

Drifting Away?
Policy and Regulatory Drift in the Canadian Health Care System

— First Draft —

Comments are welcome!

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Abstract

Most analyses of welfare state reform show that the radical retrenchment of social programs is rare in advanced industrialized countries. But more recent studies argue that despite widespread path dependence, welfare state institutions frequently undergo significant policy drift: even though their formal structures remain largely stable, they increasingly fail to achieve their institutionalized goals, thus creating growing disparities between policies and outcomes. In this paper, we apply the concept of policy drift to the case of the Canadian health care system. By reviewing the development of the Canadian health care system since the enactment of the Canada Health Act in the early 1980s, we argue not only that there is policy drift, but also a second form of drift that is underestimated in existing accounts: regulatory drift. The system's formal structure—the Canada Health Act—has not been modernized, and the implementation of the existing principles embodied in it has decreased significantly during the past two decades.

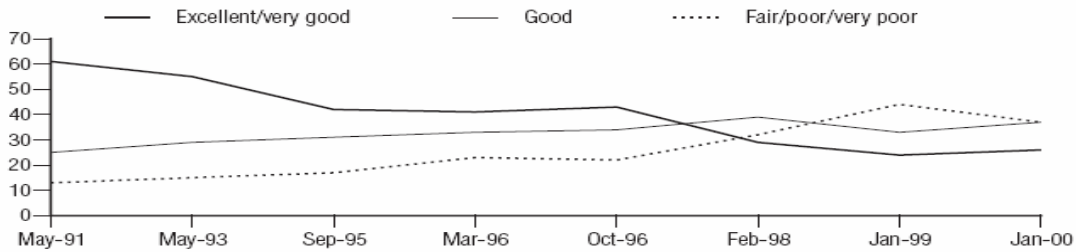
Introduction

Times, they are a-changin'. While Bob Dylan was far from a Canadian health policy scholar, he provides valid insight into the evolution of the health care systems across Canada. Canadians have been picking up on symptoms of the health care transformation that is underway. These signs have varied in degrees for different citizens and scenarios, ranging from the barely detectable small "curve in the road ahead" markers to multiple bright orange flashing billboards warning of the approaching construction site they are about to enter. These signs may come in the form of an increase in the delisting of services covered by provincial and territorial health insurance plans or the private payment of diagnostic testing that enables the queue jumping ahead of others who cannot afford the same luxury. Whatever the indicator or however these are interpreted, most everyone comes to the same conclusion. Canadians know that for the health care systems in Canada, times - they are definitely a-changin'.

Frequently, the recognition of these changes in the health care systems in Canada has been met with disapproval. This discontent shows the deviation between the direction that changes have been moving and the preferred course; Canadians have largely not viewed the developments of the health care systems favorably. Diagram 1 dramatically illustrates the difference in the assessment of the health care system by Canadians over time. The evaluations believing the performance of the health care system to be excellent or very good decreased, while there was increase in number of fair, poor, or very poor responses. The satisfaction of Canadians with their health care system has declined.

Diagram 1. Satisfaction of Canadians with the Health Care System

Canadians' Overall Assessment of Canada's Health Care System



Source: Vail, Stephen. "Canadians' Values and Attitudes on Canada's Health Care System: A Synthesis of Survey Results". The Conference Board of Canada: Ottawa, 2000. Chart 3.

What makes Canadian health care reform such an interesting case to study is that these changes that Canadians, on the whole, have not received positively, did not result as the logical outcome of major, formal changes to policies. This transformation is taking place even though there have been no revisions to the framework that guides health care policies. Regardless, significant changes in outcomes have still been able to emerge. While there are many developments occurring in the Canadian health care system that make it a worthwhile case study, this paradox makes it especially worthy of investigation: how is it that the health care system in Canada is experiencing change in the absence of associated variations in legislation?

Popular social programs that have developed strong feedback over the years have presented a significant challenge to those looking to scale back in these areas (Pierson 1994; Pierson 1996). The upfront retrenchment of social policies in welfare states is politically dangerous as these actions can be attributed to both politicians and parties. Given a good memory of the electorate, the beneficiaries of such programs can punish

those for their actions come the next election (Weaver 1986; Weaver 2004). An appealing option that can facilitate the achievement of the same goals without the negative repercussions is to permit policy drift (Hacker 2002; Hacker 2004). Through the allowance of drift outcomes can shift without visible decisions. This informal process produces changes in practice without changes in policy. Drift is a relatively new concept that is increasingly relevant to capture what is occurring in developed welfare states (Streeck and Thelen 2004).

This paper will explore whether, and in which forms, drift occurred in the field of health policy, specifically by examining the case of the Canada Health Act (CHA or Act). It seeks to provide an introduction and overview of the issue of drift in the context of Canadian health care. The CHA is federal legislation that sets out to create standards and uniformity throughout the provincial and territorial health care systems. The Act provides an excellent exploratory case for the study of policy drift. The CHA is thought by many Canadians to embody the values of the country and has received strong support by them since it was enacted in 1984. Despite the steady public support for this policy, its significance has diminished over time. Since policy drift is an informal process that may have serious societal consequences, it may explain the paradox of change as experienced by a popular social program in the absence of formal decisions. The application of the concept of drift to the CHA not only leads to a better understanding of this particular case, it also allows further conceptual development. Based on an analysis of the Canadian case, we suggest the classification of two forms of drift: *policy drift* and what we term *regulatory drift*. We argue that both forms led to significant changes of the Canadian health care system even in the absence of a formal revision of the Canada Health Act.

The Concept of Policy Drift

The concept of policy drift has grown out of literature on welfare state reform. Explanations of change to account for what was occurring in developed welfare states shifted from expansion to retrenchment (Huber and Stephens 2001; Pierson 1996; Pierson 2001). According to Paul Pierson, retrenchment specifically refers to:

policy changes that either cut social expenditure, restructure welfare state programs to conform more closely to the residual welfare state model, or alter the political environment in ways that enhance the probability of such outcomes in the future (Pierson, 1994, 17) .

Paul Pierson has been influential in the analysis of retrenchment and has provided valuable insight into its political difficulties. Retrenchment within the welfare state “is generally an exercise in blame avoidance rather than credit claiming, primarily because of the costs of retrenchment are concentrated (and often immediate), while the benefits are not” (1996, 145). This is significant when studying cases of retrenchment as politicians are acting in a manner completely different from cases of expansion. Thus, motivations need to be considered. In an attempt to circumvent responsibility for changes that will not be received well by many voters, politicians may be able to initiate a transformation that is less visible, more complex, more gradual, and does not start at an identifiable point in time. Punishment at the polls can provide a strong motivation for politicians to develop such strategies for implementing changes in the welfare state that are unpopular among constituents. Along with the creation and then expansion of the many social policies and programs “have come dense interest-group networks and strong popular attachments to particular policies, which present considerable obstacles to reform” (Pierson, 1996, 146). Elected officials, particularly those who are advocates of

welfare state retrenchment, may develop new strategies to avoid these barriers. More generally, these strategies “attempt to lower the visibility of reforms, by making it hard for voters to trace responsibility for these effects back to particular policymakers” (Pierson, 1996, 147).

Even though welfare state scholars have paid attention to strategies that potentially make reforms less visible, they have often concentrated on formal changes of policies. As Jacob Hacker has argued, they have thus “missed fundamental ways in which the welfare state is changing” (2005, 41). Most importantly, Pierson’s conceptualization of both expansion and retrenchment was based on formal processes, on decisions made in the legislative process which will alter a policy and in turn change the outcomes that a policy produces. This focus on changes of legislation raised a number of questions with regards to changes that were increasingly occurring outside this formal process: when a shift in outcomes occurs in the absence of a change in policy, how can that be characterized? What does this informal process look like? How can visibility be brought to an invisible process? If Pierson’s observation was correct that governments “confronting the electoral imperatives of modern democracy will undertake retrenchment only when they discover ways to minimize the political costs involved” (1996, 179), then there is a need to study policy drift as a potentially very effective strategy to reduce electoral costs. The concept of drift helps explain “hidden forms” of retrenchment in mature welfare states. Jacob Hacker’s work on policy drift has been particularly influential in filling this theoretical gap. Hacker defines drift as “changes in the operation or effect of policies that occur without significant changes in those policies’ structure” (2004, 246). His work has focused on the case of the United States, specifically on health

care and pension programs. Hacker describes the contradictory policy development of policy drift as “change without change”. This expression denotes circumstances that have seen little to no formal changes in policy, but changes can be observed in policy outcomes. According to Hacker, drift provides “a revealing example of the less visible, but no less consequential, forms of institutional change that the standard lens on retrenchment tends to occlude” (2005, 45).

Change without Change in the Canadian Health Care System

The application of the concept of drift is valuable in paradoxical cases that have experienced no formal changes in policy but changes in the outcome. As we argued above, the Canadian health care system is such a case. The Canada Health Act is federal legislation in the area of provincial and territorial jurisdiction. The Constitution dictates that health is a field that primarily is the responsibility of the provinces and territories. However, the federal government has been influential in the health care systems across the country by passing Acts that provide financial support in exchange for national standards. The CHA is the most recent of these national requirements, continuing on from where the Medical Care Act of 1966 (Medicare) and the Hospital Insurance and Diagnostic Services Act of 1957 (HIDSA) left off. Each province and territory secures full federal funding by complying with the CHA. The federal government pays to play, as some have described this arrangement; the financial contribution to provincial and territorial health care systems buys the ability to influence how each operates.

The CHA was not only a renewal and reaffirmation of some of the standards that had already been established by previous Acts, it also served to update federal health

policy. There are five principles and two provisions embedded in the CHA. These elements were intended to outline the values that are to be represented in each of the provincial and territorial health care systems. The implications on receiving federal funding for not complying with the CHA are discussed below.

The five principles are those of public administration, comprehensiveness, universality, portability and accessibility. Section 8 of the CHA, public administration, seeks to guarantee that health insurance in the provinces and territories are administered and operated publicly on a not for profit basis. Section 9 of the CHA, comprehensiveness, sets forth that the provincial and territorial health care systems cover all of the insured services provided in hospitals or by physicians or dentists. Section 10 of the CHA, universality, requires that every resident insured under the provincial or territorial health plans access care on uniform terms and conditions. Section 11 of the CHA, portability, protects Canadians' mobility rights so that when citizens move from one part of the country to another, they continue to be covered by the insurance plan of their "home" province or territory. Finally, section 12 of the CHA, accessibility, is at the heart of the health care system in Canada. The intent of the accessibility principle is to ensure that Canadians have reasonable access to insured health services. Deductions made for violations to any of these five principles are at the discretion of the Minister of Health.

The two provisions were an impetus for the creation of the Canada Health Act. The extra-billing of patients by physicians and the charging of user fees by hospitals were on the rise in the early 1980s. Extra-billing is when a patient is charged an amount in addition to the fee paid by the government. A user fee is a supplemental cost paid by the patient that is associated with costs of the facility. Both extra-billing and user fees can act

as significant impediments to obtaining health care and, as outlined in the CHA, they violate the accessibility criterion. For both of these provisions, there is a mandatory dollar for dollar financial penalty in the form of a deduction to the federal transfer to offending province or territory.

The concept of drift provides a new lens through which the development of Canada’s social programs, in particular the health care system, can be analyzed. Support for the Canada Health Act remains strong; overall its principles have continued to be “very important” to Canadians, as demonstrated in Table 1. It is important to note that the values and expectations of Canadians have remained quite stable. Through the many changes that have happened over time, the ups and downs of the economy, the rise and fall of governments—Canadian’s priorities have endured. The Canada Health Act continues embodies these beliefs.

Table 1. *Popular Support for the Principles of the Canada Health Act*

	Support for Maintaining the Principles of the Canada Health Act (Percent Indicating “very important”)			
	1991	1994	1995	1999
Universality	93	85	89	89
Accessibility	85	77	82	81
Portability	89	78	81	79
Comprehensiveness	88	73	80	80
Public Administration	76	63	64	59

Source: Vail, Stephen. “Canadians’ Values and Attitudes on Canada’s Health Care System: A Synthesis of Survey Results”. The Conference Board of Canada: Ottawa, 2000. Table 1.

It is quite appropriate to apply the concept of drift to a policy that is as popular as the CHA. As Jacob Hacker observed, policy drift is most likely to occur “when the barriers to internal change are high (meaning it is hard to shift them to new needs) and the status-quo bias of the external political context is also high (meaning it is hard to eliminate or supplant existing institutions)” (2005, 48). The second of these barriers is particularly strong in the case of the CHA because it receives very strong support. Attempts by politicians to change the CHA in a way that is not consistent with its origins or to openly undermine it would be met with disapproval by many Canadians. Deviations from the principles of the CHA could be something as straightforward as charging patients additional fees to receive insured services or, more controversially, the delisting of medically necessary procedures from insurance plans. This support for the CHA, at the very least, acts as a considerable deterrent to launching a frontal attack on the policy. The motivation would be great for opponents of the tenets embodied in the CHA to pursue their goals in a way that would not identify them as responsible for their actions. Drift is a very appealing strategy as it allows the desired goals to be reached while avoiding politically damaging blame.

Even though there was no change in the formal policies that govern the Canadian health care system and no change in citizens’ support for these policies, there are signs of changes in outcomes: Canadians do not believe that the principles of the CHA are upheld in practice any longer (see Table 2). Changes are occurring that are in conflict with the priorities of Canadians.

Table 2. *Popular Beliefs about the Outcomes of the Canada Health Act*

	Percentage Saying the Health Care System Is Living Up to the Five Principles of the Canada Health Act, 1999
Universality	82
Accessibility	62
Portability	63
Comprehensiveness	50
Public Administration	59

Source: Vail, Stephen. “Canadians’ Values and Attitudes on Canada’s Health Care System: A Synthesis of Survey Results”. The Conference Board of Canada: Ottawa, 2000. Table 2.

A detailed study of outcome drift with regards to the CHA is beyond the scope of this paper, but three examples are offered here for illustration of how a policy in practice can differ from a policy in theory. First, the most transparent example of outcome drift from the CHA, as identified by Flood and Choudhry, is the province of Quebec’s breach of “the portability criterion by refusing to compensate for health care services that its residents receive in other provinces” (2002, 5). This is in direct violation of the portability principle and has been identified by the federal government for years, yet it has continued to occur. Second, a practice has developed whereby a patient with the financial means is able to go outside the public system and buy diagnostic services that are not considered medically necessary but “just looking” procedures, for example an MRI. When the diagnosis has been made, the patient is then able to reenter the public system ahead of others who did not have the same options available to them due to the

financial barrier. In the end, patients who are able to purchase a faster diagnosis will receive treatment earlier than patients who cannot. This permitted queue jumping is in clear violation of the accessibility principle, which outlines that Canadians should receive health care equally, regardless of their ability to pay. Third, there has been a steady increase of private clinics in Canada that require payment for the provision of insured health care services which clearly offends the principles of universality and accessibility. It is a violation of the extra-billing provision for patients to be charged in addition to the amount paid by the provincial and territorial governments. Canadian citizens are not supposed to be out of pocket for receiving insured health care services. For example, there have been complaints that Copeman Health Care Inc., a company that operates private clinics across Canada provides “preferred access based on the ability to pay rather than need” (Sack Goldblatt and Mitchell, 2006). If there is a disparity between policy and practice like in the cases just discussed, studying how this incongruence might have developed could improve our understanding of the forms and processes of drift. How could changes in the health care systems in Canada have occurred while policies have remained the same?

Two Forms of Drift

We argue that there are at least two forms of drift that produce institutional change: *policy* and *regulatory*. Policy drift occurs when there has been insufficient *updating*: no response in policy to changes that have occurred within the latter’s environment. This form has received the most attention in the literature on welfare state reform and is the focus of Hacker’s work. Regulatory drift occurs when there has been

insufficient *upholding* of the policy: the administration of a policy has not been adequate. Even though this form is implied in Hacker's discussion of drift, so far it has not been distinguished from policy drift. The result of either of these two forms of drift is expected to be change in the outcome of a policy, as discussed above. Whether there is a drift in the *updating* (policy drift) or *upholding* of a policy (regulatory drift), the general impact will be the same.

As Streeck and Thelen have noted, policies are in need of:

active maintenance; to remain what they are they need to be reset and refocused, or sometimes more fundamentally recalibrated and renegotiated, in response to changes in the political and economic environment in which they are embedded (2005, 24).

Without such responses to sustain the policy, outcomes can drift away from the intended goals. This is especially relevant in the field of health policy which is particularly susceptible to shifting variables such as new technologies and fluctuating budgets. If there is no response in policy to the changes that occur within its environment, then the outcomes will logically also change. It is not reasonable to expect that a policy could remain appropriate or capable of achieving its goals while its environment experiences change. For a policy to remain relevant it has to be consistently responding to modifications within its scope. Without regular updating of a policy, the ability to obtain its objectives gradually becomes more and more restricted. In its most basic form, policy drift facilitates the revision of social policies and programs through informal means. Policies require adjustments and modifications to remain as relevant and applicable as when they were first created. The shifting setting in which the policies exist

must be taken into account if they are supposed to remain effective. When these shifts in their environment are not taken into account policies drift and institutions change endogenously and gradually. A crucial aspect of change that occurs through policy drift is that detection is difficult particularly because the impression of stability that is given.

It does not matter how up to date or strong a policy is, if the process ends there. The importance of a policy is not only what exists in a document; policy is also significant through execution. What is done with a policy is of equal importance as what it contains. The operation of the policy in practice should be reflective of what was outlined “in theory”. For a translation from policy into practice to occur, the policy needs to be upheld. Without the consistent upholding of a policy, regulatory drift can occur. For this to be avoided, the administration of the policy must be effective. The “on the ground” performance of the legislation must be regularly monitored and assessed in terms of how well the policy has achieved the objectives that have been laid out. Issues that compromise the ability of the goals to be reached must be addressed. While some policies may have many well-designed mechanisms for influencing the supervision of the policy, others may not. Since the administrative capabilities of some policies will be more constrained than others, they need to be assessed on a case-by-case basis. In addition, the needs of a policy to be upheld may change over time in relation to its context. Unanticipated challenges never previously taken into consideration may become relevant. This flexibility in administration can be an important factor in the development of regulatory drift. The ability to adapt to evolving circumstances strengthens the capacity to uphold a policy.

Regulatory, like policy, drift is also an attractive option for infiltrating change through the bypassing of any formal processes with the expectation that there will be less resistance. Undoubtedly, it is improbable that the average Canadian is able to follow the administration of federal legislation, even a much beloved one. With the understandable ignorance of citizens, politicians can pay lip service to a policy without being held accountable for its operation. Not providing the means with which to uphold a policy may as well be synonymous with not establishing or updating it in the first place as the impact on the ability to achieve the stated goals is similar. The impact that drift will have is generally the same whether through policy or regulatory: the toleration of drift will produce changes in policy outcomes. Failure to utilize all available means to uphold the policy severely limits the ability to meet the intended objectives. While the policy itself is, of course, important for policy outcomes, what is done with that policy is of comparable significance. Detection of the presence of regulatory drift thus requires a thorough examination of the administrative procedures and an analysis of a policy's operation "on the ground".

Policy and Regulatory Drift of the Canada Health Act

We identified the Canada Health Act as a case that likely experienced both policy and regulatory drift. Diagram 2 illustrates the interactive effects that non-updating or non-upholding of a policy can have and locates the case of the CHA at two different points in time. Initially, following the introduction of the Act, no form of drift existed as the policy was appropriate. It was an *updated* policy, and highly relevant to the time as it responded to the most recent changes that had emerged in the health care programs across

the country. It was an *upheld* policy as violations were identified and penalties levied on offending provinces and territories. Since this was the status of the CHA in the 1980s, it is shown in the upper left quadrant of the diagram. However, over time a situation has emerged in which the CHA drifted in two significant ways. In the over 20 years since the policy was enacted, it has not been updated. In addition, the policy has not been upheld to its full ability. Since this is the CHA’s current status, it is shown in the lower right quadrant.

Diagram 2. *Drift of the Canada Health Act from the 1980s to the 2000s*

		<i>Upholding</i>	
		Yes	No
<i>Updating</i>	Yes	No Drift (CHA in 1984)	Regulatory Drift
	No	Policy Drift	Regulatory & Policy Drift (CHA in 2006)

Policy Drift

As Tommy Douglas, the father of Medicare, insightfully noted, “you have to run as fast as you can to stay where you are. Any program needs to be changed. Any program has to be looked at periodically and re-examined” (1984). There is perhaps no one who would better know what is required to maintain the health care systems in Canada than Douglas. The contextual changes that have occurred since the early 1980s such as the

significant increase in “day surgery, less invasive care, increased reliance on community-based care and home care” (Brimacombe 2002, 11) necessitate a response in policy that has yet to come. There were a variety of developments that occurred within the scope of the CHA, and without updating, the relevance of policy easily declined.

With the advancements that have been made in medicine and the changes in the provision of care since the CHA was written, health care systems across Canada have transformed significantly. Perhaps the most significant of these transformations, related to the CHA, is that “shorter stays in hospitals have shifted costs that were previously covered by the public system to the private sector (where prescription drug costs, for example, will be paid for by out-of-pocket expenditures or private insurance claims).” (Brimacombe 2002, 9). The implication of this is that the care and drugs that twenty years ago would have been provided within a hospital, and thus publicly funded, are increasing the responsibility of the individual. This transfer of responsibility from the government onto the individual has been steadily rising. Reduced health care spending in the public sector has shifted the financial burden onto the private sector. The share of health care costs that are paid for by the individual has increased while the publicly funded proportion has decreased. Related to the “distribution of total health spending, the public share decreased from 76 per cent in 1980 to 71 per cent in 2000, while the private share increased from 24 per cent over the same period” (Brimacombe 2002, ii). This paints an overall picture of the contrary direction the health care system is moving, in part, due to an outdated policy. While the care or medication may still be medically necessary, once it has moved outside the hospital walls the onus shifts from society to the individual. While the values remain embodied in legislation, the context of this policy has

changed and there has been no effort made to adjust the policy to reflect this difference. These changes have not come through any formal reform. Left without a response in policy to such contextual changes, the influence of the policy has been distorted.

The needs of Canadians have not remained the same since the early 1980s and the health care insurance plans would need to reflect this development. There has been an increase in the use of alternative medicines; the services provided by mid-wives, acupuncturists, herbalists, naturopaths, massage therapists are more in demand than ever before. Support for expanding coverage under the CHA to include pharmacare and home care has consistently grown though no efforts have been made to reflect this in policy (see Table 3).

Table 3. *Popular Support for Adding Pharmacare and Home Care to the CHA*

	1996	1997	1998
Support to include pharmacare	49	67	77
Support to include home care	N/A	83	85

Source: Vail, Stephen. “Canadians’ Values and Attitudes on Canada’s Health Care System: A Synthesis of Survey Results”. The Conference Board of Canada: Ottawa, 2000. Table 18.

Just as extra-billing and user fees in the early 1980s presented a serious threat to the Canadian health care systems and required a genuine response in policy, there now exist significant challenges that need the same reaction. The more time that goes by where these opponents of health care in Canada are tolerated, the further embedded they will become; the more likely it becomes that they will be able to change the direction of

our systems in Canada. The reality has become, through the evolution of all of these contextual changes devoid of responses in policy that “many health services that Canadians rely on fall outside the scope for the Canada Health Act” (Vail 2000, 7). Maintenance or evolution of the CHA cannot have occurred for this to be the case.

A modernization of the CHA is long overdue. Two significant reports commissioned by the federal government, one for the House of Commons and the other for the Senate, spoke of the need to update the Act. If this renewal were to take place, then this would act as a barrier to stop policy drift that may be occurring and help to move the legislation back on track.

Regulatory Drift

In the current climate of uncertainty, the importance of regulation of the Canadian health care systems cannot be understated. While consistency in policy and practice is always important, this is especially true now in the context of health care policy in Canada. According to Choudry, the role and value of supervisory institutions will be

of central importance to the future of Medicare, no matter what scenario unfolds, because any future system will include some national standards. These standards, to be effective, must be interpreted, applied and enforced by institutions of some kind (2000, 3).

Canadians should be able to take these future “plans” regarding their most treasured social security program at face value. In the case of the CHA, this is not possible as there is a difference in policy and practice as it is not consistently nor thoroughly upheld. As Choudhry has stated, in the absence of the institutions to effectively uphold the CHA, “national standards for Medicare are merely political

platitudes” (2000, 3). Canadians expect from their health care systems more than empty promises.

For the Canada Health Act to be upheld, there are two requirements that must be met. First, the execution of the CHA in each province and territory must be adequately monitored to accurately determine the performance of the policy in practice. Second, in situations where violations have been identified, the policy must be consistently enforced. Policy observers have detected a “failure to properly monitor, investigate and enforce the requirements of the Act” (CUPE, 2003, 34). In the absence of adequate monitoring and consistent enforcement of the Canada Health Act, the legislation experienced regulatory drift. In an ideal situation, what is written in the policy would directly and easily translate into reality. However, with competing ideologies and motivations the realization of a policy is never that simple. This is particularly true in the case of the CHA where there is a power struggle between the federal and provincial and territorial governments. The real teeth of the CHA lie in the ability of the federal government to withhold funding from governments that have been found to be in violation of the Act. These teeth are not made especially useful by soaking in water on the nightstand.

The current monitoring of the CHA in each province and territory is not adequate to make an accurate assessment of its impact. The Auditor General of Canada has observed in many reports that the monitoring of the CHA is insufficient and must be improved. The Canada Health Act Division (Division), an office within Health Canada that is charged with the administration of CHA, publishes an annual Canada Health Act Report. These Reports are supposed to specifically address if, and to what extent, the CHA is complied with across the country. However, the information is provided by each

of the provinces and territories and contains inconsistent information, often excluding details that are most relevant to the monitoring and enforcement of the Act. Monique Bégin, a former federal Minister of Health has gone as far as to state that “recent annual reports of Health Canada made mandatory by the legislation, are now devoid of any significance” (1999). Without effective monitoring the state of the CHA will not be accurately known and possible violations will not be identified. According to Health Canada, when a potential violation of the Canada Health Act “has been identified and remains after initial inquiries, Division officials would then ask the jurisdiction to investigate the matter and report back” (Canada 2004, 11). There is something inherently contradictory about asking the alleged offending government to investigate itself. The federal government has not taken an active approach in the monitoring process and instead has been passive in its methods. This has occurred to the extent that the Division “relies on news articles as a source of information for potential violations” (Canadian Centre for Policy Alternatives 2003, 4). It is surprising that, with all of the resources at the disposal of the federal government, happenstance media coverage now acts as a significant means of identifying potential violations of the CHA. This inadequate monitoring is not sufficient to uphold the Act.

If a violation to the CHA has been identified then it is the “legal responsibility of the federal government to intervene. As the 2002 Auditor-General’s report indicates, the federal government is not abiding by its own legislation” (Canadian Centre for Policy Alternatives 2003, 4). The federal government has been reluctant to impose financial penalties on provinces and territories that have violated the CHA. This has been true even in cases that have violated the extra-billing and user fees provisions, which are expected

to elicit mandatory deductions. While there is evidence that would merit the deductions of federal funding due to contravention of the principles, this has rarely happened. The unwillingness to financially penalize offenders has crippled the federal government's chance of achieving compliance across the country. If the provinces or territories are not under threat of receiving penalties for violating the CHA, then what is the motivation to comply? Sujit Choudhry has commented on the "dismal record of the federal enforcement of the existing national standards of the *Canada Health Act*" (2000, 40). Supporting this view Peter Graefe has likened the mechanisms of the CHA to "a blunt tool that the federal government has neglected to use, to the point of being in gross non-compliance with its enforcement provisions" (Graefe 2003, 92).

The inadequate monitoring and the weak enforcement of the CHA have seriously impeded its upholding. By not taking full advantage of the tools at its disposal, whether intentional or not, regulatory drift can occur. The federal government needs to improve the monitoring of the implementation of the CHA in each province and territory to accurately assess the impact that this policy has on the health care systems. When violations are identified, penalties should not be applied as they currently are - rarely and hesitantly. Greater enforcement of the consequences for disobeying the Act would provide a deterrent for offending governments that does not exist now. This improved upholding of the CHA would act to stop the regulatory drift that may be taking place and would help to move the policy back on track.

Conclusion

We showed that the Canada Health Act provides a good case study for the operation of policy drift. In the application of this concept, two forms of drift were distinguished: policy and regulatory. Our study of these forms is a preliminary one. Further study is needed of each provincial and territorial health care system. This will provide a much better understanding of the existence and extent of policy drift, particularly as provincial policies and the impacts that they have on policy outcomes are crucial. Focusing on the Canada Health Act at this exploratory stage provides only an introduction to the concept of policy drift and an overview of the relevant developments in the Canadian health care system. However, further study should move the analysis to the level of government with primary jurisdiction over health. In addition, a comprehensive review of outcome drift in provincial health care systems would be a valuable contribution to future research. More concrete examples and comparable figures of outcome drift are needed in order to assess the magnitude of “on the ground” changes that have resulted from policy and regulatory drift.

More generally, our brief study of drift in the Canadian health care system points to the broader question of welfare state development: are welfare states in the process of being quietly dismantled under the veil of seemingly solid policies? This is a question that increasingly needs to be asked. Although the informal, invisible and potentially subversive aspects of drift make it challenging to analyze, its consequences are no less significant than those of formal, legislative change. In fact, in many ways these features make it more imperative to apply drift theory to more programs. Over time, a setting for change can be created by not reporting on changes that are not made through formal

procedures. The impression can be given that a natural evolution has occurred when in fact it was politically stimulated. The opportunity for politicians to avoid blame is very attractive in this process. That motivation increases the likelihood of drift, highlights the necessity to improve accountability, and supports the need for greater investigation into the area. .

While Canadians are increasingly becoming aware of the changes that are occurring in their health care system, the process by which this could be taking place might surprise them. During the past election politicians made, time and again, references to the Canada Health Act and its importance, but the lack of commitment is evident as it has not been updated nor has it been upheld. This inaction has allowed for the possibility of change, through policy and regulatory drift, which is contradictory to the CHA. The lip service paid by politicians needs to turn into real and official action in terms of updating and upholding the CHA so that the possibility of drift can be eliminated. Otherwise, the Canada Health Act is in danger of drifting away.

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