1985, the year after the Canada Health Act was enacted, and again in 1991. The percentages answering “yes” were 95 and 96 (cited in Mendelsohn 2002, 27). In 1998 a poll by Earnscliffe found that over 86 percent of respondents agreed that “medicare embodies Canadian values” (ibid.). It had thus become near-impossible for any government or would-be government to question the merits of the Canada-wide public payment paradigm.

Many years after the enactment of the Canada Health Act, Monique Bégin, the former federal minister of health who had led the Liberals on this issue, acknowledged that medicare, as reflected in the CHA, had acquired a symbolic status. She also argued that it had become too narrow, too restrictive: “Legislation based solely on hospitals and doctors, as is the CHA, is not appropriate at all, and is even detrimental to good health policy” (Bégin 2002, 4). She argued that it could and should be reopened and proposed a list of reforms that included most of the issues that had been part of the First Ministers’ Accord in 2000.

Bégin may not have been wrong that the issue should be reopened, but it has been more than 10 years since she delivered her message and not much has happened. For leaders to the right-of-centre, it appears that the overall popularity of medicare has entailed political risks vis-à-vis their electorates that they were just not willing to take. For leaders to the left-of-centre, the goal was to extend the services covered by the CHA. It appears, however, that they were unwilling to risk reopening the CHA without the certainty that the outcome would improve insurance coverage and that commensurate incremental financial resources would be made available for that purpose. Even during the years of fiscal plenty, this would have meant arguing for more money against other worthy causes. Implicit in this latter position was that there was nothing to be gained by attempting to improve the design of the CHA (using equity and efficiency criteria) within existing resources, even though it is difficult to find a leader, political or otherwise, who would design the medicare program as it exists now if she or he were starting from scratch. In evolving from a health insurance program to something politically sacred, the
CHA has seemingly narrowed the room for certain kinds of macro-health policy reform. Indeed, it has been argued that the values embedded in the CHA have become so entrenched in most provinces, both politically and in provincial health insurance legislation, that the narrowing affects reform prospects in individual provinces as it does at the pan-Canadian level (Gildiner 2006).

Relations between Provincial Governments and Provincial Medical Associations

When individual provinces first began implementing their publicly insured system of medical services, each decided to use the fee schedule of the existing not-for-profit insurance company that was owned or approved by the medical association in that province. This made it unnecessary for provincial governments to develop new fee schedules from scratch or to replace them entirely with alternative payment methods such as capitation or salary. Developing new fee schedules would have required governments to assess the value of primary care physicians relative to specialists and to take a stance as well on the relative value of different kinds of specialists and their procedures. The process would have been technically complex and politically very difficult. Introducing a method of payment other than fee-for-service would have been less technically complex but even more problematic to relations between governments and the medical associations and unions (Quebec only) that represented physicians. In contrast, adopting existing fee schedules was a simple approach. Adopting the schedule was also a way of assuring physicians that neither their livelihood nor manner of serving patients would be endangered by publicly financed medical services. The technical complexity could be avoided in the short run.

The short-run benefits of adopting existing fee schedules had long-run consequences. The adoption of these schedules established a pattern in the relationship between provincial governments and provincial medical associations that continues to this day. On the one side, provincial governments came to rely on medical associations for help in determining how to allocate periodic adjustments to physician fee schedules. On the other, provincial medical associations and unions came to value their insider role in allocating fees. Over time provincial governments recognized the medical associations in their provinces as the sole authorized bargaining agents on behalf of physicians. (Quebec had separate unions representing general practitioners and medical specialists.) Periodically, a newly elected provincial government would question and even challenge this recognition. But in each case the government backed off, apparently deciding that there was more to be lost than gained by challenging organizations representing physician interests.
Negotiating medical services budgets and their allocation was not the only role that provincial medical associations played relative to provincial governments, although it was the most publicized. By the 1990s, the provincial government–provincial medical association relationship had evolved stepwise into something greater (Lomas et al. 1992). Since fee negotiations alone did not provide a firm ceiling on the medical services budget, the fee negotiations were expanded to include items like physician supply and utilization intensity. Lomas et al. (1992) noted that items like the relative value of different services, alternative forms of payment like capitation and salary, and quality assurance also had the “potential” to be absorbed through this channel. They proved prescient. Tuohy (1999) subsequently described the relationship between provincial health ministries and provincial medical associations as one based on “mutual accommodation.” Tuohy also observed a trend toward more formality in the way these bodies related to one another and confirmed that the agenda was becoming much broader.

Legislatures have given periodic approval to changes in physician remuneration, and provinces have acknowledged medical associations or unions as exclusive bargaining agents for physicians. But to our knowledge, the wider relationships referred to by Tuohy and Lomas have not been thoroughly debated in any of Canada’s legislative bodies. They appear not to have been anticipated in the 1960s and 1970s when medical insurance was introduced. But they flowed logically out of the decisions taken then to continue with fee-for-service as the prime mode of physician payment. For more than a decade now, these arrangements have been governed by master agreements between the provinces and their medical associations. These agreements have, on the whole, become increasingly long, formal, and complex. They are also opaque. It is thus difficult for the outside observer to assess their impact.

**Road Map**

Chapter 2 elaborates on the methodology and theory that underpin our research. Chapters 3 to 7 analyze the six reform issues in Alberta, Saskatchewan, Ontario, Quebec, and Newfoundland and Labrador.

Chapter 8 analyzes the 30 cases to determine the kind of reform and extent of reform in each. It then accounts for the reform decisions, treating the five provinces as a single entity. Using cross-provincial and cross-issue analysis of the 30 cases, chapter 9 provides both a more comprehensive and yet fine-grained explanation of the reform decisions. Chapter 10 provides alternative ways of “measuring” reform. It also compares our findings to the existing literature.

Chapter 11 focuses on the period from 2004 to 2011. It analyzes the extent of reform and the evolution of the factors that shaped outcomes. Chapter
12, the final chapter, links the past to the future, asking what our studies suggest about the prospects for health policy reform going forward.

NOTES

1. These are observations often made by pollsters Nanos Research (2012) and Ipsos-Reid (2010), respectively.

2. The start date for Canada-wide hospital insurance was 1958 and for Canada-wide medical insurance 1966. However, the start date for the first provincial hospital insurance plans was 1 January 1947 and for medical insurance 1962.

3. The annex is based on reviews of these reports undertaken for this project by Kevin O’Fee. The reviews are available on the project website at http://www.queensu.ca/iigr/Res/crossprov.html.

4. Our focus in this book is on health-care policy reform, although in some places we refer simply to health-care reform for ease of reading. We acknowledge that much reform often occurs for reasons unrelated to policy change, for example, as a result of new breakthroughs in science and technology.

5. Mendelsohn’s “review examined surveys from CROP, Decima, Earnscliffe, Ekos, Environics, Goldfarb, Ipsos-Reid, and POLLARA, as well as Canada Health Monitor/Berger Report, the Centre for Research and Information on Canada’s annual ‘Portraits of Canada,’ and quantitative and qualitative data collected by the National Forum on Health (Government of Canada), the Saskatchewan Public Commission on the Future of Medicare, and a number of international studies” (Mendelsohn 2002, 1).

6. The 2009 OECD figure for total Canadian health expenditure as a share of GDP is slightly above the CIHI figure for the same year. The OECD adjusts national figures to ensure data comparability.

7. In addition to Canada, countries surveyed include Australia, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom, and United States.

8. The Medical Care Act, 1966 had no preamble that set out its lofty aims. The Canada Health Act, 1984 has a preamble that spells out its overarching purposes.