Preface

THIS IS A STUDY OF the development of the Canadian health insurance system. It is also a study of the policy-making process in federal and provincial governments that, over a period of thirty years, brought the system into being.

Because hospital insurance and medical care insurance were introduced a decade apart, each province made two decisions, for a total of twenty. The federal government made three separate decisions, the first in 1945 in the famous Green Book Proposals, which was aborted, the second on hospital insurance in 1956, and the third on medical care insurance in 1966. While all of these were large and complex decisions for the governments making them, and all worthy of analysis, it was simply impossible to include all of them in this study. It was necessary, therefore, to select those decisions which were *determinative*, in that they launched the system and created the program design. Careful analysis indicates that there were six determinative decisions: the three by the federal government, that of Saskatchewan for hospital insurance in 1946 and similarly of Ontario in 1955, and Saskatchewan's decision on medicare in 1959. There was one other that, although not determinative, was of such importance as to warrant inclusion. Quebec's decision on medicare in 1970 reveals the extraordinary difficulties of government decision making in a federal state, and especially under the turbulent conditions that led to the October Crisis, with its simultaneous withdrawal of services by the Federation of Specialists. It is a graphic illustration of the problems created for provinces by federal initiatives in fields of provincial jurisdiction.

There were, of course, earlier decisions by provincial governments that contributed to the evolution of health insurance in this country.

British Columbia passed a health insurance act in 1935, only to have the program cancelled three weeks before it was to go into operation. I have examined that attempt elsewhere in some detail[1] but since it was aborted it cannot be considered as having been a determinative decision. Nor can the statutes passed by Alberta in 1935, Saskatchewan in 1944, Ontario in 1944, or Manitoba in 1945. All of these, and the legislative inquiries and royal commissions that preceded them, undoubtedly advanced the cause of health insurance in Canada but shaped the outcomes only marginally.

Seven decisions, therefore, are analyzed for the contribution they made to the Canadian health insurance system and the light they shed on the governmental process. The purpose of the analysis is to identify and examine the impact of ideas, public opinion, interest groups, and political forces as they came to bear on the perceived problems, caused the decisions to be made, and shaped the design of the proposed solutions. This is followed by a summary of the short-term results (i.e., to about the end of 1971) of the policies and programs that were adopted.

As an aid to understanding the policy-making process, I have adopted (and adapted) the *systems analysis* construct of David Easton[2] and of elaborations by such others as Daniel Katz, Robert L. Kahn,[3] and Ira Sharkansky.[4] In Easton's conceptual framework, the political system, like all social systems, is characterized by "boundaries." The system receives "inputs" from the environment in the form of demands and support. These are then subjected to the "conversion process"—the dynamic "withinputs" of political leaders and the bureaucracy. The results are the "outputs" of policy in the form of legislation, regulations, and taxes, and in the strategies developed to implement the program. These outputs of policies and strategies have effects on the environment that are characterized as "outcomes." Information about these is returned to the political system as further inputs in the form of "feedback," enabling the system to make new adjustments in the policy or strategy to improve the quality of the outcomes. It is a continuous, cyclical process with the system responding to the stress that is both imposed upon it from without and generated from within.

The political system differs from all other systems in that it is, as Easton says, "predominantly oriented toward the authoritative allocation of values in a society."[5] It is the only system having a monopoly of the legitimate use of coercion. This fundamental characteristic of government is profusely illustrated in the analysis that follows, for the history of health insurance in Canada is largely about conflicts in values held by the medical profession, the insurance industry, labour unions, farmers' associations, political parties, and provincial governments, and about

the decisions made by governments in their allocations of values that would be authoritative.

I have adapted the Easton conceptual framework by organizing each case study to answer the following questions; with the headings used in the text in parentheses.

1. Why was the decision made? (The Action Imperatives)
2. What were the constraints limiting the policy choices? (The Constraints)
3. What were the risks? (The Uncertainties)
4. What were the contributions of external forces to the content and timing of policies? (The External Contributions)

The answers to these four questions comprise the *inputs*.

The fifth question relates to the governmental process.

5. What were the contributions of the bureaucracy and the government ministers, Cabinet, caucus and Legislature, or Parliament? (Internal Contributions)

These are the *withinputs*.

The next two questions are concerned with what emerged from the "conversion process."

6. What kind of program was created? (The Policy)
7. How did the government introduce the program? (The Strategy of Implementation)

These are the *outputs*.

The final question relates to the environment.

8. What were the results of the program?

These are the *outcomes*.

Diagramatically, the analytic frame of reference appears as follows:

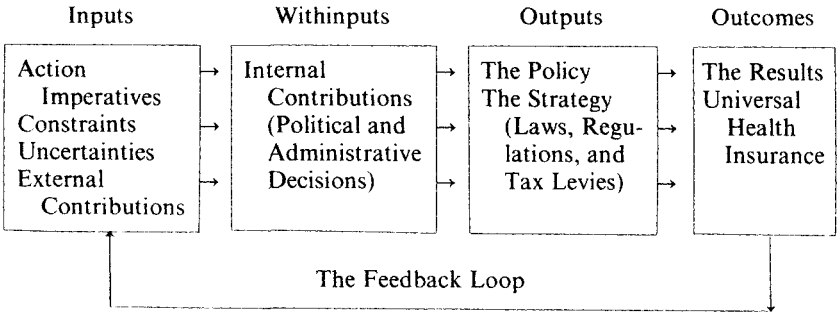

Figure 1. The Policy-Making Process

It would be comforting to believe that the governmental process follows so neat and logical a course, but, obviously, it does not. Unforeseen obstacles appear, unpredictable events (such as an election defeat) occur, and feedback from the environment warns of the need for changes in policy or strategy. With each of these decisions taking from two to six years to bring to conclusion, new inputs and withinputs appear at different times, and in some of the cases, therefore, several stages in the strategy of implementation can be discerned before the objective is reached.

This study, like a number of recent works,[6] focuses on the interaction of federal-provincial relations as well as on government-interest group relations, highlighting how extraordinarily complex the Canadian governmental system has become in the post-war era. The more one examines the roles of interest groups and national and provincial political parties in the formulation of policies, and the increasing interdependence of the federal and provincial governments, the less the two-tier federal system resembles the traditional "layer-cake" concept and the more it exhibits the idiosyncratic confusion of a marble cake. It is hoped that the following analyses will enhance our understanding of the complexities of the system, but I would not claim to have fully probed or discovered all its labyrinthine ways.

SECOND EDITION

This second edition presents an updating of the original edition by the addition of two chapters. Chapter eight examines the outcomes of the medical and hospital insurance programs in terms of the health care resources (both institutions and personnel) created under the two programs, and the costs of them, shared by the two orders of government. The major decisions changing the shape of the two programs are then chronicled: the Established Programs Financing Act of 1977, the three public inquiries that followed this momentous change, and the passage of the Canada Health Act in 1984 and provincial responses to it. Chapter nine then looks to the future, examining five of the major problems with which policy-makers must contend. Chapter ten incorporates chapter eight, "Reflections," from the first edition and adds a new section.

I have not used the systems analysis concept in chapter eight as I did in the first seven chapters, for although the individual actors have changed, the major interests in the continuing drama—consumers, providers, and federal and provincial governments—were pretty much the same, acting in familiar, almost predictable, ways.