Project Research Paper

A Cross-Provincial Study of Health Care Reform in Canada

Academic Literature Review: Synthesis Paper

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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 the domains of 'political contention', and the division between technical and political spheres, or the domains of 'political control' (Starr 1982; Starr and Immergut 1987).

It is unsurprising therefore that Canada's health programs invite considerable debate. The 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 of greater market intervention and incentives. Criticisms are also echoed, although somewhat more circumspectly, by traditional allies of the welfare state, who argue, "the edifice of social protection in many countries is 'frozen' in a past socioeconomic order that no longer obtains…" (Esping-Andersen 1996:2).

Despite these significant social, economic and political pressures, the essential features of Canada's health care system have remained largely unchanged for well over four decades. Canadians continue to receive first-dollar coverage for all medically necessary hospital, diagnostic and medical services according to the principles laid out in the first Royal Commission on Health (the Hall Commission) in 1964, and since enshrined in the *Canada Health Act* of 1984. This paper will survey the Canadian public policy literature to explore and better understand the sources of this apparent stability.

THEORETICAL FRAMES FOR POLICY ANALYSIS

The remarkable resilience (or stagnation, depending on one's perspective), of Canada's health care system has been the subject of numerous studies and analyses. These analyses can be characterized according to the primary variable on which they focus: institutions, ideas, interests and political-economic structures. Before moving to a review of the Canadian public policy literature on health reform, these four theoretical frames for policy analysis will be reviewed briefly.

Institutional Approaches

Institutions are broadly defined as "the formal or informal procedures, routines, norms and conventions embedded in the organizational structure of the polity or political economy" (Hall and Taylor 1996:938). The historical school of the institutionalist approach is prominent in the analysis of the development and reform of Canada's health care systems (for example, see Hacker 1998, and Maioni 1998). These studies posit a direct, mutually constitutive relationship between institutions and the behaviour of state and societal actors. "[H]istorical institutionalism represents an attempt to illuminate how political struggles 'are mediated by the institutional settings in which [they] take place.'" (Thelen and Steinmo 1992:5). These institutional settings influence, but do not determine, the selection of particular policy goals, the perceived interests of actors, and the resources through which they can pursue both goals and interests. The historical approach incorporates the importance of path dependence (i.e., the fact that past decisions necessarily limit the range of possible actions and decisions at any given point in time) (Rose and Davies 1994; Thelen and Steinmo 1992; Wilsford 1994), and policy feedback (i.e., that past policies themselves create and influence politics) (Coleman, Atkinson and Montpetit 1997; Heclo 1974; Pierson 1993).

Historical institutionalist analyses demonstrate broadly the importance of institutional variables, ranging from formal macro-level political structures (such as parliamentary systems and federalism) to meso-level structures (such as party systems and the number and type of access points to government decision makers), in influencing how some policies become institutionalized, and therefore successful, while others do not. Institutions influence the government's policy capacity (Boase 1996; Hacker 1998; Steinmo and Watts 1995; Weaver and Rockman 1993), create opportunities and constraints for societal groups (Coleman and Skogstad 1990; Immergut 1992; Maioni 1997; Maioni 1995), and facilitate the promulgation of policy ideas (Thelen and Steinmo 1992:25; Hall 1992; Maioni 1997).

The impact of institutions on government's capacity to make policies is evident in the 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 opportunities or constraints for social groups to influence the policy process. For example, "the organization of provider interests in the health field mirrors the federal structure of the state" and 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 and community, and region and country… The fact that the division of federal 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

In addition to institutions, policymaking occurs within the "context of a prevailing set of political ideas. These include shared conceptions about the nature of society and the economy, various ideas about the appropriate role of government, a number of common political ideas, and collective memories of past policy experiences." (Hall 1989:283). Ideas are more than simply functional 'hooks' on which to hang self-interest and motivations. They have a formative influence on political goals, institutions and interests. They establish the basic moral and empirical parameters within which an issue comes to be seen as a political problem (agenda setting or issue framing), and influence the choice of causal stories and strategies for its solution (policy formulation) (Blyth 1997; Goldstein and Keohane 1993; Kingdon 1994; Rochefort and Cobb 1993; Stone 1989). In fact, "many political struggles can be understood as efforts to embed systems of meaning and political discourse within a nation." (Atkinson 1993:26).

Ideas are comprised of *values* – normative beliefs and assumptions about how things ought to be – as well as *knowledge* – learned cognitive models based on information and experiences about how things actually are – about causal pathways between desired goals and the strategies to attain them (Bhatia and Coleman 2003). These ideas constitute the political discourse of a nation, the structure of which becomes embedded in institutions and associations of actors. For example, the normative values that underpin Canada's health care system are represented by the principles of the *Canada Health Act*, most importantly universality and equality of access to necessary medical care (Giacomini et al. 2000; Marmor et al. 2002). The cognitive paradigm that structures the majority of health policy issues in Canada, and indeed many developed nations, is a rather short and straight causal pathway between curative medical intervention and good health (Burke and Stevenson 1993; Lewis 1999). Alternative causal pathways, such as those articulated by Evans and Stoddart (1990), include numerous other determinants of health which are difficult, if not impossible, to reconcile politically with the deeply institutionalized medical paradigm (Lavis 1998).

Interest-Based Approaches

Interest-based approaches place the focus of analysis on the groups involved in the policy process. The most prominent of these approaches is pluralism. Pluralist approaches posit that competition between and reconciliation among different groups in society is the most influential political dynamic underlying the policy process (Howlett and Ramesh 1995). In an ideal-type pluralist system of interest representation, all groups in society would be represented and would compete equally for information, resources and influence. For example, in the health care system, service and provider groups, including physicians, as well as manufacturers of pharmaceuticals and medical equipment, private insurers and employers, and consumers and citizens, would each have equal power and resources to influence policy decisions. However, it is clear from the example of health care, where the dominance of the medical profession is largely undisputed, that all groups are not equal. Furthermore, traditional pluralist approaches also diminish, or at least underestimate, the role of government actors in the policy making process. The significant presence of the state in Canadian health care politics is self-evident in the 'private practice, public payment' social bargain on which the system is premised.

Recognizing these limitations, pluralism has evolved into what are referred to as 'neo-pluralism' or 'post-pluralism' approaches. This reformulation recognizes that not all interests are necessarily represented and not all elements of a specific community of interests are represented (Pross 1992). Within this body of work are included the concepts of 'policy communities' and 'policy networks'. Following Coleman and Skogstad (1990:25), policy communities "include all actors or potential actors with a direct or indirect interest in a policy area or function who share a common 'policy focus' and who, with varying degrees of influence shape policy outcomes over the long run." Policy communities thus include state actors and organized interest groups, as well as the general public, academics and the media (Pross 1992). Policy networks, on the other hand, are a smaller subset of the policy community and consist of the "relationships among a particular set of actors that forms around an issue of importance to the policy community." (Coleman and Skogstad 1990:26). Networks are conditioned by institutional rules and structures, which concentrate or diffuse power and resources among some groups, particularly the state. Group characteristics – such as their size and degree of organization and integration – are also important.

The Canadian health sector is largely characterized by fragmented or dispersed degree of state authority and low organizational development of interest groups (Lexchin 2001; Tuohy 1976). This has resulted in what Coleman and Skogstad (1990) refer to as 'clientele pluralism', where state officials are dependent on key interest organizations (particularly medical associations and pharmaceutical manufacturers) to provide expertise and information and to ensure regulatory compliance by their members, and offer such groups opportunities to participate in some aspects of the policy process.

Further complicating policy analysis in the area of state-society relations is the growing activity of 'public interest groups' – that is, groups which purport to "represent very broad, diffuse, non-commercial interests which traditionally have received little explicit or direct representation in the processes by which agencies, courts, and legislatures make public policy." (Schuk, as quoted in Pal 2001:239). These groups are often organized around non-territorial identities, championing a diversity of issues and views that represent 'post-modern' or 'post-materialist' values. They reflect the general decline of deference toward authority, the shift from preoccupation with material gain to lifestyle and social concerns, and the predominance of 'rights talk' (Pal 2001: 64; Nevitte and Kanji 2002; Redden 2002).

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 provincial counterparts, including Alberta's Friends of Medicare and the Ontario Health 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-making (Lomas 1997), and professional regulation (Boase 1994; O'Reilly 2000)

In subsequent sections, the policy literature analyzing health reform initiatives and processes in Canada will be reviewed.

INSTITUTIONS AND THE REFORM OF HEALTH CARE IN CANADA

Federalism

Federalism is by far the most dominant and well-explored variable in the Canadian health policy literature. Constitutional rules allocate jurisdictional authority for health care to provincial governments but a stronger fiscal capacity to the federal level. The resulting political independence (based on 'multiple independent decision points' [Banting 1997]) and policy interdependence has created a shifting dynamic that permeates federal-provincial relations and has profoundly influenced health policy development. Federalism creates a set of autonomous political actors (namely, the constituent governments) which interact with the central government to create a number of different dynamics, including competitive state building, policy innovation, blame avoidance and petitioning of the central government (Pierson 1995:459). As a result, the dilemmas of shared decision making that are inherent in federalism are more likely to result in satisficing rather than optimal policy outcomes; focus on institutional and jurisdictional protections more than actual policy content; and lead to opting-out or unilateral action on the part of both levels of government. Furthermore, federalism creates an important dynamic within the party system since it tends to channel partisan conflicts along federal-provincial lines. At the intergovernmental interface, partisanship coupled with jurisdictional dilemmas "in general…produce policy outputs such as might have been expected from a large coalition government." (Tuohy 1989:143). Finally, federalism also affects how and which societal interests will organize to influence policy. The more decentralized a federation, the more opportunities societal groups (particularly business) have to exercise exit options and enhance their relative power (Pierson 1995). Decentralized federations tend toward decentralized interest group organizations that are able to strategically direct their focus to the level of government that will be most favourable to their cause.

a. Federal and Provincial Government Effects

The era of cooperative federalism following the immediate post-war period gave birth to medicare through conditional, shared cost programs for hospital construction, hospital and diagnostic care, and finally, medical care. State building during this period was less competitive than collaborative between the two orders of government. Relations were typically acrimonious but nevertheless reflected a problem solving decision style based on trust, shared interests and broadly common goals (Dupré 1985). The motivations for entering into negotiations for national

health care programs were different for each order of government, but they shared in the objectives of addressing inequities in the burden of illness both between individuals as well as provinces, and in smoothing Canada's transition to an industrial economy (Banting 1987; Simeon 2002). Both orders of government were also subject to political pressure from their respective constituencies and from other players (namely, organized labour, farmers and the Cooperative Commonwealth Federation) who expected and advocated for a stronger role for government in social provision (Banting 1998; Maioni 1995; Taylor 1987). "In effect, pan-Canadian social policy seemed to rest on a pan-Canadian consensus on the social role of the state." (Banting 1998:59).

In the 1960s, cooperative federalism began to break down, driven initially by the rise of secular Quϑbec nationalism and compounded by other regional conflicts over energy and resources in the 1970s (Simeon 2002:7; Cameron and Simeon 2002). The 1980s brought rapidly rising health care costs coupled with fiscal constraints, placing pressure on both levels of government to reduce their health expenditures. Concurrently, newly elected conservative governments at the federal level and in a number of provinces began to challenge what were perceived to be the appropriate bounds of the social role of the state (Banting 1995; Pierson and Smith 1993; O'Neill 1996). Questioning of policy goals and the nature of the federal political community shifted federal-provincial relations toward a more competitive and conflictual dynamic.

Initially, the renegotiation of the federal shared cost commitment to health and social programs, resulting in the block grants of the Established Programs Financing (EPF) system, appeared to ease some of the tensions between the two levels of government. The 1977 EPF

> removed Ottawa's intervention [into provincial jurisdiction] and the distortion of provincial priorities that the provinces saw as an aggravating property of earlier arrangements. From Ottawa's perspective, the main advantage of EPF was that a large federal spending program was no longer tied to provincial decisions and therefore beyond the control of the federal government. (Malsove and Rubashewsky 1986:104; Taylor 1987).

However, the satisfaction with the new arrangements was short-lived, particularly on the part of the federal government (Maslove and Rubashewsky 1986, Maslove 1998). In addition to fiscal considerations (namely, that the provinces were receiving more money than they would have under the old arrangements; see Brown 1986), the federal government was dissatisfied with its reduced visibility to most Canadians – it "felt that it was not receiving any political credit or recognition for the very large level of funding it was providing." (Maslove and Rubashewsky 1986:108) Moreover, it accused provincial governments of reneging on the agreement by diverting funds to non-health care programs and eroding medicare by tacitly allowing user charges (Taylor 1986:19). The government moved toward unilaterally modifying these federal-provincial arrangements. On the one hand, it reduced its fiscal commitment by limiting the cash portion of the EPF transfers, and on the other, it increased the public visibility of its role by legislating the *Canada Health Act* (CHA) in 1984, which formalized federal conditions on how health transfers were spent by the provinces and instituted cash penalties for provincial non-compliance. The CHA is a classic case of federal unilateralism and state building. Implemented against the loud and unanimous objections of provincial governments, the CHA allowed the federal government to "be seen to be acting to preserve a popular national program without having to take responsibility for implementation. Moreover, …[the Act] cost the federal government very little." (Gray 1991:129; Taylor 1986). The federal minister of health was given

the power to withhold funds from provinces in which she felt that the principles of the Act were not being met. The dispute resolution mechanism of the Act required minimal consultation with the affected province, and essentially left the federal minister full discretion to interpret and enforce the legislation (Lazar et al. 2002).

The culmination of this federal unilateralism was the federal government's announcement of the Canada Health and Social Transfer (CHST) in 1995, which consolidated program transfers to the provinces into a single block payment and reduced the overall cash amount substantially. The CHST was purported to loosen federal conditions on cash transfers, but at the same time, enhance Ottawa's position to enforce some of those very same conditions in the near future (Maslove 1996; Phillips 1996). The announcement of the CHST seemed to follow in the same pattern of unilateralism as the CHA, and was widely viewed as simply another federal government tactic to reduce expenditures and its deficit at the expense of the provinces (Cohn 1996; Maslove 1996; Phillips 1996).

Events in the mid-1990s, particularly the very narrow margin of victory by federalists in Quɘbec's October 1995 sovereignty referendum and the economic crisis faced by much of the country, forced a shift in Ottawa's approach to federal-provincial relations (Lazar 1998). Learning from the failure of 'mega-constitutional' politics in the early 1990s, the federal government committed itself to a 'non-constitutional renewal' of the Canadian federation. This renewal was intended to demonstrate greater flexibility in federal-provincial relations on various policy issues, including social policy. Negotiations aimed at arriving at a new 'social union' for Canada reflected a more collaborative and less hierarchical tone. Recent intergovernmental agreements, such as the Social Union Framework Agreement (SUFA), stress that formal constitutional authorities remain unchanged, but that governments are committed to "exercise these powers in a 'coordinated manner'"(Cameron and Simeon 2002:63; Lazar 1998). However, intergovernmental relations in Canada remain rather ad-hoc and unpredictable. The intergovernmental process "has no constitutional or legislative base, little backup by bureaucrats linked to the success of the process rather than to individual governments, no formal decision-making rules, and no capacity for authoritative decision-making. This means that the scope or extent of intergovernmental relations remains heavily dependent on whether the first ministers, especially the prime minister, find it advantageous or not. The system in this sense is fragile." (Cameron and Simeon 2002:64). Despite recent intergovernmental discussions about implementing one, Canada also lacks a formal dispute resolution mechanism specific to health care. "Instead, it has relied on a system of intergovernmental relations that is weakly institutionalized, with no decision-making rules and no settled process for tackling the resolution of disputes." (Lazar et al. 2002:14; O'Reilly 2001)

The past two decades have engendered some of the most trenchant debates and analyses of federalism and its role in Canadian health care policy. While most analysts agree that federalism has had a formative role, the nature of that role is disputed on both normative and empirical grounds. Far from pointing the way forward, these analyses demonstrate the complexity of the issues and relationships involved.

Competitive State Building. As Keith Banting (1995:270) notes, "The welfare state has long been recognized as an instrument of social integration, capable of mediating conflict and preserving stability in divided societies." Although a great deal of attention has been given to the role of the welfare state in mediating social cleavages, less attention is given to the important effects of social policy on integrating territorial political communities. To the extent that Canadians are a 'federal society', the latter function has particular resonance in Canada.

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. "[T]he core of the citizenship regime was a strong and active federal government, providing and protecting the social rights of individuals and the culture of Canada" (Jensen 1997: 636). This regime included social programs, health care in particular, and was premised on the idea that "Canadian citizens should have similar social rights and obligations regardless of the province in which they live." (Lazar and McIntosh 1998:7; Banting 1998; Mhatre and Deber 1992; Redden 2002). Banting suggests that the "pan-Canadian dimensions of the post-war social union contributed to higher levels of equity and efficiency in the design of the welfare state than could have been reasonably expected from a more decentralized regime." (1998:51). The success of the federal government's state-building seems evident in public opinion: "At the symbolic level, Canadians are highly attached to the Canadian universal health care system, believe it is part of the Canadian identity, and resist changes that would destroy this symbol…72% [of Canadians] believe that Medicare embodies Canadian values…" (Mendelsohn 2002:2).

Notwithstanding public opinion, however, provincial governments have increasingly challenged the legitimacy of both the notion of a pan-Canadian identity and the federal government's role. A number of provincial governments, particularly Quʒbec, have argued for classical federalism, or the 'federal principle',[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 Quʒbec 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, as is the case with the CHST for health programs, is a form of 'hegemonic cooperation' and a violation of the federal principle on which Canadian federalism was based (Noël 2000).

Policy Preemption. The constitutional division of powers in Canada along different sectors results in

> a system of parallel rather than interlocking governments, with each government asserting the right of unilateral action in its separate jurisdiction…The wide scope for unilateral action arising from the way powers are divided in the constitution provides the conditions for the aggressive unilateralism and 'thrust and riposte' that characterizes much of the recent history of Canadian intergovernmental relations. In these conflicts, the rules themselves have been high on the political agenda. (Painter, as cited in Pierson 1995:464).

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[1] The federal principle is defined as "'the method of dividing powers so that the general and regional governments are each, within a sphere, coordinate and independent.'" Thus "federalism represents a system of government 'under which the ordinary powers of sovereignty are elaborately divided between the common or national government and the separate states.'"(A.V. Dicey, as cited in Telford 1999:6)

This pattern of policy preemption – that is the initiatives of one level of government that complicate and in some way influence the initiatives of the other level – is quite evident in medicare's development. The *Canada Health Act* and changes in the level of cash transfers to the provinces are classic examples of this dynamic. Since federal jurisdiction in health care is limited mainly to the spending power, the only unilateral decisions it can make are respecting cash transfers.

The actions of provincial governments within their own jurisdictions have been used to justify and explain a number of pre-emptive federal initiatives. The growing prevalence of user charges in virtually all provinces and for all insured services was a primary impetus for federal action in enacting the CHA (Bégin 1988). Conversely, federal actions have clearly complicated provincial policy initiatives as well. Apart from the obvious shaping of provincial priorities in the development of medicare through targeted transfers, such as those for hospital construction, hospital and medical insurance, federal spending has also had an impact on the way provincial governments have tackled health care reform. Reductions in federal transfers have been a significant factor in shifting the public-private ratio of health expenditures at the provincial level, but primarily in sectors not covered by the *Canada Health Act*, such as home care and pharmaceutical products (DiMatteo 2000). Some provinces also used the guise of federal cutbacks to undertake their own extensive reductions in a number of health sectors. Federal cutbacks have also complicated, or in some cases 'crippled' the transition toward more integrated delivery systems in many provinces since provincial governments were forced to reallocate funds from new reform initiatives toward supporting existing programs (Fierlbeck 2001). Interestingly, CHST cutbacks also influenced the pattern of spending between other departments within each province. "[D]espite the fact that other provincial departments' budgets were cut in order to maintain health spending, the recent increases in federal transfers are conditional upon only being used within the health sector." (Fierlbeck 2001:164). The implication is that provincial priorities in these other departments – ranging the gamut from education to environment to roads – are also indirectly but profoundly affected by federal decisions regarding health transfers.

Policy Innovation and Diffusion. A central tenet of federalism is that a decentralized and disentangled federation encourages competition between jurisdictions and may result in better public policy. "[Competition] originates in the desire of government to obtain the support of citizens by providing them with the policies they want…" and thus creates incentives for government to develop more innovative and efficient new policy ideas (Breton 1989:476; Courchene XXX; Richards 1998). John Richards (1998:94-95) suggests "decentralization encourages a more efficient use of scarce resources because it encourages innovation, reduces managerial scope, constrains the ability of politicians and interest groups to shift costs, and lowers the costs of determining public preferences." He cites the pioneering role of Saskatchewan in medicare as a prime example of the positive effects of this dynamic (also see Maioni 1988; Taylor 1987).

At the same time, however, it is clear that some centralization is necessary to facilitate diffusion of policy innovations within the federation. Without fiscal equalization and federal cash transfers, many provinces could not sustain the level and quality of health and medical care they currently provide. The role of the federal government in reducing inter-provincial differences in fiscal capacity was and continues to be critical for ensuring reasonably similar levels of programming across the nation (Adams 2001; Maioni 1998; Taylor 1987). Furthermore, the federal government has also helped to "reduce political barriers to the expansion of social programs and their diffusion across the country…The federal government played a

critical role in forging an ideological compromise among provincial governments on the main directions of social policy." (Banting 1998:52). This latter role is largely a function of the federal 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 efficiency, Banting (1998:55) argues that "a strong social union reinforces the internal economic union" by "reducing formal barriers to [interprovincial] mobility in the form of residency requirements on one hand, and by reducing inefficient incentives to mobility in the form of sharply different benefit levels on the other."[2] Furthermore, a national mechanism limits the exit options of capital and mitigates against a 'race to the bottom' with respect to levels 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.

John Richards (1998:83) argues that "all variants of collaborative federalism entail shared jurisdiction and reduce political accountability of any one government for the quality of social programming." He suggests that strict accountability, which is only possible when the 'water-tight' compartments of classical federalism are respected, generates good social policy, citing Saskatchewan's pioneering in medicare as example. This clear accountability allowed the government of Saskatchewan to innovate in a particularly contentious program area without undue influence from other governments and despite interest group opposition, and, in the spirit of democracy, enhanced the transparency of the government's decisions for the electorate. The lack of clarity in jurisdictional responsibility that is fostered by collaborative federalism enables, and indeed encourages, the buck-passing phenomenon between governments unwilling to take the blame for unpopular policies. Wrangling over health care has become an art form in Canadian intergovernmental politics as each level of government attempts to blame the other for the problems of medicare (Boychuk 2002; Simeon and Cameron 2002)..

The issue of government accountability in health care is one that resonates with Canadians. In recent years, intergovernmental disputes have, in the words of the Royal Commission on the Future of Health Care (2002:53), become "complex and perhaps

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[2] Although Richards (1998) also opposes residency requirements, he argues that instead of using fiscal penalties imposed by the federal government to discourage them, such requirements should be challenged on grounds of Charter mobility rights instead.

dysfunctional," and "Canadians have come to expect greater accountability from the government generally and the health care system specifically…" (Mendelsohn 2002:17). Although Canadians 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 that "the federal government should be actively involved in the health care system" and "by a margin of 59 to 39%, Canadians believe that the federal government has a key role in sustaining the system and ensuring standards, not merely writing cheques." (Mendelsohn 2002:19).

However, as many critics of executive federalism have noted, the often-secretive nature of federal-provincial negotiations violates basic democratic principles by not only compromising accountability, but also excluding the public from debate (Boase 2001; Cameron and Simeon 2002; Simeon and Cameron 2002). This 'democratic deficit' of executive decision-making is particularly salient in times of fiscal restraint, when retrenchment entails imposing sometimes significant losses on members of the citizenry. It may also become more salient in the context of the broader trend toward a decline in the level of confidence the public has for political institutions (Nevitte 1996). There is very little evidence to support a democratization trend in executive federalism in relation to health care despite recent federal-provincial-territorial agreements (such as the SUFA) that include proposals for greater citizen participation and collaboration. The reluctance of both the federal and provincial orders of government to take action on these proposals lends credence to the charge of a democratic deficit within the intergovernmental forum. As Simeon and Cameron (2002:287-8) note, to the extent that strategic issues such as turf wars, credit claiming and blame avoidance, predominate the intergovernmental agenda, "there is little room for participation of groups in particular policy areas."

b. Political Parties and Federalism Effects

The prominence of intergovernmental issues has emphasized region versus centre conflicts, and the relative weakness of Canada's intrastate institutions has shifted mediation of these conflicts to non-parliamentary arenas. Political parties are important arenas for playing out these regional conflicts, particularly regionally based third parties at both the provincial and federal levels (Maioni 1998). The expression of regional interests through the federal structure has two main effects on the party system. First, regionally dominant parties are more likely to emerge in response to regionally defined interests (for example, the Bloc Québécois) and second, in order to accommodate regionally distinct interests, federal parties must make pragmatic, non-ideological alliances between these interests in order to achieve electoral success. In other words, federalism, when based on regional or territorial cleavages, encourages the formation of "distinctive regional majorities or coalitions...[and at the national level] very loose, non-programmatic catch-all formations that can accommodate regional interests." (Chandler, 1987:152-3)

Maioni (1998) and others (for example, see Taylor 1987) use this dynamic to explain the policy innovations that led to medicare in Canada. Maioni (1998:161) concludes that the existence of a social-democratic third party in Canada (the CCF) forced governments at both the provincial and federal level to confront and take action on the issue of medicare. The CCF was a regional party with its primary base of support in the western provinces, and was a coalition of agrarian, labour and socialist interests that had come together in protest against the policy programs of the major parties (the Liberals and Conservatives). One of the key platforms of the CCF was "'publicly organized health, hospital and medical services…'" (as cited in Maioni 1998:56). By 1945, the CCF had been successful in forming the government in Saskatchewan,

and had achieved official opposition status in Ontario. Upon election, Saskatchewan's Premier Tommy Douglas, who is recognized as the father of Canadian medicare, made a personal and political commitment to ensure that health services would become an "inalienable right" of all citizens (as cited in Taylor 1987:80), which he quickly followed through on. In 1947, the government of Saskatchewan introduced the first province-wide hospital insurance plan, and fifteen years later introduced the first public medical insurance plan in North America (Maioni 1998; Taylor 1987).

At the federal level, the demonstration of effect of the CCF government in Saskatchewan was an important factor in pressuring the federal government to proceed with a national program. However, perhaps more significant than policy learning was the political dynamic that the popular CCF was able to engender. The two main federal parties were forced to be more accommodating of 'socialist' views in order to maintain their popularity. The CCF (and later its successor, the NDP) was increasingly popular among Canadians, in part because of its dogged pursuit of a national health insurance scheme in the federal parliament, and the Liberals and Conservatives saw no way to retreat gracefully from the issue. A national hospital insurance plan was introduced by the Conservative federal government in 1957, and with somewhat more effort, the Liberals introduced a national medical insurance plan in 1968. In the latter case, "the fact that all Canadian parties ended up endorsing the measure reflected more the political stakes that its proponents had built up around the issue than an ideological convergence on national health insurance in the Canadian political community." (Maioni 1998:135).

Clearly, the influence of federalism on political parties proved to be critical in the development of Canadian medicare. The salience of this influence has not waned in recent years, although it may be working in a different policy direction. With the regional fragmentation of the federal party system, the official opposition status in the federal House of Commons has, since 1993, been given to one of two regionally-based third parties: the Bloc Québecois (BQ) from 1993 to 1997, and the Canadian Alliance (formerly Reform) from 1997 to the present (Tanguay 2002). True to its western roots and almost exclusively western support base, the Alliance and its predecessor have campaigned on a platform including a decentralized federation, with greater power for the provinces to make policy in many areas, including health care. Although the party has backed away from explicitly endorsing private financing and delivery of traditionally public health programs, it has left open the possibility of such changes by advocating sole provincial jurisdiction for health care. On the eastern front, the BQ, which dominates federal ridings in Québec, has also promoted a highly decentralized federation (when not actively pushing for Québec sovereignty). Although not ideologically opposed to the principles of Canadian medicare, the BQ has simply refused to engage in any debates about the goals of health and social policies that involve a federal role. It seems unlikely that the right-wing Alliance has influenced the federal Liberal government to weaken its commitment to the goals of medicare, given the immense popularity of both the program and of the Liberal party. However, the pressure from the Alliance and BQ to decentralize the federation has undoubtedly added to the urgency felt by the federal government to harmonize intergovernmental relations, including for health care.

At the provincial level, the election of a series of neo-liberal governments, particularly in the two wealthiest provinces Alberta and Ontario, has been the impetus for policy experimentation and innovation in health care, just as the election of a CCF government in Saskatchewan was half a century ago. Some of the experimentation has been in the direction of introducing stronger market incentives and greater private financing into provincial health care

systems (for example, see Barlow 2002; Boase 2001; Evans et al. 2000; McFarlane and Prado 2002). To the extent that some of these innovations are successfully implemented, other provincial governments may also consider adopting them in the future. To date, the federal government has largely refrained from taking action, rhetorical or otherwise, in support or opposition to provincial initiatives.

c. Federalism and Interest Group Effects

Federalism also influences the organization of interests into a federal and provincial structure, and affects their ability and capacity to facilitate or inhibit policy innovations (Tuohy 1989:143). "It is commonly held that federalism multiplies the points of access to government, increases the total number of interest groups within the polity, and affords greater opportunity for groups to exert pressure to remedy grievances." (Weir 1973:59). However, Cairns (1988:159) argues that federalized interest groups may be less effective than unitary ones because local or provincial organizations may compete and contradict one another at the centre, straining the cohesion of the national organization. This may be particularly true in a policy arena that is rife with federal-provincial conflict, such as health care.

The medical profession has been and remains the most significant interest group in the health arena. The Canadian Medical Association (CMA) and its provincial counterparts have been engaged in the political debate about a national health insurance plan in Canada since the 1940 proposals of the Rowell-Sirois Commission. As discussions about state-financed health insurance became more prevalent during the Depression years, the profession strengthened and formalized its confederal structure to facilitate better collaboration between federal and provincial members (Naylor 1986; Weir 1973). As a result, the CMA was able to more effectively represent the profession at the national level and was the most influential group in the formulation of the 1945 federal policy proposals for health insurance (Naylor 1986; Taylor 1987). With the failure of the federal proposals, government inaction facilitated the expansion of private, profession-sponsored medical plans. At the provincial level, medical associations engaged in their own policy pre-emption by organizing their members and providing support for the expansion of physician-sponsored plans in response to the perceived threat of government intervention (Naylor 1986). Furthermore, provincial associations were able to "influence those provincial governments that were ideologically opposed to national health insurance to implement programs which conformed to the CMA's own aims. In Alberta, Ontario and British Columbia, conservative provincial governments went along with profession-designed plans." (Coburn 1988):101-2). Contrary to Cairns' contention, there seems to be little evidence to suggest that the confederal structure of Canadian medicine has created centre-periphery tensions within the profession.

At the same time, however, nor has the national organization been particularly successful in influencing health politics at the national level. The enactment of national medical insurance in 1966, and the consolidation of medical and hospital care in the Canada Health Act in 1984 came despite the concerted and very vocal opposition of the CMA. Weir (1973) argues that the CMA could not effectively counter the concentrated political power created by the parliamentary system, suggesting that federalism has only limited effects on the policy capacity and influence of the medical profession. Similarly, Gray (1991:205) suggests that there is little evidence from Canada (or Australia) to "support the argument that federalism augments the power of groups by multiplying points of access to the processes of policy making… Indeed a case can be made that suggests that the division of power provided governments with a degree of flexibility that facilitated implementation [despite intense opposition from interest groups]." This flexibility

worked in two ways. First, the influence of the federal government and the demonstration effects of successful (and popular) programs in other provinces increases the pressure on remaining provinces to implement those programs, despite strong opposition from provincially-organized interests such as the medical profession (Gray 1991). Second, federalism allows provincial governments to use different methods and policy instruments to tailor the implementation of policies to their own circumstances. Finally, the secretive nature of intergovernmental relations in Canada, discussed in earlier sections, mitigates against the 'greater access' thesis by limiting the degree of effective interest group input (Boase 1994). In the final analysis, Gray (1991: 206) concludes that "to the extent that the provinces are the senior level of government in relation to health, Canada resembles ten unitary systems with ten independent medical associations."

Institutional Structures and State Capacity

Canadian governments are generally considered to have a mix of 'strong state' and 'weak state' characteristics. State strength is a function of a state's autonomy and policy capacity. State autonomy refers to "the degree of independence from societal groups possessed by state actors when they formulate policy objectives. The goals of an autonomous state, including its diagnosis of societal problems and the formulation of policy alternatives to deal with these, are internally generated and not simply reflective of societal interests or demands." (Coleman and Skogstad 1990: 15). State capacity refers to "the ability of the state to draw on sufficient institutional resources both to design policies that will realize its policy objectives and to implement these policies." (Coleman and Skogstad 1990: 16). Autonomy and capacity do not necessarily vary together, nor are they consistent across all policy sectors or all state agencies (Orloff 1993). They may even vary within a specific sector, such as health care, depending on the issues. Since the relationship between the state and societal interests lies at the heart of state autonomy, state autonomy in Canadian health policy will be discussed in conjunction with interest-based approaches in a later section. Discussion in this section will focus on state capacity.

The strength of the state is associated with institutional structures and rules including: constitutional provisions, such as the fused executive and legislative branches of government in Westminster parliamentary systems; rules of convention such as strong party discipline; and electoral rules, such as the first-past-the-post system that tends toward single-party majority governments (Immergut 1992; Weaver and Rockman 1993). Each of these factors influence the number of discrete decision points at different institutional locations – the greater the number of decision points, the larger the number of potential vetoes or "points of strategic uncertainty" (Immergut 1992: 66). In Canada, the executive government in Parliament is selected from members of the governing party, and is almost always assured of parliamentary approval for its decisions. Strong party discipline ensures the support of members of the governing party and the single-member plurality electoral system favours stable parliamentary majorities and thus ensures the support of Parliament. Since there are few decision points at which the executive can be vetoed, the executive is the "effective point of decision" (Immergut 1992: 65). Institutional factors thus create powerful governments at both federal and provincial levels. However, "institutions which concentrate power…[also] tend to concentrate accountability. While power concentration enhances the capacity of governments to achieve their policy objectives, it also increases the risk of being held accountable by the general public for…unpopular decisions…" (Bonoli 2001: 239). In parliamentary systems, the electorate is often the only effective veto on parliamentary decisions, and is of greatest impact when elections are approaching or during times of electoral shifts (Immergut 1992). As a result, the policy impact of strong state capacity and power is "highly contingent." (Bonoli 2001: 244; Weaver 1986).

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 party, which subsequently "caved in" to the CCF demands and agreed to the federal proposals (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 trace, governments will seek to avoid electoral retribution for unpopular decisions. Paradoxically, concentrated accountability makes blame avoidance both a necessary political strategy as well as a particularly difficult one to engage in. In Westminster style polities, governments are preoccupied with blame avoidance, while opposition parties in the legislature are focused on generating blame in lieu of effective involvement in policy formulation (Weaver 1986). Weaver (1986: 393) concludes that blame avoidance "has an important impact on policy outputs, if only the passive one of influencing choices made from a set of alternatives determined by 'good policy' advocates and credit claimers. But blame avoidance also affects the alternatives that are considered."

The stability of popular health care programs may be one policy impact of blame avoidance by government. As groups with vested interests in the policy form around specific programs – the 'claimant and provider classes' – they are more likely to mobilize in opposition to changes in the programs that will adversely affect them (Pierson 1994; Reiger and Leibfried 1998). This opposition raises the profile and public perceptions of high costs associated with the government's policy. "[P]olicymakers fear that new policies will not win them as much support as dismantling the old ones will lose. They are thus afraid to dismantle policies, and when they do, they may 'grandfather' in current beneficiaries so that they do not become losers." (Weaver 1986: 394). Certainly the beneficiaries of the current medicare policy regimes in Canada, particularly providers, are among the most organized and vocal groups on issues of health care reform. Lavis (2002: 8) notes that "physician associations… have been influential as a force for the entrenchment of elements of the core bargains (e.g., maintenance of private practice and fee-for-service remuneration in the *National Medical Care Act* of 1966) and as a force against

proposed repeals of an element of the core bargains (e.g., primary care reform that involves a change in the physician-remuneration method from fee-for-service to capitation)." Among the 'claimant class' – namely the public – medicare programs are also very popular. Public opposition to expenditure reductions and service cutbacks, for example, has frequently been a critical element of government policy reversals (for example, see Cohn 2001 and Bhatia and Coleman 2003).

A second policy impact of blame avoidance is that policymakers will seek out strategies that limit or reduce government discretion, because "they believe that exercising discretion forces them to make unacceptable choices between obtaining substantial credit but very bad policy, on the one hand, or incurring substantial political blame, on the other." (Weaver 1986: 393). Governments can limit their own discretion in a number of ways. Building 'automaticity' into policy instruments, such as prohibiting budgetary deficits, implementing across-the-board budgetary reductions, or developing formula grants in favour of discretionary transfers, helps reduce the visibility of unpopular decisions. Each of these strategies have been used by governments in Canada to contain health expenditures (for examples, see Church and Noseworthy 1999, Phillippon and Wasylyshyn 1996, and Plain 1997 for discussions of these strategies in the health reforms of Alberta; and Pierson and Smith 1993, Phillips 1996, and Maslove 1996, for a discussion of similar strategies employed by the federal government to reduce federal transfers to the provinces).

Another strategy used to create the appearance of reduced government discretion is to deflect blame for unpopular decisions to others. Governments can either pass the buck for the decisions to another group, or when they cannot pass the buck, they may seek a scapegoat on whom to attribute the blame (Weaver 1986). Scapegoating usually involves the claim that the current administration was forced to take action because of the missteps of its predecessors. For example, when elected to office in 1995, the new Conservative premier of Ontario claimed that health system restructuring "was required to undo the disastrous damage of the last 10 years that has left us with an overburgeoning bureaucracy and $10 billion a year in deficits." (Harris, as cited in Harden 1999: 212). While blame-generating claims do not obviate the need to make unpopular decisions, they do attempt to shift the responsibility for the consequences of those decisions to other groups and, at the same time, claim some credit for trying to set things right.

Passing the buck for difficult decisions is a common strategy used by governments in federal systems where jurisdictions overlap or lines of accountability are unclear. However, individual governments in a Westminster parliamentary system are unlikely to be successful in avoiding blame by delegating difficult decisions to others because in such a system, "there are no institutional barriers that a government or its individual ministers can cite to avoid responsibility for a decision or a refusal to act. (Cohn 2001: 33). Cohn goes on to note that "the genius and curse of the Westminster model of government is that it compels the majority party to govern, as the majority has no excuse not to govern." (2001: 41). Nevertheless, governments do seek to pass the buck using a number of different strategies.

An ubiquitous strategy in health care reform has been decentralization, and represents the most extensive reform of the system since its inception (Hurley, Lomas and Bhatia 1994). Since the early 1990s, nine of ten provincial governments have engaged in the regionalization of their health care systems, transferring varying degrees of governance and decision-making authority to sub-provincial regional boards. Although many different rationales are given by governments for pursuing this particular reform strategy (some of which will be discussed in later sections), one that is never given but is almost always inferred is blame avoidance. Lomas (1999: 175) points out that an important government motivation for health system regionalization is "the desire to

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 governments' main motivation for devolving authority." The fact that many of the newly created 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 "join with and orchestrate the local discontent." (Lomas 1999: 181).

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 mandate, it was granted significant governance authority that normally resides with the minister of health (Cohn 2001). The regulations that created the HSRC "allowed the government to offload responsibility for announcing all of the bad news associated with health care reform (hospital closures, layoffs, etc.) onto the HSRC and take credit in the media for announcing all of the good news (the funding of expansion at the surviving hospitals, new jobs in the non-hospital sector, etc.)" (Cohn 2001: 29). However, this particular blame-avoidance strategy failed because the government could not effectively dissociate itself from the decisions of the commission. Cohn (2001: 33-34) points to features of the Westminster system to account for this failure. First, no matter how expert or well-resourced the members of an independent commission are, perceptions of bias will still obtain since they are appointed by politicians from the party in power. Second, the mandate and terms of the commission are established by a minister of the executive of the governing party and are thus equally prone to perceptions of partisan bias. Finally, the minister or cabinet that appoints a commission has virtually unlimited authority to retrieve the authority that is delegated to it. All of these factors came into play in the Ontario case. Perceptions of partisan bias were reinforced by the government's interventions in a number of specific decisions of the HSRC (for example, the commission's plans for restructuring hospital services in the rural ridings of Conservative MPPs and its decision to close the Montfort Hospital, the only French-language teaching hospital in the province). Furthermore, the overall restructuring process generated so much public opposition that the government could not credibly refuse to intervene without appearing to abrogate its responsibilities. The HSRC was shut down one year short of its mandate and the government reinstated health care funding back to its original levels (Cohn 2001).

It is clear that both the scapegoating and buck-passing forms of blame avoidance are particularly difficult strategies for governments to undertake in Westminster systems since "no ad hoc commission, nor other government agency, can be truly independent, since there are no serious checks on the government's ability to remake the agency, its mandate, its composition, nor even any barriers to the government's termination of an independent agency's existence. In other words, such an agency has no guarantee of autonomy beyond the refusal of the responsible minister to use his or her power. This situation is only magnified by the fact that most ad hoc independent agencies in Canada… do not enjoy a direct legislative mandate… but rather have a mandate based on an order-in-council regulation." (Cohn 2001:41). As a result, governments in Canada must resort to different ways of avoiding blame – namely, keeping potentially

contentious issues off the political agenda or by redefining issues in ways that diffuse or obfuscate negative policy outcomes (Weaver 1986). For issues that cannot be kept off the agenda, for whatever reason, governments may use delay tactics to at least influence when the issues will have to be addressed. A particularly effective way, and one which Canadian governments commonly use, is delegating issues to advisory commissions to be studied and reported on at a later date. For example, the Royal Commission on Health Services, announced by Prime Minister John Diefenbaker in 1960, was intended to "remov[e] the issue of health insurance from his active agenda for the next three years [until after the next federal election]. In any event, he had enhanced the confidence of the CMA [which was adamantly opposed to a national medical insurance plan] that the decisions on health insurance would be made rationally by an independent commission and not be distorted by the pulling and hauling of politics." (Taylor 1987: 335). Similarly, countless other commissions, task forces, and committees with a broad range of mandates involving the health care system, have been appointed in Canada at both the federal and provincial levels over the past six decades (for a review of some more recent ones, see Angus 1992 and Mhatre and Deber 1992). Although the use of these groups as a means to delay difficult decisions has not been systematically studied, their numbers suggest that they are an important political strategy and should as such be analyzed further.

The Courts

The judiciary is the 'third branch of government' in Canada and has, particularly since the advent of the Canadian *Charter of Rights and Freedoms* in 1982, had an increasingly significant role in public policy. The basis of judicial review is two-fold: federalism, that is, the judiciary as "an umpire of the federal system," and constitutionalism, that is, the interpretation and application of the Canadian constitution – the 'supreme law of Canada' (Russell 1987; Sharpe and Swinton 1998). The former has given way to the latter in large part due to the addition of the *Charter of Rights and Freedoms* and an explicit acknowledgement of constitutional supremacy in the 1982 *Constitution Act*. The constitutional rules and conventions governing the judiciary in Canada establish "as a matter of law the power of the judiciary to review the constitutional validity of legislation and acts of the executive…" (Russell 1987: 94). The courts may become involved in health policy issues when a complaint is brought forward about the legality or constitutionality of an action or decision of government. Judicial intervention can result in one of three possible policy outcomes: the policy may be confirmed as conforming to legal and constitutional standards; the implementation of the policy may be amended; or the policy may be completely abolished (Greene 1993: 184).

Judicial review of the division of powers has had a profound impact on the nature of Canadian federalism and continues to be an important, if less frequently used, means to resolve jurisdictional disputes. Judicial interpretation of the division of powers has been an influential factor in the decentralization of the Canadian federation from the early federal dominance that was implicit in the *British North America Act* of 1867 (Hogg 1985). Constitutionally assigned jurisdictions for health care are relatively narrow, limited to 'quarantine,' 'naval hospitals' and similar institutions, but have been broadly understood to give provincial governments jurisdiction over health insurance and the supply of health-related goods and services to their populations (with the exception of aboriginal population who are covered by federal jurisdiction). Over the course of the past century, the courts have played an important role in resolving jurisdictional questions and have established the constitutionality of the federal spending power to coerce provinces to participate in programs such as medicare. The federal criminal law power and the 'peace, order and good government' power are also used, although in a very limited fashion, to

justify federal regulation of drugs, new technologies, and narcotics (Flood 2002). The federal government's reliance on the financial penalties of the *Canada 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 modern society, "health is not a matter which is subject to specific constitutional assignment but 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 question." (Estey, as cited in Flood 2002: 12).

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 adjudication "clearly puts the courts in the position of overruling the democratically elected representatives of the people on value-laden questions of public policy." (Sharpe and Swinton 1998: 21). The courts have generally 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)[3], which ensure parliamentary supremacy. Furthermore, governments themselves have abrogated some of their responsibilities by relying inappropriately on the courts to make decisions on overtly political questions – yet another strategy of blame-avoidance for politically or otherwise unpalatable policy decisions (Manfredi 1993).

Notwithstanding the differing views on the democratic impact of the Charter, Charter-based judicial review in issues of health policy has been limited in number and scope. Recent constitutional challenges of government actions in the health sphere have been based on two sets of rights claims: the right to health care (Section 7 of the Charter: "the right to life, liberty and the security of the person and the right not to be deprived of these rights except in accordance with the principles of fundamental justice"); and equality rights (Section 15 of the Charter: "the right to equal treatment before and under the law without discrimination") (Jackman 2002; Sweatman and Woollard 2002; von Tigerstrom 2002). Additional claims have been made by physicians on Section 6 grounds (mobility rights). It is important to note that judicial review regarding rights is not limited to Charter interpretations, but may also include other domestic laws and international human rights conventions (Jackman 2002; von Tigerstrom 2002).

Section 7 of the Charter has clearly established the negative rights of the individual – that is, the right to be free from actions that will threaten the "life, liberty and security of the person." The courts have interpreted this provision to include the right to refuse health care that is perceived to be such a threat, as in consent to treatment cases brought forward on behalf of psychiatric patients and minors (Jackman 2002). Furthermore, the *Morgentaler* case established

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[3] The 'reasonable limits' provision reads: "The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject to only such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society." To apply this provision, the courts have developed the Oakes test, which requires that the government's reason for limiting a right must be pressing and substantial, and that the means used to limit that right must be proportional to the objective.

that restrictions on abortion were a violation of the Section 7 rights of women, and struck down the Criminal Code restrictions on access to abortion services (Greschner 2002). However, a positive legal right to receive health care, or specific health care services, has not been as clearly established through section 7, despite the fact that "government has recognized for some time that access to basic health care is something no sophisticated society can legitimately deny to any of its members." (Wilson, as cited in Jackman 2002: 50). The courts have limited their interpretation of positive rights under section 7 to avoid "unwarranted judicial interference in the health care system," concluding "that 'finding the public funding of particular medical services to be considered an element of the right to life, liberty or security of the person would expand the parameters of judicial review, well beyond its present scope.'" (*Cameron* 1999, as cited in Jackman 2002:5). A particularly interesting and relevant case for governments considering health reforms is *Chaoulli* v. *Québec* in which a physician and his patient challenged Québec legislation which prohibits private insurance payment for services covered under public plans, even in the absence of timely access to insured services. The lower court and Québec Court of Appeal both concluded that section 7 does include a fundamental right to access publicly funded health care services, but that the right of an individual to privately purchase necessary services is subject to the principles of fundamental justice. In this case, the courts used Section 1, the reasonable limits provision to determine that the state is justified in limiting private purchase of services because "allowing a private parallel system would affect the rights of the rest of the population. It would threaten the integrity, functioning and viability of the public system… As a result, it was concluded that the infringement of life, liberty and security of the person was in accordance with the principles of fundamental justice, and there was no violation of section 7." (von Tigerstrom 2002: 166).

Equality rights in section 15 of the Charter have been only marginally more successful bases for challenging government decisions. Given that governments have already established their roles in the provision of health services, they must ensure that these services are available to all without discrimination. "The Supreme Court 'has repeatedly held that once the state does provide a benefit, it is obliged to do so in a nondiscriminatory manner.'"(*Eldridge* as cited in von Tigerstrom 2002). However, the courts have also recognized the realities of the fiscal environments in which health systems must operate, and have accordingly been reluctant to "second-guess the policy making process." (Sweatman and Woollard 2002: 289).

The tenor of the recent court decisions suggests that the courts have, so far, been understandably reluctant to enter into health policy making in any significant way. These decisions have confirmed that the challenged policies conform to legal and constitutional rules, suggesting that concerns about the courts overreaching their roles are largely overstated (at least in the health care arena). As Sweatman and Woollard (2002: 289) conclude, "there is limited room for a plaintiff to successfully challenge a health care resource allocation decision. In that case the only recourse left to patients and their families is to lobby governments for political change." Ultimately, the courts have recognized most policy decisions in health care as inherently political, and have limited the role of the third branch of government.

Summary: The Policy Impact of Political Institutions
The capacity of governments in Canada to make policies is theoretically strong – the Westminster system concentrates a great deal of power in the executive and creates virtually no parliamentary vetoes over the decisions of the government of the day. Moreover, societal interests are also sidelined by centralized decision-making since they have no institutionalized

access points at which to influence policy decisions. The implementation of key pieces of federal legislation in the formation of medicare demonstrates the capacity of government to push through policies despite vocal opposition both within and outside the legislature. Similarly, at the provincial level, a number of governments have been able to enact controversial legislation (for example, Bill 11 in Alberta) despite widespread opposition.

However, there are a number of factors that counter the institutional power of governments in Canada. The first is federalism. Federalism may reduce government capacity insofar as it requires intergovernmental collaboration on many key issues in health policy. Collaboration is clearly not antithetical to the federal tradition, but has been complicated by contextual factors, such as budgetary constraints, as well as by the diverging policy goals and changing perceptions of political community and identity of the governments involved. As Hacker (1998: 73) observes, "the relationship between federalism and broader aspects of the political and fiscal environment is often a more important determinant of policy outcomes than the fact of federalism itself." It is these relationships, arguably, that have been the impetus for the competitive dynamic, unilateral behaviour, and buck-passing between federal and provincial governments in recent years. Conversely, in certain political and economic contexts, federalism can contribute to the policy capacity of governments by facilitating policy innovation and experimentation, as was the case in the development of medicare. Provinces may serve as laboratories within which new policy ideas are generated as well as sites for testing and refining these ideas. Although federalism fragments state authority for health policy between levels of government, it does not seem to privilege societal groups in any definitive way. The confidential nature of intergovernmental negotiations generally excludes all non-state actors, including the public, from directly participating in or influencing policy decisions. Similarly, although some analysts have argued that federalism diminishes the organizational capacity of interest groups, there is little conclusive evidence to support this in the health sector.

The electoral veto is another counterweight to strong state capacity. Concentrated political authority also concentrates political accountability, and governments are reluctant to make unpopular decisions that may compromise their electoral support. Given the deep and stable popularity of medicare with the public and many provider groups, governments are particularly anxious to avoid the negative consequences of policy decisions that involve health program retrenchment. As a result, partisan politics, particularly in the lead-up to elections can have a significant impact on policy agendas. Canada's multi-party system at the national level is a function of the confluence of a number of institutional factors: the single member plurality electoral system, the weakness of intrastate federalism, and the regional/federal nature of domestic cleavages. The electoral threat posed by smaller parties to the larger brokerage parties serves to broaden the spectrum of policy ideas by shifting electoral and political alliances. The Westminster system not only concentrates accountability in the government of the day, it explicitly confers a blame-generating responsibility to the opposition parties. Thus the impetus to avoid electorally unpopular decisions becomes even stronger, and limits the range of policy options that policy makers will consider. To the extent that governments prefer a problematic status quo to making changes that will further alienate their electoral constituencies, blame avoidance behaviour will promote policy stability. When avoiding decisions is impossible, governments may choose to pass the buck by delegating them to others, such as regional health authorities or other arms-length agencies. At the intergovernmental interface, blame avoidance behaviours have been an important part of the poisonous intergovernmental dynamic as each government has tried to avert criticism by redirecting it to the other level.

Judicial review also checks state capacity, but has had only marginal impact on health care policy to date. Although the courts have been deliberately circumspect in their rulings to avoid entering into political debates about public policy, the *Charter* nevertheless greatly expands the number of potential access points for societal groups and for individuals to influence policy decision-making.

This brief overview of institutional analysis in health policy making suggests a highly contingent role for institutions in influencing the policy capacity of governments, the organization of societal interests, and the policy ideas that are dominant. These contingencies include: the nature of the policy domain, namely the beliefs, values and knowledge that define the policy problem; the power relations amongst societal groups and between state and society; and broader structural factors in society itself.

IDEAS AND HEALTH REFORM

Ideational approaches to understanding public policy focus "on processes of *meaning* which may subsequently engender [the] choices [that actors make]. Human choice is the result of attempts of actors to *understand* and *interpret* the world." (Braun 1999: 12; original emphasis). Ideas thus have two dimensions: normative and cognitive. The normative dimension of a policy idea confers subjective meaning on the basis of norms or values, and helps actors to interpret how things *ought* to be based on perceptions of right or wrong, good or bad. This dimension includes beliefs about the nature of a problem, or problem definition, as well as a causal story that "explains how the problem came to be, assigns blame for it, and identifies the goals or expectations to be pursued in solving the problem." (Bhatia and Coleman 2003, in press). The cognitive dimension structures our understanding of the world by providing algorithms or schemata about how things actually *are*, so that issues can be understood with respect to cause-effect relationships, and feasible actions can be developed. Cognition is the product of policy learning, and may be based on previous experience, policy feedback or from assessments of a policy's feasibility, coherence and consistency (Campbell 1998; Hall 1993). Together, normative and cognitive components of ideas form a policy paradigm – "a framework of ideas and standards that specifies not only the goals of policy and the kind of instruments that can be used to attain them, but also the very nature of the problems they are meant to be addressing." (Hall 1993: 279). Paradigms are collectively constructed and intersubjectively valid – that is, they must be widely shared to have any currency in a polity. The ideas embedded in them serve to "order the world. By ordering the world, ideas may shape agendas, which can profoundly shape outcomes." (Goldstein and Keohane 1993: 12).

Policy paradigms influence policy in a number of ways. They create a coherent structure or framework with which to make sense of complex issues that are often fraught with uncertainties. Paradigms may function as 'road maps' and thus limit choice by excluding some interpretations of a problem or issue and favouring others. "Ideas serve the purpose of guiding behaviour under conditions of uncertainty by stipulating causal patterns or by providing compelling ethical or moral motivations for action." (Goldstein and Keohane 1993: 16). New policy paradigms may lead to policy change in circumstances where the old paradigm is discredited by failures or inconsistencies.

To the extent that they are shared between groups and individuals, policy paradigms may also facilitate collective action "because actors can share principles and norms and know what they want and how they should achieve it when they follow the script…" (Braun 1999: 15).

Thus, ideas may be 'focal points' "that define cooperative solutions or act as coalitional glue to facilitate the cohesion of particular groups" (Goldstein and Keohane 1993: 12). Conversely, differing policy paradigms may be the basis of significant political conflict between groups, since they will compete with one another to have their particular paradigm become accepted and influential.

Finally, ideas may become institutionalized and direct policy in the absence of innovation. They continue to exert their influence because they become embedded in the terms of political debate, and in the rules and structures within which policy problems are discussed and resolved (Goldstein and Keohane 1993).

Policy paradigms can also change, although this happens relatively infrequently. Hall (1993) describes three types or phases of policy change. First order change is simply an incremental adjustment to policy instruments in order to stay on course of the original policy goals, for instance, an increase in a regional authority's budget allocation to meet the demands of a growing local population. Second order change involves a change in the type of policy instruments used to achieve the policy goals, for example, moving from global budget envelopes based on retrospective costs for local home care services to negotiated purchase contracts in an internal market structure. Third order change is what Hall refers to as the paradigm shift in that it involves not only a change in policy instruments, but more importantly, a change in policy goals as well. For example, this would include a shift from universal to means-tested benefits from the publicly funded health care system. Although Hall argues that a paradigm shift normally takes the form of a radical or 'big bang' change, under unusual and very public circumstances, Coleman, Skogstad and Atkinson (1997) demonstrate that paradigmatic change can also be the result of much more gradual and incremental adjustments that occur without a great deal of public debate or visibility. This type of paradigm shift is more likely to occur within tightly knit corporatist networks.

Canada's Dominant Health Policy Paradigm

The key elements of the dominant health policy paradigm in Canada are captured by Naylor's (1986) description of the system: public payment, private practice. The *Canada Health Act* 1984 contains implicit normative beliefs about equity and fairness in its five principles: universality, accessibility, comprehensiveness, portability, and public administration. Cognitive elements are reflected in the way the system is organized: it is tax-financed and publicly administered, but private practitioners and private hospitals deliver services. These ideas have been largely unchallenged in Canadian health policy, or when alternative ideas have been put forward, they have met with considerable resistance.

Embedded in this dominant policy paradigm are values and beliefs about the appropriate place of health care in the public vs. private domain (Starr and Immergut 1987). Canada's post-war citizenship regime "assigned an active role to the state, in order to promote social justice; accepted as a guiding role for the state in economic development; recognized a single Canadian community…" (Jenson 1997: 634). In Canada, as in most industrialized nations, health care is considered an integral part of social citizenship rights which include "the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in the society." (Marshall, as cited in Redden 2002: 21). These rights, accompanied by civil and political rights, were a means to offset the inequalities created by private markets in capitalist societies by ensuring "equal substance of citizenship." (Redden 2002: 50). Health care as a right of social citizenship (as distinct from a legal right) is a central normative element of Canada's

health policy paradigm and it carves out a legitimate role for state involvement. Although the nature and degree of that involvement has been regularly contested by various groups in society, a relatively stable compromise exists about the public/private boundaries of health care, and is reflected in the 'public payment, private practice' bargain.

A different but related set of ideas embedded in this paradigm are the "ideas we have about, and the explanations we offer for, what health is and what determines it, as well as the particular practices that are produced by these ideas." (Robertson 1998: 155). The biomedical model is the dominant cognitive model for understanding health in Canada and in most industrialized nations. In this model, the body is understood as a machine, and illness is the result of mechanical injury, a specific microbe or chemical. Arising from this understanding of illness is the causal assumption that health care is has a primary role in improving health (Coburn 1998; Evans and Stoddart 1990; Lavis and Stoddart 1994; Lewis 1999). In the post-war era, the development of technological expertise and growing authority of science and scientific methods reinforced these understandings of health and illness, and helped to transform health care into a technical rather than political issue. The biomedical model of health confers authority and responsibility for health care on specific groups in society. "As science has risen to a privileged status in the hierarchy of persuasive belief, its institutionally validated interpreters – notably physicians, who are its emissaries in the most personal matters of physical and mental health – have developed stronger claims to authority, not only in scientific and clinical matters but also over the social and political relations surrounding them." (Starr and Immergut 1987: 224).

Implications of the Dominant Paradigm for Policy Change

The notion of health care as a right of social citizenship and the biomedical model of health are the core ideas that constitute the dominant policy paradigm in Canada. They give order to very complex health and social issues that are fraught with conflicts and uncertainties, and provide tangible road maps for strategies and solutions. These ideas also enable collective action on the problems of health and health care by bringing together groups and individuals who share similar beliefs and values. As a result, both ideas have become deeply embedded in the institutions of the health care system and in the social, political and economic structures of society.

a. Health Care as a Right of Social Citizenship

Values in the context of policy studies, "sometimes referred to as core beliefs, have to do with conceptions of what is desirable and they form the basis of judgments citizens have about their social, economic and political worlds." (Nevitte 2000: S74). They have both a prescriptive component and an evaluative function. The dominant 'national values' of Canadians regarding health care include beliefs about health states, such as health as a basic social good; about equity, such as fairness of opportunity in obtaining necessary health services; about relationships among citizens, such as collective responsibility and compassion for the vulnerable and weak. Health system values also include beliefs about efficiency and effectiveness, such as the obligation to maximize benefits to all with the available scarce resources (Giacomini 2002; Marmor 2002; National Forum on Health 1997; Stingl 1996; Vail 2001; Wilson 1998). The normative ideal of health care as a social right encapsulates these beliefs, which have set the terms of debate for health policy in Canada. The acceptance of and degree of attachment to these values is expressed in public opinion polls, surveys of health providers and policy-makers, and countless other groups in Canadian society. Equally significant is the institutionalization of these values, most explicitly in the Canada Health Act, but also in rules regarding financing arrangements, norms

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. When a set of ideas becomes deeply institutionalized, "there is no specific organization whose entire mission is defined by these ideas. Instead, the ideas function as a broad mandate authorizing and guiding actions by many different organizations." (Moore 1988: 72). Phillip Clark, in a comparison of Canadian and American geriatric health policy, suggests that this institutionalization of collectivist ideals in the Canadian policy paradigm "has implications not only for the Canadian government's commitment to providing universal health care services, but also for the kind of political process addressing emerging social problems… [As a result of Canada's collectivist ideals], health care dialogue, discussion and even disagreement are channeled into the political process…" and are more likely to lead to consensus on pressing 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 Canada, "social rights hold constant the mechanics of the health care system. The principles and 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 to translate as reluctance to question the institutional logic of the system." (Redden 2002: 62). 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 'universal' human experiences or needs, like health or illness. "It is important 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 public plan." (Redden 2002: 126).

The economic shocks of the 1970s and the development of a 'new right' political 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 distinguish it from the social rights discourse. First, "the welfare state is seen as a safety net that catches individuals who have failed to find their niche in the market economy, rather than protection against the market's failure to provide sufficient opportunities for work and subsistence." (Maioni 1997). Second, the universality of benefits is supplanted by a means-tested approach to allocating societal resources. Finally, there is an emphasis on individual rather than collective responsibility. In this paradigm, "the recourse to social programs becomes associated with the failure of personal incentive rather than the need for security…[An] emphasis on means-testing involves ranking access to social protection among 'deserving' individuals or groups, opening the door to the redirection of funding priorities in which clientele groups are played off one against another…" (Maioni 1997). This alternative 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.

Both the 'social rights' and 'new right' ideas have instrumental functions as focal points around which societal groups have mobilized. For example, Evans (1997: 427) argues that

"current interest in market approaches represents the resurgence of ideas and arguments that have been promoted with varying intensity throughout this century…because market mechanisms yield distributional advantages for particular influential groups." Similarly, Skocpol (1997) has developed a compelling narrative about how a version of the 'new right' thesis was so effectively 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 Progressive Conservative parties share a "market citizenship model" which gives preeminence to 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 "'social democratic citizenship' model in which political and social values play a large role in constraining the operation of the private market and its values," (Laycock and Clarke 2002: vii) and also has allies in the academic and professional communities of experts. Together, each of these allied groups form an advocacy coalition – "people from a variety of positions (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-trivial degree of coordinated activity over time." (Sabatier 1993: 25; Lindquist 1993). Peter Hall (1989) and others have demonstrated the importance of such communities – consisting mainly of economists – in shifting the paradigm of economic policy from Keynesianism to monetarism in a number of industrialized countries over the past three decades. However, there is little research done on the structure and influence of these types of epistemic communities or advocacy coalitions in Canadian health policy.

The preferences that actors have for particular goals or strategies may also be based upon moral motivations or beliefs about causal relationships, which are called upon to inform new and unfamiliar situations. In these situations, ideas are like road maps – they stipulate what is right and what is wrong, what works or doesn't work – in the absence of more or better information (Goldstein and Keohane 1993). The process by which these ideas are reinforced is policy

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[4] For example, the following headline: "Fiscal crisis looms if health care costs continue to skyrocket." The columnist goes on to predict that health care spending in Ontario "will essentially double from $21 billion this year to about $40 billion in current dollars by 2015, creating a budget crisis that could cripple government." One of the "horrifying" effects of this may be that government will be "raising taxes at every turn…" John Ibbitson (1999). Fiscal crisis looms ifhealth care costs continue to skyrocket. *The Globe and Mail*, December 2, A4.

learning – a form of 'puzzling' or problem-solving – which is based on past experiences, information and knowledge. For example, recent debates about health care reform concern the dissonance between the values embraced by the Canada Health Act with respect to universality, equity and comprehensiveness, and the patchwork of public/private financing of equally medically necessary pharmaceutical products and home care services. Moreover, the rapidly growing size of pharmaceuticals as a proportion of total health expenditures, particularly in the private sector, creates efficiency as well as equity concerns. On both moral and causal grounds, the proposed policy solutions to these problems are patterned on the familiar public financing/private provision model used for hospital and medical services (Romanow 2002).

b. The Biomedical Model

The experience of the Great Depression and wars had devastating effects on the health of Canadians, making the development of adequate and accessible medical facilities a political priority. Public investment in hospitals, and later, medical and hospital insurance, expanded rapidly, and was supported by significant health gains made by the development of wartime drugs and technologies. "[T]he critical role played by science and technology in the victory of allied forces in World War II convinced many that government could be more successful by putting aside political differences and providing science the resources and authority to uncover solutions to problems." (Ingram and Schneider 1996: 3). Thus the biomedical model of health and illness gained legitimacy in the post-war era, and the medical industrial complex grew as governments and private corporations invested more and more resources in research and development of these technologies (Taylor 1987; Torrance 1998).

Robertson (1998: 155) argues that "biomedicine represents the most successful discourse on health… Characterized by scientific medicine with its principles of specific etiology and nosology of diseases, particular clinical diagnostic and treatment protocols, all in the context of the individual physician-patient relationship, biomedicine has functioned as the dominant discourse on health in Canada…" This model of health and illness is deeply entrenched and reproduced by the organization of the system, including through legislation and regulation, funding arrangements, and the structure and organization of management and delivery institutions (Contrandriopoulos et al. 1998). For example, the Canada Health Act, and the Hospital and Diagnostic Services and Medical Insurance Acts before it, clearly endorse and institutionalize biomedicine by providing for the financing of hospital and medical services but no other forms of care. Hutchison et al. (2001) discuss the Canada Health Act as a barrier to primary care reform in Canada: "By defining the 'comprehensiveness' standard as coverage of only hospital and physician services, the act had the important effect of reinforcing hospital- and physician-centred health care, limiting the potential for innovations in health care delivery based on alternative settings and providers, even in situations where they might be more appropriate or efficient." (Hutchison et al. 2001: 119). As a result of this institutionalization,

> [the] unquestioned and general enactment of the values, meanings and practices associated with [the biomedical] model structures the agenda of health care politics, and ensures that prevailing practices, modes of service delivery, patterns of resource allocation and power are recreated and placed beyond challenge, and that health policy development and consumers' expectations are bounded by prevailing conceptions of health and illness. Widespread acceptance of the biomedical model is also important in justifying the traditional dominance of the

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 – which "block the path towards multiple strategies that are advocated by the new public health." (Lewis 1999: 156). Instead, health promotion and determinants of health initiatives are used by governments in an instrumental way, "to advance predetermined goals and means to these ends." (Lavis 1998: 23). For instance, the government of Prince Edward Island 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 was driven primarily by a need to justify overall expenditure reductions and rationalization during a time of fiscal restraint; the determinants rhetoric served to obfuscate the cuts on one hand and garner support of the health care community on the other (Lavis 1998).

The biomedical model, with its positivist epistemology in framing the problems of health and illness, is part of a larger cognitive schema that permeates Western societies. Biomedicine is premised on science and scientific inquiry as the road map for structuring new knowledge development and acquisition in unfamiliar issue areas. Underlying this cognitive model is the belief that "if a problem can be based on objective scientific knowledge, then we can avoid the 'messiness' of politics. And…we can avoid the even more dreaded messiness of moral reasoning." (Robertson 1998: 161). Similarly, Schneider and Ingram (1996: 12) argue that issues captured by science are "portrayed as too important or too complicated to be left to political choice… Such issue areas often seem best addressed by proven scientific approaches or technical solutions." However, limiting decision-making to technical criteria tends to have a conservative, status quo bias, because the criteria themselves are usually static. Moreover, Schneider and Ingram contend that policies designed on scientific criteria and by experts narrow the range of policy options and minimize political and citizen input. This latter issue is also posed by Redden (2002: 83) in her analysis of the relationship between medical dominance in health policy and democracy. She points out that "if democratic values are being promoted within the health care system… then the dominance of an elite group of decisions-makers with no direct accountability to voters should be considered a problem."

Toba Bryant (2002) examined the role of different types of knowledge in the hospital restructuring process in Ontario. She found that the scientific, positivist models of knowledge used by policy experts in government and the Health Services Restructuring Commission resulted in vastly different understandings and expectations than the critical and anecdotal knowledge called upon by civil society actors. "By using objective indicators the Commission depoliticised the restructuring process which tried to separate values from the health care issues to be

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[5] Robertson (1998) distinguishes between 'social determinants' and 'population health' approaches on the basis of what she suggests are fundamentally different normative and epistemological ideals. The population health perspective, she argues is simply an extension of the neo-liberal discourse about the relationship between wealth and well-being and justifies moving resources away from the provision of social programs toward expanding the economy. Health promotion based on a social determinants model begins with social inequalities as the root of health inequalities, and proposes the development of political community premised on a commitment to social justice and redistribution, independent of total wealth or wealth production. Robertson's analysis is an excellent example of the significance of ideas, both with respect to how they very literally constitute perceptions of problems and policy goals, as well as the strategies that are developed for achieving them.

addressed." (Bryant 2002: 201). Considerations of quality of care and history of service to a particular community (women, in the case of the Women's College Hospital closure), for example, were given different weight in the Commission's criteria than they were in those used by societal actors. Similarly, in the case of the bilingual Montfort Hospital in Ottawa, the Commission's recommendations for closure were criticized for failing to take into account the 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 and women with disabilities. "Charged with rationing scarce resources, [home care] case managers use a medical discourse that questions the legitimacy of some needs and seeks to off-load responsibility for care from the public sector…" (Aronson and Neysmith 2001: 159). By doing so, they marginalize people who rely on services to the realm of 'service users' rather than 'citizens' who should and are able to participate fully in community life.

The primacy of biomedical model is also reflected in the beliefs and deliberations of policy actors. Charles et al. describe the evolution of the very central concept of medical necessity in Canadian health legislation. Originally, medical necessity was left to the discretion of the professional authority of medicine, because medical practice was premised on scientific fact and "physicians would provide only scientifically proven, needed care" (Charles et al. 1997: 372). In the 1980s, when governments faced more difficult fiscal situations, medical necessity came under greater scrutiny of policy actors, and was more narrowly defined as "'what is scientifically justified' on the basis of the best available evidence from clinical trials, technology assessment, and practice guidelines…" This was then "transformed into an explicit evaluation process for identifying a smaller subset of 'core' effective and appropriate health services from the more comprehensive service package that is currently publicly funded" (Charles et al. 1997: 378). This view subsequently informed the appointment of various expert committees at the provincial level to undertake delisting exercises to reduce the range of services covered by provincial health plans. However, in each of these exercises, as well as similar attempts in other jurisdictions, little progress was made in arriving at an agreed upon definition that would have meaning for decision makers at both the clinical and policy level (Hurley et al. 1997).

The biomedical model establishes the medical profession as the purveyor of scientific and technical authority about health and illness. Paul Starr writes:

> The medical profession has had an especially persuasive claim to authority. [It] enjoys close bonds with modern science, and at least for most of the last century, scientific knowledge has held a privileged status in the hierarchy of belief. Even among the sciences, medicine occupies a special position. Its practitioners come into direct and intimate contact with people in their daily lives; they are present at the critical transitional moments of existence. They serve as intermediaries between science and private experience, interpreting personal troubles in the abstract language of scientific knowledge. (as quoted by Moran 1999: 100)

The medical profession has used the power of the biomedical model in an instrumental way to mobilize its members as well as other societal groups. The model confers to the profession the legitimacy and authority to regulate itself, as well as to influence health policy making, and is "strengthened by the legally supported monopoly over practice that it has enjoyed for most of [the last] century." (Lewis 1999: 158). Professional autonomy of physicians is premised on their technical authority over the science and practice of medicine. However, Naylor (1986) makes the point that technical autonomy can, and has been, checked by indirect constraints related to

economic incentives and resource availability: "These links between technical and socio-economic matters not only heighten professional concern over third party mediation in the medical services marketplace; they also provide organized medicine with an important weapon in political battles to ensure that intervention by the state or other agencies occurs in patterns salutary to professional status, incomes and working conditions. Disputes over remuneration can, for instance, be turned into crusades for better-quality care…" (Naylor 1986: 13). Medical associations have often appealed to these arguments in attempting to broaden public support for their opposition to greater state intervention in medical billing and remuneration policies. Strikes by physicians in Saskatchewan, Ontario and Quebec, and the vocal opposition of physicians to the Canada Health Act are some instances in which the profession launched very public campaigns against government policies to limit extra-billing, what it alleged were undue intrusions on professional autonomy and practice (Heiber and Deber 1987; Stevenson et al. 1988; Tuohy 1988). However, smaller groups of physicians have also appealed for autonomy on a more principled basis. Tuohy (1992) describes a 'strategic minority' of physicians in Ontario, based primarily in the medical schools and College of Physicians and Surgeons of Ontario, who lobbied in various forums to maintain professional and clinical autonomy, even at the expense of entrepreneurial discretion, to ensure that physicians are allowed to continue to act as ethical agents for their patients.

As health care itself has become a more significant public concern and post-modern values challenge traditional sources of authority, society is no longer content to leave decision-making in the hands of physicians. Research into health care utilization and medical effectiveness reveal significant gaps in evidence and unexplained variations in utilization patterns across geographic regions. These studies raised "pointed questions about medicine's claim to scientific authority: If medicine is a scientific enterprise, why do practicing physicians treat similar patients so differently? And, if medical practice is not based on science, what is its basis (and how do we justify its costs)?" (Tanenbaum 1996: 519). Notwithstanding these questions, the power of the biomedical model is far from being displaced. What has been displaced is the legitimacy of the medical profession as the sole arbiter of medical knowledge. The development of evidenced-based medicine is an antidote to uncertainty and a focal point for the medical effectiveness 'movement'. This epistemic community is comprised of researchers and experts from a variety of disciplines who espouse the view that solid scientific research is the key to good medical practice and public policy. Medical effectiveness research is the cornerstone of various strategies, such as technology assessments, practice guidelines and utilization review, to influence medical practice based on scientific information. Despite the ambiguity of the policy implications of its findings, this research is also increasingly used by policy makers to inform a whole range of policy decisions, including the scope of public coverage (Tanenbaum 1996). Evidence-based policy making and administration are parallel attempts to encourage the use of social scientific and management research to better inform health care decision making (Innvɸr et al. 2002; Lavis et al. 2002). However, Mykhalovskiy (2001: 157) argues that health services research may also work "as an obfuscating discourse that negates more politicized or embodied ways of understanding the organization of health care." Similar to Bryant's contentions, Mykhalovskiy suggests that health services research and the scientific discourse are themselves a form of 'social practice' that shape applied inquiry and the organization of health systems, and must be understood in a reflexive rather than positivist way.

The impact of research use on public policy making is difficult to assess. There are a number of ways in which policy makers use research information: instrumental or direct use for problem-solving; selective or symbolic use for strategic purposes, such as legitimating or

justifying predetermined positions; and enlightening or conceptual use for establishing new goals or deepening understanding of issues (InnvΦr et al. 2002). Direct use of research seems to be rather limited in the policy making process, whereas conceptual use appears to be more widespread. InnvΦr et al. (2002) and Lavis et al. (2002) suggest that more direct communication between the epistemic community producing the research and policy makers making the decisions would improve the direct use of research information. The extent to which this is possible depends in part on the nature of the problem: the more technical the issue, the more likely research information is used (Lavis et al. 2002). Furthermore, the greater the degree uncertainty among the scientific community about a particular issue, the more opportunity there is for divergence in policy advice, and the less likely it is that policy consensus will emerge (Harrison 2002: 89). Finally, even when technical information is definitive and largely undisputed, "the 'road map' offered by science…[is] most compelling when it offer[s] policy-makers a route to achieve predetermined political goals through familiar institutional terrain." (Harrison 2002: 65)

Summary

Following Hall's model of policy change and paradigm shifts, it is clear that little more than first, or less frequently, second order changes have occurred with respect to the dominant sets of ideas that constitute Canadian health policy. Health care as a right of social citizenship is arguably more entrenched as a normative ideal now than it has ever been, and the positivist, scientific biomedical model continues to dominate the way in which governments and societal actors think about health and health care.

Although challenges have been mounted against both sets of ideas, there is little evidence that the institutional embeddedness of either has been loosened in any notable way. This may be due to the 'stickiness' of institutions – the institutions of government and its bureaucracies, as well as the institutional structures of society, such as epistemic communities and policy networks – that uphold the dominant norms of and rules for policy debates and decision-making.

Like the institutions that sustain them, ideas may themselves be 'sticky', by serving as road maps or focal points in polity. Ideas define the identities and interests of their constituencies by serving as focal points and are used by their supporters to act on their identities and interests by serving as road maps. Although some groups argue that one or both sets of ideas in the dominant paradigm have outlived their usefulness in planning for the future of the health care system, each commands large and vocal groups of supporters on normative and cognitive grounds. A system based on health care as right of citizenship has moral as well as cognitive purchase: a collectively financed, publicly administered system is not only an embodiment of deeply held values about equity and social responsibility, but is also demonstrated to be more efficient and effective in allocating societal resources. The biomedical model, meanwhile, reflects the dominance of the scientific paradigm in modern societies and is valued both for its perceived objectivity in mapping out otherwise complex and insurmountable problems and its relative success in addressing these problems with technology and research knowledge. As a result, there is no widespread consensus that the goals of the extant paradigm are no longer valid, nor is there agreement that it has entirely failed to meet expected goals. Much of the current debate about health care reform appears to focus on making first or second order adjustments to the existing paradigm, rather than searching for a new alternative.

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* way dictated by the strong state structures of the Westminster system or federalism. Alternative, less formal structures or forums for state-society accommodation have arisen and come to dominate health policy making in Canada. These include clientele networks that characterize relations between the state and the medical profession, and also include newly developing modes of interaction between the state and its citizens. Furthermore, as the discussion of ideas has illustrated, beliefs and knowledge are the coalitional glue that brings groups together and are the impetus for group action, while institutional factors mediate the forum within which groups interact, both with one another as well as with the state.

Clientele Networks: Physicians and the State

"Canadian medicare…rested from its inception in the 1960s on a fundamental accommodation between the medical profession and the state…". (Tuohy 1999: 30). This accommodation was essentially corporatist in nature – the state delegated broad discretionary authority to the medical profession to police its own ranks by regulating its scope of practice, establishing codes of ethics, and setting fee structures for its members. In exchange, governments limited (but did not eliminate) the entrepreneurial discretion of physicians by demanding a single provincial fee structure and excluded physicians from setting the terms of health insurance programs. Individual physicians continued to have the freedom to work in their choice of location, select their own patients and types of practice, as well as to bill patients over and above the established fees (Tuohy 1976a).

The foundation of this accommodation is related to the dominance of the biomedical model and modes of scientific inquiry over which the medical profession was perceived to have a monopoly – governments recognized and respected the technical authority of the profession to both regulate itself and to make health care decisions. However, although a number of different bargains may have been struck to ensure the technical authority was not unduly intruded upon, the final 'private practice, public payment' bargain was the product of political compromise to ensure the cooperation of a crucial group in the health polity. The compromise was made necessary by the fact that, despite their capacity for strong legislative action, governments (either federal or provincial) did not have the bureaucratic capacity to manage an entirely state-run system, as in the United Kingdom. Physicians, on the other hand, had well-established private practices scattered throughout each community across the country. Furthermore, the legacy of the past failures to develop a national plan was the successful and widespread proliferation of private insurance plans, many administered by groups of physicians. The success of these existing plans created a path dependency effect, and served to limit the scope of organizational alternatives for service delivery. In the end, governments chose to simply underwrite the costs of medical and hospital care, but leave the private delivery system virtually untouched (Hacker 1998; Tuohy 1992).

The impact of this historic compromise is evident in the structure of the health care system we have today. It also has had a profound impact on relations between the profession and the state, as well as with other groups. First and foremost, it excluded most other groups from the

policy network governing health – third-party payers were effectively shut out, and other providers had long been subject to the control of the medical profession (Coburn 1993; Tuohy 1999). Second, it placed physicians in a position of strength vis B vis government by allowing them to negotiate the terms and conditions of their work *en masse*. This monopoly power of medical associations to negotiate contracts with government has since become institutionalized, including in provincial legislation, ensuring that the medical profession remains the dominant participant in the health policy arena. Coleman and Skogstad (1990: 21) propose that in order to become an effective policy participant, an association must be able to "order and coordinate a range of complex information and activity so as to arrive at positions on relatively sophisticated policy questions. Second…the group must be sufficiently autonomous from members to be able to transcend their short term interests and to take a longer term perspective on policy while still guaranteeing members' compliance." The capacity of medical associations to coordinate activities and information was enhanced substantially with the advent of medicare, particularly as the provincial associations banded together under the CMA umbrella. The ability of the associations' leadership to remain autonomous from their membership has also been gradually strengthened over the years, so that now in most provinces the provincial association has legal authority to negotiate fees on behalf of all its members, while the provincial regulatory college monitors and regulates the professional practice of its members. Although there were often pockets of discontent and even groups that broke off from the provincial or national association, "common interests welded the overwhelming majority of doctors into a strongly united group." (Naylor 1986: 251).

As Immergut (1992: 41) notes, "contrary to what is often believed, medical monopoly [based on technical or professional authority] is not a key element in influencing legislative decisions. The exclusive right of doctors to treat patients was off-limits in these debates – and in that sense, professional autonomy was entirely successful … – but this professional autonomy did not translate into political influence concerning economic aspects of national health insurance." Therefore, in addition to policy participation on professional or technical issues, the profession also engaged in pressure tactics to influence government on entrepreneurial concerns. One such tactic is lobbying government officials, although the effects of lobbying activity on decision makers are limited by the Westminster system (Weir 1973). Another is the withdrawal of services, which has had limited success in Canadian health policy disputes. Finally, the profession has also frequently formed strategic alliances with other groups – business representative associations, the insurance industry to further its entrepreneurial efforts (Naylor 1986).

Over time, as health systems expanded in scope and complexity, government bureaucracies also grew in size and expertise. The relationship between the profession and the state began to change as governments became more interventionist than they had in the first decade of medicare. In part this was motivated by the rapidly rising costs of health care, particularly during the climate of fiscal constraint in the late 1970s. To control their expenditures, governments contemplated intervening in areas that had traditionally been left to the discretion of the profession. Instead of directly regulating the types and volumes of services that physicians provided (which would been strongly opposed on grounds of professional autonomy), governments demanded more stringent control over the price of medical services. The nature of the relationships between individual provincial governments and the profession varied from "Gallic statism" in Quebec to adversarial collective bargaining in British Columbia, Ontario, Alberta and Manitoba, and in between, "mutual accommodation" in Saskatchewan and the Atlantic provinces (Tuohy 1999). Gradually, however, each of these relationships seemed to

converge in the 1990s as governments sought to both "assert their roles more forcefully and also to elaborate the terms of their accommodations with the profession. In this process, both the informal mechanisms of the 'mutual accommodation' model and the more formalized but more narrowly focused mechanisms of the adversarial collective bargaining model began to change." (Tuohy 1999: 210). Tuohy contends that the new relationships facilitated greater collaboration between government and the profession, and resulted in the development of formalized 'co-management' structures – 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 opposition when necessary, but prefer to "establish a 'shadow' within which their negotiations with the profession [will] proceed." In other words, they prefer the quiet accommodation of 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 profession. Over time, the threat of government's legislative power has attenuated the power and influence of the medical profession. "The profession, fearful of exclusively top-down policy decisions, has remained rhetorically aggressive while becoming progressively more conciliatory in negotiation. It has grudgingly yielded the centre of the policy community to government bureaucracy, and its reluctant acquiescence to its more circumscribed role has encouraged governments to pursue ever more top-down policy directions." (Boase 1996: 298). The Canadian experience does not differ substantially from that in other countries, where similar fiscal imperatives gave governments the necessary leverage to push for health care reform and system restructuring, even over effectively mobilized powerful interests. The ways in which governments pursued changes, and the changes they pursued, however, do differ across nations (O'Neill 1998; Wilsford 1995). These findings suggest that institutional and contextual factors, such as state capacity and fiscal imperatives, are equally if not more important in moderating relations between governments and the profession than the internal structures and capacities of professional organizations.

Citizen Engagement in Health Policy

Canadian political culture – the relations between political communities and their governments – has changed significantly in recent decades. The explanations for these changes are multiple, ranging from tensions between individual and group rights in industrialized nations to the growth of post-material values and cultural pluralism. The direction of the change is

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:

> Canadians are more supportive of individual autonomy and choice, and are more resistant generally to collective provision of services. More Canadians now seek out information on their own, and increasingly make much more diverse health care choices, some of which are outside the current health care system. The increasing diversity of Canadians, and their desire to exercise more freedom of choice in many aspects of their lives, represents a challenge for a "one-size-fits-all" model of health care delivery. Having said that, Canadians remain deeply committed to the collective provision of health care and universality for the health care system, though within that system there is a tension as more informed, more autonomous Canadians, who are often better off financially, demand more control and more ability to make choices.

Canadians are more disengaged from traditional forms of political participation, such as voting and political party affiliations, and instead seem to favour alternatives such as direct involvement in public interest groups and voluntary associations of civil society. Governments themselves have undertaken to provide greater opportunities for citizen involvement, although not entirely (or even mainly) due to pressure from the populace to enhance democratic principles and institutions.

a. Citizen Governance and Regionalization Initiatives

Formalized relationships between citizens and governments in the health care system have taken a number of different forms and have had different objectives. Abelson and Eyles (2002) outline the 'governance ideals' of citizen engagement in the health care system. These ideals include: improving the quality of information about citizen preferences and needs, presumably to make the system more responsive; encouraging debate about some of the fundamental, but increasingly contested, tenets of medicare; enhancing democratic governance and transparency to ensure greater public accountability; and protecting the public interest. After reviewing a number of different initiatives to improve citizen involvement in system governance, Abelson and Eyles conclude that, despite its potential, public participation has not been particularly effective in achieving or improving upon any of these goals.

Other more instrumental objectives of government for greater citizen involvement in regional health boards have been elaborated by Lomas (1997: 819). First, governments wish to cultivate allies, "in the form of local citizens, for health care restructuring. By using community empowerment, governments hope to establish an alternative source of legitimate power over dominant interests that have historically prevailed." Next, citizen governance mechanisms at the local level enable government to "exact more than blunt budgetary control over health care providers." Micro-system planning initiatives to improve efficiency and effectiveness in the system are more palatable, and practical, when implemented at the local level than centrally. Finally, governments have delegated difficult resource allocation and retrenchment decisions to local boards to avoid blame from their constituencies. Lomas concludes that governments have

had limited success in meeting these objectives through local boards, in part because of the limited budgetary authority given to the boards and in part due to the complexity and confusion in accountability relationships between board members, their constituents, providers and government.

Lessons learned from the regionalization and devolution of health system governance and management in most Canadian provinces suggest that the concentrated interests of provider groups and others who derive their income from the system dominate the more diffuse and fragmented interests of the public. "Not surprisingly, the most vocal opposition to the role of the devolved authorities has come from providers, who feel disenfranchised from decision making previously under their control" (Lomas 1997). Moreover, people with high levels of education and income were over represented, opening up the potential for criticisms from groups who were already marginalized and underrepresented in the system. Even when representation was balanced, active participation and influence were confined to groups with concentrated interests. In their study of regional boards, Lomas et al. demonstrated that "those employed in the health sector have a greater propensity to become involved in local health care decision making and that the 'average' citizens are ready to assign local decision-making to 'health care experts'" (Lomas 1997: 820; Abelson and Eyles 2002). Furthermore, the multiple and competing goals of public participation in any given instance create role confusion among citizen members – a finding echoed by O'Reilly (2000: 222) in her study of health professional regulation in Ontario – "Are the public representatives there to represent the individual patient, the aggregate of patients, or the public at large – or even themselves?" Finally, meaningful participation in governance or even consultation was frustrated by the lack of formal decision-making authority. "[I]t is likely that participation in such state-sponsored activities is alienating in that participants perceive decision-making authority when there is none." (Redden 1999: 1385)

b. Public Opinion and Deliberation

Although citizen involvement as a means to health system reforms seems to hold little promise in its current forms and structures, the significance of public opinion in the deliberations and decision-making processes of policy actors suggests that the public plays no small role in influencing policies. Jacobs (1993: 232) argues that public opinion has contingent relevance to policy decisions – it is most relevant "on issues that attract 'high and loud politics,' for example on policies that attract sustained debate in the media and among major politicians and in which the public has long-standing experience." The impact of public opinion in directly influencing health politics and the views of decision makers has not been systematically studied in Canada, but there appears to be strong agreement, based on anecdotal evidence, that public opinion matters. Canadian politicians seem reluctant to make large-scale changes in the health care system because it is so strongly supported by a large majority of Canadians.

The reverse – whether and how public opinion is shaped by politics – is also not systematically studied in the health sector. Public opinion research has long suffered from a credibility deficit, in large part a function of problematic survey methods that revealed little about the dynamic process of opinion formation. Recent studies and methods demonstrate that values and beliefs are important factors in shaping public opinion, even where those values compete or clash on specific issues. Furthermore, the new techniques allow assessments of the impact of broader political debate, and demonstrate that these debates do in fact influence public opinion (Gidengil 2002). However, it seems Canadians as a whole are relatively uninformed with respect to political information; only a small minority of people (the socially, economically and

politically privileged) are able to substantiate opinion with specific information or knowledge of an issue (Fournier 2002).

Abelson et al. (2003) discuss the use and success of deliberative methods for obtaining citizen input in health policy decisions. Deliberation is distinct from polling in that it is a form of collective problem solving that includes sharing of views and preferences, as well as information, and leads to a set of decisions or recommendations. It may involve citizen governance but is not limited to such forums. In their review, Abelson et al. conclude that the deliberative methods used in the health sector, in Canada and other nations, present more challenges than successes so far. Even in deliberative methods, involved citizens may be easily swayed by vested interests; they may be given biased or incomplete information for deliberation; they may not be adequately representative of the population; they may not be held accountable for their decisions or recommendations; and deliberation processes lack supportive infrastructure within communities and public institutions. A recent example of deliberative polling in Canada is reported by Maxwell, Rosell and Forest (2002), who discuss the results of citizen dialogue sessions that were used to inform the Royal Commission on the Future of Health Care in Canada. This exercise, the authors argue, has had real impact on the final recommendations of the Commission although whether they will be implemented by governments remains to be seen.

c. Activism and Social Movements

A public interest group is an "organizational entity that purports to represent very broad, diffuse, non-commercial interests who traditionally have received little explicit or direct representation in the processes by which agencies, courts and legislatures make public policy." (as cited in Pal 1993: 20). In contrast to other interest groups, public interest groups are motivated by non-material interests or values, rather than material gain. Social movements are distinct from interest groups in a number of important ways: they are less formally organized and structured, and consist of more than one group; they are not focused on a single issue but rather may advocate on a number of related concerns that flow from their 'identity based politics'; finally, they seek not only to influence government but also civil society itself (Phillips 1999: 371; Pal 2002). Social movement groups are not primarily reactive; rather, they actively engage in the process of identifying and framing issues to mobilize and motivate others to action – the process of naming, framing and collective action (Phillips 1999).

Both of these types of groups have gained prominence in Canadian politics across the issue agenda. In the health care arena, public interest groups have been mobilized on a range of issues, including hospital closures (Bryant 2002) and specific pieces of government legislation, such as the Consumers' Association of Canada opposition to Alberta's Bill 11 (Bhatia and Coleman, forthcoming), or health benefits for particular groups, such as the Canadian Association of Retired Persons (CARP [now called something else]). While there is a paucity of research on these public interest groups in the health arena, there is enough anecdotal experience to suggest that the activities of these groups do occasionally have an impact on policy decisions. For instance, Cohn (2001) and Tuohy (1999) demonstrate the effectiveness of public interest group mobilization in preventing the closure of the Montfort Hospital in Ottawa, against the recommendations of the HSRC.

Rayside and Lindquist (1992), in their study of AIDS activism, documented one of the few analyses of social movement activation on issues related to health policy in Canada. The epidemic, and the relative neglect of it by government agencies in its early years, challenged the gay community "into the development of a network of AIDS groups that has not only established a range of services for the sick and worried, but also forced state officials into policy directions

that break in important ways from traditional state regulation of disease." (Rayside and Lindquist 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 therapies), activists "also pushed for further recognition of the discrimination issues associated with HIV and AIDS, particularly in light of the connection with homosexuality." (Rayside and Lindquist 1992: 40). The authors argue that the state's initial reluctance to take action was the product of existing public health practices and norms that reinforced the perception that disease is spread by groups at the margins of society, of the social and medicalized deviance that was associated with homosexuality, and of the fiscal constraints governments were facing in the early 1980s. Rayside and Lindquist suggest that the success of AIDS activists in moving the government agenda forward and changing societal beliefs and perceptions of both the disease and its early victims was related two factors. First, these groups were able to develop, synthesize and harness expertise about the disease to inform policy and as well as take an active role in service provision; and second, they were able to bring together a broad coalition of groups and influential individuals, including members of the medical profession, the media and elected politicians.

Public interest groups may face challenges in mobilizing citizens when the benefits of their activities are diffusely spread throughout the population; instead of joining them, people may be tempted to 'free ride' to receive the benefits they acquire (Pal 1993). Financial and technical support for such groups from state agencies is not uncommon, and a number of groups involved in the AIDS movement received support from the federal government prior to and during the epidemic. Despite this support, however, these groups were not co-opted by government officials – they were able to effectively critique and lobby government agencies for policy and program changes. In fact, government support *created* rather than eliminated the room to generate radical criticism of state policies." (Rayside and Lindquist 1992: 69). This observation is also made by Pal (1993) in his study of citizenship interest groups in Canada, and illuminates the complex relationships between the state and societal groups. At times, the state helps to create and support groups, which in turn challenge the policy decisions and autonomy of state actors. This reflexivity helps to both constrain and redefine state-society relations as well as the political discourse about policy problems and solutions. The relationship between the state and interest groups is in part the result of policy feedback effects that create new constituencies or interest groups (Pierson 1993). However, they are also part of a strategy by government to mobilize citizens to engage in and support collective deliberation and debate, and thereby enhance the democratic and citizenship ties of citizens to the state (Pal 1993).

Summary

Policy networks, advocacy coalitions, epistemic communities, public interest groups and social movements are all configurations of different actors that in some way or another have an interest in and capacity to influence public policy making. An important observation about these relationships is that they seem to be mutually constitutive in that they influence and are influenced by the state: which groups are or become influential is a product of the prevailing ideas – both normative and cognitive – that govern a particular policy issue. The prevailing ideas, in turn, are subject to challenge and change by the state and societal groups.

The relationships between interest groups (such as the medical profession or pharmaceutical manufacturers) and the state are determined by a number of factors, including but not limited to institutional variables discussed in preceding sections. They are influenced by the "specific economic and social propoerties of the firms or individuals comprising the sector, the manner in which they organize their interests, and the relative capacity and autonomy of state

agencies making policy for the sector. Such organizational attributes will often vary significantly from sector to sector and from class to class." (Coleman and Skogstad 1990: 20). In the health 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 B 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, however…to strengthen citizen commitment to health programs and to encourage 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 II capitalist welfare states have been characterized by greater government intervention into the economy, a more articulated system of labour relations, and a significant expansion of the role of government in social provision (Burke and Stevenson 1993:52). They are premised on the need to address the social and economic problems that arose from laissez-faire capitalist development

beginning in the late 19th century (Polanyi 1944). These problems created fundamental inequalities between classes, regions, sexes, cultural groups and races, and resulted in "enormous tensions…that provide the dynamic aspects of the [health care] system and much of the basis for change." (Armstrong and Armstrong 1996:5). While political economy approaches focus on structural aspects of state-society relations, they also assume a set of underlying ideas about the appropriate role of the state.

States have developed a range of welfare systems for addressing these problems, which Esping-Andersen (1990) has grouped into liberal/residual, corporatist, and social democratic/universal ideal types. These ideal types vary according to the degree to which the state intervenes in the private market to ensure individuals are protected from its negative effects. Social democratic welfare states offer services on a universal basis, corporatist welfare states structure social welfare programs on the basis of socio-economic class, and liberal welfare states are needs-based programs that provide only residual services in limited circumstances. Canada is part of a small group of liberal/residual welfare states in which governments' social programs are essentially seen as a last resort to private market or private community modes of social security. However, Canada's medicare system stands out from other programs of the Canadian welfare state in that it is the only remaining universal program – that is, a comprehensive range and level of medical benefits are available to all Canadians on a universal basis, outside of the private market. This anomaly is explained by Donald Swartz (1993) as the result of class conflict – the rise of industrial unionism and militantism among the working class in the 1950s and 1960s forced governments to at least partly capitulate to their demands. The power of capital (business organizations) and private interest (the medical profession), however, remained strong in that the insurance system established under medicare simply froze in place the "existing structure of power in the [health] sector." (Swartz 1993: 229). Swartz argues that "in short, state hospital and medical insurance effected no change in the nature of the health care system. Its control remained firmly in private hands, held by physicians and the drug and medical supply corporations. What public health insurance amounted to under these conditions was a virtually unlimited subsidy to those fractions of the bourgeoisie in the form of a guarantee by the state of payment for any services and goods physicians mandated." (Swartz 1993: 231). Vivienne Walters (1982) also makes a political economy argument, although she suggests that the state was responding not to class conflict when it implemented medicare but to the needs of capital for a healthy, productive and efficient labour force.

> Inefficiencies in the organization, delivery and financing of health care prompted a federal strategy of rationalization in the health sector and Bill C-227 [the Medical Care Act] can be seen as one step in such a process of rationalization. The federal government was acting in the long-term interests of the capitalist class (overriding the opposition of some provincial governments which supported regional economic interests) and seeking to improve the organization and delivery of health care in order to increase the productive capacity of labour and reduce the economic costs of illness. The introduction of insurance for physician care promised to increase capital accumulation at the same time as it met some of organized labour's requests for reform. (Walters 1982: 169).

This compromise resulted in the amorphous and contradictory nature of health care under medicare as at once a commodity sold on a (highly regulated) private market and as a decommodified public good provided through political arrangements, and is at the root of debates about health care reforms today (Burke and Stevenson 1993: 53).

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; Williams et al. 2001). The 'profitization' of health care in these sectors is driven by government 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 Canadian health policy are entirely consistent with the liberal welfare state parameters of it's original development, and do not reflect a shift in the underlying ideological basis medicare. Her analysis demonstrates that little measurable retrenchment has actually occurred, and that there has been a shift toward an integrative regime – i.e., one that combines state intervention with market-like forces – that is driven by 'substantive rationality' and is essentially a problem-solving approach undertaken by the state in collaboration with societal actors. While Ruggie's analysis does not take an explicitly political economy approach to explaining policy change, it does ground policy change in a specific political economic context – that is, the liberal welfare state – and it offers a counter-hypothesis to those who argue that a shift toward a neo-liberal ideology explains the changing political discourse in health care. Ruggie's analysis is bound in an historical institutionalist explanation of the stability of the health care system, and is premised on a 'natural' continuing evolution of the welfare state. The key institutions in her analysis are the policy regimes constructed within liberal welfare states – the mix of market and state mechanisms used to create and sustain the health sector. Another distinguishing feature of Ruggie's analysis is the strong agency argument in her thesis – that political actors can and have rationally, deliberately and collectively undertaken to solve the problems of the system.

In a similar argument, Tuohy (1999) also focuses on two variables in her explanation of the relative stability of the health policy paradigm in Canada: the structural balance of key policy actors and the institutional mix. First, examining the role of interests, she focuses on the stability of the position of the medical profession as the dominant non-state actor in health policy. Second, she suggests that the institutional mix in Canada has also been stable, and is characterized as professional/collegial in which the policy instruments used by the state are corporatist in character. As a result, "the terms of an accommodation between the medical

profession and the state kept the system relatively stable though under increasing pressure." (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 – similar to Kingdon's unpredictable 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.

In describing the formation of Canada's medicare system, Jacob Hacker (1998: 59) argues "that the structure of a nation's political institutions systematically influences both the types of interests and ideas that enter into political debates and the kinds of policies that countries adopt." In other words, government institutions – namely, federalism and the parliamentary system – created opportunities for and constraints on the prospects for policy change. However, Hacker adds another dimension or variable to the historical institutionalist analysis: temporal sequence. He suggests that the timing and sequence of events are just as important as the events themselves: the order in which things happen affects how they happen, and this will lock-in a particular path of policy development (Hacker 1998; Pierson 2000). In this, Hacker's analysis is consistent with Tuohy and others who suggest that a certain randomness exists in the opening of 'policy windows' or occurrence of 'critical junctures' during which the prospects for change are higher than usual, and that these windows or junctures are largely determined by events exogenous to the health care system itself. In Canada, Hacker argues that the failure of the 1945 federal proposals allowed private plans to flourish, and thereby limited the scope of options government could consider when it finally resolved to implement a national program years later.

> The growth of private plans effectively ruled out the possibility that Canada would follow British precedent and establish a national health service. The private plans accustomed the Canadians who benefited from them to a largely unfettered fee-for-service system, and by offering coverage to the middle and upper classes, they no doubt decreased public demand for reform. But the most critical effect of the private plans was on the medical profession itself. From its conciliatory position in 1945, the CMA completely reversed itself within a decade and came out against all but the most modest of reforms. The reason behind this is not hard to find: 'Each year, as enrollment of the member plans of the TCMP increased, so did the confidence of the profession that a voluntary system might prevail.' [Taylor 1986: 190]. The failure of the 1945 proposals did not, therefore, simply mean that an opportunity for national health insurance had been missed. It meant that future proposals for national health insurance would face a new and powerful foe. (Hacker 1998: 99).

While the failure of the 1945 proposals precluded 'social medicine', the enactment of universal health insurance in the 1960s preceded the growing opposition to and concerns about financing the welfare state which may have defeated the proposals had they come at a later point time, as in the US. Thus, the timing of the HIDSA and the MCA, which occurred during fiscal expansion of the state (which itself was an internationally-determined critical juncture), locked-in a particular pathway for policy development.

Gildner (2001) illustrates the constraints and path dependencies created by institutions in her analysis of a health sector outside the traditional domains of the hospital and medical care

covered by the Canada Health Act. In her case study, examining the rehabilitation sector in Ontario, Gildner (2001: 178) argues that "the strength of existing institutional frameworks favoured incremental policy change over the radical changes proposed along the way… Institutional organization – the fragmenting of rehabilitation policy amongst decision makers operating separately and with different capacities but with unforeseen consequences for each other – prevailed." The already private nature of rehabilitation that was embedded in the workers' compensation and car insurance liability systems facilitated the further expansion and privatization of care that governments and hospitals were no longer willing or able to finance. Moreover, because the decision-making structures in the sector were fragmented, governments and other payers were able to allow these changes to happen incrementally and largely unnoticed.

However, Sokolovsky (1998) cautions against over-reliance on path dependencies and institutionalist approaches, at the expense of the agency of actors, to explain policy. Coming from a critical political economy perspective that views state-societal relations in terms of power and material interests, she notes that

> the underlying structure of society, including class, racial and gender divisions, become merely part of the background within which the game of institutional incrementalism is played. Lost is the way in which actors attempt to manipulate, choose, and invent institutions to fit their requirements… [I]nstitutions are not neutral exogenous factors. Rather they are fundamental weapons of struggle within a landscape of competing powers and identities. While the result of past conflicts, institutionalized in governmental structures, limit the options of political contenders we should not underestimate the agency of actors to reshape or reinterpret structures in accordance with changing relations of power. In other words, although form may shape outcomes, forms themselves are social constructs that must be recreated continually. (Sokolovsky 1998: 248).

In a similar vein, Blyth (1997: 231) critiques institutionalist analyses for inappropriately minimizing the significance of policy ideas. He argues that:

> Ideas in such [analyses] are ultimately secondary to the mode of analysis in which they are employed. Their definition, operationalization, and explanatory power are simply derivative of the wider theory in which they are embedded. Thus, the choice of institutional analysis will largely determine the type of ideas employed, their theoretical level, and their explanatory scope… If one starts with a particular notion of institutions, then one's views of ideas derives from this notion…

Instead, Blyth argues, one should begin with an understanding of how ideas themselves provide the "necessary conditions for successful collective action" and their "role in the redefinition of existing interests and the creation of new ones…". Furthermore, "ideas can be seen as both facilitators of radical policy change and a prerequisite of it." (Blyth 1997: 246). The policy framing approaches discussed next go part of the way in addressing the issues raised by Blyth.

Policy Framing and Political Discourse

The interaction between ideas and agents – namely, political elites – is the nexus of the policy framing and discourse literature on policy change. Studies of political discourse and the importance of language and communication in defining problems and strategies for their solution suggest that political discourse matters in building coalitions of support, including with the

public. "As both a set of ideas about the necessity and appropriateness of reform and an interactive process of policy change construction and communication, discourse can create an interactive consensus for change." (Schmidt 2002: 169).

Policy frames are the combination of normative and cognitive idea elements that together form a particular policy paradigm. "A frame is a set of cognitive and moral maps that orients an 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 with added power in a policy field." (Bleich 2002: 1063). 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 in part because of the incompatibility of an explicitly 'two-tiered' system with the core value of equity. Furthermore, the arguments put forward by the government about the advantages of private financing were inconsistent with available research evidence and experience from other jurisdictions about the impact of patient charges or a two-tiered system on equity and efficiency in the system (Bhatia and Coleman 2003).

The consistency and coherence of an alternative policy frame is alone not a sufficient condition for its success. According to Schmidt and Radaelli (2002: 4), discourse "represents both the policy ideas that speak to the soundness and appropriateness of policy programs [i.e., the policy frames] and the interactive processes of policy construction and communication that serve to generate and disseminate those policy ideas." The ideas in the frame must be communicated to a broader audience, and this communication is an exercise in persuasion.

There are certain situational conditions under which policy actors are more likely to be persuaded by an alternative paradigm, such as when they are in a novel or uncertain environment (Checkel 1999), or when the problem is perceived to be very severe or of crisis proportions (Bhatia and Coleman 2003; Edelman 1977). Furthermore, Checkel (1999) suggests that a 'moral entrepreneur' or agent, who is well-placed within decision-making structures, is critical for promoting an alternative policy frame and creating windows of opportunity for the frame to be promoted. Finally, both the actors who are involved in discourse construction and those who need to be persuaded are determined by the institutional decision-making structures of the policy area. "[D]ifferent institutional contexts tend to frame the discursive process, determining who is involved in the initial elaboration of the policy program and discourse and toward whom the discourse is directed." (Schmidt 2002: 171). Schmidt argues that single-actor systems, in which power is concentrated at the centre, as in the executive in Canada, involve very few actors in discourse construction but must persuade a broad range of actors, particularly the public, because "here the debate and deliberation over major policy initiatives tend to go on in the wider public sphere (if at all), as policies formulated unilaterally by a small elite face public scrutiny and where the discursive process is therefore adversarial, as the public, if not convinced of the

necessity and appropriateness of the policies, can impose sanctions through periodic elections and protest" (p. 172). 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 government's priority agenda? In this model, the underlying premise about policy development and change is that "policy making is often the fate of random, unpredictable events." (Blankenau 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 opening of a window allows an issue to rise in priority on the government's agenda (Kingdon 1995). Joe Blankenau (2001) uses the MS model to explain the passage of the Medical Care Act in Canada.

The 'problem' stream consists of: *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 put forward onto a government's agenda (Kingdon 1995). Blankenau (2001) 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 concerns about the quality of care that was available. A crisis or external focusing event can also force an issue onto a government's agenda, and Blankenau (2001: 50) argues that the Saskatchewan doctors' strike "propelled the issue onto the national agenda." Finally, policy feedback is also important and in Canada, the popularity and success of the Hospital and Diagnostic Services Act had a positive demonstration effect that made the Medical Care Act easier to sell.

The 'policy' stream includes the policy development – basically, this is a set of policy solutions looking for a policy problem. In this stream, people are developing a policy proposal by assessing its technical feasibility (is it do-able?), its cost (is it affordable?), and its acceptability (will people – the public, politicians, interests – find it consistent with their values and beliefs?) (Kingdon 1995). Once a policy problem arrives on the horizon for which this policy may be a solution, efforts are made to link the two. According to Blankenau's analysis, the Medical Care Act was deemed to be marginally feasible in terms of costs, but only with cutbacks in other health spending areas and thus did not cover all of the services that had been recommended by the Hall Commission. The technical feasibility was not in question since the HIDSA had demonstrated that government had the expertise and capacity to administer such a program. Finally, the values of the program were consistent with many, but not all, policy makers, but seemed to find greater resonance with the public (Blankenau 2001).

The 'politics' stream includes: the national mood, consisting of the views of the public, interest groups and policy makers; interest group activity; and a change in government or governing party (Kingdon 1995). Canadians were supportive of a national medicare program but "were ambivalent about how medical care insurance should be implemented." (Blankenau 2001: 51). The program was adamantly opposed by key interest groups, particularly the medical

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 Canada's Medical Care Act, 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 politics stream with the pressure of the CCF/NDP as the third party. These streams were joined with the problem stream (namely, the problems of poor accessibility to and quality of available health care) by key policy entrepreneurs, such as Paul Martin *pater* in the Liberal cabinet and Tommy Douglas in the Saskatchewan government and later the federal NDP, to create a window of opportunity in 1966.

Summary

This overview of the policy literature reveals one important lesson: there is no obvious and parsimonious theory or model that will explain policy development and change, even within a single country (Canada), a single sector (health care), and a single point in time (e.g., the Medical Care Act). Instead, there are multiple factors and contingencies that are specific to the issue in question and to the particular contextual environment of the time. Although each of these integrative approaches illustrates different combinations of the three I's – institutions, interests, and ideas – there are a number of commonalities that are worth drawing out.

First, all contain a strong element of agency – the notion that actors have both the will and the wherewithal to act on their beliefs and/or interests. Whether their motivations are based on material interests and power, or whether on professional values and expert knowledge, state and societal actors are not passive automatons that simply respond to structures and circumstances beyond their control.

Second, institutions define the parameters within which interactions among actors and between actors and ideas are played out, but do not determine them in a definitive way. They may limit choices but institutions do not determine which among those remaining options will be selected. Institutions do have a direct impact on state capacity and decision making processes, which in turn influence which actors are involved or consulted and how.

Third, ideas – both normative and cognitive – have a key role in interest formation and in motivating collective action. Ideas become deeply embedded in institutional structures of state and society and may be as difficult to change as the institutions themselves.

Fourth, policy legacies and feedback are important: what has happened in the past fundamentally shapes what exists in the present, and what is possible in the future. Furthermore, the *sequence* of events, more than simply the events themselves, is critical for establishing the particular path in which subsequent policies develop.

Fifth, the occurance of significant policy change – 'big bang' reform – is rare and unpredictable. The policy windows or critical junctures that create opportunities for such

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.

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