

# **CANADA, HEALTH AND HISTORICAL POLITICAL ECONOMY**

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Healthcare in Canada is at an important political and economic crossroads. In 2014, the 10-year Canadian Health Accord will conclude, and the role of the federal government in supporting both health research and health delivery – the latter being a responsibility of the provinces – should be the subject of intense public discussion. The 2004 Health Accord responded to a perceived crisis in the Canadian system, known as Medicare, by guaranteeing stable additional federal funding for the provinces and setting out a number of objectives oriented around quality of care. Over the next year, public figures and health experts from province to province will debate which financing models effect optimal health delivery in the face of rising, off-loaded costs. The federal government’s refusal to bargain with provincial Premiers as a whole on federal funding, as well as its ongoing encouragement of ‘experimentation’ across provincial health systems, will increase pressure towards system transformation (Barlow and Silnicki 2012). That said, institutional practice, political culture and social resistance can make short order of reformers’ attempts to alter the basic character of health delivery. This is why understanding health care delivery in historical context gives us greater insight into the system’s vulnerability to change, and the extent to which the limits of reform can be assessed.

In historical and practical terms, Canada presents a comparative analytical conundrum. Its proximity and deep historical interrelation with the United States should reinforce and ensure a trajectory along Anglo-American liberal lines. In large part, this has proven true, albeit with important historical specificities unique to Canada. But this otherwise thriving liberal-capitalist ethos within Canada does not square easily with the political strength of its universal and solidaristic health

insurance. Chiefly, it appears to run counter to influential U.S. trends, where:

By taking the most costly and difficult-to-insure populations out of the private insurance system, Medicare and Medicaid at once strengthened private insurance and removed much of the remaining political pressure for reform. This was not the only reason that proposals for universal health insurance failed in the 1970s and 1990s, but it did contribute to these political defeats and, more subtly, to a continuing transformation of the goals of reformers (Hacker 2002:290).

It could be argued that U.S. bolstering of private health care is the exception in the advanced industrial world, but surely it remains a highly significant 'exception' for Canada and Canadians.<sup>1</sup> If the U.S. is a uniquely liberal example of state involvement in social policy, why has Canada not followed suit, given its deep integration, as well as geographic, linguistic and philosophical propinquity? In blatant contrast to the U.S., universal, state-run insurance schemes emerged and expanded across the Canadian provinces, culminating in legislation and involvement of the Federal Government and reducing private insurance to a complementary role. Not surprisingly, this distinction makes up an important component of national identity construction, wherein 'being Canadian' becomes, in part, mere differentiation with facets of American societal organisation – as one significant survey report made clear, the majority of Canadians believe that 'Medicare embodies Canadian values' (Mendelsohn 2002:vii).

Nevertheless, this article argues that the entire Canadian health model does indeed fit faithfully into the Anglo-American trajectory, even if it is conditioned by certain historical peculiarities. Health in the Canadian context exhibits strong pressures towards accelerated biomedical

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<sup>1</sup> While not the subject of this study, other Anglophone countries, such as Australia, will prove of comparable interest to readers of this issue. Australia exhibits structural similarities with Canada, operating both a federal health care system and exhibiting a rough 70-30 public-private split in health care expenditures. The same research question could be put to the Australian system, as the ideological and systemic pressures to bolster and expand private health insurance continue to have mixed effects. Some have argued, however, that it is precisely their comparability that suggests that Australian rounds of reform might offer certain warning signs to Canadian policymakers. For greater detail, see: Jeremiah Hurley *et al.* (2002).

accumulation as well as increasing privatisation of health care delivery. Indeed, the use of historical political economy is valuable here, precisely because it points towards common global pressures across the health domain while remaining sensitive to the historical and institutional peculiarities of specific national contexts.

In this vein, the article begins with a conceptual discussion of health as a burgeoning arena of commodification, both in terms of production and care delivery. It also suggests that the extent to which this commodification will proceed apace depends, in part, on historically specific institutional and cultural trajectories emerging out of capitalist transition. As such, it then turns to consider, briefly, the transition to capitalism in Canada and the specific political and institutional forms to which it gave rise. It then proceeds to outline the distinct ways in which Canada's peculiar historical trajectory have helped lay the basis for disproportionately robust biomedical research and production, as well as increasing pressure towards competitive market dynamics in health care delivery.

## **Conceptualising Health in the Advanced Industrial Context**

Across the advanced industrial world, health has long constituted a field of production and profit. This should hardly surprise us, as, '[capital] is the lifeblood that flows through the body politic of all those societies we call capitalist, spreading out, sometimes as a trickle and sometimes as a flood, into every nook and cranny of the inhabited world' (Harvey 2010:vi). Capitalism is, at its heart, a set of social relations in which commodities are produced for the competitive market, 'down to the basic necessities of life...where even human labour-power is a commodity for sale, and where all economic actors are dependent on the market (Wood 2002:2). There is little doubt that this process has been intensified since the mid-1970s, when a neoliberal agenda gained pre-eminence in political circles. The neoliberal project combines fervent classical liberal tenets with a disdain for Keynesian trends of the 20<sup>th</sup> century. It has been constituted by a relentless class struggle, in which the limited gains of working classes under previous Keynesian or even social democratic policy trajectories has fallen under siege. Neoliberal policies are the product of both an intellectual and practical program to recapture

political power in national and global terms, adjusting the balance between social forces – along with the distribution of wealth – on a long-term basis (Peet 2003:8-13; Gill 2002:47-65). During this period, then, health has been a domain increasingly subjected to market imperatives, with an expressed purpose of ever intensifying value accumulation. Not only does the health terrain offer new possibilities for accumulation, overcoming constraints on profitability, but its boundaries remain tantalizingly expandable. There are no obvious limits on the level of health to which societies should aspire, and medical conditions are subject to medical (professional, expert) interpretation, itself highly subject to influence. Saturation of the market is feasibly overcome by reinterpretation of medical need, a process now inexorably caught up in medicalization – that is, the phenomenon whereby increasing array of conditions are being drawn into medical diagnosis and treatment (Kenan 1996; Moynihan *et al.* 2002; Williams and Calnan 1996).

Much of this involves institutional adaptation, as arenas of public policy are substantially altered, in order to admit private transactions as a legitimate activity. David Harvey's (2003) 'accumulation by dispossession' – where existing forms of productive creativity, health identities, social organisation and delivery are channeled into the private domain, so that value can be either siphoned off or extracted anew – resonates strongly. Perhaps most indicative of the lucrative appeal of biomedical production is the manner in which the industry seeks a legal shelter with which to carve out niche commodification, protected from the vicissitudes of real competition (Loeppky 2010:60). Trade secrecy, data exclusivity and patent protection all form the basis for corporate actors' contradictory desires to advocate for a competitive environment while safely escaping it, on the way to extraordinary returns. That all of this has been sanctioned by the state reflects its participation in – and contribution to – a competitive international environment, where innovative biomedical development strategies are purported to bring positive – even powerful – returns on investment.

However, the power of this production-provision-profit cycle still depends on health care delivery as a market, and capital seeks to overcome political configurations that represent potential 'chokeholds' on its sought-after profit stream. Massimo De Angelis (2007:chapter 3) has emphasised the point that the capitalist world is not solely a world of capitalism. Rather, we are caught in between the systemic impulses of capital to normalise its values and other spheres of life that do not readily

avail themselves to such value. Much of this is mediated by the state, which must be understood as dependent on but not wholly an instrument of capitalist social relations. As a terrain of struggle, its ensemble of institutions and actors operate to reproduce the conditions for capitalism in ways that demonstrate a ‘relative autonomy’. As Leo Panitch and Sam Gindin (2013:3-4) put it:

...what states do and how well they do them, is the outcome of complex relations between societal and state actors, the balance of class forces, and, not least, the range and character of each state’s capacities. Capitalist states have developed varying means of promoting and orchestrating capital accumulation, as well as anticipating future problems and containing them when they arise, and this has often been embodied in distinct institutions with specialized expertise. It is in these terms that we should understand the ‘relative autonomy’ of capitalist states: not as being unconnected to capitalist classes, but rather as having autonomous capacities to act on behalf of the system as a whole.

As such, when accumulation logic across health meets with friction, insofar as it requires the elimination or at least optimisation of barriers, it is the state’s capacities to reorganise conditions that takes center stage. In health, this has meant, in the first instance, an ongoing struggle to reorder values and institutional modes related to biomedical research and knowledge production. From at least the mid-1970s onward, capital has advocated – and, in large part, received – a progressive transformation of biomedical sciences from an almost exclusively academic sphere to one in which technology transfer, public-private partnerships, and profit potential form the core objectives of research (pure, applied or clinical) (Kenny 1986; Gottweis 1998; Loepky 2005; Peekhaus 2013). Similarly, the regulatory sphere that makes technology transfer orderly and predictable has become subject to consistent politico-economic scrutiny. Finally, health delivery, has typically been constituted by a series of politically rigid structures that, from the perspective of capital, needs to be re-evaluated by the state for ever-expanding accumulation possibilities. In this regard, relatively generous advanced industrial health systems represent both a bonanza and limit on explosive biomedical growth in the West.

The common accumulation dynamics across OECD countries, however, should not necessarily signal homogenisation towards market reform. In fact, understanding the political economy of health needs to be a

comparative-historical endeavour, because the concrete reality of 'diversity' throughout the capitalist world continues to 'nag' homogenizing accounts of economic development, trade and health. Understanding this diversity requires some account of institutionalist perspectives, as they have done the most to demonstrate the importance of institutions as social entities with self-reinforcing and conservative tendencies, which foster and shape trajectories along so-called path dependencies (Hodgson 1996:16; Streeck and Yamamura 2001). Indeed, authors such as Susan Giaimo and Philip Manow (1999), Jakob Hacker (2002), and Wolfgang Streeck and Kozo Yamamura (2001) have gone far to demonstrate that the contours of 'decisive' institutions over time exhibit continuity and, thus, centrality in capitalist organisation and state policy, including in the area of health. At the same time, while institutional accounts are critical for understanding specificity, they do not suffice. We still require politico-economic explanations that situate their emergence and continuing existence in terms of social structure. In order to elucidate this dynamic interplay between the social imperatives of capitalist relations and institutional rigidity, it is necessary to pay closer attention to capitalist transition, as elements formative to capitalist transition can exhibit resounding – albeit evolving – effects on political outcomes over time.

Ellen Wood (1991:167-8) suggests, for example, that the contemporary facets of Anglo-American capitalism are a function of its more extensive historical absorption of *indigenously* emergent capitalist social relations, with the result that state structures were subordinated to the supremacy of 'civil society'. In contrast, continental European capitalism, imposed by the state under geopolitical duress, was part of a political strategy to preserve the pre-capitalist social order. As such, European continental states continued to exhibit an array of *pre-capitalist* social and institutional traits, and this pre-capitalist residue constitutes the social and historical basis from which future rounds of dense regulation and intervention would emanate. Most importantly for this work, it was the specific form of transition to capitalist social relations, differing greatly between the Anglo-American and continental contexts, which would condition (not determine) the varying degrees of solidarity within each state-society complex. This means that societal organisation within the advanced industrial world, as it relates to health as both an area of public policy and industrial activity, needs to be understood in the context of

each society's specific historical relation to capitalist transition and development.

Importantly, capital as a social force, operating through state policymakers, the WTO, the OECD, the EU and NAFTA must *perforce* adapt to a variety of socio-political contexts across advanced industrial states. This means that the push for enhanced biomedical production and transformed private health delivery channels must square with the reality of national populations, constituted by complex and diverse social relations. Corporate actors may seek a form of *homogenisation*, but they must accept adaptive circumstances. This maneuvering can be understood as 'accumulation by institutional adaptation', wherein the industry seeks to optimise its operating environment, given current and probable future historico-political circumstances. While there may exist a *tendency* toward homogenisation, it remains unrealised in a world of shifting political struggles – even outright social resistance – that inhabits national cultures and institutions. The question in the Canadian context is how long-term structural features of capitalist accumulation and the specific state-society complex bend towards an Anglo-American or continental trajectory. Such a question can only be meaningful answered against the backdrop of Canada's unique turn to capitalist development in the late 19<sup>th</sup> century.

## Capitalism and Canada

As in the case of the U.S., it makes little sense to assume that capitalism streamed off of boats with settlers, as the conditions faced by those settlers need to be understood in their specific context. Indeed, while there may have been an intention to expand capitalist agricultural production, '...local conditions made it impossible for persons employing wage labour in agriculture, to do so profitably' (Johnson 1981:102). Independent producers may have done limited production for the market, but they were hardly *capitalist* in character.

In the mid-century industrial census, 53.4% of the working population was directly part of non-capitalist production (agricultural, artisanal or mercantile/financial). Conversely, of the 31.9% listed as 'labourers', the majority of these were actually sons performing service on their own family farms (Johnson 1981:107).

None of this is to say that self-sufficient petty producers were not productive – at least in Upper Canada this was highly productive agriculture, and it most surely offered the prospect of a growing internal market. Whether such an internal market could emerge depended on the long-term character of the labour market. While the crown attempted reform of land, taxation and immigration policies, low cost property for sale and the wide availability of credit remained right up until mid-century, staving off the necessity of wage labour (Johnson 1981:104-6). In part, this had been the subject of Upper and Lower Canada rebellions of 1837, wherein Reform movements struggled with the Tories over the extent to which the state should alter a republican or independent way of life (Smith 1987:14-5). The transition from these circumstances remains under-researched, but it is clear that the crushed 1837 rebellions, post-1840 immigration waves and evolving state policies affected the availability of both property and wage-labour. Large immigration waves began to undermine easy access to cheap land, and the best land would ultimately be parceled off to the Canada Pacific Railway Corporation, in a deal that would prove highly beneficial for that company. In general, one finds a punctuated process that undermines the ‘civic humanism’ and gives way to a classical liberal notion of individualism and a market supportive state (McKay 2000:635). With production for exchange increasingly coming of age among petty producers, amidst increasingly competitive farming (more immigrants, more lands settled, Western competition), a liberal subordination of the state to commercial development became more prevalent.

This subordination did not mirror the U.S. experience, but instead involved state *intervention* to shore up capitalist development. Unlike the European tradition, such intervention focused on the well being of the market, rather than any paternalistic or reactionary guidance of the citizenry or industrial relations. Instead, the state ‘was seen as the essential arbiter of class relations much earlier than it was in Britain and in sharp contrast to the United States where manufacturers tended to engage in collective, self-help voluntarist associations to further their ends’ (Price 1983:180). A central and interventionist state would invoke policies both to consolidate a market and attract foreign investment in economic development. The resulting growth in efficient staple production occasioned the state to push through construction of the railway, expanding wage labour across construction, steel and resource industries. It also intervened in reaction to growing labour conflict,



reacting to high wages on par with the U.S. with a protectionist National Policy (Panitch 1981:15-8). With no ‘hint of corporatism,’ this ‘impartial umpire’ accelerated arbitration and mediation between capital and labour in moments of conflict, operating on a case-by-case basis, never fostering or allowing the kind of sedimentation visible in the European continental tradition, such as the state mandated use of associational structures (Price 1983:181). The ultimate effect was the endorsement of state intervention without any permanent structure, the latter of which might be considered a long-term constraint on future actions of either the state or capital.

The Canadian economy is generally still viewed as highly reliant on both resource-based wealth accumulation and foreign investment capital. Canada is no less ‘capitalist’ on this count, but the predominance of primary sectors and North American-integrated domestic manufacturing capital has not, typically stimulated high levels of innovation. This is not to say that no innovation occurred during the postwar period in the Canadian economy – rather, the state’s interventions on behalf of capital were not predominantly to foster the kind of scientific and technological innovation occurring south of the border. With the extraordinary fluctuations of world resource prices from the 1970s onward, as well as the ongoing concern with the degree to which the economy was foreign-owned, state energies were directed toward such policies as the National Energy Program, wage and price controls and the establishment of the Foreign Investment Review Agency (Howlett *et al.* 1999; Albo and Jenson 1989). However, in a neoliberal era, a state assisted program of ‘catch up’ (with other OECD countries) has involved a range policies leading to regulatory re-articulation and politico-economic transformation. Through this, the latitude of state action remains *ad hoc* but extensive, in everything from state divestiture of assets to the settling of sectoral industrial relations – from Canada Post to Air Canada (Campion-Smith and Lu 2011; Stanford 2011). As we will see, biomedical innovation questions – direct or indirect – have also tended to be a matter of state guidance, a guidance deeply interwoven with accumulation objectives.

## Canadian Political Economy and Biomedical Development

Canadian activity around biomedicine and health has occurred as reaction to the perceived laggard position of industry, with an eye to future economic development. All OECD states have done this, but the Canadian case has to be understood as state-led encouragement of *laissez faire* development. Prior to the neoliberal era, Canadian policy exhibited a trajectory of protectionist policies, the most predominant of which was the post-1969 enforcement of compulsory licensing on pharmaceuticals. This ensured the fostering of a domestic generic drug industry, but, at the same time, was also cited as the predominant reason why research-based pharmaceutical companies remained largely inactive in Canada. As a result, the kind of early interaction between capital pursuing new areas of potential accumulation and a state seeking to accommodate that process (as in the United States) was largely forestalled.

Biomedical development was initially part of policy shifts spanning across 1980s, which largely repositioned Canadian political economy *vis-à-vis* events south of the border. The Conservative government of Brian Mulroney sought to re-regulate as a means to accommodate foreign investment capital. As an initial salvo, the federal government introduced bill C-22 — and later bill C-91 — to bring Canadian patent regulations in line with the U.S. (Kuyek 2002:24-36). This came at the behest of foreign-owned pharmaceutical companies and a nascent biotechnology community, and it involved considerable pressure on the Canadian government for greater politically-derived protection from generics. This was part of a government reaction in the mid-1980s to a prevailing sense of restructuring across the advanced industrial world and the need for Canada to take measures to prevent its potential 'laggard' status.

The Science Council of Canada advised the government that changes in biomedical development — particularly the advent of biotechnology — would not only alter human health but also foster technological and economic growth in ways that the country could not afford to pass on. Importantly, the government received this with an eye explicitly geared to private market development, with the creation of a private sector task force that would eventually help the government render its National Biotechnology Strategy in 1983 (Peekhaus 2013:28-9). The 1983 strategy, with funding of \$122 million, oriented the government towards

clarifying the regulatory environment surrounding new biomedical products while also fostering innovation and economic development. The revamping of the National Biotechnology Strategy into the Canadian Biotechnology Strategy in 1998 signaled a redoubling of efforts on the part of the state to bolster its capacity to enable biotechnology as an industrial and scientific activity. Augmenting this policy reformulation, \$145 million in research funding was supplied in 1999 and 2000, as well as the start of Genome Canada in 2000, supporting the development of genomics to the tune of \$600 million, by 2005. Along with this, the founding of the Canadian Foundation for Innovation (CFI) has seen funding amounting to \$3.65 billion, along with the ample resources put at the disposal of basic research through the Natural Sciences and Engineering Research Council (NSERC) (Government of Canada nd.).

Similarly, by the early 1990s, there was a strategic arrangement of the manner in which biotechnology practices and products would be evaluated and regulated. Biotechnology regulation in Canada emerged gradually in response to the product development process, giving rise to no central regulator for such products in Canada – instead, line departments have been called upon to adapt to the 1993 Federal Regulatory Framework for Biotechnology. This framework sought to contribute, ‘to the prosperity and well-being of Canadians by fostering a favourable climate for investment, development, innovation and the adoption of sustainable Canadian biotechnology products and process’ (Doern 2000:3). It also ensured a regulatory system in line with the objectives of centralised agencies -- Industry Canada, the Privy Council Office, and the Treasury Board. It explicitly excluded any mention of the Canadian Environmental Protection Act (CEPA), and downgraded the authority of line departments – Environment Canada, Health Canada and Agri-Food Canada (Doern 2000:4). The imperative of a cost-efficient, risk-oriented, non-intrusive conception of biotechnology regulation, grafted onto a regulatory regime with vertical authority, has largely avoided a system of transparency, openness and political debate. This has been accompanied by a general demand among regulatory line departments, particularly Health Canada, to shorten evaluation times for new products, including medical devices, pharmaceuticals and biologics. For example, the Therapeutics Products Directorate (responsible for drug review in Canada) introduced a cost recovery program, similar to the Prescription Drug User Fees Act in the U.S. (OECD 2007:10-1).

Fiscal incentives have also emerged across the health industry, as a means to grow this area of economic development. Since the 1980s, the government has repeatedly sought to fine tune and optimise its tax measures as a means to attract high-tech investment (Madore 1998). This has constituted a bonanza for pharmaceutical, biotechnology and medical device corporations. The Scientific Research and Experimental Development (SR&ED) tax incentive in Canada has remained consistently lucrative, offering up to 35% refundable tax credits on broadly interpreted set of activities constituting R&D. In fact, a major tax consulting operation has consistently rated Canada first among G-7 nations for competitive tax rates across health-related industrial production (KPMG 2010:20, 24, 38, 40).

The results have been dramatic across the health industry. On both the pharmaceutical and medical device end, there has been extensive growth since the 1980s, when the government first sought to make conditions more conducive to industrial activity. The medical device industry in Canada had reached a market of 6.4 billion by 2008, with year on year growth of 2%, and exports almost doubling (Industry Canada 2013a). For its part, the pharmaceutical industry has virtually exploded in Canada, with sales doubling to \$21 billion between 2000 and 2009, and domestic production growing during that period at an average annual rate of 8.5% to \$12 billion (Industry Canada 2013b). As far as capitalizing on biotechnological progress, the results of heavy state support have also born fruit. Between 1999 and 2005, biotechnology firms in Canada increased their R&D spending at an average of 10% per year, in constant 2000 prices, and they ranked third in private biotech R&D among OECD countries (van Beuzekom and Arundel 2009:24-5). There were, by 2006, 532 public and private biotechnology firms in Canada, and a 2010 Ernst & Young report (2010:54) continues to assert that Canada ranks among biotechnology leaders in the OECD.<sup>2</sup>

The industry will continue to push hard for both state support and restructuring that accentuates growth models for the future. Biotechnological and pharmaceutical industries are angling towards

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<sup>2</sup> In both the pharmaceutical and biotechnology spheres, the dominance of foreign investment is clear, with all major pharmaceutical players present in Canada. Additionally, between 2003 and 2011, over 60 foreign companies have invested in greenfield investments in pharmaceuticals or biotechnology. For further details, see: Government of Canada (2012).

increased profit streams by emphasizing new treatment models. In a smaller sales market like Canada, it is not surprising to see a heavy emphasis on the future tenability of personalised medicine. According to BIOTECanada (2013:21-5), 'The industry today is seeing a number of key blockbuster drugs coming off patent, low R&D productivity, changes in healthcare reform and the advent of personalized medicine'. This is echoed in the area of genomics, where Canada has made substantial revenue investments and is hoping for the development of 'tailored products' and the development of 'niche markets' (Doern and Prince 2012:157). Along the lines of institutional adaptation, this would mean carving out new configurations of public and private health product utilisation. This may explain the push by the OECD for Canada to consider, on the one hand, moving pharmaceuticals into the core public service delivery for Medicare while, on the other, recommending the introduction of co-pays or deductibles in health delivery (OECD 2010). This would expand the use of niche drugs, biologics or diagnostics, while also supplementing this use with out-of-pocket payment structures that alleviate spending pressure (by unloading it on individuals).

It is difficult to avoid the conclusion that such growth leads to pressure on health delivery as an instrument of market demand. This, in turn, pushes governments to experiment with market provision, payment and incentive structures. As we will see below, the pressure to 'experiment' is felt at all levels of government, and the likelihood that the system will withstand such pressures remains open to considerable question and controversy.

## **Biomedical Development and Health Care**

When considered comparatively, the existence and continuing longevity of the Medicare system represents a perplexing case among OECD biomedical complexes. This is because the existence of the Medicare system does not fit easily into the Anglo-American scenario, where one would expect a market-centered approach to predominate. But Canada has achieved and sustained universal health insurance, albeit somewhat short of comprehensive coverage. The question, then, remains: what accounts for a system universal in character, against expectations, and what is the extent of this system's structural tenacity?

In fact, the same argument that can be made for U.S. Medicare and Medicaid can also be made for the Canadian Medicare system. Like in those systems, Canadian Medicare is 'intimately bound up with the prevailing social relations of power and thus with developments occurring within capitalism itself' (Whiteside 2009:79). Heather Whiteside has made the argument that Medicare is both the product and potential victim of the state's reaction to accumulation crises in capitalism. It was deeply implicated in the drawn-out 'Keynesian' reaction to inter-war capitalist crisis, which culminated with universal care in Canada. In keeping with this, however, it is equally entangled with the state's neoliberal strategies to clear pathways for enhanced accumulation and profit through system transformation.

It is important to note that the Canadian health care system, like its U.S. counterpart, is a latecomer to advanced industrial economies. It took until after World War II for the issue to emerge seriously on the political radar, and this was no doubt, in part, a reaction to the large numbers of Canadian military recruits that had been rejected during the 1940s, due to less than optimal health (Whiteside 2009:87). More importantly, however, postwar class expectations and the resistance of professional associations also played an extensive role. The rising influence of the state in the mediation between capital and labour – a role consistent with its interventionist roots – meant that social policy became an increasingly prevalent tool to deal with the aftermath of both capital's collapse through the depression and its reconsolidation following the Second World War. According to David Coburn (1999:841), in relation to health care,

...the use of state power to ameliorate the Depression or to advance the war effort, in combination with the burgeoning role of labor and working-class movements generally, led to a hugely increased role for the state in Canada, including an increase in welfare state measures. Universal medical insurance, provided through government auspices, was one of the last welfare state measures enacted across Canada by 1971—an implementation highly influenced by the Saskatchewan example, by the rise of labor power, and by the electoral 'threat' of socialism at the federal level at the end of the war.

Labour struggle, over the period of two decades slowly blended into a situation in which dominant players accepted universal coverage as both

a source of increased income (medical practitioners) and a structural support for capital. In the aftermath of the war, with substantial room for capital growth, states sought to instantiate policies that provided a social wage, ensuring a bolstered labour force for effective capital growth – a strategy that also fit the need to ‘sink’ capital in ways that would stave off overproduction. Medicare, as with so much other Anglo-American social policy, is closely related to the cyclical nature of conflictual class relations in Canada.

As concrete social policy, health care lagged until political and professional resistance could be overcome, and in Canada it grew to completion between 1948 and 1971. Importantly, however, the instantiation of coverage never challenged the organisational and professionalised structure of medicine, but only insured its coverage, making the ‘buy-in’ of the Canadian and Provincial Medical Associations more likely (Tuohy 2002:35). Federal universal insurance had actually been upstaged in the left-leaning Prairie Province of Saskatchewan, where CCF leader Tommy Douglas had already moved in the immediate post-war environment to introduce universal hospital (then medical) insurance. At the national level, this proved more difficult, given the greater variance across different regions of the country; constitutionally-embedded provincial responsibility for health; and the ever-present resistance of the professions across the country. The introduction of medical coverage emerged in stages, beginning with the 1957 Hospital and Diagnostic Services Act. This insured hospital stays through a 50/50 cost-sharing agreement between the federal government and the provinces. By 1966, the Medical Care Act utilised the same enticements to set up insurance for physician visits, and in 1968, the two Acts were consolidated into the Medical Care Insurance program. The latter, instituted five principles that needed to be met for federal funding to the provinces: systems needed to be 1) universal; 2) accessible (no extra charges); 3) portable across provincial lines; 4) comprehensive; and 5) administered on a non-profit basis. These five principles would later be enshrined in the 1984 Canada Health Act (CHA), promulgated by the Trudeau government, as means to re-establish the federal role in health care funding and fend off provincial ‘experimentation’ with the system’s parameters.

By the time of the latter Act, advanced industrial capitalism had shifted gears in a postwar reaction to waning accumulation. Capitalist economies experienced a prolonged downturn from the mid-1960s onward, and the

1970s witnessed years of stagflation and high unemployment (Brenner 2002, 2006). Capital's reaction, widely understood as the neoliberal turn, included a progressive re-articulation of the federal state's role and fiscal responsibility in social provision. Since the 1980s, this has been the political order of the day in Canada, with only minor modifications between center-Left Liberal and center-Right Conservative governments. In relation to health funding, by the late 1970s, the federal government was already tying its provincial social (health) transfer to growth in GNP (rather than actual demand) and transforming some transfers to tax points. This lowered federal leverage in health care delivery, occasioning 'experimentation' on the part of some provinces to challenge the CHA, particularly Alberta (Church and Smith 2006).

The incentive for provinces to see alternative funding sources was intensified by the federal government's increasing turn towards neoliberal management models. In this, funding structures placed downward pressure on provinces to make do with less – ceilings were placed on transfers in 1986 and 1990-92, while an outright freeze in funding prevailed between 1992 and 1995 (Whiteside 2004:90). These challenges led to tussles in federal-provincial relations that might have remained manageable until the Liberal government's move in 1995 to consolidate a number of social transfers to the provinces under the Canada Health and Social Transfer (CHST). The CHST dramatically lowered transfer amounts to the province, placing them in a relative fiscal crisis in relation to health care delivery, the costs of which had grown in absolute terms over time. In the environment of waning funds and rising costs, provincial governments found – and continue to find – occasion to experiment with alternative forms of delivery. These challenges amount, in part, to a redesign of provincial systems and, in part, to an allowance of activities otherwise disallowed by the CHA. What has become abundantly obvious across Liberal and Conservative administrations is that the Federal Government, since the mid-1990s, no longer seems intent on enforcing the CHA, such that efforts at privatisation, increasing public/private partnerships and not-so-subtle allowance of extra-billing are not being seriously questioned at the federal level.

The growing public sense of a pressurised health care system came to a head at the end of the 1990s and into the 2000s. There was a growing public perception – fed by the media – that the system had grown unresponsive, and that it had become chronically underfunded. The



degree to which such ‘public opinion’ was – or is – reliable, rather than a reflection of the media’s filter on health care issues, remains an important question. Damien Contandriopoulos and Henriette Bilodeau (2009:111) have recently made a compelling case about health care and public opinion in Canada, arguing that,

the data...indicate quite clearly that citizens’ anxiety about their healthcare system does not arise from their personal experience as patients. On the contrary, our hypothesis is that the source of this generalized anxiety can be found in media exposure to a discourse that positions the system as being a problem. This ‘problematization’ of the situation creates a media demand for poll results and these results tend to reinforce both the media attention and the anxiety.

Whatever the source of anxiety, the achievement of a substantial fiscal surplus by the Liberal government, through a combination of increased tax revenues and dramatic cuts to provincial transfers, offered an obvious point around which critics of government policy could rally. Both Federal and Provincial governments had a vested interest in reacting to this public outcry, and the manner in which they did so remains telling with regard to the Canadian system.

Comparatively, in the United States, while the existence of Medicare and Medicaid may constitute the largest single-payer systems in the world, they are also systemically positioned as ‘run-off’ for the private insurance system. In actuality, their critics are uninterested in the fact that both programs remain remarkably more efficient in cost than their private-provider counterparts. The basis for transformative attacks on those structures stems largely from an ideological and historical bias that posits ‘big government’ programs as inherently inefficient and dangerous for people’s well being. In Canada, by contrast, while there may have been ideologues seeking the diminished role of the state in established programs like health care, criticisms of public health care could not easily take that entry point. First, Medicare is not a ‘run-off’ but rather constitutes the whole of the system, a structure that cannot be easily replaced. Moreover, with the state’s established role in directing programs related to economic development, including social programs, the ideological scare concerning government’s role lacks the same political resonance. Nor could it easily be argued that any Medicare ‘crisis’ – real or imagined – was the inevitable result of a bloated state, as

Provinces and their populations had witnessed hefty reductions in federal funding over the previous half-decade.

This meant that structural reform of health care in the late 1990s and 2000s – carried out by provincial governments – was carried out in the name of ‘rationalizing’ care in the face of a perceived funding crisis and rising costs. Across multiple jurisdictions, regionalisation of health purchasing was instigated, from Regional Health Authorities in Alberta to Local Health Integration Networks in Ontario (Church and Smith 2008; Fenn 2006). Various forms of regionalisation have been introduced along the general theme of rationalisation in care, establishing different payment structures and relationships with providers (Lazar 2009:10-1). There are numerous interpretations as to whether such rationalisation achieved its goals, but there is also considerable controversy in terms of the real motivations for such reforms. There are obvious funding controversies in the Federal-Provincial-Territorial relationship, but that is qualitatively different from the projection of a spending crisis. Robert Evans has highlighted the fact that depictions of spending at the provincial level are deliberately set in the context of budget expenditures, and this renders carefully constructed but misleading figures. Expenditures are not revenues (or potential revenues), and when the former are consistently whittled down, health spending appears to consume an ever-larger piece of the pie. Importantly, however, health spending in Canada has remained stable:

[A]ggregate provincial Medicare spending - doctors and hospitals has not been rising relative to GDP.... Medicare took up virtually the same share of our national income in 2005/06 as it did a quarter of a century earlier. Total provincial spending on health took up a somewhat larger share, but this includes provincial spending on pharmaceuticals, which has been escalating rapidly. As is now well understood, sole-source funding permits cost control – fragmented financing does not. Costs have been contained in the Medicare programs, not in the mixed public-private programs, which is why pharmaceutical manufacturers bitterly oppose universal Pharmacare. It is also why the Canadian Medical Association advocates more private payment to its members (Evans 2008:279-82).

And this is precisely the rub in Canadian provincial systems, which have become transfixed with the notion that collapse is imminent. The political moves here are always carefully orchestrated, demanding more

money for the existing system through Federal transfers but also arguing that structural change is imperative. The latter, involves, on the one hand, an 'objective...to shift more money into health care, but at the expense of users, not taxpayers, so as to distribute more of the burden farther down the income spectrum' (Evans 2008:279). It is, also, however, a move to expand usage, as efforts to make more care – including 'alternative' care – available to patients. Advocacy for 'experimentation' with US-style financing means opening up avenues for 'expanded private payment [which] permits those able to control and charge for access to raise their prices and incomes' (Evans 2009:272).

As all levels of government sought political solutions to the perceived weaknesses of the system, their agendas followed the well-sustained Canadian formula of directing a federal state-led plan to inject more money. This was the thrust of the 2004 Health Accord, which increased funding to the provinces by \$41 billion, and established an automatic increase of 6 percent to the Canada Health Transfer each year for the ten-year life of the agreement. In terms of reform, however, the interesting part of the Accord is its goal-orientation, with little or no consideration of method. The Accord states the collective provincial intention to reduce waiting times in particular procedures (joint surgery, diagnostics, heart surgery, and sight correction); increase availability of health human resources; create programs with full coverage for home care; greatly increasing access to primary care, including through tele-health and e-health; the creation of a national pharmaceutical strategy, including, potentially, a national formulary and plans for catastrophic coverage; and increased efforts at 'health innovation' (Health Canada 2004). Importantly, the agreement stated squarely that the intention to address the shortcomings brought out through citizens' criticisms, especially around waiting times and system capacity, but was silent on the manner in which such issues would be addressed. As the Canadian Health Coalition (2004:1) reported at the time, 'The agreement does not mention, let alone address, the most serious threat to the integrity and sustainability of public health care in Canada – the tide of privatisation and commercialization. Perhaps the economic priorities of the Government of Canada [on 'Health Innovation'] explain why there is no plan to stem the tide of privatization.'

Combined with the abovementioned focus of the media and polls on an impending health care 'crisis', the moves toward 'experimentation' have become all the more palatable.

[At] a programmatic level...whatever the real public opinion might be – if indeed there is any – on proposals to reform Canada's and Quebec's healthcare systems, current poll results provide a useful window of opportunity to those who would like to reform the system through increased privatization of funding. If such reform projects are successful – and in the case of Quebec, it seems plausible to believe they will succeed at least in part – then the performative loop of the political use of polls will have completed its circle, like the serpent biting its own tail (Contandriopoulos and Bilodeau 2009:111).

This problematic mix of media representations and federal ambivalence concerning enforcement of the Canada Health Act leaves considerable leeway for the provinces to 'experiment' with forms of privatisation and alternative payment structures in care delivery. Not surprisingly, then, we find across the country, but predominantly in BC, Alberta, Ontario and Quebec, various forms of experimentation with privatisation efforts and alternative payment structures. Natalie Mehra (2008) has conducted thorough research on the extent of privatisation efforts across the different provincial jurisdictions, and her conclusions suggest that such efforts have progressed rapidly. This has roughly spanned the lifetime of the Health Accords, as provincial governments have sought ways to address increasingly backlogged care demands. The expansion of privately organised clinics and diagnostic services, which take large parts of their funding from public contracts, have grown considerably, ostensibly with an eye to reduced waiting times and increased quality of care. However, the results are more than just the allowance of private hospital/clinic services – there has also been a not-so-subtle set of challenges to the Canada Health Act. The latter, of course, disallows extra-billing for medicare-listed services, two-tier health care, and double remuneration on the part of providers in the public system.

The numbers are substantial, and the effects, according to Mehra (2008:7), constitute a threat to the public integrity of provincial systems.

Across Canada in total we found 42 for-profit MRI/CT clinics, 72 for-profit surgical hospitals (clinics) and 16 boutique physician clinics. The surgical clinic numbers exclude those that sell only medically unnecessary cosmetic surgery and other such procedures.... Among these clinics we found evidence to suspect 89 possible violations of the Canada Health Act in 5 provinces.

These include clinics that appear to be selling two-tier health care and extra billing patients for medically-necessary services.

The problems which emerge from such challenges are also substantial. First, private clinics find ways to 'extra bill', especially through yearly dues or 'block charges', in which the patient pays an annual membership fee to clinic services, despite the fact that they are often receiving core Medicare services. Alternatively, procedures will be combined, so that both the public and private purse can be charged. More alarming, perhaps, is the fact that physicians and specialists are being drawn away from public sector work, in order to perform services in for-profit clinics. This, in certain cases, actually exacerbates the problem with availability of services. In at least two provinces, non-profit hospitals have experienced stress resulting from the loss of personnel to for-profit clinics. Clinics also tend to take the easiest case loads – a process known as cream-skimming – and leave more acute, expensive cases for the public system. Finally, services are often overcharged and sometimes medically unnecessary, leading to questionable benefits for provincial populations.<sup>3</sup>

It is clear enough that much of this should not occur under the CHA, even though the spirit of the Health Accord was ostensibly to preserve the principles of this Act while bolstering the capacities of provincial systems. However, it is also clear that, in most cases, the provincial and federal governments have mostly ignored these trends and failed to defend the integrity of the CHA. Institutional adaptation, then, continues to undermine the integrity of Canadian health care. This is also true in the careful manipulation of calls for better coverage – a fact most evident in the ongoing debate surrounding pharmacare. The Health Accord called for the instantiation of a national strategy in pharmaceuticals, but the degree of success has been extremely limited, with uneven and constrained programs across a patchwork of provinces (Health Council of Australia 2011). Indeed, even catastrophic coverage has been very

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<sup>3</sup> This forms another interesting point of comparison with Australian case, which has typically allowed both a public and private purchasing mix, subsidizing the purchase of private insurance, and allowed for extra billing. While Australia's system has clearly achieved both universal access and highly acclaimed care, there are reasons to believe that the post-1996 push to reinvigorate the parallel private financing system has led to care inequalities, upward income redistribution and little to no alleviation of systemic costs. For further details, see: Hurlley *et al.* (2002); van Doorslaer *et al.* (2008); Boxall (2010).

weakly implemented, and that, in any event, would do little to stem the tide of growing pharmaceutical costs in Canada. It has been recognised that the growth in costs in provincial Medicare systems, as a proportion of GDP, are stable while total provincial spending on health is growing – a fact almost entirely attributable to growth in pharmaceutical costs (Evans 2008:279). This overall fiscal stability is borne out very clearly by OECD statistics, where numbers remain somewhere between the U.K. and Germany, whether measured as a percentage of GDP (11.2 percent in 2012) or on a per capita basis (\$4665 in 2012) (OECD 2013). Critics, who have made a compelling economic argument for pharmacare, point out that Canada's growth in pharmaceutical prices have led the OECD with almost eight percent per year between 2001 and 2007 (Gagnon 2010:8). Indeed, the limitation of the debate in Canada around catastrophic coverage is no coincidence:

Public 'catastrophic' coverage, with a high deductible, could remove the embarrassment of the wholly uninsured while leaving plenty of room and market for private insurers after the deductible. It also preserves a fragmented payment system in which the market power of pharmaceutical companies can be fully exploited without meeting any countervailing power from a single public purchaser. High deductible coverage will thus preserve the past trend of higher prices and expenditures for Canadian patients, taxpayers and employers, corresponding to continuing escalation of pharmaceutical industry revenues (Evans 2009:23).

Pharmaceutical coverage in Canada is very weak, and it incorporates the one of the highest percentages of private coverage across OECD states. Debates surrounding its inclusion in core medical coverage follow the same logic as wider 'costs of healthcare' debates in Canada, with all their attendant erroneous claims about uncontrollable costs, aging populations and public vs. private efficiencies. In fact, with the highest proportion of private coverage next to the United States, and an almost two-decade search for social program 'efficiencies', Canada's universal insurance is hardly immune to prying open.

As Prime Minister Stephen Harper made clear immediately following his party's Spring 2011 election victory, Federal and Provincial governments will continue to 'experiment' with health care payment and delivery (Picard 2011). And the Conservative government has recently moved in a direction that validates many of the critiques of the Health Accord,

promising to extend spending volume for a short time, but with much greater allowance for provincial diversity. In other words, the government has made clear that funding will be issued regardless of each province's fidelity to the CHA. As the much-respected Romanow Commission on Canadian Health Care put it, this is '...astounding and maybe unprecedented and...potentially very dangerous to the future of medicare in Canada (Ibbitson *et al.* 2011:A1, A5).' In the long run, the Health Minister also seem to be making clear that, in the coming years, there is to be a \$36 billion cut in federal health funding. This is on top of existing cuts to 'health care for refugees, RCMP, veterans' long-term care beds, and the Health Council of Canada' (Douglas *et al.* 2013). Such up-and-down unilateral program announcements on the part of the federal state will, no doubt, please some provincial governments and raise the ire of others. Either way, it is perfectly in keeping with the reactionary state-led disposition towards reform, that the specific – no less neoliberal – Canadian trajectory would lead us to expect.

## Conclusion

The health industry continues to be a focal point for progressive, high-tech development of the Canadian economy. At the same time, Canada does not, at first glance, fit the contours of the Anglo-American trajectory of capitalist development, at least when it comes to health care. To explain this difference from its Southern neighbours, this article has pointed to the fact that capitalist transition, within a colonial framework, left a state more inclined to direct intervention, even if it did so squarely in the name of capitalist development. The results are clear to see: a state-led drive to develop a disproportionately large biomedical industry, paired with a universal health insurance program, supplemented by a private insurance market. As such, while the case may initially appear to invalidate explanations of political economic trajectories rooted in a specific historical understanding of capitalist transition, the latter's centrality is reaffirmed in any meaningful understanding Canada's specific historical and contemporary conditions.

In this regard, the pressures to bring Canadian health care in line with a more rapidly developing market are very real, and they are an obvious consequence of burgeoning biomedical research and development within the Canadian sphere. Each round of reform brings with it a frenzy of

claims concerning 'unsustainability', and even though there are many ways to address sustainability questions, one dynamic trumps all others across health production and delivery: 'New techniques - and especially new drugs - that offer expanded treatment (and income) opportunities proliferate rapidly, but it is very difficult to get providers to do less, regardless of the evidence. 'More is better' is deeply ingrained...' (Evans 2008:284). Unlocking core Medicare financing through extra funding (as in the Health Accord) will neither forestall increased *per capita* health spending nor dampen calls to introduce forms of private financing and delivery.

Importantly, the argument here does not contend that Canadian Medicare (or the UK's NHS) is subject to imminent transformation - social programs are popular politically, even if subject to popular criticism. Indeed, there is a rather consistent, somewhat casual claim made that Medicare constitutes a core part of Canadian values. But it is difficult to see how this offers any structural or societal protection to the health care system. Rather, those who advocate transformation have already and will continue to introduce incremental measures, simultaneously undermining elements of the system while proffering hyped interpretations of private alternatives. And the state - either in its federal or provincial guises - is likely to help direct this evolution in a manner that increasingly subordinates public interest to competitive imperatives.

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