

CPSA ANNUAL CONFERENCE

Session L5A

**“The Canada Health Act, Federal Funding, and
the Future of Health Care in Canada”**

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June 4, 2004

Abstract

Health care is an extremely important issue to all Canadians. It has also been one of the most study topics in Canadian public policy research. What needs to be considered at this point, in the health policy discussion, are the factors which must be present in order for a change in policy to take place. Why is that when so much has been written about the health care system, we have only seen two periods of substantial policy change (Medicare Act, and the Canada Health Act)? This paper examines the implementation of the Canada Health Act, and identifies the key variables that are present at the time of a substantial policy shift (or paradigm shift to occur). An important finding of this paper is that federal government's use of its spending power is a key variable in understanding the timing a paradigm shifts in health policy. This paper concludes by examining the effects that the change to the CHST may have on the future of health policy in Canada. The potential appears to exist for a substantial shift in health policy to occur in the near future.

Healthcare has become one of the most important issues in Canadian society. It has also been one of the most studied areas of public policy. Numerous articles, books and dissertations have been written discussing what is to be done about “fixing” the “problems” in healthcare. Many who have previously examined health policy in Canada have been concerned about which policy is implemented, and which policy would have been the best alternative to the status quo. However, one area that seems to have largely been ignored is the timing of policy change. What factors need to be present in order to have a health policy dramatically change direction? This paper will examine the factors that exist in society, that provide the backdrop for a major policy paradigm shift. This paper discusses and analyzes the causes of major change, and is not concerned with actual policy that is developed, but rather the conditions that are necessary for a policy change to occur.

The Canada Health Act represents a third order change in Canadian health policy. It represents a fundamental change in institutional structure surrounding health policy. The CHA represents the federal government’s attempt to institutionalize a role for itself in health policy by maximizing its use of the spending power. The federal spending power, and the willingness of the federal government to use it plays an important role in the analysis of this paper. Before the introduction of the Canada Health Act, the provinces were largely independent in the area of health policy. The provinces were constrained by their constitutional limits on taxation and the federal government was largely constrained due to the fact that they did not have formal jurisdiction over health policy. However, one of the goals of the federal government was nation building,

partially to be accomplished through the development of national social policy, and in order to do this they had to have control over how the money was spent.

The federal government attempted to and succeeded in changing the institutional structure. The CHA removed the old structure and “locked in” a new institutional arrangement, where the federal government was the dominant player. The provinces were now constrained, not only financially, but by the federal government through the CHA. The federal government is essentially only constrained by itself and the limits that it placed on its own spending. The federal government, because of its spending power, can in fact direct health policy largely in the direction it sees fit, and the provinces are then constrained to follow that direction, due to their dependence on federal fiscal resources.

The CHA, not the constitution, sets out the federal-provincial framework through which all subsequent health policy has been formulated. The Canada Health Act, 1984, elevated healthcare to the federal political agenda. The CHA has laid out the institutional framework in Canadian society, and it determines who has standing and what they can do. This paper will examine the process that led to the breaking of the policy “lock in” that existed prior to the introduction of the Canada Health Act, showing that the CHA was a third order change, and created a new “lock in” in health policy. Furthermore, this paper will also examine the current state of health policy in Canada suggesting that the window of opportunity may exist for the occurrence of a dramatic paradigm shift (third order change) , breaking the current policy “lock in.”

Theoretical Underpinnings

Before we proceed with our analysis of the Canadian case of health care policy we must take a step back and examine some of the theoretical arguments that provide the backdrop for the analysis presented in this paper. The concept of a policy “lock-in” was first articulated as such by Douglas North. North argues that institutions provide the formal rules of the game in a society. They constrain actors, allowing them to do certain things, while denying them the right to do others. There are both formal and informal constraints that exist, that limit the policy choices available at any given time. They do allow for marginal adaptation of the institutions, but they become “locked in” to a particular pattern (North, 1990, 68). North’s argument allows us to explain Canadian health policy during the periods that were relatively stable. “Lock ins” allow for the arrangements to be stable and for all policy to be conducted within a set framework of choices. Canadian health policy during the past twenty five years can be largely understood through North’s concept of “lock ins”. However, North’s argument in regarding a gradual transformation over time of the institutions in a policy field (North, 1990, 68) exists as the standard pattern of development throughout most of history. There have, however, been several major changes in Canadian health policy that are not completely explained by North’s ideas. This is because, although for long periods of our health policy history, institutional arrangements have been static, several exogenous shocks have added a surge of dynamic energy to an otherwise stable system

In order to understand some of the drastic changes in Canadian health policy, we must examine the effects that an exogenous shock will have to the system. This paper will examine the effects that an exogenous shock will have on the system. In our case the

exogenous shock to the system is the changing in the federal use of the spending power. The effects exogenous shocks have on policy systems is best described by Peter Hall. Hall argues that policy systems will function in a stable environment for periods of time, only adjusting the technical policy issues without fundamentally altering the goals of the policy (Hall, 1993). When there is a massive change in values underlying the policy, Hall refers to this as a third order change, and indicates that a third order change (exogenous shock) is driven largely by political actors as opposed to experts (Hall, 1993, 288). We can see an example of how this occurred in Canadian health policy, as the drive to introduce the Canada Health Act was largely driven by the federal government, and not experts such as doctors. A third order changes breaks us from the reinforcing influence that policy paradigms have on the institutional structure in society (Hall, 1993, 290). The exogenous shock that Hall attributes as being a potential source for shifts in policy paradigms (1993, 284), is manifested in Canada through shifts in the federal governments use of its spending power.

However, understanding the process of lock ins and paradigm changes still leaves one aspect of policy change that needs to be explained. Why is it that every time there is a shift or a change outside of the system there is not a third order change? The election of a new government does not guarantee that a third order change will occur, neither does a shift in federal funding. Each of these creates a window of opportunity which must be seized in order for the change to occur (Tuohy, 1999). In other words, there may be many of opportunities for a paradigm shift to occur throughout a stable policy period (when policy is locked in), however it requires a certain set of circumstances in order for change to occur. Health policy is like a ball placed at the top of a hill. It is full of potential

energy, but it does not start rolling because it is wedged against a rock (lock-in). In order for the ball to move, the rock must be removed from its path (exogenous shock=potential to break lock in). Additionally, in order for the ball's potential energy to be converted to kinetic energy, and for the ball to move to another position it must be kicked or pushed, (exogenous shock=third order paradigm shift). However, many people may choose not to kick the ball (for various reasons, they like where it is, worried about upsetting people who enjoy looking at the ball), or they may not have the strength (energy) to move the ball, or the rock may still be impeding the progress of the ball. Therefore a change in the ball's position requires the right person to pass its way, at the right time (when the rock has been removed), and recognize the possibility for change exists (see that the rock has been removed). The same is true for health policy. The opportunity for change may also exist but it requires the right opportunity in order for the exogenous shock to break the lock-in.

Cohen, March and Olsen have attempted to explain how change can occur. They use their garbage can model in an attempt to provide some reasoning in a chaotic world (1972). Using their discussion participant energy and energy costs in matching problems and solutions, we can understand why specific policies were adopted at certain junctures and not at others.

Combining the three theoretical perspectives allows us to gain a comprehensive understanding of the Canadian healthcare system. The system operates under predominately locked in conditions. However, there have been at least one and perhaps another third order change that has occurred, or is occurring in the last twenty five years. Furthermore, the garbage can model also helps us to understand why the CHA was the

solution that was matched to the problems in health care in 1984. Furthermore the garbage can model can help us to understand the current situation and the conditions necessary for another third order change in Canada.

From a Lock In to a Third Order Change: Exogenous Shock

The Canadian health system evolved over a number of years, but it reached a national scale involving both the federal and provincial level of government in 1966, with the passage of the Medical Care Act. Under this program Ottawa contributed directly to programs that covered the cost of physician services, in addition to funding that was already being contributed towards hospital insurance (Strick, 1999, 31). Under this original agreement, the federal government contributed fifty percent to the cost of hospital and physician services (Veldhuis & Clemans, 2003, 3). This was the prevailing nature of the federal provincial dynamic before the introduction of the CHA. The provinces were responsible for the initiation of new programs and Ottawa would assist the provinces by paying for half of the costs. The formal constitution, the Constitution Act 1982, was still the prevailing institutional structure, and any change to the system that was made was done in an incremental fashion that did not radically alter the fundamentals of the program. Under the Medical Care Act, there were a few key principles, such as universality, and the funding did help to enforce these, although in comparison to the CHA the principles were minor. Some doctors were able to opt out of this scheme, or they were allowed to extra-bill (Wilson, 1985, 356).

In 1977 the federal government switched the way in which it funded social transfers to the provinces from cost sharing programs to block grants. The provinces

would now receive a lump sum of money for social programs rather than a sum of money that was dependent upon the level of provincial money spent (Coyte and Landon, 1990 818-821). This represented a fundamental shift in the financial aspects of social policy and specifically health policy in Canada. The switch to block funding substantially lowered the ability of Ottawa to enforce the principles of the Medical Care Act (Boase, 2001 197). The federal government had altered the way in which it used its spending power, which caused a direct challenge to the current policy lock in, which was based on the foundation of cost sharing. Provinces began to attempt to replace lost funding under the new EPF funding framework with the introduction of facility fees, and extra-billing (Wilson, 1985, 356). The change in funding allowed for a breakdown in the consensus that largely existed in pre-1977 Canada. The reduction of the use of the federal spending power forced a reduction in the role that Ottawa was able to play within the existing lock in. In other words the options available to the federal government were limited by their own self-imposed restrictions of spending. This allowed for the provinces to begin adopting policies (such as extra-billing) which would have been nearly impossible to implement previously. Canadian health policy was entering a period of flux.

Opening the Window

We have seen that the changing of funding formulas has allowed new ideas to enter into the health care arena, and the potential was therefore a third order change. However, just because the potential was there does not mean that it was adopted. In fact Tuohy has argued that the CHA represented nothing more than a continuation of the traditional roles for health policy (Tuohy, 1999). However, this paper will show that the

CHA did create a new set of institutional dynamics that had to be adhered to, a new lock in that was distinct from the previous lock in period.

The switch to EPF provides the impetus for the third order change in policy, but why did it occur? One of the reasons was that under the EPF agreement of 1977 the penalties were very severe, and that made them unenforceable. The law was far too rigid, as Ottawa only had one solution to the problem of extra-billing and that was to completely cut off the province (Begin, 1988, 66 and 94). Furthermore, there were many cutbacks in the civil service which led to there not being enough auditors to properly enforce any of the principles of the Medical Care Act. This meant that user fees became a de facto legal policy instrument (Begin, 1988, 66). The 1977 agreement had also managed to remove many of Ottawa's contacts within the provincial capitals thus lessening the grip that Ottawa had on the provinces' use of federal money and the direction that health policy took (Begin, 1988, 86). The unique situation, of lack of money, and ability and will to enforce penalties that occurred in the late seventies and the early eighties assisted in the opening of the window. The rock that is impeding the ball has now been removed from its path.

Seizing the Moment

The window for change had clearly been opened and in order for there to be a fundamental shift the actors had to seize the moment and make the changes. Given this fact, we saw many new interest groups being formed during the period. For example the Friends of Medicare organization was formed in 1979 (Friends of Medicare, 2003). The development of these new groups attempting to influence the politics was important, as

these groups attempted to lobby the political actors and not to work with the bureaucrats on changing the system. Remember that Hall identifies a third order change by identifying the actors that are involved in the decision making process. A third order change involves the political level and not the bureaucratic level.

In fact it is clear that the adoption of the Canada Health Act was not a bureaucratic decision, but a decision that was driven by political forces. Begin indicates that when she took over as the federal Minister of Health the department was largely ill-informed in regards to issues surrounding user fees and proposed options for reform. There were no clear answers as to how much extra-billing was going on, and where it was occurring. The agreement to exchange information between the provinces and federal government never got off the ground. According to Begin, “the Department was in the dark,” about issues surrounding user fees (Begin, 1988, 23). The decision to proceed with the Canada Health Act was certainly an initiative at the political level, as the bureaucracy did not have the capacity at this point to enforce current legislation let alone begin to develop new ideas (Begin, 1988, 23). After the passage of the EPF legislation, the number of bureaucrats responsible for Health Insurance was nearly cut in half, as the department did not feel that with block funding it would need to enforce the provisions of the Act as stringently (Begin, 1988, 23).

Furthermore, a main source of the opposition was from political forces. The province of Alberta was one of the leading proponents in the fight against the Canada Health Act. Russell was Alberta’s Minister responsible for hospitals during the debate surrounding the implementation of the CHA. He argued that the federal government was trampling on provincial rights and ignoring the Constitution (Russell, 1984, 73).

Additionally he argued that the reason for the user fees being imposed was the cutback in federal funding, and that the federal government could not throw its weight around in health care without a subsequent source of financial support (Russell, 1984, 73). Russell argues that this use of the federal spending power goes far beyond any other use of the federal spending power. Its use through the CHA was an attempt to control provincial spending priorities (Russell, 1984, 79).

This debate between the federal and provincial levels of government was again taking place at the political level. Most of the debate was not over the technical issues of what actually makes for the better system of delivering health care, but rather it was centered on broad principles of federalism and provincial rights. Additionally, the entire conflict had largely been bound up in partisan politics. At this time in Canadian history, Alberta was governed by the Conservative Party, whereas the Liberal Party was in power federally. Furthermore, Alberta was still enraged at the federal government for the NEP and the effects of that policy contributed to the inflation of the rhetoric used in the debate surrounding the CHA.

Adopting the Canada Health Act, 1984: Matching the Solution to the Problem

The last step needed to explain the adoption of the Canada Health Act is to discuss why the Canada Health Act was the solution matched to the problems in the Canadian health system. The first reason is that Begin brought a considerable amount of energy to the table (or will, and ability to push the ball). Throughout the book that she has written on the adoption of the CHA, one can clearly see her determination to stop the

provinces from allowing extra-billing and charging facility fees (Begin, 1988). This level of persistence is remarkable and led to her being able to take the lead. The federal government also received an energy boost by the fact that a substantial majority in each province was against the use of extra-billing (Begin, 1988, 118).

Contrary to the strong energy brought by the federal government, the provincial governments brought a lot less energy into the system. Only Alberta brought a lot of energy to the table. Ontario acknowledged early on in the process that when push came to shove, they would have to concede the doctor's right to extra-bill in order to receive federal money (Frtiz, 1984, 12). The federal government clearly had the energy advantage, which helped enable them to attach their solution to the problem. The Canada Health Act also enjoyed another significant bonus. It would not anger Quebec. Dealing with the separatist issues in Quebec during this period was perhaps the dominant issue in Canada. Trudeau had just patriated the Constitution without the support of Quebec, and was anxious not to provoke them any further. Begin argued that the CHA would not anger Quebec because Quebec was not charging user fees and would therefore not be harmed by this legislation (Begin, 1988, 120). This meant that the energy required to match the CHA to the problems in Canadian society (as defined by Begin - user fees) was lowered as it would not provoke a confrontation with Quebec.

Another factor helped to lower the energy cost of the Canada Health Act. The CHA was the only constitutional option available to the federal government. The federal government could not simply pass a law in regards to extra-billing or regulate the compensation paid to doctors, as these were clearly in the provincial domain. The only way to influence health policy was to provide federal funding for federal objectives

(Begin, 1988, 103-105). This significantly lowered the energy cost of adopting the CHA, as it severely limited the other potential solutions that were available in the “garbage can”

Within the field of health policy, interest was also divided. There was a definite split between the doctors and the nurses, with the former preferring the extra-billing while the latter wanted to stop extra billing. Most of the medical profession preferred to be allowed to continue to extra-bill. They felt that they had the right as did any other profession to make money. All physicians tended to have a mixture of self-interest, professional ideology, and free enterprise ideology within them. The particular mix of ideology that each individual doctor had, determined whether or not the individual doctor charged user fees (Globerman, 1990, 11-23). On the whole the Medical Associations were against the CHA. It was in the doctors’ self-interest to continue charging user fees. The nurses were in line with the federal government and its decision to end extra-billing. This is largely because their immediate self-interest is not hindered by the ending of extra-billing as they are not allowed to extra-bill for their services (Fritz, 1984, 4). The fact that the medical community was so divided based on self-interest prevented them from presenting a united front. Thus they were not able to bring a lot of energy into the debate; most of their energy was expended internally.

Additionally, it was easier to pass the Canada Health Act, because it fit in with the overall ideology of Trudeau’s vision of the country. The Canada Health Act would focus Canadians on a central issue, and unify conditions on programs that would attempt to ensure a similar health system in each region of the country. It meshed well with the concept behind the Charter of Rights and Freedoms. Both policies fit Trudeau’s attempts to foster a pan-Canadian identity, within Canada (McRoberts, 1997). The proposed shift

in policy it would appear, need not only happen at the right time, but also push in the correct direction. If Begin's proposal for health reforms had contradicted the direction in which Trudeau was stirring the country it is doubtful that it would have ever started. The ball cannot roll uphill.

These factors lowered the energy level (made the strength needed to start the ball rolling) of the CHA to a level where it was possible to adopt it (push the ball down the hill). The window of opportunity for a third order change had been seized, and Canada now had the beginning of a new policy lock in. Now that we understand how the CHA was adopted and why it had the potential to be third order change, we can now show that it was indeed a third order change. In order to show that the CHA was a third order change we need to examine the effects that it has had over the last twenty years on Canadian society.

Institutional Change

Under the CHA, a new set of institutional dynamics have developed. The CHA is now the overarching dynamic that is referred to in health policy discussion as opposed to the Constitution. As mentioned earlier, Tuohy claims that the CHA was not a significant shift in policy from the previous era. However that clearly is not the case when we examine the institutional changes that have occurred. The ball has clearly rolled down the hill.

The first shift that has occurred is the federal government has been successful in enforcing national standards on provincial policy areas. The tying of national objectives to national dollars makes it extremely hard for provinces to forge their own path. When

there are federal dollars available, it becomes difficult for provinces to turn away from federal funding (Wilson, 1985, 366). The federal spending power is a very important institutional dynamic. The fining of provinces makes it difficult for them politically if they continue to charge user fees. The average tax payer looks at the dollar for dollar fine and discovers that the province loses whenever a user fee is charged. Therefore why are citizens forced to pay for the service when the federal government, at least on the surface appears to be willing to fund the total cost? The provinces, therefore, need the federal money and tend (even if reluctantly) to accept the national standards. The more money that Ottawa gives the provinces the more say they garner in the operation of the health system (Boase, 2001, 197).

Secondly, we can see that there has been institutional change in the actions now undertaken by the provincial governments. The Canada Health Act effectively changed the options that were available to provincial governments. The extent to which this has become institutionalized is quite remarkable. In the early years of the CHA many provinces charged user fees and were penalized for this by Ottawa. In effect, according to the annual report of the CHA in 1984-1985 (the first year in which the act was effective), seven of the ten provinces were penalized for continuing the practice of extra-billing or for charging user fees. The total amount of money that was retained by Ottawa equaled approximately eighty-five million dollars (Health and Welfare Canada, 1985, 21). However, the picture has radically changed over the past twenty years. In fact by the time that the annual report for the year 2001-2002 was published there was only one province that was being penalized for charging facility fees. Nova Scotia had \$39,000 withheld for not paying the full facility fees for non-medical abortions (Health Canada, 2002, 11).

Clearly the CHA has altered the institutional structure in health policy. User Fees and Facility Fees have been effectively eliminated. The only province that was fined under the CHA was fined for abortion fees, which probably have less to do with health policy and more to do with moral choices. The CHA has removed an option that was available to the provinces before the implementation of the Canada Health Act. The Act has become institutionalized through the process of policy learning. The provinces have found that their exclusive Constitutional right to legislate in the field of health care has been modified by the adoption of the Canada Health Act.

Value Change

In addition to the change in institutions that we have seen, the CHA has also altered the values that surround the development of health policy in Canada. If we go back to an issue of Doctor's Digest from 1979, we can see that the Alberta Medical Association was a strong proponent for the use of user fees (Editorial, 1979, 1-2). However by 1988, proposals for reforms focused on other areas of the health care system without a mention of user fees. Specifically, calls for reform were being made in regards to the structure of healthcare delivery, the technological developments in the field, and the ethics of physicians, but not about user fees (Higgins, 1988, 4-5). Furthermore, in an article from 2001 we can see that College of Family Physicians of Canada felt that user fees were not the preferred funding option (Rich, 1519). In another article from the same year the President of the AMA argues that in order to find new sources of funding we must not limit access to the system, which user fees may have the tendency to do (Cairney, 2001, 1519). We can clearly see that the medical community has changed

positions on the place of user fees within the system. This is likely due to the fact there has been an entire generation of doctors produced within the CHA institutional framework (William et al, 1995, 307). Initially in response to Ontario limiting the ability of physicians to charge user fees, there was a Doctor's strike (1986). This was a clear indication of the displeasure that the doctors had for the arrangements in health care (William et al. 1995, 306). In 1982, 38.2% of family physicians favored a return to the pre-public medical system. However, eleven years later the percentage of family physicians supporting a return to the pre-public system fell to only 15%. Furthermore, the number of physicians supporting the privatization of Canada's health care system has fallen from 57% in 1982 to only 44% in 1993 (Williams et. al 1995, 309). Despite the initial negative reaction to the CHA by the medical community they have undergone a value change. The Medical Associations no longer focus on balance billing (a term physicians use for extra-billing, meaning that they bill the patient for the difference between the actual cost of the service, and what the government was reimbursing them) as a tenant of their professional ideology. It has been replaced by a focus on the access to the system, and other areas for reform, such as professional ethics and structure of the healthcare profession. After the implementation of the CHA the medical lobby has undergone a change of core values, and what the group perceives as its self interest has been altered.

Among the Canadian population there has also been a value change in regards to our health care system. Before the introduction of the CHA, about 42% of Canadians felt that user fees created a problem for the health care system (Begin, 1988, 29). By the early and mid 1990's Canadians had fully embraced the principles of the Canada Health

Act. During the 1988 debates over free trade it was clear that health care had effectively become a defining element of Canadian identity (Tuohy, 1999, 102). In fact, in 1991, the support that Canadians had for all of the pillars of the CHA was extremely high, between 80-90%. Support for private funding was quite low and a majority of Canadians believed that increasing funding would improve the quality of care (Tuohy, 1999, 103). Canadians had clearly embraced the principles of the CHA and were extremely satisfied with the system itself. We saw the support for public administration and universality increase dramatically, between the passage of the CHA and beginning of the 1990's. This led to the belief that health care as a social trust was a part of the Canadian identity. What had started out as a simple piece of legislation (although as mentioned above, a piece of legislation which fit the model of Trudeau's pan-Canadian identity idea) had now fundamentally altered the framework of Canadian health policy, and the value and belief structure of Canadians.

A New Lock In

The rock now clearly appears to be back in place, preventing the ball from rolling down the hill. Monique Begin was able to institutionalize a change in Canadian health policy. As seen above the Canada Health Act represented a third order change, because it altered the institutional arrangements in health policy, and shifted the values of Canadians. The opportunity for a third order change presented itself, and was taken advantage of, as Begin was able to lower the necessary energy level of the CHA in order to match the problems in Canadian health policy. Additionally, we have seen the CHA launched a process of institutional and core value change in Canada.

How do we know that we have reached a lock in period? We are in lock in position because all of the options for reform of the system, and all policy reforms that are being suggested are referenced through the framework that was laid out in the CHA, in 1984. Okma suggests to us that all of the reform debates almost always focus around the compatibility of these reforms with the CHA (2002, 18).

One example of the extent to which the CHA has become locked in is the extent to which the province of Alberta operates within the framework. Alberta, as shown above, was the province that put forward the largest resistance to the adoption of the CHA. However, Alberta, under Canada's "maverick" Premier Ralph Klein, has gone to great lengths in order to justify their controversial Bill 11 in terms of the principles of the Canada Health Act. Premier Klein, in a letter to an Albertan concerning the introduction of the use of private clinics in Alberta says, "I wish to confirm that under that the Government of Alberta would not, under any circumstances, approve any health care related project that contravenes the five principles of the Canada Health Act" (Klein, 1996). The Premier, in this letter, assures this citizen of Alberta that the government will not attempt reforms that contravene the CHA. Again, this is an example of the extent to which we are locked into the CHA framework. Any reforms that are to be attempted must be within the framework of the CHA.

In addition when Bill 11 was presented to Albertans the government attempted to show the *Health Care Protection Act* is within the confines of the Canada Health Act. One of the measures that the government took to ensure that Bill 11 was within the framework of the CHA was to have an independent legal opinion drafted by Professor Levy from the University of Calgary. He has argued that the Bill 11 in no way is in

conflict with any of the principles of the CHA, nor does it require the government to proceed down a policy road that would lead to further policies that would contravene the principles of the Canadian health care system (Levy, 2000, 2).

All the reform activity that was conducted in Canada during the 1990's was all simply first or second order changes. This meant that any change that did occur was minor and consistent with the overall goals of the CHA. Here is where most of the study on health policy has been focused. The policy tools are altered but the framework remains the same. The ball is spun around, but never rolls down the hill. The hospital restructuring and the regionalization of health care do not pose any real challenges to the framework laid out in the CHA. The reforms may have been controversial but they were certainly well within the current framework (Tuohy, 1999, 100-101).

Another clear sign that the CHA system of managing health care comes from the fact that health care has become the major issue of concern during the last federal election. Every major party during the election campaign focused on health care. Each of the parties' election platforms indicated that they strongly supported the CHA and that it should be maintained and strengthened (Blais et al, 2002, 21-22). In fact, the most important issue to Canadians, during the 2000 federal election, was health care (Blais et al, 2002, 146-147). This contrasts with the influence that Health Care had on the pre CHA elections. During the election campaign of 1979, health care and user fees did not even register on the election campaign. In fact people wondered why Begin would spend her time during the election campaign fighting the provinces as opposed to the Conservatives (Begin, 1988, 29-30). This again shows that the CHA system has clearly become locked in. Before the introduction of the CHA health care was not high on the

federal agenda during elections. In fact people wondered as to the sense of campaigning against the provinces in health care. It was not seen as a federal issue but as a federal/provincial issue. However, by the time that the 2000 election rolled around, health care had clearly risen to the top of the list of the issues debated. It was now the federal parties debating amongst themselves on an issue that twenty years earlier was not considered a federal issue. The CHA has clearly secured a place for the federal government in health policy. The new lock-in has generated an informal framework in health policy that has replaced the constitution as the fundamental framework through which health policy was conducted.

Are We Headed to Another Third Order Change?

In 1996, the federal government again altered the way in which it used its federal spending power. It introduced the Canadian Health and Social Transfer, which rolled the federal transfers to the provinces for social programs into one central block grant consisting of both tax points and cash (Strick, 1999, 31). This grant gave the provinces essentially what they always wanted. A centralized block grant that would allow for them to spend transfer payments on their own priorities as opposed to federal ones (Veldhuis & Clemens, 2003, 3). Again, as with the introduction of the EPF, it is possible that a radical change in funding formulas could allow for third order change to occur. Ottawa's ability to enforce the CHA is a function of their financial contribution to health care. The further they reduce their spending, the further their influence is reduced. It has been argued that the cuts made under the CHST have harmed Ottawa's moral and political ability to enforce national standards in health care (Fierlbeck, 2001, 172).

The federal government has attempted to minimize its commitment while maximizing its influence in health care. They have made the largest funding cuts and then are attempting to pass the blame onto the provinces when they are forced to cut back in services (O'Reilly, 2001, 20-21). The effect of the federal cutbacks means that health spending now represents a substantial portion of the provincial budgets. In fact the budget space that health care occupies has been increasingly expanding. This means that health has been promoted at the expense of other programs (Adams, 2001, 10 and Boychuck, 2002, 23). This has elevated the status of health policy, and made it more important to the provincial governments. The fact that health now occupies such a large portion of the provincial budget makes it even more important to the provinces than it was before. The more important politically it becomes, the more control the provincial governments want to have over health policy. This leads to the provinces being less willing to be forced to adhere to the CHA and its framework. The reduced funding limits Ottawa's ability to enforce the CHA as it now has a smaller stick, and the provinces are also now more determined to exert themselves in the wake of reduced federal funding.

Another factor that may indicate that we are headed towards a third order change is the fact that increasing health spending is occurring outside of the jurisdiction of the CHA. For example in 1984 57% of health spending in Canada was covered by the CHA, whereas now, only 45% of health spending is covered by the principles of the CHA (HEAL, 2002, 2). As more and more of the healthcare system operates outside of the CHA, its power as an enforcement tool is weakened. Many Canadians are increasingly surprised at the amount of out of pocket expenses for health services that they pay, in what they assume to be a single payer universal system (HEAL, 2002, 3). Again as more

and more of our health expenses are falling outside of the principles of the CHA, the possibility for radical change in the system increases.

Actor Change

Another sign that we may be headed towards another third order change in Canadian health policy is the fact we are again seeing changes in the actors in the health policy field. To a large extent external government committees and bureaucrats have been unable to find a concrete solution to the intergovernmental impasse that has been reached in health policy (Adams, 2001, 8). This has led to the elevation of the policy discussion to the political level, which is another prerequisite for a third order change.

Again around the time of the introduction of the CHST, and shortly afterwards, we have seen the development of new interest groups. HEAL is an umbrella lobby organization that contains all of the key health care organizations. It was organized to be effective in lobbying efforts around the CHST and the CHA. This is more of a health management organization, than our next organization which is a union based organization.

Additionally, the CHC or Canadian Health Coalition has been formed by groups concerned with extra-billing and new delivery methods in health care (O'Reilly, 2001, 34-35). As we did before the introduction of the Canada Health Act, we are seeing new actors springing into being that deal with the political level, not the bureaucratic level. The express function of these groups is to influence the political level of the process.

There have also been changes within the medical community. We have seen increasing divisions both within the medical community and in the relations between the medical community and the government. For a long time the physicians have been the

dominant player in the medical community. Under the CHA model, the doctors tended to work with government in a corporatist model of governance (O'Reilly, 2001, 26).

However, these networks are breaking down, with the increased push towards coordination and efficiency. Recent attempts by the government to control physician supply and movement have soured their collegial relationship. Furthermore, the government, through the addition of nurse practitioners and midwives, as well as attempts to extend the scope of practice of other professions, has been attempting to limit the monopoly of influence that the doctors have over the medical community (O'Reilly, 2001, 27-28).

Secondly, the medical community is not a unified structure. Within the community, integration and scope of practice issues have caused battles between organizations within the medical community. The rational self-interests in the medical community have become increasingly conflicting in the period of fiscal restraint (O'Reilly, 2001, 31).

Opinion surveys of the public are also beginning to change. More and more people are beginning to feel that there is a crisis in medicare. Chen et al, found that between 1998 and 2000 the number of people ranking health reform as their top priority increased from thirty to fifty-five percent (2002, 18). Only 37% of Canadians feel that the current system is functioning properly, and most Canadians believe that the system will not be fixed by merely infusing it with more money (Mendelsohn, 2002, 28).

Furthermore, Canadians no longer view health care as the "sacred cow" that it once was. People are beginning to show support for the development of a parallel private health system, and the re-introduction of user fees (Blais et al, 2002, 147-149, and Marshall,

2000, 48). There is a real sense that the medical system is in crisis in Canada, and that Canadians are beginning to accept alternative ways of financing the system (Enviro-nics Research Group, 2002, 1).

The consensus surrounding the five pillars of Canadian health care seems to be breaking down. Health Care no longer appears to be the same corner stone of Canadian identity that it was ten years ago. However, it must also be noted that same survey conducted by Marshall also indicated that there is still substantial support for a public system (MacLean's Global, 2000, 52). What is important to note is that the window for change is opening. Canadians have not completely abandoned their universal system, but increasingly they want fundamental change, and are becoming more accepting of a separate system, in addition to the universal system. The value change that society is undergoing indicates the potential for a third order change.

Fundamental Attitude Shifts in Society

Another interesting change that has occurred in Canadian society is the nature in which federal/provincial relations are conducted. Boychuck has suggested that the real crisis in health care is the collapse of the support for the inter-governmental relation system upon which healthcare is supported (Boychuck, 2002, 22). Furthermore, with the reduction of the federal role in policing the CHA, citizens have demanded an increased role for themselves in the health care policy debate. It has been the average citizen that has worked to ensure that the CHA has maintained some salience over the past five years (Fierlbeck, 2001, 172). This has meant that no matter what model of reform is chosen there will be a need for consultation with Joe Q Public (O'Reilly, 2001 36). The

increased role that citizens have taken in regards to defending public health care has led them to demand a greater role in the health care reform process.

There has not been a push to include a bill of rights for patients in any reform package. In a poll conducted by Pollara for the Romanow Commission¹, there was general agreement that a patient's bill of rights would improve the quality of the health care (2002, 56). This idea of a patient's bill of rights is essentially another extension of the CHA, which provides Canadians with a limited list of rights. However, by specifically referring to Canadians having rights, it opens up a whole new set of arguments in regards to health care reform. If healthcare is recognized as a right, then, the debate surrounding its reform will center on the interaction between government and citizens instead of focusing on government vs. government, as is currently the case.

This focus of individual action and input in the health care debate reform would fundamentally alter the institutional structure. The CHA framework requires executive federalism in order to work. The idea that the provinces and the federal government should decide major national issues, is no longer widely accepted. Canadians want direct input into the government and no longer want elite accommodation, in its current form, to determine policy outcomes. The legacy of the failure of constitutional reforms in the early 1990's was to ensure that any future executive federalism surrounding the constitution would have public input (Brock, 1995, 102), as we can see by the influence on HEAL (shown below) the rejection of elite accommodation appears to spreading to

¹ This poll is not completely scientifically accurate and broad generalizations can not be made much beyond the sample. The poll was conducted on the internet, and was voluntary. Therefore its respondents tend not to be overly representative of the Canadian Population (they tended to be more highly educated, and needed to have internet access (Pollara, 2002, 10-12). This poll was included in my analysis as it was conducted for the Romanow Commission and bears the official seal of the Government of Canada, which makes its results relevant for a study of current issues in health reform.

other policy areas. The CHA framework thus becomes outdated as it requires support for executive federalism in order to properly function (Adams, 2001, 63).

HEAL, which is a healthcare lobby group, has argued that any reform to the health system must include an open process. They feel that all information should be made available to all stakeholders, and everyone must be given a chance to provide input into the process (HEAL, 2000, 5). HEAL's position shows us how the demand for public input into the process has begun to arise. Instead of leaving policy to elite accommodation, interest groups, as seen by HEAL's position are demanding a more representative process.

One piece of anecdotal evidence in regards to the changing nature of the actors is the covers of the annual reports of the CHA. If you look at these reports from the early years 1984-1987 the cover has the seals of the provinces and the seal of the Government of Canada. This clearly symbolizes that the act is meant to be an interprovincial agreement. However, the cover for the last couple of years features pictures of Canadians, interacting with the healthcare system. Again, this is another symbol that the focus of health policy is shifting away from provinces and towards people (Health and Welfare Canada, 1984-1985, 1986-1987, and Health Canada 2000-2001, 2001-2002).

A Helping Hand.....Towards a Fundamental Shift

The federal government also has profound institutional interest in promoting the idea of more direct federal involvement. The CHA establishes a direct link between the federal government and the provinces. This link between the federal government and the people is lacking in most other areas of government service provision, apart from income

security. In the field of income security, it has been argued that this direct link has helped to maintain the *raison d'être* of the federal government. Without direct service links to the people the federal government would lose much of its power (Banting, 1987, 176-178). The CHA is important to the federal government as it provides a direct link to the people in the healthcare, thus helping to expand the power of the federal government.

Additionally, the federal government has another reason for fostering the expansion of individualism in health policy. As the provinces have constitutional responsibility for the legislative process surrounding health care, the federal government needs to be able to undercut the provinces' legislative ability. The encouragement of the popular initiatives in healthcare can directly undermine the ability of the legislative body to proceed as it wishes (Tsebelis, 2002, 132). Therefore, it makes sense for the federal government to encourage and foster a citizen focus in healthcare as it undercuts the ability of the provinces to legislate, while at the same time, through the Canada Health Act, creates a direct link between people and Ottawa in the field of health policy. By trying to reposition the actors in the field of health policy, Ottawa is attempting to restructure the current lock-in. By fostering actor change, Ottawa can counteract its loss of influence through the decrease in spending.

The rise of the individual focus in the health care debate is also a sign that we are perhaps entering a period where third order change is possible. The shift in dynamics in health policy, away from its traditional focus, could potentially radically alter the institutional arrangements if a third order change does occur. The focus of health policy would no longer be exclusively intergovernmental, but at least partially societal.

Resistance to a Third Order Change

Despite the fact there is much evidence supporting the idea that we are on the road to a possible third order change, there are elements in society that indicate that we may just be in a period of program, but not policy change.

The Social Union framework represented a step taken by both the federal and the provincial leaders to resist pressures for radical change in current social policies. The agreement showed a clear link between federal dollars and provincial commitment to the CHA (Boase, 2001, 201). The Social Union was then an attempt to maintain and repair the current lock in situation in which we find ourselves. It attempted to restore the system back to its proper course and remove any of the discrepancies in health policy that it was nothing more than an attempt to fix the current system, not change the current framework.

The amount of success that the Social Union will have is ultimately dependent on the tide of public attitudes. If public opinion remains against elite compromise then the inter-governmentally negotiated framework is bound to be defeated by the public at large.

Another proposal that has been suggested is to create a National Health Council. The idea behind the Council is the fact that it would create a body that could deal with health matters and provide for conflict resolution. However, in order for the Romanow Commission to be successful the provinces must be in agreement with the report. Additionally, many provinces are skeptical and feel that the federal government is just trying to find a new method of controlling them (Esmail, and Graham, 2003, 29). Again this proposal appears to have been designed to maintain the current lock in. However, the National Health Council will ultimately fail if there is not a corresponding influx of

federal money. If the federal money does not come then there is no incentive for the provinces to join the Council, nor will the Council be effective. Furthermore, if the general trend towards public participation continues then (despite token public representatives) the Council will ultimately fail as it is still an intergovernmental solution that will not match with the current problems and actors.

Another source of resistance to a possible third order change is the emphasis placed on renewed funding in the Romanow Commission report. The Romanow Commission has been considered by many to be the most important report on health care since the 1965 Hall Royal Commission, and it directly addressed the issues of funding (Augustine, 2003, 1). In a media release Health Canada emphasized the need for a renewed commitment to funding for the health care system. Romanow recommended that the federal government infuse the system with immediate funding, and develop a strategy to ensure that there is stable funding for the future (Health Canada, 2002, 2).

However, as we have already seen, in the minds of many Canadians the system is in need of more than just more funding. Unless Canadians see change to the actual way in which the system functions then additional funding alone, may be insufficient to close the window, and maintain the policy status quo.

A final source of resistance to a third order change in the Canadian healthcare system has been articulated by Tuohy. She argues that one of the main reasons that we have not seen fundamental change in society is the corporatist nature of health policy making in Canada. Many of the links between the Medical Associations and the provinces have become institutionalized. There has become a culture of accommodation and negotiation (Tuohy, 1999, 203-204, 234). The recent cutbacks have forced some

restructuring within the policy networks around healthcare. However, despite these cutbacks the networks, may be realigned, but are still corporatist in nature (Tuohy, 1999, 224-231). It is the corporatist network that allows for accommodation and incremental change that prevents there being a radical departure from the current paradigm.

However, Tuohy underestimates the strength of the rejection of elite accommodation in Canadian society. Part of the fundamental shift in society is the fact that people are no longer willing to leave important policy matters solely in the hands of the government. The changing nature of society is a threat to Tuohy's corporatist networks. As mentioned above, groups such as HEAL are calling for the reform process to be opened up, beyond the traditional actors. The fact that society is less accepting of the corporatist model of elite accommodation, indicates that there is a very real possibility that the window of change maybe opening.

Another component of Tuohy's argument is that institutional change has not occurred in health policy as neither level of government has had the energy to undertake significant reforms, nor has either level of government been able to consolidate enough power in order to proceed with substantial change (Tuohy, 1999, 246). Tuohy is correct in her assertions, as neither level of government has been able to undertake substantial change. Just as the implementation of the CHA in 1984 required a particular energy matrix, so does a third order change today, require a specific energy matrix. What may differ in today's society, as opposed to 1984, are the demands that Canadians are placing on the system. As previously mentioned health care was the most important issue in the last federal election. The public may be able to force one level of government to act on

this issue, adding the necessary energy to government, allowing them to match a solution to the problems in health care.

Conclusions

In conclusion we can see that Canadian health policy has moved from one period of lock in to another period of lock in (which may now be ending). In order for the lock in to be broken we need to have an exogenous shock to create a third order change. In the case of Canadian health policy the exogenous shock to the system was provided courtesy of the federal government and its use of the federal spending power (the rock is removed). In order for a third order change to be successful and break the lock in, actors must take advantage of the window of opportunity that has been created (someone must push the ball). In 1984, Begin was able to take advantage of the window of opportunity in order to break the old lock in and to create a new lock in. With the change in the funding formula to the CHST (and now the CHT and the CST) it appears that the rock preventing the ball from rolling has been removed. It still remains to be seen if the potential for a third order change that currently exists will find an actor capable of matching a solution to a problem (an actor capable of pushing the ball).

Health policy appears to be relatively stable in Canada with third order change occurring only every twenty years (1966, 1984, and 2005??). Furthermore, the trigger for a third order change in Canada appears to be a switch in the federal use of the spending power. When the federal government feels the need to exercise this power, or retract its use, there is the potential for a corresponding change in policy. Health policy in Canada has followed this trend.

After the impediment to policy change has been removed by a third order change, this opportunity needs to be seized. Politicians must be able to capitalize on change, and this change must fit within the general trend of the nation's policy. The Medicare Act was developed out of cooperative federalism, and the CHA meshed with the pan-Canadian view of Trudeau. Thus in order for the ball to start rolling, an actor must be able to push the ball in the right direction, and at the right time.

The lack of use of the federal spending power, was the triggering effect for the adoption of the CHA, and the switch to the CHST, has provided a new impetus to the potential third order change that currently exists. It would appear that the ball is no longer wedged against a rock, and it remains to be seen if an actor will be able to give it a push, in the correct direction to start the ball rolling (initiate a paradigm shift).

Lock ins are difficult to break, and require not only a window of opportunity to be present but also require someone to seize the moment, and have the ability to initiate a paradigm shift at the right time, and in the right direction.

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