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Royal Commissions and
the Policy Cycle in Canada:
The Case of Health Care

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**Royal Commissions and the Policy Cycle in Canada:
The Case of Health Care**

Gregory P. Marchildon
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Public Lecture at the
Saskatchewan Institute of Public Policy
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For his public lecture, Dr. Gregory Marchildon—our first Government of Saskatchewan Senior Fellow—examined Royal Commissions and the policy cycle in Canada, specifically the case of health care.

Dr. Raymond B. Blake
Director, Saskatchewan Institute of Public Policy

**ROYAL COMMISSIONS AND THE POLICY CYCLE IN CANADA:
THE CASE OF HEALTH CARE***

Gregory P. Marchildon
Government of Saskatchewan Senior Fellow,
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The Policy Life Cycle

Before I try and explain what I mean by the “policy cycle,” I had better attempt to define that much used and much abused word “policy.” First of all, let me say that as a rule of thumb, the broader the definition, the more limited is its explanatory power. If, for example, you define public policy as a government’s “plan of action” or a “statement of aims or ideals” as I have recently read in a dictionary, then you can end up with Thomas Dye’s widely quoted definition of public policy as being whatever a government chooses to do or not to do.¹

Fortunately, there are less flatulent definitions. William Jenkins defines public policy as a set of “interrelated decisions taken by a political actor or groups of actors concerning the selection of goals and the means of achieving” these same goals. James Anderson goes further in stating that public policy is a “purposive course of actions” aimed at “dealing with a problem” identified by government.² These definitions at least start to capture some of the key elements involved in the making of public policy, including the linkage to government.

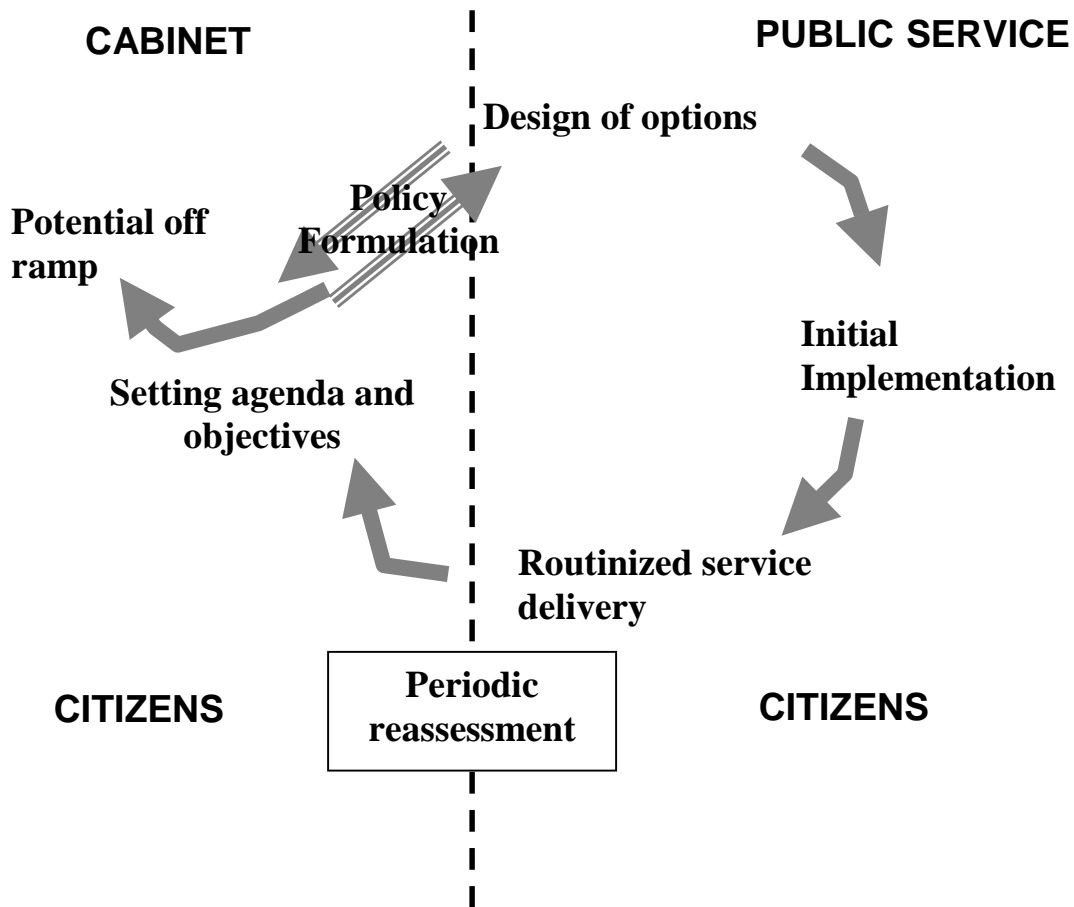
Building on Jenkins, I would like to propose my own definition of public policy as the “systematic laying out of the objectives of a government” as well as “the practical

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measures that are proposed to achieve those objectives.”³ Consistent with Anderson’s views, those objectives are almost invariably related to overcoming a problem that is actually recognized as a problem by any given government.

The first part of my definition relates to the political tier of government. For federal and provincial orders of government in our Westminster style Parliamentary system, this means the cabinet. The second part of the definition refers to the role of the bureaucracy as it is charged with coming up with the various operational options that will give life to the general policy.⁴ This definition fits well with Figure 1, a diagrammatic representation of the policy life cycle based upon my personal experience of managing central agencies within a provincial government.

Figure 1: The New Policy Life Cycle



What this diagram makes clear is the iterative nature of policy formulation between political actors on the one hand and the bureaucratic actors on the other. While it is up to Cabinet to set the fundamental agenda and choose the major policy objectives, the civil service is responsible for designing the options that will come back to Cabinet and, in the process, shape the more specific policy objectives in the process. In my experience, this often involves a constructive tension between the two tiers of government necessitating compromise on both sides to produce workable policy options while still achieving the original objectives of Cabinet. And often it requires two or three iterations between the civil service and Cabinet (or cabinet committees) before ministers are comfortable with one or another policy option.

This policy cycle is the regular business of government. It is incremental, continuous and hopefully as systematic as possible. In most contexts, these qualities are its strengths. But they can also become its weaknesses if circumstances suddenly change or if long held assumptions underpinning a set of policies, no longer hold, or are perceived to be fundamentally flawed, either by the electorate or the elected members sitting in the cabinet room. In such situations, the policy cycle can be punctuated by a major, and often discontinuous, shift in political agenda setting.

This sudden shift may spring from an emergency within the government such as a major internal budgetary crisis. Or it may emanate from an unexpected threat that is external to the government, as the recent events of September 11th so graphically illustrated. It may be triggered by a change of government after an election in which the winning party had campaigned on a detailed platform of change. Finally, it may

represent the final climax of a permanent structural shift forcing a long overdue policy change.

On occasion, the governing party can initiate a major policy shift if it feels that a particular policy area requires a fundamental re-examination, in part because of a profound dissatisfaction by Cabinet with the status quo, particularly when this unhappiness is shared by a significant percentage of the public. There are numerous reasons that the government may choose to “outsource” this examination before making a final decision. It may feel under-equipped internally to address the policy problem, or it may prefer an external authority’s imprimatur on what it suspects may be very unpopular policy advice. This has been the context for many Royal Commissions and similar external instruments of policy review. As Neil Bradford puts it, there are “turning points” in which “scholarly notions of policy incrementalism, bounded rationality, and routine change all fall by the wayside” and “governments preside over comprehensive breaks with long-standing practices.”⁵

The Royal Commission as an Extraordinary Instrument

When governments have concluded that such a fundamental re-examination of current policy is necessary and some new approaches are necessary, they are often tempted to reach beyond both tiers of government. Because the political tier of government is perceived to be constrained by both partisanship and the adversarial political process, governments, in reviewing the fundamentals of any given public policy, rarely use parliamentary and legislative committees. At the federal level, the Senate and its committee process, with its more relaxed approach to partisan politics and the adversarial

political process, can offer an alternative. While the Senate lacks the democratic legitimacy of parliamentary committees, Senate committees have occasionally been used for policy reviews, particularly in areas that demand less input from the general public.⁶

Governing parties can always rely on their extensive bureaucracies to conduct policy reviews. In Canada, however, more often than not, the bureaucracy has “acted more as a conservative force of continuity” than as an “instigator of change.”⁷ There are also times that government will want the review completed by an entity with fewer or no ties to the status quo policy and by a person or organization that is seen to be independent of the entire government and therefore “objective.” This “independence” is an important feature if the governing party wants the latter to open up the inquiry to the general citizenry to get its input.

There are a number of potential vehicles available to governing parties at the federal and provincial levels, each with different attributes. Three of the more common instruments are compared in Table 1. Each has its advantages and its disadvantages. No one instrument is inherently superior to the others. More importantly, the very structural characteristic that is a strength in one set of circumstances can become a weakness in a different set of circumstances. Without doubt, these instruments can be used by governments as a means to “buy time”, to delay making decisions on extremely difficult and controversial policy changes. Or they can be used to seek out external validation for a policy direction already decided but not yet acceptable to the general public. Such uses, however, can come at a high political price as the Canadian public and media is far less accepting of these less than justifiable uses than in the past.

Table 1: External Instruments Available for Extraordinary Policy Review

TYPE OF INSTRUMENT	TEMPORARY OR PERMANENT	POLICY CAPACITY	NEW RESEARCH EVIDENCE	PUBLIC CONSULTATIONS	INDEPENDENCE FROM GOVERNMENT	PUBLIC REPORTING
PERMANENT EXTERNAL ADVISORY BODY	Permanent	Can be extensive	Varies	None to limited	Yes	Yes
MINISTERIAL TASK FORCE	Temporary	Varies considerably	Varies (no strong expectation)	Can be extensive	Yes/ No	Yes/ No
ROYAL COMMISSION	Temporary	Extensive	Yes (strong expectation)	Extensive	Yes	Yes

The permanent external advisory body – a law reform commission for example – should provide ongoing advice aimed at fundamental reform in one policy subject area. As specialized organizations with a lengthy tenure, their policy capacity is generally quite extensive. They are structured to be arm’s length, and therefore independent, from government. Their reports are made public although generally targeted to those that have are directly affected by their recommendations. Traditionally, external advisory bodies have not held consultations with the general public although they are at least informally in touch with the organized stakeholders in the system.

The strength of permanent advisory bodies is that they provide a very long-term stream of focused advice to governments. Their weakness is that interest in the body’s work can decrease with time as the system adjusts to the general tenor of the advice and the novelty wears off. On a more negative note, some permanent advisory bodies have been know to become overly influenced, or even captured, by the powerful interest groups that populate their subject area thereby reducing the utility of the policy advice they offer.

Departmental or ministerial task forces are temporary external advisory bodies appointed by the minister of a department or, in some cases, the first minister on behalf of the minister of the affected department. At least four recent provincial health “commissions” – the Sinclair Commission in Ontario⁸, the Clair Commission in Quebec⁹, the Fyke Commission in Saskatchewan¹⁰, and the Mazankowski Task Force in Alberta¹¹ – are all Ministerial task forces. The National Forum on Health was established as a federal Ministerial task force, delivering its report to the Prime Minister and the Minister of Health Canada (as co-chairs) in 1997.¹²

Ministerial task forces are sometimes seen as too tied to the governments that create them, a perception reinforced by the fact that many of their supporting personnel are often drawn from the appointing Ministry even if the Chairperson and committee members are drawn from outside government.¹³ The external task force, however, can be seen as independent if the external individuals appointed are seen as independent and behave accordingly, including conducting extensive public consultations. The advantage is such a task force can draw quite extensively on the resources of the given government department, including a number of departmental personnel. The disadvantage is that the task force may be perceived as dependent on the department and its advice. I think this may be one of the reasons that, in Canada, these instruments are generally referred to as Ministerial task forces rather than departmental task forces, the general descriptor used in the United Kingdom.¹⁴

Royal commissions are the third extraordinary instrument available to both federal and provincial governments for fundamental policy review. Created under Part I of the *Inquiries Act*, federal royal commissions come in two varieties. They are either

policy commissions or investigative commissions of inquiry. The former are mandated to research and develop policy options with public input on wide-ranging issues while the latter are judicial inquiries generally set up to investigate individual or institutional misconduct. Unlike the United Kingdom where two separate pieces of legislation govern these two quite distinct processes, Canadian royal commissions operate under a single piece of legislation.¹⁵

Some recent federal commissions of the policy type include the Royal Commission on Aboriginal Peoples (RCAP) of the early 1990s, and the Royal Commission on Canada's Economic Union and Development Prospects (Macdonald Commission) of the early 1980s.¹⁶ As for provincial royal commissions, there have been very few during the last two decades, although at least three – the Quebec Commission on Health and Social Services (the Rochon Commission)¹⁷, the Newfoundland Royal Commission on Hospital and Nursing Homes Costs and the Nova Scotia Royal Commission on Health Care – did deal with aspects of health care reform in the 1980s.¹⁸

The royal commission has two principle advantages. As an organization created under the federal Inquiries Act or its provincial equivalent, it has legal autonomy from the government in power. As Peter Aucoin has pointed out, a royal commission can be a government's "most effective option" because of its "greater capacity to be, and to be seen to be, independent and objective" than other potential instruments.¹⁹

In addition, policy-oriented royal commissions are provided with the budget necessary to conduct their own, intensive, research independent of government. Indeed, they are expected to conduct scholarly social science research that will be published in order to meet the implicit educational portion of their mandates.²⁰ Royal commissions

have had a tradition of sponsoring external research that it then draws upon to whatever extent the commission deems useful or relevant. Unlike most ministerial task forces, the work itself is often then published under the researcher's name either under the auspices of the commission or independently after the commission has completed its work. This work can lead to contradictions with the commission's analysis and recommendations but is highly tolerated.²¹

Finally, as Seymour Wilson put it, royal commissions provide an "open, extra-Parliamentary, forum for policy discussion." This "public consultation" function is important enough that it is explicitly written into the order-in-council mandates for royal commissions. In Jane Jenson's words, royal commissions are "institutions that provide representation by providing access for individuals and groups to a forum of debate and policy-making." Historically, they have been the locales for some of the major shifts in the ways that Canadians debate representations of themselves, their present and their futures. These representations are "crucial, not only to policy-making, but to politics in the largest sense", according to Jenson, "because they set out the terms of who we are, where we have been and what we might become."²² When royal commissions succeed in doing this, they can have a generational impact on Canadians even if the recommendations are not picked up by governments in the immediate term.

Royal commissions also have significant disadvantages. Independent, they can easily go beyond the mandates and time lines initially set by governments. And they almost invariably cost more than ministerial task forces because their research, consultations and infrastructure costs are not borne or subsidized by existing government institutions. These are well-known features in the history of royal commissions, and as a

consequence, governments are highly resistant to using this instrument where another, less costly or less time-consuming instrument, might do as well.

My own use of the word “extraordinary” reflects my own view that none of the instruments described in Table 1 should be used unless necessary. As Tommy MacLeod pointed out long ago, it is likely counter-productive bypassing the civil service except in the most exceptional circumstances.²³ First of all, the civil service does have detailed subject knowledge of the policy area and will certainly know more about how different policy options can actually be implemented. Second, from the perspective of the citizen and taxpayer, we are already paying for this governmental machinery so why not use it to its full potential.

The question is whether you truly require an off ramp from normal governmental processes in order to obtain more innovative and higher quality policy advice. Certainly, this proposition could be used to test the past output of external advisory bodies, committees, task forces and commissions relative to what was being offered to cabinet by the civil service just before the decision was made to take the off ramp.

In any case, even when their use is justified, these extraordinary instruments are supplements to the governmental decision-making process, not replacements for it. The ultimate reports produced by these extraordinary instruments are, in the end, only advisory to governments. It is the democratic responsibility of the political tier of government to make final policy decisions. On this last point, it has always been a false criticism of task forces and commissions that they are of limited value because no government has to adopt their recommendations. The argument is not only

fundamentally flawed in terms of democratic theory but misunderstands as well the nature of public policy formulation.

As illustrated in Figure 1, a task force, committee or commission report gets back into the regular policy cycle through cabinet selecting which, if any, of the recommendations it wants to proceed with. The civil service is left with the task of designing the options that will give life to the recommendations. These are then brought back to cabinet for decision and, quite often, returned to the civil service for further refinement.

This is a very important step given that most external reports are focused on ultimate destinations rather than the various ways a government can get from point A (the status quo) to point B (the recommended destination), and as we all know the extent to which the “devil can lie in the details.” This process, including the political job of cabinet selecting among a series of controversial options, can take a very long time.

Choice of Extraordinary Instrument: The Royal Commission

Once a decision is made in favour of getting “outside help”, governments must carefully consider the choice of instrument. In terms of independence, cost and time, royal commissions are the most “extraordinary” of the extraordinary instruments available to government when it requires a temporary (although not necessarily brief) off ramp from the regular policy life cycle. In my view, royal commissions should be restricted to cases where:

- The policy problem at hand is both significant and fundamental in nature therefore eventually requiring a basic directional decision by government;

- The particular policy problem and its potential solutions would benefit from being fully aired in public;
- The policy problem and its proposed solutions would benefit from drawing, in a temporary organization special built for the purpose, on research and analysis from individuals and groups outside government;
- The extensive consultations with the general public and interested stakeholders are better conducted by a legally independent third party from government;
- The government itself has fundamental questions about the direction and options surrounding the policy problem in question and it is willing to wait for the deliberations and recommendations of a royal commission; and
- The government needs a creative road map (i.e. implementation detail) of how to get from the status quo to a new and quite different policy destination.

I think most, if not all, of the above conditions have been met in terms of the policy debate swirling around the future of public health care in Canada today. First, take the issue of sustainability from a narrow fiscal federalism standpoint. Provinces have been arguing for years that the decline in federal cash transfers was a critical element in the financial sustainability of Medicare. The federal government has, in turn, argued that despite the decline in transfers starting in 1995, federal financial support has been substantially increased in the last three years. Whatever the merits in the debate, Canadians know that any government offloading of services that are currently covered under Medicare will be picked up by them through out-of-pocket payments. This may be reason enough to push the “locale” of the debate from governments to a third party such

as a royal commission independent of both orders of government. If not reason enough, however, you could point to the current “crisis” of confidence by the general public in the quality and timeliness of delivery of health care services. Strong evidence of this can be found in polling as well as in media coverage on problems. Whatever the source of their angst, Canadians are, for the first time since its introduction in the 1960s, expressing great concerns about the sustainability of Medicare.

This is unsurprising in one sense. There have been major systemic changes since Medicare was first introduced. Much more health care is delivered outside hospitals and doctors’ offices, the traditional core services of the public system. As a consequence, more and more important medical services are falling outside of public coverage. We now pay more for prescription drugs than for physicians in this country yet most public drug coverage (outside hospitals) by the provinces and territories is limited to the very poor. There has been a sharp rise in chronic diseases that require more home care and long-term care outside of hospitals yet we continue to focus our public coverage on hospital care.

The reasons for the current policy angst go beyond these systemic changes, however. They even go beyond the average citizen’s immediate concerns about quality, timeliness, cost and sustainability today. Canadians are suffering collective angst because of their intuitive knowledge that their governments are at the precipice of making major directional decisions concerning the future of Medicare. But they are confused on the fundamental direction of this change.

On one side, supported by the findings of the National Forum on Health and numerous health policy experts, they are encouraged to continue going down the road of

expanding universal, public coverage beyond hospital and physician care to prescription drug care, home care and long term care. On the other side, they are told that we must limit public coverage for hospitals and doctors (or replace it with private coverage), and that we need to reduce unnecessary utilization through patient co-payments and user fees.

As I discussed earlier, governments throughout this country are responding to this collective angst through a variety of extraordinary instruments. While Quebec, Saskatchewan and Alberta used ministerial task forces, other governments have chosen to rely on their internal policy formulation mechanisms even while supplementing these with external consultations conducted directly by government. This has been the approach taken by some provinces, including Ontario, New Brunswick, and Newfoundland. In April 2001, the federal government itself decided to create a royal commission with a mandate to consult and do research on the future of the health care in Canada with a final report due before the end of 2002. Along with this is a Standing Senate Committee on Social Affairs, Science and Technology that began its inquiry into the federal role in health care policy in December 1999.²⁴

While this appears to be an unprecedented amount of activity, it is symptomatic of a basic re-thinking of our health care system today. As Canadians, it is worth reminding ourselves that we have been there before.

The Hall Commission

The late 1950s and early 1960s were a difficult time for both Canadians and their governments in terms of health care policy, specifically as it related to public coverage. Beginning in 1957, hospitalization was introduced nationally. Universal public coverage

for catastrophic health care quickly became the accepted policy throughout Canada. However, a huge debate surrounded the question of whether a universal, single-payer, income tax-funded system of public coverage should be extended to physician services. The alternative, a multi-payer system of private insurance, had grown dramatically in the postwar period and seemed a viable alternative, particularly when combined with targeted, means-tested, public coverage for the very poor.

Although many Canadians were attracted to the notion of expanding public coverage, governments were divided for both ideological and financial reasons. The Diefenbaker government was itself torn on the issue and appointed the Royal Commission on Health Services (the Hall Commission) in June 1961 to help it sort out the future policy direction for the country. When he first announced the Commission in the House of Commons, Diefenbaker read a letter he had just received from the Canadian Medical Association requesting such a commission. At the time, the CMA was strongly in support of the private coverage option (combined with publicly-paid or subsidized private insurance coverage for the poor) and hoped that a federal commission might preempt any move towards government-sponsored universal coverage.²⁵

By this time, two provincial governments were adding to the polarization by introducing quite different models: Saskatchewan with public Medicare; and Alberta with a targeted system built on voluntary private insurance coverage that many journalists dubbed “Manningcare” after the Alberta premier of the day, Ernest Manning. To further add to the polarized environment, Saskatchewan went through a bitter doctors strike that divided the province into warring camps while implementing Medicare in 1962. Covered

extensively by the North American media, the confrontation put a spotlight on what quickly became a pan-Canadian public policy debate.²⁶

Emmett Hall and his commission members did their best to distance themselves from the growing controversy. He repeatedly said that his commission was about health care more broadly defined and was upset that his hearings became the focal point for a narrower debate about whether public coverage should be extended beyond hospitals to physicians' services. In the Regina hearing in January 1962, he went "out of his way to say that the commission had no intention of 'taking sides' in the simmering dispute" and sharply questioned the Saskatchewan health minister on his pro-Medicare submission.²⁷

The Final Report, delivered two years later, came as a surprise to many. Hall went far further than anyone expected in recommending the extension of comprehensive and universal public coverage beyond hospital care for:

- Medical services;
- Prescription drugs;
- Home Care services;
- Prosthetic services;
- Dental services, for children, pregnant mothers, and welfare recipients; and,
- Optical services, for children and welfare recipients.

For good measure, Hall threw in a proposed *Health Charter for Canadians*, the goal of which was the "achievement of the highest possible health standards for all" Canadians and that this "become a primary objective of national policy" as well as a cohesive factor contributing to national unity." This was, in the report's words, "best

achieved through a comprehensive, universal Health Services Programme for the Canadian people.”²⁸

Hall turned over his expansive menu (or, as some said at the time, his “expensive” menu) to Prime Minister Pearson’s Liberal government. Hall suggested that Ottawa use the federal spending power to entice the provinces into introducing public coverage, adding that the provinces should exercise “the right to determine the order of priority of each service and the timing of its introduction.”²⁹

Pearson first had to deal with the division within his own cabinet between those who supported the immediate introduction of Medicare (the word that had become a synonym for public coverage beyond hospital care although how much beyond had not yet been defined) and those that wanted to wait until public finances were on a more solid footing. After preparatory work by key civil servants accompanied by much strife within the cabinet and caucus, the Medicare bill was finally passed in December 1966, with a late start date of July 1968 to begin negotiations with the provinces and territories. These negotiations would take almost four years to complete. The reason for this is simple: provincial governments (cabinets and bureaucracies), particularly those with deeply rooted systems of private coverage, had to carefully work out the ways in which public coverage could be introduced with minimal disruption to private insurers and doctors as well as to their own budgets. In the end, it would take a total of eight years to implement Hall’s one recommendation on public coverage for physician services throughout Canada.³⁰

We must always be careful with historical facts, particularly when they conflict with current conventional wisdom. Today, the Hall report is viewed as one of the more

successful royal commissions in our history in terms of its “big bang” impact and speed of adoption. I am sure that it did not feel like that to Emmett Hall as he waited from 1964 until 1972 to see his report recommendations implemented, and even then, only partially adopted.³¹

Conclusion

While there are some striking similarities in terms of the policy debate of the early 1960s and today, much has also changed since the Hall Commission such as medical technology and research as well the locus of delivery caused by changes in our patterns of disease, injury, illness and health to give only two examples. These changes have had an impact on our notions of comprehensiveness and accessibility as described under the *Canada Health Act* services that constitute the core of Medicare. It is now more difficult to see a health care system as “comprehensive” if it is limited to hospital and physician services. It is equally difficult to define our access to home care and long term care services for the chronically ill – access that continues to be based more on ability to pay than on need – as the kind of “accessibility” foreseen by the architects of Medicare.

As in the early 1960s, a basic directional decision on Medicare is now required. Despite their ideological predilections, governments are in a genuine quandary about what to do. More right-of-centre governments would like to see the private sector take up some of the space currently covered by public actors or public administration in the current system but face electorates that are uneasy about such changes. Left-of-centre governments would prefer to keep or expand public coverage but are concerned about their ability to continue funding health care out of their general revenue funds without

cutting into other important public services. Citizens themselves are very concerned, knowing that they will ultimately pay the growing bill for health care, either through their taxes or directly out of pocket. At the same time, most are very proud of, and very attached to, a social policy that has come to define their citizenship more than any other single policy.

In the circumstances, I would argue that an independent royal commission calling upon the best research and policy analysis available as well as conducting a dialogue with the Canadian public could be extremely useful. To save money and time, however, it should avoid as much overlap with, and duplication of, the work of other task forces, committees and commissions to the greatest extent possible. To provide clarity, it must produce a final report with hard decisions on the most difficult, directional matters. And to provide direction, it must produce a report with viable and politically feasible recommendations.

In the end, however, it will be governments that shall make the final decisions on a royal commission's recommendations. At the point of cabinet decision and implementation, the function of the extraordinary policy review will have come to an end, and health care policy will again be subject to the internal policy cycle where it will hopefully remain for at least a few years.

ENDNOTES

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- ¹ T.R. Dye, *Understanding Public Policy, 9th Edition* (Englewood Cliffs, NJ: Prectice Hall, 1998).
- ² Both are quoted in M. Howlett and M. Ramesh, *Studying Public Policy: Policy Cycles and Policy Subsystems* (Toronto: Oxford University Press, 1995).
- ³ G.P. Marchildon, “Policy, Delivery and Engagement in an Era of Continuous Change”, speech delivered to the Public Management Development Partnership Conference, Regina, February 15, 2001.
- ⁴ I am indebted to Lloyd Barber who used this very useful “two tiers of government” analogy during a recent panel discussion with myself and Art Wakabayashi.
- ⁵ N. Bradford, “Innovation by Commission: Policy Paradigms and the Canadian Political System”, in J. Bickerton and A. Gagnon, eds., *Canadian Politics, 3rd Edition* (Peterborough: Broadview Press, 1999), 541.
- ⁶ On the limitations of Parliamentary and Senate committees, see J.E. Hodgetts, “Should Canada be De-Commissioned? A Commoner’s View of Royal Commissions”, *Queen’s Quarterly*, Vol. 70 (1964), 480.
- ⁷ N. Bradford, “Innovation by Commission”, 546.
- ⁸ The Ontario Health Services Restructuring Commission was established as an advisory body to the Ontario Minister of Health in 1996. Chaired by Duncan G. Sinclair, its report – *Looking Back, Looking Forward* – appeared in 2000.
- ⁹ The *Commission d’étude sur les services de santé et les services sociaux* (Commission of study on health and social services) was legally created on June 15, 2000. An advisory Committee to the Quebec Minister of State for Health and Social Services, it was chaired by Michel Clair who worked with nine other appointed Commissioners. The Clair Commission’s final report, *Emerging Solutions*, was issued in late December 2000.
- ¹⁰ Legally created on June 14, 2000, The *Commission on Medicare* was an advisory body to the Premier under a sole Commissior, Kenneth J. Fyke. The Fyke Commission’s final report, *Caring for Medicare: Sustaining a Quality System* was issued in April 2001.
- ¹¹ The *Premier’s Advisory Council on Health* was established by the Alberta government in August 2000. Former Deputy Prime Minister Don Mazankowski was appointed chair of the 12 person advisory body that issued its final report – *A Framework for Reform* – in December 2001 (and publicly released one month later).
- ¹² The National Forum on Health was first established in October 1994 with 24 member advisors. Its final report – *Canada Health Action: Building on the Legacy* – was delivered in January 1997.
- ¹³ F. Schindler and C.M. Lanphier, “Social Science Research and Participatory Democracy in Canada”, *Canadian Public Administration*, Vol. 12 (1969), 486.
- ¹⁴ On Royal Commissions and departmental committees in the UK, see: T.J. Cartwright, *Royal Commissions and Departmental Committees in Britain: A Case-Study in Institutional Adpativeness and Public Participation in Government* (London: Hodder and Stoughton, 1975). R.A. Chapman, ed., *The Role of Commissions in Policy-Making* (London: George Allen and Unwin, 1977). There are few parallels to Royal Commission in countries with non-Parliamentary systems of government such as the United States: see C.J. Hanser, *Guide to Decision: The Royal Commission* (Totowa, NJ: Bedminster Press, 1967), 225.
- ¹⁵ N. d’Ombrain, “Public Inquiries in Canada”, *Canadian Public Administration*, Vol. 40 (1997).
- ¹⁶ N. Bradford, “Writing Public Philosophy: Canada’s Royal Commissions on everything”, *Journal of Canadian Studies*, Vol. 34 (1999/2000).
- ¹⁷ The *Commission d’enquête sur les services de santé et les services sociaux*, chaired by Jean Rochon (June 1985-December 1987), was a provincial royal commission even though the word “royal” was not used in its official title.
- ¹⁸ D.E. Angus, *Review of Significant Health Care Commissions and Task Forces since 1983-84* (Ottawa: Canadian Hospital Association, Canadian Medical Association and Canadian Nurses Association, 1991).
- ¹⁹ P. Aucoin, “Contributions of Commissions of Inquiry to Policy Analysis: An Evaluation”, in A.P. Pross, I. Christie and J.A. Yogis, eds., *Commissions of Inquiry* (Toronto: Carswell, 1990).
- ²⁰ As a consequence of the controversy over the allegedly inadequate and secretive research efforts of the Royal Commission on New Reproductive Technologies (the Baird Commission), the Social Science Federation of Canada introduced guidelines on the conduct of scholarly research by royal commissions.

See J. Jenson, "Commissioning Ideas: Representations and Royal Commissions", in S. Phillips, ed., *How Ottawa Spends, 1994-95: Making Change* (Ottawa: Carleton University Press, 1994), 43.

²¹ G.B. Doern, "The Role of Royal Commissions in the General Policy Process and in Federal-Provincial Relations", *Canadian Public Administration*, Vol. 10 (1967).

²² Jenson, "Commissioning Ideas", 39-40.

²³ T.H. McLeod, "Glassco Commission Report", *Canadian Public Administration*, Vol. 6 (1963).

²⁴ This Standing Senate Committee is made up of 12 senators and is chaired by Michael J.L. Kirby. It has produced four reports thus far: *Volume 1: Historical Background and Overview* (March 2001); *Volume 2: Current Trends and Future Challenges* (January 2002); *Volume 3: Health Care Systems in Other Countries* (January 2002); and *Volume 4: Issues and Options* (September 2001). The fifth and final volume, including recommendations, is expected by June 2002.

²⁵ D. Gruending, *Emmett Hall: Establishment Radical* (Toronto: Macmillan, 1985), 81.

²⁶ E.A. Tollefson, *Bitter Medicine: The Saskatchewan Medicare Feud* (Saskatoon: Modern Press, 1964).

²⁷ Gruending, *Emmett Hall*, 88-9.

²⁸ *Royal Commission on Health Services [Hall Report], Vol. 1* (Ottawa: Queen's Printer, 1964), 11.

²⁹ *Hall Report*, 19.

³⁰ M.G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System* (Montreal: McGill-Queen's University Press, 1977), chapter 6.

³¹ Writing in 1967, Bruce Doern's more extreme view was that "many" of Hall's recommendations "were basically rejected by the federal government." See G.B. Doern, "The Role of Royal Commissions in the General Policy Process and in Federal-Provincial Relations", *Canadian Public Administration*, Vol. 10 (1967), 426.

About the Author

Dr. Gregory Marchildon completed his Bachelor of Arts and Masters of Arts in History and Economics at the University of Regina. He earned his Bachelor of Laws at the University of Saskatchewan and his PhD in Economic History at the London School of Economics and Political Science. Dr. Marchildon most recently served as Deputy Minister to the Premier and Cabinet Secretary in Saskatchewan. Concurrently, he was also an adjunct professor in the Faculty of Administration at the University of Regina and the Department of Agricultural Economics at the University of Saskatchewan. Upon leaving the government in September 2000, he became the Government of Saskatchewan Senior Fellow at SIPP as well as a Visiting Fellow in the School of Policy Studies at Queen's University. In April 2001, he was appointed Executive Director of the Commission on the Future of Health Care in Canada by Roy Romanow, the sole chair of the Commission. He is the author of numerous articles, books and edited books on subjects ranging from economic history to contemporary policy.

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