DRIFTING AWAY?: THE CASE OF THE CANADA HEALTH ACT

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Abstract

Most analyses of welfare state reform show that the radical retrenchment of social programs is rare in advanced industrialized countries. But more recent studies argue that despite widespread path dependence, welfare state institutions frequently undergo significant policy drift: even though their formal structures remain largely stable, they increasingly fail to achieve their institutionalized goals, thus creating growing disparities between policies and outcomes. In this paper, drift in the Canadian health care system is explored through the application of this theory to the Canada Health Act. This study has identified two forms of drift, policy and regulatory. These types of drift have developed in the absence of adequate updating and upholding. As a result of the drift that is occurring, the implementation of the existing principles embodied in the Canada Health Act has decreased significantly during the past two decades.

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My family and friends have been incredibly supportive throughout this process. Mum, Dad and Liam - thank you for believing in me and for all of the pep talks. Peter, Kristen, Meaghen, Heather and Hilary – thank you for cheering me on and never glazing over when I would go on about the "Big T".

"Courage my friends. 'Tis not too late to make a better world."
- Tommy Douglas

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Introduction

"Canada no longer looks the secure home of public medicine, and contrast to the United States, that it once did"[1]. This observation made in The Economist references the slow transformation that the Canadian health care systems has been undergoing. The significance of changes in the health care system in Canada cannot be overstated. Medicare, as this program has affectionately become known to Canadians, has been noted by many as having reached iconic status in the country. The implications of this symbol, which for so long has illustrated what it means to be a Canadian, becoming more figurative than reflective are considerable. It should not be surprising then that the evolution, or devolution as some would characterize it, of Canada's most beloved social program has become the focus of many studies conducted by both governments and academics. Governments at the provincial level have produced the Mazankowski, Fyke and Clair reports. The federal government was responsible for the commissioning of two in-depth reports, Romanow and Kirby. Canadian health scholars have also been active in their research into the reforms experienced in the Canadian health care systems.

A leading focus of these studies has been on the impact that increased privatization has had on the development of the health care system. Maude Barlow, Chairwoman of the Council of Canadians, represents the view of many when she states that "not-for-profit health care is under unprecedented attack"[2]. There has been growing recognition that health care costs are increasingly being shifted from society onto the individual. According to data from the Organisation for Economic Co-operation and Development, just two decades ago, in 1985, public spending represented about 75.5% percent of total expenditures on health but in 2004 this figure had dropped to 69.8%[3]. This has occurred even though "to date, this shift has been unplanned."[4] There is a belief that the changes observed in the Canadian health care system are synonymous with the increased privatization that has been identified.

Carolyn Tuohy has described the developments that the Canadian health care systems have experienced as *passive privatization*[5]. There has been talk that these changes are occurring slowly and subversively. It has been observed by Normand Laberge, the chief executive officer of the Canadian Association of Radiologists, that "the Canadian population has not elected any government to privatize health care, but it is happening"[6] despite this. As noted by Canadian health care scholars, there has not been a significant increase in new legislation or reformed legislation that would dictate a greater role of the private sector in the funding of health care services. This presents a challenge when attempting to assess what is occurring to health care in Canada because traditional explanations, those that focus on the formal policy changes, are not appropriate in accounting for what is currently taking place. This difficulty exists in terms of identifying how it is that privatization may be occurring.

This shift from public towards private is remarkable as the federal legislation that governs health care, the Canada Health Act (CHA or Act), has remained unchanged for

over twenty years. The Canada Health Act, since being passed in 1984, has not received major or minor reforms, however the policy in practice is not consistent with the policy in theory. An examination of the CHA may be useful in providing a survey of ways in which the healthcare system may experience change through unconventional means.

Lisa Priest, a journalist at the Globe & Mail, obtained confidential documents from Health Canada through the Access to Information Act that provides information on the suspected cases of non-compliance with the Canada Health Act under investigation. The list revealed that *every* province is named as a potential violator of the CHA. Some of the 25 offenses include: patients charged for drugs administered in hospitals; patients charged for medically necessary MRI scans; user fees charged for medically necessary CT scans; user fees charged for bone density scans; abortion services only partially covered by provincial insurance when performed at private clinics; failure to reimburse total costs incurred for health services obtained outside of Canada, to an amount lower than the home province rate; failure to reimburse total costs incurred for health services obtained outside of province, and; facility fees paid that enabled queue jumping.[7]

In a legal case that was filed in 2002 against then federal Minister of Health, Anne McLellan, a group of organizations argued that the Canada Health Act is not doing what it is designed to do.[8] Taking legal action such as this exemplifies the fear and sense of crisis that Canadians feel towards the changes in the health care system. In addition to the information found by Priest, this legal action along with the research from Canadian health scholars, encourages the examination of the role of the CHA in the developments of the Canadian health care systems. According to one health lawyer, with many years of experience working in the Ontario Ministry of Health and Long-Term Care, the CHA is:

> not on the radar screen. The politicians will pay lip service to it, and they will whip out the five principles and talk about how important they are and soon, but on the ground there is two tier and three tier medicine in Ontario

The accumulation of this information begins to suggest that perhaps it is through the content and the administration of CHA that changes in the Canadian heath care system can emerge.

Accounting for how these changes may occur in relation to the CHA is problematic given the absence of formal and visible change that it has experienced. Radical policy change explanations are not appropriate as there have not been any major revisions to the Canada Health Act. Incremental policy change explanations are not appropriate either because there have not been any minor revisions to the CHA. There have been no formal changes of any kind, radical or incremental. So then, how may changes occur given this absence of this formal change?

The impact that informal processes may have has not been adequately taken into account in previous research studying the changes that are occurring in the Canadian

health care system. If the federal health policy has remained untouched since 1984 then policy reforms cannot account for any changes that have occurred. What might provide some insight into how this process might occur?

Popular social programs that have developed strong feedback over the years have presented a significant challenge to those looking to scale back in these areas. The upfront retrenchment of social policies in welfare states is politically dangerous as these can be attributed to the actions of both people and parties. Given a good memory of the electorate, the beneficiaries of such programs can punish those for their actions when the next election is called. An appealing option that can facilitate the achievement of the same goals without the negative repercussions is to permit drift as has been studied by Hacker[9]Through the allowance of drift outcomes can shift in the absence of active and visible decisions. This informal process produces change in practice without a change in policy. Drift is an emerging concept that is increasingly relevant to describe what is occurring in developed welfare states. In particular, I suggest in this thesis that this concept is capable of providing insight into the Canadian health care system by examining the possible ways in which drift may occur through the Canada Health Act. Tom Kent's view is that the Canada Health Act "had quickly become too popular for politicians to risk much messing about with"[10] and so there is an implication that there would be considerable incentive to find ways that produces change while avoiding blame. It is the "popularity of medicare that made public opinion its real guardian"[11]. In allowing a policy to become obsolete, the same objectives of formal retrenchment can be achieved through drift. However, drift avoids the negative repercussions that politicians and parties associated with such actions are in danger of suffering. Public opinion is not a concern when the public is not aware of what is occurring.

The policy in content has remained the same, yet the policy in practice has changed. Greg Marchildon believes that the acceptance of the "status-quo is really death by stealth for medicare"[12]. As time goes by and contexts change a policy has to be updated to respond to these developments so that it may remain relevant. Is it the case that the CHA in not being updated has become irrelevant to current circumstances? How might the process of drift take place in relation to the CHA?

This study endeavors to determine how it is that drift may occur in the context of Canadian health policy, specifically as applied to the case of the Canada Health Act. The CHA provides an excellent case study of policy drift because of the paradox that exists, of changes in the outcome of the legislation in the absence of any formal or visible reforms to dictate this. This popular social program changing in the absence of formal decisions begins to illuminate an informal process that can have serious societal consequences. This is the first study to be conducted that examines the possibility of drift in relation to the CHA and accordingly the goal is set to be modest. This introductory research is expected to provide an overview of the issue, potentially illuminating a problem. It is also anticipated that the application of drift to the case of the CHA will

provide an opportunity to further develop the concept by reflecting what was learned in this study.

Methodology

There was a wide variety of qualitative data used in the preparation of this study. Government documents, academic articles, newspaper articles and law cases provided the main sources for information. An extensive literature review is at the heart of this study. The foundations and major principles of drift will be explored. Previous applications of drift, such as the studies carried out by Jacob Hacker, have been examined and taken into consideration when this study was designed. As drift is a relatively new concept and studies employing it have been few, there was not one model or plan that had emerged that would be logical to follow. Interviews were conducted with a variety of people from a variety of backgrounds, though all able to provide valuable information related to the Canada Health Act. Auditor General Reports, specifically from 1987, 1999 and 2002 were very useful in determining the operations of the CHA. The affidavits and factum in the case against the Minister of Health were very helpful for making this determination as well. Every Canada Health Act Annual Report was meticulously reviewed. The work of scholars who have conducted relevant work on the Canada Health Act has become very important as commentary is quite limited. Particularly, the work of Sujit Choudhry and Colleen Flood has been of great influence.

Quantitative data was collected from the Canadian Institute on Health Information (CIHI) and the Organisation for Economic Co-Operation and Development. The absence of data as relevant to this study, particularly the CHA, was apparent. The need for data on a wider variety of issues is a later critique made as it appears that even Health Canada does not have necessary data on the performance of the CHA.

Following approval from the McMaster Research and Ethics Board, requests for interviews were made for many different people ranging from politicians, bureaucrats, lawyers, journalists and academics. When a request was accepted, a place and time were arranged and the question guide was sent to each interviewee ahead of time. Anonymity was a condition of all of the people that were interviewed, with the exception of one who will be named below. Interviews were conducted with top bureaucrats at the Canada Health Act Division (CHAD). The CHAD is part of Health Canada and charged with the administration of the Canada Health Act. Interviews were attempted with former and current politicians. An interview was conducted with the Honourable Roy Romanow, former Premier of Saskatchewan who was chosen by the House of Common to lead the Commission on the Future of Health Care in Canada. An interview was conducted with a politician who, at the time, held the position of health care critic for their party. Interviews were also conducted with lawyers and health law specialists with experience working in the Ontario Ministry of Health. The interviews were a useful resource in the confirmation of what was implied in literature though not explicitly stated. However, the information gained through speaking with people provided disappointingly little new

information. When the interviews did contribute to significant findings, it will be referenced in this thesis, though this is often limited by the necessity for anonymity of interviewees.

Theoretical Approach

The concept of drift seeks to explain changes that have occurred in the outcome of a policy that has not experienced any formal change. This contradiction has increasingly been identified in developed welfare states. The application of drift to case studies provides innovative and insightful information on the ways in which change is occurring. Due to drift being a new concept consistent definitions and operationalizations have not been established which necessitates further conceptual improvement and development through case studies such as the one conducted in this thesis.

The application of the concept of drift allows for the consideration of methods of change that have long been left out of the welfare state reform literature. The omission of change that may occur outside the formal process leaves explanations incomplete or lacking. It is the inclusion of the informal processes by which change can occur that enables drift to make such a valuable contribution to the discussion of advanced welfare state reform. The application of this concept to policies and programs potentially tells a new story that has yet to be adequately told.

The most prominent application of drift is by Jacob Hacker who applied it to the pension and health care systems in the United States. Hacker helped to develop the concept of policy drift and this theoretical basis has served as a foundation for much of this work. Through the study of the Canada Health Act, I suggest that another form of drift exists that relates not to policy-making but to administration. Hacker explicitly identified policy drift and implied what we may term "regulatory drift" but the two forms are made distinct here.

Case Selection

The concept of drift will provide a new lens through which the developments of Canadian social programs, and in particular, the health care system can be analyzed. As an exploratory study of drift in the Canadian health care system, the application of this concept to the Canada Health Act is supposed to provide a good overview of the issue. Possible ways in which drift might take place will be reviewed.

While health care is under provincial and territorial jurisdiction, research and analysis into the federal government's role is seen as a better starting point for the study of drift. Placing this study at the federal level will provide a better overview of the issue nationally. While exploration at the provincial level would be expected to provide more

detail of the issues, a regional interpretation at this exploratory phase in the research does not provide enough of an overview of the matter.

While the provincial and territorial governments are expected to have a role in the changes experienced in the Canadian health care system, it cannot be denied that the federal government shares at least part of the responsibility. This is endorsed by Barlow, again speaking on behalf of the Council of Canadians, when she stated that "although people tend to blame the provinces for the erosion of health care, we're saying a great deal of the blame, perhaps the lion's share, lies right at the feet of the federal government"[13]. This role will be explored through the application of drift to the CHA, the federal legislation that governs health care across the country.

Support for the Canada Health Act remains strong; overall the criteria have continued to be "very important" to Canadians, as demonstrated in Table 1. From the perspective of drift, it is of great significance to note that the values and expectations of Canadians have remained quite stable. Through the many changes that have happened over time, Canadian's priorities have endured. The Canada Health Act embodies these principles. However, according to Globe & Mail reporter Brian Laghi "virtually every province is breaking the Canada Health Act and the federal government doesn't have the will or tools to crack down"[14].

Table 1 **Support for maintaining the Principles of the Canada Health Act** (per cent indicating "very important") [15]

	1991	1994	1995	1999
Universality	93	85	89	89
Accessibility	85	77	82	81
Portability	89	78	81	79
Comprehensiveness	88	73	80	80
Public Administration	76	63	64	59

Taking into account Paul Pierson's reflection that hidden retrenchment becomes more attractive in the context of a policy or program that is likely to produce negative repercussions if changed, it is quite appropriate that drift theory be applied to a policy that is as popular as the CHA. This is supported by Hacker's observation that policy drift if most likely to occur "when the barriers to internal change are high (meaning it is hard to shift them to new needs) and the status-quo bias of the external political context is also high (meaning it is hard to eliminate or supplant existing institutions)"[16]. While both of these are valid in the case of the CHA, it is particularly true that this is a policy that is much loved and supported by Canadians. Attempts by politicians to change the CHA in a way that is not consistent with its origins or to openly undermine it would be met with disapproval by many Canadians. Contraventions to the CHA could be something as straightforward as charging patients additional fees to receive insured services or more controversially, the delisting of medically necessary procedures from insurance plans.

This support for the CHA, at the very least, acts as a deterrent to launching a frontal attack on the policy. The motivation would be great for opponents of the tenets embodied in the CHA to pursue their goals in a way that would not hold them responsible for their actions. Drift is an appealing option in this way as it potentially allows the desired goals to be reached while governments and political actors are able to avoid blame.

The selection of the CHA as a case study for drift is also justified as despite the steady support for the principles of the federal legislation, Canadians do not believe that they are upheld in practice any longer, as shown in Table 2. This inconsistency has emerged in the absence of changes in policy. Changes are occurring that are in conflict with the priorities of Canadians, so it is not through constituent pressure that this is happening. If there is a disparity between policy and practice, studying how this incongruence might have developed could provide an understanding into the process that drift may follow.

Table 2 **Percentage saying that the health care system is living up to the five principles of the Canada Health Act, 1999**[17]

Universality	82
Accessibility	62
Portability	63
Comprehensiveness	50
Public Administration	59

Drift theory may be able to provide valuable insight into institutional changes that have previously been overlooked but impact on the health care of Canadians nonetheless. The difficulty in identifying changes without the ability to trace their origin back to a formal policy does not prevent the study of such a case, but it does make it more challenging. An approach in the early stages of this study was to identify where the opportunities for change originated. It is this method that will be employed here with the case of the Canada Health Act. It is an aspiration that this recognition will provide a possible starting point for potential research to follow. Providing possible ways in which drift may occur has the potential to illuminate methods of change that were previously obscured. In what ways could changes in the health care systems in Canada have occurred in relation to policies and programs that have remained the same?

Case Study Results

An examination of the Canada Health Act reveals two forms by which drift may occur in this case. The first form, policy drift, is identified as potentially occurring due to the lack of updating that has taken place. The context of the Canada Health Act has changed but there has not been a response to this in policy. This is the more customary form of drift and resembles Hacker's concept of policy drift. Applying the concept of policy drift to the case of the CHA is fitting, as the anticipated role of this form of drift is significant.

The second form, regulatory drift, is identified as potentially occurring due to the lack of upholding that has taken place. The Canada Health Act has not been adequately administered. While this has been implied in Hacker's work, policy and regulatory drift had not been specifically distinguished from each other. The case of the CHA emphasizes the need to make such a distinction between the two forms of drift, policy and regulatory. Exploring policy drift as the sole account of what may occur in the CHA leaves out an important part of the story. While some of Hacker's concepts of policy drift are applicable to the CHA, as the suitability of the legislation itself is important here, there is not enough importance placed on what is done with the legislation. Policy drift and regulatory drift will be explored as the two potential ways in which drift may occur in the Canadian health care systems, specifically shown as taking place through the CHA.

Policy drift concerns the actual content of the document. As time goes on the context of the policy is likely to shift. Without updating the policy to reflect this change, the intended outcomes are increasingly unlikely to be obtained. Response in policy to shifts in context are required to maintain a policy's ability to meet its objectives. Failing this, policy drift may occur.

Regulatory drift concerns the regulation of the policy. What is done with the policy is at least as significant as what it says. Without upholding the policy, the intended outcomes are increasingly unlikely to be obtained. It is crucial that the complete and thorough administration of the policy is required for its ability to meet its objectives. Failing this, regulatory drift may occur.

Chapter Overview

In chapter 2, the theoretical background of drift is given to show conceptual development and give context to this study. The distinction is made between policy drift and regulatory drift. These two forms of drift that have been identified are then applied to the Canadian health care system. In chapter 3, the case study of the Canada Health Act is reviewed so that this legislation can be analysed in terms of drift. The concept of policy drift is then applied to the case study of the Canada Health Act. The potential ways that policy drift may occur through the CHA are explored as relating to the lack of updating the legislation. In the absence to update the CHA, policy drift can occur. In chapter 4, the concept of regulatory drift is further developed through the application to the case study of the CHA. The potential ways that regulatory drift may occur through the CHA are explored as relating to the lack of upholding the legislation. In the absence of adequate monitoring and consistent enforcement of the CHA, regulatory drift can occur. Finally, chapter 5 will provide a summation and implications of the findings as well as suggestions for future studies.

Notes

[1] The Economist, "Edging to Market. (Canada's public health system growing less secure)", The Economist May 8, 1999 v. 351

[2] Lisa Priest, "Enforce Health Act or face suit, Ottawa told", Globe & Mail [Toronto] 22 Nov. 2002: pNA.

[3] Organisation for Economic Co-operation and Development. Public expenditure on health. (OECD: Paris, 2006) Available: http://www.oecd.org/dataoecd/59/49/35529832.xls

[4] Canadian Healthcare Association. "The Private-Public Mix in the Funding and Delivery of Health Services in Canada: Challenges and Opportunities" Canada Healthcare Association (Ottawa: Canadian Healthcare Association, 2001): 27.

[5] Carolyn Tuohy, Accidental Logics: The Dynamics of the Health Care Arena in the United States, Britain, and Canada (New York: Oxford University Press, 1999) 235.

[6] Lisa Priest "Private diagnostic clinics on the increase in Canada" Globe & Mail [Toronto] 21 Nov. 2001: pNA.

[7] Lisa Priest "List reveal provinces violated health act" Globe & Mail [Toronto] 13 Dec. 2002: pNA.

[8] Priest Enforce Health Act.

[9] Jacob S. Hacker, "Review Article: Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform" British Journal of Political Science 43 (2004): 722.

[10] Tom Kent, Medicare: It's Decision Time (Caledon Institute of Social Policy: Ottawa, 2002) 3.

[11] Kent 8.

[12] Gregory P. Marchildon, Three Choices for the Future of Medicare (Caledon Institute of Social Policy: Ottawa, 2004) 8.

[13] Priest Enforce Health Act.

[14] Brian Laghi "Auditor-Generals' report: almost all provinces break medicare law, auditors find". Globe & Mail [Toronto] 9 Oct. 2002: pNA.

[15] Stephen Vail. Canadians' Values and Attitudes on Canada's Health Care System: A Synthesis of Survey Results. (The Conference Board of Canada: Ottawa, 2000) 6.

[16] Jacob Hacker, "Policy Drift: The Hidden Politics of US Welfare State Retrenchment," Beyond continuity: institutional change in advanced political economies, eds. Wolfgang Streeck and Kathleen Thelen (New York: Oxford Press, 2005): 48.

[17] Vail 7.

Institutional change

Institutional change is significant in the study of politics. There are a large variety of theories that attempt to explain the causes and patterns of institutional change. To borrow the definition from Streeck and Thelen, institutions will be identified here as the "*building blocks of social order*: they represent socially sanctioned, that is, collectively enforced expectations with respect to the behavior of specific categories of actors or to the performance of certain activities"[1]. They are systems of rules, principles or guidelines that structure the behaviour of actors. The application of this characterization allows the classification of the Canada Health Act as an institution: the CHA attempts to influence the behaviour of actors at the provincial level in order to produce national standards in health care. At the federal level, the CHA provides the principles that are expected to be reflected in the provincial health systems.

Since institutions in the public policy sector are important, there is a notable value in studying changes that occur within, or to, institutions such as the CHA. Variations in institutions, whether radical or incremental, have an impact on people involved in it. Institutional change can take "multiple forms, and strategies of institutional change systematically differ according to the character of institutions and the political settings in which they are situated"[2]. The existing theories of institutional change are diverse in focus, but all hope to identify the explanatory element that lead to adjustments.

There has been a bias in past theories that have attempted to explain institutional change as occurring from a punctured equilibrium or shock to which institutions respond. Streeck and Thelen have in fact stated that "much of the institutionalist literature relies – explicitly or implicitly – on a strong punctuated equilibrium model that draws an overly sharp distinction between long periods of institutional stasis periodically interrupted by some sort of exogenous shock that opens things up, allowing for more or less radical reorganization"[3]. Concepts such as these suggest that an event or incident initiates a reaction from institutions. Theories of this type ignore the endogenously instigated change and disregard the longer term incremental change in favor of short term immediate, and perhaps more radical, transformations.

Conceptualization about processes of change that occur slowly or without external pressures or causes are valuable in contributing to the wide variety of accounts of institutional changes, without which all realities of transformation in this field are not explored. It is not reflective of reality that all possible or predominant changes will occur directly or in response to an outside factor, nor that they transpire in a way that is radical. This is especially true of the institutional changes that are happening in developed welfare states. Changes that are internally produced, slow developing and often difficult to observe are the most common form taken on by transformations of institutions in mature welfare states. When thought is given to policy feedback, legacy and economic limitations, it is quite logical that adaptation in social policies and programs should occur in this incremental way. Growing economic pressure fuels the argument that the welfare

state should be cut back. This force naturally clashes with the well-established groups of recipients that exert their own pressure on elected representatives in an attempt to protect the programs and policies from which they benefit. The result can perhaps be seen as an arrangement between these two sides through which change occurs, but incrementally through less immediate or visible methods.

We learned in kindergarten that it is a waste of time to try and fit the triangle puzzle piece in the circular shape – they just do not match no matter how hard you try and shove the two together to make them fit. It is time to develop relevant theories, or find the correct puzzle piece to fit into the corresponding shape. It is the "processes through which (institutions) are currently changing (that) can provide a particularly fertile terrain within which to explore frequently overlooked mechanisms and modes of change more generally"[4]. Policy drift is one theory among others, such as conversion, layering, and displacement that provides new and important commentary on how processes of change occur. These theories are providing increasingly relevant views on what is currently happening in developed welfare states in comparison to the more traditional analyses that focus on the formal aspects of incremental change. Far more interesting is the story that can be told about the incremental change that takes place in the absence of these formal changes. It is these theories that will be able to more accurately tell the story of what has been, and is, occurring to significant social policies and programs. Unfortunately, the "central properties of the developments currently underway in the advanced political economies are not being adequately theorized, nor even fully recognized"[5]. The longer that inappropriate theories attempt to explain the situation at hand the longer we will continue to misdiagnose issues of critical importance.

Current change is more adaptive than radical, and this is a major difference that needs to be taken into account in descriptions and explanations. Real and significant change can occur endogenously and gradually, just as it can come about exogenously and immediately. Though internally initiated change can be seen as a continuation of the 'old' – it nonetheless can produce something that is different from the 'old' and is therefore new – this is a distinction that people have shied away from making. The same reasoning can be made for externally produced change that occurred immediately as the change developed from the same 'old' point, but for some reason that result is more widely accepted as new. Endogenously occurring change can provide a greater insight into a little explored method of change in which "actors cultivate change from within the context of existing opportunities and constraints – working around elements they cannot change while attempting to harness and utilize others in novel ways"[6].

As time moves on and society changes, theories have to evolve and adapt to these differences to be able to adequately respond to what is occurring. Theories are not stable and cannot expected to be successful in explanation without revision. Accounts of institutional change are no exception.

Welfare state reform

Policy drift, the theory to account for institutional change that will be used and further developed within this thesis, has grown out of the welfare state reform literature. The significant changes that occurred in the developed welfare states required applicable theories and explanations. Theorists first responded to this need by attempting to apply the theories and concepts of the literature on welfare state expansion.

The welfare state reform literature has expanded over the last few decades. Scholars responded to the expansion of welfare states around the world with many thoughts on why this had occurred. Economic growth, left leaning governments, and institutional conditions have been offered as some of the explanations for the expansion of social programs and policies.

To reflect developments occurring in advanced welfare states, the focus shifted from attempts to explain expansion to attempts to account for the retrenchment occurring in developed welfare states. The reasons for, and the politics and analyses of, expansion are very different from those of retrenchment. The development of appropriate theories thus needed to reflect this variation.

Welfare state retrenchment

The period of welfare state expansion was followed by one of welfare state retrenchment. According to Paul Pierson, retrenchment refers to "policy changes that either cut social expenditure, restructure welfare state programs to conform more closely to the residual welfare state model, or alter the political environment in ways that enhance the probability of such outcomes in the future"[7].

In comparison to welfare state expansion, "welfare state retrenchment remains largely uncharted terrain"[8]. Initially, accounts of welfare state retrenchment attempted to reapply theories of welfare state expansion. This was insufficient in accounting for what was occurring.

The three theories in particular that were 'borrowed' from welfare state expansion and applied to welfare state retrenchment, were that of (i) economic progress, (ii) political power, and (iii) structures of institutions. The first theory, that of economic progress, proposes that there is a correlation between the state of the economy and the status of a country's welfare state. The wealthier the country, the stronger the welfare state, and contrarily the poorer the country, the weaker the welfare state is expected to be. The second theory, that of political power, suggests that the ideology of the party in power is associated with the success of the welfare state. A conservative, or right leaning, government would contribute to a restrained welfare state but a socialist, left leaning, government would support an expansive welfare state. The third theory, that of

institutional structures, advises that the particularities that make up an institution will influence the type of welfare state. A prediction of how each individual institution will impact the welfare state is complicated as there are many factors that need to be taken into account. These factors can be broken down into two areas. The first area is the determination of a strong state established on "governmental administrative capacities and institutional cohesion"[9]. A country believed to have a strong state is expected to have a strong welfare state. The second area is related to policy legacies and feedback[10], the outcome of which are quite specific to strengths established, but generally would come down to the greater the strength in each area, the stronger the welfare state and logically, the weaker the legacy and feedback the weaker the welfare state.

Retrenchment within the welfare state "is generally an exercise in blame avoidance rather than credit claiming, primarily because of the costs of retrenchment are concentrated (and often immediate), while the benefits are not"[11]. This is of great significance in the study of retrenchment as politicians are acting in a manner completely different from that in the case of expansion. In an effort to circumvent responsibility for changes that will not be received well by (at least some) voters, the process of change can become less visible, more complex, more gradual, and not initiated by an obvious outside event or cause. Punishment at the polls can provide a strong motivation for politicians to develop a new way to implement changes to the welfare state that will not be welcomed by constituents. Along with the creation and then expansion of the many social policies and programs "have come dense interest-group networks and strong popular attachments to particular policies, which present considerable obstacles to reform" [12]. Elected officials, particularly those who are advocates of welfare state retrenchment, are developing new strategies in efforts to avoid these obstacles.

These new strategies have predominantly taken the form of an "attempt to lower the visibility of reforms….. by making it hard for voters to trace responsibility for these effects back to particular policymakers"[13]. When changes are occurring in these new methods, the way in which these processes are studied needs to be changed as well. The formal and visible changes that are easy to identify are not the focus for these new types of change as this is not the form in which it takes. It is the informal and less visible shifts that need to be discovered and analysed. This presents a greater challenge when studying such a form of change. It is not as simple anymore as tracing the formal or traditional changes. As Hacker argues, in concentrating "on active changes in policy rules, welfare state scholars have thus missed fundamental ways in which the welfare state is changing"[14]. Thus, the focus must be shifted from these more formal and highly visible processes of change onto the less conventional means of change that are more difficult to detect.

Paul Pierson is credited with making the much needed and very significant distinction between processes of welfare state expansion and those of welfare state retrenchment. In his words retrenchment "is not simply the mirror image of welfare state expansion"[15]. The politics, method, development, issues, and other factors are all very different in

expansion and retrenchment – which might seem obvious considering the inherent differences in the nature and purpose of each of these changes, each in very different directions. Pierson himself has made note of this disparity as the "profound difference between extending benefits to large numbers of people and taking benefits away"[16]. It is naïve to expect that old theories will still apply and be suitable in a new environment, creating a very different context.

Pierson has rejected the three predominant theories borrowed from welfare state expansion as not adequately explaining the process of retrenchment and has been careful to stress the inherent differences between these two processes. These fundamental disparities logically exclude the easy exchange of explanations as well as approaches to study the changes experienced by welfare states. It is essential that suitable theories and methods are developed and applied that reflect the reality of the developments.

Pierson's proposal for measuring retrenchment "relies on a combination of quantitative data on expenditures and qualitative analysis of welfare state reforms"[17]. Focusing on solely quantitative or qualitative information is not enough, as it will not provide an indication of the complete situation, but only a portion of it. In his work, Pierson finds that change in terms of retrenchment in advanced welfare states has been gradual; in fact, he found that is was difficult to find radical changes[18]. Finally, a major contribution made by Paul Pierson was the suggestion that governments "confronting the electoral imperatives of modern democracy will undertake retrenchment only when they discover ways to minimize the political costs involved"[19]. Pierson identified "a crucial emerging factor (as) the mature welfare state itself, and its broad and deep reservoirs of public support"[20] which had not been adequately taken into account when attempting to apply the same theories to a changed situation. The impact that feedback has had on welfare state reform, according to Pierson, is significant.

Simply applying old theories to new developments and a new situation is not sufficient. The need to create new theories of welfare state retrenchment, as proposed by Paul Pierson, became widely accepted among scholars who undertook this new challenge[1]. A theory that responded to many of the issues raised by Pierson is policy drift. The concept of policy drift provides a new and useful lens through which the development in welfare states can be assessed.

Policy drift

Policy drift has emerged as a theory that helps explain the current institutional changes that are occurring in developed welfare states and is identified as taking on hidden forms of retrenchment. This theory has been advanced, principally, by Jacob Hacker who believes that drift can be very insightful when attempting to explain what has happened in

[1] See Wolfgang Streeck and Kathleen Thelen, Beyond Continuity: Institutional Change in Advanced Political Economies. (Oxford: Oxford University Press, 2004).

mature welfare states, and has particularly focused on the case of the United States, in the fields of health care and pensions. Policy drift offers a "new perspective on social policy reform that broadens the range of policies and forms of change under consideration". [21]

Hacker describes the contradictory policy development of policy drift as "changes in the operation or effect of policies that occur without significant changes in those policies' structure"[22]. This expression denotes circumstances in which there have been little to no formal changes in policy, but significant changes that can be observed in policy outcomes. This method of change is gradual and produces real change. This emerging theory provides "a revealing example of the less visible, but no less consequential, forms of institutional change that the standard lens on retrenchment tends to occlude"[23].

In its most basic form, policy drift relates to the revision of social policies and programs. In the context of the real world, institutions require adjustments and modifications to remain relevant and applicable as when first created. The shifting setting in which the policy exists must be taken into account throughout its duration. When the transformation of the environment is not taken into account there is a drift in policy, and institutions change endogenously and gradually. Policies "require active maintenance; to remain what they are they need to be reset and refocused, or sometimes more fundamentally recalibrated and renegotiated, in response to changes in the political and economic environment in which they are embedded"[24]. Without responding to changing situations, institutions "can be subject to erosion or atrophy through *drift*" [25]. A crucial point of change in circumstances such as these, is that detection is difficult particularly because the impression of stability that is given. The focus has demonstrably been on the outcome of drift and not on the process that it may take.

Hacker suggests three ways in which policy drift may occur. First, he proposes that policy drift can occur through natural trends. There is "shift in the context of policies that significantly alters their effects"[26]. The setting in which the policy exists evolves, therefore changing, de facto, its function. Second, Hacker recommends that drift may also occur "by gaps in rules allowing actors to abdicate previous responsibilities"[27]. Third, Hacker speculates that drift can occur in an artificial manner, through political cultivation. In this context change can happen as a result of "passive aggressive behavior refusing to end the 'slippage' caused by exogenous developments that made existing institutions slowly lose their grip"[28]. The absence of action may intentionally take place in an effort to create the appearance that a policy is not operating to full potential. Within a setting "of new or worsening social risks, opponents of expanded state responsibility do not have to enact major policy reforms to move policy toward their favored ends"[29]. The policy can be changed in practice by simply allowing it to become "stale". The absence of action to keep a policy relevant and applicable can significantly damage the ability to achieve the goals it had set out to do. This inaction would allow the policy to move away from its original objective.

The framework can develop when "neither internal structure nor political contexts favor reform, advocates may instead aim to foster 'drift', preventing the updating of institutions to changing circumstances"[30]. In this case those wishing to see welfare state retrenchment may decide it is not in their best interests to make a frontal attack on the policy itself, but instead to block updating and allow outcomes to move away from its original intent. So, it seems that policy drift can occur unintentionally, however, "much of it is quite clearly mediated by politics – a result not of failures of foresight or perception, but of deliberate efforts by political actors to prevent the recalibration of social programs"[31].

A circumstance in which change through formal means is difficult encourages advocates of welfare state retrenchment to achieve their goals through different methods. Drift can provide an attractive option. Hacker speculated that policy drift is most likely to occur "when the barriers to internal change are high (meaning it is hard to shift them to new needs) and the status-quo bias of the external political context is also high (meaning it is hard to eliminate or supplant existing institutions)"[32]. Disregarding these barriers and initiating an informal process, such as drift, provides opportunities to achieve change without the complications that these challenges provide.

It is quite appropriate that policy drift would be applied in the context of a policy that is as popular as the CHA. It is quite easy to imagine the public outcry that would result if an attack was to be made on this federal legislation. The persons and parties associated with such an assault on the CHA would likely feel the revenge of voters at the polls. Continuing on from this reasoning, drift presents a convenient and advantageous means of achieving over a longer period of time the same results that a formal change would over a short period of time, though avoiding the politically undesirable consequences otherwise attached to such actions. Given the realities of this context, drift can easily become the preferred method of policy change, as it is still able to achieve the desired outcomes without the negative repercussions that formal or visible methods would have. A politician could be able to realize the benefits of the retrenchment of social programs and policies without the costs of loss of voter support.

In measuring policy drift it is imperative that in addition to any formal changes studied, that on the ground changes are also examined because this is where evidence is expected to be located. On the ground changes specifically refers to outcomes of the policy that are not consistent with the policy itself. A disparity between a policy in practice and a formal policy may indicate a case of drift. Analysis of such a discrepancy moves research into an analysis of the gaps between policy in theory and policy in practice. The study of changes on the ground, or policies as they occur in practice, is so important, in addition to what policies state in theory. Hacker has stated that "the need for comprehensive data on the ground-level effects of risk protection policies is pressing, and scholars have only started to move toward assembling the types of evidence that might allow more conclusive answers"[33]. While this is completely valid, and the evidence of policy in practice differing from policy in theory may provide the initial sign that drift

may be occurring, the processes by which this change occurs is also of significant practical importance for governments and perhaps even more so for citizens.

This is a particular contribution that policy drift scholarship can make, a shift from determining change solely as occurring through formal changes. Research that focuses on budget changes, particularly cuts in funding, does "not exhaust the definition; analysts need also to consider structural reforms that move the welfare state toward a more "residual" role, in which government does little to shift the distribution of income and services in a progressive direction"[34]. It is not only difficult, but also erroneous to "judge policy effects simply by reading the statute books or examining disputes over policy rules"[35]. Stepping back to view a larger part of a sector, particularly in early stages, is expected to give a better indication of the issue than the analysis of a smaller segment would.

Policy drift in the health care sector

Developments within national health care systems are an important feature of welfare state reform on the whole, but particularly provides information concerning retrenchment. The "unpopular strains in many nations – from waiting lists and eroding facilities to co-payments and coverage gaps"[36] provides an excellent window into what was, and is, occurring in mature welfare states. However, this is still an area that requires further scholarship and more appropriate descriptions and analysis.

In advanced industrial states, such as Canada, health care reform has "been marked by a paradoxical pattern of 'reform without change and change without reform', in which large-scale structural reforms have had surprisingly modest effects yet major ground-level shifts have, nonetheless, frequently occurred"[37]. The health care sector is a particular part of the welfare state that is experiencing policy drift in practice. Hacker believes that the specific pattern of drift in health is "rooted in the interplay of political decision procedures and the structure of the medical sector in a climate of budgetary austerity"[38].

Tied to policy drift in the health sector is the gradual privatization of care as "social risks have shifted from collective intermediaries – government, employers – onto individual and families"[39]. This is valid and in need of greater analysis on a case-by-case basis. The implications of this are significant. Hacker has found that "in a striking demonstration of drift, beneficiaries pay more out of their own pockets for medical care today than they did at Medicare's passage"[40]. In addition Hacker has also found, and it can be said that this is also the case in Canada, that "conservatives opponents of the welfare state have turned to strategies designed to abet policy drift, eroding long-standing programs like Medicare by reducing tax revenues and blocking efforts to adapt existing policies to shifting social risks"[41]. An examination of the correlation between privatization and drift would be illuminating. This is not a suitable endeavor in the earlier

stages of investigation of drift, as a basic foundation should first be established so that broader arguments, such as this, could be developed.

Drift in health care policy has elements particular to this field. The restraint of "health spending became a paramount issue in the 1980s"[42] and welfare states experienced severe fiscal strain and pressure in the health sectors. It was remarkable the consistency with which health sectors changed in different countries. Even though "national embodiments of this shift were distinctive, its general direction was consistent and its cumulative results profound"[43]. Cuts were made in health care spending across the globe.

This cost containment experienced by many countries in its health care sector elicited similar responses from citizens, mostly discontent. What is distinctive among these countries is the particular structural reforms that took place were different from country to country. Even given this, Hacker found that when examining the changes in the health care system, specifically in the countries of Britain, United States, Germany and Canada that policy drift is "robust and general; and… that it is rooted in the interplay of financing structures and the rules of the political game"[44]. Furthermore, in each of these four countries, the "largest changes in ground-level outcomes were the result not of structural reforms, but of the long-term effects of cost-containment policies as they played out within distinctive health financing arrangements"[45].

Hacker has found that "reform without change and change without reform is the dominant health policy dynamic in advanced industrial states"[46]. This is a compelling finding that requires greater research. Particularly, the developments of the Canadian health care system require further study through the application of a theory such as policy drift to provide new insights and commentary as to what has occurred. Has the CHA intentionally been left to "wither on the vine"[47] as Republican Newt Gingrich explained in 1995 about the intentions of what was expected of Medicare? The ways in which drift may occur in the Canadian health care system must be explored. Examining the CHA as a case appears a logical first step as it provides a national outlook and a clearer idea of what future studies could focus on.

Limitations

The measurement of policy drift is inherently very difficult to achieve in a reliable and consistent manner. As Hacker has stated, there is a necessity to compare the institution as written out in theory to that in practice – to determine the extent of drift from the policy to the ground. However, even in policies that have not experienced drift, there is not an automatic conversion from concept to performance. It is unrealistic to expect what exists on paper to be represented identically in real life. The trouble then is to critically differentiate between what is the acceptable threshold for an outcome.

Of particular concern is the challenge to evaluate non-decisions. A crucial element to part of Hacker's policy drift conceptualization is the examination of decisions made in

the form of non-decisions. However, the ability to consistently and dependably review a process of non-decisions is impossible because of the informal nature of this practice. Hacker acknowledges that this non-decision process is important to acknowledge and analyze, but offers no suggestions as to how it is that this is supposed to be carried out in practice.

It is expected that it would certainly be the exception and not the rule in which causes of policy drift could be proved to be deliberate. The scenario that Hacker laid out by which policy drift may artificially occur, though entirely likely in theory, would be incredibly challenging to prove has happened in reality. If a decision is made to do nothing to maintain an institution, how is this to be proven? With the exception of improbably candid interviews by politicians and policymakers there would be no way to definitively prove that a lack of action was in fact the result of strategic planning. Inaction can only be proved as action through the disclosure of motivations, which cannot be known through the examination of a process or an outcome. While motivations can be suggested, without the confirmation of what contributed to the end result, it is nothing more than speculation.

In the drift literature, specifically as it has occurred in the Canadian health care system, nothing has been provided on the ways in which drift may occur. How might the process of drift take place in the case of the Canada Health Act? Where do the opportunities exist whereby drift may develop? This is constructive information in the reality of drift. Without knowing how it is that drift is occurring, efforts to end or impede the process will be misplaced if not futile. Even though this is such an important contribution to make, it has yet to be explored.

Due to the very limited application of this theory, there are few actual case studies or research reports to use as guides. The lack of references that can serve as examples presents a challenge in the research design process. Given this, in combination with the inherent challenges that are present in the study of drift, the research design of such inquiry is problematic. With that understanding, emphasized by the fact that the most practical contribution to be made is in the identification of ways in which drift may be occurring, it is proposed that the focus be placed on proposing the potential that such a form of change could take. This is in alternate to attempting to detail every on the ground outcome that is in contrast with the policy or trying to unearth whether drift has been deliberate or unintentional. In addition to providing valuable practical information, proving information on how drift may occur in the Canadian health care system, serves to fill an important gap in the literature.

The Canada Health Act as a case study of drift

The theoretical foundation has been reviewed and the positioning of this study established. While the work of Hacker and Pierson have been significant in the formation of drift as previously conceived, new research needs to continue to contribute and expand

on what has already been proposed, particularly as this is such a relatively new theory. The application of drift to the case of the Canada Health Act is an excellent opportunity to adapt and expand the concept of drift. Tracing the potential paths that drift may take contributes to the elaboration of this concept. Drift theory can be operationalized in this case study and refined by taking into account the experience of the CHA.

Policy and regulatory drift and CHA

The Canada Health Act has been identified as a case that may have experienced drift. Two possible ways in which this drift may take place, policy and regulatory, will be considered. Figure 1 below illustrates the impact that the updating or upholding of the CHA can have on the Canadian health care system and the possibility that policy and regulatory drift can have in the process of drift in this case. This is a visual representation of what will be explored in this thesis.

Initially, following the introduction of the Act in 1984, no drift existed as federal policy was both appropriate and supported. The Canada Health Act represented an updated policy, highly relevant to the time as it responded to the most recent changes that had emerged in the health care systems across the country. The CHA also constituted an upheld policy as violations were identified and penalties levied on offending provinces and territories. This was the status of the CHA in the mid-1980s and is shown in the upper left quadrant.

However, over time the CHA may have experienced drift in two significant ways. In the over 20 years since the policy was enacted, it has not been updated nor has it been upheld to its full ability. This is proposed as the current status of the CHA and is shown in the lower right quadrant.

Figure 1.
Drift Assessment Rubric Chart[a]

UPDATING	UPHOLDING: YES	UPHOLDING: NO
YES	NO DRIFT **(Canadian health care system following the implementation of the CHA in 1984)**	REGULATORY DRIFT
NO	POLICY DRIFT	REGULATORY & POLICY DRIFT **(Canadian health care system in 2006)**

[a] This chart illustrates the relationship between upholding, updating and two forms of drift, policy and regulatory. The case of the Canadian health care system is in bold.

Notes

[1] Wolfgang Streeck and Kathleen Thelen, Beyond Continuity: Institutional Change in Advanced Political Economies. (Oxford: Oxford University Press, 2004) 9.

[2] Jacob S. Hacker, "Privatizing Risk Without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States," American Political Science Review 98 (2004): 244.

[3] Streeck and Thelen 1.

[4] Streeck and Thelen 2.

[5] Streeck and Thelen 5.

[6] Streeck and Thelen 19.

[7] Paul Pierson, Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment. (New York: Cambridge University Press, 1994) 117.

[8] Paul Pierson, "The New Politics of the Welfare State," World Politics 48 (1996): 143.

[9] Pierson, The New Politics 152.

[10] Pierson, The New Politics 153.

[11] Pierson, The New Politics 145.

[12] Pierson, The New Politics 146.

[13] Pierson, The New Politics 147.

[14] Jacob Hacker, "Policy Drift: The Hidden Politics of US Welfare State Retrenchment," In Beyond Continuity: Institutional Change in Advanced Political Economies, eds. Wolfgang Streeck and Kathleen Thelen. (Oxford: Oxford University Press, 2005) 41.

[15] Pierson, The New Politics 156.

[16] Pierson, The New Politics 144.

[17] Pierson, The New Politics 157.

[18] Pierson, The New Politics 174.

[19] Pierson, The New Politics 179.

[20] Pierson, The New Politics 156.

[21] Hacker Privatizing Risk 243.

[22] Hacker Privatizing Risk 246.

[23] Hacker Policy Drift 45.

[24] Streeck and Thelen 24.

[25] Streeck and Thelen 24.

[26] Hacker Policy Drift 45.

[27] Streeck and Thelen 25.

[28] Streeck and Thelen 25.

[29] Hacker Privatizing Risk 246.

[30] Hacker Policy Drift 42.

[31] Hacker Policy Drift 46.

[32] Hacker Policy Drift 48.

[33] Hacker Policy Drift 69.

[34] Hacker Privatizing Risk 244.

[35] Hacker Policy Drift 47.

[36] Jacob S. Hacker, "Review Article: Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform" British Journal of Political Science 43 (2004): 722.

[37] Hacker Review Article 693.

[38] Hacker Review Article 693.

[39] Hacker Policy Drift 57.

[40] Hacker Policy Drift 59.

[41] Hacker Policy Drift 75.

[42] Hacker Review Article 699.

[43] Hacker Review Article 701.

[44] Hacker Review Article 709.

[45] Hacker Review Article 709.

[46] Hacker Review Article 722.

[47] Hacker Privatizing Risk 253.

The Canada Health Act as a case study of policy drift

The application of policy drift to the case of the CHA is expected to illuminate potential ways that drift in the Canadian health care system may occur. It is also expected that this case study will allow for the continued development of the concept of policy drift. A brief overview of the development of Canadian health care policy and, in particular, the Canada Health Act will be provided. Following this, the potential process that policy drift may take in relation to the CHA will be explored. While it is unfeasible to examine the exhaustive ways in which policy drift can occur, the most likely options will be selected.

Introduction to the Canada Health Act

The Canada Health Act is not a document that introduced new concepts or values in the Canadian health care system in 1984. Rather, it became the most recent embodiment of previous Acts and ideas that had already formed the institution that Canadians had come to love. The CHA was the avenue taken to update and renew the federal role in health care across the country. In this light, the Canada Health Act has a strong purpose and clear direction. While the non-explicit nature of some of the Act can leave it vulnerable to be taken advantage of and misinterpreted, when the legislation is viewed in light of the history leading to its creation its objectives are very clear. However, background is often not taken into account in the application of policies and the CHA is no exception to this. It is crucial to review the developments that have led to the establishment of the Canada Health Act to illuminate the presence of legislative drift.

Although health is an area of provincial and territorial jurisdiction, the federal government has long outlined national values to be included in the development of the systems that emerged across the country. Regardless of where Canadians lived, the federal government sought to establish some uniformity in the health policies and care received. The involvement of the federal government in the area of provincial and territorial jurisdiction is permitted due to the financial transfers that are related to the maintenance of the Acts. This arrangement has been referred to as "paying to play" that sees the federal government buying influence over health care in areas that it was not given jurisdiction over. The provinces and territories can agree to run their health care systems with federal influence and receive financial support in return.

The shared costs formula has developed in conjunction with the development of health policy and has a significant impact on the Canadian health care systems. Prior to exploring the legislative changes that have taken place, the amendments to funding arrangements will first be reviewed. The changes in the intergovernmental distribution of funds are looked at to provide a more complete picture of the growth of the Canadian health care system, all of which has, obviously, contributed to the current setting. However, the implications that the forms of funding have had in relation to drift will not be assessed. The initial creation of federal health care policy, which will be explored

below, established a cost-sharing formula of 50/50. For every dollar that the provinces spent on health care, the federal government would reimburse them 50 cents. In 1977 this arrangement was replaced by Established Programs Financing (EPF), which provided cash as well as tax point transfers to the province. However EPF was no longer based on provincial expenditures, shifting greater financial pressure onto the provincial governments. Then the Canada Health and Social Transfer (CHST) replaced the EPF arrangement in 1995. The CHST combined payments made for health and social services; funds allocated for health care, welfare, and education services were merged into one transfer. The provinces argued that the CHST in effect reduced the amount of funds provided for health and that as a result of that there was even further burden placed on them.[1] In 2004 the current shared costs arrangement came into effect in the form of the Canada Health Transfer (CHT). The CHT is linked directly to the CHA and, like the EPF and CHST, is made up of a combination of cash and tax points transfer.[2] While obviously related to health policy, funding mechanisms are separate from policy and have evolved independently of legislative changes of the CHA.

There are two prominent Acts, the Hospital Insurance and Diagnostic Services Act (HIDSA) and the Medical Care Act (Medicare Act), that are able to chronicle the development of the health care system at the national level and form the path that leads to the Canada Health Act.

The Hospital Insurance and Diagnostic Services Act was legislated in 1957 to facilitate universal hospital insurance in every province. Under HIDSA, health services provided in a hospital were covered and eligible for federal funding at fifty per cent of the cost. Although some provinces were developing health care systems, this federal Act set what Saskatchewan had achieved as the benchmark. Aside from greater uniformity, this also raised the bar for most provinces in the care that it would provide for its citizens. HIDSA moved to integrate the efforts of hospitals, doctors, civil servants and citizens. The influence of HIDSA is significant and shaped the health care system of generations of Canadians to come.

As Taylor G. Malcolm stated, when taking into account "its humanitarian objectives, its potentialities, its implications, its risks, its costs, and its declaration of faith, it was a policy choice of the highest magnitude"[3]. While this can largely be true of most actions within the field of health policy, especially at the federal level, it was particularly the case of the HIDSA as it was such a trailblazer. The Hospital Insurance and Diagnostic Services Act "was the largest governmental undertaking since the war and it would require federal-provincial cooperation on a scale never before known"[4]. HIDSA was not only significant in its own merit, but also as it was an impetus in the development of the health care systems across the country. It was rightly touted by Taylor as "the most constructive example in Canada to that time of those great legislative landmarks that are the products of political wisdom, social insight, and crystallized national conscience"[56].

Though the coordination may have been challenging, the HIDSA has created a continuing health policy legacy, at least in theory. With the generous offer of "federal cost-sharing, six provinces that had not previously been involved in hospital insurance launched programs meeting the federal conditions"[7]. This momentous accomplishment observed "ten provincial plans melded into the reality of a national program. By 1961 almost the total population of Canada was entitled to the same comprehensive hospital care benefits"[8]. The Hospital Insurance and Diagnostic Services Act was a success as it had "achieved its primary objectives of meeting hospitals' operating costs and protecting individuals and families from financially crippling hospital bills"[9]. This constituted a massive expansion of coverage from what had existed previously and help to form the foundations of the Canadian social safety net.

Eventually it was time for the next step. HIDSA had been a great success and thoughts turned to when the base that had been established would be built upon. For Canadians, "it had become a natural, normal expectation that awaited only the time when a special concatenation of political forces, public attitudes, and determined leadership would reach the necessary "critical mass" and the dream would be realized."[10] This dream started to become a reality in 1961 when "the federal government set up a royal commission headed by a Supreme Court judge (the Hall Commission)"[11] to report on the state of health care in Canada. It was in 1964 that the Hall Commission published its findings. While HIDSA had done a great job in accomplishing what it had set out to do, it was still rather limited in scope as it only related to those services provided in hospitals. The primary recommendation was for the federal government to "cost-share a universal medical insurance program based on the"[12] model developed in Saskatchewan. This recommendation started to take shape in the Medical Care Act.

The Medical Care Act, enacted in 1966, worked from the objective as outlined by the Hall Commission to "provide everybody in Canada with comprehensive coverage regardless of age or state of health or ability to pay, upon uniform terms and conditions"[13]. While this is a shared goal of the HIDSA, it moves coverage outside of the hospital and into doctor's offices, funding more services. This expansion was welcomed by Canadians and viewed by them as the logical development of Canadian health policy, continuing to build on what had already been achieved.

Under the Medicare Act, there were four criteria that had to be met for provinces to receive federal support: "(1) comprehensive coverage, (2) portability of benefits between provinces, (3) public administration either directly or through non-profit agencies, and (4) universal coverage"[14] on uniform terms and conditions. Comprehensive coverage refers to the requirement for the funding of approved services as administered by doctors, hospitals and dentists providing services in hospitals. Portability serves to protect Canadian's mobility rights and ensures that Canadians are covered by their "home" province if visiting or in the initial stages of moving another province. Public administration guarantees that the management of health care systems cannot be sold or contracted out to private companies. Universal coverage indicates that every eligible

citizen is entitled to receive the benefits of public insurance. Given that provinces were willing to uphold each of these criteria, then they could join the program and would be eligible to receive federal payments based on the "national" *per capita* costs calculated on the costs in *participating* provinces rather than in all provinces"[15]. Therefore, the numbers would be readjusted when additional provinces enter the arrangement.

The Medical Care Act was passed with a final vote in the House of Commons of "177 ayes to two nays – almost reaching the unanimous vote on hospital insurance ten years earlier, undoubtedly reflected the recognition of the Canadian people that a new system must come into being"[16]. As the HIDSA before it had created a policy legacy, Medicare contributed to this and furthered the expectations of Canadians.

As time passed since the enactment of the Medical Care Act, there were developments in the field of health care that necessitated responses in policy. In particular, there had been a significant increase in extra-billing and user fees. Extra-billing, the payment by patients for insured services in addition to the amount as paid for by the public insurance, and user fees, costs charged to insured persons for the use of facilities, were both identified by Hall as threats to the Canadian health care system. The creation of the CHA, while not providing the focus of this study, could serve as the basis of additional research on the case of the CHA in relation to drift, but as a response to drift itself. New developments, such as extra-billing and user fees, created drift from the Medical Care Act. The required response by the federal government to these emerging pressures came in the form of the Canada Health Act. The creation of the CHA corrected for the drift that had been occurring and was able to help put the Canadian health care system back on track. The CHA has since become known as a symbol of "many of our Canadian values and our "Canadian way" of doing things"[17] and a source of pride for Canadians.

The CHA was a renewal and reaffirmation of some of the existing elements as already established by previous Acts but it also served to update federal health policy. Both HIDSA and the Medicare Act "included four explicit conditions for provincial public health care insurance plans – namely universality, public administration, comprehensiveness and portability"[18]. These previous pieces of legislation did not, however, include any sanctions on the direct billing of patients, nor did they include a condition on accessibility. It was these last omissions that particularly necessitated the updating of health policy by means of the Canada Health Act. The CHA, consequently, included two provisions on extra-billing and user fees and an additional principle of accessibility in an effort to create policy that best responded to the current realities that had existed in the Canadian health care system.

It was in 1980 that "the Health Services Review by Justice Hall reported that health care in Canada ranked among the best in the world, but warned that direct patient charges were posing a threat to the principle of free and universal access to health care throughout the country"[19]. While the previous acts had served Canadians well, there were new

emerging concerns that needed to be addressed so that what had been achieved could be maintained or even improved on. The identification of rising pressures and the growing impact and potential effect that these had on the health of Canadians required action to rectify what had been occurring. It was in an effort to deal with these emerging threats to the Canadian health care system that the Canada Health Act was passed unanimously in 1984.

There are two conditions, two provisions and five principles that make up the CHA. The conditions given to the provinces and territories are the most straightforward and have caused the least confrontation. The first condition is the annual provision of information to Health Canada. The second condition is the recognition of the federal contribution to the health care of Canadians.

The two provisions were the primary impetus for the creation of the Canada Health Act. The extra-billing of patients by physicians and the charging of user fees by hospitals were on the rise in the early 1980's. Extra-billing is when a patient is charged an amount in addition to the fee paid to the doctor by the government. User fees are supplemental facility costs that are paid for by the patient. Both extra-billing and user fees can act as significant impediments to obtaining health care and for that reason are, as outlined in the CHA, not expected to exist in provincial systems. For both of these provisions, there is a mandatory dollar for dollar financial penalty in the form of a deduction to the federal transfer to the offending province.

The five principles are those of public administration, comprehensiveness, universality, portability and accessibility. The first principle, or section 8 of the CHA, is *Public Administration*. This criterion is to ensure that the "provincial and territorial health insurance plans are administered and operated on a non-profit basis by a public authority, which is accountable to the provincial or territorial government for decision making on benefit levels and services, and whose records and accounts are publicly audited"[20]. The second principle, or section 9 of the CHA, is *Comprehensiveness*. The principle of comprehensiveness expects that "the health care insurance plan of a province or territory must cover all insured health services provided by hospital, physicians or dentists"[21]. The third principle, or section 10 of the CHA, is *Universality*. This criterion requires that "all insured residents of a province or territory (are) entitled to the insured plan on uniform terms and conditions"[22]. The fourth principle, or section 11 of the CHA, is *Portability*. The principle of portability upholds Canadians' mobility rights, stating "residents moving form one province or territory to another must continue to be covered for insured health services by the "home" jurisdiction"[23]. Finally the fifth principle, or section 12 of the CHA, is *Accessibility*. The intent of the accessibility principle is to "ensure insured persons in a provinces or territory have reasonable access to insured hospital, medical, and surgical-dental services"[24].

Extra-billing, the provision specified in section 18, is related to provincial and territorial billing for services that are covered by Medicare. *User fees*, the provision

specified in section 18, is concerned with fees that are not a result of services but the use of facilities. If a patient were charged for a service that is insured, this would be a case of extra-billing. If a patient who received an insured service at a hospital was billed with a facility fee, this would be a case of user charge. The practice of extra-billing and user charges is "seen as a barrier or impediment for people seeking medical care, and is therefore contrary to the accessibility criterion"[25]. For this reason, these two provisions of the CHA are identified as two areas in which deductions can be made from the federal cash transfer to the offending province or territory if it is determined that extra-billing and user charges have taken place. The provisions against extra-billing and user fees are the operationalization of the accessibility principle to specific threats.

The experts who spoke before the Senate Committee responsible for producing the Kirby Report, appropriately explained how the CHA was the logical continuation from previous Acts. These specialists also noted that the Canada Health Act was the required response to a change of circumstances in order to maintain relevance. Abby Hoffman stated that the CHA "combined and updated the conditions set out in the two federal acts of 1957 and 1966"[26]. As to why the Canada Health Act was adopted, Marc Lalonde submits the explanation that it was "in response to the erosion of the public health care insurance"[27]. This would be consistent with the approach taken with the CHA. The Canada Health Act reaffirmed those principles or concepts that were still relevant and included new requirements to update Canadian health policy.

A guiding objective of the CHA, and stated in its preamble, was to provide Canadians "access to quality health care without financial or other barriers"[28]. In addition to the more obvious and specific goals of the CHA, found in the principles and provisions, the achievement of the stated intention above serves a more wide-ranging aspiration. As a general premise, developments that establish barriers to Canadians receiving insured health care are impediments in the achievement of the goal of CHA.

Contextual changes of the CHA demonstrating the necessity to update the CHA

Preservation of the Canadian health care systems can no longer be accomplished with the current Canada Health Act. There have been too many changes that have occurred, in the over twenty years since the CHA was passed, to expect that this policy would still be sufficient in its original form. Perhaps what is more mystifying in light of the developments that have occurred within the scope of the CHA, is not that no reform has taken place, but that there have not even been any attempts made to update this piece of legislation that impacts the lives of every Canadian. While "there has been much public discussion about the need to reform the health system"[29], there have been no steps taken to update the CHA to make it more relevant.

The implication of a stale policy is clear: the more changes occur within the context of the CHA, the less effective it becomes. In the absence of genuine effort to respond to contextual changes, a policy slowly drifts in its relevance, gradually distancing itself from the very goals it was laid out to do. Canadians have increasingly become concerned about the performance of their health care system in such evolving contexts. In 1997 this fear was expressed in a federal report by the National Forum on Health:

> Newspaper headlines regularly suggest that the health care system is in crisis. Conflicts are escalating between health care providers and governments. People see hospitals closing, and they are told that waiting lists for surgery are getting longer and that physicians are leaving the country. Families and friends have to assume more responsibility for care in the home. Governments have frozen or reduced health care expenditures. The private sector is pressing to gain access to new business opportunities in a sector that, up to now, has been beyond its reach.[30]

Almost ten years ago, the impact of contextual changes was receiving notice from a federal report, an acknowledgement from politicians that they were aware of the growing problem. As indicated by Roy Romanow[31], the Canadian health care systems have experienced significant contextual changes including an increase in technology, an explosion of pharmaceuticals, short hospital stays and an adjustment in public expectations and demographics. Romanow acknowledges that the emergence of these variations have had the effect of putting more pressure on the health care systems and have changed the practice of the CHA. Action might be expected following the identification of a problem. This was not the case. Rather, contextual changes have continued to develop, and be identified by the federal government itself among others, changing the effect of federal health policy.

Table 3 is an attempt to provide a snapshot of some of the contextual changes that have occurred in context of the CHA since it was enacted in the mid-1980s. While the information is by no means exhaustive, it is intended to show some of the changes and demonstrates the need for an updated policy.

Table 3: **Changes within the scope of the CHA - Then and Now**

Indicator	"Then"	"Now"	Interpretation	Implication
Percentage of health care costs paid for publicly	76% in 1984[32]	70.1% in 2003[33]	Decrease in the percentage of health care costs that are publicly funded	The Government is decreasingly responsible for health care costs
Percentage of health care costs paid for privately	23.9% in 1984[34]	29.8% in 2003[35]	Rise in the percentage health care costs that are privately funded	The individual is increasingly responsible for health care costs
Total inpatient hospital days	23,326,06	20,423,817	Decrease in the total amount of	Canadians have spent less time as

	8 in 1995-1996[36]	in 2002-2003[37]	days that Canadians stayed in hospitals by approximately 12.4% from 1995/1996 to 2002/2003	inpatients in the hospital; costs associated with this now shift from the hospital on to the individual
Same-Day Surgery Visits	1,096,276 in 1995-1996[38]	1,715,660 in 2002-2003[39]	Increase in the amount of day surgery visits by approximately 56.5% from 1995/1996 to 2002/2003	With aftercare responsibilities shifting from the hospital and its staff there is a greater burden and cost for the individual
Number of MRI Scanners in Canada	22 in 1991[40]	151 in 2004[41]	Increase in the number of MRI scanners in Canada	Diagnostic capabilities have evolved
Number of CT Scanners in Canada	200 in 1991[42]	338 in 2004[43]	Increase in the number of CT scanners in Canada	Diagnostic capabilities have evolved
Public expenditures on home care	Approx. $205 million in 1980-81 (.6 % of the total public health care expenditures)[44]	Approx. $2.5 billion in 2000-2001 (3.5 % of the total public health care expenditures)[45].	Increase in the percentage of budget allocated to homecare	Home care has become a more significant part of total health care spending but has still not become included in coverage under the CHA
Total cost of pharmaceuticals as a percentage of total costs of health care	9.6% in 1985[46]	17.7% in 2004[47]	Increase in pharmaceutical spending as a percentage of the total health expenditures	Pharmaceuticals have become a more significant part of total health expenditures but has still not become included in coverage under the CHA unless services are provided in the hospital

There are a variety of developments that have taken place within the scope of the CHA and these have necessitated a response in policy that has yet to come. We can use specific data to demonstrate some of the changes that have transpired in the context of the current federal health legislation. These changes have served to decrease the effectiveness of national health policy. There has been a change in the CHA in practice although there have not been any changes made to the legislation. The outcome of this policy has been able to change over time although such a difference has not been the result of an informed discussion in public. Such changes have not come through any formal reform. Left without a response in policy to contextual changes, the influence of the policy has been distorted. The contextual changes that have occurred since the early 1980s, such as an increase in "day surgery, less invasive care, increased reliance on community-based care and home care"[48], necessitate a response in the CHA that has yet to occur.

There has been a transfer of responsibility from the government onto the individual from the time when the Canada Health Act was created to now. As health care "spending in the public sector was constrained, some would argue that it had the effect of transferring some of the costs to the private sector"[49]. In fact, this is the position taken here, that the financial burden related to health has shifted more pressure onto the individual. The changes in context coupled with an increasingly out of date policy has had one particular overarching impact of great significance, the increased financial pressure on the individual. The Canada Health Act "has historically privileged hospitals and physicians (but) shifts in the setting in which Canadians receive services and products have resulted in an increasing reliance on private health service finance"[50]. The share of health care costs that are paid for by the individual has increased while the publicly funded proportion has decreased. Related to the "distribution of total health spending, the public share decreased from 76 per cent in 1980 to 71 per cent in 2000, while the private share increased from 24 per cent to about 30 percent over the same period"[51]. This paints an overall picture of the contrary direction the health care system is moving, in part, due to outdated policy.

With the advancements that have been made in medicine and the change in the provision of care in the twenty plus years since the CHA was written, health care systems across Canada have been transformed significantly. Perhaps the most significant of these transformations, related to the CHA, is that "shorter stays in hospitals have shifted costs that were previously covered by the public system to the private sector (where prescription drug costs, for example, will be paid for by out-of-pocket expenditures or private insurance claims)."[52]. The reduced length of hospital stays "have also introduced other direct and indirect private costs that are borne by patients (and their families) who return home to recover"[53] The implication of this is that the care and drugs that 20 years ago would have been all provided within a hospital, and thus publicly funded, are increasingly the responsibility of the individual. This is of immense significance as the CHA, due in part to the legacy created with HIDSA, is centred on hospital services. When the CHA was created it would have meant more to Canadians receiving health care at that time than it would to those receiving it today, as it covered more at that time.

Where years ago someone going in for a surgery that would have required them to stay in the hospital for a week, would neither be responsible for the cost of care provided by health professionals nor be presented with a bill to cover the medications that they needed. However, with day surgeries, any care or drugs that are required after leaving the hospital become the sole responsibility of the patient and his/her family. With the increase in day surgeries, these individual expenses have increased as well. These changes are a result of advancement in technology and delivery, not in the medical necessity of a service. While the care or medication may still be medically necessary, once it has moved outside the hospital walls the onus shifts from society to the individual. While the values remain in policy, the context of this policy has changed and there has been no effort made to adjust the policy to reflect such a difference.

There are fewer services covered by provincial health care systems now than were covered soon after the enactment of the CHA. With the decreased financial support from the federal government, the provinces have had to cover more of the costs of health care. As a result, provinces have reacted by delisting many services from the public insurance. Services that had once been defined as medically necessary and paid for publicly have been reclassified and now the burden is on the individual to finance them. The federal government transferred more financial burden onto the provinces that did the same thing and shifted more responsibility onto Canadians.

This shift in health care responsibilities and costs from society to the individual is evident in a variety of numbers, in addition to the increase in day surgeries and the decrease in length of hospital stays. The day surgery and length of hospital stay information can perhaps be viewed as part of the cause for the shift while changes in homecare and pharmaceutical numbers can be perceived as the effect. There "has been a continuing shift away from in-patient care to ambulatory care"[54]. Since the fiscal year 1992, "home care expenditures have continued to grow, but at a rate that was fourfold greater than that for other health spending, 9.0% to 2.2%. These figures are indicative of a dramatic increasing emphasis on home care service"[55]. The spending on pharmaceuticals has also been steadily increased. In 2004 "spending on pharmaceuticals accounted for 17.7% of total health spending in Canada, up from 15.5% in 1999 and 13.1% in 1994"[56].

There have been great technological advancements in health from the time when the Canada Health Act was created until to now. This progress obviously has an impact on the health care systems. The development in diagnostic capabilities has been significant. Although data for 1984 was not available, even from 1991 (the oldest related data that could be obtained) until 2004, the number of CT and, in particular, of MRI scanners in Canada has increased dramatically. Changes in the capabilities of health services qualify as a reason for updating a policy to reflect this. This is intensified as the private/public payment arrangement, which is at the very heart of Canadian health policy, is threatened. The definition of medically necessary must be reestablished, specifically addressing the acceptability of "just looking" diagnostic tests. Leaving the situation open for

interpretation is not an acceptable approach in the legitimate pursuit of the goals of the CHA. The debate needs to take place on whether diagnostic services should be available outside of hospitals. If it is determined that it is acceptable that such capabilities are acceptable in private clinics, then what are the funding implications and the relationship that will exist with the public system?

Complementary or alternative medicine has become increasingly popular in Canada. There has been a rise in the use "of a broader range of providers (e.g., midwives, practitioners of alternate medicines and physiotherapists)"[57]. These services are often paid for out of pocket. The delisting of insured services provided by chiropractors, physiotherapists and optometrists, as was carried out in 2004 by the Ontario Ministry of Health, again pushes increased costs onto the individual.

There are new concerns and threats to the traditional health care systems. While extra-billing and user fees presented the major threat at the time that the CHA was created, there are additional risks that have developed since 1984 which necessitate a response. Such a response is needed to produce the health care systems that were intended. Private clinics have increased since the enactment of the Canada Health Act. Private for profit facilities are "rapidly expanding their services across the country, but even the industry's own advocacy group lacks definitive numbers on the size and scope of the private health care sector."[58]. Private clinics threaten the accessibility of the Canadian health care systems by creating barriers, of health and finances. The growth of privately funded health services also furthers a two-tier system in a country where anyone in the country is supposed to be able to receive the same care regardless of their ability to pay for it. Allowing the expansion of the private sector in health is not continuing in the same direction that the CHA came from. This is supported by Colleen Flood who states that payments "for access to family doctors would mark a monumental shift in Canadian health care"[59]. While the CHA does not prohibit the provision of privately funded health care services that are not covered through public insurance, it is a possibility to explicitly prohibit this in an updating of the legislation. It would be consistent with the intent of the CHA to update it so that it prohibits the continued rise of privately funded health care.

A concern that has received a considerable amount of media coverage is the length of time that Canadians have to wait before they receive care. Since the CHA was created, the amount of time that a patient has to wait to be treated has increased. This conflicts with the origin of the CHA. Canadians may die while waiting to receive health care. Many Canadians have spoken out against the increased wait times. It would be consistent with the intent of the CHA to update it so that it puts a cap on the amount of time that a patient could wait to receive care.

Just as extra-billing and user fees in the early '80s presented a serious threat to the Canadian health care systems and required a genuine response in policy, there now exist significant challenges that need the same reaction. The more time that goes by where these threats to health care in Canada are tolerated, the further embedded they will

become; the more likely they will contribute to a change in the direction of the health care system in Canada. In the context of this study this is not a political argument but a projection of what can occur if drift is allowed to occur over time. It is proposed that after long periods of drift, the situation will be accepted as the norm.

The reality has become, through the evolution of all of these contextual changes devoid of responses in policy that "many health services that Canadians rely on fall outside the scope for the Canada Health Act"[60]. Maintenance or evolution of the CHA cannot of transpired for this to be the case.

Further evidence of the need to update the CHA

Over the last ten years there has been a variety of studies and reports, both at the provincial and federal level, on health care in Canada. Many of these inquiries have, in particular, commented on the Canada Health Act and the impact that it has had since its implementation. All of the sources reviewed for this analysis concurred that changes need to be made to the CHA. The two reviews conducted at the federal level share the same scope in examining the systems across the country from the national perspective. The provincial reports, such as Fyke in Saskatchewan, Clair in Quebec and Mazankowski in Alberta, work from a much more narrow and self-interested point of view. Particularly for reasons of comparison, and more importantly as the Canada Health Act is a piece of federal legislation, it is these national reviews that will provide the basis government initiated evaluations. The first analysis that will be reviewed is from the Romanow Commission for the House of Commons. The second study that will be reviewed was prepared for the Senate and has become known as the Kirby Report. These two documents not only represent an extensive amount of work, but also are the product of the top scholars and experts in health care in Canada. The range of information contained in either of the reports is limited; these resources cannot be an infinite supply of information. Even so, these two reports are tremendous assets. The involvement of academics, think tanks, Health Canada, elected representatives and citizens in the analysis of the state of health care in Canada has never happened on a scale like it did in these two cases and as a result they provide unprecedented and valuable information.

While there have been many reports from different sources and from a variety of perspectives presenting a lot of different pieces of information, what they all share is the position that the CHA no longer corresponds to the field it is intended to represent. The specific recommendations about how to best go about correcting this is where the paths start to diverge. While some propose the explicit authorization of privately funded health services in legislation others advise the opposite; the CHA needs to prohibit the growth of the private sector in health care. The perspective taken for this study will be to side with those reports that are generally in support of strengthening the CHA so that it continues to correspond with the spirit within which it was written. This direction is one that follows in the path of previous federal health policy and is consistent with the origins of

the Canadian health care system. Support for increased privatization or changes contrary to the current legislation is not assessed as updating, in an effort to maintain or reinforce, but rather as a change the direction of development. The two federal Reports, Kirby and Romanow, are considered to offer, at the very least, recommendations that would maintain the character of the CHA. Thus, it is these documents that will be used as the source concerning proposals to modification to the CHA and with the scope of the policy.

An effective policy, which is contrary to a policy that has drifted, must respond not only to the more obvious contextual changes as they arise, but at its core it must also ensure the maintenance of the intent of the legislation over time. This could, for example, require responses to emerging ideologies that threaten such maintenance. While this is likely more controversial than responses to contextual changes as its nature is less identifiable than concrete change that can be measured, it is at the centre of the issue of drift. Canadians are increasingly worried about the state of health care systems in Canada. Why is that the case? If the Canada Health Act were a reactive and relevant policy, would the same degree of concern exist? At the very least, the expectation is that the federal government would need to respond to the contextual changes that have developed in the over 20 years since the CHA was implemented for the policy paradigm to be maintained and the values or norms be preserved.

The principles of the CHA have served Canadians well in establishing fundamentals in the systems across Canada. However, these principles now require both expansion and clarification to adequately represent the present day situation. While the current five principles are of great significance and have valuably influenced the formation of the health care systems across Canada, with new concerns or issues comes the need for new principles or the renewal and improvement of those already existing.

The scope of the CHA is incredibly intricate and constantly evolving. Included in Table 3 above are just some of the elements that make up the field of health that continue to change. These represent changes that are measurable and more distinctly demonstrate the need to adjust policy in reflection of such variations. In absence of such a reaction, the CHA has been allowed to drift and as a result does not effectively represent the actual scope of the policy.

Updating of the Canada Health Act must be consistent with its origins

It should be clarified that all recommendations to update the CHA may not be consistent with its origin. This is true even though it might be phrased in language that stresses the desire to strengthen or improve the Canadian health care system. For example, one may believe that the health care systems in Canada would be enhanced with authorization of extra-billing of patients. While this argument could be framed in terms of helping to decrease the waiting times, as the extra-billing would provide a deterrent to those seeking

unnecessary care, and therefore improve the reasonable access of Canadians in obtaining care. While this might superficially appear to reinforce the CHA, it actually violates it. Aside from the obvious, with the removal of a significant tenet of the policy, the sanctioning of extra-billing also contravenes the CHA as it violates the same principle it could be argued it supports, that of accessibility. Authorization of the additional billing of patients would make care for some inaccessible. This supplementary fee discriminates against those who do not have the ability to pay for it. A distinction must be made between subversive dismantling of a policy and desire to build on it.

While there have been significant contextual changes within the scope of the CHA the direction of the obligatory responses to these must be consistent with the origins of the policy. While these changes have occurred and necessitate an updating of CHA, the support "for the principles of the *Canada Health Act* has remained high throughout the past decade"[61]. This consistent endorsement of the content of the CHA, as demonstrated in Table 4, reveals the necessity to remain loyal to the spirit of the policy; the path that was laid in the early 1980s must be upheld, or tracing its origins back even further, updating should reflect the spirit of the influential HIDSA and Medicare policies.

Table 4 **Support for maintaining the Principles of the Canada Health Act** (per cent indicating "very important") [62]

Principle	1991	1994	1995	1999
Universality	93	85	89	89
Accessibility	85	77	82	81
Portability	89	78	81	79
Comprehensiveness	88	73	80	80
Public Administration	76	63	64	59

While these principles still continue to be a priority, Canadians do not feel that they are being upheld well. As shown in Table 5, citizens do not feel that the CHA is being well maintained. The implications of Tables 4 and 5 show Canadians as perceiving drift in the light of strong institutional support. Citizens support the principles of the CHA however, they do not that think they are fully realized in practice. This yet again demonstrates the need in updating the Canada Health Act so that it can, at the very least, be preserved, with the only possible exception according to this poll being the principle of Universality.

Table 5 **Percentage saying that the health care system is living up to the five principles of the Canada Health Act, 1999**[63]

Universality	**82**
Accessibility	**62**
Portability	**63**
Comprehensiveness	**50**
Public Administration	**59**

A major issue "in recent years has been the scope of coverage under the publicly funded health care system as specified by the *Canada Health Act*"[64]. Not only is there support for maintaining the CHA, but there is also a desire to continue to develop the policy and increase the number of services that are covered under it. There is "considerable support for including prescription drugs and home care in the *Act*, with higher support for home care"[65]. As Table 6 illustrates, the interest in expanding the CHA, has been steadily growing and the most recent figures show that it has reached significant levels. The expansion would be consistent with the origins of the CHA and would continue to develop the policy further along the path from where it came. Canadians want an expansion of the CHA to provide greater coverage. The dramatic increase to the final numbers available from about 50% to 77% supporting the inclusion of pharmacare and a level of support of 85% for the inclusion of home care into the CHA, suggest the impact that the contextual changes have had on Canadians. More specifically costs of drugs and provision of care in the home have become a major concern. Citizens are feeling more pressure now than they did in the mid-1980s and are looking for greater support that is consistent with the origins of Canadian health care systems. There is a desire (and need) to return to their roots.

Table 6 **Support for including pharmacare and home care under the Canada Health Act** (per cent)[66]

Support To....	**1996**	**1997**	**1998**
Include *pharmacare*	49	67	77
Include *home care*	n.a.	83	85

Given such strong support by Canadians for the principles of the CHA, their belief that the latter are not being met in practice, and their desire for the legislation to be expanded to include more services, it is really quite surprising that the debate on the updating of federal health policy has not led to more action.

Options to update

In concept, without sufficient responses to the changes that occur in context, principle or spirit, the CHA will experience policy drift. It has been the observation of this author that this is what has happened in practice. This can also be construed from the

recommendations made in the Kirby and Romanow Reports. The two eminent reports released by each of these sources share the same goals, generally, through the roads that they pave out to reach those objectives are different. The proposals made in these reports seek to move the CHA back on track so that it can achieve what the policy had originally set out to.

Perhaps the most well known of the two efforts was the Commission on the Future of Health Care in Canada, known as the Romanow Commission after the former Premier of Saskatchewan, Hon. Roy Romanow, who led the inquiry. The Romanow Commission was established in 2000 by then Prime Minister, Jean Chrétien. It was the target of the Commission to investigate a wide variety of areas related to health care in Canada and report back to the House of Commons. In preparation for the Report, the Romanow Commission made a significant effort to involve Canadians, traveling across the country and holding public meetings to gather the opinions and perspectives of citizens on the issues that were being explored. As a result of this dialogue that took place across the country, the Romanow Commission reinforced that Canadians "remain committed to a national approach to health care, and expects that a broad range of necessary and high-quality health services will be available to all citizens of this country on an equal basis"[67]. This is perhaps the most valuable and most significant product to come out of the Report, as it confirmed the authority of continuing in the same direction from where the CHA originated.

The Commission recognized the need to update the Canada Health Act. The Romanow Commission explained the need to modernize the federal health policy as ensuring "that it provides a solid foundation for managing our health care system in the 21st century"[68]. The perspective of the College of Family Physicians of Canada has clarified that "'revisiting' and 'updating' do not mean "abandoning" the Canada Health Act"[69]. This was an opinion shared by the Romanow Commission as its motivation behind the updating of the CHA was to make it more applicable than it currently is. Updating ensures that "the Act and its principles are relevant and meaningful to the world we face today and the one we are heading into tomorrow"[70]. The interest here is not only in correcting for past drift, but perhaps more importantly, in the expansion of the CHA and the creation of safeguards for the future.

There were five key recommendations made by the Romanow Commission regarding changes to Canada Health Act. The first proposal made relates to the principles. It was submitted that the CHA would be strengthened by "confirming the principles of public administration, universality and accessibility, updating the principles of portability and comprehensiveness, and establishing a new principle of accountability"[71]. These changes alone would constitute a strengthening of the Act.

Regarding changes involving the principles, the most straightforward of these suggestions is to reaffirm the commitment of the federal government to the principles of public administration, universality and accessibility. These principles were reviewed and

determined to be absolutely essential to the Act and as such they should be maintained and upheld.

It was advised that the principle of portability should be updated so that out-of-country health care coverage would not be a requirement under the CHA. Portability should support mobility within the country, which requires the coverage of health services for Canadians moving between provinces and territories. Therefore, the Romanow Commission recommended that this principle should be preserved and better enforced. While the principle of comprehensiveness should be maintained, it requires modification to better apply to the current environment it is supposed to correspond with. The principle of comprehensiveness should be upheld "not so much as a description of existing coverage under the *Canada Health Act* but as a continuing goal"[72]. The Commission saw two stages to the expansion on the principle of comprehensiveness. The first, and short-term, modification consists of immediate changes to "expand services to include medically necessary diagnostic and home care services". This directly relates to and supports the proposition above that the CHA should not only be maintained, but also expanded. The second, and longer-term, development is that "the principle of comprehensiveness should be revisited and updated periodically"[73]. How this recurring revision is to take place is not specified in the Report, though perhaps this would be in the form of a sunset clause, written into the Act that after a specified period of time the principle is to be reevaluated.

The final recommendation that was made in regards to the principles of the CHA is the addition of a sixth, that of accountability. The given rationale for this additional principle is "as the owners, funders, and users of the health care system, Canadians have a right to know how their system is being administered, financed and delivered, and which order of government is responsible for which aspects of the health care system"[74]. Although this justification may appear obvious, it provides a commentary on how information is guarded, particularly that related to the Canada Health Act. It has been the experience of the author that CHA information is guarded at best and held in secrecy at worst. The information that came from interviews conducted with officials at the Canada Health Act Division (CHAD) was little more than can be found on the Health Canada website. The officials refused to answer questions such as "Has the CHAD initiated changes to the monitoring and enforcement processes?", "Has the CHAD made attempts to improve the provincial and territorial submissions for the CHA Annual Reports (more information and consistency between jurisdictions)?" and "Why has CHAD not interpreted or provided information on the information submitted by provinces and territories for the CHA Annual Reports?". Some questions were given responses of "there's information about that on the internet" and requests to elaborate on the vague details that they referred to were refused. The interviewees declined some requests, for contact information of regional CHAD representatives and to view letters from the federal minister to provincial counterparts, for example. The only opportunity to obtain documents in some cases turned out to be through submissions made through the Access to Information Act (AIA). Specifically, the CHAD Policy Interpretation Manual was

obtained through an application under the AIA. The difficulty with the Access to Information Act is that in addition to documents that are not accessible, the request has to be very specific – so you already need to know that you are looking for. With so much information shroud in secrecy by Health Canada, the most valuable source for revealing documents that can provide further information was the reports made by the Auditor General. It was in these that specific references were made to documents that could then be requested under the Access to Information Act. Granted, even then, as in the case of the policy interpretation manual, some of the content was removed prior to my receipt of it. There is an apparent paradox in this situation where information that is directly and significantly related to the public is not openly available to them. The call for greater accountability concerning the CHA is an increasingly relevant and justified demand.

These proposed alterations and the addition to the current criteria, would be expected to produce "a renewed *Canada Health Act* with six solid principles" that "will provide a strong foundation and ensure that the health care system not only reflects Canadians' values but also continues to change and evolve to meet Canadians' needs"[75].

The second recommendation made by the Commission in regards to the CHA is to expand "insured health services beyond hospital and physician services to immediately include targeted home care services followed by prescription drugs in the longer term"[76]. As introduced with the discussion of the principle of comprehensiveness, there is a "gap between what should theoretically be included as part of medicare and the services that are actually included as "insured health services" under the current *Canada Health Act*"[77]. This is an excellent insight and one that cannot be overemphasized. This recommendation by the Commission speaks to the opportunity not taken to rejuvenate the CHA and move it further in the direction of where it originated. The most basic drift has occurred as what originally existed was left to decay. It could be argued that in addition to this most basic type of drift taking place, an entirely different level of drift has occurred as well by the failure to rejuvenate the policy.

The Commission acknowledged the impact that the "advances in medical technology and changes in health care delivery since medicare was introduced have meant that many services can now be provided outside hospitals and by professionals other than physicians"[78]. This has an impact, in theory (as it obviously has not had any effect in practice on the CHA) as not only is it directly within its scope, but it specifically relates to the content of the policy itself. These realities in the Canadian health care system have to be taken into account in the federal legislation that applies to it. For a policy to remain relevant over time, it absolutely must not only be maintained, but also evolve; it must respond to changes in the environment it governs.

The third recommendation made by the Commission related to the CHA is to clarify "coverage in terms of diagnostic services"[79]. The idea here is that the CHA "be amended to clarify that it covers all diagnostic services reasonably required to assess a patient's need for medically necessary hospital and physician services"[80]. This proposal would be

regarded as an effort to maintain the original policy. The Commission found that "currently, there are serious backlogs in wait lists for access to advanced diagnostic services across the country"[81] and citizens that can afford to go outside the public system buy diagnostics test privately. While the original tenets still exist practice and experience will identify changes that need to occur to preserve the Act. This could make a big difference to what some people see as an encroaching two-tier system. When people are able to buy access to a more speedy diagnosis, they will enter the publicly funded system ahead of another Canadian who could not afford the same advantage and as a result will not be treated a speedily as the person who could. The threat of an emerging two-tier health care system has many Canadians worried about the future. The Report stated that "for the same reasons that private payment for diagnostic services is contrary to the basic principle of medicare, this "public" form of queue-jumping should be redressed in a modernized *Canada Health Act*"[82].

The Commission proposed that "in the event of any further violations, the federal government would be obliged to withhold its medicare contributions by an amount equal to that paid out-of-pocket by individuals for MRI and other diagnostic tests"[83]. This particular recommendation could go far in preventing the entrenchment of a two-tier health care system, especially with the potential for enforcement. However, this particular suggestion of greater enforcement relates to changes that are required in the administration of the CHA, as opposed to modifications in policy itself. Drift in administration can take a significant role in the drift in public policy. Administrative drift of the CHA will be the focus of the following chapter.

The fourth recommendation made by the Commission in regards to the CHA is to include "an effective dispute resolution process"[84] to help in the making of joint decisions between provincial and federal levels of government. The establishment of a dispute resolution process is expected to help in the administration of the CHA. Curiously little detail was provided on the current administration of the legislation. Details on this process are provided in the following chapter as the upholding of the policy itself has been identified as significant in the drift experienced in the case of the CHA.

The fifth, and final, recommendation made by the Commission in regards to the CHA is to establish "a dedicated health transfer directly connected to the principles and conditions of the *Canada Health Act*"[85]. This Canada Health Transfer (CHT) replaced the Canada Health and Social Transfer (CHST). The CHST provided block funding for numerous areas including post-secondary education and social services which changed with the CHT that specifically provided funding for health care. By reorganizing and simplifying the provision of resources for health is both easier to assess federal support and trace expenditures. This funding arrangement was intended to be provided in cash only (as opposed to tax credits), however in operation the transfer is provided as a combination of the two. In order to "provide long-term stability and predictability, the Transfer should include an escalator that is set in advance for five year periods"[86]. The consistency in funding would allow provincial health care systems to develop long-term

strategies and planning. The new proposition would also guarantee federal funding. Deductions to the CHT could be made to governments that are guilty of violating the CHA.

The Senate also requested an investigation into the state of the Canadian health care system. The product of this study was a report produced by the Standing Senate Committee on Social Affairs, Science and Technology. This document, published in October 2002, became known as the Kirby Report after Senator Honourable Michael J.L. Kirby who chaired the committee.

Among the recommendations made in the Kirby Report, many that are within the scope of the CHA suggest working outside of the legislation rather than inside. The Kirby Report actually makes no favoured recommendation to change the CHA. While it does outline a possible avenue that involves changes of the CHA, it is not the preferred course of action. As a report from the Conference Board of Canada noted, the Report "is against revising the Canada Health Act, arguing that doing so would put the five medicare principles at risk and could worsen federal-provincial relations."[87]. It was the understanding of the Senate Commission that the system can be expanded without modifications to the Act itself.

According to the Kirby Commission, the ideal approach is to move outside of the CHA and create two supplemental pieces of legislation. Although these suggestions were recommended to take place in addition to the CHA, they are related to the scope of the policy and will therefore be taken into reflection accordingly. Prior to reviewing the proposed legislation, it must be stressed that it is Kirby's preference to work within the context of the CHA, but not actually involving the policy itself. The first of the two new pieces of legislation was to implement the National Health Care Guarantee. The intention was that this new "legislated health care guarantee will improve access to set of hospitals and doctor services that are currently insured under the *Canada Health Act*"[88]. This act would be regarded as an attempt to maintain the policy. The second recommended piece of legislation to be created was expected to institute "health care coverage for catastrophic prescription drugs, post-hospital home care and some palliative care in he home"[89]. If this suggestion were to be implemented it would be considered an effort to move the CHA further in a manner consistent with its origins.

While the Kirby Report believes that there are some important elements within the CHA that should be maintained, the authors assert that there are changes that need to be made so that the field governed by the Act can be improved upon. Why the authors have proposed that such changes happen outside the Canada Health Act is not adequately explained. Is the CHA in effect hooked up to life support solely to give us peace of mind in knowing that it is not actually dead? Though little do we know that those who run our country have already pronounced it dead and are in the process of slowly and covertly building other institutions to take its place under the guise of improving the one already beloved by Canadians? While recommendations made in the Kirby Report would work to

update the content of the CHA, by not pushing to modernize the CHA as needed, the policy itself has been weakened. Rather than looking at the scope of the CHA as in need of improvement and working outside of the legislation, the concern should be with strengthening the policy itself. A more appropriate and applicable policy can improve the impact that it has. The problems that exist within the scope of the CHA can be remedied through the legislation itself rather than separate legislation.

Failure to update

It is proposed that the CHA is a case in which policy drift is evident, as explored, through the lack of updating that has occurred. There has been a growing need for responses in policy both to maintain and rejuvenate the CHA. This has not occurred in the most basic of expectations. The CHA has remained identical to the Act that was legislated in 1984 despite the significant contextual changes that have occurred during this time. Interviews, including with the one conducted with Romanow, have revealed that there has not even been proposals put forth in the House of Commons attempting to make the needed updates. The lack of change in policy contrasts with the change that has been experienced in practice. The performance of the CHA has been steadily drifting further away from the intent of the policy. This situation that has developed paints a picture of what Jacob Hacker has proposed in his work: change without change.

It is baffling how such a paradox of change without change could develop, be identified and then left to continue. This is particularly surprising in light of the findings of the two federal commissions. If the two studies commissioned by the federal government which both recommended the updating of the CHA sees no action, then what would? Romanow believes that the Canadian health care system is "long overdue now for reforms to reflect the way in which modern health care is being delivered"[90]. This is echoed by a health lawyer who worked in the Ontario Ministry of Health and Long-Term Care for years, who states that the Canada Health Act "has to be significantly amended to reflect the new world".

Given the implicitly authorized decay of the CHA, how it could ever be expected that this policy could possibly remain relevant is a mystery. At the outset of this study motivations were noted to not be an intent, however it must be remarked here that it is possible that the irrelevancy of the policy could be a goal. This would be a reflection of Hacker's notion of artificially created drift. The assessment of whether policy drift in the case of the CHA is intentional or not will not be made here, but merely offered as a possibility.

Regardless of why such a predicament has occurred, the CHA has eluded undergoing renovation in the over 20 years since it was passed. This, when combined with the fact that the context of the policy has experienced changes, has had the impact of changing the effect of the policy in practice. This situation may be a process by which drift may

occur in the case of the CHA, facilitating change without change: while no formal changes have occurred in policy, the practice has changed.

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The Canada Health Act as a case study of regulatory drift

The application of drift to the case of the CHA emphasized the incompleteness of the existing concept which is limited to policy drift. In the exploration of ways in which drift might occur in the Canadian health care system, through the CHA, it was found that focus on the policy and contextual changes told only a part of the story. What was done with the policy, or the administration of it, has a significant role in the explanation of drift. Based upon the case of the CHA, it was determined that a distinction must be made in the conceptualization of drift to specifically identify the possible impact of regulatory drift. Analysed in this chapter is the possibility of regulatory drift of the CHA as one of the ways in which drift may occur in the Canadian health care system. A development of the concept of regulatory drift will be provided. Following this, the potential process that regulatory drift may take in relation to the CHA will be explored. While it is unfeasible to examine all ways in which policy drift can occur, the most likely options will be selected.

Conceptualization of regulatory drift

For the goals of a policy to be achieved, it must be carried out to its full potential. This means that every effort within the capacity of the policy to realize the intended outcome must be made. This will vary from policy to policy depending on the mechanisms that were written into each, or the abilities of the body trusted with its administration. If there are inherent mechanisms within the policy itself or if there is a possibility to draw on other means available to allow the achievement of the end goals, they must be pursued. Failure to uphold the policy severely limits the ability to meet the objective as intended. While the policy itself is, of course, important to its outcome, what is done with that policy is of comparable significance. As Sujit Choudhry has stated, in the absence of the institutions to effectively uphold the CHA, "national standards for Medicare are merely political platitudes"[1].

In the end, it doesn't matter how up to date or strongly worded a policy is if the process ends there. Policy is more than what exists in a document; it is also execution of what has been laid out. It is a reasonable expectation that a policy will be translated into practice. With the recent developments that have occurred in the Canadian health care systems, the need for adequately administering national health legislation has never been more important. As Choudhry argues, the role and value of "supervisory institutions will be of central importance to the future of Medicare, no matter what scenario unfolds, because any future system will include some national standards. These standards, to be effective, must be interpreted, applied and enforced by institutions of some kind"[2]

For the transition from policy to practice to take place, what is written on paper must be upheld. Without such consistency, regulatory drift can occur. Regulatory drift concerns the quality of the implementation of the policy itself. How well is the policy being administered? If there is a problem in obtaining the end goals of the policy, what

efforts are being made to correct this failure? Is there thorough and consistent support offered to the staff charged with the achievement of the policy? Questions such as these need to be asked in the application of regulatory drift to a case study. How well the policy is being upheld is of central concern to this form of drift.

Application of regulatory drift to the CHA

The general impression of the CHA is that it sets out rules for the operation of the provincial and territorial health insurance plans. While this may be true in the political implications of the policy, legally the CHA outlines the requirements that must be met for the federal government to lawfully transfer fund to the provinces and territories. The CHA is a legal document that binds the actions of the federal government that interestingly are dependent upon the actions of the provinces and territories.

There have been some questions raised about whether the federal government has acted unlawfully in its administration of the Canada Health Act. One dispute took the form of a law suit against the Minister of Health in 2003 filed collectively by a variety of organizations, including the Canada Union of Public Employees, the Council of Canadians, the Canadian Health Coalition, the Communications, Energy and Paperworkers Union of Canada, and the Canadian Federation of Nurses Union. The applicants believed that the Minister of Health and the Government of Canada was in fact liable for the failure to uphold the CHA. The application was dismissed as the judge ruling in this case, the Honourable Mr. Justice Mosley, found that while the "application raises important questions, they are of an inherently political nature and should be addressed in a political forum rather than in the courts"[3]. The factum and affidavits for this case have provided high quality and expert information. These sources have served to further illuminate the argument that the CHA is not being sufficiently upheld and that the federal government is not fulfilling its responsibilities. Unfortunately, they also set out the challenge in demonstrating the occurrence of regulatory drift.

The importance of adequate monitoring and consistent enforcement to upholding the CHA

The administration of the Canada Health Act is the responsibility of the Canada Health Act Division (CHAD). The CHAD is part of the Intergovernmental Affairs Directorate of the Health Policy Branch at Health Canada and located in Ottawa, and receives support from regional offices.

For the Canada Health Act to be upheld, there are two requirements that must be met. First, the execution of the CHA in each province and territory must be adequately monitored to accurately determine the performance of the policy in practice. Second, in situations where violations have been identified, the policy must be consistently enforced. The case of the CHA is currently one of inadequate monitoring and weak enforcement

that has limited the possibility of achieving in practice what it has laid out in policy. In an ideal situation, what is written in the policy would directly and easily translate into reality. However, with competing ideologies and motivations the realization of a policy is never that simple. This is particularly true in the case of the CHA. As contended by Pat Armstrong, there has been a "failure to properly monitor, investigate and enforce the requirements of the *Act*"[4]. In the absence of adequate monitoring and consistent enforcement of the Canada Health Act, the policy has experienced regulatory drift.

Originally, the CHA was actively upheld. Following the enactment of the legislation, Health Canada went to great efforts to oversee the implementation process in each province and territory and investigate possible cases of non-compliance. [5] When violations to the extra-billing and user fee provisions were identified, the federal government deducted funds from the transfer to the offending jurisdiction. Monique Bégin, former federal Minister of Health, notes that in 1987, $245 million were withheld from governments that were found to be in violation of the CHA.[6] Within three years of the introduction of the CHA, the Auditor General found that threats that extra-billing and user fees presented to the Canadian health care systems were successfully brought under control.[7] Conveying the considerable impact that CHA once had on governments, a health lawyer with significant experience working in the Ontario Ministry of Health and Long-Term Care reflects that the federal policy "was taken quite seriously, it appeared in briefing notes regularly and every initiative would be tested against the principles because you didn't want to run afoul with Ottawa". However, the initial success of the CHA being upheld faded. In two crucial ways the CHA has experienced regulatory drift: through inadequate monitoring and inconsistent enforcement the policy has not been realized in practice.

Inadequate monitoring of the CHA

Adequate monitoring is an essential part of the long-term success of a policy as it provides a picture of how it is functioning in practice. The determination of how a policy is performing allows failures to be identified and necessary reforms can then be made to correct for any policy or regulatory weaknesses. The case of the CHA is no exception and the importance of complete and effective monitoring cannot be understated in the achievement of its intended goals. Specific to the monitoring of the CHA, relevant information related to the policy must be actively collected by federal staff and then an analysis of what the information means must be conducted. Currently, neither the information nor the analysis have been sufficient and together have failed to provide an accurate reflection of the performance of the Canada Health Act.

One of the conditions of the CHA, that of *Information*, outlined in section 13 (a), concerns the presentation of information relating to the CHA by provinces and territories to the federal Minister of Health. There is no specification as to the exact information that should be transferred from levels of government. The recognition condition relates to the

requirement for provinces and territories to acknowledge the financial contribution of the federal government. Bégin has stated that the provinces do not comply "with the request for information included in the *Act* (and nothing was done about it), and the recent annual reports of Health Canada, also made mandatory by the legislation, are now devoid of any significance"[8]. The collection and dissemination of information related to the CHA is crucial for the sufficient monitoring so that an assessment of the performance of the policy in practice can be determined.

To help achieve accountability, section 23 of the CHA requires the Minister of Health to report annually to Parliament in regards to the administration and operation of the Act. According to the CHA, the report is expected to include "all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions"[9] to receive funding. This annual reporting is intended to keep the Members of Parliament up to date on the performance of the CHA and facilitate informed decision making regarding federal health care policy. For this projected process to be successful it is absolutely essential that the information related in the House of Commons is accurate so that the elected representatives are able to determine what is successful and what is not.

It is acceptable to expect that the investigation into the performance of the CHA in each province and territory occur in a timely manner. Section 17 of the Act states that action to reduce or withhold funds from a government that has been found to be in violation of the criteria or conditions is to be "imposed in the fiscal year in which the default that gave rise to the reduction or withholding occurred or in the following fiscal year"[10]. There is only a window of two years to make deductions. If the investigation exceeds two years, which according to the most recent Auditor General reports appears the norm, then the opportunity to impose a penalty is lost. Health Canada does not impose timelines for monitoring. This would prevent enforcement from being jeopardized due to missing deadlines. The length of time the Canada Health Act Division takes seems to be of no concern at all.

To provide accurate information in order to make a legitimate appraisal of the state of the CHA in practice, it is expected that there would be an active and thorough system of monitoring. It is the responsibility of the Ministry of Health to investigate how the CHA is being carried out in each of the provinces and territories. Within Health Canada, the Canada Health Act Division (CHAD) was created for the purpose of overseeing the administration of the policy. The collection of information has devolved to a state where the CHAD does little more than compile information it has received from three different sources. According to the Auditor General, information is pulled together from third-party sources, public complaints, and voluntary submissions by the provinces and territories, and assembled into the annual report.[11]

Third party sources are principally media reports. Public complaints are self-evident; citizens come forward to bring attention to a potential violation of the CHA. Voluntary

submissions are made to Health Canada by the provinces and territories. As Pat Armstrong has observed, the resources that are used by CHAD are only able to provide "a patchwork quilt of information that is incomplete, often not compatible, and that varies quite considerably from one jurisdiction to the next"[12]. The inconsistency of information is powerfully demonstrated in the review of the Canada Health Act Annual Reports. The information provided for each government is not uniform and even the presentation of this information changes from one jurisdiction to the next. This lack of uniformity makes it very difficult to compare the CHA in practice across Canada. The deficiency of information makes the assessment of the accurate performance of the CHA in practice unlikely in the first place.

While media may be useful in supplementing the monitoring of non-compliance with the CHA, it is not the role or responsibility of the journalists to be policing the execution of the CHA. Even though media has uncovered valuable information about violations of the CHA, it is the duty of the federal government to investigate the performance of its policy. It is not sufficient to leave the monitoring of the federal health policy to unknowing journalists.

In concept, public complaints could be a good source of identifying cases of non-compliance, particularly as beneficiaries are in the best position to observe how well policies operate in practice on the ground. However, the current setup is not sufficient to be depended on. Too many Canadians are under informed about what their rights are and what would constitute a violation of those rights, and this cannot be depended on to extract all cases of non-compliance. Armstrong has argued that Health Canada "does not inform Canadians of the opportunity to lodge complaints relating to the *Act*, nor does it indicate how much complaints should be formulated or where they should be lodged"[13]. Also, it is unclear if a formal grievance process exists or how complaints are reported and to where. When interviews were conducted at the Canada Health Act Division, officials declined to provide insight into the public complaints process. Through the course of interviews with health lawyers, it was discovered that no formal process exists for citizens. Individuals who make a complaint do so because of their own initiative and not because of any effort made by the CHAD which does not officially seek or collect this information.

The means of gathering and sources of information are unacceptable for the purposes that they are supposed to serve. Impartial independent sources, not biased to either level of government, should provide the information that is necessary to monitor the performance of the CHA. It is inherently contradictory and puzzling why the Ministry of Health would hand over its responsibility to the potential violator, its provincial and territorial counterparts, which is the current accepted practice. It is reasonable to believe that the provinces and territories have a strong motivation to put their best foot forward; the presentation of information that guarantees the full federal transfer is more likely than data that leads to the imposition of penalties. A dependence on provinces and territories

to use the honour code system is illogical. Self-regulation will only guarantee less conflict, not accuracy.

The active and independent pursuit of information that is required to determine the performance of the CHA across the country does not exist. In reality information is simply cut and paste from these three sources with little CHAD identified additions and without any assessment or commentary from the organization responsible for this. In 1999, the Auditor General found that "Health Canada does not have the information it needs to effectively monitor and report on the extent of compliance with the *Canada Health Act*"[14]. The acknowledgement of this huge failure by such a competent and respected source as the Auditor General decisively shows the ignorance of the CHAD to investigate as it is expected and trusted to do. The passive approach taken by the CHAD creates a void of information that severely limits the capacity of the CHA to be effectively monitored. Armstrong has observed that importance of this "missing information for the purposes of evaluating the performance of Canada's health care systems is widely acknowledged"[15].

Following the reproduction of submitted information, an assessment is to be made about how governments are complying with the CHA. This is also to be included in the report. However, an evaluation has never been given on how well or poorly the CHA has done in practice. This could be due to the fact that Health Canada is aware of the inadequacy of the information that it compiles and does not want to highlight this in an analysis. Or, this oversight could be consistent with the passive approach that it takes. Regardless of the reasons for the absence of the evaluation, the Auditor General found that by not "assessing and reporting to Parliament on the extent of provincial compliance, the Minister is not discharging fully his responsibilities under the Canada Health Act."[16]. Analysis is crucial in the monitoring of the CHA. Granted, the preceding step to this is the active collection of complete and consistent information. Given such a foundation, thorough evaluation and interpretation of the information in relation to the CHA must be carried out so that the citizens of Canada and Parliamentarians are informed on the performance of their federal health policy.

In 2002, the Auditor General declared "Health Canada should, in collaboration with the provinces and territories, fulfill its obligation to administer the *Canada Health Act* by collecting the information it needs to enforce and report compliance with the Act"[17]. Such progress would help to correct the regulatory drift that the CHA has experienced, in part, because of the inadequate monitoring of the federal health policy. As it stands currently, the Canada Health Act Division is not even in a position to assess what information is outstanding in a complete analysis of the CHA in practice (if such a thorough examination were to take place).

Inconsistent enforcement of the CHA

Consistent enforcement can have a significant impact on the success of a policy. In the case of the CHA, federal transfers can act as either the carrot or the stick. If a province or territory complies with the Canada Health Act then it is fittingly rewarded with a carrot, or in actuality, the full federal transfer that it is warranted. However, if a province or territory is found to be in violation of the CHA, then it is punished with the stick, also known as a deduction of funds from the transfer. This reward-or-punishment arrangement provides motivation for achieving one result, the success of the policy. A key element in the use of this tactic is the consistent appropriate response to the action. That is to say, when there was a positive action it requires a positive response, and when there is a negative action it requires a negative response. When such a reward/punishment mechanism exists but only rewards are given regardless of whether the policy is complied with or violated, the enforcement mechanism is disabled. In the circumstances relating to the CHA, the motivation for a province or territory to respect the policy is reduced if it is guaranteed the same amount regardless of its actions.

Sections 14-17 of the Canada Health Act lay out the details of the enforcement mechanism available to the federal government when a province or territory violates the legislation in respect to the criteria or conditions. These four sections provide instructions after a case of non-compliance has been identified and, vaguely, what constitutes a breach. The federal Minister of Health must consult with his or her equivalent in the offending province or territory and inform him or her of the violation. Following this "consultation", if the government has not resolved the issue in an acceptable amount of time (which is at the discretion of the federal Minister), the federal Minister then refers the case to the Governor in Council. If the Governor in Council has found that there is an infringement on the criteria or conditions, there are two options. The Governor in Council may reduce the amount transferred to the guilty government or withhold the entire sum, depending on the how grave the default is considered to be. This penalty may be imposed year after year if the violation continues to occur. This whole process of regulation: the monitoring, investigation, identification, consultation, and this series of steps to impose penalties has to occur within two years, as stated in section 17, for deductions to be allowed.

Sections 20 and 21 of the Canada Health Act provide the information on penalties that must be imposed on provinces or territories that violate the extra-billing and user charges provisions. The federal Minister of Health is under the obligation to deduct funds that are equal to the amount of the default. As section 21 states, while deductions are mandatory, they must be applied within three years of the fiscal year in which the violation occurred.

According to the CHA, it is illegal for the federal government to permit a complete transfer of funds to a province or territory that are guilty of non-compliance. The "teeth" of the CHA exist in the ability of the federal government to withhold funding from

governments that have been found to be in violation of the Act. In the case of a violation of the provisions, deductions are supposed to be automatic and dollar for dollar. This is intended to be the much more straightforward scenario: a violation is identified and then a deductions is made in the amount that is equal to the figure of the user fees and/or extra-billing. In a case of a violation of the conditions or criteria, deductions are at the discretion of the federal Minister of Health. This presents more of a grey area, as there are no predetermined or mandatory actions if a violation of a principle or condition has occurred. Both the decision to make a deduction at all and what the amount would be is left to the staff of the Canada Health Act Division to make a recommendation to the Minister of Health who has the final choice on what action to take.

Health Canada has a weak record of enforcement of the Canada Health Act and this has the impact of allowing the intended outcome of the policy to remain unachieved. Health Canada has, as noted by the Auditor General, developed a track record of administering "the *Canada Health Act* in a non-intrusive manner. This approach has not brought about the speedy resolution of non-compliance issues and differences in interpretation of the Act"[18]. While it is an important part of any consultation process to include every party involved, the final decision lies with the federal government. Where is the motivation for provinces and territories to comply with the CHA when penalties are rarely and reluctantly given out? Even when deductions are made, the process takes so long that the offending jurisdiction is able to continue to violate the CHA for years. The reasons why investigations into cases of non-compliance take so long are not clear. One of the conditions of the CHA is that provinces and territories must provide information needed for the Ministry of Health to assess if it is complying with the policy. In addition to this, confusion over the interpretation of a policy that is over 20 years old is unacceptable. It may be a convenient excuse for provinces and territories that Health Canada is not doing an adequate job in educating governments what is expected of them. The Canada Health Act Policy Interpretation Manual was obtained from Health Canada under the Access to Information Act. The CHA Policy Interpretation Manual serves as an example of the institutional uncertainty that pervades the administration of the legislation. While the Manual is the one presently used by employees at the Canada Health Act Division, it appears dated, not even providing the correct references to the current cost share funding arrangement of the CHT (referencing instead the obsolete CHST). The interpretation of the CHA, given the over 20 years that it has been administered, would be expected to be well established with clear guidelines. In actuality, there is inconsistency and flexibility that is evident in the CHA Policy Interpretation Manual. There is no standard of enforcement that exists.

There are a variety of mechanisms that exist to encourage or enforce compliance with the Canada Health Act. According to the Auditor General, these methods can include "education and communication, incentives, self-regulation, consultation, discussion, persuasion and negotiation, and penalties. These mechanisms can take the form of practices, policies, and regulations"[19]. There has been too much time and effort put into all but the last of those options. As Peter Graefe observed, penalties have been shied

away from to the point of the federal government "being in gross non-compliance with its enforcement provisions"[20]. An investigation by the Auditor General observed "the majority of the non-compliance issues identified by Health Canada over the past 10 years have remained unresolved for five years or longer. Few penalties have been levied for non-compliance with the provisions of the Act. No penalties have been levied for non-compliance with the criteria of the Act"[21]. Information gathered in interviews suggests that the reluctance to penalize offending governments relates to a concern over aggravating inter-governmental relations. This political concern impedes the upholding of the CHA.

If a legitimate attempt has been made by Health Canada to educate, communicate, provide incentives, allow the provinces and territories to self-regulate, consult, discuss, persuade and negotiate yet there continues to be cases of non-compliance that are allowed to persist, then penalties must be applied more aggressively. It is understandable that penalties may not be the preferred first course of action when attempting to ensure the implementation of the CHA. However, there comes a point after other options have not produced acceptable results that the impact that penalties can make outweighs the unpleasantries that they may bring. The application of penalties can be politically difficult and lead to intergovernmental conflict. Yet disregard for the Canada Health Act produces negative consequences that are not less than those that would result from imposing penalties. If the federal government feels that the CHA is important to the health of Canadians then why are such ineffective mechanisms of compliance used? It is not only important that cases of non-compliance and resolved, but that this happens in a timely manner.

In 2002, Health Canada informed the Auditor General that it:

> hesitates to impose penalties. (Health Canada) has shown a strong preference for consultation and negotiation to resolve disputes in collaboration with the provinces and territories. (Health Canada) believes that if it were to impose penalties, the provinces and territories could simply choose to absorb them and continue to contravene the Act[22].

The issue with this is the federal government knowingly transferring funds for health care to provinces and territories that are in non-compliance with the CHA is completely inconsistent with its role as administrator. Further to this, providing financial support for provinces and territories that are in breach of the CHA not only actively undermines the policy but also reduces the ability to achieve the intended outcomes. Anticipating a situation that may occur is an illogical way to administer a government policy. Particularly as history has shown that imposing penalties when the CHA was violated had a positive impact on the initial administration of the legislation. Deductions were made and provinces made changes so that their practices would be in line with the Canada Health Act. In addition, the larger the sum of money given to the provinces and territories, the larger the impact of the CHA will be. If Health Canada is genuinely concerned over the overlooking of its financial contributions, perhaps more thought should be put into increasing the amount of the transfers. Finally, Health Canada in its

rationalization has not taken into account the influence of voters. Interviews, one in particular with the Hon. Roy Romanow, emphasized the importance to provincial governments to be seen as committed to upholding the CHA. Penalties carry weight, not only because of the financial impact that they have but also because of the impact on public image. Governments do not want to be labeled violators of the Canada Health Act and would be concerned about the negative publicity that could come when penalties for non-compliance are administered.

The Ministry of Health has *never* given out penalties due to a violation of the five principles. Deductions made to financial transfers because of non-compliance with the criteria are optional. It should be stressed that the absence of penalties administered for this reason have not been because of lack of complaints or evidence to suggest that there have, in fact, been cases of non-compliance. Supporting this is Armstrong who also believes that there is "significant evidence that provincial health care insurance plans have failed, and some continue to fail to comply with certain criteria of the Act"[23]. According to the most recent investigation by the Auditor General, Health Canada admits that five provinces currently may be considered in breach of the out-of-country hospital rate requirement (portability criterion) of the Canada Health Act[24]. This admission is likely the tip of the iceberg, acknowledging a violation that is publicly well known but it in no way indicates the true magnitude of the problem of non-compliance with the principles. What is so disturbing is not that this problem has just not been recognized, but that it has been identified time and again with the problem just being ignored. Even though there have been complaints made concerning the violation of provincial and territorial health plan failing to comply with the CHA there have not even been investigations conducted by the Ministry of Health[25].

According to the law firm of Sack Goldblatt and Mitchell, officials from Health Canada "have significant and outstanding issues of concern with respect to whether provinces are satisfying the criteria of portability, comprehensiveness and accessibility, and concede that no steps have been taken to correct under section 14 to address them"[26]. This account emphasizes the severity of the situation and the inability of the federal government to gain compliance when violations have been identified. For a potential case of non-compliance to not even be investigated demonstrates the gross disregard that the Ministry of Health has for its role as administrator of the Canada Health Act and really brings into question the commitment it has to the success of the policy. The argument has been made that concerning the administration of the CHA there has been a tradition that has developed to systematically decide "to ignore violations of the Act" and that the Minister of Health has "entirely abdicated his public duty to enforce the Act"[27].

In the assessment of whether or not there has been a violation of the CHA, taking into consideration factors that are unrelated to the Act are "irrelevant at law and effectively amounts to rewriting the statutory conditions under which the Minister's discretion is exercised"[28]. Despite this, other factors including "health systems issues, pressures and priorities, the state of intergovernmental relations in the health care field, financial and

budgetary issues, and the impact that the opinion may have on other activities relating to the Act"[29] are taken into account in the Minister's decision-making process. The other factors that are deliberated upon in the performance analysis of the CHA do not impact on whether or not there are cases of non-compliance and function to distract from the task at hand. The only factors relevant in the evaluation of whether there have been violations to the Canada Health Act exist in the provisions, criteria and conditions of the policy itself. Deliberation on other outside issues not only goes beyond what is expected of the administration of the CHA but it actually serves to circumvent the ability to reach the intended goals of the policy. Ministers are not fulfilling their responsibility to administer the CHA when they look to other considerations outside the functions of the policy. As Choudhry insightfully observed, the "enforcement of the CHA is currently conditioned not by the need of the health-care system's clients, but the political needs of the federal government"[30].

It is Armstrong's view that the significant and "persistent evidence of non-compliance suggests that the Minister has adopted a policy of non-enforcement concerning the five criteria that represent the core elements of Canada's health care system"[31]. This informal arrangement directly challenges the objective of the CHA and is clearly inconsistent with the actual policy. It is this unofficial shift that is such a threat to the regulation of the Act. Decisions and actions that take place outside of any formal process exist off the record, and implicit with that is the difficulty in ensuring their suitability with the policy that they correlate with. This unofficial process is also incredibly challenging to monitor. Without access to this procedure as it unfolds there is limited ability to identify the problem as it develops as the indicators will only be visible after repetition and a period of time. Failing a perfect policy, Bégin believes that "decisions have to be made to ensure that the rules of the game are respected and that the current Act is enforced"[32]. The Canada Health Act is not perfect legislation and decisions do need to be made but evidently they are not always in the interest of enforcement. The interpretation of the CHA and the discretionary power in its administration are not expressly at fault for the inadequate enforcement of this policy. The problem lies in the interpretation of the CHA and the discretionary power that are each in contradiction of the policy.

The federal government must "start using its legal and moral authority to snuff out the growth of the private sector"[33]. By not enforcing the CHA, particularly in regards to its criteria, the Ministry and Minister of Health are not doing the job entrusted to them by Canadians. Moving in a direction that is not consistent with the origins of the CHA goes beyond inconsistency. The fundamental concept behind the Canada Health Act "demands a generous approach to determining Medicare's coverage". Abandoning this theory would fundamentally change the very nature of the CHA. Such a change should be made by Parliament with the attendant political consequences. Additionally, in Choudhry's view, by not proceeding by this route, "the courts would allow provincial governments to achieve a *de facto* amendment to a federal statue by changing their definitions of medical necessity, even though the CHA does no make an express delegation"[34]. The implications

of the "failure to exercise its discretionary enforcement power accordingly reflects a loss of legitimacy and political capital on the part of the federal government"[35]. This is a reality that will influence the future enforcement of the CHA. Substantial reform is necessary to counteract this tolerated political and legitimacy deficit.

Necessity to uphold

Monitoring

Monitoring is a significant factor in the regulatory drift of the CHA. Better monitoring by the federal government would make a substantial impact to correct for the drift of the CHA that has occurred. The poor federal record of monitoring the Act has already been established above. A proposal for improved monitoring will be made here. The blueprint that follows attempts to take into account the current state of monitoring and what can be done to move beyond this.

While the CHA provides an outline of the process that is to be followed once a violation has been confirmed, the equivalent method of monitoring is not offered. This is a major shortcoming of the Act as it leaves a very important part of the regulation of this federal legislation completely open. The approach taken by Health Canada has not been sufficient. This is in part due to the excessive amount of time that it takes to assess whether there has been a violation committed. This is particularly significant considering the timeline imposed by section 17 and the deadline that this places on monitoring so enforcement is even an option. There is a direct connection between monitoring and enforcement, even in terms of the length of time it takes to examine the issue. There should be a maximum amount of time that a potential case of non-compliance can be investigated for. At the end of each CHAD self-imposed deadline, a decision should be made as to whether or not a violation has been identified.

Through its investigations and reports, the Auditor General has developed a practical outline of what is fundamentally expected from the federal government to adequately monitor the Canada Health Act. These are measures from which the Auditor General worked to assess the performance of the Ministry of Health in its administration of the Act. These standards have developed over the years and have been insightful in taking into account new requirements that would be necessary to maintain adequate monitoring.

From the beginning, the Auditor General expected to observe departmental procedures that included "reviewing provincial and territorial legislation to ensure it reflects federal requirements, reviewing and discussing with the provinces and territories the means by which they satisfy themselves that these requirements are complied with, and keeping abreast of current developments in the health field"[36]. Showing its farsightedness in anticipation of questionable transparency with the procedures used, the Auditor General expected that the Ministry of Health clearly define "how information

collected for monitoring purposes should be used"[37]. This is a very important part of the monitoring process; the "hows" and "whys" need to be made explicitly clear. This increases the accountability of the actions of the federal government as the ability to follow each of its actions and better understand the motivations behind them.

The information to be collected to be reviewed in the assessment of the performance of the CHA should not only concern statutory and legislative developments but, more importantly and more likely to be disregarded, is the actual operation of the provincial and territorial plans. This is particularly important when taking into consideration possible regulatory drift at the provincial and territorial level. It is entirely feasible that the review of a health care system in policy will not detect any violations while inspection of operation tells a different story. Determining the performance of the CHA "on the ground" would have to become a priority in the monitoring process.

Information to be used in the assessment of the performance of the CHA should come from any and all reliable sources, not solely from the provinces and territories. There are many dependable sources with information relevant to the assessment of compliance to the CHA by provinces and territories. Resources should not be limited to governments especially if there is a competing incentive to not release incriminating evidence. There is far too much faith given to the provinces and territories to provide the information needed to determine violations. This especially true as the information received is inadequately assessed and with no requirements made compulsory. The Canadian Institute for Health Information (CIHI), for example, is capable of providing very valuable information relating to the performance of the CHA. However, the Canada Health Act Division has never made an attempt to set up an arrangement with such a significant resource. As well, the use of existing CIHI data has never been incorporated in an analysis of the CHA in practice. A valuable contribution to obtaining information from a source such as CIHI is that it is impartial and is void of motivation to manipulate data.

A simple, organized and well-publicized complaint process could be developed for citizens to inform Health Canada of potential defaults on the CHA. Users of the health care system across Canada are in an excellent position to determine how the CHA performs in practice. Regulation by those on the ground who would experience the on the ground changes that may come out of drift could increase identification of cases of non-compliance and improve accountability of provinces and territories to their citizens.

When the Auditor General became very concerned about the quality of analysis and reporting on the CHA by the Ministry of Health, it was clarified that the expectations of monitoring also included "procedures for measuring and reporting performance"[38]. While the identification of relevant information and then collection of those facts is obviously essential it is not sufficient in and of itself. It is not enough to merely collect relevant information, but a crucial part of the monitoring process is the analysis and dissemination of this data as well. Specialists in the field of health policy should do this analysis. Politicians should review CHA Annual Reports so that they can be informed of

developments related to the CHA and act when necessary. Information on the CHA in practice should be easily accessible for citizens as well, helping to improve accountability.

The Auditor General stressed the importance of an engaged and persistent monitoring process that is committed to investigating on the performance of the CHA. It is not satisfactory to assume that all of the information that is required will present itself to the Canada Health Act Division. As noted by Choudhry, the Ministry of Health has an obligation to actively monitor "the provincial and territorial health care systems and constantly and consistently assess each one for the extent of compliance with national standards spelled out in the CHA[39]. The passive "collection" and compilation of information is not satisfactory. It is completely conflicting that the information is submitted and the investigation conducted by the potential violator without Health Canada providing even an assessment. The provinces and territories are subject under the "information" condition of the CHA to submit records to the federal government. This needs to be regulated by the Ministry of Health to clearly specify what information must be submitted and ensure that this data is received. Following the receipt of relevant information there needs to be a thorough analysis completed to determine the extent of provincial and territorial compliance. Health policy experts concerned only with the policy itself, and disregarding political or other issues, should be responsible for the interpretation of the CHA. Written recommendations on cases of non-compliance, with clear reference to the supporting evidence, should be made to the Minister of Health. This advice, along with a written response from the Ministers detailing why they have decided to accept or reject the suggestion, should be made publicly available.

The annual report could be a hugely valuable part of the monitoring process; documenting everything that had taken place throughout the year that relates to the administration of the CHA. An effective report would contain a constructive analysis of the facts and a clear explanation of how that information relates to compliance with the CHA. A comprehensive report would provide a record of every action taken in regards to enforcement (recommendations made, responses from Ministers, communication to provinces and territories, deductions made, etc.). The increase in the quality of the annual report would help to keep parliamentarians and citizens informed about the performance of the CHA and the federal government accountable for its actions. It is imperative that our Members of Parliament are informed to represent their constituents and in relation to the performance of the CHA, an annual report that accurately reflects the circumstances of each province and territory, would put them in a much better position to do so. The impact that this could have in the House of Commons is significant.

Enforcement

Enforcement of the CHA is crucial to its success. What is the motivation to abide by a policy when compliance or non-compliance results in the same outcome? It goes back to old carrot and the stick – reward for obeying and punishment for disobeying.

Governments must be held accountable in a consistent manner reflecting the policy for the actions each takes and it is the task of Health Canada to ensure this happens. Failing such execution, the policy is not supported in practice allowing for the possibility of outcomes that are different than those intended.

A detailed enforcement mechanism of the criteria and conditions is spelled out in sections 14 to 17 of the Act. Sections 20 and 21 of the act provide the mandatory deduction information when a violation of a provision occurs. This information provides a comprehensive process that should be followed at the time when a case of non-compliance has been identified. Strictly adhering to these guidelines would officially be sufficient to correct for the enforcement element of the regulatory drift experienced.

The Auditor General outlined expectations of the federal government in the enforcement of the CHA. In order to fulfill its responsibility and administer the CHA in an effective and transparent manner, the Auditor General expected Health Canada to have a clearly established process of data collection, interpretation and enforcement. The CHA interpretation manual used by staff at the Canada Health Act Division should be made explicitly clear, and establish "case law", or decisions that have been made about cases of non-compliance and acceptable timelines with deadlines for mandatory action. This improved clarity would help to lift the veil of secrecy around what constitutes a violation and work to create a standardization and consistency of action that does not currently exist. This interpretation manual should be distributed to each province and territory and updated yearly. Currently, provinces and territories are not permitted to view the interpretation manual, which is contrary to promoting transparency in the enforcement and does not help gain compliance.

Further expectations of the Ministry of Health by the Auditor General support the use of the enforcement mechanisms as outlined in the CHA. Means of obtaining the goals are provided in the policy, but they have to be used to be effective. Consultations and negotiations alone do not generate compliance with the CHA. Penalties are a method of improving compliance. When a violation has been identified swift and substantial deductions must follow. Every time a penalty is given due to non-compliance, there should be a press release detailing the reasons why this has occurred. As noted previously, interviews revealed that provincial and territorial motivation to obey the CHA is not only out of interest to avoid penalties but also to avoid identification as a government that is guilty of breaching the much beloved policy. The political costs are as much of a concern as the financial loss.

The benchmarks of performance, though not explicitly labeled as such, exist in the policy and need to be observed. Examination is necessary of each case as it relates to each criterion, provision and condition, and this interpretation must be consistent with the origins and the spirit of the CHA.

When decisions about penalties are being made, the only information that should be taken into account is that which is relevant to the compliance of the CHA. Other issues raised previously such as the state of inter-governmental relations or the potential impact that one decision may have further down the road do not change whether or not there has been a violation of the CHA. Identifying cases of non-compliance and penalizing violators are necessary in the administration of the Canada Health Act. This responsibility should be looked at individually and not in combination of other concerns that can be exploited as excuses for not taking action.

The federal government cannot be afraid to penalize offending provinces or territories. Or if "conditions" are not right for enforcement, for example if federal transfers to provinces and territories are low and there is a concern that there is not enough on the table to be "convincing", then the necessary changes need to be made. As Choudhry has argued, the federal government has to be "willing to take the provinces to task for non-compliance with the *CHA* and to bear the political consequences of doing so"[40]. If it is not prepared to hold up its end of the bargain, and it continues to let violations exist without penalty then the provinces and territories are going to have a more difficult time complying if the time ever comes when they are brought in line with the policy.

The responsibility of the federal government, as carried out by its Ministers of Health and their Ministry, cannot be abandoned when convenient. Health Canada's role is to "assess the extent to which health care delivery in the provinces and territories complies with the *Act*'s criteria and provisions and to authorize the payment of the CHST based on that assessment."[41] When those charged with this duty do not fulfill this reasonable expectation, corrective measures must follow so that this trust may be preserved. The particular actions necessary to rectify the poor maintenance of the policy are completely reliant on the degree of lack of support that has been exhibited.

Options to uphold

What needs to be done to correct for the failure to uphold the Canada Health Act must be accompanied by ideas of how that can be facilitated. This is a process that needs to be attempted and explored in reality. Academics can make endless proposals about what needs to be done or how this can be achieved but without action taken by Health Canada itself they are worthless. We will never actually know what will make the difference in stopping the regulatory drift that the CHA has experienced in the absence of real action.

Arms-length agency – not as influenced by political concerns

It is proposed that an arms-length agency be created in place of the Canada Health Act Division. The CHAD has not proven itself able to withstand political influence and has not been successful in administering the policy. This ineffective division should be

replaced with an organization that is more independent from the Minister and further removed from the political climate. This greater impartiality can help to focus on the policy as opposed to other, at times competing, interests. A back to basics approach would be expected to have a dramatic improvement on the upholding of the CHA. In addition, concentrating on the necessities of the policy can work to bring the outcomes back on track. With a clearer role and objective that is concerned solely with the CHA, it is expected that this arms-length agency would be better able to administer the policy than the Canada Health Act Division has.

Use of all available resources

It is proposed that all relevant information that provides insight into the operation of the CHA, in any province or territory, be used in the assessment of the performance of the policy. Currently, the monitoring of the CHA is lacking, as the information that forms the basis for assessment is not sufficient. To obtain all applicable information it is necessary to enforce the information condition of the CHA, so that provinces and territories are actually required to submit informative, appropriate and uniform data. This will require the creation and dissemination of the specific requirements for the information that provinces and territories are expected to report on. In addition, if other organizations collect data relevant to the assessment of the CHA that governments do not, then this information should also be collected. For example, the Canadian Institute for Health Information (CIHI) collects and analyzes information that is reliable and of high quality. An arrangement can be made for CIHI to provide the data relevant for the assessment of the CHA in practice to the organization charged with the administration of the CHA.

Organized and well-publicized citizens complaint process

It is proposed that an open, formal and well-publicized citizens complaint process be organized to report cases of potential violations of the CHA. Users of the health care system are in the best position to observe the CHA in action. If Canadians were better informed about what is expected of the federal legislation and there was a free and easy way to convey issues of concern then this would be expected to increase the knowledge of cases of non-compliance. Increased public awareness would also be expected to act as a new motivation for governments to ensure that the CHA is being upheld. It would be very important for these complaints to be made public to increase the transparency of the monitoring process as this improves accountability.

Administrative organization staffed with experts

It is proposed that the organization responsible for the administration of the CHA, whether the CHAD or a new arms-length agency, be staffed with professionals trained in health policy. The more knowledge a person has in the field, the better it will be for the operation of the policy. The selection and interpretation of data should be the

responsibility of those who have a proficiency in doing so. Interviews conducted at the CHAD revealed that the backgrounds of bureaucrats charged with the administration of the federal health policy were varied and unrelated to the work they were engaged in.

Legal challenges by informed citizens provide clarification and get public attention

It is proposed that citizens or organizations be diligent in following the performance of the CHA and the role of governments in ensuring that it is upheld. If violations are identified and action is not taken in an acceptable amount of time, whether through the resolution of the non-compliance or in the administration of penalties, then opposition must be made - to the point of taking the issue to court. The "criteria of the CHA are capable of giving rise to legal liability. The scope of liability, however, would most likely be limited to the federal government, since the CHA is probably not directly enforceable against the provinces"[42]. Regardless of the outcomes of the verdict itself, the political value of litigation makes it worthy of the effort. Pursuing legal action is a way to bring attention to important issues and puts pressure on governments to work together to uphold the CHA. Court cases also increase the research and discussion around the failure of the CHA to translate into practice, which is scarce considering the implications of this problem. Clarification of acceptable and unacceptable practices of the CHA as a potential outcome of greater dialogue on the subject would be a valuable contribution.

Increased federal funding

It is proposed that the federal transfers to provinces and territories are increased. Enhanced transfers improve "the potential for enforcement of the CHA, and the impact of the enforcement"[43]. The more money that is offered to governments, the more motivation there is to meet the standards laid out, thus guaranteeing funding. If the political will and commitment is present to realize the goals of the CHA, then increased federal funding is not such a far-fetched proposition. The federal government would have to be careful in this scenario to attentively administer the CHA, and not increase financial support with the same poor enforcement of the policy.

Federal health transfers made conditional on provincial and territorial legislation

It is proposed, though admittedly this would likely be the source of significant conflict, that the federal government makes a new condition of funding that requires provinces and territories to pass legislation that directly implements the CHA. This differs from the current reality of provincial and territorial legislation that are reflective of the federal legislation. Following this idea, financial transfers would be withheld from governments that failed to explicitly embed the content of the CHA into its health care system. The direct implementation of the CHA principles, provisions and conditions as opposed to a

more flexible version of them, would bring policies across the country in line, create a legacy on a different level. While monitoring at the federal level would continue, it makes self-regulation more compulsory.

Failure to uphold

The application of the concept of drift to the case of the CHA has allowed for the designation of a new form of drift. The case of the CHA highlighted the impact that the failure to uphold a policy can have in terms of drift. In this case study there was a significant need to differentiate between policy drift and regulatory drift. This regulatory drift applied to the Canada Health Act was explored as a possible way in which drift may occur in the context of the Canadian health care system.

It is proposed that the CHA is a case in which regulatory drift may occur, as explored, through the failure to uphold the legislation. There has been a disinclination from the federal government to adequately monitor or consistently enforce the CHA in practice. This case has developed even though these issues and the ramifications of such non-actions have been clearly identified by a variety of sources including the Auditor General of Canada, NGOs, and health policy scholars. This situation was reviewed as a potential process by which drift may occur in the case of the CHA, as explored through the application of regulatory drift.

Notes

[1] Sujit Choudhry, "Bill 11, the Canada Health Act and the Social Union: The Need for Institutions" Osgoode Hall Law Journal Spring (2000) 3.

[2] Choudhry, Bill 11 3.

[3] CUPE et al v. The Minister of Health. Reasons for Order and Order. (Docket T-709-03, Citation 2004 FC 1334) Available: http://decisions.fct-cf.gc.ca/fct/2004/2004fc1334.shtml

[4] Pat Armstrong, Affidavit for CUPE et al v. The Minister of Health (Docket T-709-03, Citation 2004 FC 1334) 34.

[5] Auditor General of Canada. Report of the Auditor General of Canada to the House of Commons (Ottawa: Government of Canada, 1987) 12.98.

[6] Monique Bégin, "The Future of Medicare: Recovering the Canada Health Act," Justice Emmet Hall Lecture, Conference on Health Economics, Canadian Health Economics Research Association, University of Alberta, Edmonton, 20 August 1999.

[7] Auditor General of Canada, 1987 12.94.

[8] Bégin

[9] Canada. Canada Health Act. (Canada: Government of Canada, 1984) Available: http://lois.justice.gc.ca/en/C-6/233402.html Section 23

[10] Canada, Canada Health Act Section 17.

[11] Auditor General of Canada. Report of the Auditor General of Canada to the House of Commons (Ottawa: Government of Canada, 2002) 3.41-12.

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[13] Armstrong 14.

[14] Auditor General of Canada. Report of the Auditor General of Canada to the House of Commons (Ottawa: Government of Canada, 1999) 29.7-5

[15] Armstrong 15.

[16] Auditor General of Canada, 1987 12.108.

[17] Auditor General of Canada, 2002 3.59-14.

[18] Auditor General of Canada, 1999 29.2-5.

[19] Auditor General of Canada, 1999 29.42-15.

[20] Peter Graefe. "From Deadbeat Dad to Quality Time Parenting?: The Federal Government and Intergovernmental Relations in Health Policy" International Journal of Canadian Studies 28 (2003): 92.

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[23] Armstrong 30.

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[25] Sack Goldblatt Mitchell LLP Factum for CUPE et al v. The Minister of Health (Docket T-709-03, Citation 2004 FC 1334) 17.

[26] Sack Goldblatt Mitchell LLP 26.

[27] Sack Goldblatt Mitchell LLP 26.

[28] Sack Goldblatt Mitchell LLP 27.

[29] Sack Goldblatt Mitchell LLP 27.

[30] Sujit Choudhry, "The Enforcement of the Canada Health Act" McGill Law Journal 41 (1996) 476.

[31] Armstrong 5.

[32] Bégin

[33] Canadian Centre for Policy Alternatives. Canada Health Act? Or Canada Health Inaction? (Ottawa: Canadian Centre for Policy Alternatives, 2003) 1.

[34] Choudhry, The Enforcement of the Canada Health Act 494.

[35] Choudhry, Bill 11 9.

[36] Auditor General of Canada 1987 12.97.

[37] Auditor General of Canada 1987 12.109.

[38] Auditor General of Canada 1999 3.18-6.

[39] Choudhry, Bill 11 4.

[40] Choudhry, Bill 11 4.

[41] Auditor General of Canada, 2002 3.18-6.

[42] Choudhry, The Enforcement of the Canada Health Act 507.

[43] Sheila Block. "What Does the Increased Federal Funding for Health Care mean for Medicare Advocates?" Behind the Numbers ? (Ottawa: Canadian Centre for Policy Alternatives, 2004) 3.

Developments of the Canadian health care system

The Canadian health care system appears to be under renovation. Canadians have been picking up on symptoms of the health care transformation that is underway. On the ground it is quite clear that changes have been occurring and that the health care system of today is noticeably different than the system of twenty years ago. However, explanations for this reform have been tricky. Using the federal government as the level of analysis, a better explanation for the developments of the health care systems must be pursued. There have not been any major or minor reforms to the federal health policy, so that does not provide any insight into what is occurring. In one assessment, of the policy itself, there has been no change. In another assessment, of the outcome of the policy, there have been changes. Roy Romanow observed that "on the ground, what you could see was an erosion of public confidence in the public health care system…….. occasioned by the lack of reforms"[1]. How can this paradox occur? A new theory, drift, has emerged that speaks to this very process.

Drift

Drift has developed as a concept that is increasingly useful to explain the developments occurring in developed welfare states. The insight that can be gained through the application of drift to social policy reform is so valuable as it provides a new perspective that other theories have not been able to contribute. Drift focuses on the changes that can occur in a less visible manner through non-formal processes. In this way, the concept of drift moves beyond the restrictions of other theories as it does not share the same limitations of looking solely to the formal reforms that have occurred.

Canada Health Act as case study of drift

The application of the concept of drift is valuable in paradoxical cases that have experienced, changes in the outcome of a policy while there have been no formal changes to dictate this. The development of the Canadian healthcare system in the absence of formal reforms provided parameters for a study of drift. The federal government was selected for analysis despite health being the primary jurisdiction of the provinces and territories. As this was the introductory study of drift in the Canadian health care system, it was anticipated that a national perspective would provide greater insight into the issue across the country. The Canada Health Act, the federal health policy, was selected as the case study. The CHA is intended to achieve national standards set out in the policy. Canadians strongly support the CHA, although in practice there is concern that it is not achieving what it set out to.

Failure to update the CHA has opened the door to policy drift

As Tommy Douglas, the father of Medicare, insightfully noted, "you have to run as fast as you can to stay where you are. Any program needs to be changed. Any program has to be looked at periodically and re-examined"[2]. There is perhaps no one who better knows what is required to maintain the health care systems in Canada than Douglas. Increases in day surgery, greater expenditures and reliance on pharmacare and home care, improved diagnostic capabilities, and the rise in particular illness are part of the developments that have contributed to the contextual changes relevant to the Canada Health Act. These contextual changes that have occurred since the early 1980s, particularly in the effect that they have had of placing greater financial burden on the individual, necessitate a response in policy that has yet to come. There are a variety of developments that have evolved within the scope of the CHA and without the legislation being updated, the relevance of policy is in decline.

Support for the Canada Health Act remains strong and the values have remained the same since the legislation was passed in 1984. Contextual changes have developed not through a formal process of reform. Left without a response in policy to these contextual changes, the policy in practice has changed. The needs of Canadians have not remained the same since the early 1980s and the health care insurance plans need to reflect this development.

The application of the concept of policy drift to the case of the CHA has revealed a possible means through which drift can occur in the Canadian health care system. The CHA has not responded to contextual changes that have emerged since it was enacted. Better updating of the Canadian federal health policy would help to correct for the developments that have occurred due to policy drift.

Failure to uphold the CHA has opened the door to regulatory drift

While consistency in policy and practice is always important, this is especially true in the current context of health care in Canada. The potential impact that regulation has on drift is significant, as identified and explored in the case of the Canadian health care system. A genuine effort should be made to uphold the national standards expressed in Canada Health Act in reality. Upholding the CHA requires adequate monitoring and consistent enforcement of the federal health policy. The performance of the policy must be realistically assessed, and if violations that have been identified are not remedied, then penalties should be administered. The real teeth of the CHA lie in the ability of the federal government to withhold funding from governments that have been found to be in violation of the Act.

The current monitoring of the performance of the CHA in each province and territory is not adequate to make an accurate assessment of the impact that it has. The Auditor General of Canada has observed in many reports that the monitoring of the CHA is insufficient and must be improved. The Canada Health Act Division has taken a passive approach to the collection and dissemination of data. Without effective monitoring the state of the CHA will not be accurately known and possible violations will not be identified.

The federal government has been reluctant to make deductions to the financial transfers to provinces and territories that have violated the CHA. Sujit Choudhry has commented on the "dismal record of the federal enforcement of the existing national standards of the *Canada Health Act*"[3]. The reluctance to enforce the CHA has seriously impeded its ability to be upheld.

The application of the concept of regulatory drift to the case of the Canada Health Act has revealed a possible means through which drift can occur in the Canadian health care system. The CHA is not upheld as demonstrated through the inadequate monitoring and inconsistent enforcement. As Choudhry has stated, in the absence of the institutions to effectively uphold the CHA, "national standards for Medicare are merely political platitudes"[4]. Better upholding of the Canadian federal health policy would help to correct for the developments that have occurred in the occurred due to regulatory drift.

Implications

The potential for drift to occur in the context of the Canadian health care system was shown to be possible through two forms, policy and regulatory. The quiet dismantling of the federal health policy experiencing drift is significant.

In the case of drift, national standards will fade away and health care systems in Canada will share less in common. With greater flexibility, different governments are likely to pursue different paths. National health care will lose meaning as the services that are insured from jurisdiction to jurisdiction will vary even more. There are already "very large contrasts among Canada's provinces and territories in the health of the population overall. Large gaps in health status also exist between geographic areas within provinces"[5] and in a scenario of drift, this would be expected to be exacerbated.

A significant implication of drift in the Canadian health care system is the increased responsibility of the individual. Jacques Chaoulli believes that "governments will tolerate an increase in private health care as long as it's not too obvious..... (they) want to save their face"[6]. Brett Skinner, the Director of Health and Pharmaceutical Policy Research at the Fraser Institute, has observed that there is "an evolutionary change that's underway that will be incremental, year over year — a slow expansion of private options, and the development of private insurance for those things"[7]. There must be consideration given to the relationship between drift and privatization.

While the implications of the findings of this study are significant to the Canadian health care system, it also carries an important lesson for other social programs and welfare states. The potential for drift is not unique to health care nor is such a process limited to develop only in Canada. Every social program and every welfare state has the possibility of experiencing drift. Are welfare states in the process of being quietly dismantled under the veil of seemingly solid policies? This is a question that increasingly needs to be asked. Although the informal, invisible and potentially subversive aspects of drift make it challenging to analyze, this makes the process of change no less significant. In fact, in many ways these features make it more imperative to apply drift theory to more programs. Over time, a setting for change can unnaturally be created by not reporting on these changes that are not made through formal procedures. The impression can be given that a natural evolution has occurred when in fact it was artificially stimulated. The opportunity for politicians to avoid blame is very attractive in this process. This increases the likelihood of drift occurring, which also supports the need for greater investigation into the area and improve accountability.

Reformation of the most beloved social program in Canada through the "back door" will have serious consequences for Canadians. Increased study of drift is merited, more generally, but in particular in the context of the Canadian health care system.

Future Studies

Further study is needed of each provincial and territorial health care system. This will provide a much better estimation of the problem, particularly as provincial policies and the impacts that they have on drift is crucial. Focusing on the Canada Health Act at this exploratory stage was beneficial at providing an overview of the issue and an introduction into drift in the Canadian health care systems. However, further study should move the analysis to the level of governments with direct jurisdiction over health care delivery systems. It is expected that future investigations examining provincial and territorial case studies will be very revealing on the issue of drift in health care systems in Canada. Following this, cross-country and regional comparisons would likely continue to add significant data to this body of research.

A comprehensive review of outcome drift of the health care systems would be a valuable contribution to future research. Concrete examples are needed of outcome drift, and figures would be constructive in grasping the extent of the problem. What is the magnitude of "on the ground" changes that has resulted from the policy and regulatory drift that is possible, or has this not become a significant problem?

In conclusion

While Canadians are increasingly becoming aware of the changes that are occurring in their health care system, the process by which this could be taking place might surprise them. During the past election politicians were, time and again, referring to the Canada Health Act and its importance, but the lack of commitment is evident as it has not been updated nor has it been upheld. This inaction has allowed for the possibility of change, through policy and regulatory drift, which is contradictory to the CHA. The lip service paid by politicians needs to turn into real and official action in terms of updating and upholding the CHA so that the possibility of drift can be eliminated. Otherwise, the Canada Health Act is in danger of drifting away.

Notes

[1] Roy Romanow, interviewed by Dr. Martin Hering and Skye Mitchell on 16 Nov. 2005.

[2] Tommy Douglas, Proceedings of the Conference on Medicare: The Decisive Year, November 12 and 13, 1982: We Must Go Forward (Ottawa: Canadian Centre for Policy Alternatives, 1984).

[3] Sujit Choudhry, "Bill 11, the Canada Health Act and the Social Union: The Need for Institutions" Osgoode Hall Law Journal Spring (2000) 40.

[4] Choudhry 3.

[5] Auditor General of Canada. Report of the Auditor General of Canada to the House of Commons (Ottawa: Government of Canada, 1999) 29.26-11

[6] Canadian Medical Association Journal, Chaoulli decision resonates one year later (CMAJ: Ottawa, 2006) Available: http://www.cmaj.ca/news/09_06_06.shtml

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