



1994

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AN INTERNATIONAL PERSPECTIVE --  
Principles and Power in the Health Care Arena:  
Reflections on the Canadian Experience**

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**Recommended Citation**

Carolyn Hughes Tuohy, *SYMPOSIUM JUSTICE AND HEALTH CARE: AN INTERNATIONAL PERSPECTIVE -- Principles and Power in the Health Care Arena: Reflections on the Canadian Experience*, 4 Health Matrix 205 (1994)

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# HEALTH MATRIX: Journal of Law-Medicine

## PRINCIPLES AND POWER IN THE HEALTH CARE ARENA: REFLECTIONS ON THE CANADIAN EXPERIENCE

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**A**S A POLITICAL SCIENTIST who has devoted considerable attention to the Canadian health care system, I have two purposes in this article. One is to describe the evolution of the Canadian health care system in comparison with that of some other systems, notably those of Britain and the U.S., and in brief comparison with another component of the Canadian welfare state — the public pension system. The other is to explain this evolution by making a central argument. Welfare states institutionalize principles of distributive justice. In so doing, they translate those principles into structures of power. It is through those power structures that principles of distributive justice will be expressed and will have their impact. The central feature of the power structure of the Canadian health care system is an accommodation between the providers of health care, most particularly the medical profession, and the state. In this accommodation, the medical profession has traded off a substantial part of the entrepreneurial, economic discretion of physicians in order to preserve their clinical autonomy. This accommodation itself is evolving over time, but it will continue to be central to the development of the system in the future.

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## PRINCIPLES UNDERLYING THE WELFARE STATE

If you seek to understand the prevailing principles of distributive justice in a given nation, look to the structure of its welfare state. In terms of the principles of distributive justice which underlie them, one can identify four types of welfare states in advanced capitalist nations: social democratic, corporatist, residualist and what, for want of a more descriptive term, might be called the “Beveridge” model.<sup>1</sup>

Social democratic welfare states have universal and generous programs whose benefits are available on uniform terms and conditions to all citizens.<sup>2</sup> Entitlement to benefits is on the basis of membership in the national community — in this sense there is a citizen’s “right” to benefits — and programs are designed to be attractive to all members of the community, not just those who have no private alternatives.<sup>3</sup> Indeed, the assumption is that there will be little recourse to private markets for social or health services or for insurance against income disruption or decline.<sup>4</sup>

Corporatist welfare states offer differentiated benefits through social insurance for defined groups (primarily occupationally defined) within the population. These programs tend to be generous overall, but the level of generosity varies within “a labyrinth of status-specific insurance funds.”<sup>5</sup> Entitlement is based on contribution, and levels of both contribution and benefits are determined by occupational status.<sup>6</sup>

The residualist welfare state is market-oriented. The underlying assumption is that the market is the primary mechanism of allocation and distribution.<sup>7</sup> Health and social services as well as income ought to accrue to individuals not on the basis of a social entitlement, but primarily according to the individual’s “marginal rate of productivity.” Welfare state pro-

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1. See GØSTA ESPING-ANDERSEN, *THE THREE WORLDS OF WELFARE CAPITALISM* 26-27 (1990) (describing what I have termed as the “corporatist” and “residualist” types of welfare states as “conservative” and “liberal” respectively). Esping-Anderson does not identify a separate “Beveridge” type.

2. *Id.* at 27.

3. *See id.*

4. *See id.* at 28.

5. *See id.* at 24.

6. *Id.* at 22.

7. *Id.* at 26-27.

grams are directed primarily to those most disadvantaged in the market—hence, the term “residualist.” Means-tested programs predominate, benefits are relatively low so as not to draw labor out of the market, universalism is limited and the middle and upper-classes turn to the market, not the state, for health and social services and income protection.<sup>8</sup>

Finally, the Beveridge model combines elements of each of the other three types. From the corporatist model comes the social insurance principle that benefits are to be based on contributions.<sup>9</sup> But contributions and benefit schedules are not status-specific; rather, they are based on the social-democratic principle of universality.<sup>10</sup> Finally, like the programs of the residualist welfare state, Beveridge-type programs are limited in their generosity. The underlying principles assume that all individuals have a citizenship right to participate in a social insurance plan providing a minimum level of benefits, but that any individual ought to be able to substantially improve his or her position through participation in the market.<sup>11</sup>

These four models represent pure types. In the real world, each of these models has been subject to strain and evolution over time. The social democratic model has been most closely approximated by Sweden, although the level of generosity of the Swedish welfare state has become increasingly contested in the late 1980s and 1990s. Germany most closely corresponds to the corporatist model, and the U.S. to the residualist model.<sup>12</sup> And of course, the empirical expression of the Beveridge model is identified in his name, referring to the vision of the Beveridge Report of 1942 on which the post-war reform of the British welfare state was based.<sup>13</sup> But the growth over time in the relative importance of means-tested “supplementary benefits” has given the British welfare state an increasingly residualist cast.

Some systems, moreover, combined elements of at least three of these models. Japan, for example, arguably combined corporatist, residualist and Beveridge models in the design of

8. *Id.* at 22.

9. *See id.* at 22.

10. *Id.*

11. *See id.* at 23.

12. *Id.* at 27.

13. WILLIAM BEVERIDGE, U.K. INTER-DEPARTMENTAL COMM. ON SOCIAL INS AND ALLIED SERVS., SOCIAL INSURANCE AND ALLIED SERVICES, REPORT BY SIR WILLIAM BEVERIDGE (HMSO 1942).

its health insurance and pension systems.<sup>14</sup> And Canada presents the joint phenomena of a social democratic health insurance system, a quasi-Beveridge-style pension system and a residualist system of income maintenance.

I want to focus in this article on the Canadian case, first to consider the distinctive character of the Canadian health insurance system, then to view the health insurance system in comparison with some other national systems and with the Canadian public pension system. The Canadian case suggests that quite different models of distributive justice can coexist in different components of a given welfare state, even when those components came into being at the same time and within the same institutional structures. I will argue that the answer to this apparent anomaly lies in the evolution of the welfare state over time, an evolution shaped only indirectly by the principles of distributive justice that the system embodies. Any set of principles of distributive justice, once institutionalized in a set of programs and structures, implies a structure of power. And it is that power structure, at least as much as the principles and ideas embedded in the system, that will determine the system's evolution.

In the case of health insurance systems, a central component of the power structure is the role of the medical profession. In the Canadian case, I will argue, much of the "success" of the system — its universality, its comprehensive coverage and its record of relatively moderate rates of increase in costs over time — is attributable to the particular nature of the accommodation between the medical profession and the state.

## PRINCIPLES UNDERLYING THE CANADIAN HEALTH INSURANCE SYSTEM

State-sponsored health insurance was first introduced in Canada at the provincial level, as various provincial governments introduced different models of hospital and medical insurance in the 1940s through the 1960s.<sup>15</sup> The contemporary

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14. See Samuel H. Preston & Shigemi Kono, *Trends in Well-Being of Children and the Elderly in Japan* in *THE VULNERABLE* 277, 285-86 (John L. Palmer et al. eds., 1988) (describing the Japanese health insurance system).

15. See generally Malcom G. Taylor, *The Canadian Health Insurance Program*, *PUB. ADMIN. REV.*, Jan./Feb. 1973, at 31 [hereinafter *Canadian Health*]; MALCOM G

universal Canadian health insurance system, however, had its genesis in the province of Saskatchewan, under the social democratic New Democratic Party ("NDP").<sup>16</sup> The NDP introduced universal comprehensive hospital insurance in 1944,<sup>17</sup> and universal comprehensive medical care insurance in 1962.<sup>18</sup> Each of these models was in due course replicated at the federal level, with the passage of the Federal Hospital Insurance and Diagnostic Services Act in 1958<sup>19</sup> and the federal Medical Care Act in 1966.<sup>20</sup> By 1971, all provinces had universal medical and hospital services insurance plans eligible for federal cost-sharing.<sup>21</sup> To be eligible, provincial programs had to meet five essentially social democratic general criteria: universal coverage (at least ninety-five percent of the population), comprehensive coverage of medical and hospital services, provision of coverage on uniform terms and conditions, portability across provinces and public administration.<sup>22</sup> These criteria were consistent with the "Health Charter for Canadians"<sup>23</sup> that had been set out by a federal Royal Commission on Health Services that had reported in 1964, recommending a universal comprehensive state-sponsored system of health insurance.<sup>24</sup> Notably, the Health Charter also included commitments of "freedom of choice" for patients in the selection of physicians and *vice versa*, and to "free and self-governing professions."<sup>25</sup> While these latter two principles in the Health Charter were not specifically enshrined in legislation, they were clearly embedded in the system that resulted.

Indeed, the advent of national health insurance in Canada essentially froze in place the delivery system that existed in the 1960s, by underwriting its costs. One has only to compare Canadian developments with those in Britain on the one hand and in the U.S. on the other to appreciate this point. In Britain,

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TAYLOR, INSURING NATIONAL HEALTH CARE: THE CANADIAN EXPERIENCE (1990) [hereinafter INSURING NAT'L HEALTH CARE].

16. See INSURING NAT'L HEALTH CARE, *supra* note 15, at 7.

17. *Id.* at 7, 67-68.

18. *Canadian Health*, *supra* note 15, at 34 n.13.

19. R.S.C., ch. H-8 (1956-57) (Can.).

20. R.S.C., ch. M-8 (1970) (Can.).

21. *Canadian Health*, *supra* note 15, at 31.

22. *Id.* at 36.

23. Contained in 1 CAN. ROYAL COMM'N ON HEALTH SERVS. REPORT (1964).

24. See INSURING NAT'L HEALTH CARE, *supra* note 15, at 134-39.

25. *Id.* at 135 (quoting the Health Charter).

massive organizational change was inherent in the establishment of the National Health Services in 1948. In the U.S., organizational change flowed from the very *absence* of national health insurance in the 1970s and 1980s.<sup>26</sup> In Canada, organizational change was forestalled by the introduction of a system of financing which essentially underwrote the costs of the existing delivery system without changing its structure.

The health care delivery systems of Canada and the U.S. were very similar in the 1960s; medical services provided by physicians in private fee-for-service practices; hospital services provided in non-profit institutions owned by voluntary societies, religious orders, municipalities and universities; extended care facilities owned by such non-profit groups or by private independent for-profit operators. In the 1990s, the delivery system in the U.S. appears transformed. In the absence of national health insurance, public policy has elaborated both categorical programs and regulatory constraints. The resulting complexity has given a competitive advantage to providers with the resources to invest in understanding the system and responding strategically. Public policy has thus fostered organizational change not only directly (as in the case of health maintenance organizations, preferred provider organizations, etc.) but also indirectly (as in the case of large multi-institutional changes, many of them for-profit, which have sprung up in response to the increasing complexity of the system).<sup>27</sup>

In Canada, organization change has been much more modest. The proportion of large group practices has increased, and there have been a number of hospital mergers; but Canada has seen nothing like the "coming of the corporation" to the health care arena on the scale that has occurred in the U.S.<sup>28</sup> Organizational change is, however, on the agenda of the 1990s — a point to which I shall return below.

The proportion of total health care spending in Canada that flows through the public treasury, at just under three-quarters, is close to the Organisation for Economic Cooperation and Development ("OECD") average.<sup>29</sup> Canada differs from

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26. See Paul Starr, *The Social Transformation of American Medicine* 419 (1982).

27. *Id.* at 428.

28. *Id.* at 419, 420, 428.

29. CAROLYN TUOHY, SOCIAL POLICY: TWO WORLDS, IN *GOVERNING CANADA INSTITUTIONS AND PUBLIC POLICY* 275, 285 (Michael M. Atkinson ed., 1993).

most OECD nations, however, in the *pattern* of public and private expenditure. In most other nations public and private expenditures are divided on a “tiered” basis—with private alternatives to publicly funded services within each category of service. In Canada, however, public and private expenditures are segmented. Certain segments — notably medical and hospital services — are almost entirely publicly funded; others, such as dental care, drugs and eyeglasses as well as other prostheses, are in the private sector.<sup>30</sup>

Canada, then, interpreted the social-democratic principle of universality as implying *the removal of financial barriers to access an established health care system*. Accordingly, it provides universal first-dollar coverage for a comprehensive range of medical and hospital services, within delivery structures that preserve the patient’s choice of physician and *vice versa*. And it has done so at relatively “generous” levels. Government spending on health care, which ranged between five and seven percent of GDP in the 1980s, is comparable to Western European levels, and well above that in both Britain and the U.S.<sup>31</sup>

## THE EFFECTS OF CANADIAN MEDICARE

The medical and hospital system which Canadian governments undertook to finance in the 1960s was an expensive one, in international perspective, due in large part to the intensive use of hospital services. And it is still relatively expensive: per capita costs are second (albeit a fairly distant second) to those in the U.S.<sup>32</sup> However, the rate of cost escalation has been relatively moderate. Canadian health care expenditures (both public and private) increased 70% faster than Gross Domestic Product (“GDP”) from 1960 to 1985, as compared with 120%

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30. U.S. GENERAL ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN, COMMITTEE ON GOVERNMENT OPERATIONS, HOUSE OF REPRESENTATIVES, CANADIAN HEALTH INSURANCE: LESSONS FOR THE UNITED STATES, DOC. NO. GAO/HRD-91-90, 102d Cong., 1st Sess. 23 (1991) [hereinafter GAO REPORT]. Various provinces have plans covering drugs or dental care for certain categories within the population, such as children’s dental care or drugs for those over sixty-five. *Id.* In the hospital sector, various amenities such as private rooms, can be purchased on an individual basis.

31. NEW ORIENTATIONS FOR SOCIAL POLICY, OECD Social Policy Studies No. 12, at tbl. 2 (1994); see also Michael O’Higgins, *The Allocation of Public Resources to Children and the Elderly in OECD Countries*, in *THE VULNERABLE* 29, 214-15 tbl. 9.6 (1988).

32. CAROLYN J. TUOHY, POLICY AND POLITICS IN CANADA: INSTITUTIONALIZED AMBIVALENCE 105 (1992).



in Britain, 130% in the U.S., 200% in Sweden and an OECD average of 90%.<sup>33</sup>

The removal of financial barriers to care, moreover, appears to have had its intended effects. There have been a number of studies of the impact of Medicare on the utilization of medical and hospital services across income classes. Despite some methodological difficulties, and some modest variation in the findings, a recent comprehensive review of these studies could fairly conclude that "a notable policy achievement [has] been realized resulting in the progressive redistribution by class in the use of health care."<sup>34</sup>

As the issue of national health insurance has waxed and waned on the policy agenda of the U.S., the "Canadian model" has periodically been raised in that context by both enthusiasts and skeptics. Many of the perceptions of the Canadian system are based on anecdotes or misinformation. One benefit of the increased American interest in the Canadian system, however, at least from an academic perspective, has been an increase in the number of comparative studies of the two systems.

#### a) Cost Control and Access

There is little debate that the Canadian system provides access to a wide range of medical and hospital services to a far larger proportion of its population while remaining less costly than the American system.<sup>35</sup> The Canadian system provides first-dollar coverage of medical and hospital services for all residents; and while the range of services covered varies somewhat from province to province, the range of services covered is extensive.<sup>36</sup> In the U.S., about fifteen percent of the population has no health insurance coverage;<sup>37</sup> and for the remainder the extent and terms of coverage vary widely between public and private plans and among private plans.<sup>38</sup> In Canada, charges to patients in excess of the government benefit for insured services

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33. *Id.* (citing Schieber & Poullier 1987).

34. Robin F. Badgley, *Social and Economic Disparities Under Canadian Health Care*, 21 INT'L J. HEALTH SERVS. 659, 662 (1991).

35. See GAO REPORT, *supra* note 30, at 20-24, 28-29 (1991).

36. *Id.* at 23.

37. *Id.* at 23-24.

38. *Id.* at 24.

are banned, and there are no deductibles or co-payments.<sup>39</sup> In the U.S., "co-payments and deductibles are common, and it is not unusual for health care providers to bill the patient for charges in excess of the standard insurance reimbursement."<sup>40</sup>

As for cost, total per capita health care expenditures in Canada (including public and private expenditures) are about two-thirds of those in the U.S.<sup>41</sup> As a proportion of the GDP, total health care expenditures rose from 8.5% to 10.0% between 1985 and 1991 in Canada, for a compound annual increase of 2.7%.<sup>42</sup> In the U.S. in the same period, total health expenditures rose from 10.5 to 13.2% of GDP, for a compound annual increase of 3.9%.<sup>43</sup> (It should be noted here that the U.S. and Canada have the two most expensive health care systems in the OECD.<sup>44</sup> The fact that Canada is a distant second to the U.S.<sup>45</sup> is of great interest in the context of North American debates over health care policy; but it should not obscure the expensiveness of the Canadian system.)

Canada achieves its lower costs in a number of ways. In the first place, the administrative costs of the "single payer" Canadian system are considerably lower than those of the U.S.<sup>46</sup> For Canadian public insurers, "there are no marketing expenses, no costs of estimating risk status in order to set differential premiums or decide whom to cover, and no allocation for shareholder profits; the process of claims payment, although not free of costs, is greatly simplified and much cheaper."<sup>47</sup> For Canadian providers, the single-payer system means less administrative overhead. In 1987, for example, office expenses for physicians in Canada amounted on average to about thirty-six percent of their gross billings, as compared with forty-eight percent in the U.S.<sup>48</sup> The General Accounting Office of the U.S. Congress ("GAO") has estimated that difference in insurers'

39. *Id.* at 23.

40. *Id.* at 4.

41. George J. Schieber et al., *DataWatch: Health Spending, Delivery and Outcomes in OECD Countries*, 12 HEALTH AFFAIRS 120, 121 (1993) (utilizing 1991 statistics).

42. *Id.*

43. *Id.*

44. *Id.* at 121-22.

45. *Id.*

46. Robert G. Evans et al., *Controlling Health Expenditures: The Canadian Reality*, 320 NEW ENG J MED. 571, 573 (1989).

47. *Id.* at 572-73.

48. GAO REPORT, *supra* note 30, at 5.

overhead accounts for about seventeen percent of the difference in cost between the two systems.<sup>49</sup> Others have estimated that if provider overhead related to the costs of the multi-payer system in the U.S. are included, differences in administrative costs may account for more than half of the difference between the two systems.<sup>50</sup>

### b) Payments to Providers

Canada's lower expenditures on health care also reflect lower levels of payment to health care providers. In 1987, Canada spent thirty-four percent less per capita on physician services and eighteen percent less per capita on hospital services than did the U.S., despite the fact that Canada had roughly the same number of physicians and about forty percent more hospital beds per capita.<sup>51</sup> Differences in spending on physicians reflects two factors: a different specialty mix (the U.S. has a higher specialist: general practitioner ratio) and the level of physician fees.<sup>52</sup> In the decade following the introduction of Canadian Medicare, real physician fees rose much faster in the U.S. than in Canada; indeed in Canada (with the exception of British Columbia and Alberta), real fees declined over that period.<sup>53</sup> Between 1971 and 1985, real fees declined eighteen percent in Canada and rose twenty-two percent in the U.S.<sup>54</sup> Differences in net income are less than might be expected, however, partly due to lower practice expenses. Because of the different specialty mixes in the two countries, income comparisons are best made by specialty. One such comparison, related U.S. physicians to their counterparts in Ontario.<sup>55</sup> In 1986, average net incomes in general practice and family practice were marginally higher for the U.S. than for Ontario physicians.<sup>56</sup>

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49. *Id.* at 29.

50. Evans et al., *supra* note 46, at 572-73.

51. Morris L. Barer & Robert G. Evans, *Riding North on a South-bound Horse?: Expenditures, Prices, Utilization and Incomes in the Canadian Health Care System, in MEDICARE AT MATURITY* 53, 78-80 (Robert G. Evans & Greg L. Stoddart eds., 1986).

52. See GAO REPORT, *supra* note 30, at 35-38.

53. See *id.* at 35.

54. *Id.*

55. John K. Iglehart, *Canada's Health Care System Faces Its Problems*, 322 *NEW ENG. J. MED.* 562 (1990). Ontario physicians represent about 40% of all Canadian physicians; and both net professional incomes and medical fees are close to the Canadian average. See Barer & Evans, *supra* note 51, at 78, 94; Iglehart, *supra*, at 563, 568.

56. See Iglehart, *supra* note 55, at 568.

The differences were more pronounced in obstetrics and gynecology, with U.S. physicians earning on average one-quarter to one-third more than their Ontario counterparts.<sup>57</sup> In pediatrics and internal medicine, however, the net earnings of Ontario physicians were on average marginally higher than those in the U.S.<sup>58</sup> In this respect, as in a number of others shortly to be discussed, the most pronounced differences between the two systems are related to areas of intensive care.

### c) Hospital Utilization

Differences in hospital expenditures reflect in part different mixes of hospital activities: the U.S. favors intensive, high-technology services while Canada leans toward long-term chronic care.<sup>59</sup> (Hence, hospital costs can be lower in Canada than in the U.S. even while hospitalization rates are higher.) But even after allowing for such differences, a study of hospital costs in California, New York, British Columbia and Ontario found that "the cost of an average intensive care day in California in 1985 was more than twice that of a corresponding day in a Canadian hospital. . . . Canadian hospitals appear to combine lower treatment intensity with longer inpatient stays."<sup>60</sup> Even with longer stays, Canadian costs per discharge were about thirty percent lower than those in New York hospitals and thirty-eight percent lower than those in California in 1985.<sup>61</sup> It is worth noting, however, that Canadian and American hospitals were much more similar with regard to the costs of outpatient visits.<sup>62</sup>

### d) High Technology and Queues

These cost advantages of the Canadian system have led American skeptics to look for the potential downside: in particular, restrictions on the availability of high-technology service, and waiting times or "queues" for service. It is with regard to such allegations that the relevant data tend to become more

57. *See id.*

58. *See id.*

59. Evans et al., *supra* note 46, at 574.

60. Jack Zwanziger et al., *DataWatch: Comparison of Hospital Costs in California, New York, and Canada*, HEALTH AFF., Summer 1993, at 130, 137.

61. *Id.* at 135.

62. *Id.* at 134.

anecdotal and less systematic; but some work has been done to provide a basis for comparison.

There is little doubt that the U.S. exceeds Canada in the availability of high-technology procedures. This is consistent with the general phenomenon that the diffusion of technology has been greater in systems with high proportions of specialists and less centralized cost control.<sup>63</sup> As a matter of public policy, Canadian provincial governments control the diffusion of medical technology. Operating funds for certain types of equipment such as imaging machines will not be provided unless acquisition of the equipment has been approved by the government.<sup>64</sup> Furthermore, under the hospital global budgeting system, any significant change in the volume of service, including high-technology services, must be approved in order for the hospital to receive the necessary additional operating funds.<sup>65</sup>

Neither nation systematically collects data relating to the availability of high-technology services; but a study by a senior policy analyst for the American Medical Association, based on interviews and the review of relevant documents and literature, compared the availability of selected technologies in Canada, the U.S. and Germany.<sup>66</sup> He found "(1) nearly eight times more MRI [magnetic resonance imaging] and radiation therapy units per capita in the United States than in Canada; (2) over six times more lithotripsy centers per capita in the United States; (3) roughly three times more cardiac catheterization and open-heart surgery units per capita in the United States; and (4) slightly more availability of organ transplantation units per capita in the United States."<sup>67</sup> German ratios were intermediate between Canada and the U.S. in the case of cardiac catheterization, radiation therapy, lithotripsy and MRI, and were below Canadian ratios for open-heart surgery and organ transplantation.<sup>68</sup>

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63. See J. ROGERS HOLLINGSWORTH ET AL., STATE INTERVENTION IN MEDICAL CARE: CONSEQUENCES FOR BRITAIN, FRANCE, SWEDEN AND THE UNITED STATES, 1870-1970 (1990).

64. GAO REPORT, *supra* note 30, at 48.

65. *Id.* at 48-49.

66. Dale A. Rublee, *DataWatch: Medical Technology In Canada, Germany, And The United States*, 8 Health Affairs 178 (1989).

67. *Id.* at 178.

68. See *id.* at 180 Exhibit 1.

Other comparative work has focused on one of these technologies — open-heart surgery, and in particular, coronary artery bypass surgery (“CABS”). A survey of California, New York, British Columbia, Manitoba and Ontario hospital discharge data found that in 1989 the age-adjusted CABS rate in California was twenty-seven percent higher than in New York and eighty percent higher than in the three Canadian provinces combined.<sup>69</sup> In the two American states, however, CABS rates were higher in high-income areas; while in Canada, rates varied little by the income of the area of residence.<sup>70</sup> Earlier work comparing hospital discharge data for Manitoba and Ontario with Medicare data from the U.S. for 1983 found markedly higher rates of CABS for elderly patients in the U.S. than in Canada.<sup>71</sup> For the sixty-five to seventy-four age group, U.S. rates were over twice as high as in Canada; and for patients over seventy-five the U.S. rate was four times the Canadian rate.<sup>72</sup> In the case of other surgical procedures for the treatment of ischemic heart disease, however, differences were much less pronounced. The rate of cardiac-valve procedures for all patients over sixty-five years of age was only twenty percent higher in the U.S. than in Canada; and with regard to other major reconstructive vascular surgery and pacemaker implantation, Canadian rates were higher.<sup>73</sup>

The lesser availability of some high-technology services in Canada has given rise to concern about waiting times or “queues” for various services. There is a plethora of anecdote, as well as a dearth of systematic data regarding waiting times for service on both sides of the Canada-U.S. border. Press coverage of waiting times for certain procedures in Ontario reached a mild crescendo in the late 1980s. The U.S. GAO, in the context of a study of the Canadian health care system, conducted a survey of selected specialty units in Ontario’s twenty-six teaching hospitals in October 1990 (by which time some steps had already been taken to shorten waiting times in a

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69. Geoffrey M. Anderson et al., *Use of Coronary Artery Bypass Surgery in the United States and Canada*, 269 JAMA 1661, 1661 (1993).

70. *Id.*

71. Geoffrey M. Anderson et al., *Hospital Care for Elderly Patients with Diseases of the Circulatory System: A Comparison of Hospital Use in the United States and Canada*, 21 NEW ENG. J. MED. 1443, 1447 (1989).

72. *See id.*

73. *See id.* at 1446-47.

number of areas, as noted below) to determine the extent of queuing for services in eight areas of high-technology: CAT (“computerized axial tomography”) scan, MRI (“magnetic resonance imaging”), cardiovascular surgery, eye surgery, orthopaedic surgery, lithotripsy, specialized physical rehabilitation and autologous bone marrow transplants.<sup>74</sup> The GAO found virtually no queues for “emergent” cases, except in the case of lithotripsy, for which, at the time of the GAO study, there was only one unit in the province.<sup>75</sup> It did, however, find considerable variation in waiting times for urgent and elective cares. (Another study also found considerable variation in the classification of CABS cases as “emergent,” “urgent” and “elective.”<sup>76</sup>) The longest queues for elective cases existed for lithotripsy (twenty-four months) and for MRI (up to sixteen months).<sup>77</sup> For cardiovascular surgery, waiting times in urgent cases ranged from one day to one week, and in elective cases from one week to six months.<sup>78</sup> It should be kept in mind that these data were collected from hospital administrators at a time when the provincial government was responding to queues in part by providing hospitals with additional funding, and as the GAO noted, there was no independent source of data from which it could verify these figures.<sup>79</sup> The GAO did not present comparable data for the U.S.

The existence of such queues brought about responses on the part of provincial governments. Some of the responses involved the approval of additional equipment and facilities. In Ontario, a second lithotripsy unit was approved,<sup>80</sup> and open-heart surgery capacity was expanded, including the opening of an additional unit.<sup>81</sup> Bottlenecks in related areas such as intensive care units were also addressed with additional funding.<sup>82</sup> In addition, responses focused on the better management of queues on a regional basis and greater attention to case selec-

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74. See GAO REPORT, *supra* note 30, at 55 tbl. 4.1.

75. *Id.* at 56.

76. C. David Naylor, *A Different View of Queues in Ontario*, 10 HEALTH AFFAIRS 110, 114 (1991).

77. *Canadian Health*, *supra* note 15, at 55 tbl. 4.1.

78. *Id.*

79. *Id.* at 54.

80. *Id.* at 56 n.h.

81. Naylor, *supra* note 76, at 115-16.

82. *Id.* at 116.

tion and classification and to the use of alternative techniques.<sup>83</sup> The backlog of CABS patients was also reduced by referring about sixteen percent of waiting patients for treatment in the U.S.<sup>84</sup> This combination of responses led to a dramatic decline in waiting times. By January 1991, waiting times in elective CABS cases had been reduced to a few weeks, down from three months or more in some facilities a year earlier.<sup>85</sup>

As noted, some of the backlog of CABS cases was cleared by referring patients to U.S. facilities. This raises the question of the extent to which the U.S. functions as a "safety valve" for the Canadian system. In a recent cross-national survey of physicians, nearly one-third of the Canadian respondents (as compared with nineteen percent of respondents in western Germany and seven percent of American respondents) reported referring a patient outside the country for treatment.<sup>86</sup> But the number of patients involved is relatively small. Informal surveys of border hospitals by the Pepper Commission in the U.S. and by the American Medical Association in the late 1980s suggest that Canadians accounted in most cases for less than one percent, and in no case more than three percent of admissions.<sup>87</sup> Large numbers of Canadians vacation in the U.S., particularly in the winter months, however; and the high cost of reimbursing them for medical and hospital care received in that context has led some provincial governments, notably Ontario, to limit the rate of reimbursement.<sup>88</sup>

The constrained availability of high-technology services is only a problem, of course, to the extent that such services are not available for cases for which they are truly indicated, and in which they will be efficacious. And in this regard, there is still much research to be done. In commenting on his findings of the differences in the availability of high-technology services

83. *See id.*

84. *Id.*; see also GAO REPORT, *supra* note 30, at 60-61.

85. Naylor, *supra* note 76, at 115, 116.

86. Robert J. Blendon et al., *Physicians' Perspectives on Caring for Patients in the United States, Canada, and West Germany*, 328 NEW ENG. J. MED. 1011, 1014 (1993).

87. GAO REPORT, *supra* note 30, at 60.

88. It should be noted that there is also a flow of patients in the other direction, both legally and illegally. Hospitals in Ontario have been directed by the Ministry of Health to ensure that their acceptance of U.S. patients does not restrict the availability of facilities for Canadian patients. The issues of the fraudulent use of government health care insurance cards by non-residents has also received considerable attention both within the Ministry of Health and in the press.



in Canada, the U.S. and Germany noted above, Dale Rublee pointed out that "the differences can be interpreted to suggest overprovision in the United States rather than underprovision in Canada or Germany."<sup>89</sup> And, noting the wide variation across geographic areas within as well as between the U.S. and Canada in the utilization of CABS, the GAO cautioned that, "Canada's lower rates for certain procedures do not conclusively represent underservicing, nor do U.S. rates conclusively represent over-provision of service."<sup>90</sup>

#### e) Patient and Provider Satisfaction

As most comparative studies of health care systems suggest, different systems entail different trade-offs. The Canadian system offers much broader accessibility and generally less service intensity than is the case in the U.S. These trade-offs have resulted in a system which, while not without its critics, is overwhelmingly popular. Medicare has virtually become a defining element of the Canadian identity. During the heated and wrenching public debate over the Free Trade Agreement ("FTA") with the United States in 1988, politicians opposing the agreement repeatedly invoked Medicare as one of the things that distinguished Canada from the U.S., and alleged that it was threatened by the agreement. Public opinion polls showed that this allegation was the most effective way of galvanizing opposition to the FTA.<sup>91</sup> Polls have consistently demonstrated that Medicare is by far the most popular public program in Canada.<sup>92</sup> And a 1988 cross-national poll showed that Canadians were more satisfied with their health care system than were either American or British respondents, and that they overwhelmingly preferred the Canadian system to the British or the American systems.<sup>93</sup> A large majority of American respondents, on the other hand, preferred a Canadian-style

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89. Rublee, *supra* note 66, at 181.

90. GAO REPORT, *supra* note 30, at 51.

91. Richard Johnston & Andre Blais, *A Resounding Maybe*, THE GLOBE AND MAIL (TORONTO), Dec. 19, 1988.

92. Robert J. Blendon, *Three Systems: A Comparative Survey*, 11 HEALTH MGMT Q 2-10 (1989).

93. *Id.* at 5.

system to their own.<sup>94</sup> Subsequent polls have reinforced these results.<sup>95</sup>

What is perhaps more surprising is the relatively favorable light in which the system is viewed by health care providers. Even in briefs critical of government policy, medical groups, for example, typically present the Canadian system as one of the best in the world, while expressing some concerns about its future.<sup>96</sup> The twin specters of the U.S. system (intrusive regulation, corporate dominance, inadequate coverage) and the British system (inadequate resources, excessive rationing) are frequently evoked. Attitude surveys of physicians find large majorities are satisfied with their conditions of practice and positively oriented toward Medicare — although sizable pockets of discontent remain. A 1986 survey of Canadian physicians, for example, found less than one-quarter dissatisfied with medical practice and less than one-third dissatisfied with the functioning of Medicare.<sup>97</sup> Sixty percent believed that Medicare had positively influenced health status, but seventy-five percent believed that it had reduced the individual's personal sense of responsibility for health.<sup>98</sup>

A more extensive comparative survey in 1991 shed light on the judgments of physicians in Canada, the U.S. and western Germany regarding the trade-offs implicit in their health care systems. In general, although a majority of physicians in each country believed that some fundamental changes in their health systems were necessary, satisfaction with the health system was higher among Canadian and German physicians than among American physicians.<sup>99</sup> When respondents were asked to identify the most serious problems with their system, the sharpest differences arose between Canadian and American physicians, whose judgments of their respective systems appeared virtually as mirror images of each other. American physicians were much more likely than Canadian physicians to identify the fol-

94. *Id.*

95. *E.g.*, GALLUP CANADA, THE GALLUP REPORT, August 1, 1991 (Toronto 1991).

96. *See, e.g.*, TUOHY, *supra* note 32, at 144-45.

97. Michael H. Stevenson, Eugene Vayda & A. Paul Williams, MEDICAL POLITICS AFTER THE CANADA HEALTH ACT: PRELIMINARY RESULTS OF THE 1986 PHYSICIANS' SURVEY, Paper Delivered at the Annual Meeting of the *Canadian Political Science Association*, McMaster University, Hamilton, Ontario (1987).

98. *Id.*

99. Blendon et al., *supra* note 86, at 1012.

lowing as serious problems with their system: delays or disputes in processing insurance forms and in receiving payment, the inability of patients to afford some aspect of necessary medical care, external review of clinical decisions for the purpose of controlling health costs and limitations on the length of hospital stays.<sup>100</sup> On the other hand, Canadian physicians were much more likely to complain of limitations on the supply of well-equipped medical facilities.<sup>101</sup>

### ACCOMMODATION BETWEEN THE MEDICAL PROFESSION AND THE STATE

These observations point to a central feature of Canadian Medicare: its birth may owe much to social democracy, but its ongoing maintenance and development depends upon an accommodation between the medical profession and the state. It is useful here to distinguish, as Patricia Day and Rudolph Klein<sup>102</sup> have done in the British case, between the "constitutional" politics that surrounded the *establishment* of Canadian Medicare, and the ongoing *distributional* politics that have flowed in its wake. The establishment of the system had more to do with partisan and federal-provincial politics than with the relationship between the medical profession and the state. The social democratic NDP government of Saskatchewan pioneered both hospital and medical insurance, and it has been argued that it was the growing popularity of the NDP at the federal level that prompted the governing federal Liberals to introduce a wave of welfare-state legislation, including the Medical Care Act, in the minority parliament of 1964-68.<sup>103</sup> Furthermore, the medical profession did not enter the Medicare era without protest: medical strikes accompanied the introduction of universal medical care insurance in both Saskatchewan and Quebec.<sup>104</sup> But the terms of the "constitutional" understandings reached by the profession and the state surrounding the introduction of Medicare ensured that the medical profession would

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100. *Id.* at 1015.

101. *Id.*

102. Patricia Day & Rudolph Klein, *Constitutional and Distributional Conflict on British Medical Politics: The Case of General Practice, 1911-91*, 11 *POLITICAL STUDIES* 462, 462 (1992).

103. See, e.g., *INSURING NAT'L HEALTH CARE*, *supra* note 15, at 142-43.

104. See *id.* at 117

play a central policy-making role. The Medicare era itself has been marked by an accommodation between the profession and the state.

The particular nature of that accommodation varies across provinces, for it is at the provincial level that health care policy has been made, within broad federal guidelines. In some provinces, notably British Columbia and Manitoba, the profession-state relationship has been adversarial; in Quebec it has been more "statist"; and in other provinces it has been more collaborative, albeit marked by episodes of conflict.<sup>105</sup> But each of these accommodations has revolved around two pivotal trade-offs for the medical profession: one between the entrepreneurial and the clinical discretion of physicians; the other between their individual and their collective autonomy.

The first of these trade-offs arises from the principles embodied in the Canadian health insurance system: the removal of financial barriers to access medically necessary services. The removal of financial barriers at the point of contact with the system implies that the state assumes the costs of medical and hospital services. The state thus acquires a direct interest in those costs, an interest that brings it into conflict with the traditional entrepreneurial discretion of the physician to set the price, as well as to determine the volume and mix of the services that he or she provides.

Almost all of the conflict between the medical profession and the state that followed in the wake of the adoption of Medicare concerned the price of medical services. Under Medicare, as the federal government progressively withdrew from cost-sharing agreements, provincial governments became the primary bearers of the costs of medical and hospital services. In seeking to control these costs, provincial governments turned first to prices: fees for medical services and charges for hospital patient days. Rather than paying the medical fees that were "usual and customary" in particular localities as did U.S. third-party payers, provincial governments at first agreed to pay physicians on the basis of the fee schedules set by the pro-

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105. JONATHON LOMAS, CATHY CHARLES & JANET GREB, *THE PRICE OF PEACE: THE STRUCTURE AND PROCESS OF PHYSICIAN FEE NEGOTIATIONS IN CANADA* 168-69 (McMaster University Centre for Health Economic and Policy Analysis Working Paper #92-17, 1992). For an analysis of the fee negotiation in each province, territory and generally, see *id.* generally.

vincial medical associations,<sup>106</sup> prorated by a given percentage. Soon, however, the schedule of payments was set through negotiations between the government and the medical association in each province. In most cases they negotiated overall increases in the payment schedule, leaving the allocation of these increases across individual items in the fee schedule to be carried out internally by the medical associations themselves.<sup>107</sup> In making these internal allocations, medical associations have typically been more concerned with smoothing income differentials across specialty groups than with measuring the relative costs or benefits of given procedures.<sup>108</sup> In reaching their accommodations with the state, that is, medical associations have had to manage delicate internal accommodations, a point to which I shall shortly return.

Over time, the agenda of these negotiations has broadened to include the establishment of more-or-less firmly fixed caps on total expenditures on physicians' services under the government plans.<sup>109</sup> The rationale for the establishment of these limits was to take account of utilization increases.<sup>110</sup> In fact, however, a comprehensive survey of the negotiation process in all ten provinces concluded that the purpose of government was to establish global limits: arguments about increased "utilization" simply provided a politically feasible way of doing so.<sup>111</sup>

As a result of these negotiations, then, the entrepreneurial discretion of individual physicians has been limited. Prices are established centrally, and the economic pay-off from varying volume and mix may bump up against either individual or global caps. One effect of Medicare, then, has been to increase substantially the role of organized medicine. This brings us to the second, and indeed more basic trade-off with which physicians are faced under Canadian Medicare. In order to retain some power over the price of their services, individual physicians have had to cede their ability to set prices to the central association. This process was not without conflict; and each

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106. *Canadian Health*, *supra* note 15, at 36.

107. *See* LOMAS, CHARLES, & GREB, *supra* note 105, at 184-85.

108. *Id.*

109. *See id.* at 178.

110. *Id.*

111. *Id.*

provincial association has had to manage a complex and delicate internal accommodation.

For a time, there was an option for physicians to escape these constraints to some extent by "extra-billing" their patients, that is, by billing patients over and above what the government plan would pay. Only about ten percent of physicians exercised this option, and the amount of extra-billing was estimated at only about 1.3% of total physician billings under Medicare.<sup>112</sup> In no province did this amount exceed three percent.<sup>113</sup> The economic and political significance of extra-billing was increased, however, by the fact that it was "clustered" in certain specialties and localities.<sup>114</sup> Even more important in political terms, extra-billing flew in the face of one of the fundamental principles underlying Canadian Medicare — the removal of financial barriers to access medical and hospital care.

In the early 1980s, a federal Liberal government declining in popularity and facing non-Liberal governments in each of the provinces, seized upon the issue of extra-billing as a way of symbolizing its commitment to preserving the universality of the nation's most popular social program. It portrayed non-Liberal governments in the provinces as allowing the principle of universality to be eroded by condoning extra-billing, and passed legislation, the Canada Health Act of 1984,<sup>115</sup> penalizing those provinces by providing for federal transfer payments to be reduced by an amount equal to the estimated amount of extra-billing in any given province: a dollar-for-dollar penalty.<sup>116</sup>

In one sense, at least, the federal strategy back-fired. The federal Conservatives, whom the Liberals had hoped to tar with the same brush as their siblings in power in several provinces, supported the Canada Health Act in Parliament.<sup>117</sup> With its passage in 1984, the politics shifted to the provinces and were shaped by the relationship between the medical profession and the government in each province. In all cases but one, the process of negotiating the ban on extra-billing was relatively non-

112. TUOHY, *supra* note 32, at 116-117.

113. *Id.*

114. *Id.*

115. R.S.C., ch. C-6 (1984) (Can.).

116. R.S.C. ch. C-6, §§ 18, 20.

117. See TUOHY, *supra* note 32, at 129; Peter Ward, *Medical Care Laws Are Likely to Change*, BOSTON GLOBE, Dec. 18, 1983, available in LEXIS, Papers Database.

conflictual, and the medical profession achieved substantial gains in the form of fee schedule increases and binding arbitration mechanisms for future fee schedule disputes.

The exception was Ontario, where the banning of extra-billing occasioned unprecedented conflict between the Ontario Medical Association ("OMA") and the government, culminating in a four-week doctors' strike.<sup>118</sup> This conflict was largely the result of the disruption of the accommodation between the OMA and the provincial government resulting from the accession of the Liberals to power after forty-three years of Conservative rule. The episode poisoned the relationship between the OMA and the government for a time, but in 1991 a wide-ranging agreement between the OMA and the social democratic NDP government, which had by then replaced the Liberals, inaugurated a new era of profession-state accommodation.<sup>119</sup>

Throughout this process, the *clinical* discretion of individual physicians — the ability of the individual physician to exercise his or her clinical judgement in individual cases according to professionally determined standards — has remained virtually untouched. Financial constraints have been global and across-the-board; within those constraints, physicians experience relatively little second-guessing by third parties. Utilization review committees established in several provinces to monitor physicians' practice patterns have focused on only the most aberrant cases, identified by volume of billings.

It can legitimately be argued that the clinical autonomy of physicians is constrained to the extent that the diagnostic and therapeutic options open to them are limited by available facilities and equipment. It must be remembered, however, that the facilities subject to the greatest constraint in Canada, are those involving certain high-technology procedures;<sup>120</sup> and there is considerable debate among clinical epidemiologists as to the range of conditions for which such procedures are in fact indicated. As for other resources such as hospital beds and nursing staff, Canada has fewer hospital beds per capita, but more employees per bed than the OECD average. (In the U.S., the

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118. Ingelhart, *supra* note 55, at 565; TUOHY, *supra* note 29, at 122-23.

119. TUOHY, *supra* note 32, at 131.

120. See *supra* notes 63-64 and accompanying text.

bed:population ratio is even lower, while the employee:bed ratio is higher.) In the three-nation survey of physicians cited above, Canadians were not significantly more likely than Americans to complain of a shortage of competent nursing staff.<sup>121</sup>

The point remains that within gross over-all constraints, the clinical autonomy of the individual physician, and of the profession as a whole, has been maintained. As the agenda of health policy evolves in Canada, the various accommodations between the medical profession and provincial government that underlie the preservation of clinical autonomy will be tested. So far, these accommodations have proved remarkably resilient. This can be seen by considering the course of development of several major items on the health care agenda of the 1990s: user fees, de-insurance, clinical guidelines and organizational change.

## THE EVOLVING AGENDA

### a) User Fees

The issue of "user fees" for insured services was put to rest for a time with the passage of the Canada Health Act and the compliance of all provinces with that federal legislation. The issue of user fees has re-emerged, however.<sup>122</sup> The Canada Health Act, which bans such charges, has become increasingly toothless. In its efforts to reduce spending, the federal government is progressively withdrawing from sharing the cost of provincial health insurance plans. With the end of federal contributions in some provinces toward the end of this decade,<sup>123</sup> the federal government's ability to enforce the provisions of the Canada Health Act will come to an end as well, unless funding is restored or some other enforcement mechanism is introduced.

Without the discipline of the federal legislation, it is possible that some provincial governments will re-introduce user fees. Any government that sought to re-introduce extra-billing

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121. See Blendon et al., *supra* note 86, at 1015.

122. The federal government in 1994 reduced its transfer to the British Columbia government as a penalty for allowing extra-billing by a local group of physicians. It has also established a deadline for provinces to cease allowing private clinics to charge "facility fees" in addition to the amount covered by governmental insurance.

123. Kenneth Norrie, *Social Policy and Equalization, in THE FUTURE OF FISCAL FEDERALISM* 163 (Keith G. Banting et al. eds., 1994).



would do so at a great political risk, however, for little political or fiscal gain.

### b) De-Insuring

So far, provincial governments appear to be more attracted to the option of de-insuring some services than to the imposition of user fees as a cost control measure. This response is, indeed, more consistent with Canada's "segmented" rather than "tiered" approach to the role of the public and private sectors. The Canada Health Act made even more explicit the premises of its predecessor legislation: on its face, it requires provincial health insurance plans to cover fully all "medically required" physician services and a broadly defined set of "necessary" types of hospital services in order to qualify for federal financial contributions.<sup>124</sup> Provincial governments, in complying with the federal legislation, have either *de facto* or *de jure* accepted "medical necessity" as the standard for coverage under their respective plans. The determination of which physicians services are "medically required" and which hospital services are "necessary," however, has not been defined in legislation.

In the hospital sector, the operational definition of "necessity" has been negotiated by government and health care providers. Through a process of prospective global hospital budgeting, provincial governments have, since the 1970s, been negotiating with individual hospitals about how many beds, imaging machines, etc. are "necessary." Differences of opinion in this regard resulted for a time in hospitals breaching their budgets to adopt non-approved programs.<sup>125</sup> The resulting deficits were tolerated and forgiven for a time by governments, but the limits of that tolerance were reached in the late 1980s.<sup>126</sup>

The question of what physicians' services are "medically required" has, until recently, not been a matter of negotiation between providers and governments. As noted earlier, fee schedule negotiations between medical associations and provincial governments have generally focused on the overall percentage increase in fees, not the relative value of items nor the scope of the services covered, which has changed little since a

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124. R.S.C., ch. C-6, § 2.

125. See TOUHY, *supra* note 32, at 120.

126. See *id.*

broad base of coverage was established in each province upon the establishment of Medicare.<sup>127</sup>

There have been, however, recent attempts to de-limit the scope of coverage under Medicare. Under the letter and the spirit of both federal provincial legislation, services can be de-insured only if they are deemed not to be medically necessary. Negotiations to identify potential candidates for de-insuring have been undertaken between the medical profession and government in a number of provinces. To date, there has been very little effect on the comprehensiveness of coverage, but the discussions around these issues are worth briefly considering here for what they can tell us about the shape of future developments.

Most of the services and procedures considered for “de-insuring” are related to cosmetic surgery, mental health and reproduction. The selection of these procedures for consideration has resulted in part from the ideological agendas of governments, and in part from a consideration of income differentials within the medical profession. In Alberta in 1985, as part of the negotiations between the Alberta Medical Association and the provincial government pertaining to the banning of extra-billing, it was decided that several services be “de-insured,” including family planning counseling, tubal ligations, vasectomies and mammoplasty. This selection was driven largely by the conservation social policy ideology of the governing Conservative Party of the day. From the perspective of the medical profession, however, it focused with few exceptions on fairly lucrative procedures performed by relatively high-earning specialists. Furthermore, the de-insurance of such services freed physicians to bill privately at rates of their own choosing. As an internal accommodation within the profession, it allowed for some smoothing of differentials in Medicare earnings while allowing a “safety valve” for the specialties affected. This agreement did not survive the public protest that ensued, however, and funding for most of these services was restored.

In Ontario, a number of services has also been proposed for de-insuring. In this case, the list includes some cosmetic procedures and *in vitro* fertilization (“IVF”) in some circum-

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127. See *supra* notes 105-11 and accompanying text.

stances.<sup>128</sup> (Ontario is the only province in which IVF is a publicly insured service.) Again, these are lucrative services and procedures are performed by relatively high-earning specialists. Their de-insurance would allow them to be offered in private markets. The OMA, however, was initially less disposed to enter into this type of accommodation than its Alberta counterpart had been. The response in Ontario was essentially a procedural one; the provincial government and the OMA came to an agreement on the structures through which decisions would be made about the efficacy of various procedures through health services research and determined that decisions about insurance coverage would be made on that basis.

As part of the wide-ranging 1991 agreement between the Ontario government and the OMA noted above, a Joint Management Committee ("JMC") was formed between the Ontario government and the OMA, and under its aegis an Institute for Clinical Evaluation Sciences was established, based at a Toronto teaching hospital. The process of developing a list of procedures to be de-insured went on for over a year until it became entailed in the government's broad expenditure control agenda in the Spring of 1993. The unfolding of that episode casts further light on the evolving nature of the profession-state accommodation, and merits some elaboration here.

As part of a broad expenditure control package in June 1993, the NDP government of Ontario introduced legislation giving it broad powers to de-insure services, and to limit payments under the government health insurance plan on the basis of the utilization profile of the patient, the practitioner or the facility involved.<sup>129</sup> The OMA reacted strongly and vociferously against these provisions, accusing the government of preempting the JMC process, and mounting an extensive public relations campaign. The government, for its part, stated that the legislation provision constituted a "fail safe" to take effect only if a negotiated agreement with the OMA could not be

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128. See Clyde H. Farnsworth, *Costs Drive Canada to Limit Free Health Care*, OR-EGONIAN, March 27, 1993, available in LEXIS, Papers Database.

129. That is, payment for a given service could be reduced or denied if the number of services provided to a given patient, or by a given physician, or within a given facility exceeded a prescribed maximum during a particular time period. The legislation also granted the government broad regulatory powers to control expenditures, limit the number of practitioners and affect the geographic distribution of practitioners and facilities.

reached. In the result, the OMA and the government reached an agreement on a range of cost-control measures, including a three-year freeze on medical fees and a "hard cap" on total physicians' billings. The JMC process for the determination of which services were to be de-insured was reinstated, tied to tighter deadlines, given a set dollar volume (\$420 million) by which billings were to be reduced through de-insurance, and augmented by an advisory panel including "members of the public" as well as medical and governmental representatives and tied to tighter deadlines.

There are at least three points worth noting about these developments in Ontario for what they suggest about the evolution of the profession-state accommodation. First, they suggest that governments may be more willing to flex their legislative muscle to establish a "shadow" within which their negotiations with the profession can proceed. Second, they suggest the resiliency of the profession-state accommodation even under conditions of growing fiscal constraint. And third, they suggest that the government's approach to accommodation may be shifting the balance of power within the medical profession over time. In the past, academically-based physicians were at the core of profession-state accommodation; and the OMA played a varying role depending upon the vagaries of its internal politics.<sup>130</sup> The NDP government of Ontario has preferred, however, to deal primarily with the OMA as the legitimate "bargaining agent" for the profession.<sup>131</sup> For its part, the OMA has worked its way through a wrenching internal process which has left it more open to accommodation with the state. Now for the first time a body central to the profession-state relationship, the JMC, has no academically-based medical members.

This new accommodation between the OMA and the provincial government in Ontario has not been without controversy within the profession. There is still a minority body of opinion which holds that the OMA has been too concerned with the preservation and enhancement of the power of organized medicine at the expense of the autonomy of the individual physician. The 1991 agreement, which not only established the JMC but also provided for an automatic check-off of member-

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130. See TUOHY, *supra* note 32, at 126.

131. *Id.* at 151.

ship dues to the OMA from each individual physician's payments under Medicare, was strongly contested by this minority. The agreement was finally ratified at a highly publicized mass meeting of the OMA membership in a Toronto hockey arena.

### c) Clinical Guidelines

The tension between the collective autonomy of the profession and the individual autonomy of the practitioner is raised even more squarely by the development of clinical guidelines. The issue of using clinical guidelines developed by professional bodies to shape the behavior of individual practitioners has been on the agenda of Canadian health policy, to very little effect, for well over a decade. In the early 1990s, however, this mechanism has achieved greater prominence. A number of provinces have developed joint profession-government bodies to develop clinical guidelines, although the fiscal sanctions associated with the guidelines vary considerably. Ontario's Institute for Clinical Evaluative Sciences, under the aegis of the JMC, is one such mechanism, and the status of the guidelines it is to develop is as yet unclear. An earlier initiative in Ontario in which guidelines on the use of Caesarean sections were widely distributed to obstetricians was unsuccessful in modifying practitioner behavior. In Saskatchewan, however, guidelines on thyroid tests issued by the Health Services Utilization and Research Commission resulted in a marked drop (sixty-five to seventy-nine percent) in the ordering of certain tests in circumstances in which the guidelines suggested they were not indicated.<sup>132</sup> In British Columbia, an undertaking to develop clinical guidelines backed by legislation and fiscal sanctions formed the centerpiece of an agreement negotiated between the British Columbia Medical Association and the BC government in August 1993. As governments and professional bodies thus move slowly in the direction of "managed care," relations between the profession and the state, and between individual practitioners and professional bodies, will be under increasing pressure.

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132. Rod Mickleburgh, *\$1-Million to be Saved by Cuts in Thyroid Tests*, THE GLOBE AND MAIL (Toronto), Aug. 31, 1993, at A1-2.

## d) Organizational Change

The relationships between governments and professional bodies will also be strained as the health care system increasingly confronts issues of organizational change. These issues have been on the agenda of Canadian health policy since the 1970s, but outside Quebec there has been very little action in this regard. Now these issues are rising on the agenda in a number of provinces, although the response has varies depending on a mix of factors including the partisan complexion of the government and the degree of populism or statism in the political culture. Under NDP governments, for example, both British Columbia and Saskatchewan have recently announced plans to decentralize policy-making structures by establishing systems of local (and, in British Columbia, regional) health authorities with greater budgetary and managerial powers than have been granted to similar bodies in the past. In less populist Ontario, the NDP government has made a number of decisions centrally, such as the decision to regularize the practice of midwifery, that have important implications for the re-organization of health care delivery, and has not expanded the powers of district health councils beyond their traditional advisory functions. Quebec and New Brunswick, under Liberal governments, have established or re-organized regional boards with somewhat more limited scope and more constrained powers than those proposed in British Columbia and Saskatchewan. Organizational reforms in Nova Scotia, begun under a Conservative government and continued under a Liberal government, established a system of regional planning agencies with advisory powers only. In Manitoba, under a Conservative government, proposals for a re-structuring of the delivery system have emanated from the provincial government without the creation of local or regional councils.<sup>133</sup>

There is, then, at least in theory, considerable scope for variation across provincial plans: the definition of "medical necessity" and the structure of the health care delivery system have been determined in the context of an accommodation be-

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133. JEREMIAH HURLEY, JONATHAN LOMAS & VANDNA BHATIA, *IS THE WOLF FINALLY AT THE DOOR? PROVINCIAL REFORM TO MANAGE HEALTH-CARE RESOURCES* (McMaster University Center for Health Economics and Policy Analysis Working Paper 93-12, 1993).

tween the medical profession and the state in each province. And it is true that costs, supply and utilization vary considerably across provinces.<sup>134</sup> What is remarkable is that the variation is not greater than it is, given the loose constraints of the federal legislation. This variation is limited because the interests of the medical profession are fundamentally similar across provinces; and, if clinical discretion is to be maintained while entrepreneurial discretion is limited, these interests militate in favor of a comprehensive and generously funded scheme. For the same reason, the progressive withdrawal of the federal government, which is likely to continue over the rest of this decade, will not lead to substantially greater variation across provinces.

In summary, the Canadian health insurance system has removed financial barriers to the access of a comprehensive range of services, while leaving the definition of that range essentially to the medical profession. These defining principles of the system imply a distribution of power and its flip side, autonomy. It places physicians in a position of power/autonomy to determine the range of services provided while limiting their economic power and autonomy.

The "social democratic" character of Canadian Medicare is not simply a function of its founding principles. Rather, it is a function of the expression of those principles in power structures. Let me further develop this point by drawing two contrasts: one, international, between the Canadian and British health systems, and the other, intra-national, between the Canadian health care system and the Canadian public pension system.

### HEALTH CARE IN BRITAIN AND CANADA

First, let us contrast the Canadian and British health care systems. In Britain, governmental health costs amount to about 5.5% of the GDP, and about over eighty percent of total health care costs.<sup>135</sup> Most accounts of the British system, before the 1990 reforms, suggest that physicians retained considerable clinical discretion within broad budgetary constraints, although the balance between individual and collective autonomy might

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134. TUOHY, *supra* note 32, at 137.

135. TUOHY, *supra* note 29, at 285 & n.7.

have been tilting more toward the collective end of the scale over time. A study of medical decision-making under conditions of "rationing" in Britain made this point.<sup>136</sup> They observed that although governmental budgetary decisions regarding equipment and staffing established overall budgetary constraints, there was virtually no regulatory control over the diagnostic and therapeutic decisions of individual physicians.<sup>137</sup> In cases in which those decisions resulted in "excessive" expenditures, "actions were taken by senior [medical] staff which led to voluntary curbs by the physicians responsible."<sup>138</sup> Arnold Heidenheimer, in contrasting the British and German systems, argued that British physicians have even more clinical autonomy than do German physicians, precisely because the British National Health Service, with its greater control of broad budgetary parameters, can tolerate greater freedom within individual practices.<sup>139</sup>

The 1990 reforms do not substantially change this characterization. As in the Canadian case, however, public policy changes may bring about shifts in the balance of power *within* the medical profession. In Britain, the establishment of fundholding general practices ("g.p.") may change that balance by subjecting consultants to closer questioning by g.p.'s. (Interestingly, the funding-holding reforms have reintroduced a dimension of entrepreneurialism to general practice, a feature which explains much of its appeal to the "first wave" of g.p. fundholders.) But a potential shift in the balance of power between g.p.'s and consultants does not threaten the clinical discretion of physicians *per se*. Furthermore, there is some evidence that referral patterns have not changed as a result of these reforms.<sup>140</sup> Nor have District Health Authorities so far proved to be a threat to professional autonomy rather, they have shown themselves, if anything, to be more cautious about disputing

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136. William B. Schwartz & Henry J. Aaron, *Rationing Hospital Care: Lessons from Britain*, 310 NEW ENG. J. MED. 52 (1984).

137. *Id.* at 54 (mentioning the only possible control as the intervention of other staff physicians).

138. *Id.*

139. ARNOLD J. HEIDENHEIMER ET AL., *COMPARATIVE PUBLIC POLICY: THE POLITICS OF SOCIAL CHOICE IN EUROPE AND AMERICA* 61 (2d ed. 1983).

140. Angela Coulter & Jean Bradlow, *Effects of NHS Reforms on General Practitioner's Referral Patterns*, 306 BRIT. MED. J. 433-37 (1993).



the professional judgements of providers in the hospital sector than are g.p.'s.<sup>141</sup>

The budgetary constraints within which physicians must operate in Britain, however, are considerably more stringent than those which exist in Canada, as is apparent in the lower overall levels of governmental spending on health care in Britain.<sup>142</sup> In the fact of these constraints, and in contrast to the Canadian case, a private market in medical and hospital services has been maintained as a kind of "safety valve."

In order to understand the differences between the Canadian and British systems, we need to go back to the genesis of the programs, to the prevailing policy ideas and power structures of the time. The NHS was born in the era of Beveridge reforms, in a context in which the medical profession was organizationally divided between general practitioners and specialists who held different views about the appropriate direction of public policy. In such a context, the trade-off between economic and clinical discretion was made on terms more unfavorable to the profession than was later to be the case in Canada.

National health insurance was first considered in Canada at the time the NHS was being born in Britain. In 1945-46, the federal government presented a set of proposals for a cost-shared national health insurance problem to the provinces, proposals that had been shaped in part by the observation of contemporary developments in Britain.<sup>143</sup> At the time, there existed a remarkable consensus among medical, hospital and insurance interests favorable to the establishment of a comprehensive health insurance plan in the public sector.<sup>144</sup> Viewing such a plan as "necessary . . . and probably inevitable,"<sup>145</sup> these groups supported it in principle and sought to maximize their influence over its development and implementation. The sense of inevitability arose in no small part from their observation of events in Britain. Had national health insurance been adopted at that time, it would undoubtedly have borne a closer resemblance to the NHS than did the scheme that ultimately

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141. Howard Glennerster & Manos Matsaganis, *The U.K. Health Reforms: The Fundholding Experiment*, 23 *HEALTH POLICY* 179, 189 (1993).

142. See *supra* notes 33, 135 and accompanying text.

143. *Canadian Health*, *supra* note 15, at 32-33.

144. *Id.* at 33.

145. *INSURING NAT'L HEALTH CARE*, *supra* note 15, at 49.

resulted.<sup>146</sup> As it was, however, the federal proposals went down to defeat, tied as they were to a broader package of proposals for federal-provincial fiscal arrangements that were unacceptable to the provinces.<sup>147</sup>

The resulting delay gave time for private plans to develop and expand, and for various provincial governments to experiment with different models of governmental health insurance plans. By the late 1950s and 1960s, when a federal-provincial climate more favorable to the launching of a national plan had developed, a substantial proportion of the population had become accustomed to relatively generous and comprehensive coverage under private insurance plans.<sup>148</sup> Furthermore, opinion within the medical profession had come to favor governmental subsidization and supplementation of private plans.<sup>149</sup> Although its view ultimately did not prevail, the medical profession presented a relatively united front, and could establish a policy price for its participation in the program. The system was hence launched on an economic and political base favorable to more generous financing and a greater degree of medical influence than had been the case in Britain.

## HEALTH CARE VS. PUBLIC PENSIONS IN CANADA

If Canadian Medicare has a social democratic character, the Canadian public pension system clearly does not. As the system developed over time, means-tested pensions introduced at the federal level in the 1920s were replaced by a three-tiered system of universal, contributory and income-tested supplemental benefits.<sup>150</sup> The universal tier, the Old Age Security ("OAS") pension, was introduced in 1951.<sup>151</sup> It provides a flat-rate benefit and is financed from general revenues.<sup>152</sup> The OAS

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146. See *INSURING NAT'L HEALTH CARE*, *supra* note 15, at 33 (discussing the historical background and development of the Canadian Medicare system); TUOHY, *supra* note 32 at 144-45.

147. *Canadian Health*, *supra* note 15, at 33.

148. *Id.* at 33-34.

149. *Id.* at 34.

150. See Paul D. Pierson & R. Kent Weaver, *Imposing Losses in Pension Policy, in DO INSTITUTIONS MATTER? GOVERNMENT CAPABILITIES IN THE UNITED STATES AND ABROAD* 110, 124-25 (R. Kent Weaver & Bert A. Rockman eds., 1993). JOHN MYLES, *OLD AGE IN THE WELFARE STATE* 38, 46-47 (rev. ed. 1989); KEITH BANTING, *THE WELFARE STATE AND CANADIAN FEDERALISM* 7-11 (1982).

151. See MYLES, *supra* note 150, at 77-78.

152. See BANTING, *supra* note 150, at 7.

plan is not designed, however, to provide sufficient income for a pensioner. The pension scheme also includes a contributory tier, the Canada Pension Plan ("CPP"), introduced in 1965.<sup>153</sup> CPP benefits are related to contributions and both are related to earnings, up to a maximum. Finally, for those with income below a certain level, there is a Guaranteed Income Supplement ("GIS"), introduced in 1966, as well as other supplementary provincial plans.<sup>154</sup>

With its limited universal benefit, supplemented either by the means-tested GIS or the contributory CPP or both, this is a "quasi-Beveridge" system. As of the early 1980s, it performed relatively well, in international perspective, in raising the low-income elderly out of poverty.<sup>155</sup> But it performed relatively poorly in replacing the income of the average worker upon retirement,<sup>156</sup> and even more poorly in the case of upper-income earners. Hence, it encouraged both middle- and upper-income individuals to turn to private alternatives. It must be noted that as the contributory CPP matures, replacement rates are rising.<sup>157</sup>

As in other industrialized states, the Canadian public pension system underwent some reform in the 1980s. After an abortive attempt in 1985 to reduce OAS benefits by partially removing inflation protection, the federal Conservative government in 1989 introduced a "claw back" of the OAS pension from higher-income earners.<sup>158</sup> Accordingly, the OAS pension is now progressively taxed back at higher levels of income, and is taxed back completely for the upper five percent of income earners.<sup>159</sup> This "universal" tier was thus effectively converted to an income-tested plan. These changes, together with an enhancement of the GIS in the early 1980s, enhanced further the focus of the Canadian public pension scheme upon low-income

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153. *Id.* at 9.

154. *Id.* at 13; Pierson & Weaver, *supra* note 150, at 124-25.

155. See Timothy Smeeding et al., *Patterns of Income and Poverty: The Economic Status of Children and the Elderly in Eight Countries*, in *THE VULNERABLE* 89, 111 (John L. Palmer et al. eds., 1988).

156. See Jonathan Aldrich, *The Earnings Replacement Rate of Old-Age Benefits in 12 Countries*, 45 *SOC. SECURITY BULL.* 3, 8 (1982); MYLES, *supra* note 150, at 56.

157. See Keith G. Banting, *Economic Integration and Social Policy: Canada and the United States*, in *SOCIAL POLICY IN THE GLOBAL ECONOMY* 29-30 (Terrance M. Hunsley ed., 1992).

158. *See id.* at 30.

159. *See id.* at 29.

individuals.<sup>160</sup> The contributory CPP underwent less structural change, although modest reforms in 1986 resulted in greater flexibility in the retirement age, improvement in the rights of surviving spouses, enhancement of disability benefits and an increase in the contribution rate.

The Canadian public pension system was put into place in the 1950s and 1960s, roughly the same period in which the medical and hospital insurance system was taking shape. Why did the Canadian political system, at the same period in its history, yield a social-democratic health insurance system, and a Beveridge-style pension system? And why, in the 1980s, did fiscal pressures lead to an erosion of universality in the pension system and not in the health care system? The answer lies in the structure of interests in these two arenas. There is, in the pension arena, no group comparable to the medical profession. The pension system involves a transfer of incomes, not services. There is no other group of service providers whose income and careers are as tied up with the generosity of the system. In both arenas, the consumer interest is diffuse.<sup>161</sup> And although the "consumers" of pensions lobbied effectively against an across-the-board reduction of the basic pension in 1985, claw-backs from upper-income pension recipients occasioned much less consumer protest.<sup>162</sup>

In the absence of a strong "provider" interest, public pension policy is shaped almost entirely by the interests of governments. Banting has pointed out the extent to which income maintenance policies in Canada are shaped by the interests of "governments as governments," essentially, jurisdictional and fiscal concerns.<sup>163</sup> This means, in the first place that, since change in a number of key income maintenance programs entails a complex set of implications for the fiscal responsibilities

160. See *id.* at 30.

161. Organized labor, which has been an effective proponent of generous social programs in other nations, is too organizationally decentralized and ideologically divided to play a similar role in Canada. See David Cameron, *Social Democracy, Corporatism, Labour Quiescence and the Representation of Economic Interest in Advanced Capitalist Society*, in *ORDER AND CONFLICT IN CONTEMPORARY CAPITALISM* (John Goldthorpe ed., 1984); Rodney Haddow, *The Canadian Labour Congress and the Welfare State Debates*, paper presented at the 63rd Annual Meeting of the Canadian Political Science Association, Queen's University, Kingston, Ontario, June 4, 1991.

162. Banting, *supra* note 157, at 29-30.

163. See KEITH BANTING, *THE WELFARE STATE AND CANADIAN FEDERALISM* 43, 51 (2d ed. 1987).

of various levels of government, governmental interests have accordingly acted as a brake on policy development. Hence, there were few changes to the Canada Pension Plan, which involves a complex set of federal-provincial arrangements, in the 1980s. Second, governments frustrated by federal-provincial entanglements tend to turn to those instruments over which they have exclusive control. This explains, the focus on Old Age Security pensions by the federal Conservatives in the same period.<sup>164</sup> In addition, the interest of "governments as governments" comes into play: the way in which governments use the instruments at their command will be determined not so much by group pressure as by partisanship and ideology. This will cause the erosion of the universality of the OAS pension as part of the Conservative agenda of deficit reduction.

### CONCLUSION

Medicare is Canada's social policy success story. Its social democratic character has been attributed by a number of observers to the presence of a social democratic party within the Canadian political system. The significance of the NDP in this respect should not be slighted. After all, it was the NDP government of Saskatchewan that first introduced governmental hospital insurance in 1944 and government medical insurance in 1962, and it was arguably the electoral threat from the NDP that led the minority federal Liberal government to press ahead with the introduction of national medical care insurance in 1966. In the same era, however, the Canadian system generated a public pension system which, with its limited universal and contributory benefit tiers, and its means-tested supplemental tier, is a hybrid of Beveridge and residualist welfare-state models. In the 1980s, the universality of the health care system was preserved, and indeed enhanced, while the limited universality of the pension system was eroded. The evolution of the health insurance system, then, cannot be understood with reference to social democratic principles alone. It has depended as well on the presence of a medical profession willing to enter into an accommodation with the state, an accommodation

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164. TUOHY, *supra* note 29, at 294-95; Paul D. Pierson & R. Kent Weaver, *Imposing Losses in Pension Policy, in DO INSTITUTIONS MATTER? GOVERNMENT CAPABILITIES IN THE U.S. AND ABROAD* 148 (R. Kent Weaver and Bert A. Rockman, eds. 1993).

which trades off economic power to preserve the clinical autonomy of the profession as a whole, and to a large degree of individual physicians too.

Any set of principles of distributive justice implies a distribution of power, and it is through that structure of power that the principles will be implemented. The Canadian system places physicians, as the interpreters of the "necessity" of care, in a central role. Although the Canadian medical profession has resisted change at a number of key junctures, it has accommodated those changes.

The Canadian system is not without its problems. It remains the second most expensive system in the industrialized world.<sup>165</sup> Geographic maldistribution of facilities and services remains a problem. The treatment of the elderly, particularly as the population ages, presents an enormous set of challenges. Both the medical profession and the state, as the central shapers of the system, are part of these problems. But they are also part of the solutions. Such strengths as the system has, and they are considerable, can be attributed to both parties, and both will continue to shape the system in the future.

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165. See *supra* notes 43-44 and accompanying text.

