# Ideas and the limits on program expansion: the failure of nation-wide pharmacare in Canada since 1944[1]

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Author's final version
Published in the *Canadian Journal of Political Science*, 46(2): 419-453

Abstract: This article investigates the limits that ideas place on the scope of policy expansion though an empirical puzzle: Canada lacks a nation-wide, universal pharmaceutical insurance program, which contrasts with the experience of most mature welfare states and Canada's own broad public hospital and medical insurance. The article find that ideas matter in policy development because of the mechanisms put in place by the pace of change. A slower, incremental process of policy development leads to restricted policy ideas that limit opportunities for program expansion. The article finds evidence of a reciprocal relationship between policy ideas and public expectations in four proposals for nation-wide pharmaceutical insurance in Canada between 1944 and 2002.

Résumé: Cet article examine les limites qu'imposent les idées à la portée du déploiement des politiques publiques, et ce à partir d'un paradoxe empirique : le Canada n'a aucun programme national et universel d'assurance-médicaments, ce qui tranche avec la situation de la plupart des États-providence établis ainsi qu'avec son propre système public d'assurance maladie et hospitalisation. L'article montre que les idées influencent le développement des politiques publiques en raison des mécanismes qu'induit le rythme des réformes. Un processus de développement lent et graduel entraîne la formation d'idées restrictives, qui limitent les opportunités d'expansion des programmes. La constatation y est également faite d'une relation de réciprocité entre les idées et les attentes du public dans le cadre de quatre propositions d'établissement d'une assurance-médicaments nationale au Canada, entre 1944 et 2002.

## Introduction

What limits do ideas place on the scope of policy development and change? Since Hall's (1993) influential work on the role of policy paradigms in change, scholars have proposed various mechanisms for understanding how ideas matter for public policy, including the way broad beliefs structure actors' goals (Berman 1998), the way discourses reinforce or challenge policy frameworks (Bhatia and Coleman 2003), and the way cognitive models direct elites' attention towards certain policy alternatives and away from others (Jacobs 2009). This article investigates the role of ideas in the context of an empirical puzzle: Canada is one of the only mature welfare states that lacks a nation-wide, universal program for pharmaceutical insurance.[2] The lack of broad drug coverage contrasts with Canada's provincially-organized but nationally comprehensive public, universal hospital and medical insurance, and persists despite periodic proposals for some form of nation-wide public pharmaceutical insurance, or "pharmacare" as it is often called in Canada, since the 1940s.

This empirical puzzle points to a theoretical gap. Existing explanations for the lack of nation-wide pharmacare in Canada tend to resort to circumstantial factors or to rely on theoretical accounts that cannot explain the failure of both early proposals and later attempts. For example, there is a tendency to cite the major boom in pharmaceutical innovation and prices in the 1960s as a turning point that permanently blocked universal pharmacare in Canada, but this cannot explain the failure of proposals in the 1940s and 1950s, when similar welfare states such as the UK and Australia successfully adopted pharmaceutical insurance.

Although recent welfare state literature focuses on explaining different types of retrenchment (Hacker 2004; Mahoney and Thelen 2010), the puzzle of pharmaceutical policy in Canada suggests there are important elements of policy expansion that should be revisited. In what some have called an era of "permanent austerity" (Pierson 2001) is it easy to dismiss failed attempts at program expansion as simply too expensive, but this article contends that the ongoing lack of nation-wide pharmacare is better understood as a legacy of the ideas that developed out of Canada's incremental approach to health policy. Understanding the mechanisms that block the expansion of insured health services in Canada can provide insights into the dynamics of policy change in liberal welfare states more generally, allowing us to explain why certain types of change are more difficult than others.

The article presents a theory of how ideas influence the approach to policy development and opportunities for later change. It defines policy change, describes the mechanisms hypothesized to block certain types of change, and considers alternative, non-ideational explanations for Canada's lack of nation-wide pharmacare. Next, the article looks for evidence of the proposed mechanisms in four opportunities for pharmaceutical program adoption at the federal level in Canada: 1949, as part of the earliest plans for nation-wide health insurance; 1972, when a bureaucratic proposal for national pharmacare was rejected by cabinet; 1997, when the National Forum on Health proposed universal, comprehensive drug coverage; and 2002, when the Romanow and Kirby Reports called for nation-wide, catastrophic drug coverage. The four proposals were made under different economic conditions and in the context of different federal-provincial relations, and yet the ideas expressed by politicians were remarkably consistent and the outcomes of these proposals – no policy development – were identical. This comparison of policy episodes over time within a single country thus provides an opportunity to investigate the possibility of an independent influence of ideas on policy – that is, an effect that cannot be reduced to interests or institutions, even though these effects might be complementary – when we might expect immediate and perhaps more tangible factors such as the central government's fiscal position or its current level of conflict with subnational governments to play a larger role. The article concludes by summarizing the implications of an incremental approach to policy development for the scope of future reforms and suggesting directions for future research.

## A theory of incremental policy development

Previously, I examined pharmaceutical program development in Canada, Australia and the UK and argued that the pace of change (incremental or radical) set in motion different expectations for elites and the public (Boothe 2012). More limited policy ideas were crucial in explaining why policy development stalled in Canada and Australia, the two countries taking an incremental approach. This article focuses on the role of ideas over a longer time period in Canada. It suggests that policy ideas that develop in incremental processes help explain why expansionary change becomes more difficult over time. These ideational barriers to change complement more conventional path dependence arguments that focus on institutional barriers to change or interest-based arguments that focus on opposition from organized groups, and help understand gaps in the empirical narrative where there is little evidence of these other types barriers.

Countries taking an incremental approach to policy development begin with some notion of what a complete policy might contain, but adopt component programs in stages. In Canadian health policy, this meant early discussions envisioned covering a full range of health services, but services were adopted one at a time – first hospital and then medical insurance, after which policy development stopped. It can be contrasted with a radical approach, where countries adopt a full range of services simultaneously, as the UK did in 1946 with the National Health Service.

Defining and measuring change has been a major preoccupation of recent institutionalist and policy literature (Hacker 2004; Howlett and Cashore 2009; Mahoney and Thelen 2010; Tuohy 2011), but I take a fairly simple approach dictated by the outcomes of interest in health policy development. I discuss the particular barriers to expanding the scope of a health system: extending benefits to new groups or to cover new services (such as pharmaceuticals). This type of change is interesting in incremental processes because the language used implies that program expansion will be a minor change, a natural and expected "next step," but the nature of incremental processes actually promotes barriers to such expansionary change.

These barriers develop as a result of the type of policy ideas present in an incremental process. Ideas are causal beliefs that influence the choices and actions of political actors (Béland and Cox 2011, 3; Mehta 2011, 24). They help determine actors' goals (Berman 1998, 29) and serve as filters for information in a complex world (North 1990, 20; Denzau, North, and Roy 2007, 20; Berman 1998, 30). As Jacobs (2009, 256) argues, elites deal with an overwhelming amount of information about policy choices by using mental models that structure the information they need to pay attention to and bias the way they deal with new or disconfirming information. Mental models provide a "simplified representation of a domain or situation…that allow reasoning about cause and effect" and direct actors' attention towards particular policy options and away from others (Jacobs 2009, 257-258). Denzau, North and Roy (2007) find that ideas are most influential when they are shared and Tuohy also highlights the importance of consensus when she discusses the need for political will – "a commitment to policy change on the part of key political actors" (Tuohy 1999, 12) – in order to open a window of opportunity for policy change.

In some instances, these ideas may provide an overarching view of a policy area linked to ideology, for example, an idea that that access to universal and comprehensive health services is desirable for reasons of social equality, and that the direct public provision of health

services is the most effective way to achieve this goal. These are similar to what Berman (1998) calls "programmatic beliefs," which provide "a relatively clear and distinctive connection between theory and praxis" (Berman 1998, 21). However, I have previously found that incremental approaches to policy development are characterized by a lack of consensus on this type of "big" policy idea (Boothe 2012, 793, 801). When there is no consensus on a broad idea linking theory to practice within a policy area during an early period of policy development, program adoption is still possible but will default to a slower, less risky incremental approach. Subsequent ideas grow up around early practice and tend to be more pragmatic than ideological in their content. However, like "big" or radical policy ideas, they include causal content about the likely outcomes of certain policy choices, help define what is possible or desirable in a policy area, filter new information that policymakers receive, and are most influential when widely shared.

During an incremental process, policy ideas develop as actors adapt their expectations regarding a policy based on what has happened in the past, and these adaptive expectations influence their preferences and choices. Pierson (2000, 254-258) has written about adaptive expectations in terms of political mobilization, pointing out that the self-fulfilling characteristics of expectations helps explain how people choose outlets for collective action. I focus on expectations about policy and extend these applications to include more explicitly the reciprocal relationship between elite ideas and public expectations. By elites, I mean elected policymakers at the federal level. This restricted scope of elites is justified by the fact that although any nation-wide program of pharmacare in Canada would require significant intergovernmental cooperation, the proposals studied here assume federal commitment as a prerequisite for a policy development. I focus on politicians because they ultimately decide which items reach the government's action agenda (Kingdon 1995, 30-32). Bureaucrats' ideas may change at a different pace or even in different directions that political elites' (Kingdon 1995, 30) and may influence change when it occurs but cannot usually independently get change on the agenda. By public expectations, I mean ideas held by voters that produce electoral pressure for policy change. Public opinion researchers have found that issues that are more important to the public receive greater attention from politicians: "elected officials [are] particularly responsive on highly salient issues" (Burstein 2003, 30). They also find that salience is "almost universally linked to dissatisfaction, particularly with government performance," (Cutler 2010, 499) and is thus a reasonable measure of demand for policy action or change.

Early elite expressions of big or radical ideas about health influence public expectations by increasing awareness of the potential benefits, and this in turn promotes greater commitment from politicians. However, incremental approaches to policy development are characterized by a lack of big ideas on the part of elites, and it is expected that the public will not necessarily form independent expectations for such a complex and multidimensional policy area.[3] As Daw et al (2012) point out, pharmacare is complicated and often technical issue that is not intrinsically dramatic, particularly since the majority of Canadians are insulated by private coverage. It has all the characteristics of an issue that is expected to be "subject to a low pattern of [media] coverage punctuated by rapid issue-attention cycles, never sustaining enough traction on the public agenda to generate political incentives for change" (Daw et al. 2012). This means the public is unlikely to pay attention to the issue or develop expectations for service without elite prompting: from politicians making policy promises or debating policy options, from policy experts publishing high profile reports or recommendations, and from the media coverage that helps bring such ideas to the public's attention (Noelle-Neumann 1999, 68).[4]

Lack of elite ideas therefore means later stages of an incremental process of policy development are not publically salient, which leads to limited electoral motivations for expansion. Internal policy documents can provide evidence of plans for a broader program, but public discussion tends to be limited to the first priorities for service adoption – in Canada, hospital and medical insurance. The public may become attached to this promise of service, but without elite prompting, does not develop expectations for additional services. Over time, both elites and the public develop limited ideas about the range of relevant policy problems and solutions, the types of services they want or deserve, and the nature of pharmacare itself, and this makes it very difficult to expand the system.

### Alternative explanations: federal dynamics and organized interests

Limited ideas are not the sole barrier to the expansion of health policies, and there are important complementarities between the approach outlined above and more standard institutional accounts of barriers. The main advantage of focusing on ideas is that it explains a longer process of policy development in this case, and the fact that it is useful over this entire time period suggests it should be considered even when institutional factors are present. Path dependence literature sets out a number of features of the policy process that make it self-reinforcing and difficult to change: in his seminal article Pierson (2000) discusses large set-up

costs and learning and coordination effects as well as adaptive expectations. These factors are evident in the way alternative institutional arrangements for service delivery arise in the absence of government programs. Private actors make investments (pay set-up costs) and create networks (develop expertise and coordinate actors), making it difficult to displace them with later public policy. This is one reason the introduction of public medical insurance in Canada was more difficult than hospital insurance (Shillington 1972; Hacker 1998). However, early Canadian pharmaceutical policy challenges to this mechanism, since both public and private policy development was late: provinces began adopting limited pharmaceutical programs in the 1970s, the same time as private companies began offering commercial drug insurance (Commission on Pharmaceutical Services 1971; Grootendorst 2002). While the presence of private or provincial pharmaceutical insurance in later periods does not provide a satisfactory explanation for lack of a nation-wide program across all cases, it does prompt us to consider two alternative explanations in more detail: that a nation-wide program was opposed by provincial governments, or it was opposed by organized interests such the private insurance industry and the pharmaceutical industry.

In Canada health care is mainly an area of provincial jurisdiction, and anticipation of provincial opposition was clearly part of federal politicians' reluctance to engage the issue of nation-wide pharmacare. The federalism literature offers a rich and often conflicting set of predictions for when and how federal institutions might affect public policy, from creating opportunities for subnational innovation to creating "unnecessary multiplication of fixed costs that undercut the economies of scale" (Erk 2006, 110). However, for the purposes of this article the key concern is whether federal institutions, and particularly, relatively assertive provincial governments with jurisdiction over health policy, were the main barriers to the development of nation-wide pharmacare in Canada. Thus, it is possible to restrict our consideration of federal institutions to the possibility that constituent units will affect policy outcomes by pre-empting policy space and therefore blocking national initiatives (Pierson 1995, 456) or more generally increase the number of veto actors and therefore place constraints on policies requiring intergovernmental coordination and agreement (Pierson 1995; Jordan 2009).

Proposals for nation-wide pharmacare were made both before and after provincial governments began to preempt the policy space with limited drug programs in the early 1970s, which suggests that federal dynamics alone cannot provide a full and consistent explanation. There are additional difficulties in relying on provincial opposition to explain

the lack of a nation-wide program: first, because the proposals were rejected at the federal level *before* they were an item of serious intergovernmental contention. Therefore, the question of why nation-wide pharmacare failed to gain a place on the federal government's action agenda is prior to the question of how proposals were blocked by federal institutions. Even if expectations about how these institutions would play out contributed to pharmacare's low place on the federal agenda, provincial opposition was not the only, or even the most frequently cited reason for federal elites to oppose the development of pharmacare.

Second, there is no reason to expect provincial opposition would be uniform or consistent over time. The nature and cost of programs has varied significantly among provinces, with more limited coverage available in the Atlantic provinces and, in recent years, Saskatchewan and Manitoba (Grootendorst 2002; Kapur and Basu 2005). For provinces with limited programs, nation-wide pharmacare with federal funding could represent a windfall gain. In provinces with more ambitious policies, such as Quebec and British Columbia which introduced universal income-tested pharmaceutical insurance programs in 1997 and 2003, attempts at federal policymaking might raise fears of a least-common denominator program or an opportunity for Ottawa to claim credit for a potentially popular program that provinces had initiated. These questions about provincial preferences for and ideas about pharmaceutical programs are an important subject for future research, but this article argues that the lack of *federal-level* action on nation-wide pharmacare is a prior question that can be meaningfully separated from a study of provincial policies.

Another possible explanation for the lack of broad pharmacare in Canada is that it was blocked by private, organized interests: the most relevant groups, potentially, are physicians' or pharmacists' professional organizations, the pharmaceutical industry, and the private insurance industry. Political scientists have long been instructed to be attentive to the role of groups "in supporting the *nondecision-making process*", determining which issues become matters of political contention (Bachrach and Baratz 1962, 949), and to recognize the importance of business in influencing policy choices though the use of an "automatic punishing recoil" where any policy decision harmful to business' interests results in a natural, inevitable response of disinvestment, job loss, or other undesirable economic consequences (Lindblom 1982). Any of the groups mentioned above might have opposed pharmacare. Physicians or pharmacists might oppose pharmacare if they saw it as harmful to their professional autonomy or, in physicians' case, to their powerful position as a key partner in health policymaking. The pharmaceutical industry, insofar as it has a typical business interest

in profitability, would like to sell as many drugs as possible with as few regulations on prices and distribution as possible, and would be opposed to pharmacare to the extent it was harmful to these goals. Finally, and perhaps most compellingly, the private insurance industry could suffer direct losses if more people had public drug insurance, especially if that insurance was "first dollar" coverage intended to act as a substitute rather than a complement to existing private insurance.

However, opposition from organized groups cannot provide a cohesive explanation for the lack of policy development in each case because, like opposition from provincial governments, expected and actual group opposition varied from one policy episode to another, while the policy outcomes did not. Furthermore, in evaluating interests as a competing explanation for the lack of nation-wide pharmacare, we should be sure that we are not confronting ideational explanations with "unusual and perhaps insurmountable obstacles" (Berman 1998, 17). As Berman argues, to study ideas as independent variables, it is unreasonable to try "to prove that at no point in time was their development or acceptance influence by structural variables." Instead, it is necessary to show that ideas "cannot be reduced to some other (structural) factor in the *contemporary* system" (Berman 1998, 18). Therefore, in each policy episode I seek to demonstrate that ideational barriers to policy development occurred *before* significant opposition from organized interests, supporting the theory that politicians' own ideas about the policy area had a key role.

The position of various groups is discussed in each policy episode; here I provide an overview of the main positions. Professional groups tended to be cautiously supportive or indifferent. Unlike Australia, where pharmaceutical benefits were the first public health services to be enacted and were strenuously opposed by the medical association as a wedge towards socialized medicine (Hunter 1965), in Canada physicians did not perceive pharmacare as a threat. Their position ranged from support for public health insurance including "pharmaceutical services subject to regulation" (LAC 1944a) to being basically agnostic about pharmacare in later periods,[5] while pharmacists were concerned about how a public plan might affect their reimbursement but were at no point confronted with a sufficiently detailed plan to oppose or support on these grounds (see for example concerns expressed in LAC 1944b, LAC 1962).

For the pharmaceutical industry, as for pharmacists, the details of the plan were key, and after the development of a robust Canadian generic drug manufacturing sector in the 1970s, (Lexchin 1997) so was the distinction between multinational, research-based firms and

national, generic firms. However, for both research-based and generic firms, Canadian debates over patent legislation were much higher stakes and prompted much greater involvement than any proposals for nation-wide pharmacare, despite the potential for links between the two policies. A full discussion of the politics of compulsory licensing, a regulatory policy aimed at increasing competition among pharmaceutical manufacturers and lowering drug prices, which operated in Canada from 1969 to 1993, is beyond the scope of this article, but key points of overlap with the pharmacare proposals in 1972 and 1997 are included below. It is also worth noting that the Canadian patent regime changed a number of times over the course of the study period and while this had a significant impact on drug prices (Gorecki 1981; Lexchin 1993; Lexchin 1997), it had surprisingly little impact on politicians' ideas about the feasibility of pharmacare. Political elites thought that drugs were too costly to be part of a broad insurance program before compulsory licensing, and they maintained this view during the twenty-four years the policy was in place *and* after its demise.

The final relevant group is the private insurance industry. Private insurers were supportive of broad government health insurance in the 1940s (Taylor 1987, 31) but later joined not-for-profit, physician-sponsored private plans in opposing compulsory hospital and medical insurance (Shillington 1972; Taylor 1987, 194). Private insurance for pharmaceuticals was only beginning to develop in the early 1970s (Commission on Pharmaceutical Services 1971), but the industry presumably had a greater stake in later periods, when it provided some form of insurance to more than half of Canadians (Kapur and Basu 2005, 186). However, its response to both the National Forum and Romanow/Kirby proposals appears surprisingly muted, pointing to an important area for future research.

## Observable implications of the theory

I hypothesize that incremental processes give rise to particular ideational barriers to further policy development. Elites' initially more limited policy ideas produce limited public expectations and restrict the possibility of program expansion. It should be possible to observe this in both elites' policy deliberations, captured in archival documents and interviews, and in measures of the public salience of various reform options.[6] This article uses different measures of salience to capture both what the public was concerned about *and* politicians' assessment of what the public was concerned about: as Hay (2011) and Blyth (1997; 2002) have pointed out, actors' interpretations of their interests are at least as important as their "true" material

interests, so it is useful to measure as far as possible what politicians thought about the electoral implications of pharmacare. Therefore, conventional measures of salience such asking voters to identify the country's "most important problem" will be included along with some basic counts of media coverage, since increased media coverage has been shown to affect "the population's assessment of the urgency of [social] problems" (see Noelle-Neumann 1999, 68). These measures will be complemented by evidence from elite discussion of voter reaction to pharmacare proposals: whether elites though the proposals were sufficiently salient to require a policy response.

If elites' ideas about health policy reform become more limited over time and present barriers to the adoption of additional services, we should observe early (before any health programs are adopted) policy discussions about a range of services and subsequent (post-adoption) policy discussions about existing services only. We should observe statements by elites about the necessity of "fixing what we have" versus "adding something new". With regards to elites' policy ideas about specific reform options, such as adding pharmacare in Canada, issues that made the program a low priority initially should persist and intensify. Politicians should make "explicit, consistent reference" (Jacobs 2009, 262) to dominant understandings of insurance as unfeasible or too expensive and should focus on costs to the federal government, rather than social costs. Policy development should be limited to programs that fit these dominant understandings. In the case of pharmaceutical policy, this means focusing on management issues such as prices, patents, and drug cost-effectiveness rather than insurance. I expect these ideas to persist even in the face of some disconfirming evidence. As Jacobs (2009, 258) argues, "One of the most robust findings in all of cognitive psychology is that individuals display powerful tendencies both to seek and to take into account information confirming prior beliefs, and to avoid and to discount information contradicting them."

The theory predicts a reciprocal relationship between elite ideas and public expectations: as elite ideas about a policy area become more restricted, so does the public salience of certain reform options. If there is no elite consensus on a broad idea about a policy to prompt authoritative public discussion, it is unlikely to gain widespread public attention and support. This lack of public expectations then reinforces elites' restricted policy ideas, so when elites oppose pharmacare, they will reference a lack of public salience as well as a need to fix existing services and avoid unmanageable costs. Therefore, public opinion should reflect elites' focus on "fixing what we have": voters should be most concerned with the

perceived deterioration of existing services, and much less concerned about perceived "gaps" or services that they currently do not receive. The low salience of additional services should be reflected by their lack of coverage in opinion polls, compared to existing services. For example, it is expected that "restoring cuts to health funding" will be a greater concern to the public than "expanding public coverage to pharmaceuticals." Opinion polls will not necessarily have specific questions on a non-issue, but I expect after a major proposal for pharmacare there will be opportunities to measure salience either through indirect questions or elite perceptions. Media coverage of pharmacare proposals should be limited, particularly relative to reforms of existing services.

### 1949: The early exclusion of pharmaceuticals[7]

The earliest proposals for nation-wide health insurance in Canada included pharmaceuticals, but failed for reasons unrelated to the scope of the program or any particular issues posed by drugs. In January 1943, the federal cabinet considered draft legislation for a national health insurance program based on two expert reports (MacDougall 2009, 299). Both these reports called for comprehensive health programs, including pharmaceuticals (Marsh 1943; Advisory Committee on Health Insurance, Canada 1943). This legislation foundered on opposition from the finance department and a lack of support from Prime Minister Mackenzie King (MacDougall 2009, 302), and the proposal that went to the 1945 Dominion-Provincial Conference on Reconstruction was more cautious in scope.

The federal government proposed a comprehensive health service that provinces would "have to take, in its entirety, and in a fixed order, within a certain time limit," (LAC 1949b) but conceded that the plan should be flexible and "capable of being introduced in any province by several stages" (Canada 1945). Consistent with theoretical expectations, at this time it appeared that the full range of health services was on the table, and interviews with current policy advisors support this interpretation: they frequently cited the early assumption that health care would proceed in stages.[8] The 1945 proposal failed after being linked to tax rental agreements (where provinces were to give up powers of direct taxation in return for a fixed payment from the federal government) that the provincial governments would not accept (Taylor 1987; Maioni 1998). In 1946, the report of the Cabinet Working Committee on Health Insurance recommended that further policy development be deferred until provinces provided input (LAC 1946).

The subsequent incremental approach to policy development is predictable based on the lack of centralized authority over health resulting from Canada's federal system, combined with a lack of consensus on big ideas about comprehensive health services and a lack of electoral incentives to take radical action. At this time, key decision makers – the Prime Minister and most of his cabinet – did not have any strong commitment to a broad public health scheme, and some were quite skeptical of the plan (LAC 1950b, Martin 1985, 220-226; Maioni 1998, 77). This is despite the somewhat surprising support of the private insurance industry and the Canadian Medical Association (Taylor 1987, 31 and 27). The low public salience of health insurance in Canada during the 1940s and early 1950s also meant that there was no prompt from voters to act. Others have argued for the role of public opinion in prompting the first steps of health policy development in the 1940s. Taylor (1987, 7) finds that public opinion towards the end of World War II produced "intangible but…persuasive" reasons for policy action: "the growing conviction that the sacrifice and toil of war could be justified only if the goals were positive." He notes that all national party platforms for the 1945 election mentioned health and argues that by this time, "health insurance had become a major issue of public concern, the declarations of political parties matching citizens' response in the public opinion polls," citing a 1944 poll where 80 percent of respondents say they would contribute to a national hospital-medical insurance plan (Taylor 1987, 47). However, I argue that *support* for a policy, when questioned about it directly, differs from *salience*, or where a policy fits in voters' unprompted lists of government priorities. Although support for a policy is an important element of its ultimate success, salience helps it move up the policy agenda, and is especially important in providing politicians with the incentives to take a risky, radical approach to policy development. I find less evidence for this high level of salience in Canada in the 1940s and early 1950s. A comprehensive review of the weekly news service Gallup published on its polls between 1941 and 1960 reveal high levels of support for a national health plan between 1942 and 1945, and in 1949 when the question was asked again, but this was when respondents were questioned directly about health insurance (CIPO/Gallup 1942; 1943 (May); 1944; 1949). When Canadians were asked variations of a "most important problem" question between 1945 and 1960 the top answers were jobs, taxes, prices or price control, housing, or threat of war (CIPO/Gallup 1941-1960). Canadians also appeared to place less priority on health policy than citizens of other countries at this time. In 1943, when the Beveridge Report was generating astonishingly high levels of public attention and support in Britain (Jacobs 1993,

113), only one in four Canadians could recognize the phrase "the Beveridge Report" (CIPO/Gallup 1943 (February)). Even the compromise health policy proposals that appeared in the late 1940s failed to draw the public's attention. In 1948, only 52 percent of Canadians had heard of the new National Health Grants, a five-year program providing funds to provinces for preventative health programs and hospital construction. Of the 52 percent who had heard of the plan, about 40 percent could not describe it, leading Gallup to conclude that despite the "sweeping" nature of the plan, "there are large sections of the Canadian voting public on which the proposals have made little or impression" (CIPO/Gallup 1948).

Discussion about the scope of the health system quickly narrowed to two priorities: hospital and medical insurance (LAC 1949a; LAC 1955b). Pharmaceuticals were initially a lower priority, and during this time policymakers also began to develop strong, negative ideas about the feasibility of pharmaceutical insurance that would persist through later reform periods. In 1949, officials in the Department of National Health and Welfare (DHW) recommended leaving pharmaceuticals off the agenda for an upcoming federal-provincial conference because "all experience to date indicates that it is almost impossible to control the costs in such services" (LAC 1949a). Shortly thereafter, they advised "it would not be wise to embark on this type of [pharmaceutical] service until an adequate system of control in relation to the prescribing of drugs could be developed by a Province" (LAC 1950a). In 1955, federal and provincial deputy ministers of health concluded that pharmaceutical benefits were "not considered to be feasible at this stage" except when provided to hospital in-patients (LAC 1955a).

Both drug prices and costs were increasing during this time, as pharmaceuticals became more effective and more widely used. However, Canadian elites' idea of pharmacare as prohibitively expensive was in place well before the therapeutic revolution began to increase prices in the 1960s, and it developed during a period of economic security (Perry 1989, 48-63). Why Canadian officials were more pessimistic about the possibility of controlling the costs of pharmaceuticals than other health services, or why they were more pessimistic than policymakers in other countries, is not clear. For example, by 1949, higher-than-expected costs of prescription services were becoming an issue in the UK, but Canadian officials did not explicitly cite British experience when they discussed drug costs.[9] However, Tom Kent, the architect of Liberal health policy in the 1960s, notes that at that time, drugs were seen as more difficult to ration than doctor's visits, and it seems likely that this thinking played a role at this earlier juncture as well.[10]

Whatever the origins of this idea about the prohibitive cost of pharmaceuticals, it was persistent. In 1963, the federal Departmental Group to Study Health Insurance suggested "that in view of the difficulties inherent in the control of costs and in light of the availability of drugs provided in hospitals, that pharmaceutical benefits might be excluded from any Canadian medical care program" (LAC 1963). The 1964 Royal Commission on Health Services recommended the federal government contribute 50 percent of the cost of a Prescription Drug Benefit to be introduced by the provinces (Royal Commission on Health Services 1964), but the report focused most of its discussion of pharmaceuticals on the need for drug price control. At the 1965 First Ministers' Conference, Prime Minister Pearson said, "A complete health plan would include dental treatment, prescribed drugs, and other important services" but noted that "We regard comprehensive physicians' services as the initial minimum" (Canada 1965, 16), and it was this minimum that carried the day. By 1966 an agreement for nation-wide, public medical insurance was in place, and serious intergovernmental discussion of program expansion appeared to be over, at least for a time.

### 1972: The Drug Price Program

The 1965 conference also provides evidence of a new track for pharmaceutical policy that had been developing since the late 1950s, focusing on price control rather than insurance. Prime Minister Pearson referred to the ongoing work of the Special Committee of the House of Commons on Drug Costs and Prices, saying "We hope that its recommendations will have the effect of reducing the prices of drugs, and thereby make it easier for a complete health service to make drugs, prescribed for major illnesses, available on a prepaid basis" (Canada 1965, 16). Interestingly, this is one of the few instances of a politician linking control of pharmaceutical prices to public pharmaceutical insurance. High drug prices had been receiving both bureaucratic and public attention,[11] but outside the recent Royal Commission and the Prime Minster's 1965 remarks, policies to deal with drug prices were pursued quite separately from pharmacare. This is consistent with the expectation that limited policy ideas regarding the problem of pharmaceuticals will channel policy development towards issues that appear more tractable.

Studies of drug prices began in 1958 with a report by the federal body responsible for investigating monopolies, which was prompted by "informal complaints about the high cost of drugs" (Canada. Director of Investigations and Research, 1961). Between 1958 and 1969, drug prices were the subject of at least four more government inquiries, both internal and

public.[12] The problem was identified as drug patents, which produced a monopoly and high prices, and the solution was changes to patent law and tariffs in 1969. Although this had a significant impact on drug prices (Gorecki 1981, xii), an unintended consequence was to reinforce previous ideas about the prohibitive cost of drugs and to direct politicians' views of pharmaceutical policies in a way that made it very difficult for them to consider later proposals for pharmacare. The dominant model of pharmacare was a program with the potential for uncontrollable costs. Pharmaceutical patents and price control, or pharmaceutical *management*, was seen as a much more tractable problem: it did not involve jurisdictional issues, since the national government had authority to regulate pharmaceuticals, and it was a relatively inexpensive regulatory policy, rather than a new expenditure program. This meant when federal politicians considered pharmaceutical issues, they understood the relevant problem to be prices (which they dealt with through patents, although an insurance program might also affect prices), and they understood insurance to be an unfeasible or undesirable option.

Despite significant changes to patent laws, concerns about high drug prices persisted (Lang 1974, 248). In 1971, the Minister of Health proposed a Drug Price Program that would include the extension of Medicare (as nation-wide health insurance was known) to cover prescription drugs (LAC 1971). The bureaucratic authors of the proposals clearly saw them as a principled policy choice that would not only reduce drug prices, but also fill a gap in the provision of health care and rationalize the use of existing public services. A draft memo from the DHW entitled "Some Social Reasons for Pharmacare" argues that "[i]t does not make much sense to pay a physician under Medicare to examine and prescribe for his patient if the patient is unable to [afford the medicine]" (LAC n.d.). They recommended benefits be introduced on a universal basis, since the federal government would have the most bargaining power over prices as the single purchaser of drugs (LAC 1972a).

These ideas about pharmacare as a way to lower the *social* cost of pharmaceuticals contrast with the position of cabinet ministers. Consistent with their ideas concerning health and pharmaceutical policy, they did not consider the department's recommendation for a universal program, and seemed most concerned with containing the cost of pharmaceuticals *to the federal government.* In cabinet, the Prime Minister said he did not wish to extend Medicare to drugs "because of the considerable expenditures involved and the difficulty of getting the provinces to pay their share" (LAC 1971). Ministers thought pharmacare should be avoided because "the government's first priority should be to restore public confidence in its economic

policies" (LAC 1972b),[13] and that "pharmacare would be the beginning of a very expensive program which would undermine the confidence of the middle-income groups in the government's ability to control the budget" (LAC 1972b). Although the primary focus of the memorandum was price control, and the cabinet debate focused on overall cost, there was also some reference to the interests of organized groups. The memorandum's authors argued that the program would be popular with health professionals and the drug industry, but this did not appear to convince cabinet ministers, who suggested that the "drug lobby [pharmaceutical industry] would learn of the interdepartmental studies [of drug insurance] and would react violently against them,"[14] and that the inclusion of prescription drugs in the still-new Medicare scheme would "only exacerbate" the medical profession's dissatisfaction with it (LAC 1971). Crucially, the proposal never left the confines of cabinet, so the validity of these concerns was not tested, and the quotes above represent the complete interest group discussion: ideas about costs were much more prominent. Provincial preferences and policy development also received little attention in federal cabinet. When cabinet reviewed the Drug Price Program, it had not yet been presented to provincial governments (LAC 1972b). DHW predicted that the program would be popular with the Quebec government, noting that it had previously requesting federal cost-sharing for drugs for the low income seniors and social assistance recipients, and was generally optimistic about the potential for provincial cooperation (LAC 1972c). However, ministers did not discuss the proposals in light of the provinces' preferences or their existing pharmacare programs, but instead concentrated on opportunities for the federal government to claim credit with voters. The minister of health, John Munro, commented that he did not anticipate opposition from the provinces, but he was concerned that the federal government should be able to claim credit for any program, saying it would be preferable to make a positive initiative than to wait for provincial consensus to develop. In cabinet discussion, other ministers argued "that the federal government would only get credit for a new initiative if it was put forward as a major Pharmacare program; it would not get much credit for an offer to discuss with provincial governments the possibility of introducing a staged program" (LAC 1972b).

Despite this concern, and on the recommendation of the Minister of Health, cabinet focused on a "staged program" that would provide drug coverage to the elderly and eventually expand to cover children and other groups. The result was pharmacare proposals were not debated as a principled extension of Medicare, but rather as one of a number of unrelated options for assisting elderly Canadians (LAC 1972b). DHW attempts to frame

pharmacare as a tool for price control failed, and this failure is a legacy of politicians' policy ideas about the nature of both the drug price and drug insurance problems. Elites had developed a consensus that patents caused high drug prices. This allowed for strong action in this policy area, but it also made it difficult for politicians to conceptualize the drug price issue in any other way: despite the name of the proposal, in cabinet discussions of the Drug Price Program the issue of drug prices received few mentions. Politicians interpreted the proposals solely as a benefits program that had historically been dismissed for cost reasons, and in the end decided pharmaceutical insurance for seniors was only one of "various possible ways of providing further assistance to older people [that] should be considered in the more comprehensive financial content of the budget and deferred until such time as that could be done" (LAC 1972b).

There is limited evidence regarding electoral motivations for pharmacare at this time, perhaps because there were few opportunities for public expectations to develop. A memo arguing for the Drug Price Program notes that federal departments "have received and continue to receive many letters from the public complaining about the high cost of prescription drugs and many requests that a drug insurance program similar to Medicare be made available" (LAC 1972a). However, the same memo goes on to discuss strategies for implementing a program and says that since the federal government is not in a position to act unilaterally, it could "wait…for provincial and public pressures to build up," or actively encourage these pressures in hopes of igniting a desire for intergovernmental cooperation on the issue (LAC 1972a). This suggests that proponents of pharmacare recognized the potential for public opinion to aid policy development, but that the necessary pressure did not yet exist.

Furthermore, most provinces did not begin to introduce targeted public drug benefits (for seniors and social assistance recipients) until the early 1970s, so Canadians' first experience with public insurance for drugs was both late and restricted to a relatively small portion of the population (Grootendorst 2002). A 1963 study of prescription drugs in Canada reported that private drug insurance had only recently become available, and eight years later, private coverage was still limited (Department of National Health and Welfare (Research and Statistics Division) 1963; Commission on Pharmaceutical Services 1971). Certainly the campaign promises of political parties, and policy agendas of governments, never alluded to pharmacare as anything other than a vaguely distant possibility. Although it is possible that the public was beginning to develop expectations about drug insurance based on a perceived

"gap" in the now-comprehensive public hospital and medical insurance they enjoyed, there is little evidence for this kind of public pressure.

### 1997: National Forum on Health proposes universal insurance

After the quiet failure of the 1972 Drug Price Program, pharmaceutical policy at the federal level continued on a track of managing prices and patents. In 1985, the Commission of Inquiry on the Pharmaceutical Industry presented recommendations to the federal government regarding new patent rights and price competition in the industry (Eastman 1985). The Commission's only comment on pharmaceutical insurance was a recommendation that provincial governments ensure public benefit programs require a "significant contribution to each purchase by the consumer, arranged in such a way that price competition is induced," and encourage private plans to do the same (Eastman 1985, xvii). In 1987, federal Parliament made significant changes to the compulsory licensing provisions that had helped limit Canadian drug prices since 1969; compulsory licensing was abolished in 1993 (Douglas 2008).

The next federal attention to pharmacare came in 1997, with the report of the National Forum on Health. The Forum was chaired by the Prime Minister but drew its membership from nongovernmental policy experts, and was convened to fulfill a commitment in the Liberal 1993 "Red Book" platform (Liberal Party of Canada 1993, 78). Interviewees said it was seen in government as an opportunity to consider general health reform "without being in crisis mode", to assess and improve cost control, and in the words of one respondent, "to buy time."[15] Its final report, published in February 1997, made a bold, though high-level recommendation for nation-wide, public and universal pharmacare: "Because pharmaceuticals are medically necessary and public financing is the only reasonable way to promote universal access and to control costs, we believe Canada should take the necessary steps to include drugs as part of its publicly funded health care system" (National Forum on Health (Canada) 1997).

This proposal received more attention than any previous call for pharmacare at the national level. The June 1997 Liberal platform "endors[ed] pharmacare as a long term national objective," and pledged to work with provinces and territories "to develop a national plan and timetable for introducing prescription drugs into our medicare system" (Liberal Party of Canada 1997). The November 1997 Speech from the Throne announced a plan to reinvest $300 million dollars in health initiatives, including a Health Transition Fund that

would, among other things, "help the provincial governments innovate in the areas of primary care and provide more integration in the delivery of health services, home care and pharmacare" (Canada, Governor General 1997). In the same speech, the government also stated its intention to "develop a national plan, timetable and a fiscal framework for providing Canadians with better access to medically necessary drugs" (Canada, Governor General 1997). These promising plans did not, however, result in significant policy development. According to Marie Fortier, Executive Director for the Secretariat of the Forum and former Associate Deputy Minister of Health, "after the Forum, the whole idea of national pharmacare sort of fell down…in a black hole."[16] When pharmaceuticals next appeared on the federal government's public agenda in 2000, the focus had returned to pharmaceutical management policies (Canada 2000).

Given the apparent momentum of the National Forum's proposals, why did they fail? The proposals came at the end of a very difficult economic period in Canada. The pain of a severe recession in 1990 and 1991 was extended when high levels of public debt at both the federal and provincial levels resulted in a downgrading of the country's triple-A credit rating. As one interviewee noted, when the Liberal government came to power in 1993, "there was no money at that time. Canada had been declared nearly bankrupt, a third world country, in the Wall Street Journal."[17] After four years of deep cuts, including federal health transfers to provinces in the previous year, the country was just on the cusp of recovery when the proposals were made public (Treff and Perry 1997; 1998). Provincial governments were angered by the federal changes to health transfers and only beginning to recover themselves, and were in no mood to negotiate what they called "boutique programs," according to Paul Genest, a former advisor to two federal health ministers. He explained that provinces "were not ready to talk about these new horizons or adding new things on when they felt that they were struggling mightily to deal with the core."[18] There was also a more specific issue of pharmaceutical regulatory policy: there is some evidence that the 1993 passage of Bill C-91, which abolished compulsory licensing, increased drug prices (Lexchin 1997), which would have increased the cost of an expanded public pharmacare program. However, the federal House of Commons Standing Committee on Industry reviewed the legislation in April 1997, and committee members apparently did not make this link. Their first recommendation, which they admitted was on a topic "strictly outside the Committee mandate," was "to investigate the feasibility of a national pharmacare program" following the recommendations of the National Forum on Health (Standing Committee on Industry 1997a). Their third

recommendation was to retain the 20-year patent protection granted by Bill C-91, despite hearing testimony from both the Canadian generic industry association and former National Forum experts that this would tend to affect the cost of a national pharmacare program (Standing Committee on Industry 1997b).

These immediate circumstances clearly had a role in the failure of the National Forum plan, but I argue elites' limited policy ideas and correspondingly limited public expectations, which developed in the 1940s and 1950s and blocked policy expansion in 1972, were also evident in this later policy episode, preventing the extraordinary ideational and electoral circumstances that might have overcome institutional and fiscal hurdles.

I expected to observe statements by policy elites about the necessity of "fixing what we have" versus "adding something new" when considering whether to adopt pharmaceutical programs, and this was reflected in the comments of federal policymakers and advisors on the failure of the National Forum proposals. Interviewees reported prioritizing improvement of the existing health programs over system expansion, and although elites tended to frame limited ideas about the scope of the health system as a response to the long period of government cuts, these ideas are evident at earlier periods (such as the 1972 Drug Price Program), and later during relatively good economic times (such as the 2002 Romanow and Kirby proposals).

A policy advisor recalled that when the Liberals were planning their 1993 election platform, the main goals regarding health were to "reassure people that medicare did not need to be dismantled."[19] The federal and provincial governments shared responsibility for health and an overlapping constituency of potentially concerned voters, so reassuring the public also meant appeasing provinces, which had suffered from federal cuts to health transfers. Fortier suggests when the National Forum reported, it was "too early in the post-deficit years to think about something big like [pharmacare], also some of the cuts were still hurting…There was a lot of anger [in the provinces] about the…reductions overall in transfers."[20] The Honourable Roy Romanow, who was premier of Saskatchewan when the National Forum report was published, confirmed this. He recalls that most premiers at this time were "more preoccupied with the withdrawal of federal funding to the overall healthcare system in the 1990s…than it was about specific programs."[21] Genest noted that he did not think the provinces took the National Forum's pharmacare proposals seriously enough, but also admitted that "when they're having trouble affording bread and butter and we're saying, let's work on cheese, you can appreciate their point of view."[22] In short, even when health

reforms were on the federal agenda, the adoption of additional services was not. In 2008, Abby Hoffman, assistant deputy minister in Health Canada in charge of pharmaceutical management policies, summed up the lack of serious attention to pharmacare by federal governments: "I think, reflecting back on the last fifteen years, I don't see any government actually seriously saying, the next building block in the evolution of Canadian medicare is a comprehensive, universal pharmacare regime…nobody has gone down that road."[23]

This limited idea of what the health system should do posed an important barrier to reform, but so did a limited idea of pharmacare itself. I expect that if elites' ideas about pharmaceuticals become more limited over time, they should make "explicit, consistent reference" (Jacobs 2009, 262) to a dominant understanding of insurance as unfeasible or too expensive and should pursue policies on a non-insurance track aligned with this understanding, and this was the case in Canada. A policy advisor remembers that during the deficit period, "The fear of opening the floodgates to something hugely expensive and uncontrollable [like pharmacare], which you could never take away from anybody, was there for everybody."[24] Similarly, Hoffman said that after the National Forum, "there wasn't real political appetite to really carry these ideas forward…even if there was some sort of publicly and privately funded universal program, the costs were just regarded as so daunting." She went on: "Even if…a universal system would provide more access and be less burdensome on the economy than this fragmented mess that we have today, this is a great example of a terrific academic idea…that is impossible to sell, and it will continue to be impossible to sell as long as costs…go up at the rate they are going up."[25] Provincial pharmaceutical programs did not appear to influence federal policy ideas in this area, perhaps because political decision makers did not have detailed knowledge of them – one policy advisor commented on the perception that the federal government did not have much experience delivering health care and the provinces for the most part did not trust the federal government to know what to do.[26] To the extent that federal elites did know about provincial programs, their knowledge reinforced ideas about pharmacare being financially unfeasible. A political advisor detailed the measures the Chretien government had undertaken to control the federal deficit in the 1990s and then asked where pharmacare fit into these efforts, saying that "the experience in the provinces was that costs are runaway."[27]

Between 1997 and 2000, there was a shift in focus towards management policies aimed at controlling drug prices and ensuring cost effective prescribing – an echo of the 1970s focus on prices rather than insurance. A policy advisor noted that the next major

intergovernmental discussion of health policy, the 2000 First Minister's Meeting, concentrated on pharmaceutical management rather than insurance because it was about cost containment, and this was easier to get agreement on than insurance.[28] She recalled that the provinces' message to the federal minister was "don't give us another responsibility, we're drowning…if you ask us to do anything big, we will refuse."[29] Instead, the conference communiqué included a statement about pharmaceutical management, saying that federal and provincial health ministers would develop "strategies for assessing the cost-effectiveness of prescription drugs," while the federal government would work to strengthen surveillance of drugs that were already on the market (Canada 2000). A year later, the Annual Conference of Federal-Provincial-Territorial Ministers of Health announced progress on pharmaceutical management goals, citing plans for a nation-wide common drug review, a national system to provide "critical analysis of price, utilization and cost trends", and a review of reports on increasing drug costs (Canada 2001). The communiqué focused on drug prices and optimal use of drugs rather than insurance or expanded government purchasing of drugs.

As in previous periods, the absence of strong political backing for an expert proposal on pharmacare contributed to limited public salience, which in turn reinforced elites' limited ideas about the feasibility and desirability of a nation-wide pharmaceutical program. There are few direct measures of public awareness of or support for pharmacare at this time. However, the relevant polls do suggest that public attention to health issues was firmly focused on the problems of existing services, while elites tended to focus on existing services *and* the role of alternative institutions in dampening the salience of pharmacare. Elites consistently and without prompting cited the prevalence of private, employer-sponsored drug insurance for the middle class, and the high levels of concern about the problems of the existing system of medical and hospital insurance, such as wait times and overcrowded hospital emergency rooms, as reasons that the public did not pay attention to proposals for nation-wide pharmacare. Hoffman offered that while there are significant numbers of Canadians without sufficient drug coverage, "it is not something that affects a large number of Canadians all the time." She noted that Canadians are concerned about wait times and doctor shortages, but drugs have not captured the public imagination.[30] Jane Coutts, a former health reporter for the Globe and Mail newspaper who covered the National Forum on Health, suggested that Canadians didn't focus on pharmacare because there were (and are) insulated by private, employer-sponsored drug plans or public plans for seniors in most provinces, but wait times were much more visible. However, she also cited the legacy of

limited expectations about pharmacare, saying, "They [Canadians] don't expect it. They expect fast care…but [pharmacare] has never been part of medicare, and never seems as urgent."[31] Another political advisor commented on the media attention directed towards overcrowded emergency rooms in the late 1990s, saying "it was on the news every night…it was like a national disaster," and this greatly increased the pressure to increase transfers to provinces for primary care. He contrasted this issue with pharmacare, which he said, "probably wouldn't come up as a top-of-mind issue," for voters.[32]

These assessments are borne out in public opinion polls released in 1997 and 1998. Beyond concern with existing health problems, there was a high level of concern with economic problems. Voters were concerned about health care and supportive of increased health spending when questioned about it directly, but their overwhelming response regarding the most important problem facing Canadians was unemployment and the economy: at the beginning of 1997 these were the most frequent responses at 43.6 percent and 11.7 percent, respectively, while "other health/medical" was the most important problem for only 4.4 percent of respondents (Environics Canada 1997-1).[33] A poll at the end of the year asked voters about their knowledge of the Speech from the Throne, where the government set out their agenda for the coming parliamentary session. This provided an unusual opportunity to observe voters' knowledge of pharmacare promises, since they were mentioned in the Throne Speech (Canada, Governor General 1997). However, only 21.5 percent of respondents were "somewhat familiar" or "very familiar" with the speech, and only 1.7 percent reported that mention of a drug plan had attracted their attention, compared to 8.6 percent who noticed the promise of a balanced budget, and 5.4 percent who noticed a promise to restore funding for health care (meaning hospital and medical services) (Environics Canada 1997-2). Mendelsohn (2002, 62) finds that, when questioned about a range of policy options in 1998, Canadians preferred tax breaks for the poor, homecare, and increased transfers to the provinces over pharmacare. He notes that "When told that prescription drugs are publicly insured in most other countries, only 27 percent still believe that there should be no pharmacare program in Canada" but concludes that "many proposals for new national programs are greeted favourably in polls because trade-offs or costs are not made explicit in the question" (Mendelsohn 2002, 14). The implications of these results are that the limited elite discussion of pharmacare had not drawn public attention away from the higher-profile issues of general reinvestment in health services – "fixing what

we have" – and therefore the public did not provide any clear electoral motivations for politicians to act on pharmacare.

### 2002: Catastrophic drug coverage

I consider two final proposals for expanding public pharmaceutical insurance: the Commission on the Future of Health Care in Canada (the Romanow Report) and the Report of the Standing Senate Committee Social Affairs, Science & Technology (the Kirby Report). The Romanow Report was commissioned by the federal government in 2001 to "inquire into and undertake dialogue with Canadians about the future of Canada's public health care system" and to make recommendations about its sustainability (Commission on the Future of Health Care in Canada 2002, xi). The research for the Kirby Report was undertaken by a senate committee: its order of reference calls for an examination of "the pressures on and constraints of Canada's health care system and the role of the federal government in Canada's health care system," (Senate Standing Committee on Social Affairs, Science and Technology 2002) although in the words of one interviewee, "Kirby started because he didn't think Romanow would get it right."[34] Both Romanow and Kirby reported in 2002, and federal and provincial governments responded to their recommendations in two Health Accords, or intergovernmental agreements on health policy, in 2003 and 2004. The pharmacare proposals in both reports respond to some of the major concerns with earlier options by outlining a more limited goal of "catastrophic drug coverage" or CDC, where citizens would be protected against drug expenses exceeding a certain portion of their incomes. Although CDC had been considered before, these two reports certainly contributed to its dominance of subsequent discussion. Senator Wilburt Keon, a member of the senate committee, reported that they recommended CDC because the committee believed that most people had reasonable coverage through private or provincial plans and that only those with very high drug costs were vulnerable.[35] The former director of research for the Commission on the Future of Health Care in Canada has indicated that Romanow's recommendation for CDC was strategic, and that the commission believed that starting with a more limited universal program would allow for later expansion (Forest 2004), a position that is confirmed by a policy expert involved in researching the proposal.[36] The switch to CDC also had the potential to make the proposal more attractive to both the pharmaceutical and private insurance industries, since it would mainly target patients would might have previously had to forgo drug treatment for financial reasons and would act as a complement rather than a

substitute for private insurance. In fact, representatives from both individual pharmaceutical companies and the national association of research-based pharmaceutical companies have indicated their support for the concept of catastrophic drug coverage as recommended by the Kirby and Romanow reports,[37] a position published on the organization's website in 2010 (Rx&D 2010).

Romanow and Kirby reported during relatively good economic times, when the federal government presented its fifth consecutive balanced budget and debt-reduction targets continued to be met (Treff and Perry 2002; 2003). Pharmacists' professional groups were supportive of the CDC proposals (Canadian Pharmacists Association 2001a, 9; Canadian Pharmacists Association 2001b, 31), and a medical association interviewee noted that the infusion of federal cash in the system meant physicians were more interested in "enhancing these other areas" of health care, although their main concern was that patients have access to drugs and that physicians face the minimum additional administrative tasks.[38] The budget immediately following the reports' releases, in February, pledged "a five-year, $16-billion Health Reform Fund to provinces and territories to target improved primary health care, home care and catastrophic drug coverage," (Canada 2003a). So why did expanded pharmacare fail to materialize? Despite the differences in the details of the plan and the economic circumstances, the calls for CDC failed for the same reason as the calls for first-dollar coverage did in 1972 and 1997: restricted policy ideas on the part of elites that told them fixing existing services was more important than expanding services, and that pharmacare of any type was an expensive program without potential for cost control, and public expectations that reinforced those ideas.

The 2003 First Minister's Accord on Health Care Renewal included language about CDC but no clear commitments, and devoted equal or greater attention to issues of pharmaceutical management, in line with theoretical expectations. The 2003 Accord listed catastrophic drug coverage as a priority along with primary health care, home care, access to diagnostic/medical equipment and information technology and an electronic health record (Canada 2003b). It listed a number of pharmaceutical management goals and promised that "First Ministers will take measures, by the end of 2005/06, to ensure that Canadians, wherever they live, have reasonable access to catastrophic drug coverage" (Canada 2003b). However, there was no indication of what this might entail or how it would be achieved, and certainly no conditions placed on provinces to receive funding. The first ministers' communiqué the following year pledged to "develop, assess and cost options for catastrophic

pharmaceutical coverage" but devoted significantly more space to discussions pharmaceutical management (Canada 2004). It created a ministerial task force to draft a National Pharmaceuticals Strategy. In 2006, the task force recommended additional research on CDC along with four other management priorities, but has issued no further reports (Health Canada, Strategic Policy Branch 2006).

The authors of the Romanow and Kirby report tend to cite situational factors in explaining why recommendations were not adopted. Senator Keon argued that Kirby's CDC proposals failed because of the lack of an individual or group at the provincial or federal level to handle the issue, although he also noted criticism of the proposal as potentially extremely expensive.[39] Roy Romanow was generally positive about what the commission achieved but noted that, "the report fell into the Martin-Chretien battle", when leadership of the governing federal Liberal party was in question, and this hampered adoption of its recommendations. According to Romanow, the new Health Reform Fund fixed the funding problem highlighted by the report, but unfortunately without conditions, so provinces were not obliged to make changes to pharmacare programs.[40] However, the response of federal policy advisors and observers reflects the influence of longstanding policy ideas about pharmaceuticals and the scope of the health system as well. Interviewees emphasized the degree to which pharmacare competed with other reform priorities (a focus on "fixing what we have") as well as the barriers posed by cost, the desirability of focusing on management as a more feasible policy option, and also jurisdictional issues. A senior federal official involved in planning the 2003 and 2004 First Ministers' Meetings sums up these barriers, saying "caution was the order of the advice." He said the 2003 Health Reform Fund was "a classic example" of the problem of multiple priorities: "We have a number of priorities overall. Getting deeply into in this one [pharmacare] could be very expensive and could detract from our focus on those other areas." He went on to say pharmacare was less attractive than other issues because "analytically and in policy terms, it was extremely complex…and it is costly." Finally, there was the jurisdictional issue, "did the federal government want to get involved…in actually administering a program."[41] Fortier indicates that in 2004, questions of pharmacare and management were separate and management was emphasized because "everyone deliberately wanted to make progress on pharmaceuticals without having to open the insurance can of worms." According to her, pharmacare "is kind of a non-story, really, because with pharmaceuticals, at least the insurance side of it, has just been dismissed time and time again."[42] As was the case in 1972 and 1997, there is little evidence of the various

provincial pharmaceutical programs affecting federal ideas about the policy area. When asked how provincial programs influenced federal goals for pharmacare after the 2000 Health Accord, Genest noted that federal health policy analysts were making compendiums of different provincial programs and there was certainly a bureaucratic interest in these options but "as far as models [of pharmacare programs], I wouldn't say that really percolated up to the top level, we weren't in that space. The legwork was being done but I don't think there was a view that we'd take on a Saskatchewan approach or a Trillium approach."[43] Romanow himself indicated that the Commission had been interested in Nova Scotia's approach to pharmaceuticals, and had also looked at Quebec and British Columbia,[44] but this was not evident in the final report.

Assessing public expectations for expanded public drug insurance after the Romanow and Kirby reports is problematic, because there is a lack of publically available polling data on how aware voters were of the reports, and the recommendations of which they were most aware. Certainly pharmacare was a low priority for Canadians prior to the reports' release. Mendelsohn (2002) reports on a qualitative research project in 2002 that asked Canadians to rank their goals for health system reform and found that "adequate numbers of nurses, doctors and specialists across the country" was the top priority, while pharmacare was the lowest – a finding he notes was repeated in "a large survey conducted around the same time" (Mendelsohn 2002, 15). The release of the Romanow and Kirby reports generated slightly more media coverage of pharmacare than the National Forum on Health: a review of coverage of pharmacare in three national-level, English language newspapers between 1990 and 2010 found less than thirty substantive articles on pharmacare in the months around the release of the Romanow and Kirby reports in 2002, and less than ten articles around the release of the National Forum's report (Daw et al. 2012, see figure 2). However, neither level of coverage is particularly high, and while a nation-wide, universal pharmacare program was one of three major recommendations by the National Forum (along with homecare and improved health information systems), the smaller-scale proposals for catastrophic drug coverage were one of approximately twenty-three recommendations from the Kirby Report, and forty-seven recommendations from Romanow. In the absence of clear evidence that CDC stood out in the public's mind, it seems plausible that it was even less publically salient that then the National Forum's earlier pharmacare proposal.

Interviewees were in consensus about the lack of public salience of expanded public drug insurance. This is significant because even if a variety of advisors all made the same

mistake about public opinion, their assessments were being passed on to political decision-makers. Their assessment of low public salience in 2002 was similar to 1997 and was based on two factors: the public was more concerned about fixing or funding existing services (for example, dealing with wait times for hospital and medical services), and the idea that a combination of private and targeted provincial insurance programs served most people fairly well. Keon explains the Senate committee's decision to focus on CDC, saying that although the patchwork of provincial plans was complex, the coverage it provided was generally acceptable: "the one outstanding issue…was individuals who were subjected to catastrophic costs."[45] Owen Adams, the assistant secretary general in charge of policy analysis for the Canadian Medical Association, argued that in terms of public attention, pharmacare "is losing in the competition…and governments know this. Expanding medicare doesn't roll…because most Canadians have some kind of coverage."[46] Two Liberal policy advisors offered more direct insights to the government's priorities for health reform in the early 2000s. Fortier noted that although pharmacare was mentioned in 2003 and 2004 Health Accords, Prime Minister Martin and his team chose to focus on wait times, and put a lot of money into it, because "they were looking for something that affected people and that people understood. Wait times were a big top-of-mind issue at the time."[47] Genest echoed this view, saying that on 2004 Accord,

> I think they went for popular pieces: wait times was way up on the radar screen of what the public wanted; pharma policy was merely good and sound policy but so many people had private insurance…The Martin government was very much a poll-driven government, and because it wasn't way up there in the polls, they decided to put their eggs in the wait times basket.[48]

Stephen Lewis, a policy advisor and researcher who was a member of the National Forum and also involved in the Romanow Commission, reiterated that pharmacare stays off the agenda because the middle class has private insurance and most provinces provide coverage for seniors. As he eloquently put it, "I think the public's expectations have been stripped in this area. They have bought the argument that it's not affordable, even though they are paying for it in the end."[49]

## Conclusion

This article investigates a theoretical question: what limits do ideas place on the scope of policy development and change? It aims to answer this question by applying it to an

empirical puzzle: Canada's lack of a nation-wide, universal pharmacare program, which contrasts with the experience of most mature welfare states and Canada's own broad public hospital and medical insurance. I find that ideas matter in policy development because of the mechanisms put in place by the pace of change. A lack of consensus on "big" policy ideas contributes to a slow process of policy development, and this process in turn reinforces limited policy ideas. An incremental process sets up certain expectations on the part of elites and the public and leads to policy ideas that restrict consideration of program expansion later on, even if it was originally part of the plan for an incremental process. Because ideas filter new information about a policy area, tending to direct elites' attention to alternatives and interpretations that fit their existing models, they are reinforced over time. For example, while pharmacare was a potential "next step" in the 1940s and even as late as 1965, according to Prime Minister Pearson's comments at a First Ministers' conference (Canada 1965, 16), it was clearly an "extra" in health reform discussions in the 1990s and early 2000s, after more than thirty years of experience with the core health system as hospital and medical insurance. Once elites had a restricted idea about what a health system should do (hospital and medical insurance) and about the cost problems of posed by pharmaceuticals (insurmountable), it was almost impossible for them to consider proposals for pharmacare on their own merits – based on their prospects for controlling drug prices and social spending, increasing access, or rationalizing the use of health services. This limitation of elite policy ideas fed into limited public expectations of service: voters were not prompted to consider pharmacare by prominent elite-level ideas, and instead focused on the problems of services they already received. Over time, the low public salience of pharmacare was also reinforced by institutional developments: public demand for program expansion was dampened by the expansion of private drug insurance and initiation of provincial programs for seniors and social assistance recipients that developed starting in the 1970s. This article found ideational and institutional limits on program expansion are complementary, but in this case ideational barriers are prior to institutional barriers. There was no clear public demand for pharmacare *before* the late development of alternative institutional arrangements, and alternative institutions may obscure but to do not negate real gaps in pharmaceutical coverage.[50]

This article demonstrated that ideational barriers to policy development were significant at the federal level, and future research is required to investigate the role of policy ideas of pharmaceutical policy in the provinces over time. Certainly some provinces have instituted significant changes to their pharmaceutical programs since their limited beginnings

in the 1970s, and it would be interesting to know whether changing policy ideas played a role here. Future research should also test ideational barriers to policy change in different policy areas and for different types of change. I have proposed that when policy development is approached incrementally, adaptive expectations produce particular barriers to program expansion, but they may also affect reform of existing programs by influencing the directions reforms take or shaping the opportunities for reforms to occur. Canadian health policy presents an opportunity to investigate these mechanisms in hospital and medical services, and similar welfare states that achieved pharmaceutical and other programs by different paths provide points of comparison.

Finally, for those interested in the prospects for broad pharmaceutical programs in Canada, the results of this research are sobering. In past proposals and policy analysis there has been a tendency to focus on institutional and financial barriers to expanded public pharmaceutical coverage, but this article has shown that ideational barriers might be even more daunting. Designing an efficient and cost-effective system in abstract is unlikely to be enough if political elites are conditioned by their policy ideas to discount the potential benefits of pharmacare, and the public has no context to demand it.

## Notes

1. Acknowledgements: An earlier version of this article was presented at the 2012 Annual Meeting of the Canadian Political Science Association in Edmonton, Alberta. I thank Kathryn Harrison, Alan Jacobs, and Steve Morgan for their assistance with earlier versions of this work and Clare McGovern, Peter Graefe and the journal's anonymous reviewers for helpful comments on the article. I thank Hubert Rioux for assistance with the French abstract. This research was supported by a fellowship from the Social Science and Humanities Research Council of Canada.
2. Universal public drug insurance or benefits exists in all other OECD countries save the United States, Mexico, and Turkey (Jacobzone 2000).
3. I thank an anonymous reviewer for suggesting this point.
4. Another possible way to increase the public salience of pharmacare is interventions from interest groups, but Olson's (1971) classic problem of collective action applies: patient groups that advocate for the chronically ill, which are expected to have an unequivocal interest in expanded pharmacare, are less organized and politically powerful than industry or professional groups that tend to be more ambivalent in their support. This possibility is further complicated by the fact that many patient groups are funded by the pharmaceutical industry (Mintzes 2007).
5. Owen Adams, interview, Ottawa, 21 October 2008. All interviews were conducted by the author. Interviewees are cited by name or by their chosen designation.
6. Interviews were conducted with individuals with expertise in federal health and pharmaceutical policy. They included three political advisors, three federal bureaucrats, four representatives of professional organizations or the pharmaceutical industry, two former politicians, one journalist, and two non-governmental policy experts. Polls consulted: the weekly CIPO/Gallup Poll of Canada, *Public Opinion News Service Release* (on microfilm), 1941-1960; Environics Focus Canada Polls, 1997, and Mendelsohn's (2002) review of "All available Canadian public opinion polls since 1985 on health care" prepared for the Commission on the Future of Healthcare in Canada. Historical newspaper coverage was restricted to the question of public concern with drug prices (see note 11) and was based on a search of the Historical Globe & Mail (ProQuest Database) for articles containing "drug prices" from 1950-1965. For recent newspaper coverage, I consulted Daw et al's (2012) review of coverage of pharmacare in three national-level, English language newspapers between 1990 and 2010.
7. The following two sections expand on Boothe 2012.
8. Paul Genest, former advisor to Health Ministers David Dingwall and Allan Rock, Ottawa, 24 October 2008; political advisor, Ottawa, 21 October 2008; and policy advisor, Toronto, 23 October 2008, interviews.
9. However, Health Minister Martin (1985, 39) notes the Canadian Medical Association's warnings about the cost of adopting British-style "socialized medicine" around 1948, and both the DHW and the CMA undertook studies of the NHS in 1949.
10. Tom Kent, interview, Kingston, 11 February 2008.
11. For public concern, see "CCL [Canadian Congress of Labour] Asks Ottawa Check on Gouging in Drug Prices." *Globe and Mail* December 16, 1955, p.39; "Free Lifesaving Drugs

are Urged: Price Formula Suggested." *Globe and Mail* October 6, 1960, p.3.; Gibson, John A. "Drug Prices Take Record Drop After Probes." *Globe and Mail* January 24, 1961, p.25.
12. Reports where authored by the Restrictive Trade Practices Commission (Report Concerning the Manufacture, Distribution and Sale of Drugs, 1963); the Interdepartmental Committee on Drugs (1964); the Royal Commission on Health Services (Hall Commission, 1964); Special Committee of the House of Commons on Drug Costs and Prices (Harley Commission 1966/1967).
13. The recession of the mid-1970s had not yet hit and the economy was still reasonably strong at this point (Perry 1989, 14-16).
14. At this time, pharmaceutical industry groups were engaged in an expensive lobbying effort against the new compulsory licensing regime (Lexchin 1993, 150), and it is possible that internal government proposals for insurance schemes were simply of less importance to them. Interestingly, the link between compulsory licensing and a more affordable drug insurance program was not made in the cabinet memorandum – instead, the Drug Price Program was framed as an *additional* method of lowering drug prices.
15. Policy advisor; Genest, interviews.
16. Marie Fortier, interview, Ottawa, 15 October 2008.
17. Genest, interview.
18. Ibid.
19. Policy advisor, interview.
20. Fortier, interview.
21. The Honourable Roy Romanow, interview, Saskatoon, 31 October 2008.
22. Genest, interview.
23. Abby Hoffman, interview Ottawa, 16 October 2008.
24. Policy advisor, interview.
25. Hoffman, interview.
26. Policy advisor, interview
27. Political advisor, interview.
28. Policy advisor, interview.
29. Policy advisor, interview.
30. Hoffman, interview.
31. Jane Coutts, interview, Ottawa 15 October 2008.
32. Political advisor, interview.
33. These numbers were fairly consistent for the remainder of 1997.
34. Senior federal official, interview, Ottawa, 16 October 2008.
35. Senator Wilbert Keon, interview, by phone, 6 November 2008.
36. Steve Morgan, personal communication, 29 June 2012.
37. Aimee Sullivan, Manager, Life Sciences Sector Strategy, Pfizer Canada, interview, Ottawa, 17 October 2008; Mark Ferdinand and Stuart Reynolds, Rx&D, interview, Ottawa, 28 October 2008.
38. Adams, interview.
39. Keon, interview.
40. Romanow, interview.
41. Senior federal official, interview.
42. Fortier, interview.
43. Genest, interview.
44. Romanow, interview.
45. Keon, interview.

46. Adams, interview.
47. Fortier, interview.
48. Genest, interview.
49. Stephen Lewis, interview, Saskatoon, 31 October 2008.
50. In 2008, 38.4 percent of pharmaceutical expenditures in Canada were provided publicly, compared to 54 percent in Australia and 84.7 percent in the UK (Canadian Institute for Health Information 2011). The lack of a nation-wide program also means there are substantial differences in the level of public coverage available in different provinces (Canadian Institute for Health Information 2011).

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