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Political Elites and their Influence on Health-Care Reform in Canada

by

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Highlights

- Two core bargains underpin Medicare: the ‘private practice, public payment’ bargain with physicians, and the ‘private ownership, public payment’ bargain with hospitals. Provincial government officials have the sole authority to make decisions about physician and hospital services. Three groups have the most to win or lose from these decisions: federal government officials, physician associations, and hospital associations. These groups can be considered political elites.
- Political elites’ support for and opposition to reforms that implicate the core bargains have not remained constant over time. Their positions have always hinged on the circumstances surrounding the proposals in play at any given time, including the strength of the forces supporting changes to the core bargains.
- Federal government officials appear to have been most influential when the electoral resources that accrue from the ‘public payment’ element of the core bargains were at stake. Physician associations appear to have been most influential when the professional autonomy that follows from elements of the core bargain with physicians was at stake. Hospital associations have been far less influential.
- Political elites have exerted their influence directly by voicing their opposition publicly, as well as behind closed doors. But they have also exerted their influence indirectly by engendering an anticipatory reaction on the part of provincial government officials: these officials anticipated opposition and did not feel they had the necessary political resources to take on this opposition.
- Physician associations’ potential influence on subsequent reform proposals that implicate the core bargains appears little different after a decade of service-integration efforts. Hospital associations’ potential influence appears, if anything, further diminished.
- Three ways forward are proposed:
 - Establish a credible commitment between the federal and provincial governments about the public payment element of the two core bargains to stop the finger pointing that allows both to avoid accountability.
 - Establish a credible commitment between provincial governments and physician associations about the professional autonomy elements of the core bargain with physicians to reconcile physicians’ strong desire for professional autonomy with many other groups’ strong desire for new primary-care delivery models.
 - Plan now to increase opportunities for and diminish constraints on the next round of health-care reform by investing in training for new groups to acquire the knowledge, skills, and political resources to act as a countervailing influence on political elites privileged by past or current reforms.

Executive Summary

Provincial government officials have the sole authority to make decisions about physician and hospital services. Three groups have the most to win or lose from these decisions: federal government officials, physician associations, and hospital associations. Reform that involves these groups, which can be called political elites, is perceived to be difficult to achieve without their support. This paper addresses the question: “How do political elites’ interests and perspectives influence change in health care, either as barriers to or facilitators of change?”

Studying Political Elites

The influence of political elites on change in health care can vary dramatically according to the domain under discussion. This paper focuses on the influence of political elites on possible changes to the two core bargains that underpin Medicare:

1. private practice for physicians with (first-dollar, one-tier) public (fee-for-service) payment; and
2. private (not-for-profit) hospitals with (first-dollar, one-tier) public payment.

These bargains embody many of the core values that Canadians hold, rule out some policy alternatives under discussion, and influence the likelihood that seemingly unrelated policy alternatives could be adopted. This paper adopts a case survey approach to study the influence of political elites on real and proposed changes to the two core bargains, drawing conclusions from a survey of detailed case studies of particular policy decision-making processes that have been conducted by others.

Political Elites’ Support for and Opposition to Reforms that Implicate the Core Bargains

Political elites’ support for and opposition to reforms that implicate the core bargains have not remained constant over time. Political elites’ positions appear always to have hinged on the circumstances surrounding these decisions. Certainly, any decision that would have (on balance) diminished the electoral or financial resources of a particular group, or threatened its autonomy, has typically been opposed by the group (and vice versa). But political elites’ positions are also influenced by the strength of the forces supporting the core bargains.

Political Elites’ Influence on Reforms that Implicate the Core Bargains

Federal government officials appear to have been most influential when the electoral resources that accrue from the ‘public payment’ elements of the core bargains were at stake (e.g., banning extra-billing by physicians). Physician associations appear to have been most influential when the professional autonomy that follows from the ‘private practice’ and ‘fee-for-service’ elements of the core bargain with physicians was at stake (e.g., primary-care reform).

How Political Elites Influence Reforms that Implicate the Core Bargains

Federal government officials have exerted their influence directly – by voicing their opposition both publicly and behind closed doors – to help create, entrench, and maintain the public payment element of the two core bargains. But they have also reaped the benefits of their sources of influence in indirect ways, by engendering an anticipatory reaction on the part of provincial government officials: these officials anticipated opposition and did not feel they had the necessary political resources to take on this opposition. Physician associations have also exerted their influence both directly and indirectly to entrench the ‘private practice’ and ‘fee-for-service payment’ elements of their bargain with provincial governments. Physician strikes have been rare in Canada and largely unsuccessful.

Service-Integration Efforts and their Effects on Political Elites

Over the last decade, a number of service-integration efforts – most notably regionalization – have had profound effects on hospitals’ autonomy and, if anything, have further diminished the potential influence of hospital associations on reforms that implicate the core bargains. Service-integration efforts such as primary-care reform pilot projects and regionalization have typically preserved physicians’ autonomy and largely left them alone as the fixed components in a system around which everything else is shuffled. Physician associations’ potential influence on subsequent reform proposals that implicate the core bargains appears little different after a decade of service-integration efforts.

Caveats

This paper addresses the influence of federal government officials, physician associations, and hospital associations on decisions in which the core bargains with physicians and hospitals were implicated. But the efforts of these political elites in other domains can have important spillover effects on the ‘core’ of our provincial health-care systems (i.e., on hospital-based and physician-provided care). Also, this paper shines a light on political elites as an important and often neglected factor in the dynamics of health-care reform. But their role can be overstated. Other factors, such as public opinion, research knowledge and political institutions, also have a profound influence on health-care reform.

Implications

Based on this analysis, I propose three ways forward. First, establish a credible commitment between the federal and provincial governments about the public payment element of the two core bargains and any new bargains under consideration (e.g., prescription drugs and home care). The most pressing concern for health care in Canada is the finger pointing between federal and provincial government officials that allows both to avoid accountability (and, when appropriate, blame). Second, establish a credible commitment between provincial governments and physician associations about the professional autonomy element of the core bargain with physicians. The second most pressing concern for health care in Canada is the inability of

provincial government officials and physician associations to reconcile physicians' strong desire for professional autonomy with many other groups' strong desire for new primary-care delivery models. Third, plan now to increase opportunities for and diminish constraints on the next round of health-care reform by investing in training for new groups (e.g., nursing and home care associations) to acquire the knowledge, skills, and political resources to act as a countervailing influence on political elites privileged by past or current reforms.

Introduction

There have been numerous and sustained calls for significant reform of health care in Canada. Commissions and task forces have recommended many changes, including service integration, user charges, primary-care reform, and evidence-based practice (see, for example, Alberta – Premier’s Advisory Council on Health 2001; Quebec – Commission d’étude sur les services de santé et les services sociaux 2001; Saskatchewan – Commission on Medicare 2001). The Canadian public began to call for large changes in the health-care system in the early 1990s – a significant change after many years of being generally satisfied with the system, unlike the citizens of many other countries (Donelan, Blendon, Schoen, et al. 1999). But reform has been difficult to achieve (Lewis, Donaldson, Mitton, and Currie 2001). In other countries, scholars and the media often identify political institutions – especially the many veto points at which opponents can kill reform efforts, coupled with powerful opponents to reform – as an important explanation for inertia (Immergut 1992; Marmor 2000; Morone 1992). In Canada, with our relative lack of veto points, scholars and the media are more likely to identify political elites as a reason for our lack of health-care reform.

Who are these political elites, and how do they influence the prospects for change and for improved cooperation in bringing about change? The elites can include government officials at both the federal and provincial level who are engaged in constant finger pointing over health care, with federal government officials repeatedly saying to their provincial counterparts “administer the system better” and with provincial government officials responding “give us the money we need to run the system properly.” Meaningful reform of any kind is difficult to achieve amidst such a dynamic, which some have called the “politics of blame avoidance” (Weaver 1986; Pierson 1995). The elites can also include representatives from the dominant health-care provider associations, especially physician and hospital associations (and more recently regional health authority associations), and representatives from biomedical industries and disease-based groups. Meaningful reform that involves these groups is perceived to be difficult to achieve without their support.

This paper addresses the general question: “How do political elites’ interests and perspectives influence change in health care, either as barriers to or facilitators of change?” More specifically, the paper addresses the following four questions:

1. Which major reform efforts (both structural and substantive) have generally been supported by political elites, which have been opposed, and what explains these patterns of support and opposition?
2. Which major reform efforts (both whether change occurs and the nature of the change) have generally been most influenced by political elites, which have been least influenced, and what explains these patterns of influence or lack of influence?
3. How do political elites influence major reform efforts?
4. To what extent have regionalization and other approaches to integrating services altered whether and how political elites influence major reform efforts?

The paper does not, however, assess the relative importance of political elites compared to other factors (such as public opinion, research knowledge, or political institutions) in their influence on health-care reform; its goal is to shine a light on political elites as an important and often neglected factor in the dynamics of health-care reform.

Studying Political Elites

The influence of political elites on change in health care can vary dramatically according to the domain under discussion. For example, physician associations may be particularly influential when Canadian provincial governments are considering changes to physician-remuneration mechanisms. Pharmaceutical companies may exert significant leverage over changes to the Canadian federal government's prescription-drug patent legislation. These political elites do not arise spontaneously, however, they are in large part created. Past reforms have privileged some groups over others, and over long periods of time groups acquire the knowledge, skills, and political resources to occupy the position created for them (Pierson 1993; Pierson 2000). A physician association in a more market-driven health-care system such as the United States would exert little influence when health-maintenance organizations consider changing how they remunerate physicians. Similarly, pharmaceutical companies would have little leverage in a country that lacks a large research-based pharmaceutical industry.

This paper focuses on the influence of political elites on possible changes to the two core bargains that underpin Medicare through the *Canada Health Act*:

1. private practice for physicians with (first-dollar, one-tier) public (fee-for-service) payment (called the 'private practice, public payment' bargain by Naylor 1986); and
2. private (not-for-profit) hospitals with (first-dollar, one-tier) public payment (the 'private ownership, public payment' bargain).

The payment features of the two core bargains are common to both physician-provided and hospital-based services: cost-sharing is prohibited for insured services (which guarantees first-dollar coverage), as is private insurance to cover these insured services (which supports a one-tier system). Most Canadian physicians work in private practice and are remunerated on a fee-for-service basis. Exceptions include physicians working in organizations such as Quebec's Centres locaux de services communautaires or Ontario's Health Service Organizations. Almost all Canadian hospitals operate as not-for-profit organizations owned by local communities or religious charities. Exceptions include publicly owned facilities such as the now phased-out public psychiatric hospitals and the for-profit cosmetic surgery facilities in Ontario.

Studying the influence of political elites on real and proposed changes to these two core bargains can provide a particularly illuminating window into the politics of health-care reform in Canada. These bargains embody many of the core values that Canadians hold: an aversion to people profiting from others' illness and an attachment to allocating health care based on need, not ability and willingness to pay (Mendelsohn 2002). These bargains also rule out some policy alternatives under discussion, such as user fees and a two-tier system for insured hospital-based and physician-provided services, and the bargains would have to be re-opened before these policy alternatives could be implemented. Moreover, these bargains influence the likelihood that seemingly unrelated policy alternatives will be adopted: service integration and major technology investments in primary care, for example, are unlikely when many physicians continue to work as solo practitioners in private practice.

This paper adopts a case survey approach to study the influence of political elites on real and proposed changes to the two core bargains, drawing conclusions from a survey of detailed case studies of particular policy decision-making processes that have been conducted by others (Gray 1991; Hacker 1998; Maioni 1995; Maioni 1998; Naylor 1986; Taylor 1987; Tuohy 1999). Sampling from the pool of available political analyses was conducted in two stages: 1) decisions in which a core bargain was implicated were identified (for a total of six decisions); and 2) political elites that faced concentrated benefits or costs in each decision (typically physician associations and hospital associations) were identified. Data about political elites' support for and opposition to each of the six decisions, and their influence on each decision, were then extracted from the political analyses. In doing so, however, the paper strives to recognize the dynamic nature of these decision-making processes.

Two definitional issues arise from this approach. First: What constitutes a political elite when the analysis is focused on decisions involving the two core bargains? A group can comprise a political elite when its voice is privileged in a debate about a change to one of the core bargains. Physician associations like the Canadian Medical Association and their provincial counterparts clearly fall into this group (while provincial medical colleges, the profession's regulatory bodies, do not). Hospital associations also fall into this group. But a group need not be a stakeholder to be considered a political elite. The federal government has responsibility as an overseer and partial source of finance: its voice is clearly privileged in a debate about a change to one of the core bargains, so it too can be considered a political elite. For the purposes of this paper, provincial governments are not considered to be a political elite, however, because they constitute the final authority on physician and hospital services (as established by the *British North America Act*). Provincial government officials are the decision-makers that political elites try to influence. For both political elites and the provincial government officials that they are trying to influence, it is important to recognize that groups are not monolithic: physician and hospital associations and government officials, for example, are comprised of sub-groups that may hold very different views than the dominant faction.

Second: What constitutes health-care reform when the analysis is focused on decisions involving the two core bargains? For simplicity, the paper uses the term health-care reform to refer to changes to the two core bargains that underpin Medicare (i.e., the core bargains with physicians and hospitals). Whether these changes constitute 'major' or 'meaningful' reform, a good outcome or a bad outcome, a likely possibility or a remote one, is left to the discretion of the reader. My colleagues and I have argued elsewhere, based on a historically grounded political analysis, that incremental changes probably offer more potential in the long-run for primary-care reform given that such reform likely requires a revisiting of the core bargain with physicians (Hutchison, Abelson, and Lavis 2001) – a possibility that we considered unlikely at the time. But this paper is about identifying insights based on an analysis with a longer time frame – a time frame that includes the decisions to create and entrench the two core bargains – and thus about identifying insights that can be used to inform whether and how to craft a new political bargain.

Political Elites' Support for and Opposition to Reforms that Implicate the Core Bargains

Five major decisions about Canada's provincial health-care systems have implicated a core bargain (Table 1). In three decisions that involved all provincial health-care systems, federal government officials faced concentrated benefits (e.g., continued electoral office with a minority government in 1966) and concentrated costs (e.g., a substantial increase in financial obligations in 1945). In the three decisions that implicated the core bargain with physicians, the members of physician associations faced concentrated benefits (e.g., guaranteed payment for services provided by physicians in Saskatchewan in 1961 and across the country in 1966) and concentrated costs (e.g., lost income from extra-billing for physician services in 1984). Similarly, in the two decisions that implicated the core bargain with hospitals, the members of hospital associations faced concentrated benefits (e.g., guaranteed payment for services provided by hospitals in Saskatchewan in 1946 and across the country in 1957) and concentrated costs (e.g., lost income from patients who could pay for a 'higher' level of care in 1957).

The one major proposal that was not acted upon would have generated additional bargains involving prescription drugs, home care, and dental care. Members of pharmaceutical company associations, nursing associations, and dental associations would have faced concentrated benefits and costs if this recommendation had been acted upon. Because these political elites did not face concentrated benefits and/or costs in subsequent decisions, however, the remainder of the discussion will focus on federal government officials, physician associations, and hospital associations.

Political elites' support for and opposition to reforms that implicate the core bargains have not remained constant over time (Table 1). Federal government officials, for example, weakly opposed establishing the public payment bargain with hospitals *initially*, in large part because of concerns about its budgetary implications. But these officials came around to weakly support the bargain when Ontario's strong declaration of support brought to the fore electoral advantages that outweighed any financial concerns. Physician associations provided grudging support or at least muted opposition to the health insurance proposal in 1945 and yet they opposed all subsequent reforms that implicated the core bargains.

What explains the pattern in political elites' support for and opposition to reforms that implicate the core bargains? Political elites' positions appear always to have hinged on the circumstances surrounding these decisions. Certainly, any decision that would have (on balance) diminished the electoral or financial resources of a particular group, or threatened its autonomy, has typically been opposed by the group. The opposite also holds true: any decision that would have increased a group's electoral or financial resources or its autonomy has typically garnered their support. But a number of political analysts have concluded that political elites' positions are also influenced by other contextual factors, most notably by the strength of the forces supporting the core bargains (Hacker 1998; Maioni 1998; Taylor 1987; Tuohy 1999). Physician associations, for example, provided grudging support or at least muted opposition to one proposal that enjoyed widespread political and public support - the health insurance proposal in 1945. Given the limited opportunities for a veto in a parliamentary system with a party-government regime such as we have in Canada, once support builds for a particular decision it can become an exercise in frustration to oppose it formally (Hacker 1998; Maioni 1998).

Table 1 Political Elites' Responses to Major Decisions and Recommendations Involving the Core Bargains with Physicians and Hospitals		Response to Decision or Recommendation ²		
		Major Elements	Federal Government Officials	Physician Associations
Decisions ¹				
Health Insurance Proposal (1945)	<ul style="list-style-type: none"> Failed attempt to introduce coverage for general practitioner-provided care, visiting nurse-provided care, and hospital-based care and (in later stages) medical specialist-provided care, other nurse-provided care, pharmaceuticals, laboratory services, and dental services 	Weak support (relative to support in some provinces such as Saskatchewan)	Weak support	Weak support
Saskatchewan Hospital Services Plan (1946)	<ul style="list-style-type: none"> Established (first-dollar, one-tier) public payment for hospital-based care Enshrined the 'private ownership / public payment' bargain for hospitals 	Neutral	Weak opposition	Weak opposition
National Hospital Plan (1957)	<ul style="list-style-type: none"> Extended public health care regime to rest of Canada 	Weak opposition then weak support (relative to support in some provinces such as Ontario)	Weak opposition	Weak opposition
Saskatchewan Medical Insurance Act (1961)	<ul style="list-style-type: none"> Established (first-dollar, one-tier) public (fee-for-service) payment for physician-provided care Enshrined the 'private practice / public payment' bargain for physicians 	Neutral	Strong opposition (including a physicians' strike in 1962)	Not assessed
National Medical Care Act (1966)	<ul style="list-style-type: none"> Extended public health care regime to rest of Canada 	Weak support (relative to support of coalition partner and to support in some provinces such as Saskatchewan)	Weak opposition in some provinces and strong opposition in Quebec (including a physicians' strike in 1971)	Not assessed
Canada Health Act (1984)	<ul style="list-style-type: none"> Banned extra-billing by physicians (thereby reaffirming first-dollar coverage for physician-provided care) Entrenched the 'private practice / public payment' bargain for physicians 	Strong support	Weak opposition in some provinces and strong opposition in Ontario (including a physicians' strike in 1986)	Not assessed

¹ Sources: Taylor (1987), Tuohy (1999).

² Sources: Gray (1991), Hacker (1998), Maioni (1995), Maioni (1998), Naylor (1986), Taylor (1987), Tuohy (1999).

A caveat: deducing political elites' support for and opposition to reforms that implicate the core bargains can be difficult for political analysts. The historical record can sometimes tell a very different story when groups like federal government officials and physician and hospital associations hold privileged positions in decision-making, as they do when the decisions implicate the core bargains. Federal government officials, for example, can convey their views informally through intergovernmental fora. Similarly, physician and hospital associations are often given the opportunity to participate in the decision-making process through "joint management committees" in exchange for the information and expertise they can bring to the process and the compliance of their members once a decision has been made. This form of elite accommodation has been called a "clientele pluralism" network (Coleman and Skogstad 1990).

Political Elites' Influence on Reforms that Implicate the Core Bargains

Despite the opposition to the introduction of the core bargains (and their entrenchment in the *Canada Health Act*) and the support in some quarters for these core bargains to be repealed, the 'private practice, public payment' bargain with physicians and the 'private ownership, public payment' bargain with hospitals remain intact. The majority of physicians continue to work in private practice and the vast majority of physicians have the option to do so. Almost all hospitals are private, not-for-profit facilities. Insured physician-provided and hospital-based services continue to be paid for by provincial health-care insurance plans. Physicians and (to some degree) hospitals remain the fixed components of a system around which everything else is shuffled. By this I do not mean that the financial resources of physicians and the financial resources and autonomy of hospitals have not suffered over the last decade, but that the core bargains have proved remarkably resilient, in large part because of the influence of political elites.

Two groups of political elites appear to have most influenced both whether reform that implicates the core bargains occurs and the nature of the change (Gray 1991; Hacker 1998; Maioni 1998; Taylor 1987; Tuohy 1999). Federal government officials have been influential as a force for the entrenchment of the core bargains (e.g., maintenance of public payment for insured physician-provided and hospital-based services in the *Canada Health Act* of 1984) and as a force against proposed repeals of an element of the core bargains (e.g., introduction of user charges and thus a move away from first-dollar coverage of these insured services). Physician associations have also been influential as a force for the entrenchment of elements of the core bargains (e.g., maintenance of private practice and fee-for-service remuneration in the *National Medical Care Act* of 1966) and as a force against proposed repeals of an element of the core bargains (e.g., primary-care reform that involves a change in the physician-remuneration method from fee-for-service to capitation). Hospital associations have been far less influential, especially in recent times. Their influence was not even examined explicitly in political analyses of the *Saskatchewan Medical Insurance Act* (1961), *National Medical Care Act* (1966) or *Canada Health Act* (1984).

What explains the pattern of political elites' influence on reforms that implicate the core bargains? Consider, for example, the changes recommended by recent commissions and task forces (Table 2). Grouping the changes by policy category (following Lavis, Hurley, Ross, et al. 2002) does not provide much illumination: 'big' policy changes such as regionalization were as likely to be implemented as smaller scale policy changes such as revisions to scopes of practice. But identifying changes that implicate one of the two core bargains that have been studiously maintained for more than 30 years does provide illumination.

Federal government officials appear to have been most influential when the electoral resources that accrue from the 'public payment' elements of the core bargains were at stake. They have consistently rebuffed initiatives to increase the share of financing borne by individuals through out-of-pocket payments (i.e., user charges) or private-insurance premiums and/or create a two-tier system for physician-provided and hospital-based care. Opinion polls

clearly indicate that these initiatives would be unpopular with voters (Mendelsohn 2002). Not surprisingly, these officials have been least influential when the electoral advantages were not as clear-cut, such as with primary-care reform that involves a change to physician-remuneration methods. While federal government officials created a transition fund to promote innovation in primary-care delivery, provincial government officials have made the decisions about which models would be implemented and evaluated.

Physician associations appear to have been most influential when the professional autonomy that follows from the 'private practice' and 'fee-for-service' elements of the core bargain with physicians was at stake. For example, they have successfully opposed any primary-care reform effort that would have changed physician-remuneration methods from fee-for-service to capitation (Hutchison, Abelson, and Lavis 2001). Indeed, the professional autonomy of physicians has suffered far more at the hands of private actors in the United States than at the hands of public actors in Canada (Grumbach and Bodenheimer 1990; Schlesinger 2002). Provincial government officials have been consistently unwilling to make decisions about reforms that might undermine the core bargain that governs their relationships with physicians. That said, these officials have certainly been willing to contain costs through a number of mechanisms that targeted physicians, which is likely the domain in which physician associations have had the least influence.

Table 2 Changes Recommended by Recent Commissions and Task Forces¹			
Policy Category	Proposed Policy Change	Political Bargain Implicated?	If Political Bargain Implicated, Who Could Lose (Gain) What?
Governance	Regionalization ²	No unless hospital boards are replaced by regional boards	N/A
	Service integration ³	Yes if it involves physicians or hospitals	Physicians and hospitals could lose autonomy
	Hospital restructuring ⁴	Yes	Hospitals could lose financial resources and autonomy
Financial Arrangements	Change in public/private mix <ul style="list-style-type: none"> ▪ Increase use of for-profit delivery (one type of privatisation)⁵ ▪ Increase share of financing borne by individuals through out-of-pocket payments or private insurance premiums (another type of privatisation)⁶ ▪ Decrease share of financing borne by individuals through out-of-pocket payments or private insurance premia (e.g., pharmaceuticals and home care)⁷ 	Yes if it involves hospitals Yes if it involves physicians or hospitals No	Hospitals could lose financial resources Physicians and hospitals that treat poor (rich) patients could lose (gain) resources and federal government officials could lose electoral resources N/A
	User charges ^{7,8}	Yes if it involves physicians or hospitals	Physicians and hospitals that treat poor (rich) patients could lose (gain) resources and federal government officials could lose electoral resources

¹ For reviews of the changes recommended by commissions and task forces in the more distant past, see Angus (1991) and Mhatre and Deber (1992).
² See, for example, Quebec – Commission d’enquête sur les services de santé et les services sociaux (1988) on regionalization in Quebec, and Saskatchewan – Commission on Directions in Health Care (1990) on regionalization in Saskatchewan.
³ See, for example, Saskatchewan – Commission on Medicare (2001) on service integration through primary-care networks in Saskatchewan.
⁴ See, for example, Saskatchewan – Commission on Directions in Health Care (1990) and Saskatchewan – Commission on Medicare (2001) on hospital restructuring in Saskatchewan, and Ontario – Health Services Restructuring Commission (2000) on hospital restructuring in Ontario.
⁵ See, for example, Canada – Standing Senate Committee on Social Affairs, Science and Technology (2001).
⁶ See, for example, Alberta – Premier’s Advisory Council on Health (2001) on increasing the share of financing borne by individuals on physician-provided and hospital-based care through de-listing services and charging variable premia.
⁷ See, for example, Canada – National Forum on Health (1997) on decreasing the share of financing borne by individuals on pharmaceuticals and home care through new national programs, and Quebec – Commission d’étude sur les services de santé et les services sociaux (2001) on decreasing the share of financing borne by individuals on long-term care through a new long-term care insurance program.
⁸ User charges are defined as any cost to the patient that varies directly with the amount of services used (the more services used, the more paid). Examples include a flat charge per service, co-insurance, deductibles, de-insurance, extra-billing, taxable benefits, and medical savings accounts.

	Two-tier ^{9,10}	Yes if it involves physicians or hospitals	Physicians and hospitals that treat poor (rich) patients could lose (gain) resources and federal government officials could lose electoral resources
Delivery Arrangements	Primary-care reform with or without capitation payment for physicians ¹¹	Yes	Physicians could lose financial resources and autonomy
	Revisions to scopes of practice ¹²	No	N/A
	Evidence-based practice ¹³	No	N/A
	More health promotion	No	N/A
Program Content			

⁹ See, for example, Canada – Standing Senate Committee on Social Affairs, Science and Technology (2001) on two-tier options in Canada.

¹⁰ A two-tier system is defined as a system that allows patients to pay extra for faster, higher quality or more comprehensive physician-provided or hospital-based care (i.e., more than just amenities).

¹¹ See, for example, Quebec – Commission d'enquête sur les services de santé et les services sociaux (1988) on primary-care reform involving alternative payment mechanisms in Quebec, Saskatchewan – Commission on Directions in Health Care (1990) and Saskatchewan – Commission on Medicare (2001) on primary-care reform involving interdisciplinary teams in Saskatchewan, Quebec – Commission d'étude sur les services de santé et les services sociaux (2001) on primary-care reform involving family medicine groups in Quebec, and Alberta – Premier's Advisory Council on Health (2001) on primary-care reform involving alternative payment mechanisms in Alberta.

¹² See, for example, Ontario – Health Professions Legislation Review (1989) on revising existing scopes of practice and establishing scopes of practice for new health professions in Ontario.

¹³ See, for example, Saskatchewan – Commission on Medicare (2001) on the need for a Quality Council to facilitate evidence-based practice in Saskatchewan, and Alberta – Premier's Advisory Council on Health (2001) on goal-setting to facilitate evidence-based practice in Alberta.

How Political Elites Influence Reforms that Implicate the Core Bargains

Political elites can draw on both their political resources and their financial resources to influence reforms. Federal government officials, for example, can speak directly to Canadians about the core bargains (a topic that many Canadians want to hear about), can control the agenda at federal/provincial/territorial conferences of Ministers or Deputy Ministers at which the core bargains are discussed, and can take advantage of cleavages among their provincial counterparts on issues pertaining to the core bargains. Moreover, they can use the significant financial resources available to them to steer reforms that implicate the core bargains in the direction that suits them. Physician associations can also draw on a number of sources of influence. Their members, who are still viewed by many citizens as authoritative agents acting in their best interests, speak one-on-one with about 78% of Canadians every year (Canadian Institute of Health Information 2002). Moreover, federal and provincial physician associations have large annual budgets that can be used to pay for opinion polls and advertising campaigns. Hospital associations are in a relatively weaker position: their members have neither the professional autonomy nor direct patient contact that physicians enjoy and their budgets are a small fraction of physician associations' budgets.

Political elites can use their political and financial resources to influence reforms in one of three ways. First, and least visibly, political elites exert their influence indirectly by engendering an anticipatory reaction (Lindblom 1982) on the part of provincial government officials (see, for example, Maioni 1998, p. 157). Political elites can be influential even when they do not formally oppose a reform proposal, and this constitutes an important and often overlooked type of political power (called "the second dimension of power" by Gaventa 1980). Reform proposals may never make it past the consideration stage because provincial government officials anticipate opposition from political elites (called "dominant structural interests" by Alford 1974) and do not feel they have the necessary political resources to take on this opposition. Second, and next most visibly, political elites exert their influence directly by voicing their opposition either publicly or behind closed doors. Third, and very rarely, political elites exert their influence by taking more extreme action: going out on strike. The latter two ways to exert influence have typically been the ones studied in political analyses, in large part because they lend themselves more readily to study.

Federal government officials have successfully drawn on their political and financial resources to help to create, entrench, and maintain the public payment element of the two core bargains. They have exerted their influence directly by voicing their opposition publicly as well as behind closed doors in, for example, federal/provincial/territorial conferences. But they have also reaped the benefits of these sources of influence in indirect ways: provinces are typically loath to propose a reform that implicates the public payment element of the core bargains because they know that the reaction from the federal government will be hostile. Exceptions to this general pattern do exist: Ontario and Alberta, for example, have sometimes acted under the impression that the electoral advantage to them of being seen to oppose the federal government outweighs the risk of engendering a hostile reaction.

Physician associations have also drawn on their political and financial resources, but in their case primarily to entrench the ‘private practice’ and ‘fee-for-service payment’ elements of their bargain with provincial governments. They too have exerted their influence directly by voicing their opposition publicly as well as behind closed doors in fora like the joint management committees that many provincial governments have established in conjunction with physician associations as part of their approach to elite accommodation. And they have also reaped the benefits of their political and financial resources in indirect ways: provinces have been hesitant to propose a reform that involves a move away from private practice and/or fee-for-service remuneration. Physician strikes have, however, been rare in Canada, with only one strike in each of Saskatchewan, Quebec, and Ontario. These formal protests have never succeeded in reversing a provincial government decision and they have sometimes undermined Canadians’ respect for physicians and thus risked physicians losing an important source of influence.

Service-Integration Efforts and their Effects on Political Elites

Over the last decade a number of policy initiatives, many motivated in large part by a desire to integrate services, have had profound effects on hospitals. Most significantly, regionalization was accompanied in some provinces by the replacement of hospital boards with regional health authority boards. This change in governance altered a key element of the core bargain with hospitals: their autonomy as private institutions. In these provinces, hospitals remained publicly funded, not-for-profit facilities but hospital executives and managers now answer to boards that are accountable for the health of a geographically defined population, not to boards that are accountable for the role of a single facility in contributing to the health of a population from a (typically ambiguously defined) ‘catchment area’. No comprehensive analyses have yet been conducted to establish whether this change in governance has led to different decisions about hospital services.

But even in provinces where regionalization was not accompanied by the replacement of hospital boards with regional health authority boards and in the one province where regionalization did not take place (Ontario), hospitals’ autonomy was undermined. In Ontario, for example, a government-appointed Health Services Restructuring Commission made mock of many hospitals’ autonomy through forced closures, conversions, and mergers. As well, the Ontario provincial government has appointed trustees to take over the administration of many hospitals, and has done so far more frequently than in past decades.

Unfortunately, no comprehensive political analyses of these hospital governance decisions have been conducted to determine whether hospital associations supported or opposed them. While hospital associations appear to have had little demonstrable impact on regionalization and the forms it took in different provinces, this would need to be confirmed through document reviews and elite interviews. Some hospital executives may well have supported a regionalization proposal given that it may have given them what they wanted: a larger remit (assuming that they were appointed to a comparable executive position in a new regional health authority). And while Ontario hospitals may have played a role in the Ontario provincial government’s decision against regionalization, their autonomy was far from untouched at the end of the Health Services Restructuring Commission’s mandate.

Similarly, no political analyses have been conducted on hospital associations’ (or regional health authorities’) influence on subsequent reform proposals that implicate the core bargains. Certainly, their purview does not include these domains. For example, hospital and regional health authority associations cannot consider new financing arrangements (e.g., user charges for hospital-based and physician-provided care) or new remuneration and delivery arrangements that involve physicians. And the hospital governance decisions over the last decade have, if anything, diminished further the potential influence of hospital associations on reforms that implicate the core bargains. While it appears that regional health authority representatives have emerged as a somewhat influential political elite in Quebec – where they have had several decades to acquire the knowledge, skills, and political resources to influence some aspects of the decision-making process – and the same is occurring in provinces that undertook regionalization more recently,

the influence of regional health authority associations would also need to be confirmed through document reviews and elite interviews.

Over the last decade, a myriad of primary-care reform pilot projects – many motivated in large part by a desire to integrate services – have been launched, albeit with little apparent effect on the core bargain with physicians (Hutchison, Abelson, and Lavis 2001). These projects have typically preserved physicians' autonomy by letting them choose whether and how they participate in a project and often by including a fee-for-service element in a blended remuneration method. Regionalization also had little apparent effect on the core bargain: physician services were excluded from regional funding envelopes in every Canadian province. Again, no political analyses of these regionalization decisions have been conducted to determine whether physician associations supported or opposed them, but the decisions were certainly consistent with physicians' desire for autonomy. Physicians, if not always hospitals, remain the fixed components in a system around which everything else is shuffled.

Physician associations' potential influence on subsequent reform proposals that implicate the core bargains appears little different after a decade of service-integration efforts. The primary-care reform pilot projects and the regionalization decisions of the past decade have, if anything, confirmed the influence of physician associations on reforms that implicate the core bargain with physicians. The one change that may diminish this influence over time is physicians' work preferences, especially among female physicians who represent a growing proportion of physicians (Woodward, Ferrier, Cohen, and Brown 2001).

Caveats

This paper addresses the influence of political elites that faced concentrated benefits or costs (i.e., federal government officials, physician associations, and hospital associations) in decisions in which the core bargains with physicians and hospitals were implicated. By design, it focused on what is a relatively “closed” world (Berry 1989), albeit one that representatives from biomedical industries and disease-based groups can occasionally influence. Some groups, such as cardiovascular disease and cancer groups, may attempt to buy their way into this closed world by putting money into public/private partnerships. Other groups, such as HIV and breast cancer groups, may attempt to open it up so that they too can participate (called “socializing conflict” by Schattschneider 1970). More often, these groups remain focused on other domains, most notably primary care (e.g., Hutchison, Abelson, and Lavis 2001), chronic care (e.g., Baranek, Deber and Williams 1999), rehabilitation care (e.g., Gildiner 2001), and prescription drugs (e.g., Wiktorowicz and Deber 1997).

But the efforts of these political elites in other domains can have important spillover effects on the ‘core’ of our provincial health-care systems. For example, recent research on the rehabilitation sector, a part of the health-care system that has undergone a wholesale (and largely passive) privatisation in provinces such as Ontario over the last 15 years, has highlighted how a series of decisions made by a group of political elites – the insurers that provide automobile insurance, the employers that pay workers’ compensation premiums, the for-profit rehabilitation companies that provide rehabilitation care, and the provincial governments and boards that regulate them – has created a second-tier of rehabilitation care (Gildiner 2001). This second tier is an option of last resort for individuals who did not sustain an injury either in an automobile accident or at work, and who cannot afford to pay the full cost of care (i.e., for many of the individuals who have been treated for acute injuries by physicians or in hospitals).

This paper shines a light on political elites as an important and often neglected factor in the dynamics of health-care reform. But their role can be overstated. Other factors, such as public opinion, research knowledge, and political institutions, also have a profound influence on health-care reform. That said, we have a growing body of research knowledge about what works and doesn’t work, and we have political institutions that offer at least the potential to minimize the capacity of narrowly focused groups to veto proposed changes. The question of how best to break out of our current patterns of engagement with political elites therefore warrants consideration even if these elites are not the sole influence on health-care reform.

Implications

Based on this analysis, I propose three ways forward. The first way forward involves establishing a credible commitment between the federal and provincial governments about the public payment element of the two core bargains. The most pressing concern for health care in Canada is the finger pointing between federal and provincial government officials that allows both to avoid accountability (and, when appropriate, blame). This finger pointing has existed for a long time but it has escalated in recent years with Ontario and Alberta provincial government officials' transition from problem-solvers to problem-makers within the federation. The result is the elevation of sectoral politics (where the focus of the entire policy community is on health care) to 'high' politics (where the focus turns to federal/provincial relations and health care is used as a political football). Meaningful reform of any kind is difficult to achieve when so much time is spent finger pointing.

A credible commitment between the federal and provincial governments should specify the 'public payment' elements of the two core bargains and any new bargains under consideration. For example, the commitment should specify whether (first-dollar, one-tier) public payment for physician-provided and hospital-based care will continue as specified in the two core bargains, whether public payment for prescription drugs and home care (as two possible examples) will be entrenched as new core bargains, the level or share of financing that the federal government will provide to provincial governments, and the nature of provincial governments' accountability for the performance of provincial health-care systems that federal government officials and the Canadian public can reasonably expect. Surely creative minds in federal and provincial departments of intergovernmental affairs can craft a commitment that ensures that the political benefits that accrue to both sides from a commitment are greater than the political costs to either side of withdrawing from or not supporting it. The time for blame avoidance is over.

The second way forward also involves establishing a credible commitment, this time between provincial governments and physician associations about the professional autonomy element of the core bargain with physicians. After the finger pointing between federal and provincial government officials over health care, the next most pressing concern for health care in Canada is the inability of provincial government officials and physician associations to reconcile physicians' strong desire for professional autonomy (which does serve an important social purpose) and many groups' (including some physicians') strong desire for, say, organizational models that facilitate access to a comprehensive range of health care, funding mechanisms that provide incentives for team-based delivery models and evidence-based care, and technological innovations that will enhance the quality of drug prescribing. Meaningful primary-care reform is difficult to achieve when the issue of professional autonomy is not given attention.

A credible commitment between provincial governments and physician associations should specify the proposed elements of a new core bargain with physicians. For example, the commitment should specify the organizational model within which physicians will work, the funding mechanisms through which they will be paid, the technology that they will have available to them, the working conditions that they can expect, the one-time transition costs that will be covered, and the nature of their accountability for the performance of the primary-care system that provincial government officials and the Canadian public can reasonably expect.

Surely creative minds in provincial health departments and in physician associations can craft a commitment that ensures that the political benefits that accrue to provincial governments match the professional and financial benefits that accrue to physicians.

The third way forward involves planning now to increase opportunities for and diminish constraints on the next round of health-care reform by investing in training for new groups (e.g., nursing and home care associations) to acquire the knowledge, skills, and political resources to act as a countervailing influence on political elites privileged by past or current reforms. As physician associations have so well demonstrated over the last 30 years, groups can acquire the knowledge, skills, and political resources to occupy the position created for them. But given the long-standing lack of opportunities for other groups to contribute to discussions about reforms that involve the core bargains with physicians and hospitals, it will take proactive investments in training to help these groups catch up (Rachlis and Kushner 1994). Investments in nursing research and knowledge transfer funds, such as the one located at the Canadian Health Services Research Foundation, represent a step in the right direction.

Conclusion

Two political bargains, both in place for more than 30 years, have had a profound steering effect on Canada's health-care system. Changes that would meaningfully alter the political bargain with physicians have not been successful. And changes that would meaningfully alter the political bargain with hospitals have for the most part been unsuccessful as well, even though hospital associations lost some of their already limited potential to influence provincial government officials over this time period. With numerous and sustained calls for significant reform of health care in Canada, both from commissions and task forces and from the Canadian public, perhaps the time has come to act on what we've learned from past reform efforts. Doing so involves establishing credible commitments among the political elites who have much to lose (and potentially gain) by re-opening the core bargains. To avoid such credible commitments will leave provincial governments where they've been for 30 years: reforming the 'periphery' of the system while leaving its 'core' (physician-provided and hospital-based services) largely untouched.

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