

**Pharmaceutical benefits in time:  
The puzzle of Canadian distinctiveness**

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Paper prepared for CPSA Annual Conference, Ottawa, May 27-29, 2009  
Draft – please do not cite without permission

## **Abstract**

Although Canada prides itself on its universal and comprehensive public health insurance system, it is the only country that provides widespread public health benefits but does not provide similar pharmaceutical benefits. This presents both an empirical puzzle and a theoretical challenge, which cannot be accounted for by the literature on variation among national health insurance systems. Canada's outlier status suggests that pharmaceutical benefits cannot simply be subsumed into health insurance policy, and more generally, that closely related aspects of social policy might be subject to quite different dynamics. In this paper, I demonstrate that Canada's failure to provide nation-wide public coverage of pharmaceuticals is a product of its earliest decisions about how to approach health policy, and that over time, ideas and public expectations interact to set strict limits on the opportunities for policy development.

## **1. Introduction**

Canada is a country that prides itself on its universal and comprehensive public health insurance system. However, it is the only country that provides broad public health benefits but does not provide similar pharmaceutical benefits. This anomaly has received little research attention, but it represents a significant gap in Canada's public provision for health services, and in the literature on variation among national health insurance systems. Canada's outlier status suggests that pharmaceutical benefits cannot simply be subsumed into health insurance policy, and more generally, that closely related aspects of social policy might be subject to quite different dynamics.

To explain Canada's sharp divergence from similar welfare states, I trace the development of its health policy from 1945, when the federal government made its first proposals for public health insurance, to 1972, when hospital and medical insurance were fully implemented across the country. I discuss a little-known federal proposal for pharmaceutical insurance in 1972, the failure of which pushed drug benefits off the federal agenda for decades. By explaining why Canada failed to introduce nation-wide pharmaceutical insurance during its major era of health policy development, this paper provides insight into the way countries make choices about different aspects of health policy, and provides a foundation for understanding current variation in pharmaceutical policy outcomes across countries.

I argue that Canada's failure to provide nation-wide public coverage of pharmaceuticals is a product of its decision to implement health insurance one service at a time, and its decision to relegate pharmaceuticals to an undefined "later stage." These two crucial decisions were influenced by the governing party's lack of consensus on the idea of comprehensive health care, and later, by the development of public expectations for certain types of services and not others. Without a push from ideological consensus on the part of policymakers, or expectations of service on the part of the public, policy development was stymied by institutional veto players, organized interests, and simply by a perceived lack of resources

The next two sections discuss my theoretical framework and research methods. Section four examines the decision to implement health insurance in stages, and section five explains the way priorities for stages were determined. Section six discusses why policy development stalled after the implementation of medical insurance, and section seven concludes.

## 2. Theoretical framework

It is logical to assume that the provision of pharmaceutical benefits is closely related to health care benefits, particularly since pharmaceutical benefits are usually restricted to prescription medicines that can only be obtained by seeking formal medical care. However, the national health insurance literature cannot account for the fact that Canada's public health insurance is uniquely lacking in pharmaceutical coverage. This literature (Hacker 1998; Immergut 1992; Maioni 1998; Tuohy 1999) suggests a range of explanations for varied national health insurance systems including political and economic institutions, past policies, and social forces such as political parties. Many of these works (particularly Hacker) emphasize the path dependent, contingent nature of health policy development. This consensus on the relevance of history directs us to carefully consider the role of sequence and policy legacies in pharmaceutical policy, but the specific explanations for variation in national health insurance do not provide a satisfactory answer to the puzzle.

I argue that crucial decisions about health policy development are made early in the post-war period, and these decisions have long-term effects on opportunities for future policy development. The first decision countries must make is whether to attempt to implement a wide range of health services simultaneously (as in the UK, for example), or to proceed in stages (as in Canada and Australia). If a country takes a staged approach to health insurance, it also makes a decision about the sequence of policies to be implemented. Countries choose priorities differently, which contributes to different outcomes: because policy arenas tend to become less flexible over time, each step is progressively more difficult to accomplish. The simultaneous approach is more radical: it requires more significant government commitments with regards to health, and will therefore be more difficult to achieve. Although the staged approach to health services still requires a significant break with past policies (or lack of policies), it represents a smaller initial outlay of resources, and affects fewer potential opponents.

The primary determinants of how a country makes these key decisions are (a) the degree of consensus on ideas about health policy (what value is placed on the public provision of universal and comprehensive services or benefits?), and (b) the ways these ideas, and initial policies, affect public expectations about health services over time. The interaction between policymakers' ideas and public expectations determines whether policies can overcome barriers to their development, including a high number of relevant institutional veto points, opposition from organized interests, and the basic resource constraints faced by any government contemplating an expensive new program. This emphasis on sequence, timing, and the legacy of past decisions draws on a wealth of historical institutionalist and path dependence literature (see for example Pierson 2004; Pierson 1994; Mahoney 2000; Bennett and Elman 2006), but my framework makes two main theoretical innovations.

First, it attempts to refine our understanding of the role of ideas over time by proposing a specific mechanism by which the legacy of ideas has an effect: its influence on public expectations. This mechanism builds on Weaver's (1986) concept of blame avoidance and Pierson's (1994) insights about the way welfare policies develop "supportive constituencies" of beneficiaries to suggest a new way of conceptualizing the role of the public in social policy development. I hypothesize that even before policies are implemented, campaign promises, party platforms, and other public articulation of ideas about health policy affect voters' expectations about the type of services to which they are entitled. These ideational influences combine with

voters' own experiences with early policies or non-governmental methods of service provision, resulting in public expectations that can act as an important prompt to policy action, and later, as a barrier to certain types of policy change. I do not propose that this mechanism is identical to the role of public opinion, as usually understood in the literature, where voters choose parties based on the distance between their preferences and party platforms, and parties adjust their platforms in an effort to capture the median voter (Downs 1957). In Canada, as in the UK and Australia, there was no groundswell of public demand for health insurance or benefits in the 1940s that determined its place on the policy agenda,<sup>1</sup> and it was rarely a defining electoral issue. However, later in the policy process, decision makers do cite public expectations when deliberating on whether and how to act in this field, in the context of avoiding blame for unfulfilled policy promises or frustrated expectations of a certain type of service.

Second, the framework captures the effect of federalism on the introduction of pharmaceutical benefits by focusing on the role of subnational governments as veto players: collective actors whose agreement is required for policy change (Tsebelis 1995). Because the current research is limited to a single policy decision (albeit one that unfolds over decades), it is possible to simplify our theories of how federal institutions affect social policy outcomes, which so far have offered limited traction on the problem (Pierson 1995). Since Canadian provincial governments have a veto over the federal government's decision to implement a nation-wide pharmaceutical insurance program (and, of course, the decision to implement any nation-wide health benefits), we can explain provincial governments' decision to support or oppose federal action in the same way we explain the federal decision-making process. Do policymakers' ideas or public expectations outweigh resources constraints or opposition from organized interests? The nature of federalism also places unique constraints on provincial governments as veto players, however: since provincial and federal governments face an overlapping constituency, a sufficiently motivated federal government may bypass provinces to appeal to directly to the shared public, and thus effectively make provincial governments an offer they can't refuse. Provinces' veto power still theoretically exists, but blocking a popular federal policy may simply be too costly.

In summary, I hypothesize that the multiplication of relevant veto points in federalism presents a barrier to the simultaneous development of nation-wide health services, and that unless there is a high degree of ideological consensus and motivation on the part of the national government, health policy development will proceed in stages. After deciding to implement health insurance in stages, governments face a second choice regarding their order of priorities, which I hypothesize is determined by perceptions of resource constraints, the preferences of provincial veto players and organized interests, and the way public expectations for service develop over time. Although the decision to proceed in stages is often closely connected to the choice of the first priority, later priorities become more difficult to implement as initial policies increase cost concerns or opposition from veto players or organized interests. Again, these barriers can only be overcome by ideological consensus on the part of governments, or clear expectations for service on the part of the public.

### **3. Methods**

This paper focuses on policy development in Canada, but it is occasionally helpful to refer to two similar welfare states with different paths of health policy development. In the UK, all public health services, including pharmaceutical care, were instituted simultaneously in 1946,

under the National Health Service (NHS). In Australia, the Pharmaceutical Benefits Scheme was implemented in 1950, and public hospital and medical insurance followed in 1984. Like the UK and Australia, Canada attempted to develop health insurance policies immediately after World War II, but nation-wide hospital insurance was not implemented until 1957, with medical insurance following in 1966. Pharmaceutical insurance, of course, was never introduced in Canada.

I take a process-tracing approach with the goal of identifying causal mechanisms, the processes by which explanatory variables affect policy outcomes. Process tracing is a method that Hall suggests is particularly suited to dealing with “theories...based on path dependence or strategic interaction” (2003). Instead of “assessing the ability of a theory to predict outcomes,” it assesses theories’ ability to “predict the intervening causal process” implied by the hypothesis (George and Bennett 2005). Process tracing allows a researcher to build detailed and specific accounts of how causal relationships work in a given case, and to identify common mechanisms across time.

The paper uses both secondary sources and original archival research, as well as an expert interview from a larger project on current pharmaceutical policy.

#### **4. The first crucial decision: health insurance in stages**

To explain Canada’s puzzling lack of pharmaceutical coverage, we must turn to its first proposals for health insurance, and examine how their form and content affected the development of policy over the ensuing two decades. After the failure of the initial 1945 proposals for comprehensive health services, federal bureaucrats produced less ambitious, staged proposals. Health insurance was discussed briefly at the 1950 Federal-Provincial Conference, and at length at the 1955 Federal-Provincial Conference. By this time, the decision to proceed with health insurance in stages seems well established, and in 1957 the first stage, nation-wide hospital insurance, was implemented.

Why did policy develop this way? Although Canada lacked the relatively centralized, unitary control present in Britain, the British Beveridge report on universal and comprehensive social services made a significant impression on Canadian policymakers (Marsh 1943) and some of the first studies and proposals from experts in the Department of National Health and Welfare (DHW) emphasized the benefits of a comprehensive program (Marsh 1943; Canada. Advisory Committee on Health Insurance 1943). Canada’s federal institutions posed a significant barrier to simultaneous policy development, and this, combined with a lack of consensus in the federal government about the idea of universal and comprehensive health services, made the staged introduction of health insurance a seeming inevitability to most decision makers.

##### **4.1. The role of federalism**

I hypothesize that federal institutions will block the simultaneous approach to health policy, which requires an exceptional degree of coordination and consensus. In Canada, health care is constitutionally a provincial responsibility. Provincial governments have tended to be protective of their jurisdiction, at least with regards to policies that allow them to claim credit with voters, such as health benefits (Cairns 1977; Harrison 1996). The federal fact in Canada appears to have ruled out the simultaneous approach quite early: although the 1945 proposals called for health services to be introduced one at a time, they were envisioned as parts of a

complete program provinces would “have to take, in its entirety, and in a fixed period order, within a certain time limit.”<sup>2</sup> This proposal failed after being linked to tax rental agreements (where the federal government takes over provincial tax room in exchange for a payment of lost revenue) the provinces would not accept (Maioni 1998; Taylor 1987), and in 1946 the Cabinet Working Committee on Health Insurance recommended that “further consideration of the second stage of the Health Insurance Proposals be deferred pending the outcome of the reports from the provinces regarding planning and organization.”<sup>3</sup>

In 1949, the DHW outlined two additional options for health insurance that recognized provinces’ desire for flexibility. The first option was to propose a program provinces could take up as they liked, and the second was to offer a program starting with one basic service (either general practitioner services or hospital care), with the rest “following in a related order of priority, possibly within a fixed period of time.”<sup>4</sup> When health insurance proposals were discussed at the 1955 Federal-Provincial conference, Prime Minister Louis St. Laurent noted that the federal government would not “wish to be party to a plan for health insurance which would require a constitutional change or federal interference in matters which are essentially of provincial concern,” and solicited provincial input “as to the order of priority of the various services” (Canada 1955).

Provincial preferences for a staged approach to health insurance persisted even after hospital insurance was implemented in 1957. In 1964, British Columbia recommended that “a National Health Services Programme be designed in such a way so as to permit the step-by-step implementation, and that each province should be free to introduce phases of the programme as it sees fit.”<sup>5</sup> A survey of provincial departments of health in 1965 found that “[t]he majority of the provinces stated that their ultimate aim was complete health services available to everyone, but stressed the importance of priorities, phasing and timing.”<sup>6</sup> So the institutional barriers to simultaneous policy development were considerable, and as the next section demonstrates, there was insufficient ideological consensus about the value and importance of comprehensive services to overcome these barriers.

#### **4.2. The lack of ideological consensus**

I hypothesize that in order to achieve radical policy change such as the simultaneous implementation of a broad range of health services, an extraordinary level of ideological consensus is necessary. Post-war Britain provides an example of such consensus, but ideas about health care were more divided in Canada. In Britain, Labour’s post-war victory brought the party and its ideology of social reform to power for the first time. In Canada, the Liberal party had been in power for almost a decade, and had included health insurance in its platform since 1919 (Boychuk 2008). However, the Liberals only promised action on social security in 1944 because of the electoral pressure from the Co-operative Commonwealth Federal (CCF), a social democratic party that was gaining power at both the provincial and the federal levels (Hacker 1998; Maioni 1998). Pressure from the CCF meant the Liberal government was forced to act on health insurance, but action was a political compromise rather than a principled imperative for the party, resulting in a slow, staged introduction of actual policy.

The lack of consensus on health policy within the Liberal party is well documented by Paul Martin Sr., the Minister of National Health and Welfare from 1946 to 1957. He recalls that in 1948,

I knew that some of the most powerful voices in cabinet did not share my desire to move quickly towards a national insurance plan. Although the party had proclaimed its support for such a scheme on many occasions, I had my work cut out to keep it fully committed to proceeding towards this objective (Martin 1985).

Martin struggled to get support from Prime Minister Mackenzie King, and from King's successor, Louis St. Laurent. Beyond concerns about difficult federal-provincial negotiations or expense, it seems that St. Laurent simply did not perceive health insurance to be a "good policy" idea. Instead, he favoured the expansion of voluntary insurance through existing private plans (Maioni 1998). The Conservative premier of Ontario, Leslie Frost, pushed for hospital insurance's inclusion on the 1950 dominion-provincial conference agenda, and Martin reports that, "St. Laurent was taken aback. He did not believe in health insurance and was amazed that a Conservative premier would openly confess that he was for it" (Martin 1985).

## **5. The second crucial decision: priority of services**

Once it became clear (as early as 1946) that implementing the various aspects of health insurance simultaneously or in a brief, closely related series of steps would not be possible, policymakers turned to the question of the order in which services should be introduced. There was extensive debate within the DHW about the order of priorities, which resulted in an early federal decision to take pharmaceuticals off the table. The final decision about priorities was based on pragmatic concerns about the resources necessary to implement the program, the need to negotiate with provinces and avoid confrontation with the medical profession, and evolving public expectations about health insurance.

### **5.1. Resource constraints: the cost of pharmaceuticals**

The cost of providing health insurance was a constant concern within the DHW, the federal cabinet, and in intergovernmental discussions. Surprisingly, in Britain the financial implications of the NHS were not discussed during its creation (Klein 1995), but in Canada cost concerns stalled consideration of pharmaceutical benefits very early. Although drugs were included as part of the "later stages" of the 1945 proposals (Canada 1945), when the DHW reconsidered service priorities before the 1950 Federal-Provincial Conference, officials recommended leaving pharmaceuticals off the agenda entirely, because

... All the experience to date indicates that it is *almost impossible to control the costs in such services*, and, until something has been developed in this connection, we do not feel capable of making any suggestions at all as to cost (emphasis added).<sup>7</sup>

Why Canadian officials were more pessimistic about controlling the costs of pharmaceutical benefits than other health services, or why they were more pessimistic than policymakers in other countries, is not clear. By 1949, the high cost of prescription services was becoming an issue in Britain, but Canadian officials did not explicitly cite British experience at this time.<sup>8</sup> Australian policymakers were more concerned about pharmaceutical costs than the British initially, but they focused on designing tools for cost control.<sup>9</sup> However, Tom Kent, an architect of Liberal health policy in the 1960s, has noted that drugs were seen as more difficult to ration than doctor's visits, and that it was easier to "want too much" in terms of pharmaceutical products, which helps explain policymakers' caution.<sup>10</sup>

Whatever the reason for Canadian policymakers' reluctance to grapple with the financial implications of pharmaceuticals, it was persistent. In 1955, a meeting of federal and provincial deputy ministers of health concluded that pharmaceutical benefits outside hospital were "not considered to be feasible at this stage."<sup>11</sup> After hospital insurance was implemented, another round of priority discussions again dismissed pharmaceuticals. In 1963, the federal Departmental Group to Study Health Insurance suggested "that in view of the difficulties inherent in the control of costs and in light of the availability of drugs provided in hospitals, that pharmaceutical benefits might be excluded from any Canadian medical care program," although the group also considered options for "acquiring drugs at a reduced rate," such as bulk purchasing.<sup>12</sup>

The decision to place a low priority on pharmaceutical benefits is a result of the somewhat contingent way cost concerns manifested themselves in the DHW in the 1940s and 1950s, although as will be discussed below, federal bureaucrats took a different position on costs of pharmaceutical benefits in the 1970s, when the wide range of expensive new drugs might lead us to expect bureaucrats to be even more wary of costs. The order of priorities that won the day – hospital and diagnostic services, with medical services following after a lag of nine years – is predictable given the federal-provincial dynamics and organized interests faced by Canadian policymakers. Understanding why Canadian health insurance developed in these stages can help us understand why the pharmaceutical "stage" was never reached.

## **5.2. Preferences: provincial veto players and innovators**

The conditions the federal government placed on a possible health insurance agreement after 1945 – that a majority of the provinces representing a majority of the population must reach a tax rental agreement with the federal government prior to any funding for health insurance – meant that Ontario and Quebec had an effective veto over policy development. However, there is also evidence that the innovative health policies of smaller provinces helped shape federal policymakers' ideas about the priorities for services. Thus, provincial preferences shaped priorities in both a positive sense (through an ideational mechanism) and negative sense (by acting as institutional veto players), and these preferences in turn were shaped by the interaction of resource constraints, organized interests, and ideas and public expectations about health insurance.

As the first-mover on health insurance, Saskatchewan's preferences over priorities had a clear influence on the federal government. As early as 1949, the DHW noted that there were already two provincial hospital plans launched in expectation of federal support (Saskatchewan's compulsory program was implemented in 1946, and British Columbia began a similar program in 1948), and that it would be a shame to let them lapse by not providing stable funding.<sup>13</sup> There is a two-way causal relationship between Saskatchewan's implementation of hospital insurance and the advent of federal support: the provincial government began with hospital insurance at least in part based on its expectations of federal support (Taylor 1987; Boychuk 2008). Later, the federal decision about where to begin supporting health insurance was influenced by Saskatchewan's success in the hospital field.

Taylor (1987) and Boychuk (2008) argue that Ontario's preferences were instrumental in the decision to begin with hospital insurance, and this is supported by Ontario's veto position in the quest for a federal-provincial agreement on health insurance and tax rental agreements. The federal government was well aware of Ontario's preferences: a 1955 memo to Health Minister



Martin notes that hospital insurance “was the only practical possibility at this time so far as Ontario was concerned,”<sup>14</sup> and this position was repeated forcefully by the Ontario premier in more formal federal-provincial settings (Canada 1955).

According to Boychuk (2008), the Ontario government’s preference for hospital insurance over other priorities was shaped by the extensive system of private hospital insurance in that province in the early 1950s,<sup>15</sup> which was in turn supported by a series of National Health Grants from the federal government that had funded the development of hospital infrastructure.<sup>16</sup> Instead of crowding out the development of public insurance, as Hacker (1998) suggests, pre-existing private benefits solved potential problems of administration and increased public acceptance of the principle of collective insurance (Boychuk 2008). Taylor suggests that Ontario’s desire to act on hospital insurance was also motivated by the limits of voluntary insurance that had appeared by 1953, when about one-third of the population still “did not have available a satisfactory system of budgeting their unpredictable hospital costs” (Taylor 1987). Furthermore, Taylor notes a change in public expectations with regards to insurance: “in 1945 only a small proportion of the population had any direct experience with [hospital insurance], now almost everyone was aware of it,” but coverage was far from universal, and even those with coverage faced significant additional out-of-pocket costs (Taylor 1987). Ontario’s insistence at the 1955 Federal-Provincial Conference that “at this time, our proposals relate to hospital and diagnostic services only,” (Canada 1955) appears to have overruled federal deliberations about different orders of priority, confirming the conclusion (first articulated in 1949) that “the introduction of a hospital care scheme would cause less disruption of the existing order of things.”<sup>17</sup>

### **5.3. Preferences: organized interests**

If the federal government was inclined to start with medical insurance rather than hospital insurance, as some bureaucrats preferred, it faced an additional barrier: the reaction of physicians, who in Canada had an important stake in the development of private medical care insurance. Private hospital insurance influenced Ontario’s preferences regarding health insurance priorities and hence the federal government’s decision, but this was a matter of the provincial government spotting an administrative and revenue-generating windfall: the relevant interests (hospital associations and commercial insurance companies) were not sufficiently strong to prevent hospital insurance from being taken over by the joint action of federal and provincial governments.

To understand physicians’ influence on government priorities, we must distinguish between the Blue Cross schemes sponsored by provincial hospital associations, which provided hospital insurance and additional medical insurance in some cases, and the non-profit, physician-sponsored schemes that provided mainly medical coverage. Although commercial, for-profit medical insurance existed in Canada, it was never as extensive or as influential as the physician-sponsored plans (Shillington 1972).

Physician-sponsored medical care plans began in the mid-1930s, but expanded greatly after 1945 (Shillington 1972). The explicit goal of this expansion was to “support... a viable alternative to government-sponsored health insurance” (Maioni 1998), and it meant doctors had a more stable income stream and a good alternative to government intervention. Doctors were not in a similarly strong position in other countries: in Britain at the advent of the NHS, doctors were trapped between Friendly Societies with low capitation rates and hence low income, and

the possibility of a nationalized service and the attendant loss of autonomy (Hacker 1998). In Canada, the existence of a national organization for physician-sponsored plans (Trans-Canada Medical Plans) meant that if the federal government attempted to initiate nation-wide medical insurance as the first step of health insurance, it would have to directly confront the medical associations. Given the lack of an overriding consensus on about the order of priorities within the federal government and the lukewarm position of the Prime Minister St. Laurent on the principle of compulsory insurance, it was much preferable to put off confrontation with the doctors initially, and deal with the relatively docile private hospital insurance industry instead.

## **6. Stalled policy development**

Nine years after the implementation of hospital insurance, medical insurance was introduced, and was gradually implemented in the provinces between 1966 and 1972. This second priority historically had a high place on the Canadian health insurance agenda,<sup>18</sup> and there is a wealth of detailed and insightful accounts of how it was implemented. Here I note the consistency of these accounts with the explanatory factors I have proposed for the determination of priorities, and go beyond them to explain why there were no further steps towards pharmaceutical benefits.

### **6.1. Medical insurance: the next and last step**

Nation-wide medical insurance faced generally higher barriers from provincial governments. There are some instances of provincial governments acting as innovators (Hacker 1998; Maioni 1998), or prompting a federal reaction by asserting themselves in other social fields (Boychuk 2008). However, the main federal-provincial dynamic was provincial government support for voluntary medical insurance and therefore reluctance to take part in a nation-wide compulsory scheme (Taylor 1987); and a general deterioration of federal-provincial relations, as provincial governments became more assertive and more wary of cost-shared programs (Hacker 1998; Maioni 1998; Taylor 1987). The federal government's ability to overcome these barriers and implement medical insurance demonstrates the potential for ideological consensus and pressure from public expectations to overcome barriers to policy development posed by institutions, interests, or lack of resources. As discussed in the next section, these factors were missing from pharmaceutical insurance.

The federal government's increased willingness to support medical insurance came from a number of sources. Its minority position gave the New Democratic Party (the CCF's successor in federal politics) increased leverage to push a program of comprehensive health insurance (Hacker 1998; Maioni 1998; Taylor 1987), and in 1964, the Royal Commission on Health Services provided "an extraordinary call for action" (Taylor 1987) with regards to the extension of health insurance. There was also an ideological shift within the Liberal party itself, as St. Laurent, always skeptical of government insurance, was replaced by Lester B. Pearson and a cadre of progressive cabinet ministers dedicated to the principle of public insurance (Maioni 1998; Taylor 1987).

The key to the Liberal government's ability to overcome the objections from provincial veto players, however, was public expectations, which had been conditioned by the combination of previous insurance policies at the federal and provincial levels to the point that medical insurance was a "natural, normal expectation," awaiting the right time for implementation (Taylor 1987). Although private medical insurance was extensive by the early 1960s, it did not

compare favorably with the Royal Commission's calls for broad coverage, longstanding government promises for hospital and medical insurance, and perhaps citizens' own experiences with universal, first-dollar public hospital insurance. Neither commercial nor non-profit plans provided comprehensive financial coverage. Premiums could be quite costly, and there were often significant out-of-pocket costs (Maioni 1998). Moreover, there were significant gaps in which populations could obtain coverage (the elderly were generally excluded (Department of National Health and Welfare (Research Division) 1954)) and significant variation among provinces and between rural and urban areas (Maioni 1998). So the public was well aware of the concept of comprehensive coverage for medical care, but outside Saskatchewan, did not yet receive it.

This contributed to the Liberal party's sense that medical insurance would be received favorably, and they made it an important part of their platform. Liberal pamphlets from the 1962 election promised "Health Care as Needed," and proposed coverage for medical services, with "other services" such as pharmaceuticals to follow later<sup>19</sup>. Other election materials informed voters that they "shouldn't have to worry about heavy medical costs."<sup>20</sup> In 1965, the federal government was preparing for a Federal-Provincial Conference that would discuss the extension of health insurance. Kent's comments to Pearson illustrate the degree to which the government saw medical insurance as an important response to the public: he said, "we are prepared in effect to appeal to the public over the heads of the Provinces" on this matter,<sup>21</sup> and provinces' agreement to the scheme suggests that they may have recognized this.

## **6.2. The end of federal pharmaceutical proposals**

Why was this moment of federal government unity and motivation insufficient to extend health insurance still further, to the coverage of pharmaceuticals, visiting nurses or homecare, and dental care? As we have seen, the struggle to implement nation-wide medical insurance was in many ways more difficult than hospital insurance, and this helped dampen any appetite for further reforms. However, the failure of pharmaceutical insurance can also be attributed to the legacy of its longstanding place near the bottom of the list of health insurance priorities. Pharmaceutical insurance was subject to greater cost concerns than other services, and was repeatedly removed from consideration for this reason.<sup>22</sup> This low priority position became self-reinforcing. Pharmaceutical insurance was rarely debated outside the closed circuit of the DHW and the federal cabinet, and until the 1970s the public had very limited experience with either private drug insurance or provincial drug benefits. This meant there was little basis for the formation of public expectations about drugs, analogous to the development of expectations for hospital and medical insurance over time, which I argue would have been necessary for further policy development.

Both the barriers to further policy presented by cost concerns and anticipated opposition, and the lack of ideational motivation to overcome these barriers, are illustrated in a single policy incident: the failure of the last internal, federal government proposals for pharmaceutical insurance, presented to cabinet by the DHW between 1971 and 1972. The federal government had been studying the problem of high drug prices since 1958, and had already made significant changes to patent laws in an effort to address it<sup>23</sup>, but the issue persisted (Lang 1974). In 1971, the Minister of Consumer and Corporate Affairs and the Minister of Health proposed a Drug Price Program that would include the extension of medicare (as nation-wide health insurance was

known) to cover prescription drugs.<sup>24</sup> As we will see, this suggestion of a positive association between drug benefits and the ability to control drug prices failed to convince federal politicians.

### **6.3. Anticipated opposition and cost concerns**

In a 1971 Cabinet meeting to consider the proposal, Prime Minister Pierre Trudeau noted that the provinces did not like being “forced into Medicare”, and would “undoubtedly object to the proposed extension of the scheme to drugs.”<sup>25</sup> The president of the Treasury added that “provinces should be given time to increase the effectiveness of the present Medicare scheme, before any significant additions were made to it.”<sup>26</sup> At this time, Cabinet also anticipated opposition from organized interests, saying that the “drug lobby would learn of the interdepartmental studies [of drug insurance], and would react violently against them,” and that the inclusion of prescription drugs in health insurance would “only exacerbate” the medical profession’s dissatisfaction with the scheme.<sup>27</sup> Since the proposal never left the confines of Cabinet, the validity of these concerns were not tested, but they acted as an effective barrier to policy development.

The barrier posed by concerns about the affordability of a pharmaceutical program was also evident. The Prime Minister said he did not wish to extend medicare to drugs “because of the considerable expenditures involved and the difficulty of getting the provinces to pay their share,” although he added that if the minister of health could show “the great majority of provinces wanted and were willing to pay for such service the question might be raised again.”<sup>28</sup> Later, the Cabinet Committee on Social Policy noted that in principle it supported “the provision of a prescription Drug Insurance Benefit for Canadians *when budgetary conditions permit*” (emphasis added).<sup>29</sup> However, various ministers thought pharmaceutical insurance should be avoided because “the government’s first priority should be to restore public confidence in its economic policies” (and pharmacare would detract from this priority)<sup>30</sup>, and because “pharmacare would be the beginning of a very expensive program which would undermine the confidence of the middle-income groups in the government’s ability to control the budget.”<sup>31</sup>

### **6.4. The lack of ideological consensus**

Cabinet’s focus on the financial barriers to the program and potential opposition from provinces, the medical profession, and the pharmaceutical industry demonstrate that pharmaceutical insurance was not an issue supported by a high degree of principled, ideational motivation. This can be further illustrated by comparing ideas within the DHW, where the key policy proposals were developed, to the ideas expressed by ministers in cabinet discussions of these proposals. The bureaucratic authors of the proposals clearly saw them as a principled policy choice that would not only reduce drug prices, but also fill a gap in the present provision for health services while rationalizing their use. A draft memo entitled “Some Social Reasons for Pharmacare” argues that “society has come to think of health care as being part of a total system and as a result has recognized that an important segment of the health care system is not presently being covered by an insurance program,” and furthermore, that “[i]t does not make much sense to pay a physician under Medicare to examine and prescribe for his patient if the patient is unable to benefit” because the prescription is unaffordable.<sup>32</sup> The DHW recommended that benefits be introduced on a universal basis, as a non-universal plan would not reduce prices.<sup>33</sup>

These ideas about the importance of pharmaceutical insurance contrast with the position of cabinet ministers, who did not consider the department's recommendation for a universal program: on the recommendation of the Minister of Health, they focused on a "staged program" that would provide drug coverage to the elderly and eventually expand to cover children and other groups.<sup>34</sup> The result was drug insurance proposals were not debated as a principled extension of medicare, but rather as one of a number of options for assisting elderly Canadians. One minister expressed the opinion that "[i]f anything were to be done for older people, it should be simple and dramatic," such as "a once-and-for-all increase to \$100 for the OAS" (Old Age Security program).<sup>35</sup> The issue was deferred, and there is no record of Cabinet discussing the pharmacare proposals after March 1972. Thus, earlier discussions of the proposal focused on costs and potential opposition; later discussions focused on the proposal as targeted assistance to seniors. At no point in Cabinet's deliberations was the proposal framed as a measure to lower drug prices and extend universal and comprehensive health insurance, which meant there was no opportunity to build an ideological consensus about the value of the program that might allow it to overcome the barriers to its development.

### **6.5. The lack of public expectations**

Pressure from DHW bureaucrats was insufficient to motivate politicians on pharmaceutical insurance, and pressure from the public appears to have been absent. Newspaper coverage and government debates demonstrate the public was concerned about high drug prices,<sup>36</sup> but there is limited evidence of whether there was any clear preference for or debate about price control versus public insurance. Although the challenges inherent to demonstrating an absent cause of a non-decision mean it is difficult to be fully satisfied on this point, the existing evidence suggests there were fewer opportunities for public expectations about pharmaceuticals to develop. A 1972 Cabinet memo arguing for the Drug Price Program notes that federal departments "have received and continue to receive many letters from the public complaining about the high cost of prescription drugs and many requests that a drug insurance program similar to Medicare be made available."<sup>37</sup> However, the same memo goes on to discuss strategies for the implementation of a pharmaceutical program and says that since the federal government is not in a position to implement a program unilaterally, it could "wait...for provincial and public pressures to build up," or actively encourage these pressures in hopes of igniting a desire for intergovernmental cooperation on the issue.<sup>38</sup> This suggests that proponents of pharmaceutical insurance recognized the potential for public expectations to aid policy development, but that the necessary pressure did not yet exist.

Furthermore, most provinces did not begin to introduce targeted public drug benefits (for seniors and social assistance recipients) until the early 1970s (Grootendorst 2002), so Canadians' first experience with public insurance for drugs was both late and limited to a relatively small portion of the population. A 1971 report of the Canadian Pharmaceutical Association notes that private, third-party prescription drug insurance programs "are not believed to cover a significant portion of the population" (Commission on Pharmaceutical Services 1971), suggesting Canadians' experience with private drug coverage was also limited. Certainly the campaign promises of political parties and policy agendas of governments never alluded to pharmaceutical insurance as anything other than a vague and distant possibility. Thus, although it is possible that the public was beginning to develop expectations about drug insurance based on a perceived "gap" in the now-comprehensive public hospital and medical insurance they enjoyed, there is less evidence for this kind of public pressure than there was for hospital and medical insurance, where

governments had a clear sense of having promised insurance, and of needing to fulfill those promises for electoral reasons.

## 7. Conclusion

Canada's lack of a nation-wide, public drug insurance program sets it apart from similar welfare states. As was the case in the UK and Australia, the Canadian government considered a broad program of public health services or benefits after World War II, but its decision to implement health policy in stages crucially influenced future opportunities for policy development, and blocked the consideration of pharmaceutical insurance.

I hypothesized that Canada's federal arrangements, which give provincial governments veto power over the federal government's ability to introduce health insurance policy, would act as a barrier to the simultaneous introduction of services. A government that was highly motivated by consensus on the idea of comprehensive health benefits and was supported by public expectations could potentially overcome this barrier, but these conditions were absent. The choice to develop health insurance in stages meant that the order of priority mattered: later priorities were much less likely to be implemented, and a low place on the policy agenda became self-reinforcing as a lack of debate about pharmaceutical insurance blocked opportunities to foster the same type of public expectations and sense of inevitability that developed with regards to hospital and then medical insurance.

The order of priorities was determined by policymakers' perceptions about resource constraints, the preferences of institutional veto players and organized interests (provincial governments and the medical profession), and, as noted above, politicians' sense of public expectations. The priority-setting process demonstrates a role for contingency with regards to policymaker's perceptions of costs, and that federalism may have different effects at different points in the causal process. In Canada, the existence of provincial veto players initially blocked a radical approach to health policy development, but once the decision to proceed in stages had been made, a more ideational mechanism took hold. Here, provincial governments used their influence on federal priorities to shape policy in a more positive way, by promoting their preferred policy approach (the push for public hospital insurance from Ontario) or compelling a federal reaction to their independent policy development (the example of medical insurance in Saskatchewan, or the desire to counterbalance Quebec's social policy assertiveness in the early 1960s). Furthermore, the importance of priority setting shows that closely related aspects of health policy may be subject to quite different dynamics: for instance, both hospital insurance and pharmaceutical insurance would have been expensive new programs in the early 1950s, but the impression of Canadian policymakers that pharmaceutical costs would be basically uncontrollable relegated drug insurance to the bottom of the policy agenda where it stayed for decades.

This explanation of Canadian distinctiveness with regards to pharmaceutical insurance suggests a number of avenues for future research. The theoretical framework for health policy development set out here will be applied to the UK and Australia to test its robustness in other contexts. Eventually, the research will be extended to consider more recent variation in pharmaceutical policies, and the ways this variation is linked to early decisions about priorities for health policy development. In this way, we can gain not only a better understanding of an empirical policy puzzle, but also clarify the interaction between ideas and institutions over time.

## Notes

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1. For example, around 1947 the federal health minister records that in developing health insurance, “I realized that the public demand was a weak leg on which to stand. Canadians supported health initiatives in a general way, but they had no precise idea of the preliminaries or the consequences” (Martin 1985)
2. DHW Memo 22 December 1949. Library and Archives Canada (hereafter cited as LAC). RG 29 Vol 1061 File 500-3-4 part 1.
3. Meeting of the Cabinet committee on Dominion-Provincial Relations: Report of the Working Committee on Health Insurance, 4 January 1946. LAC. Brooke Claxton fonds. MG 32-B5 Vol 138 File: “Dom-Prov Conferences DP-2 Committees and Meetings.”
4. Department of National Health and Welfare Memo 22 December 1949. LAC. RG 29 Vol 1061 File 500-3-4 part 1.
5. Statement of Principle advocated by British Columbia Respecting Preliminary Observations of the Report of the Royal Commission on Health Services, volume I, prepared for meeting 20-21 July 1964. LAC. RG 29 Vol 1133 File 504-5-11 part. 1.
6. Consolidated Report of views expressed by the provinces on health services. LAC. RG 29 Vol 1133 File 504-5-12.
7. Health Insurance brief, 7 December 1949. LAC. RG 29 Vol 1061 File 500-3-4 part.1.
8. However, Canadian policymakers were likely aware of the cost overruns in the British NHS. Both the Department of National Health and Welfare and the CMA undertook studies of the NHS in 1949 (LAC. RG 29 Vol 1111, File 504-2-4-PT2). Later, the Royal Commission on Health Services discussed NHS cost overruns and the need to avoid them (June 1964 press release. LAC. RG 33-78 Vol 27 File 2-8-2 part 3.)
9. Notes for BMA Conference, 28 January 1944. National Archives of Australia. A571, 1943/4513. See also Social Security in Australia memorandum. NAA. A571, 1943/4513. The Australian government justified its proposed drug formulary, noting it was “paying for the entire scheme and therefore must maintain a certain amount of control over what it will pay for...”
10. Author’s interview with Tom Kent, Kingston, 11 February 2008. This insight matches the early concerns of British and Australian policymakers with overprescribing, seen as a key policy problem when pharmaceutical services or benefits were introduced.
11. Draft Report to the Chairman of the Preparatory Committee for the Federal-Provincial conference 1955 on a Personal Health Care Program. LAC. RG 29 Vol 1132 File 504-5-6 part 1.
12. Meeting of the Departmental Group to Study Health Insurance, 27 March 1963. LAC. RG 29 Vol 1129 File 504-4-15 part 1.
13. Health Insurance brief, 7 December 1949. LAC. RG 29 Vol 1061 File 500-3-4 part 1.
14. Memo to Minister on Health Insurance and Ontario, 5 August 1955. LAC. RG 29 Vol 1132 File 504-5-6 part 1.
15. In 1955, voluntary hospital insurance was more widespread in Ontario than medical insurance: 71.2% of the population had some kind of commercial or voluntary non-profit hospital insurance, and 50.8% had medical insurance (Department of National Health and Welfare (Research Division) 1958).
16. Health Services Organization: Memo on Canada’s National Health Services. LAC. RG 29 Vol 2576 File 181-6-2. See also Hacker (1998) on the influence of the National Health Grants on the path of Canadian health insurance.
17. Memo December 1949. LAC. RG 29 Vol 1061 File 500-3-4 part 1.

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18. See for example Memo December 1949. LAC. RG 29 Vol 1061 File 500-3-4 part 1.
  19. Liberal campaign pamphlet, "Health Care as Needed: The Answer," 1961. LAC. RG 33-78, Vol 51, File: "Conference of Ministers of Health;" and F.W. Jackson (Director of Health Services) memo, "Priorities in a health insurance plan," 5 September 1955. LAC. RG 29 Vol 1061 File 500-3-4 part. 2.
  20. Liberal campaign pamphlet, "Take a Stand for Tomorrow: Vote Liberal," 1961. LAC. RG 33-78, Vol 51.
  21. Thomas Kent to Lester B. Pearson, 18 July 1965 (Secret - Federal-Provincial Conference: Strategy). Queen's University Archives. Thomas Worrall Kent Papers. Correspondence series, Box 4, Folder 14: July 1965.
  22. Health Insurance brief, 7 December 1949. LAC. RG 29 Vol 1061 File 500-3-4 part.1; Draft Report to the Chairman of the Preparatory Committee for the Federal-Provincial conference 1955 on a Personal Health Care Program. LAC. RG 29 Vol 1132 File 504-5-6 part.1
  23. Changes to the Patent Act in 1968 allowed for compulsory licensing of imported drugs, greatly reducing the effective patent life and creating greater opportunities for lower-cost generic copies of drugs.
  24. The Drug Price Program, 23 September 1971. LAC. RG 2 Vol 6381 Series A-5-a.
  25. Ibid.
  26. Ibid.
  27. Ibid.
  28. Ibid.
  29. Memorandum to Cabinet: "Measures to lower the unit cost of prescription drugs including a drug benefit program [*Pharmacare*]," 8 February 1972. LAC. RG 2 Vol 6397 File 145-72.
  30. "Measures to lower the unit price of drugs including a drug benefit program," 23 March 1972. LAC. RG 2 Vol 6395 Series A-5-a.
  31. "Measures to lower ..." 30 March 1972. LAC. RG 2 Vol 6395 Series A-5-a.
  32. "DRAFT – Some Social Reasons for Pharmacare" and "Arguments for Pharmacare." LAC. RG 29 Vol 1572 File 1016-1-2.
  33. Memorandum to Cabinet, 2 February 1972. LAC. RG 29 Vol 1549 File 1006-5-1.
  34. "Measures to lower ..." 23 March 1972. RG 2 Vol 6395 Series A-5-a.
  35. "Measures to lower ..." 30 March 1972. LAC. RG 2 Vol 6395 Series A-5-a.
  36. *Globe & Mail* 16 December 1955, p.39; 6 October 1960, p.3; 24 January 1961, p.25; see also Cabinet memo 2 February 1972. LAC. RG 29 Vol 1549 File 1006-5-2; Cabinet memo 24 November 1972. LAC. RG 29 Vol 1572, File 1016-1-2.
  37. Memorandum to Cabinet: "Measures to lower ... [*Pharmacare*]," 8 February 1972. LAC. RG 2 Vol 6397 File 145-72.
  38. Ibid.



## Manuscript collections

Library and Archives Canada (LAC)

RG 2: Privy Council Office

RG 29: Department of National Health and Welfare

MG 32-B5: Brooke Claxton fonds

RG 33-78: Royal Commissions: Royal Commission on Health Services

Queen's University Archives

Thomas Worrall Kent Papers. Correspondence series, Box 4, Folder 14: July 1965.

National Archives of Australia (NAA)

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