Politics and the Healthcare Policy Arena in Canada: Diagnosing the Situation, Evaluating Solutions

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From a political perspective, healthcare in Canada is a strange policy arena indeed. On the one hand, it represents a core function of modern states worldwide. For Canadians, having a reliable healthcare system that is universally available and publicly funded continues to be a national aspiration and at the top of their political priorities.

And yet, on the other hand, there is little in the way of a pan-Canadian health policy, nor is there a national “medicare” system. It bears repeating, lest we forget, that healthcare policy remains primarily and primordially in the realm of provincial government responsibilities, both in terms of organization and financing.

The unique challenge of this policy area in the Canadian context is also highlighted by the task at hand in the scope of this conference: discussing a national strategy for healthcare, engaging national stakeholders, cross-national comparisons … without any of the usual and necessary “nation-wide” policy mechanisms for the formulation and implementation of reform.

This paper attempts to address this conundrum by unpacking some of the particular political features of healthcare policy and politics in Canada: the tension between perceived citizenship rights and practical service delivery and financing; the juxtaposition of provincial innovation and federal leadership; and the unique form of decentralized policy-making in the context of national stakeholders. The paper then proposes a dose of realpolitik in suggesting avenues for attaining a better dialogue and road to reform in healthcare.

Citizenship right or provincial government service?

For scholars of the welfare state, healthcare is seen as part of the development of the “social rights” of citizenship. This notion of a link between citizenship and social policy has its origins in the work of T.H. Marshall, who described the full rights of citizenship as including not only civil and political rights, but social rights as well (Marshall, 1950). It was a theme that has had quite a bit of historical resonance in Canada, particularly during the post-war reconstruction phase of the 1940s and the so-called “golden era” of the welfare state that followed. In an ironic twist, however, the single most powerful – and popular – symbol of these “social rights,” namely healthcare, is not technically a right of citizenship in Canada.

This point is illustrated by what are referred to as international and national recognitions of rights (see Backman, 2008). Canada, like many other countries, is in effect a signatory to several international treaties that refer to the “right” to health; for example, the United Nations’ Universal Declaration of Human Rights (1948) was much influenced by its Canadian contributor, John P. Humphrey, who supported the idea of the “right to health,” even though this was initially considered to be a humanitarian consideration rather than a functional feature of international law (see Tobin, 2012). In 1946, the World Health Organization defined a more specific right to health as “access to timely, acceptable, and affordable healthcare of appropriate quality.” Successive Canadian governments have since been considered to exert substantial leadership in health promotion worldwide.

But Canadians do not enjoy a constitutional right to health, and this puts them in the company of two-thirds of countries the world over, including those that
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they would consider a peer group (e.g., Germany, the UK, France, Sweden; Backman, 2008). The rhetoric about healthcare as a right for Canadians is a popular adage in public opinion; until quite recently, polls still showed that Canadians believed in this right (Mendelsohn, 2002). This confidence has been shaken somewhat, at the same time that it has been dissected and debated in and outside of courtrooms. For example, the Senate report on the health of Canadians (Mendelsohn, 2002) outlined in detail the absence of such a right; however, some judicial scholars claim that the courts have “shown greater openness” to considering such a guarantee through the Charter of Rights and Freedoms (Jackman, 2002). And, in the well-known Chaoulli v. Quebec case (2005), differing judicial opinions prevailed, from the Quebec Superior Court Justice Ginette Piché, who concluded that access to healthcare is a right (even though the choice of provenance of that care is not), to the ruling of Supreme Court Justice Beverely McLaughlin, who wrote that “access to a waiting list is not access to health care” (Manfredi & Maioni 2006).

If healthcare is not technically a right of Canadian citizenship, it nevertheless represents a political and financial responsibility of the highest order for governments. And yet, this is not a national responsibility, but instead a provincially regulated service provided by non-public actors and funded through tax-generated revenues. Here, Canada differs even with respect to its comparator countries where, even in the most decentralized of systems, a national – or federal – responsibility is recognized as primordial in healthcare.

In fact, healthcare has become a behemoth for provincial governments for a number of reasons, not the least of which is the increase in the price of services. While economic arguments abound about how public monopolies in medical and hospital care payments can control costs better than mixed or privately-financed alternatives (see, for example, Detsky, 2012), it remains a heavy burden for provincial governments to keep pace with the competitive and expensive market for healthcare providers, and the technology and infrastructure that the ever-complex delivery of care requires. To put it in blunt terms, provincial treasuries are responsible for the income of the highest paid professionals in Canada today, specialists and family physicians (Picard, 2013). They spend billions of taxpayer dollars on healthcare without, for the most part, any way of exactly gauging the quality or outcomes of these services.

The exact split between federal and provincial monies in these health expenditures is a topic of considerable bureaucratic wrangling, but the estimates are usually in the vicinity of a 20–80% split. As the 10-Year Plan to Strengthen Health Care (Ten-Year Plan) (2004) winds down after 2014, and wanes over time as the Canada Health Transfer returns to a per capita amount tied to economic growth, the federal portion will likewise shrink. This means that provincial governments pay – and will continue to pay – the lion’s share of funding healthcare services funding, and at the same time take the largest political risks in health policy-making. Meanwhile, the most politically popular healthcare statute – the Canada Health Act – is a federal statute, which is limited in application to the monetary transfers in play from federal to provincial governments.

An icon of Canadian values, or so it seems to many, the Canada Health Act itself does little to provide an essential framework for health reform. It served federal leaders well in the past – particularly Liberal governments – in shoring up a powerful discourse of Canadian values identity, the apogee of which is the Romanow report (2002), based explicitly on the values motif. Today, the Canada Health Act and the federal role are practically absent from Conservative government conversations about values or national character. In the provinces, meanwhile, much of that debate has become moot. In Quebec, however, critics of the public monopoly have argued – with considerable backing from the provincial Liberals – that the Canada Health Act has become a “dysfunctional” element in the quest for health reform (Castonguay, 2008).

**Provincial innovation or federal leadership?**

Much ink has been spilled in describing and explaining the development of healthcare policy across Canada (see, inter alia, Taylor, 1987; Shortt, 1981; Maioni, 1998; Tuohy, 1999; Boychuck, 2009). These studies have pointed to a number of factors that account for the distinctively Canadian experience: some scholars point to the innovative edge of a social-democratic government in Saskatchewan and the demonstration effect of provincial experiments; some indicate the federal-provincial dynamic that allowed for the creation of a “collaborative” fiscal federalism framework; and some look to the elusive notion of “nation-building” that is sometimes attached to the historical experience.

Two enduring legacies stand out, however, in the historical narratives. The first is that institutions matter; the second is that politics paved the way for policy. The absence of federal policy leadership, combined with an interventionist social-democratic government, led to provincial innovation (the Saskatchewan experience). The stability, diffusion, and expansion of this experiment in Saskatchewan and across the other provinces, however, depended on the fiscal involvement of the federal government, which attempted to use fiscal levers in the absence of policy-making capacity.

But the history of these fiscal levers has shown that, while effective in deterrence and compliance, they are less useful in trying to deploy or encourage policy reform or system change. Instead, they have become part of the ebb and flow of fiscal federalism in Canada – an instrument of federal budgetary exigencies, rather than a specific instrument for health policy-making. This “pendulum” effect applies to a range of policy areas (see Robinson & Simeon, 1990), but the case of healthcare illustrates it best. In the earliest years of cost-sharing programs, through the Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Care Act of 1966, there was a hefty financial commitment – an investment, in many ways – on the part of the federal government to pay specific amounts engendered by provincial
movements in both Canada and the US lobbied for public health insurance organized labour as a counterweight in healthcare is a good example. Labour medical lobbies initially blocked public funding of medical care. Sometimes, this dynamic, in particular in the way in which professional interests such as benefits something provides are less tangible than the specific costs that may powerful in shaping the policy outcomes. This seems logical since the diffuse smaller and more tightly organized group (or "special interest") may be more (Olson, 1965): the benefits may be diffused to a large swathe of people, but a powerful in shaping policy, imposing some sort of national direction in formulation, and providing effective scope for policy learning in implementation.

Indeed, in many of the suggestions that have been made about where Canada could go for "lessons" in strategies for coordination (see for example, Carson, 2014), the elephant in the room is that these kinds of initiatives need political leadership, clear and direct accountability, and, to bring in a term from international affairs, somehow kind of "hegemon" to corral and compel government and stakeholder involvement and engagement.

Decentralized policy-making and centralized stakeholders?

Health reform in Canada is caught up in a classic public goods conundrum (Olson, 1965): the benefits may be diffused to a large swathe of people, but a smaller and more tightly organized group (or "special interest") may be more powerful in shaping the policy outcomes. This seems logical since the diffuse benefits something provides are less tangible than the specific costs that may be imposed. The history of healthcare reform around the world attests to this dynamic, in particular in the way in which professional interests such as medical lobbies initially blocked public funding of medical care. Sometimes, public goods can be championed by an interest group – the case of organized labour as a counterweight in healthcare is a good example. Labour movements in both Canada and the US lobbied for public health insurance despite the "free rider" effect; that is to say, the benefits of such reform would accrue to a larger population than their members alone. Today, in Canada, unionized healthcare workers are caught in the same dilemma as other special interests in the health field: how to effectively protect their interests while contributing to the overall coherence of the healthcare system. And physicians, meanwhile, are caught up in trying to lobby for increased public financing of healthcare as a way of sustaining their own financial interests in the reimbursement of services they provide.

Interest groups and health care in Canada are particularly interesting in the case of organized medicine. They exercise a "professional monopoly" in terms of expertise (Alford, 1975), and at the same time are part of the essential bargain at the root of the model of "public payment, private delivery" in provincial healthcare systems (Naylor, 1986). As "talking chameleons" (Pross, 1978), they adapt to governmental institutions and political realities in a nimble fashion and with laser focus, and, depending on their resources, expertise, and reach, this allows them to have considerable influence in policy-making.

In Canada, healthcare policy decision-making remains in the hands of provincial governments caught up with the immediate challenges of governance and the partisan exigencies of retaining power. What can ensue is a combination of entrenched bureaucratic immobilisme and short-term (in some cases, short-sighted) political action. This mix does little to encourage long-term thinking or set substantive reform change processes in place, nor does it provide for the kind of inspiration for provincial leaders to contribute to a national strategy for health reform.

At the same time, political leaders and public opinion are highly sensitive to stakeholders as a source of information and as influential political actors. For example, professional associations have both provincial and national organizations, which have different roles in pursuing sub-national policy input for funding and delivery decisions, while maintaining an active national scope in policy leadership.

This leads to a curious situation: "national" debate about healthcare reform has tended to be shaped – and in some cases led – by policy communities dominated by national stakeholder interests rather than the pressing needs of systemic reform itself. Consequently, reform debates became hostage to crisis discourse, even though the evidence to support such arguments was difficult to validate. A good example of this is the "wait times" issue that has dominated public discourse for over a decade. Unpacking wait times is more complicated than it looks, since waiting can be related to: the timely delivery of a service, such as non-urgent care; a number of hours related to specific situation, such as in an emergency department; or broader access to care, such as seeing a specialist or finding a family doctor. All of these situations are symptomatic of much more complex organizational and financial issues at hand. And yet, the "national" policy debate was dominated by needs and strategies to respond to wait times crises, with little attempt to understand the underlying forces at
play, or the delicate balance of supply and demand at hand. Meanwhile, issue areas that would directly target and allocate responsibilities to stakeholders, but require large data pools from comparable provincial measurements, such as quality measures, effectiveness, and the like, languish without cross-provincial coordination or national leadership.

The other phenomenon that can be noted in this dynamic of strong interest groups in the absence of strong central leadership is the ossifying effect that locks into place the contours of provincial healthcare systems. A case in point is the issue of pharmaceutical coverage, where national debate is dominated by strong stakeholders, leaving individual provinces divided in their strategy and scope for solutions.

Again, this points to a difference in the Canadian situation relative to cross-national standards, where national “peak associations” are part of policy-making formulation and implementation. Even in the German federal polity, a national practice of “concerted action” allows for the convening of the various stakeholders to help set guidelines, negotiate cost control, and the like. In the United States, there is considerable federal weight in the shaping of services and setting of reimbursement through the hefty reach of Medicare and Medicaid. In Canada, no such national mechanisms exist; instead, professional associations benefit from their bargaining power vis-à-vis sub-national governments, while simultaneously benefiting from their national networks of coordination and policy-making.

To further complicate matters in the Canadian situation, what has developed over time is a process of decentralized policy-making at the provincial level that has often been criticized as being too centralized, i.e., in its provincial administration. This led, in the past decades, to a situation of highly “centralized” delivery decisions by provincial governments – e.g., hospital closures, medical school enrollments, funding decisions – which were simultaneously exploring “decentralized” forms of healthcare policy governance.

The challenges of implementation:

Implementation is often the wild card in the policy process, and the literature on healthcare reform in Canada is riddled with questions as to why reform avenues often end up in dead ends (e.g., Renaud, 1977; Hutchison et al., 2001). Much of this has to do with the fact that implementation itself is “a struggle over the realization of ideas” (Majone & Wildavsky, 1979), where politics and administration meet.

The discussion above about the realpolitik of healthcare policy-making in Canada comes to three overall observations about the challenges of implementation. First, there is little coordination between governments or systemic structures in place that could serve to generate the kind of information and measures necessary to evaluate healthcare performance across Canada (e.g., delivery, quality, spending), or reach toward new initiatives that could target specific areas (such as those under study at this conference). Second, the institutional contours of the Canadian polity have led to a situation in which publicly accountable actors tend to have less of a national reach than non-public actors and stakeholders, making it even more difficult to “think” strategically or “do” practically in building a “system-wide” strategy for healthcare reform in Canada. And, third, this situation is at odds with what is happening in other countries, and at odds with what Canadians actually believe to be the most important issues at play in healthcare, including the need for cross-provincial learning and pan-Canadian leadership.

Attempts to break this cycle in the past have suffered from fundamental problems of federalism: namely, the perception of federal unilateralism (National Forum on Health), the inability to come to meaningful intergovernmental consensus (Social Union Framework Agreement), and the incapacity of maintaining a national body by consensus without real heft in reform debates (Health Council of Canada). Since 2006, meanwhile, the absence of federal intergovernmental initiatives in health reform, and the political void this has engendered, has meant the Council of the Federation has come to occupy a greater space, and one that includes Quebec.

There are also three main problems with these past initiatives. First, they inject an element of competition – between federal and provincial levels of government, and between the provinces themselves – that is inimical in trying to create something that is larger than the sum of its parts. Second, they buy into the myth of provincial “equality” when it is evident that there are asymmetries in size, wealth, population, and organizational capacity that need to be taken into account, and that all partners can play the same roles and have the same responsibilities when trying to envision workable solutions that can address health reform in a realistic and sensible way. Third, they tend to seal off stakeholders to “neutralize” their power in policy decisions or, in reverse, to “protect” them; rather, what a health reform strategy should do is assign responsibilities to key interest groups, making them integral actors who must not only be accommodated but be willing to accommodate in likewise fashion, and this means not only bilaterally with governments, but also multilaterally in a wider policy community.

What kind of new way forward, then, could be imagined and implemented to try to achieve some kind of pan-Canadian strategy for healthcare? The papers and discussions at this conference suggest some interesting avenues, such as national strategies in certain sectors (Carson, 2014), an evolutionary process of provincial coordination (Drummond, 2014) or an eschewing of governmental leadership in favour of other kinds of information networks (Marchildon, 2014).

In a way, none of these options is mutually exclusive, and in some senses, they could reinforce one another. Thus, we could envision a network of knowledge that could focus attention on the evidence needed to power up pan-Canadian

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strategies; at the same time, moving toward provincial coordination could set
the stage for an eventual national oversight or standards-seeking body that
could give policy direction and lead to meaningful evaluation and reform.

If the recent past is any guide, however, both the ideal of a national
coordinating oversight body and provincial processes for coordination are
difficult to realize in the Canadian political context. The provincial leadership
that was shown in the late 1990s (e.g., the Ministerial Council on Social Renewal;
see Courchesne, 1996) contributed toward pressure for increased federal
funding and later toward the 2014 Health Accord, and ultimately heralded the
kind of collaborative rhetoric underpinning the Council of the Federation’s
latest actions on healthcare. But it also opened up a political window to delve
into debates about “fiscal imbalance” (both vertical, via Quebec, and horizontal,
via Ontario).

As such, cross-provincial initiatives in healthcare have mainly been at the level of
“executive politics” designed to drive consensus, which, realistically, can
never get that far on all the essential elements of health reform. They lack the
kind of extensive coordination rooted in a permanent commitment toward
data collection, information sharing, and, ultimately, some kind of leadership.
In other words, without a different kind of evolutionary scenario that sets rules
and goalsposts, and topics and targets, and that extends the conversation to
mindful contributions from stakeholders, there is little in the way of motivating
political will.

Canada’s experience in healthcare has led to one of the most decentralized
arrangements in healthcare governance, at least in a comparative perspective.
And I have argued in the past that things like the Social Union Framework
Agreement (SUFA) and the Health Council of Canada were probably doomed –
not least of all due to seeing these initiatives through the perch of an observer
from Quebec. But that does not mean that some form of “responsible”
governance that engages both levels of government should be summarily
dismissed (Maioni, 2004). It is a policy domain that is just too costly in monetary
terms, and too important in human terms, to be left in intergovernmental
limbo. We need to have some form of real, functional coordination in the
strategies toward both immediate concerns and long-term planning, not only
between governments, but also among stakeholders as well.

Lessons of coordination:

There are plenty of lessons to be learned from elsewhere on this kind of
“responsibilization” and “coordination.” The German example of “concerted
action” in the healthcare sector involves an active role for government
vis-à-vis stakeholders, who are obliged to come to the bargaining table at
which all parties are held to account collectively (see Moran, 1999). Regional
governments buy into this type of corporatist arrangement as a way of
controlling costs and ensuring some measure of equality across populations.

The lessons here are that: cost-control requires national and sub-national
coordination, and stakeholders have to be at that table; all of the actors must
recognize the utility and responsibility of such negotiation, as a way of ensuring
the sustainability of the healthcare system for all players.

In the UK, the NHS has developed its own institutional identity as an “arm’s-
length” body, and in the process “de-politicized” itself in a way that is very
different from healthcare systems across Canada. And yet, while decisions
about funding remain political, and oversight functions remain accountable
to government, specific policy directions are very much influenced by the NHS
and its ability to garner evidence and coordinate sector-specific strategies
in working toward specific goals and objectives. The lesson here is that
coherent policy-making in healthcare requires a “global vision” based on
reliable evidence and constant coordination, and that such policy-making
may be best achieved in a “de-politicized” policy environment that remains
firmly accountable to government, but in some way that is protected from the
political crises of the day.

In Australia, a new modus operandi seems to be emerging through the
establishment of a “national strategic framework” (e.g., in primary care),
which brings together all stakeholders (including patients) in planning and
coordinating policy change. These changes will then be implemented through
both bilateral agreements (between the states and the Commonwealth) and
the work of the existing Council of Australian Governments.

The Australian example underlines three elements about federalism and
healthcare that are of particular resonance for Canada. The first is that strategic
efforts can be directed within a certain sector (in this instance, primary
care) without the necessity of remaking the constitutional or organizational
policy-making playbook. The second element is that it helps to have a robust
intergovernmental structure in place, along with a willingness of governmental
players to recognize the pragmatic considerations and mutual benefits of
exchange and coordination.

Could Canada benefit from this kind of model? There is a certain caveat in the
fact that health policy and federalism have a very different history in the two
countries (Gray, 1991). In Australia, the federal government has wider powers
in certain features of healthcare delivery. But despite, or perhaps because
of, these policy overlaps, there are already established intergovernmental
mechanisms in place, such as the annual conference of health ministers and its
advisory council, as well as the Council of Australian Governments, which also
has a functional role in negotiating federal block grants. In Canada, meanwhile,
intergovernmental relations in the health sector can be described as limited
at best (France, 2008). This is due to functional realities (the “watertight
compartments” approach to the division of powers in this instance), but it is
also due to the high stakes politics of healthcare. Despite a dialogue between
provincial health ministers, and the existence of a Council of the Federation,
there has been little in the way of institutionalized federal-provincial relations.
in healthcare. The 2004 negotiation of a multi-year health accord may have been a step in that direction, but it did not set up a formal process, nor, as we now know, a political precedent for future negotiations. And the Health Council of Canada had a role that was both broad and narrow: “to monitor and make annual public reports on the implementation of the Accord” (First Ministers, 2003), in addition to “reporting annually on health status and health outcomes” (Health Council of Canada, 2011, p. 5). However, its role was not one that involved the delivery of policy direction through a truly collaborative process.

Still, the idea of sectoral reform is appealing as a way of breaking an impasse in direction and dialogue. Part of the necessary thinking for this kind of an approach has already been accomplished through the identification of key reform needs in the scope of this series of conferences. What’s needed now is to build a model that can “test” the boundaries of a new dialogue about health reform and stretch intergovernmental parameters, allowing for new partners and players. While it would not (and does not, even in the Australian model) “de-politicize” healthcare, it could compel both political actors and private interests to focus on public needs, provide a public education function, and lead to coherent policy direction removed from the “crisis management” approach to health reform.

Any such model needs to have: 1) an understanding that pooling information and expertise is a value-added proposition for all players; 2) a common purpose for sectoral reform as the means to an end result, i.e., improving healthcare delivery, controlling health costs, enhancing health outcomes; 3) the formal and sustained involvement of policy “delegates” from government and stakeholder groups; 4) specific processes for the exchange of information that do not focus on regionalized blaming and shaming, but rather on identifying positive examples and serious needs; and 5) a commitment toward policy learning that could, ideally, be the basis for some form of coordination or mutual agreement.

**Conclusion**

The analysis of the politics of intergovernmental relations shows that there is a “missing link” in the governance of healthcare in Canada. In the expensive, challenging, and complex world of modern healthcare, what is needed is an increased capacity to be able to analyze and plan in the longer term with clear evidence and coherent implementation. While much of this could be done by provincial governments, system performance outcomes and the health of Canadians would be greatly enhanced by some kind of policy direction that would benefit from coordination – among governments who need to reach out in finding solutions, and stakeholders who need to pull up their stakes and start collaborating. Every other healthcare system in the industrialized world realizes this necessity. If the basic attraction of publicly funded healthcare is the ability to spread risk, guarantee access, and control costs, we need to think bigger about the kinds of scaling up and value-added services that a larger, pan-Canadian strategy could provide. Otherwise, we are locking ourselves in to widening the gap between money spent and care delivered, without being able to decipher results or respond to challenges, and to being forced to deal with crisis management, rather than long-term investment in healthcare, to the detriment of our collective wealth, and the health of Canadians.

**References:**


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JUNE 2013

Toward a Canadian Healthcare Strategy

Over two days in June 2013, Canadian leaders from healthcare, business, policy and research interacted with twenty-five speakers from across Canada and six other nations to test the potential elements of a Canadian healthcare strategy. By reflecting on lessons learned from a broad set of international perspectives, as well as the unique nature of the Canadian context, the first conference laid the groundwork for shared action on major healthcare challenges.

MAY 2014

Creating Strategic Change in Canadian Healthcare

Building on the high-level consensus identified at the June 2013 conference, this second event will address three vital questions:

1. What form could a Canadian healthcare strategy take?
2. What would be the substance of that strategy, particularly in areas of health human resources, integrated care, electronic health records, and pharmacare?
3. What is a viable process for change?

MAY 2015

Managing Strategic Change in Canadian Healthcare

A third and final event, scheduled for May 2015, takes the next step by considering the performance measures of a successful strategy. What targets should we set that would make us a leader on the international stage?
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