Project Research Paper

A Cross-Provincial Study of Health Care Reform in Canada

Academic Literature Review: Article Summaries

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Academic Literature Review – Article Summaries

A = Institutionalist/Organizational Frames
(i.e., historical-institutionalist, policy feedback/path dependency approaches)
B = Interests/Pluralist Frames
(i.e., rational actor, pluralist, agency approaches)
C = Ideas/Cognitive Frames
(i.e., agenda setting, ideas, discourses, values-based approaches)
D = Structural/Political-Economic/Social Frames
(i.e., political economy, political culture, social-structural approaches)

1. **Abelson, Julia and John Eyles (2002).** ***Public participation and citizen governance in the Canadian health system*****. Commission on the Future of Health Care in Canada. [B, D]**

   Abstract: This paper looks at the challenging issues associated with public participation in decision-making around health issues. What can public participation, and democratic processes more broadly, contribute to the health system, its governance and the values held by Canadians toward and in the health system? What is the history of that participation and does it contribute to a more efficient health care system? What should be the objectives of public participation in the future?

2. **Abelson J, Lomas J, Eyles J, Birch S, Veenstra G. (1995). Does the community want devolved authority? Results of deliberative polling in Ontario.** ***CMAJ*** **Aug 15, 153(4):403-12 [B]**

   OBJECTIVE: To obtain and contrast the informed opinions of people in five decision-making groups that could have a role in devolved governance of health care and social services. DESIGN: Deliberative polling. SETTING: Three rural and three urban communities selected from the 32 areas covered by a district health council in Ontario. PARTICIPANTS: A total of 280 citizens from five potential decision-making groups: randomly selected citizens, attendees at town-hall meetings, appointees to district health councils, elected officials and experts in health care and social services. INTERVENTION: Participants' opinions were polled during 29 structured 2-hour meetings. MAIN OUTCOME MEASURES: Participants' opinions on their personal willingness and their group's suitability to be involved in devolved decision making, desired type of decision-making involvement, information preferences, preferred areas of decision-making involvement and preferred composition of decision-making bodies. CONCLUSION: There are significant differences among groups in the community in their willingness to be involved, desired roles and representation in devolved decision making on health care and social services in Ontario.

3. **Adams, Duane, ed. (2001).** ***Federalism, democracy and health policy in Canada*****. McGill-Queen's University Press. [A]**

   Abstract: An exploration of the ways in which federal and provincial governments relate to one another, and to the citizenry, in the making of health policy. The future of Canadian health policy is the highest priority issue in Canadian politics and, recognizing that intergovernmental relations are central to tackling this issue, Federalism, Democracy and Health Policy in Canada examines the nature of prevalent intergovernmental regimes in the health sector and the impact of these regimes on both health policy and the health of Canadian federalism and democracy. Case studies tackle such

diverse issues as interpretation and enforcement of the Canada Health Act; the way in which Canada-wide health goals and objectives are handled; cost containment; the role of federalism in national health surveillance 'infostructure'; regionalization of the health system; and the workings of the federal-provincial-territorial health conference system. The introductory and concluding chapters provide a broad overview of the governance challenges facing Canadians in the health area. Starting with a belief that it is imperative to restore public confidence in the health system, editor Duane Adams argues that this requires a modernization of public purpose involving a new set of Canada-wide goals and objectives and that this can only be achieved through more effective and collaborative federal-provincial governance structures.

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

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

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

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

   - Chapter 1: From Medicare to Home Care: Globalization, State Retrenchment, and the Profitization of Canada's Health Care System (A.P. Williams, R. Deber, P. Baranek, A. Gildner)
   - Chapter 3: Health, Health Care and Neo-Liberalism (David Coburn)

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

ABSTRACT: This paper examines how the health care perspective that dominates home care obscures the broader processes of social exclusion that play out in this arena of public policy. A study of elderly women & women with disabilities receiving home care in Ontario reveals how managed community care generates & reinforces service users' social isolation & their spatial, institutional, & political exclusion. Analysis of study participants' experiences points to the challenges of moving away from a market discourse & a health framework to develop home care policy which achieves the inclusion & participation of elderly citizens & citizens with disabilities in need of assistance at home. 52 References. Adapted from the source document

8. **Bacchi, Carol Lee (1999). *Women, Policy and Politics: The Construction of Policy Problems*. London: Sage. [C]**

ABSTRACT: Discourse analytic, social constructivist, & feminist perspectives are used to develop an approach to the analysis of the construction of women's policy issues as problems. Issues addressed by policy proposals are interpreted & defined as problems created by the values & perceptions of the individuals involved in the policy formulation process. Thus, policy proposals address "problem

representations" eg, representations of real or objective issues. This approach emphasizes the identification & implicit & explicit influence of these problem representations in political debate & policy formulation. It is used to analyze equal pay, affirmative action, education, child care, abortion, domestic violence, & sexual harassmaent policies in Australia, Canada, the UK, the US, the Netherlands, Norway, & Sweden. An Introduction & Conclusion accompany 10 Chpts

9. **Banting, K.G. (1987).** ***The Welfare State and Canadian Federalism*****. Montreal and Kingston: McGill-Queen's University Press. [A]**

10. **Banting, K.G. (1995). The welfare state as statecraft:Territorial politics in Canadian social policy. In S. Leibfried and P. Pierson, eds.,** ***European Social Policy: Between Fragmentation and Integration*****. Washington: Brookings Institute [A]**

11. **Banting, K.G. and Stan Corbett (2001).** ***Health Policy and Federalism: A Comparative Perspective on Multi-Level Governance.*** **Montreal: McGill – Queens's University Press. [A]**

    Abstract: An examination of whether federal institutions influence policy outcomes in the health sector. Governments everywhere confront major challenges to their health care programs, but federal countries must respond through systems of multi-level governance. In Health Policy and Federalism the contributors analyse the resulting complexities in decision-making in five federations: Australia, Belgium, Canada, Germany, and the United States. They highlight the impact of federal institutions and processes on key dimensions of health policy, including the balance between the public and private sectors, overall levels of health spending, the access of citizens to services, and the capacity of policy-makers to manage their systems effectively. Contributors include Keith Banting, Johan de Cock (tThe National Sickness and Invalidity Insurance Institute, Belgium), David C. Colby (Robert Wood Johnson Foundation), Stan Corbett, Linda Hancock (Deakin University, Australia), Antonia Maioni (McGill University), and Dietmar Wassener (Universität Augsburg).

12. **Baranek, Patricia M. (2000).** ***Long Term Care Reform in Ontario: The Influence of Ideas, Institutions and Interests on the Public-Private Mix*****. University of Toronto Ph.D.Dissertation. [A,B,C]**

    Abstract: This research focuses on the reform of community-based Long Term Care (LTC) services in Ontario between 1985 and 1996 during which the three major political parties governed. Each introduced its own reform of LTC. The five models that were proposed, are analyzed from a public policy perspective, and an understanding of the factors that influenced policy formation is provided. The thesis focuses on two issues: policy content (an analysis of the design decisions of financing, delivery, and allocation) and policy process (an analysis of the interacting influence of ideas, institutions, and interests on reform). Prompted by concerns of an aging population its associated medical costs, reform began as a need to improve services for seniors to enable them to live at home for as long as possible. However, with improvements in medical technology and pharmaceuticals and concurrent hospital restructuring, care formerly provided by physicians and in hospitals increasingly shifted to the home where it was no longer covered by the <italic>Canada Health Act</italic>. Underlying the debate were the following: (1) the appropriate role of the state, (2) the public-private axis in financing, (3) models of delivery (not-for-profit versus for-profit), and (4) approaches to allocation (centrally planned, command and control decisions versus market-type mechanisms). To account for the shifts in models, a neo-institutional framework is adopted which argues the importance of considering the relative and interacting influence of ideas, interests, and institutions to account for policy development and change. None alone is sufficient. Unlike other health policy domains, the LTC policy sector was comprised of a strong state and a loose network of under-resourced societal interests, which allowed the ideas and interests of the government to

predominate over societal interests. Institutions, rather than constraining government actions, were marshalled to facilitate state ideology and interests. The analysis of the shifting public/private mix in LTC reform has broader implications for the future complexion of health care in Canada. By considering all three constructs—ideas, interests and institutions—an understanding is not only provided of the changes in the LTC sector, but also a heuristic for comprehending policy development in general.

13. **Barnes, Marian (2002). Bringing Difference into Deliberation? Disabled People, Survivors and Local Governance. *Policy-and-Politics*; 2002, 30, 3, July, 319-331. [C,D]**

    ABSTRACT: This article discusses the rules of the game in participatory democracy & the engagement of disabled people & mental health service users/survivors in the process. Drawing on theories of new social movements & of deliberative democracy the article considers how notions of "legitimate participants" are constructed within official discourse, & how those can be challenged by autonomous groups of disabled people. It also explores assumptions about appropriate forms of deliberation within participation forums & how an appeal to rational debate can exclude the emotional content of the experience of living with mental health problems from deliberation about mental health policy. The argument is illustrated by reference to research conducted by the author, & by a Canadian study of user/survivor involvement in policy making. 41 References.

14. **Behan,-Pamela (2000). Political Institutions and the Democratic Class Struggle: The Politics of National Health Insurance in the United States, Canada and Australia. *Dissertation-Abstracts-International,-A:-The-Humanities-and-Social-Sciences*; 2000, 61, 4, Oct, 1637-A. [A,D]**

    Abstract: Despite numerous studies addressing U.S. exceptionalism in welfare state policy, there is little agreement in the literature as to its determining factors. This study utilizes traditional comparative historical methods plus a recent advance, Qualitative Comparative Analysis, to systematically explore the determination of national health policy in the United States and its two most similar nations. The hypothesis of the study is that political institutional arrangements combine with the strength of social democratic forces to determine national health policy. Political histories of national health policy for the United States, Canada and Australia were constructed, and the results summarized in seventeen cases with four types of outcomes. Thirty-seven potentially causal state, class and interest group factors were measured for each case. Boolean analysis of this data set indicates that three political and one social democratic condition were present in each case resulting in a national health insurance success in these nations: federal power in the health policy field, a multiparty political system, a legislative health policy legacy, and strong trade unions. In addition, one more political institutional or class factor was present in each successful case: either a lack of political veto points, or Labor party power. These findings support the hypothesis. They also suggest that welfare state policies are conjunctural in their causation, rather than determined by a single factor or cause, and that such conjunctural causation occurs in multiple forms.

15. **Behan,-Pamela (2000). Three Trajectories: The Shaping of National Health Policy in Canada, Australia and the United States. American Sociological Association (ASA), Association-Paper. [A, B, D]** [Sociology Dept, U Colorado, Boulder 80309-0327 [tel/fax: 870-802-2510; e-mail: pbehan@fastdata.net]

    ABSTRACT: Utilizes comparative historical methods to examine the factors that have shaped national health policy in the United States & its two most similar nations, Canada & Australia. The three nations' health policy histories are described, with special attention to their class relations, interest group dynamics, & the founding events & development of their social welfare & political institutions. The three nations are found to have had highly similar social welfare institutions &

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

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

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

17. **Blomqvist, Åke and David M. Brown (1994*). Limits to care: reforming Canada's health system in an age of restrain*t. C.D. Howe Institute.**

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

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

Abstract: This article uses the case of health insurance policy in the US and Canada to try to explain how particular state-societal patterns of intermediation unfold, become institutionalized and effect quite different policy strategies. It begins by outlining the importance of formal political and administrative institutional structure in the exercise of autonomous state action. It then examines the concepts of policy community and policy network as state-specific vehicles of interest intermediation and finally it grounds the theoretical discussion in a comparative description of the evolution of health policy in the US and Canada. It concludes that to a great extent, we are the prisoners of our instutions - both political and societal -- and without fundamental change, necessitating major upheaval, the US is unlikely to embrace a national health insurance program similar to other western nations.

20. **Boase, J.P. (1998). <u>Federalism and Public Policy: Health Policy and the Canada Health and Social Transfer</u>. Paper prepared for the CPSA Meetings, Ottawa.(un pub) [A]**

21. **Boase, Joan Price (1994). *Shifting Sands: Government-Group Relationships in the Health Sector.* Queen's-McGill University [B, D]**

Abstract: In this comparative study Boase traces the evolution of relationships among governments and health care interest groups in four provinces – Ontario, Quebec, Nova Scotia and Alberta – and finds that, although they have faced similar problems, they have responded in different ways. She employs several theoretical approaches to explain these responses, including community/policy networks, institutionalism, and state traditions, and uses case studies to illustrate the intense interest group activity that has occurred in this sector. Boase reaches three conclusions: 1) with the development of the national health insurance plan, government actions have shifted from reliance on interest group liberalism towards concerted efforts to plan the structure of the welfare system; 2) the different systems of interest intermediation that evolved in the provinces reflect the underlying

political and administrative culture and institutional structures within the provinces; 3) the unique proactive approach taken by Ontario in the 1980s was a deliberate effort to modify the institutional arrangements through which groups had traditionally influenced policy. Boase suggests that the complexities of modern government and the move toward redistributive politics will lead the positive state to make extraordinary efforts to control its environment in the future.

22. **Boyce,-Rosalie-A. (1993). Internal Market Reforms of Health Care Systems and the Allied Health Professions: An International Perspective.** ***International-Journal-of-Health-Planning-and-Management*****; 1993, 8, 3, July-Sept, 201-217 [B].**

    ABSTRACT: Reports early experiences of the consequences of restructuring on the allied health professions from a five-country fieldwork study including the US, UK, Canada, Sweden, & Australia. Data suggest that decisions on new organizational structures for allied health professions are likely to affect their potential to participate competitively in the market reforms of health care systems. 1 Table, 44 References.

23. **Bradford, Neil (2000). The Policy Influence of Economic Ideas: Interests, Ideas and Innovation in Canada. In Mike Burke, Colin Mooers and John Shields, eds.,** ***Restructuring and Resistance: Canadian Public Policy in an Age of Global Capitalism*****. Halifax: Fernwood [D]**

24. **Braën, André (2002).** ***Health and the distribution of powers in Canada*****. Commission on the Future of Health Care in Canada. [A]**

    Abstract: This study deals with the constitutional distribution of powers in the area of health services. It analyses the applicable provisions in Canada's Constitution as well as their interpretation by the courts.

25. **Brown, M.C. (1986). Health Care Financing and the Canada Health Act.** ***Journal of Canadian Studies,*** **21(2):111-133. [A]**

    Abstract: This paper examines the argument that the Canada Health Act, 1984, represented the culmination of a policy of development by the federal government which forced provincial governments to finance national health insurance programs without giving these governments the financial capacity to do so. Consideration of trends over the 1972-1984 period suggests that the argument has not been valid historically, but that it might become so in the future, that the Canada Health Act was necessary to maintain the integrity of national health insurance in Canada.

26. **Bryant, Toba (2002). A critical examination of the hospital restructuring process in Ontario, Canada.** ***Health Policy*** **64:193-205. [C,D]**

    Abstract: Little work has been done to consider the roles of different forms of knowledge and civil society actors in health policy development. Research on the role of knowledge in policy change has focussed on the contributions of social science knowledge and social scientists. This view assumes that the perspectives and knowledge of experts are the only vallid input into the process and is non-critical in its analysis of health policy and health inequities. This paper challenges the reliance upon certain types of knowledge that are brought to bear on the health policy change process, and that knowledge creation are inpartial activities. This paper presents a conceptual framework of health policy change that incorporates broad concepts of knowledge and civil society actors as contributing to health policy development. It also demonstrates the different dynamics that impinge upon knowledge and its use in health policy change. A case study on hospital restructuring in Toronto, Canada, is presented. Women's College Hospital fought recommended closure and merging of its

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Abstract: The argument presented in this article is that the appointment of an ad hoc expert commission to carry out governance is unlikely to depoliticize difficult restructuring issues or to deflect blame from governments dealing with such problems in Westminster style polities. Unlike in American-style presidential systems and parliamentary systems with proportional representation experiencing frequent minority governments, such commissions can never be truly independent as there are no serious checks on the government's ability to remake the agency, its mandate, its composition, nor even any barriers to the government's premature termination of an ad hoc expert commission's authority. When governments in a Westminster style polity seek to establish the appearance that such a commission is an independent agency of governance they must work at cross-purposes to the basic rules for insuring accountability by giving such a body a very vague mandate. This will almost certainly lead to disputes between political actors and the commission over its powers and refocus blame on the government. The ministers of a government employing this strategy

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

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

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

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

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

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

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

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

- Private financing approaches suggested by the federal Senate Committee and the Alberta Mazankowski Committee
- Federal government proposals to limit or prohibit assisted human reproduction technologies, such as cloning
- Supreme Court of Canada's decisions in Latimer (euthanasia) and Dobson (liability of mother in tort to unborn fetus)
- The legal implications of such advances in medical science as the mapping of the human genome, embryo and stem cell research, and cloning.

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

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

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

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

41. Evans, R.G. (1999). Health reform: What business is it of business? In Daniel Drache and Terry Sullivan, eds., *Health Reform: Public Success, Private Failure*. Routledge. [B]

42. Evans, R.G. (1997). Going for the gold: the redistributive agenda behind market-based health care reform. *J Health Polit Policy Law*; 22(2):427-65 [B, D]

Abstract: Political conflict over the respective roles of the state and the market in health care has a long history. Current interest in market approaches represents the resurgence of ideas and arguments that have been promoted with varying intensity throughout this century. (In practice, advocates have never wanted a truly competitive market, but rather one managed by and for particular private interests). Yet international experience over the last forty years has demonstrated that greater reliance on the market is associated with inferior system performance--inequity, inefficiency, high cost, and public dissatisfaction. The United States is the leading example. So why is this issue back again? Because market mechanisms yield distributional advantages for particular influential groups. (1) A more costly health care system yields higher prices and incomes for suppliers--physicians, drug companies, and private insurers. (2) Private payment distributes overall system costs according to use (or expected use) of services, costing wealthier and healthier people less than finance from (income-related) taxation. (3) Wealthy and unhealthy people can purchase (real or perceived) better access or quality for themselves, without having to support a similar standard for others. Thus there is, and always has been, a natural alliance of economic interest between service providers and upper-income citizens to support shifting health financing from public to private sources. Analytic arguments for the potential superiority of hypothetical competitive markets are simply one of the rhetorical forms

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

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

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

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

45. Flood, C.M. (1997). Conflicts between professional interests, the public interest, and patients' interests in an era of reform: Nova Scotia registered nurses. ***Health Law J*** **5:27-43 [B]**

46. Fierlbeck, K. (1997). Canadian Health Care Reform and the Politics of Decentralization. In C. Altenstetter (Ed.), ***Health Policy Reform, National Variations and Globalization.*** **(pp 17-38). London: MacMillan Press Ltd. [A]**

47. Frankford, David M (1997). The normative constitution of professional power. ***Journal of Health Politics, Policy and Law*** **22(1):185-221. [B,C]**

Abstract: The manner in which we think and talk about power in health care policy and regulation - and the political and social practices allied with that discourse - is examined. This language inculcates an individual and social passivity in which citizens rely upon various types of representative to constitute health care for them in a manner in which they do not and cannot participate. An alternative discourse of power is possible, in which power consists of the social interactions in which all mutually participate but no one can control. This alternative discourse of power might call forth participatory practices in health care and a concomitant diminution of specialization and expansion of the public sphere.

48. **Garvin,-Theresa; Eyles,-John (2001) Public Health Responses for Skin Cancer Prevention: The Policy Framing of Sun Safety in Australia, Canada and England** ***Social-Science-and-Medicine*****; 2001, 53, 9, Nov, 1175-1189. [C]**

ABSTRACT: This paper employs the policy analytic approaches of framing & narrative to examine national differences in public health policies using a case study of Sun Safety programs in Australia, Canada, & England. The study shows how a single public health issue identified at the global scale (rising skin cancer rates) is framed differently based upon specific social, cultural, & political situations. The result is a different story, or narrative, embedded in each national policy. This study provides an example of how health policy is defined, constrained, & limited through the process of problem identification & policy resolution. The paper concludes that framing & narrative analysis are powerful tools for understanding the place-specific implementation of public health policies & initiatives. 1 Table, 75 References.

49. Geva-May, I. & Maslove, A.M. (2000). What prompts health care policy change? On political power contests and reform of health care systems (The case of Canada and Israel). ***Journal of Health Politics, Policy and Law,*** **25(4):717-741. [A, B]**

ABSTRACT: This article attempts to shed light on the complexity inherent in health care reform policies in the context of political power contests that trigger the changes imposed on the health care system. Rather than being solely a response to financial circumstances, as it is often claimed, we argue that these political contests lead to many of the changes in the systems. Furthermore, changes do not necessarily occur when worrying symptoms appear in the system, but rather when the contest reaches a peak & when neither side involved can emerge from the contest as winner or loser & as defender of the public interest. While in both cases, fiscal problems in the health systems are usually brought up in order to justify reform, the trigger for change in Israel has been the power contest between the two main parties - the Labor Party & the Likud Party - with the Likud attempting to impair the financial basis of the former. In Canada, the power contests are between the provinces & the federal government. 55 References.

50. Giacomini, Mita, Jeremiah Hurley, Irving Gold, Patricia Smith and Julia Abelson (2002). '*Values' in Canadian Health Policy Analysis: What Are We Talking About?* Report to the Canadian Health Services Research Foundation. [C]

51. Gibson, D. (1996). The Canada Health Act and the Constitution. *Health Law J* 4:1-33 [A]

52. Gildiner, Alina (2001). *What's Past is Prologue: A Historical Institutionalist Analysis of Private-Public Change in Ontario's Rehabilitation Health Sector, 1985-1999*. University of Toronto Ph.D. Dissertation. [A]

53. Glied,Sherry (1997): *Chronic Condition: Why Health Reform Fails*. Cambridge: Harvard University Press. [C, D]

Book Jacket: Chronic Condition provides a compelling analysis of the causes of the current health care crisis and of the shortcomings of reform proposals. It also offers an ingenious new framework for reform that, while minimizing government interference, would provide a means for financing care for the less affluent. Sherry Glied shows that rising health care spending is consistent with a rising standard of living. Since we can, as a nation, afford more health care, reform must address not the overall level of health care costs but the distribution of health care spending. Prior reform proposals, Glied argues, have failed to account for the tension between the clearly manifested desire for improving the quality of health care and the equally widespread interest in assuring that the less fortunate share in these improvements. After careful analysis of the ill-fated Clinton plan, Glied proposes a new solution that would make the willingness to pay for innovation the means of financing health care improvements for the less affluent. While rejecting the idea that the distribution of health care should be perfectly equal, Glied's proposal would enable all Americans to benefit from the dynamics of the free market.

54. **Gray, Gwendolyn (1991). *Federalism and health policy: the development of health systems in Canada and Australia.* University of Toronto Press. [A]**

55. **Gray,-Gwen (1998). Access to Medical Care under Strain: New Pressures in Canada and Australia. *Journal-of-Health-Politics,-Policy-and-Law*; 1998, 23, 6, Dec, 905-947. [A,C]**

ABSTRACT: Health policy changes intended to achieve cost control in Organization for Economic Cooperation & Development countries run the risk of reintroducing financial barriers to health care. Here, compared are the health policy approaches of Canada, which has preserved universal access, & Australia, which is promoting a two-tier system through the provision of public subsidies for private insurance. The evidence is that country-specific factors, eg, institutional arrangements, attitudes, & values, intersect with economic & financial factors to shape policy outcomes. Moreover, the

Canadian & Australian experiences suggest that in relation to access issues, attitudes & values are the key policy determinants. 1 Figure, 114 References.

56. **Grogan,-Colleen-M. (1992). Deciding on Access and Levels of Care: A Comparison of Canada, Britain, Germany, and the United States. *Journal-of-Health-Politics,-Policy-and-Law*; 1992, 17, 2, summer, 213-232. [A, C]**

ABSTRACT: The minimum benefits strategy for universal medical coverage preferred in the US is compared with universal coverage plans in Canada, GB, & Germany. Assessed is why Americans favoring universal coverage tend to support policies that explicitly define a minimum benefits package. In Canada, GB, & Germany, medical services are not rationed at a minimum benefit level. Rather, difficult political battles are fought in these countries about how the structure of the health care system should look, not about what constitutes an acceptable minimum level of benefits. 7 Tables, 2 Figures, 22 References.

57. Hacker, J.S. (1998). The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian and US Medical Policy. *Studies in American Political Development,* 12(Spring):57-130. [A, B, C]

Abstract: Government-sponsored health insurance is a central pillar of the modern welfare state. In advanced industrial democracies, public spending on medical care accounts for an average of 6 percent of gross domestic product (GDP), making it the largest category of social spending after public pensions. Despite the popularity and resilience of established health programs, however, the introduction of government-sponsored health coverage has been highly controversial everywhere. Few social programs involve the state so directly in the workings of the economy and the practice of a powerful profession. Few entangle the interests of so many diverse and resourceful groups. And few cast in such stark relief the ideological principles at stake. Although the participants in conflicts over health policy have differed from nation to nation, no country has acquired national health insurance without a fierce and bitter political fight.

58. Howlett, Michael (2002). Do Networks Matter? Linking Policy Network Structure to Policy Outcomes: Evidence from Four Canadian Policy Sectors 1990-2000. C*anadian Journal of Political Science* 35(2): 235 – 267 [B]

Abstract: Relatively recent contributions to the policy literature have called into question the utility of the "network" approach to the study of public policy making, including a challenge to long-held views concerning the impact of the structure of policy subsystems on policy change. This article uses empirical evidence accumulated from case studies of four prominent Canadian federal policy sectors over the period 1990-2000 to address this issue. It sets out a model that explains policy change as dependent upon the effects of the articulation of ideas and interests in public policy processes, and generates several hypotheses relating different subsystem configurations to propensities for paradigmatic and intra-paradigmatic policy dynamics. It suggests that the identification of the nature of the policy subsystem in a given policy sector reveals a great deal about its propensity to respond to changes in ideas and interests.

59. Hurley, Jeremiah, Jonathan Lomas and Vandna Bhatia (1994). When tinkering is not enough: Provincial reforms to manage health care resources. *Canadian Public Administration* 37(3):490-514. [A]

Abstract: Prompted by fiscal deficits and guided by recommendations of provincial review commissions, a number of provinces are restructuring their health care systems to improve resource

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

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

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

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

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

63. Lavis,John N (2002): *Political Elites and their Influence on Health-Care Reform in Canada.* Submission to Commission on the Future of Health Care in Canada. [B]

64. Lavis, John N. (1998). <u>Ideas, policy learning and policy change: the determinants-of-health synthesis in Canada and the United Kingdom</u>. McMaster University. [B]

Abstract: Over the past several decades, reserachers have developed a vast body of knowledge about the social determinants of health. Drawing on scholarship about the role of ideas in policy making, I developed a conceptual framework to identify institutional innovations or policy changesin Canada and the UK which may have come about, at least in part, because of the determinants of health synthesis and to determine the role that these ideas played in the politics associated with these developments. Elite interviews and reviews of primary and secondary sources suggested that the policy-relevant ideas embodied in the determinants of health synthesis played strategic, rather than instrumental, roles in any institutional innovation or policy change. The greater number of policy making bodies in Canada's federal governance structure and the different relationships between the governing party and the groups with whom ideas were associated at the time they were introduced to the political arena may explain why the cases in which these ideas did play a role were all drawn from Canada. Discordance between these ideas and specialized bureaucratic structures suggests that institutional innovations may provide (in the short term) the most likely role for the ideas and (in the long run) the most influential role.

65. **Lazar, Harvey ed. (1998).** ***Canada: The State of the Federation 1997 – Non-Constitutional Renewal*****. Kingston: Institute for Intergovernmental Relations, Queen's University. [A, C]**
    - John Richards, Reducing the Muddle in the Middle: Three Propositions for Running the Welfare State
    - Harvey Lazar, The Federal Role in the New Social Union: Ottawa at a Crossroads
    - Keith Banting, The Past Speaks to the Future: Lessons from the Postwar Social Union

66. **Lee, Sidney S. (1979).** ***Quebec's health system: a decade of change, 1967-77*****. Institute of Public Administration of Canada.**

67. **Lexchin,-Joel (1998). Drug Makers and Drug Regulators: Too Close for Comfort. A Study of the Canadian Situation. In HEALTH AND CANADIAN SOCIETY: SOCIOLOGICAL PERSPECTIVES (3rd edition), Coburn, David, D'Arcy, Carl, & Torrance, George M. [Eds], Ontario: U Toronto Press, 1998, pp 485-496. [A,B]**

    ABSTRACT: Examines deficiencies in current Canadian laws regulating drugmakers & proposes a method for addressing these deficiencies. It is shown that a system of clientele pluralism lies at the root of the deficiencies in such regulation. Pharmaceutical companies & the state have entered into an intimate relationship that fundamentally shapes the kinds of laws & how they are enforced in this industry. Although the Health Protection Branch has recently been given more resources for enforcement, it is suggested that this solution will be ineffective. Only by diluting the influence of drug companies in the formulation, implementation, & enforcement of policies in this area will deficiencies be addressed. However, given recent trends in the government's drug review process, it is unlikely that democratization in the field of drug policy will be achieved in the near future. 32 References

68. **Maioni, Antonia (1994).** ***Divergent pasts, converging futures? The politics of health care reform in Canada and the United States*****. Canadian-American Center, University of Maine. [A]**

69. **Maioni, A. (1995). Nothing Succeeds Like the Right Kind of Failure: Postwar National Health Insurance Initiatives in Canada and the United States.** ***Journal of Health Politics, Policy and Law*****, 20(1):5-30. [A]**

    ABSTRACT: To illustrate how the events of the 1940s set the stage for future health reforms in the US & Canada, the evolution of post-WWII proposals for national health insurance in the two countries is compared. Differences between political institutions, party systems, state actors, & societal groups brought about different legislative outcomes. In the US, a divided Democratic Party & the imperatives of political compromise made forging a consensus on national health insurance next to impossible. In Canada, on the other hand, the presence of a social-democratic third party led to a very different type of debate & laid the foundations for a universal health insurance system. 60 References.

70. **Maioni, A. (1997). Parting at the crossroads: The development of health insurance in Canada and the United States, 1940-1965.** ***Comparative Politics*****, 29(4):411-432. [A]**

71. **Maioni, A. (1998).** ***Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada.*** **Princeton: Princeton University Press. [A, B]**

72. Maioni, A. (2002). Health care in the new millenium. In Herman Bakvis and Grace Skogstad, eds., *Canadian Federalism: Performance, Effectiveness and Legitimacy*. Toronto: Oxford University Press. [A]

73. Manfredi, C.P. & Maioni, A. (1998). Cure or Complication: Judicial Management of Provincial Health Care Policy. Paper prepared for the CPSA annual meeting, Ottawa [A]

74. Manga, P. & Weller, G.R. (1991). Health Policy under Conservative Governments in Canada. In C. Altenstetter & S.C. Haywood (Eds.), *Comparative Health Policy and the New Right: From Rhetoric to Reality.* (pp 207-224). New York: St. Martins. [A, D]

75. Marmor, Theodore R. (2000). *The Politics of Medicare, Second Edition*. New York:Aldine de Gruyter.

76. Marmor, Theodore R., Kieke G. H. Okama and Stephen R. Latham. (2002*). National values, institutions and health policies: what do they imply for medicare reform?* Commission on the Future of Health Care in Canada. [C]

Abstract: This research tackles the issue of "national values" and how they are expressed in our health care system. Evidence from other countries shows that the same set of values can be manifested in different social arrangements or institutions. So how much room is there for reform, where Canadians still show strong support for the same Medicare values?

77. Maslove, A.M. (1992). Reconstructing fiscal federalism. In Frances Abele, ed., *How Ottawa Spends 1992-93: The Politics of Competitiveness*. Ottawa: Carelton University Press. [A]

Abstract: Established Programs Financing (EPF) is not clearly seen by both the provinces and Ottawa as a failed program, though for different reasons. Among the reasons for its failure are: 1) the excessive vagueness of the program; 2) the linking of health care and education; 3) its inability to provide the federal government with visibility commensurate with its financial commitment; 4) a lack of financial security for the provinces. The chapter examines possible rationales for federal intervention in each of these policy fields and argues that, for the most part, EPF poorly serves national purposes. However, the negotiation of new arrangements between the provinces and Ottawa is likely to be difficult because of substantive issues involved, and because of the current fiscal and constitutional environments

78. Maslove, A.M. (1996). The Canada Health and Social Transfer: Forcing the Issues. In G. Swimmer (Ed.), *How Ottawa Spends 1996-97: Life Under the Knife.* (pp 283-301). Ottawa: Carleton University Press. [A]

79. Maslove, A.M. (1998). National Goals and the Federal Role in Health Care. In National Forum on Health (Ed.), *Striking a Balance: Health Care Systems in Canada and Elsewhere.* (pp 371-421). Ottawa: Editions MultiMondes. [A]

Abstract: The series of restraints on fiscal transfers to the provnces imposed by the federal government over the last decade have raised questions about the federal role in the field of health. This paper provides a context and framework for consideration of federal policy levers and presents potential alternatives. Of particular interest are fiscal instruments -- existing, proposed and potential-- given their importanceand the scrutiny to which they are subjected. It is the thesis of this paper that a role exists for the federal government to support national health care standards and to provide policy leadership in the field of health. It can also provide a more efficient substitute for interprovincial

coordination with respect to specific components of the health system. The key policy instrument is federal financial participation. However, the structure of the Canada Health and Social Transfer (CHST), as revealed to date, does not address most of the central issues surrounding federal financial participation in health care. A conceptual framework is developed for considering national goals and the federal role in health, followed by a descriptiion of the general types of policy instruments or levers that might be used in pursuit of these goals. We then describe the structure of the current federal health policy levers and examine a range of nonfinancial instruments. Finally, we consider several models for federal financial participation beyond the existing fiscal arrangements and the CHST.

80. **Mhatre,-Sharmila-L.; Deber,-Raisa-B. (1992). From Equal Access to Health Care to Equitable Access to Health: A Review of Canadian Provincial Health Commissions and Reports.** ***International-Journal-of-Health-Services*****; 1992, 22, 4, 645-668. [A, C]**

ABSTRACT: Since equality of access to health care has been achieved in Canada, policymakers are setting new goals, within resource constraints, designed to achieve equity of access to health. Here, policy options considered by provincial royal commissions are reviewed & critically analyzed within the context of challenges in health policy, eg, insufficient access to high-technology care & the limits of medical care, & external challenges, eg, economic & demographic trends, federal-provincial disputes, & ideological beliefs. Implications of a broader definition of health & the concept of regional health authorities are considered, & it is concluded that Canada wants to achieve equitable access to health. With the shift of health policy away from the formerly protected arena of medical care, this will require both an alteration of priorities & values & considerable political will. 4 Tables, 88 References. Adapted from the source document

81. Myles, John and Paul Pierson (1997). Friedman's revenge: the reform of 'liberal' welfare states in Canada and the United States. ***Politics and Society*** **25(4):443-472. [D]**

82. Naylor, C.D. (1986). ***Private practice, public payment: Canadian medicine and the politics of health insurance*****. McGill-Queen's University Press. [A, B]**

83. Naylor, C.D. (1992). ***Canadian health care and the state: a century of evolution*****. McGill-Queen's University Press.**

84. Naylor, C.D. (1999). Health care in Canada: incrementalism under fiscal duress. ***Health Affairs*** **18(3): 9-26. [A]**

Abstract: Driven by fiscal pressures in the 1990s, Canada's provincial Medicare systems cut inpatient care, expanded community services, and consolidated hospitals under regional authorities in nine of ten provinces. Public confidence has been badly shaken by the transition. No province has successfully integrated services across the continuum of care. Home care and prescription drug coverage vary from province to province. Efforts to reform physician payment have stalled, and capacity to measure and manage the quality of care is generally underdeveloped. Thus, for the next few years, policymakers must stabilize the acute care sector, while cautiously pursuing an agenda of piece-meal reforms.

85. **Neysmith, Sheila M. (2000).** ***Restructuring caring labour: discourse, state practice, and everyday life*****. Oxford University Press. [B, C, D]**

86. **O'Neill, Michael (1997). Stepping forward, stepping back? Health care, the federal government and the new Canada Health and Social Transfer.** ***International Journal of Canadian Studies,*** **15:169-184. [A]**

87. **O'Neill,-Michael-A..(1998). Entrenched Interests and Exogenous Change: Doctors, the State and Policy Change in Canada and the United Kingdom.** ***Journal-of-Commonwealth-and-Comparative-Politics*****; 1998, 36, 1, Mar, 1-19. [A, B]**

ABSTRACT: Discusses state-medicine relations in Canada & GB as an expression of medicine's perceived dominance of the health policy field. Two main questions - how institutional frameworks affect the outcome of state-medicine conflicts, & how the medical profession reacts to challenges to its policy monopoly - are considered in two instances where determined state actors enacted legislation in the face of widespread & vocal medical opposition: the 1984 Canada Health Act & the 1990 NHS (National Health Service) & Community Care Act. Contrary to much of the literature on professional dominance, here, the predominant role of the state in the state-medicine nexus is highlighted, & the conditional & ephemeral nature of medicine's policy monopoly & this monopoly's reliance on a cooperative & acquiescent state actor are shown. Institutional factors, eg, centralization, do not offer a greater opportunity for the solidification of the medical policy monopoly. Adapted from the source document

88. **O'Neill,-Michael-A. (1996). Health as an Irreversible Part of the Welfare State: Canadian Government Policy under the Tories.** ***International-Journal-of-Health-Services*****; 1996, 26, 3, 547-559. [A, C, D]**

ABSTRACT: Provides an assessment of the health policy of the Canadian Conservative government under Brian Mulroney, 1984-1993. It is argued that, despite a political rhetoric that might have presaged a sharp rollback of Canada's Medicare, either through residualization or progressive commodification, Canada emerged from this period of New Right federal government with its state-funded health care system still in place. This argument is substantiated through a consideration of the social policy model inherited by the Mulroney government & how it was affected by the government's fiscal policies between 1984 & 1993. 41 References.

89. **Ostry, Aleck (2001). International trade regulation and publicly funded health care in Canada.** ***International Journal of Health Services,*** **31(3):475-480.**
Abstract: The World Trade Organization (WTO) creates new challenges for the Canadian health care system, arguably one of the most socialized systems in the world today. In particular, the WTO s enhanced trade dispute resolution powers, enforceable with sanctions, may make Canadian health care vulner-able to corporate penetration, particularly in the pharmaceutical and private health services delivery sectors. The Free Trade Agreement and its extension, the North American Free Trade Agreement, gave multinational pharma-ceutical companies greater freedom in Canada at the expense of the Canadian generic drug industry. Recent challenges by the WTO have continued this process, which will limit the health care system s ability to control drug costs. And pressure is growing, through WTO s General Agreement on Trade in Services and moves by the Alberta provincial government to privatize health care delivery, to open up the Canadian system to corporate penetration. New WTO agreements will bring increasing pressure to privatize Canada s public health care system and limit government s ability to control pharma-ceutical costs.

90. Peterson, Mark A (1997). The limits of social learning: Translating analysis into action. ***Journal of Health Politics, Policy and Law*** **22(4):1077-1114. [A, C]**

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

91. Phillips, Susan D. (1996). The Canada Health and Social Transfer: Federalism in Search of a Vision. In Patrick C. Fafard and Douglas M. Brown, eds., *Canada: The State of the Federation*. Kingston: IIGR, Queen's University. [A]

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

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

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

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

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

Abstract: During the past decade, there has been substantial health system reform in the United States, United Kingdom, New Zealand, and many other countries. For the most part, Canada has not pursued 'big bang' health system change but rather a variety of strategies to achieve incremental change. In this paper, we present the ways in which three arms-length organizations have been used by government to effect incremental system change in Ontario during the past several years. We observe that, (1) the influence of politics and political interference can be reduced through an arms-length organization; (2) an arms-length organization with the power to make decisions entails more political risk for government and encounters more scrutiny and criticism by providers and the media than an organization with the power to recommend only; (3) an arms-length organization with a limited lifespan faces more delaying tactics by adversely affected parties than an organization without a limited lifespan; (4) an arms-length organization with perceived influence may attract causes that are not related to its mandate; (5) the importance and difficulty of communicating complex

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

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

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

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

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

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

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

99. **Rayside,-David-M.; Lindquist,-Evert-A. (1992). AIDS Activism and the State in Canada *Studies-in-Political-Economy*; 1992, 39, autumn, 37-76. [B, C]**

ABSTRACT: Examines the impact of acquired immune deficiency syndrome (AIDS) community activism on Canadian AIDS policy, drawing on various print materials, but more substantially on interviews (N not specified) with activists & policymakers (mostly conducted 1990/1991) in Montreal (Quebec), Toronto (Ontario), Vancouver (British Columbia), & Ottawa (Ontario). It is argued that health policy is normally resistant to influence from groups outside of medically expert circles, & that the marginalization of the gay population most affected by AIDS created impediments to shifting public health authorities from their traditional top-down approach to the management of disease. The circumstances of this epidemic, though, & the characteristics of the gay male population most at risk, created unusual openings through which activists could influence public policy at all three levels of government. There are indications that officials are seeking to regain some of the initiative & some of

the capacity to define the issues lost 1985-1990, but AIDS activism has dislodged state policy from a number of its traditional moorings.

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

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

101. Redden, Candace Johnson (2002). Health Care as Citizenship Development: Examining Social Rights and Entitlement. *Canadian Journal of Political Science* 35(1): 103 – 125 [C]

Abstract: The political importance of rights in liberal democracies, and of universally accessible health care in Canada, are trite observations. However, the increasing use of the language of rights to defend existing patterns of health care in Canada is a curious if not alarming phenomenon. What do citizens mean when they say that they have the right to health care? How can health care rights be defined philosophically and politically? This article examines the increasing popularity of rights claiming for health care, and argues that the "right to health care" has a non-possessive, normative nature that is at odds with legalistic individualistic rights claiming. This is a significant philosophical finding, one that informs the political debate over health care by revealing that legal rights claims are not sufficient to defend social entitlements. The conceptual project undertaken in this article illuminates directions of reform and suggests that differentiated citizenship provides a better model than legal rights to guide reform efforts.

102. Redden, Candace (1999). Rationing care in the community: engaging citizens in health care decision making. *J Health Polit Policy Law* 1999 Dec;24(6):1363-89 [B, C]

Abstract: This article examines the theoretical and practical logics of community engagement exercises in health care rationing. To evaluate such exercises in Canada, it is necessary to compare suspected rationing exercises (such as those in Nova Scotia and Saskatchewan) with clear examples of rationing. The Oregon Medicaid reform process is considered an important example of transparent and community-level rationing from which Canadian executive-driven governments can learn a few valuable lessons. While the Oregon experiment seems to have been a (qualified) success, in the Canadian context, formal citizen participation in decision making might be incompatible with social rights and present an incongruous and antagonistic pairing of executive and popular sources of authority.

103. Redden, Candace (1998). *Through the looking glass: federal provincial decision-making for health policy*. Institute of Intergovernmental Relations, Queen's University. [A]

104. Richards, John (1997). *Retooling the Welfare State: What's Wrong, What's Right, What's to be Done.* Toronto: C.D.Howe Institute [A, C]

105. **Robertson,-Ann (1998). Shifting Discourses on Health in Canada: From Health Promotion to Population Health. *Health-Promotion-International*; 1998, 13, 2, June, 155-166.. [C]**

ABSTRACT: Arguing that discourses on health are products of the particular social, economic, & political context in which they are produced, it is shown that, in the early 1980s, the discourse on health in Canada shifted from a post-Lalonde Report lifestyle behavior discourse to one shaped by the discourse on the social determinants of health. The 1990s decade is witnessing the emergence of another discourse on health - population health - as a guiding framework for health policy & practice. Grounded in a critical social science perspective of health & health promotion, the population health discourse is criticized in terms of its underlying epistemological assumptions & the theoretical & political implications that follow. Does it matter whether talk is about heterogeneities in health or inequities in health? Arguing that it does, it is concluded that population health is becoming a prevailing discourse on health at this particular historical time in Canada because it provides powerful rhetoric for the retreat of the welfare state. It is also argued that it is health promotion's alignment with the moral economy of the welfare state that makes it a countervailing discourse on health & its determinants. 74 References.

106. Robinson, Geoffrey C. and George R.F. Elliot (1993). *Children, politics, and medicare: experiences in a Canadian province*. University of Calgary Press.

107. **Rocher, François and Miriam Smith (2002). *Federalism and health care: the impact of political-institutional dynamics on the Canadian health care system*. Commission on the Future of Health Care in Canada. [A]**

Abstract: This paper surveys the relationship between the federal government and the provinces in health care policy-making over time. It examines the way in which the division of powers in the health care system has been shared between the two levels of governments, as well as the conflicts that have arisen over direction in Medicare spending and policies. The paper also explores comparable federal systems such as Australia, Germany and the United States.

108. **Rosenau,-Pauline-Vaillancourt (1994-1995). Impact of Political Structures and Informal Political Processes on Health Policy: Comparison of the United States and Canada. *Policy-Studies-Review;* 1994-1995, 13, 3-4, autumn-winter, 293-314.. [A]**

ABSTRACT: Compares the health care systems of the US & Canada to illustrate how formal political structures & informal political processes define political conflict & impact policy outcomes. It is asserted that health policy in the US is less comprehensive than the Canadian centralized, universal health insurance system because of US political institution & policy processes that allow special interest intervention. US policy structures are partial but significant factors in the lack of health care reform legislation, as US constitutional features, the presidential system, political parties, & interest groups discourage efficient, comprehensive policy. 83 References. Adapted from the source document

109. Ruggie, Mary (1996). *Realignments in the welfare state: health policy in the United States, Britain, and Canada*. Columbia University Press. [A, D]

110. Ruggie, Mary (1999). The US, UK and Canada: Convergence or divergent reform practices? In Daniel Drache and Terry Sullivan, eds., *Health Reform: Public Success, Private Failure*. Routledge. [A, D]

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

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

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

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

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

ABSTRACT: Scholars examining the development of health insurance reform programs from an institutionalist perspective have drawn attention to the importance of state structures & administrative capacities in shaping social policy outcomes. Focusing on the introduction of the British National Health Insurance Act of 1911 & the Canadian Hospital Insurance Act of 1957, it is suggested that institutionalist analysis can obscure the historical record by: (1) ignoring the multiple institutional mechanisms that were available to policymakers at the time; (2) overlooking the contentiousness of policy battles; & (3) underestimating the extent to which similar institutions have functioned in very different ways. In the case of GB, it is argued that that national health insurance was part of a package of social reforms designed to halt the slide of GB from a position of preeminence in the world economy. The introduction of Canadian health insurance coincided with an increased role for local & federal states in fostering economic development in the nation. Institutional structures, cultural values, & political power were used in both states to create a consensus behind the new national agenda.

116. Soroka, Stuart N. (2002). ***Agenda Setting Dynamics in Canada*****. University of British Columbia Press. [A, C]**

Jacket Notes: Why do public issue like the environment rise and fall in importance over time? To what extent can the trends in salience be explained by real-world factors? To what degree are they the product of interactions between media content, public opinion, and policy making? This book surveys the development of 8 issues in Canada over a decade – AIDS, crime, the debt/deficit, the environment, inflation, national unity, taxes, and unemployment – to explore how the salience of issues changes over time, and to examine why these changes are important to our understanding of everyday politics.

117. Stevenson,-H.-Michael; Williams,-A.-Paul (1985). Physicians and Medicare: Professional Ideology and Canadian Health Care Policy. ***Canadian-Public-Policy / Analyse-de-Politiques*****; 1985, 11, 3, Sept, 504-521. [B]**

ABSTRACT: Questionnaire survey data are examined on the attitudes of 2,087 randomly selected Canadian MDs toward health care policy issues. The analyses indicate the influence of ideology on these attitudes by documenting the marked consensus on questions of professional autonomy vs government control of the health care system & the opposition to Medicare in principle, as opposed to relatively favorable assessments of the administration & effectiveness of Medicare in practice. The analysis further shows that variation in the intensity of professional criticism of Medicare is grounded, as the theoretical understanding of ideology suggests, not in objective differences of

occupational experience, but in subjective perceptions of occupational stress, threats to professional status, & differences in values concerning the definition of health problems & policy priorities. 3 Tables, 1 Appendix, 13 References

118. Stingl, M. (1996). Equality and Efficiency as Basic Social Values. In M. Stingl & D. Wilson (Eds.), ***Efficiency vs Equality: Health Reform in Canada.*** **(pp 7-19). Halifax: Fernwood Publishing Co. Ltd. [D]**

119. Stoddart, G.L. (1986). ***Medicare at maturity: achievements, lessons & challenges*****. Health Policy Conference on Canada's National Health Care System (1984: Banff, Alta.). University of Calgary Press.**

120. Swartz D. (1993). The politics of reform: public health insurance in Canada. ***Int J Health Serv*** **23(2):219-38 [A,D]**

Abstract: The centerpiece of Canadian health policy is a system of public health insurance covering the cost of hospital and medical services for all Canadians. The author analyzes the historical development of this policy and critically assesses its structure and dynamics. He argues that health insurance was won by Canadian workers through protracted industrial and political struggle. At the same time, health insurance was accommodated to the existing structure of power and privilege within the health care delivery system, which precluded a significant shift in the distribution of health care consumption and perpetuated the "irrationality" of a system that treats health as a problem located in the sphere of personal consumption.

121. **Tanenbaum,-Sandra-J.. (1996). "Medical Effectiveness" in Canadian and U.S. Health Policy: The Comparative Politics of Inferential Ambiguity.** ***Health-Services-Research*****; 1996, 31, 5, Dec, 517-532 [D].**

ABSTRACT: Compares the divergent policy responses of Canada & the US to the problem of medical ineffectiveness, finding that both demonstrate that probabilistic findings on medical effectiveness translate only ambiguously into action & are sufficient to dictate health policy. The Canadian strategy of reinforcing deprivatization & solidarity by disseminating effectiveness evidence to institutional & collective entities overstates the societal applicability of outcome research findings, while the US reinforcement of privatization & market competition by disseminating evidence to patients, physicians, & firms overstates their individual applicability. 42 References.

122. Taylor, M.G. (1987). ***Health insurance and Canadian public policy: the seven decisions that created the Canadian health insurance system*****. Institute of Public Administration of Canada: McGill-Queen's University Press. [A, B, C]**

123. Taylor, M.G. (1989). Health Insurance: The Roller-Coaster in Federal-Provincial Relations. In D.P. Shugarman & R. Whitaker (Eds.), ***Federalism and Political Community: Essays in Honour of Donald Smiley.*** **(pp 73-92). Peterborough: Broadview Press. [A]**

124. Taylor, M.G. (1990). ***Insuring national health care: the Canadian experience*****. University of North Carolina Press.**

125. Tuohy, C.J. (1987). Conflict and Accommodation in the Canadian Health Care System. In R.G. Evans & G.L. Stoddart (Eds.), ***Medicare at Maturity.*** **(pp 393-434). Calgary: University of Calgary Press. [A, B]**

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

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

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

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

Abstract: What drives change in health care systems? Why do certain changes occur in some nations and not in others? Author Carolyn Hughes Tuohy argues that the answer lies in understanding the "accidents" of history that have shaped national systems at critical moments, and in the distinctive "logics" of these systems. Tuohy looks at the experiences of Britain, Canada, and the US, offering an international comparative study of public policy systems, as well as a recent history of the circumstances in each country that have impacted on the structures of each's national health care system. The guiding focus of the book is Tuohy's study of decision making systems in each country, looking at the decisions made by those who provide, finance, and use health care services. Finally, Tuohy reviews current issues in the health care arenas of these three nations and provides suggestions to guide the strategic judgments that decision-makers must make.

130. Tuohy, C.H. (1999). Dynamics of a Changing Health Sphere: The United States, Britain and Canada. *Health Affairs*, 18(3): 114-134. [A,B]

Abstract: Different patterns of change in the American, British, and Canadian health care systems in the 1990s result from the particular logic of each system. Different balances of influence across major categories of actors, and different mixes of hierarchical, market-based, and collegial instruments have different implications for lines of accountability and for information costs, and thus create different incentives that shape behavior. Market instruments functioned differently when introduced into Britain's system of hierarchical corporatism than in the American mixed-market system. Profession/state accommodations in Britain and Canada tempered the pace of change, while the entrepreneurial logic of the US system generated a turbulent transformation.

131. Tuohy, Carolyn H. (2002). The costs of constraint and prospects for health care reform in Canada. *Health Affairs* 2002 May-Jun;21(3):32-46 [A,B]

Abstract: The sharp decline and equally sharp recovery in public health care spending in the 1990s in Canada set the stage for a broad consideration of reform options but also established hurdles to be overcome in taking action. By moving health care to the center of the federal-provincial agenda, reconfiguring the internal politics of medical and hospital groups, and heightening a public sense of the need for improvement, the legacy of the 1990s prepared the ground for reforms that would "modernize" the Canadian model. But it also yielded a degree of federal-provincial rancor and provider demands for "catch-up," which complicated the process of achieving major change.

132. Twaddle,Andrew C (1996): Health System Reforms – Toward a Framework for International Comparisons. *Soc Sci Med* 43(5), 637-654. [D]

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

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

Abstract: Sweeping changes are being proposed as Canadians examine our health care system. But what are the legal implications of health care reform? In this timely collection, lawyers and legal scholars discuss a variety of topics in health care reform, including regulation of private care, interpretation of the Canada Health Act, and the constitutional implications of proposed reforms

134. Weir, Richard (1973). Federalism, interest groups, and parliamentary government: The Canadian Medical Association. *Journal of Commonwealth Political Studies* 11(July):159-175. [A, B]

135. **Weller,-Geoffrey-R. (1986). Common Problems, Alternative Solutions: A Comparison of the Canadian and American Health Systems. *Policy-Studies-Journal*; 1986, 14, 4, June, 604-620. [A,D].**

ABSTRACT: An attempt is made to relate social & political differences between Canada & the US to policy outputs in the health care field. It is argued that three broad sets of factors affect health policy output in any society: developments in the social system, in the political system, & in the health field itself. Similarities & differences between the US & Canada in these three areas are examined. The health policy outputs of the two nations are then compared, & conclusions drawn concerning their effectiveness. Modified AA

136. Weller, G.R. & Manga, P. (1983). The Development of Health Policy in Canada. In M.M. Atkinson & M.A. Chandler (Eds.), *The Politics of Canadian Public Policy.* (pp 223-246). Toronto: University of Toronto Press. [A]

137. Williams AP, Vayda E, Cohen ML, Woodward CA, Ferrier BM. (1995). Medicine and the Canadian state: from the politics of conflict to the politics of accommodation? *J Health Soc Behaviour* 36(4):303-21 [B]

Abstract: This paper analyzes data from three large-scale surveys of Canadian physicians conducted over the past decade to examine the politics of a cohort of recently established family physicians in Ontario, and to assess the extent to which these politics represent a "softening" of professional resistance to government health insurance. Politically, this is an important cohort because the physicians in it have grown up without any firsthand knowledge of the pre-Medicare period, and because they are among the first to establish practices in the wake of the month-long 1986 Ontario physicians' strike, a high point of profession-government conflict. Factors which may have contributed to a moderation of medical politics include the progressive entry of women into medicine. Our data suggest that professional opposition to Medicare is declining and that fewer physicians

support a return to voluntary and commercial control of the health system, a shift which could assist in breaking the historical cycle of profession-government conflict and moving to the politics of accommodation. In the conclusions we discuss implications for medical politics in Canada and other countries such as the United States.

138. **Wilsford, D. (1995). States facing interests: Struggles over health care policy in advanced industrial democracies.** ***Journal of Health Politics, Policy and Law*****, 20(3):571-613. [B]**

ABSTRACT: Given alarming fiscal imperatives, states & interests in all advanced industrial democracies have struggled over health care policy. Explored here is the interface between state autonomy in health care policy & the political mobilization of provider interests, especially physicians. Evidence from Germany, Japan, Canada, & GB suggests that, longitudinally, policymakers everywhere have tried to increase state autonomy in health care, & this has generally triumphed over even effectively mobilized providers. The countries that have most successfully restrained the growth of health care expenditures - while still providing ready access to relatively high-quality care - are those where states have most actively restrained both demand- & supply-side system interests in policy making. In each country, states have increasingly articulated their own greater capacities in health care policy, pushed to do so by the imperatives, especially fiscal, embedded in the policy domain. 2 Tables, 2 Figures, 103 References.

139. Wilsford, David (2000). Ideas, institutions and resources. ***Journal of Health Politics, Policy and Law*** **25(5):975-979. [B, C]**

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

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

ABSTRACT: Explores social values in relation to health care among a sample of Canadian Bioethics Society members & their designates (total N = 353), using four Delphi-style mail surveys, 1994/95. Four consensual values emerged: (1) availability of basic health care to all without serious personal economic peril, (2) more collective responsibility & less individualism, (3) acceptance of a social welfare state, & (4) genuine concern & caring for other people. Responses emphasized the fundamental nature of these values to the design of the Canadian health care system. As such, reforms of the system must take these values into account. 1 Appendix, 43 References.

141. **Wolfe,-Samuel (1991). Ethics and Equity in Canadian Health Care: Policy Alternatives.** ***International-Journal-of-Health-Services*****; 1991, 21, 4, 673-680. [D]**

Abstract: It is argued that a broad realignment of economic opportunities & class power in Canada is necessary before health care inequity will be corrected. Four forces now at work to exacerbate inequity are identified: (1) the push for greater cost containment & tighter ceilings on health care

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

Search Strategies:

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