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In both Canada and the United States, reform of the existing health care systems by policy makers has proven to be extraordinarily difficult. The pattern of public health care reform initiatives in Canada is one of high expectations and a concerted effort followed by little in terms of genuine change or progress.[1] Explanations for this pattern have tended to focus on the political dynamics necessary to bring about effective change in social policy. In particular, two institutions have figured in the most influential accounts of why the existing Canadian health care system is so resilient. One is the distinctive institution of Canadian federalism. Genuine pan-Canadian health care reform requires the fiscal involvement of the federal government, but also requires the provincial governments to implement it. This is because, in the 1867 British North America Act, which defined the constitutional division of powers between the provincial governments and the federal government, health care was assigned principally to the provinces even though the federal government has greater scope for raising revenue. This has meant that in order for the federal government to initiate health care reform, it must do so with the cooperation of the provinces. And in practice that cooperation has proven to be very difficult to sustain in recent years because the provinces have a proven track record of not keeping their promises when accepting

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1. A description of this pattern over the past ten years can be found in the introduction to my forthcoming book, LESLEY A. JACOBS, CANADIAN HEALTH CARE POLICY REFORM: VALUES, RIGHTS, LAW (forthcoming 2006).

new federal money.[2] The other institution that has featured prominently in accounts of why the Canadian health care system is so stable and difficult to change is the distinctive arrangement within that system between the provincial governments that are the payers for the system and the physicians who deliver health care within the system on a fee-for-service basis.[3] In effect, this institutional arrangement has preserved the autonomy of physicians to make professional judgments about the care of their patients whilst at the same time provided for a single payer public scheme where ability to pay has ceased to be an issue for medically necessary services. Since many health care reforms such as primary care reform and capitation payment schemes have entailed changes to this arrangement, they have been resisted in a collective manner by physicians.

The purpose of this paper is to show that the institutional place of hospital insurance in the development of the Canadian health care system is another very important factor, albeit neglected, in the puzzle about health care reform. Hospitals were in the late 1950s the first site for publicly funded national health care. The federal government put in place through legislation a cost-sharing funding mechanism for universally accessible hospital care and diagnostic services to be implemented and administered by provincial health care systems.[4] A parallel scheme for physician services did not follow for more than a decade.[5] What I argue below is that this initial policy development – the first major step towards a federally funded universally accessible health care system in Canada – has created a policy legacy that constrains health care reform initiatives today, and that successful Canadian health care reform must adapt to these constraints through

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2. For a very recent overview, see Mary Janigan, *A National Disgrace: The Provinces are Taking $18 billion for Health Care – and not Keeping Their Promises*, MACLEAN'S, Jan. 24, 2005, at 16.

3. For the best accounts, see C. DAVID NAYLOR, PRIVATE PRACTICE, PUBLIC PAYMENT: CANADIAN MEDICINE AND THE POLITICS OF HEALTH INSURANCE (1986) and CAROLYN HUGHES TUOHY, ACCIDENTAL LOGICS: THE DYNAMICS OF CHANGE IN THE HEALTH CARE ARENA IN THE UNITED STATES, BRITAIN, AND CANADA (1999).

4. *See* Hospital Insurance and Diagnostic Services Act, R.S.C., ch. 28, § 1 (1957) (Can.).

5. *See* Medical Care Act, R.S.C., ch. 64, § 1 (1966) (Can.).

a number of distinctive institutional strategies. For the sake of simplicity, I have simply assumed that it makes sense to refer to a national health care system in Canada – as opposed to thirteen entirely separate and very different provincial and territorial health care systems—and used the case of health care in the largest province, Ontario, to illustrate this argument.

My claim that the targeting of one class of medical services – hospital services – for universal access fifty years ago still shapes health care reform in Canada today parallels (albeit with a twist) one now made about health care reform in the United States. In the United States, the initial major steps towards publicly funded health care were targeted at residual populations – the elderly and the indigent – which resulted in Medicare and Medicaid during the Johnson administration. While at the time many believed that this constituted a step towards universal access, it has in recent years become clearer that in fact this targeting has made reform directed at universal access harder to achieve, not easier.[6] There are at least three important reasons for this.[7] The first is that by targeting those in the general population who consume the most health care resources, this has raised almost from the outset the question of whether public funded universal access to health care for all Americans is affordable. The second reason is that the absence of a publicly funded health care program for the vast majority of middle-class Americans has been inevitably filled by private insurance schemes that set a higher standard for any publicly funded program to match than the threshold that existed in the 1950s before the establishment of Medicare and Medicaid. The third reason is that these developments galvanized the strength and influence of the private health care industry, which are now able to block reforms that do not serve their best interests.

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6. *See* TED MARMOR, THE POLITICS OF MEDICARE 173-75 (2d ed. 2000).

7. *See* Jacob Hacker, *The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy*, 12 STUD. AM. POL. DEL. 57, 118-19 (1998).

LEGACY AND PATH DEPENDENCY IN POLICY DEVELOPMENT

The theoretical framework for this paper is provided by the twin ideas of policy legacies and path dependency. These ideas stem from the emergence of so-called "new institutionalism" in the social sciences, especially political science and economics.[8] The main insight underlying the ideas of policy legacies and path dependency is that policy decisions made earlier in the development of a public policy such as health care have a strong impact on the options and incentives to consider other alternatives available to contemporary policy makers. In other words, once you have gone down one path, it becomes increasingly difficult to change to another one. Like with so many other realms of our lives, public policy making over time involves appreciating that going through certain doors entails closing off other doors that had been open in the past. Each fork in the path does not provide the opportunity to revisit the entire path we have followed. Instead, earlier policy decisions offer a legacy that shapes the present including the alternatives available to us.[9]

Any path dependency analysis of public policy development focuses on institutions, for it is institutions that endure over time and are the on-going legacies of earlier policy decisions. In other words, it is institutions that provide the bounds of the path of Canadian health care policy. The institutions in question vary greatly in their structure and essence. At its most abstract, an institution can be understood as a set of rules that govern behavior in a particular context.[10] Consider for example a game of

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8. For an overview, see Peter Hall & Rosemary Taylor, *Political Science and the Three New Institutionalisms*, 44 POL. STUD. 936 (1996).

9. *See* PAUL PIERSON, POLITICS IN TIME: HISTORY, INSTITUTIONS, AND SOCIAL ANALYSIS 17-53 (2004).

10. This definition of institutions and the contrast to organizations has its origins in institutional economics, especially the work of Douglas North. *See* DOUGLAS C. NORTH, INSTITUTIONS, INSTITUTIONAL CHANGE AND ECONOMIC PERFORMANCE 3 (1990). A different way to draw this distinction is between institutions and offices where, for example, the president or the prime minister is understood as an office. For instance, Karen Orren draws the distinction in this way in the context of the development of American constitutional law. *See* Karen Orren, *Officers' Rights: Toward a Unified Field Theory of American Constitutional Development*, 34 L. & SOC'Y REV. 873 (2000). For the purposes of

chess. The familiar rules of chess such as castling or en passant are an institution. In contrast, the World Chess Federation, high school chess clubs as well as neighborhood associations are best thought of as organizations. Similarly, in Canadian health care reform, organizations involved include political offices such as the provincial premiers and territorial leaders, the prime minister, health ministers, ministries of health, health care professions and their respective associations, patients groups, hospitals associations, unions, and so on. The institutions that govern Canadian health care reform, on the other hand, include federal and provincial legislation, scheduled meetings of the provincial premiers and the prime minister, principles and values, the opportunities for judicial review of health care policy, the sources of public revenue, and so on. Institutions create the opportunities for health care policy, organizations function "to take advantage of those opportunities."[11] Because organizations are not only subject to institutions but very often are the authors of the rules that constitute institutions, this distinction between the organizations and institutions can in practice be difficult to make precisely.[12] However, the belief that there is such a distinction is a reasonable one and can be shown to be fruitful for understanding Canadian health care reform. In particular, the institutions, as opposed to the organizations, of Canadian health care reform provide the key to explaining its development. My assumption is that institutions and policies function in a similar way to the extent that they structure the strategies of agents and organizations.[13]

Of course, the view that institutions matter to health care reform in Canada and elsewhere is not an especially insightful one. Indeed, most reform initiatives have held that the key to successful health care reform is new

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health care reform, however, the idea of an organization better captures the diverse nature of the players involved than the idea of an office.

11. NORTH, *supra* note 10, at 7.

12. *See* YORAM BARZEL, A THEORY OF THE STATE 14 (2002).

13. *See* Paul Pierson, *Introduction: Investigating the Welfare State at Century's End*, *in* THE NEW POLITICS OF THE WELFARE STATE 1, 8 (Paul Pierson ed., 2001); Stewart Wood, *Labour Market Regimes Under Threat? Sources of Continuity in Germany, Britain, and Sweden*, *in* THE NEW POLITICS OF THE WELFARE STATE 377 *supra*, at 367, 377.

institutions. My point is not, however, that the right new institutions matter for health care reform but rather that institutions matter because existing institutions constrain health care reform initiatives including efforts to build new institutions.

The present paper identifies two very different ways that the sequential development of existing institutions constrain health care reform in Canada. One way is through what I call an *institutional settlement.* An institutional settlement occurs when a certain practice or policy is set in place and persists over time even though the rationale for the policy or practice evolves and changes. Institutional settlements illustrate both, on the one hand, how institutions develop and evolve and, on the other hand, how they stay the same. Although Kathleen Thelen doesn't use the precise language of institutional settlements, a clear illustration of an institutional settlement is provided in her recent book, *How Institutions Evolve: The Political Economy of Skills in Germany, Britain, the United States, and Japan.*[14] Germany differs from the United States and Britain because it has an elaborate private firm-sponsored training and apprenticeship system in its industrial sector. This vocational training system has persisted in Germany since the late nineteenth century, despite two world wars and many major political upheavals and breakpoints. Although it was originally introduced to weaken industrial unions in Germany, firm-based training and apprenticeship is now strongly defended on the grounds that it strengthens these unions. What has shifted, in other words, is the rational for the institutional settlement. Yet, it doesn't follow that an institutional settlement such as Germany's vocational training system has not developed and evolved; there is, however, a certain essence of the system—the primary role of the firm in the training—that has continued since its inception more than a century ago.

Similarly, I argue below that the 1957 Hospital Insurance and Diagnostic Services Act gave birth to an institutional settlement excluding extra billing and user fees for patients utilizing publicly funded medically

14. *See* KATHLEEN THELEN, HOW INSTITUTIONS EVOLVE: THE POLITICAL ECONOMY OF SKILLS IN GERMANY, BRITAIN, THE UNITED STATES, AND JAPAN 30-34 (2004).

necessary hospital and physician services in Canada. The essence of this institutional settlement—the exclusion of extra billing and user fees—has persisted now for more than fifty years, even though the rationale for that institutional settlement has shifted. In the same way that the institutional settlement around vocational training in Germany has constrained reform of its labor skills market, likewise the institutional settlement against extra billing and user fees sets boundaries on health care reform in Canada today.

The second way that existing institutions constrain health care reform is through positive feedback mechanisms. Positive feedback occurs when an existing state of affairs is self-reinforcing in the sense that it is difficult or costly to change the status quo and switch to another state of affairs. The claim that many institutions rely on positive feedback mechanisms is central to the ideas of path dependency and policy legacies. Paul Pierson explains the logic of positive feedback in the following way: "Each step along a particular path produces consequences that increase the relative attractiveness of that path for the next round. As such effects begin to accumulate, they generate a powerful cycle of self-reinforcing activity."[15]

Positive feedback mechanisms outside of health care institutions building their effects over time are a familiar part of everyday life. They are, for example, a common feature of products in the insurance industry such as household insurance. Most insurers provide a renewal discount where your premium is reduced by say 10% for each year that you stay with the insurer. The logic is that when selecting a company for your household insurance each year, the inclination is to stay with your current insurer because you lose the renewal discount if you switch to a new carrier. In effect, the decision you made last year about which insurance carrier to use has a legacy impact on your decision this year and in this sense constrains your decision-making options.

Often, the impact of institutional positive feedback on decisions in our personal lives is not measurable simply in terms of money. Suppose for example that as a parent I am unhappy with the neighborhood public school where my

15. PIERSON, *supra* note 9, at 17-18.

children have gone for the past five years and am considering switching them to another public school in the neighborhood. Most of us are aware in these sorts of situations that even if there may be educational benefits of switching schools, there are positive feedback considerations at play that favor staying put such as the children's network of friends and knowledge of the school's community of teachers and parents. Moreover, these positive feedback considerations build over time. The longer your children have been attending the school, the more difficult it is to switch.

Positive feedback dynamics are noteworthy for two reasons.[16] One is that it explains why the costs of a dramatic policy change—a policy reversal or path change—often increase over time. It is easier to transfer law schools when you have only been there a year then when you are in your final year. The other is that it explains why issues of timing and sequencing in policy implementation is so important. What comes first can significantly impact what can feasibly follow.

The anecdotal evidence that the positive feedback of existing institutional arrangements impacts health care reform is, I believe, overwhelming, once these mechanisms are looked for in the Canadian health care system. I show below how the development in the 1950s of a hospital-centered publicly funded health care system put in place a positive feedback mechanism that self-reinforces the perpetuation of this hospital-centered system. In effect, this institutional arrangement relies on a positive feedback dynamic even though it is doubtful that it was originally designed to do so. This account explains why in the name of reform, Canadian policy makers cannot simply discard existing institutions that constrain reform and replace them with new institutions that better meet the health care needs and priorities of Canadians in the twenty-first century. It may seem puzzling why, for instance, if the over-emphasis on hospitals is in tension with the new priority of homecare, the provinces don't simply reduce funding to hospitals and divert the funds to homecare. The answer rests, I think, on the prevalence of positive feedback mechanisms. Existing health care institutions matter then

16. *See id.* at 18.

not simply because they have a hard time adjusting to the new health care needs and priorities of Canadians or because they reflect an institutional settlement but also because they invoke positive feedback mechanisms that constitute headwinds to genuine change and reform. Moreover, as Medicare grows older, the effects of positive feedback build over time, thereby making far-reaching reform more and more difficult. Hence, it was far easier for the federal government to reform Medicare in 1971 and 1984 then in 2004.

UNIVERSAL PUBLICLY FUNDED HOSPITAL INSURANCE

Although some provinces entered into the field of publicly funded health care services delivered by hospitals to some degree in the 1930s,[17] the Canadian federal government's involvement with hospital provision did not begin in any systematic way until the late 1940s. In 1948, the federal government initiated the National Health Grants Program which provided each province with grants for public health measures, mental health and hospital construction. Hospital construction constituted the largest part of the program, amounting to nearly half of the funds initially allocated to the program.[18] The hospital construction grants provided a pioneer model for cost-sharing in health care because they required that contributions by the federal government be matched by the provincial government where the hospital construction was taking place. Underlying the hospital construction grants scheme was a belief, similar to one that unified supporters of the 1946 Hill-Burton Act in the United States,[19] that hospitals were the best vehicles for disseminating the benefits of progress in medicine in Canada.

The hospital construction grants from the federal government impacted the Canadian health care system after WWII in four major ways. First of all, the grants

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17. *See* C. STUART HOUSTON, STEPS ON THE ROAD TO MEDICARE: WHY SASKATCHEWAN LED THE WAY 8-40 (2002).

18. *See* MALCOLM G. TAYLOR, INSURING NATIONAL HEALTH CARE: THE CANADIAN EXPERIENCE 81 (The Univ. of N.C. Press 1990) (1978).

19. *See* DANIEL M. FOX, HEALTH POLICIES, HEALTH POLITICS: THE BRITISH AND AMERICAN EXPERIENCE 1911-1965, at 123 (1986).

facilitated the dramatic expansion of the capacity of hospitals to provide medical services. In the period from 1948 to 1970 when the grants ended, federal funds were used to generate 130,000 hospital beds.[20] This meant that 80% of the total hospital beds in 1970 in Canada had been funded by the program.[21] The grants also expanded dramatically hospital laboratories, community health centers, teaching facilities, emergency wards, and diagnostic areas. Second, the program led to the extensive building of hospitals in rural areas and small towns across Canada. Third, because the hospitals were new and designed to take advantage of progress in medical technology and innovation, they increased the cost of hospital services for individual patients. Fourth, because the matching construction grants were restricted to so-called voluntary hospitals, for-profit private sector hospitals were not able to gain a foothold in the Canadian health care system. Voluntary hospitals are non-profit firms governed by a board of trustees representing the legal owners who are a voluntary society, university, municipality, or religious order.[22] For-profit hospitals are still virtually non-existent in Canada.

The expanded capacity for hospitalization combined with the increased cost per bed meant that in the 1950s there was an increase in pressure to develop some sort of public insurance.[23] In the 1950s, provincial medical

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20. *See* Maurice LeClair, *The Canadian Health Care System*, *in* NATIONAL HEALTH INSURANCE: CAN WE LEARN FROM CANADA? 14 (Spyros Andreopoulos ed., 1975).

21. This is my calculation based on the fact that there were 150,000 hospital beds in 1974. *See id.*

22. *See* ROBERT G. EVANS, STRAINED MERCY: THE ECONOMICS OF CANADIAN HEALTH CARE 160 (1984).

23. Ironically, the then Prime Minister Louis St. Laurent had defended extending the capacity for hospitalization as precisely a precursor to publicly funded hospital insurance, stating in 1952:

> I do not feel that the government has the right to give Canadians contractual rights to hospital treatment until there is sufficient accommodation in the hospitals to enable the government to fulfill that obligation . . . I do not feel sure there is sufficient hospital space to enable all that would have contractual rights to receive hospital treatment.

quoted in MALCOLM G. TAYLOR, HEALTH INSURANCE AND CANADIAN PUBLIC POLICY 183 (1978).

associations developed extensive prepayment plans for physician services. Combined with the prepayment plans offered through Blue Cross and commercial insurance, in Ontario in 1954, 45% of residents had some form of coverage.[24] Physicians relied, however, on insurance payments for only 28.5% of their revenue.[25] In Ontario, at the same time about 67% had some measure of Blue Cross or commercial hospital insurance.[26] Hospitals in turn were much more dependent on insurance payments for their revenue, which amounted to 46% of all revenue in 1954.[27] Hospitals were in this respect more dependent on third party insurance payers for revenue. This should not be surprising because the increased cost of hospitalization made the ability to pay of individual patients a much greater factor.

This reliance of hospitals on insurance payments raised three distinct issues. The first concerned other revenue sources for hospitals. The hospitals in Ontario also relied for revenue on direct payments by patients (25.1%), charitable donations (3.5%), and a variety of government sources including the provincial government (9.7%), Workmen's compensation (3.9%), federal funds (1.4%), and municipal governments (9%).[28] In effect, this meant that hospitals relied for a quarter of their income on a patchwork of government schemes. The second issue concerned the efficiency of relying on an insurance mechanism. Influential research findings showed at the time that relying on an insurance mechanism added 16% to the cost of providing the coverage, in effect, increasing hospital costs by 8%.[29] The final issue was that in rural areas and small towns, insurance payments were less than in bigger urban centers. This meant that the numerous new hospitals built with the funds provided by the federal government's hospital construction matching grants in

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24. *See* MACOLM G. TAYLOR, FINANCIAL ASPECTS OF HEALTH INSURANCE 54 (1957).

25. *See id.* at 53-54.

26. *See id.* at 49.

27. *See id.* at 48-49.

28. *See id.* at 43.

29. *See id.* at 47. My calculation is based on insurance payments amounting to roughly half of the total revenues of Ontario's hospitals.

rural areas and small towns faced an especially serious revenue problem. In other words, although these new hospitals had been built after 1948 principally with public money, there were not adequate funds to operate them.[30]

In 1957, the federal government entered the field of health care delivery with the enactment of the Hospital Insurance and Diagnostic Services Act. This bill was introduced by and shepherded through the federal parliament by the then Minister of National Health and Welfare Paul Martin (the father of the current Prime Minister Paul Martin). The bill provided for the federal government to begin contributing financially to the operation of institutional health care in general hospitals and related hospitals including diagnostic (laboratory and radiological) services. The provision was in other words for the federal government to underwrite some of the costs of provincially administered hospital care. The act did not involve any change in the legal ownership of hospitals. Moreover, because it did not have any serious implications for the payment structure of physicians with hospital privileges or salaried staff physicians, it was not opposed by the medical associations in Canada and widely viewed as an effective way to stabilize hospital funding.[31]

THE INSTITUTIONAL SETTLEMENT AGAINST EXTRA BILLING

At present, Canada's health care system is unique in the world because it does not allow for private payment for medically necessary hospital and physician care. All such medically necessary care is publicly funded (although the precise definition of what constitutes medically necessary is a term of art that differs from province to province.) This means, for example, that more than 90% of hospital revenue comes from public funds. The other 10% comes from charges for non-medically necessary services such as private or semi-private rooms. In 2004, $35,814,000 of public funds were spent on hospital care compared to only $3,082,700,000 from private sources.[32] Patients cannot

30. *See* LeClair, *supra* note 20, at 14, 22.

31. *See* NAYLOR, *supra* note 3, at 166.

32. This is based on the macro-spending charts provided at http://www.cihi.ca.

legally be subject to co-insurance payments, deductibles or extra billing for medically necessary services without the federal government imposing a financial penalty on the provincial health care system where the charge is applied. The result is that there is no market for private insurers for medically necessary services, although there is a significant market for private firms to offer insurance for hospital charges such as private rooms. At first glance, this unique feature of the Canadian health care system might seem to have its origins in a commitment to insulating health care from considerations of 'ability to pay.' In fact, however, it dates to the cost sharing formula between the federal and provincial governments instituted in the 1957 Hospital Insurance and Diagnostic Services Act.

The Act put in place the first major cost sharing pan-Canadian social program, which became the exemplar for the other national social programs developed in the 1960s and 1970s that constitute Canada's welfare state. Much of the focus of the hospital and diagnostic services cost sharing mechanism has been on its formulation in terms of the share of the costs the federal government would assume. The federal government agreed to pay 25% of the average per capita of costs in Canada as a whole plus 25% of the average per capita of costs in an individual province multiplied by the number of insured individuals in that province. The effect of this formula was for the federal government to pay a higher portion of actual costs in those provinces with low per capita costs and a lower portion in those with higher per capita costs. In 1957, the federal government could thus anticipate paying only 45% of the hospital and diagnostic services costs in British Columbia while paying 71% of the costs in Newfoundland.[33] The rationale for the formula was, of course, to provide individual provinces with an incentive to lower their actual costs and thereby increasing the federal government's proportion. This formula was eventually replaced in 1977.

The more lasting feature of the cost sharing formula was what it did not include in its calculation of the federal government's share. Specifically, the federal government excluded among the provincial spending on hospital and diagnostic services it would match any payment made by an

33. *See* TAYLOR, *supra* note 24, at 85-86.

individual patient or on his or her behalf by a private insurer. This idea was completely new in the 1957 Act.[34] The principal reason for excluding extra billing or co-insurance in its cost sharing formula on the part of the federal government is completely transparent: the federal government did not want to have to transfer matching funds to provincial governments that included the matching of payments by individual patients because it could then face the possibility where the federal government was paying half the costs of hospital and diagnostic services in a province where the provincial government was contributing almost nothing and individuals were contributing the other half. In effect, the federal government wanted to ensure that it was matching provincial government contributions to hospital and diagnostic services.

The impact of this provision on provincial health care systems is easy to anticipate. Provinces had a huge incentive to seek alternatives to user fees and extra billing for patients in hospitals. This is because the actual revenue from such fees, once it was discounted by the absence of matching federal funds, was only half of that collected. The obvious alternative revenue sources for the provinces to pay their share of hospital costs were general tax revenues, provincial sales tax (which in some provinces was relabeled a hospital sales tax), and a compulsory hospital insurance premium. Different provinces used one or more of these devices to match the federal contributions to hospital and diagnostic services.

The evidence that no extra billing or user fees for

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34. *See* TAYLOR, *supra* note 24, at 84 n.6. The author observes that this exclusion was not part of the federal government's proposals for national hospital insurance in 1945. Aside from Taylor's brief footnote about this feature of the Act, the innovative exclusion of extra billing or co-insurance in the 1957 Act from federal matching funds has received no academic commentary, historical or contemporary, that I have found. The issue that did receive much more attention at the time was that the Act provided public health insurance for everyone rather than just targeting the poor and those who could not afford paying private insurance premiums themselves. The hospital associations and the physician associations in Canada at the time favored a program that targeted the poor with the design of subsidizing individuals so that they could pay the premiums of private insurance schemes. The government's rejection of that the option was heavily influenced by studies at the time that showed the immense administrative costs of such a targeted program and efficiency of a program that provided for "uniform terms and conditions". *See* TAYLOR, *supra* note 23, at 230.

medically necessary hospital services constituted an institutional settlement in Canada was clear by the time that the Royal Commission on Health Services recommended in 1964 that the cost-sharing model of universal publicly funded health insurance be extended from hospital and diagnostic services to physician services. A foundational principle of that report was that the new health care system be financed through what it termed "prepayment arrangements".[35] The commission defined prepayment arrangements to include "premiums, subsidized premiums, sales or other taxes, [and] supplements from provincial general revenues."[36] The significant point is that there was no allowance for patient user fees or extra billing, for it was assumed that any federal government matching formula would prohibit it.

Like any institutional settlement, over time it is inevitable that what this particular institutional settlement means will be renegotiated in response to other changes and developments in the national health care system. Yet, what makes it an institutional settlement is that any such renegotiation will be constrained. In Canada, the reasons for renegotiating the meaning of why there would be no extra billing or user fees stemmed from the fiscal pressures the federal government was under in the mid 1970s and its efforts to limit its health care expenditures. Under the cost-sharing formula that had been in place since 1957, the provinces simply presented the federal government with a bill stating their overall expenditures and it was the federal government's obligation to pay their share based on the calculation for each province of 25% of the average per capita of costs in Canada as a whole plus 25% of the average per capita of costs in an individual province multiplied by the number of insured individuals in that province. Health care costs, especially in hospitals, increased dramatically in the 1960s and the early 1970s. The federal government sought a more predictable funding formula. In 1977, with the agreement of the provinces, the federal government shifted to a cost-sharing formula that consisted of an annual block grant for each province

35. 1 ROYAL COMMISSION ON HEALTH SERVICES 11 (Emmett Hall, Chair 1964).

36. *See id.*

determined at the outset of each fiscal year plus the transfer of a certain percentage of federal income tax revenue (tax points) to each province. The initial impact of the new funding formula was that the federal government paid more than half of the country's total public expenditures on medical services but this share steadily declined so that now the federal government pays approximately a third of those costs.[37]

The new funding agreement was largely silent, however, about user fees and extra billing. In the late 1970s, with provincial governments likewise feeling fiscal pressures, a number of provinces began to entertain the idea of introducing user fees and permitting extra billing by physicians for medically necessary services.[38] Without the matching funds scheme in place, the original main rationale for that institutional settlement was no longer in place. In 1979, the federal government commissioned Emmett Hall, who had originally chaired the 1964 Royal Commission on Health Services and was then a judge on the Supreme Court of Canada, to assess the issue of user fees and extra billing. Hall, in his report *Canada's National-Provincial Health Program for the 1980's: 'A Commitment for Renewal,'* reiterated that user fees and extra billing for medically necessary physician and hospital services be prohibited but offered a different principal rationale for this institutional settlement. Hall argued there that the principal rationale for prohibiting user fees and extra billing is that these practices inhibit "reasonable access to services".[39] Acting on Hall's recommendations, the federal government enacted the 1984 Canada Health Act, which articulated that federal contributions to provincial health care plans were conditional on those plans conforming to the five principles of Medicare—and specified that federal transfers to an individual provincial government *may* be reduced if it does

37. *See* THE HON. EMMETT M. HALL, CC., Q.C., SPECIAL COMMISSIONER, CANADA'S NATIONAL-PROVINCIAL HEALTH PROGRAM FOR THE 1980'S 11-12 (Professor R. Gautier trans.) (1980). The precise percentage that the federal government now contributes to public health care is politically contested and requires careful elaboration, which is beyond the scope of the present paper.

38. These are well described by the federal Minister of Health and Welfare at the time, Monique Bégin. *See* MONIQUE BÉGIN, MEDICARE: CANADA'S RIGHT TO HEALTH 1-21 (1987).

39. HALL, *supra* note 37, at 28-29.

not conform to the five principles and *must* be reduced if user fees or extra billing are applied in exact proportion to those fees or billings.[40] In practice, the federal government has never reduced its transfer to a province because of non-compliance with the five principles of Medicare, but it has reduced transfers in the case of user fees and extra billing.[41]

It has become very evident in the past decade that the political settlement excluding reliance on user fees and extra billing for patients has considerably constrained the options for conservative health care reformers. These reformers have often proposed introducing user fees or extra billing, only to find that the obstacles posed by that institutional settlement are overwhelming. Indeed, an important dimension of making sense of the initiatives by conservative reformers has been to challenge the very idea that there is continuity between the national health care system established in the 1950s and 1960s and the health care system enshrined in the 1984 Canada Health Act. The distinguished Canadian historian Michael Bliss, for example, writes "there have been two major experiments with universal health insurance for Canadians: the plan initiated by the Pearson government in the mid-1960s and the Canada Health Act system put in place by the Trudeau government in 1984."[42] It is the second that in Bliss's view is the problem. So he explains, "the ideological rigidity of those who see the Canada Health Act as set in Canadian stone has become a hindrance to health care reform and to the country's capacity to adjust to the continuing challenges of the modern world."[43] The analysis above shows, however, that the institutional settlement against relying on user

40. Canada Health Act, R.S.C., ch. C-6, § 7 (1985) (Can.). The distinction in the Canada Health Act between "may" and 'must" has puzzled recent commentators. *See, e.g.*, Sujit Choudhry, *Bill 11, the Canada Health Act and the Social Union: The Need for Institutions*, 38 OSGOODE HALL L.J. 39 (2000). Of course, the upshot of the emphasis I am placing on the 1957 Hospital Insurance and Diagnostic Services Act provides a clear rationale for the distinction because the concern about user fees and extra billing dates to the perceived unfairness of the federal government at the time having to match patient's private contributions and not just the contributions of provincial governments.

41. *See* Choudry, *supra* note 40, at 38-39.

42. Michael Bliss, *Health Care Without Hindrance: Medicare and the Canadian Identity*, *in* BETTER MEDICINE: REFORMING CANADIAN HEALTH CARE 32 (David Gratzer, ed, 2002).,

43. *Id.* at 33.

fees and extra billing was solid from 1957 to 1984. What evolved was the principal rationale for that settlement, not its essence or rigidity. There were not two settlements, only one.

Significantly, under pressure from conservative health care reformers, there is some evidence that the principal rationale for the institutional settlement excluding user fees and extra billing for medically necessary services is evolving once again. Roy Romanow, Chair of the Commission on the Future of Health Care in Canada, in his 2002 report to the federal government, *Building on Values: the Future of Health Care in Canada*, argues not simply that user fees and extra billing for patients inhibit access but also that it will make the health care system less effective and undermine its broad mandate to make Canadians healthier.[44] In effect, the point is that user fees will not only discourage frivolous uses of the health care system but also medically necessary ones.[45] This ongoing effort to sustain the policy legacy of the 1957 Hospital Insurance and Diagnostic Services Act demonstrates why that first step towards a national publicly funded health care system continues to bind health care reformers in Canada today.

The most important effect this institutional settlement has had on health care reform revolves around the way in which it has cemented a stable constituency for public health care in Canada.[46] Since there can be no extra billing for medically necessary hospital and physician services under federal legislation in Canada, this means that affluent individual citizens do not have access to a separate private health care system. The fact that there is this broad stable constituency for publicly funded health care in Canada means that everyone has a stake in preserving the quality and comprehensiveness of the existing system and

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44. ROY J. ROMANOW, COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA, BUILDING ON VALUES: THE FUTURE OF HEALTH CARE IN CANADA 28 (2002).

45. Robert G. Evans, *Financing Health Care: Options, Consequences, and Objectives*, *in* 1 THE FISCAL SUSTAINABILITY OF HEALTH CARE IN CANADA: ROMANOW PAPERS 139, 166-72 (Gregory P. Marchildon et al. eds., 2004).

46. *See* Jacob S. Hacker, *Privatizing Risk Without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States*, 98 AM. POL. SCI. REV. 243, 247 (2004).

any reforms that threaten this will be politically infeasible because of the high risk of electoral retribution. In effect, all Canadians are in the same risk community and for this reason share a commitment to resist reform that constitutes retrenchment.[47]

POSITIVE FEEDBACK IN A HOSPITAL-CENTERED SYSTEM

I have above described how the institutional settlement of excluding user fees and extra billing as a revenue source for Medicare emerged in 1957, how it survived a major challenge in the 1970s, and how it evolved over the past fifty years. The cost-sharing approach the federal government took in the 1957 Hospital and Diagnostic Services Act impacted not simply how Medicare was funded, it also shaped significantly how publicly funded health care has been delivered in Canada. For nearly fifteen years, until all of the provinces joined the federal government's cost sharing program for physicians in 1971, during which there was rapid expansion of Canada's health care system, the federal government provided matching funds only for hospital and diagnostic services. The 1957 Act excluded matching funds for psychiatric or mental hospitals, laboratory and clinical services performed outside of hospitals, and nursing homes for the aged among other basic components of a mature health care system.

One of the most immediate consequences of having universal public insurance only in hospitals was that there was an incentive to expand the services provided by general hospitals. In Ontario, for example, most large hospitals added a psychiatric ward. Similarly, most Ontario laboratory work was carried out in hospitals rather than in private labs. For patients without insurance for physician services, emergency wards in hospitals became a logical first point of contact when health care concerns arose.

This expansion of services provided by general hospitals was for the most part supported by provincial governments. The reason was simple: the federal government had an obligation to pay for half the cost of those services only

47. Susan Giaimo has made this point in general about universal health care systems. *See* Susan Giaimo, *Who Pays for Health Care Reform?*, *in* THE NEW POLITICS OF THE WELFARE STATE 340, 341 (Paul Pierson ed., 2001).

when they were provided by hospitals. In the language of the 1960s, the provincial governments were spending fifty cent dollars. This sort of spending structure during the 1960s created a hospital-centered publicly funded health care system. Hospitals are still by far the biggest expenditure in Canada's health care system.

One short-term effect of this expansion of services provided by hospitals was that it greatly increased unnecessarily the actual cost to the federal government.[48] Moreover, it meant that there were many services being provided in high cost general hospitals that could have been provided more cheaply elsewhere. This point about increased cost of the program should not be confused with the issue that received a great deal of attention among American researchers at the time. Their question was whether providing patients with free hospitalization would result in a dramatic increase in hospitalization, in effect causing a rush to hospitals. The evidence showed, however, that this did not happen in Canada following the 1957 Hospital and Diagnostic Services Act.[49] In other words, a universal publicly funded hospital insurance system did not lead to increased utilization of existing patient services.

The fact that the publicly funded health care system in Canada was initially so hospital-centered continues to constrain health care reform today because of its positive feedback effects that reinforce the status quo. Recall that positive feedback occurs when an existing state of affairs is self-reinforcing in the sense that it is difficult or costly to change the status quo and switch to another state of affairs. Two very important and related factors need to be highlighted. The first factor is that the workforce of hospitals increased dramatically after 1957. This increase did not reflect a dramatic increase in demand for patient care for traditional hospital services–there is no evidence of such an increase–but rather the expansion of services and resources hospitals offered. The second factor is that hospital workplaces became a major site for unionization. At present, every hospital in Canada has a unionized workforce of allied support workers and nurses. The initial reason for high rates of unionization in hospitals was

48. *See* TAYLOR, *supra* note 23, at 235.

49. *See* EVANS, *supra* note 22, at 160-64; TAYLOR, *supra* note 23, at 234.

transparent: "government-assured financial support for hospitals . . . [created] pressures for wage and benefit parity with the private sector."[50] Indeed, the overwhelming evidence is that the dramatic upward spiraling of hospital costs in the 1960s is best explained by the increased earnings of (previously underpaid) hospital workers.[51] The long term effect is, however, a large unionized workforce centered in hospitals.

These two factors bring to the forefront the positive feedback effect of Canada having developed a hospital-centered publicly funded health care system. In 2003, there were 537,000 people employed in Canadian hospitals, approximately one-third of them in Ontario.[52] Although this total had declined 6.3% from 1991, this still amounts to one of the largest concentrations of unionized workers in the country.[53] The total workforce in Canada in 2004 amounted to 15.7 million people.[54] Thus, one in thirty work in hospitals. The result is that when proposals for health care reform affect hospitals, there is immense pressure to consider the implications for such a large portion of the Canadian workforce. In particular, concerns about job and income security for these workers becomes one of the biggest factors to consider in any feasible reform to the health care system. Not surprisingly, in recent years there have been a series of influential studies, often supported by union research funds, focused on how health care reforms affect the working conditions and long term employment prospects of hospital workers.[55] Moreover, there is now

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50. LeClair, *supra* note 20, at 63.

51. Robert Evans, *Beyond the Medical Marketplace: Expenditure, Utilization and Pricing of Insured Health in Canada*, *in* HEALTH INSURANCE: CAN WE LEARN FROM CANADA?, *supra* note 20, at 151.

52. Statistics Canada, Employees in Health Care and Social Assistance, *at* http://www.statscan.ca/english/freepub/71-222-XIE/2004000/chart-e31.htm (last modified Nov. 17, 2004).

53. KENT V. RONDEAU & TERRY H. WAGAR, WORKFORCE REDUCTION PRACTICES IN CANADIAN HOSPITALS 1 (1998), *available at* http://www.industrialrelationscentre.com/infobank/current_issues_series/workforce_reduction_practices_in_canadian_hospitals.pdf.

54. Statistics Canada, Labour Force Survey, *at* http://www.statcan.ca/english/Subjects/Labour/LFS/lfs-en.htm (last modified Mar. 6, 2005).

55. *See, e.g.*, PAT ARMSTRONG & HUGH ARMSTRONG, WASTING AWAY: THE UNDERMINING OF CANADIAN HEALTH CARE, (2d ed. 2003); PAT ARMSTRONG ET AL.

recognition that the complex issues of human resources are integral to effecting change in Canada's health care system.[56]

The limitations this sets on health care reform are evident in Ontario over the past year. On June 7, 2004, the Ontario Legislature enacted Bill 8, The Commitment to the Future of Medicare Act. This Act included provisions designed to make hospitals more accountable for their spending and prohibited them from running annual operating deficits. The practice in the province has been for most hospitals to run deficits, which at the year's end, the province would provide additional funding to cover. The provincial government's objective was to stabilize its funding by ending this practice. The Act also anticipated the shifting of services provided in hospitals to more community-based provision. As the provincial government prepared for its 2005 Ontario Budget, which would implement the main provisions of Bill 8, the Ontario Hospital Association, which represents all of the hospitals in the province, presented to the legislature in January 2005 its recommendations for the new budget. The main force of the presentation was precisely to highlight the job losses that would result from the implementation of Bill 8's provisions – 2000 jobs this year, 8700 next year, and more to come the year after.[57] In order to avoid these huge layoffs, the Ontario Hospital Association recommended that the province provide "transitional funding" and increase the individual budgets of hospitals.[58] Of course, if the province were to follow these two recommendations, much of its

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"HEAL THYSELF": MANAGING HEALTH CARE REFORM (2000).

56. *See, e.g.*, PAT ARMSTRONG & HUGH ARMSTRONG, *Planning for Care: Approaches to Human Resources Policy and Planning in Health Care*, *in* 2 CHANGING HEALTH CARE IN CANADA: ROMANOW PAPERS 117 (Pierre-Gerlier Forest et al. eds., 2004); Gail Tomblin Murphy & Linda O'Brien-Pallas, *How Do Human Resource Policies and Practices Inhibit Change in Health Care? A Plan for the Future*, *in* 2 CHANGING HEALTH CARE IN CANADA: ROMANOW PAPERS 150 (Pierre-Gerlier Forest et al. eds., 2004).

57. Ontario Hospital Association, Presentation to the Standing Committee on Finance and Economic Affairs, Legislative Assembly of Ontario, http://www.oha.com/client/OHA/OHA_LP4W_LND_WebStation.nsf/page/Presentation+to+the+Standing+Committee+on+Finance+and+Economic+Affairs (last visited May 22, 2005).

58. *See id.*

anticipated benefit of undertaking the reforms would be lost.

The sheer size of the hospital sector as a proportion of the health care system and its resources also contribute to the positive feedback effect. The Ontario Hospital Association and the unions have the funds to spend on elaborate public relations campaigns designed to sway public opinion. Moreover, both can afford political lobbyists to directly access legislators and civil servants in the Ministry of Health. In these two respects, these organizations are quite unique in making their voices heard in debates about health care reform in Ontario. As I already indicated above, they also are able to fund research that investigates the negative impact of various health care reform options and, in this way, put pressure on those proposing a reform agenda to concede that deviations from the status quo will have costs.

HEALTH CARE REFORM IN THE FACE OF POLICY LEGACIES AND PATH DEPENDENCY

Above, I have argued that the fact that hospitals were the first site of universal publicly funded insurance in the 1950s has left a policy legacy that still impacts the prospects for health care reform today. In particular, I have shown how the institutional settlement against extra billing and the positive feedback dynamics of a hospital-centered health care system constrain the path for reform. Ultimately, at the centre of the analysis of Canadian health care policy offered here is an image of health care policy as a moving picture or film as opposed to a snap shot.[59] The predominant approach among policy analysts is to offer a single snap shot of the Canadian health care system, in effect, describing the health care system at some specific point in time. This sort of snapshot approach is the one that has most influenced the health care reform agenda. Yet, it is problematic precisely because it fails to capture how policy legacies actually work (e.g., through institutional settlements and positive feedback mechanisms) and

59. This metaphor is borrowed from Paul Pierson, *Not Just What, But When: Timing and Sequence in Political Processes*, 14 STUD. AM. POL. DEV. 72 (2000). *See also* Kathleen Thelen, *Timing and Temporality in the Analysis of Institutional Evolution and Change*, 14 STUD. AM. POL. DEV. 101 (2000).

therefore limits the vision of those who seek effective health care reform. Instead, by not accommodating for the policy legacies and path dependency in the development of Canada's health care system, the health care reform agenda is characterized by a recurring pattern of failed efforts to build new institutions.

Institutional settlements and positive feedback mechanisms suggest two strategies for pursuing the health care reform agenda without necessarily building brand new institutions. One strategy is that of *internal conversion.* Internal conversion involves altering the aims or operations of an existing institution without altering its formal structure.[60] Institutional settlements in health care policy such as the exclusion of extra billing and user fees for medically necessary hospital and physician services are especially susceptible to conversion. One way to view the recommendations of the Hall commission in 1980 and subsequent adoption of those recommendations by the Trudeau administration in its enactment of the 1984 Canada Health Act is in terms of internal conversion. Leaving intact the idea that the federal government's contribution would be reduced if user fees or extra billing occurred for medically necessary services, the rationale was converted from one about the fairness of the provincial government not matching the federal government's share to one about user fees and extra billing constituting a barrier to access for patients.

"The notion of conversion," observes Thelen, "provides an analytic point of departure for understanding how institutions created for one set of purposes come, in time, to be turned to whole new ends."[61] Yet, conversion can also have its pitfalls. In its 2004 provincial budget, the newly elected Liberal Government in Ontario introduced what it called a Ontario Health Premium. This premium was to range from $300 to $900 for each working adult, depending on his or her income. During the election, the party had promised not to raise taxes, so by calling it a premium, it appeared more like a payment for health insurance than a new tax. By invoking the language of premiums, the government was attempting to convert an earlier

60. *See* Hacker, *supra* note 46, at 258.

61. THELEN, *supra* note 14, at 36.

institution—Ontario Health Insurance Plan (OHIP) premiums had existed for twenty years in Ontario before they were abolished in 1987, although Alberta and British Columbia continue to have premiums—into a new revenue source for the provincial government. The Ontario Health Premium is designed to be paid for by individuals; the government did not want to impose a new sort payroll tax on employers. Yet, precisely because it sought to convert the institution of OHIP premiums, the government's new scheme has been subverted by that legacy. In the 1970s and 1980s, many unions negotiated collective agreements with employers that provided for the employer to pay the OHIP premiums for individuals and their families. Collective bargaining since then often did not strip this benefit from the collective agreement after the premiums were abolished in 1987. This has raised the possibility that some employers will be required to pay the new Ontario Health Premium for its employees under the conditions of their collective agreement that has the employer paying the OHIP premium. Two very different conclusions have been reached in the three unreported labor arbitration cases where this situation has arisen.[62] In two cases, the arbitrator ruled that the employer was not required to pay the new Ontario Health Premium, even though the collective agreement had not been stripped of the earlier condition that the employer pay the OHIP premium. In the other, the arbitrator ruled that the employer was bound to pay the new Ontario Health Premium.

The other strategy is institutional layering. Institutional layering involves developing new institutions and policies without the elimination of older or established institutions.[63] Layering occurs to the extent that these new institutions and policies are layered on top of the existing institutions and in a sense operate in a complementary

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62. *See* Guy Giorno, *Who Pays Ontario Health Premium Tax? Dispute Escalates*, Fasken Marineau Alert (Fasken Marineau) Nov. 2004, at 1 (discussing the following three cases: Coll. Comp. and Appointments Council v. O.P.S.E.U. (Oct. 29, 2004) (Shime, Arb.); Lapointe Fisher Nursing Home v. U.F.C.W. Local 175/633 (Oct. 6, 2004) (Barrett, Arb.); Jazz Air Inc. v. Air Line Pilots Ass'n Int'l (Sept. 27, 2004) (Teplitsky, Arb.)), *available at* http://www.fasken.com/web/fmdwebsite.nsf/0/2759253F3B1B30A585256F3C00468294?OpenDocument.

63. *See* Hacker, *supra* note 46, at 248-49; THELEN, *supra* note 14, at 35-36.

fashion. Although institutional layering entails reform of formal health care policy, it is noteworthy because it adds complexity to the health care system, whereas reforms that replace or eliminate existing institutions with new ones are a type of simplification. One metaphorical way to think about institutional layering is in terms of an organism: layering involves grafting on another appendage. The effects of layering are significant because in a complex system such as Canada's health care system, there are likely to be unintended and unanticipated consequences because other institutions adapt to the layering, which in turn can lead to major changes in a non-linear fashion.[64]

Institutional layering in health care can take different forms. One form is to add institutions that are explicitly involved in the delivery of health care. An example might be the establishing of convenient neighborhood after-hours drop-in clinics for families with children. These clinics obviously would reduce the demands on more expensive hospital emergency departments. But they might also impact primary care in the sense that they expose patients to units that provide primary care in a forum other than the familiar single physician practice. The establishment of these clinics constitutes a form of layering because it does not involve eliminating or closing hospital emergency departments, nor does it involve pressuring family physicians to join larger clinic-style practices. Another example of primary care reform might be to introduce financial incentives, similar to those that currently exist for those willing to practice in remote northern areas, for new physicians or students still in medical school to join larger clinic style practices rather than to open or buy a more traditional family practice.

Another form of institutional layering could graph on institutions that reflect the significant amount of recent research showing the social determinants of health.[65] Government programs that focus on early childhood

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64. See in particular Sholom Glouberman & Brenda Zimmerman, *Complicated and Complex Systems: What Would Successful Reform of Medicare Look Like?*, *in* 2 CHANGING HEALTH CARE IN CANADA: ROMANOW PAPERS 22 (Pierre-Gerlier Forest et al. eds., 2004).

65. *See, e.g.*, SOCIAL DETERMINANTS OF HEALTH (Michael Marmot & Richard G. Wilkinson eds., 1999); SOCIAL DETERMINANTS OF HEALTH: CANADIAN PERSPECTIVES (Dennis Raphael ed., 2004).

development are a good example. There are indicators that the expansion of these kinds of programs in France has been a major factor in any explanation for France's successful health care reform in the past decade.[66] These programs constitute a form of institutional layering precisely because they do not replace or eliminate the traditional focus of Canada's publicly funded health care system on hospitals and physician services. Indeed, institutional layering in a mature health care system makes sense precisely because of the complex determinants of good health.

66. *See* SOCIAL DETERMINANTS OF HEALTH, *supra* note 65, at 37.